UNIVERSITY OF KWAZULU-NATAL

EXPLORING THE PERCEPTIONS OF QUALITY NURSING CARE AMONG NURSES WORKING IN TWO DISTRICT HOSPITALS IN RWANDA

Gilbert BANAMWANA

2011

UNIVERSITY OF KWAZULU-NATAL

EXPLORING THE PERCEPTIONS OF QUALITY NURSING CARE AMONG NURSES WORKING IN TWO DISTRICT HOSPITALS IN RWANDA

2011

BY

Researcher: Gilbert BANAMWANA

Supervisor: Ms Nondumiso SHANGASE

EXPLORING THE PERCEPTIONS OF QUALITY NURSING CARE AMONG NURSES WORKING IN TWO DISTRICT HOSPITALS IN RWANDA

Gilbert Banamwana (Student Number: 209510754)

Dissertation submitted in partial fulfilment of the requirements for the degree of Masters in Nursing (Nursing Management), School of Nursing

Faculty of Health Sciences

University of KwaZulu-Natal

Supervisor: Ms Nondumiso Shangase

Year: 2011

DECLARATION

I, Gilbert BANAMWANA declare that this dissertation entitled: **"EXPLORING THE PERCEPTIONS OF QUALITY NURSING CARE AMONG NURSES WORKING IN TWO DISTRICT HOSPITALS IN RWANDA"** is my own work and has not been submitted for any other degree or examination in a University other than the University of KwaZulu-Natal. I have provided complete acknowledgements to the resources referred to in this study.

……

Signature (Gilbert Banamwana)

Date:……..

……

Signature (Ms Nondumiso Shangase)

Date:……..

DEDICATION

This dissertation is dedicated to my wife, Albertine Muhimpundu, and our beloved son, Samuel Dushimimana, for their willingness and acquiescence to stay in Rwanda while I was undertaking my scholarly journey in the Republic of South Africa.

ACKNOWLEDGEMENTS

This dissertation is a critical milestone that I have achieved and has come to an end owing to concerted efforts of a great many people. First of all, I owe thanks to Jesus Christ for the gift of life, unconditional love, mercy and fulfilment of his promise in my regard.

I wish to express my gratitude to my supervisor Ms. Shangase Nondumiso for her patience, support, advice, guidance and encouragement during my tough times while conducting this investigation. Thank you for raising my hope, teaching me to be confident in myself and guiding me during this research project.

I am grateful to Ms. Ninon Larché for translating the section A and B of the instrument and the informed consent into French; and to Ms. Jennifer Chipps and Fikile Nkwanyana for helping with the data analysis phase of this study and by so doing making the study statistically sound. I do not know how to express my deepest debt to you, Ms. A. (Mandy) Smith, for your critical comments during the early stage of this study and Mrs. Margaret Addis for genuine, expertise, and excellent help displayed while editing this work.

I extend my gratitude to the two Directors and two Chief Nursing Service Managers of the two district hospitals, namely Dr Jules Mushingantahe and Dorothée Bamurange and Dr Osée Sebatunzi and Jacqueline Uwamahoro respectively, for offering the research settings and assistance while recruiting the study participants. In this perspective, I also owe warm thanks to the participants in this study without their willing acquiescence of whom this dissertation would not be possible.

I am indebted to the Government of Rwanda, via the Rwanda Education Board (REB), my sponsor, for the financial support of my studies. As I do this, I take this opportunity to express my deepest appreciation and sincere thanks to the Kigali Health Institute, especially to former Rector Dr Desire Ndushabandi and Mrs. Donatilla Mukamana, for opening up new academic horizons for me.

My special thanks go to you Mrs. Marie Chantal Uwimana for the collaboration, commitment and wise advice that you directed to this study, despite your daily responsibilities. I cannot forget you, Alexis Harerimana, for your initiative and effort to shape my computer literacy.

My sincere gratitude goes to all my family members, relatives and friends, both in Durban and Rwanda, for their invaluable contribution to this study.

ABSTRACT

It has been reported for over the last decade that the quality of nursing care provided towards patients has decreased tremendously. The literature shows the impact of poor quality nursing to patients and assumes the influence of nurses' perceptions of quality nursing care on its delivery. However, studies about such perceptions are still few in Rwanda.

Aim: The purpose of this study was to explore the perceptions of quality nursing care among nurses working in two district hospitals in Rwanda.

Methodology: A non-experimental exploratory descriptive design which was quantitative in nature was used. A self-report questionnaire comprised items related to socio-demographic characteristics of participants, perceptions of quality nursing care, nurses' role in continuous quality improvement and factors affecting the delivery of quality nursing care. The sample was obtained through a purposive non-probability sampling of the nurses (n=150) who were available during data collection from 16 to 28 October 2011, with a return rate of 110 (73%) of completed questionnaires.

Results: The findings from demographic data indicated that many of nurses were young, with 48.2% falling into the 20 to 30 year old bracket and the majority of the participants (83.3%) were enrolled nurses. Many of the participants were new to the nursing profession, with 47.2% falling into the 6 months-5 years working experience bracket. This study suggests that nurses had an appropriate perception of quality nursing care, as evidenced by the mean score of 4.183 (SD: .5741), related to nurses' understanding of quality nursing care with mean score of 4.137 (SD: .5763) for the perceptions of the delivery of quality nursing care. The role played by nurses in continuous quality improvement was evident, but it was constrained by the factors related their nursing practice environment, including: shortage of nurses, lack of time, heavier workloads, and few opportunities for advancement.

Conclusion: In summary, this study provided insights into nurses' perceptions of quality nursing care, and their current ongoing endeavours to provide quality improvement in spite of challenges in their workforce environment. This study has described the challenges which interfere with the delivery of quality nursing care that need to be addressed so that patients may benefit from evidence-based care.

TABLE OF CONTENTS

LIST OF ABBREVIATIONS AND ACRONYMS

ACHA: American College Health Association

CQI: Continuous Quality Improvement

HRH: Human Resources for Health

Md: Median

MoH: Ministry of Health

NHS: National Health Services

PBF: Performance Based-Financing

PCOM: Process of Care and Outcomes Model

PhD: Doctor of Philosophy

PIN: Partners in Health

QHOM: Quality Health Outcome Model

QI: Quality Improvement

RN: Registered Nurses

SD: Standard Deviation

SPSS: Statistical Package for the Social Sciences

UK: United Kingdom

USA: United States of America

WHO: World Health Organization

LIST OF TABLES

LIST OF FIGURES

CHAPTER ONE: INTRODUCTION TO THE STUDY

1.1. INTRODUCTION

It has been reported over the last decade that the quality of nursing care provided to patients has decreased tremendously (Arries, 2006). This is reflected by the number of clients who have reported being overlooked by nurses during the provision of nursing care during their hospitalization (Sturgeon, 2010). Similarly, the findings from the American investigation by Thomas, Studder, Burstin, Rav, Zyeena and Williams (2000) portrayed that the occurrence of the incidence of medical events was soaring to such an extent that 3% to 4% of the patients were seriously ill due to those events. These observations are similar to the findings from a Canadian study by Baker, Norton, Flintoft, Blais, Brown, Cox and Etchells, (2004), who found cases of about one to two hundred patients who almost died as a result of circumstances that could have been averted if the patients had received the nurses' vigilance and attention. The negative attitudes of nurses towards patients living with chronic diseases were reported to be unbearable (Boult, Green, Boult, Pacala, Snyder and Leff, 2009). These illustrations display the extent to which quality nursing care has become undermined and highlights the need for a deep investigation in order to understand the reasons for the emergence of such attitudes from the nurses' perspectives (Hall, Moore and Barnsteiner, 2008). In light of this, it is important to unfold the significance of quality and quality nursing care.

Scholars have speculated about the origin of the concept of quality care and have inferred that it originated in America (Anderson, 2010). The wealth of the literature regarding nursing practice credits Florence Nightingale as being the proponent of the quality of care and its use (Hogston, 1995b). The concept of quality of care has been worked on over the past decades by a great deal of scholars (Atkinson, Ingham, Cheshire and Went, 2010; Currie, Harvey, West, McKenna and Keeney, 2005; Booyens, 1998). Thus, quality has been explained as a composite of different dimensions which include accessibility, acceptability, appropriateness, effectiveness, efficiency, and equity (Maxwell, 1984). Quality of care has also been defined as a care that is safe, timely, effective, efficient, equitable, and patient-centred (Institute of Medicine, 2001). In a study conducted in the United States of America (USA) by Carson, Carson, and Roe (1998), professionals view quality care as doing things right. They

emphasise treatment efficacy, appropriateness and doing well, and focus on treatment availability, timeliness, continuity, safety, and efficiency. According to Kunaviktikul, Anders, Srisuphan, Chontawan, Nuntasupawat and Pumarporn (2001), quality of nursing care refers to the nursing interventions rendered to patients with a view to meeting the patients' needs, taking into account their physical, psychological, emotional, social and spiritual dimensions. To sum up, Gunther and Alligood (2002) maintained that quality of care is not a single, homogenous variable, but rather a complex construct articulating values, beliefs and attitudes of individuals involved in health care interactions. Therefore, with a view to the continuous maintenance of quality nursing care, it is important to consider the different views held by major health care stakeholders (patients, providers, payers and the public) while defining quality of care (Huycke and Anita, 2000).

For continuity of quality nursing care, it is essential that quality is monitored (Lang, 1976). To monitor quality nursing care it is important to put in place quality assurance strategies (Manghani, 2011). This was stressed by Lang (1976) when he proposed a quality assurance model that was built on societal values, professional values and current scientific knowledge. Quality assurance and quality control are used simultaneously as components of quality management. Quality control is concerned with carrying out the quality requirements, while quality assurance ensures that quality requirements are implemented (Manghani, 2011). For maintaining quality assurance, it is important to set out the standards by which the nursing interventions are to be measured (Meyer, Naudé, Shangase and van de Niekerk, 2009). This process of incorporating and maintaining quality of care in nursing practice is known as total quality management (Huber, 2010).

In the nursing profession, the measurements of quality care are performed by formulating adequate professional standards resulting in quality improvement (Arries, 2006). Improving quality care in nursing is to provide harm-free nursing interventions and promote effectiveness, patient-centeredness, timeliness, efficiency, equity and sustainability of care (Atkinson et al., 2010). It is of note that the measurements are to be assessed based on the indicators. With this in mind, Pazargadi, Tafreshi, Abedsaeedi, Majd and Lankshear (2008) have delineated the nursing clinical indicators to include communication, documentation, patient/client care collaboration, patient/client care education, legal and ethical issues, patient/ client safety, the nurse therapist and professional development. Similarly, Zoschak

(2010) outlined the following ten (10) health measurements: patient safety, productivity, staffing effectiveness, regulatory requirements, leadership, education, performance improvement, shared governance, patient outcomes and magnet readiness (ability of hospitals to be recognized as meeting standards of practice for nursing excellence). Despite the fact that these clinical indicators are critical in maintaining quality care in the health system, many patients are reporting receiving poor quality nursing care (Farquhar, Kurtzman and Thomas, 2010).

According to Deming (1986), quoted by Anderson (2010), poor quality of care is inextricably intertwined with poor management. Carney (2009), in corroboration, linked the problem of poor quality care to ineffective leadership skills which engaged in poor goal setting, but failed to set priorities according to the needs of patients as well as staff. From the Iranian perspective, Pazargadi, Tafreshi, Abedsaeedi, Majd and Lankshear (2008) associated the lack of quality care to insufficient knowledge of nursing-sensitive quality indicators and lack of information of quality nursing care. The factors affecting nursing care organisations or structures have been well documented in attempts to deter severely substandard nursing care. These factors involve lack of appropriate standards within the organization, shortage of nurses, implicit duties, heavy workload, unclear and inflexible processes, unsupportive management, lack of fringe benefits as well as stressful work environments (Chiang and Lin, 2008; Alleyne and Jumaa, 2007; Ulrich, Buerhaus, Donelan, Norman and Dittus, 2005; Aiken, Clarke, Sloane, Sochalski and Silber, 2002b). In addition, Lucero, Lake and Aiken (2009) have documented certain technical constraints experienced by registered nurses which inhibit appropriate nursing care, such as new technologies, numerous providers' treatment recommendations, regulatory constraints and patients' illness severity.

The literature has documented various strategies that can be taken into account to enhance quality nursing care as they have proven to be sound in magnet hospitals. According to Buchan (1999), magnet hospitals mean those hospitals recognized as delivering high quality nursing care based on staff development, better working conditions and a staff retention policy. In this view, Van Bogaert, Meulelmans, Clarke, Vermeyen and Van de Heyning (2009) argue that to deliver quality nursing care, nurse managers and executives have to strain every nerve to create and support a nurse practice environment that attracts and retains professional nurses. This was one of the strategies adopted by the National Health Service

(NHS) in the United Kingdom (UK) which promoted a sustainable work environment and facilitated healthcare professionals to link management and leadership theories with clinical practice for streamlining the quality of the services offered to their patients (Alleyne and Jumaa, 2007).

In Rwanda, few formal studies have been conducted in relation to quality nursing care. Research that was carried out at a central level displayed some factors that undermine the provision of quality nursing care. These include poor staffing, lack of training, heavy workload, lack of policies and procedures and lack of infrastructure (Shahidi Twahirwa, 2009; Kabogora, 2008; Nkomeje, 2008; Uwayezu, 2006). Taking into consideration that quality nursing care is an issue faced by healthcare systems all over the world and that the few formal enquiries that have been undertaken in Rwanda did not explore nurses' perspectives of quality care, it is deemed necessary to explore the perceptions of quality nursing care among nurses in Rwanda, specifically in two district hospitals.

1.2. BACKGROUND TO THE STUDY

Exploring the nurses' perspectives of quality nursing care is imperative since nurses are the most appropriate persons to bring about effective changes within the health systems (Farquhar et al., 2010; Hall et al., 2008). Stichler and Weiss (2001: 60) argued that "*nurses' perceptions of quality nursing care are based on nurse-patient relationship, collaborative teamwork, and a work environment with resources and support for nurses in their patient care role"*. In a qualitative study conducted by the Ipsos MORI Social Research Institute (2010), findings showed that nurses believe that quality nursing care means looking after the patients, and making sure that they are comfortable and happy in their environment. Along the same line of thought, the Rhode Island Department of Health (1999), in Stichler and Weiss (2001) found that 65% of nurses believe that quality of care in a hospital means treating patients well and paying attention to their personal needs. However, these nurses attributed differences in quality to levels of staff training, and experience. To this end, Murphy (2007) understands quality nursing care as a care that is person centred and holistic, provided by knowledgeable and skilled staff who make an effort to know the patient better. Lynn and Moore (1997:188) documented the four dimensions of the nurses' perceptions of quality nursing care, which included: '*developing a relationship, therapeutics (supportive*

and nurturing care, and nursing care using a scientific approach); unit collaboration; environment and resources'.

To explore the concept of quality nursing care it is necessary to figure out the salient factors confronted by nurses in their daily nursing duties. Buerhaus, Donelan, Ulrich, Norman, Williams and Dittus (2005) and Teng, Hsiao and Chou (2010) conducted a survey to explore registered nurses and chief nursing officers' perceptions and found that lack of time was the main reason for failing to maintain quality of care. Additionally, short staffing, time demands and a stressful work environment were reported by hospital nurses in Belgium and Taiwan as obstacles to providing good nursing care to patients (Ma, Lee, Yang and Chang, 2009; Milisen, Abraham, Siebens, Darras and Dierckx de Casterle, 2006).

Even although nurses are capable of bringing about change that will enhance quality of care in health care delivery, those changes cannot emerge from a vacuum. High quality patient care requires a professional nursing practice environment embedded with high quality leadership and management, good staffing, trustful and mutual nurse-physician relationships, reasonable workloads and favourable working conditions (Van Bogaert et al., 2009; Milisen et al., 2006). Apart from those factors aforementioned, it has been documented that access to quality care training, professional development, involving the nurses in the functioning of the institution and empowering them in decision-making are key elements to heightening quality care in health systems (Roche and Duffield, 2010; Aiken, Clarke, Sloane, Lake and Cheney, 2008; Lake and Friese, 2006; Lake, 2002).

The Rwandan health system is a pyramidal system comprising of the central, intermediate and operational levels. The central level comprises the central departments of the Ministry of Health (MoH) and the national reference or tertiary hospitals geared to provide specialized care. The intermediate level involves the administration of the Department of Health which facilitates and guides the process of the operational level by providing the administrative, logistical, technical and political supervision. The operational level comprises of district hospitals and health centres. This level provides primary and secondary care and is confronted with issues of poor quality of care, whereby a lack of suitably qualified health professionals limits its functionality (WHO Regional Office for Africa, 2009; Kayonga, 2007).

According to the Ministry of Health's (2008) annual health report, the healthcare system of Rwanda is currently facing numerous problems, including the shortage of human resources, limited material resources, inadequate infrastructure and financial constraints. These limitations are exemplified by the fact that there is only one doctor per 18 000 people, one pharmacist for 38,000 people and one nurse per 1700 people. To grasp the severity of this staff scarcity, one can contrast this situation with that of United Kingdom (UK), where there are 123 nurses and 23 doctors per 10 000 population (Roxburgh, Taylor and Murebwayire, 2009). There are 13 doctors per 10 000 population and 28 nurses per 10 000 globally (World Health Organization, 2009). The figures quoted above pertaining to Rwanda clearly point out that nurses are the main care givers in that country. However, the high nurse patient-ratio of 1:1700 reflects a serious situation where nurses are not able to respond adequately to their daily nursing duties, thus making it difficult for them to improve the quality of care they provide to patients. This is supported by Sturgeon (2010), who states that the high number of patients, which is not commensurate with the number of nursing staff, jeopardizes the confidence of the nurses, thereby hampering their ability to provide high quality care.

The lack of human and other resources is particularly relevant to Rwanda, where nurses and other health professionals are still responding to the challenges resulting from the genocide of 1994. This is illustrated by the findings of a study conducted by Kalinganire (2010), who works for Access Project in Rwanda, a project which aims at assisting some of the health centres to run more efficiently by streamlining the health-related infrastructure. In this study, it is reported that over 300, 000 people living in sectors without a health centre travel six or more hours on foot to seek care in neighbouring sectors. This author emphasized the negative impact of inaccessibility to quality care which results in the emergence of disease as well as an increase in the maternal and child mortality rate.

It has been noted that nurses in Rwanda do not always perform their required duties with some being inconsistent in taking the patients' vital signs and others not recording children's weight (Mote and Richard, 2010). Sturgeon (2010) ascribed these behaviours to be in relation to low staffing, inadequate equipment and lack of incentives to nurses. This was supported by Francis (2010:400) who also identified the "*weak professional voice in management decisions*" as a contributory factor to poor standards of care. Van Bogaert et al. (2009) suggest that managers create and support nurses' work environment by allocating appropriate

nurse staffing, adequate nurse hours per patient-day, adequate patient to nurse ratios and involving nurses in hospital and unit policies. These management interventions are presently not realistic in Rwanda owing to the above patient ratio context.

In Rwanda, a focus of the MoH is to provide ongoing strategies that will improve the quality of health care, especially nursing care. The plan to build the capacity of Human Resource for Health (HRH) is to develop the skills of the health professionals through improved pre-service and in-service training, while also strengthening post-basic and post-graduate training. The plan to retain the capacity which has been created is to establish a support system to better manage health workers' performance, provide attractive compensation packages and ensure equitable utilization across the country (Ministry of Health, 2009). Ultimately, it has been suggested that the delivery of health services be built around the core competencies of its employees, who then provide the evidence-based services desired by its patients and clients (Carney, 2009).

1.3. PROBLEM STATEMENT

The issue of poor quality of care is of significant concern in health care system delivery, particularly in the nursing practice environment (Hurst, 2011; Kendall-Raynor, 2011; Sturgeon, 2010). Even although the factors affecting quality of care have been highlighted by a wealth of literature, few formal studies have been conducted to explore nurses' perceptions of quality nursing care, especially in the district hospitals in Rwanda.

Mote and Richard (2010) reported the extent to which quality nursing care is undermined among nurses in district hospitals and health centres in Rwanda. To illustrate this, Lee (2008), a physician who was working for Partners in Health [PIH] in Rwanda, reported that vital signs had not been taken, medications not administered and that prescribed screening tests had not been done. He also found some issues related to resources, namely inadequate staff to allow sustainable patient-to-doctor and patient-to-nurse ratios. This was supported by the WHO Regional Office for Africa (2009) reporting the insufficiency of nurses and the technical capacity of health facilities estimated to meet the minimum standards at 30%. As King (1981), referred to by Zimmerman (2007), has stated, a human being's perceptions of objects, persons and events influence his behaviour, social interaction, and health. Similarly, Burhans (2008) maintained that the way nurses perceive quality nursing care may influence the delivery of care rendered towards patients. Although a few studies have been carried out

in the Rwandan context, they have explored the factors affecting quality of care at tertiary level, but did not explore the perceptions of quality nursing care from the nurses' perspectives. Therefore, such studies are needed in district hospitals where the nursing practice environment is still challenged by poor quality services delivery and working conditions.

Although the Rwandan nursing practice environment is challenged by the shortage of nurses and limited infrastructure to provide high quality care, the contribution of nurses is invaluable. Considering the impact of poor quality nursing care on patient outcomes, it is suggested that exploring the perceptions of quality nursing care among nurses working in two district hospitals in Rwanda will be valuable in order to inform realistic context driven continuous quality improvement strategies.

1.4. PURPOSE OF THE STUDY

The aim of the study is to explore the perceptions of quality nursing care among nurses working in two district hospitals in Rwanda in order to inform realistic context driven continuous quality improvement strategies.

1.5. RESEARCH OBJECTIVES

The objectives of this study are:

1. To explore the nurses' perceptions of quality nursing care in two district hospitals;
2. To explore the nurses' perceptions of their role in providing continuous quality improvement (CQI) in the two district hospitals; and
3. To describe the factors affecting the quality of nursing care in the two district hospitals.

1.6. RESEARCH QUESTIONS

1. What are the nurses' perceptions of quality nursing care in the two district hospitals?
2. What is the role of nurses in providing continuous quality improvement in the two district hospitals?
3. What are the factors affecting the quality of nursing care in the two district hospitals?

1.7. SIGNIFICANCE OF THE STUDY

The results from this study could inform continuous quality improvement (CQI) strategies, current and future, not only in the two district hospitals, but could also be applied in other district hospitals in Rwanda as well. The hospital management may be informed of the factors affecting quality care enabling them to adopt new strategies for entrenching appropriate and adequate quality care in the nursing practice environment. Nurses may take cognizance of their critical role in quality improvement and this might positively influence their attitudes and perceptions towards CQI of care. Likewise, patients, family members, consumers and stakeholders could benefit from this study by receiving efficient, effective, timely and cost-effective nursing care interventions that improve health care outcomes.

The MoH and other stakeholders may be able to utilize the findings from this study to inform the development of education outcomes of interventions for further education, training and professional development for nurses and make the professional nursing practice environment in Rwanda more conducive to providing quality nursing care to Rwandan consumers.

1.8. OPERATIONAL DEFINITIONS

1.8.1. Perception

Perception is a belief or opinion, often held by many people and based on how things seem; the quality of being aware of things through the physical senses, especially sight or someone's ability to notice and understand things that are not obvious to other people (Cambrige Advanced Learner's Dictionary, 2008: 1054). This means that by asking nurses about their perception of nursing quality care, we are asking them to articulate what they expect or understand quality nursing care to be.

1.8.2. Quality nursing care

Quality nursing care is defined as care that is provided according to hospitals' standards and job requirements (Grujic, O'Sullivan and Wehrmacher, 1989). In the context of this study, quality nursing care is any nursing activity provided by nurses working in the two district hospitals to the patients in accordance with nursing standards of practice. The care rendered should be efficient, effective and cost-effective, timely and provide insight to the patient about the nursing interventions being implemented.

1.8.3. Nurse

For the purpose of this study, a nurse refers to both enrolled nurses (A2) and registered nurses (RN). An enrolled nurse is a nurse that has completed basic nursing, whereas a registered nurse is a nurse who has completed her professional courses in mental health, general nursing or midwifery. In the Rwandan context, a RN falls into three categories: advanced diploma in nursing (A1), a degree in nursing including: Bachelor, Honours or Masters ($A_{0);}$ and a Doctorate in nursing (PhD), according to Rwanda National Council of Nurses and Midwives (Musoni, 2009). All nurses in this study were working in two district hospitals in Rwanda.

1.8.4. Nurse practice environment

The construct nursing practice environment refers to the organizational characteristics of a work setting that facilitate or constrain professional nursing practice (Lake, 2002: 178). For the context of this study, the nurse practice environment is a practice setting that maximizes the health and wellbeing of nurses, quality patient outcomes and organizational performance in the two district hospitals (Pearson, Pallas, Thomson, Doucette, Tucker, Wiechula et al., 2006).

1.8.5. Continuous quality improvement

Continuous quality improvement (CQI) has been defined as a method of planning and implementing ongoing improvements in systems or processes to define quality health care as reflected by improved patient outcomes (Painter, 2010: 227).

1.8.6. Quality assurance

Quality assurance refers to all actions taken to be certain that standards and procedures are adhered to and that health services are provided for meeting the performance requirements (Manghani, 2011: 34).

1.9. CONCEPTUAL FRAMEWORK

1.9.1. Process of Care and Outcomes Model

The Process of Care and Outcomes Model [(PCOM) (Figure 1.1: 14)] will underpin this inquiry. It originates in Donabedian's (1966) three-demensional model involving structure, process and outcome measures. Structure standards are related to the attributes of nurses, of the materials and resources they possess, and of the practice nursing environment in which they work. Process standards include technical skills and interpersonal aspects of care as well

as nursing interventions. Outcome standards refer to improvements in status due to antecedent structures and processes (Miles and Vallish, 2010). Because the focus of Donabedian's model is based on a linear relationship between doing right things (processes) and having the right things happen (outcomes), the Process of Care and Outcomes Model will be used to explore the perceptions of nurses about quality nursing care. Of note is that the Process of Care and Outcome Model was developed based on the Quality Health Outcomes Model (QHOM), developed by the American Academy of Nursing (Lucero et al., 2009). The QHOM is used to explore the relationship between nursing interventions, client, system and outcomes (Mitchell, Ferketich and Jennings, 1998). The Process of Care and Outcomes Model incorporates elements of the structure-process-outcome and QHOM. The model posits a temporal relationship between the care environment, patient factors, the process of care and outcomes. The care environment, patient factors and the process of care have a direct relationship on outcomes (Lucero et al., 2009). This model has been adapted to suit this study by adding some concepts related to the care environment, patient demographics and process of care and outcomes.

1.9.1.1. Care environment

The traditional structural characteristics of the nursing and hospital organization are built into the care environment. Nursing care can be thought of as a healthcare organization's surveillance function for the early detection of deterioration in patients' health status. Since nurses are continually adapting to changes in the care environment and patients' health status, the association between the process of care and outcomes may be influenced by both the care environment and patient factors (Lucero et al., 2009).

The care environment encompasses hospital buildings such as amenities in the patient's room or in the service, health professionals and equipment (Kunkel, Rosenqvist and Westerling, 2007; Nguyen Thi, Briancon, Empereur and Guillemin, 2002). The organisational characteristics that are taken into considerations include budget, policy priorities, resources allocation, management, structure, culture and climate, workload, staff mix, and work environment (MeiLing, 2009; Hall and Doran, 2007; Schubert, Glass, Clarke, Schaffert-Witvliet and De Geest, 2007; Curtis, Cook, Wall, Angus, Bion, Kacmarek et al., 2006). Furthermore, the philosophy of care as an element of the care environment is concerned with the priority care standards, and local and national guidelines and procedures (Schubert et al., 2007). The care environment is also related to the attributes of nurses, such as their

knowledge, skills, experience and attitudes, that are necessary to provide nursing care interventions. The nursing practice environment is made up of an adequate resources/skill mix, interdisciplinary collaboration, nursing management, autonomy and responsibility (Schubert et al., 2007). It is of note that any variation in these environmental features is prone to impact negatively on the nursing quality care (Curtis et al., 2006).

1.9.1.2. Process of care

The process of care depends on the implementation of the nursing process in its entirety, that is, assessment, planning, implementing and evaluation using the nursing care plans. Nursing care is based on problem-solving and decision-making processes, which include several steps: assessment of the patient situation and identification of the potential problem, planning nursing interventions according to the patients' needs which have been identified, and implementation and evaluation of care. It is incumbent on nurses to evaluate the needs of every patient under his or her care for any eventual adjustment of the current care plans (Schubert et al., 2007). Collecting systematic data that can indicate how nursing process components are related to patient outcomes will result in having a way of determining the effectiveness of quality improvement initiatives (Yen and Lo, 2004).

The interpersonal process is concerned with therapeutic interactions and rapport, communication, information sharing and shared decision-making. All these should occur during treatment between nurses, physicians, patients and family members and they should all be involved in care planning, its implementation and evaluation. Technical skill refers to nurses' knowledge and mastery of nursing intervention techniques, and their ability to judge and decide the most appropriate, right and timely interventions to meet the client's needs. Nurses' knowledge, skills and attitudes are indispensables for providing evidence-based nursing interventions in a safe and caring manner (Grotle, Garratt, Klokkerud, Løchting, Uhlig and Hagen, 2010; Miles and Vallish, 2010; Salzer, Nixon, Schut, Karver and Bickman, 1996). When nursing interventions are not performed by nurses owing to lack of time, patients' needs are not met, resulting in low quality nursing care (Lucero et al., 2009).

1.9.1.3. Patient demographics

The patients' demographics include their age, sex, health status, severity of illness and morbidity. The characteristics of the patients influence health care delivery in several dimensions. The age of the patients is an important aspect in quality nursing care as shown by

Szilagyi, Shenkman, Brach, LaClair, Swigonski and Dick (2003), who suggest that caring for children demands not only extensive services, but also that nurses need to be knowledgeable, skilled and competent enough in order to respond effectively to children's special needs. In addition, Noel, Parchman, William, Cornell, Shuko and Zeber, (2007) asserted that providing care to elderly people is demanding as nurses require special skills in geriatrics in order to actively assist the patients. They also documented issues related to multiple co-occurring chronic illness management as compared to treating patients with single chronic illnesses.

Several authors have observed that patients with poor socioeconomic status are likely to be readmitted several times, as they have poor access to appropriate medical care (Knox and Britt, 2005; Shi, Samuels, Pease, Bailey and Corley, 1999).

1.9.1.4. Outcomes

This fourth component of the quality care model refers to the results of processes due to nursing interventions provided by nurses to the patients (Kunkel et al., 2007; Curtis et al., 2006). It is also the result of interventions based on the use of clinical judgment, scientific knowledge, skills and experience of nurses (Kleinpell and Gawlinski, 2005). According to Donabedian (1988), outcome is a change in the patient's current and future health status involving symptom control, complications, functional status and costs due to antecedent health care. This entails patient attitudes about treatment, patient satisfaction, health-related knowledge acquired by client and behavioural change in areas that contribute to health problems (Miles and Vallish, 2010; MeiLing, 2009; Kunkel et al., 2007; Hall and Doran, 2007; Nguyen Thi et al., 2002; Salzer et al., 1996). However, outcomes may be affected either by environmental factors, impediment of nursing care implementation, or patient characteristics leading to negative health events such as nosocomial infections, length of stay and mortality (Lucero et al., 2009).

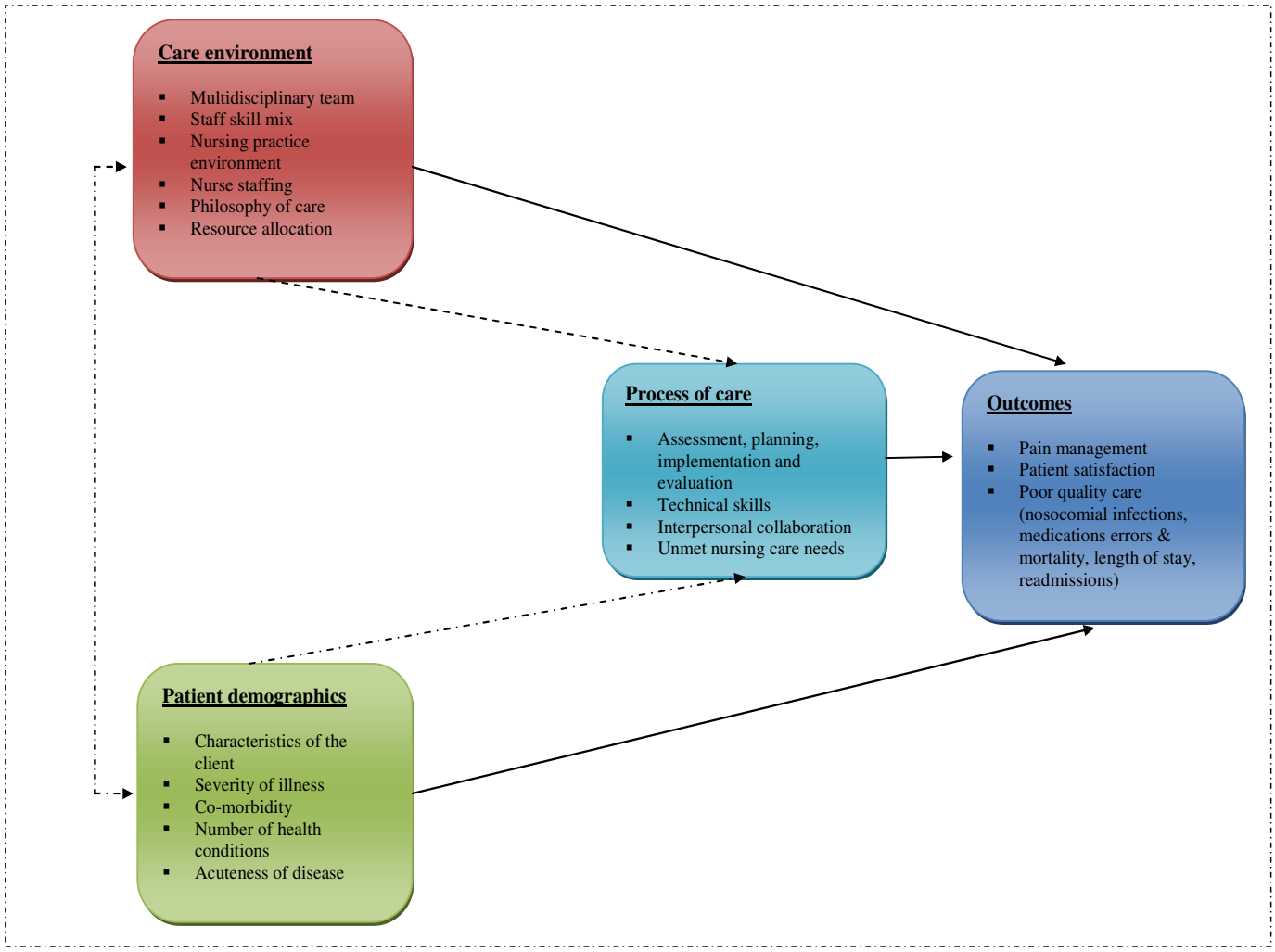

Figure 1 1: Process of Care and Outcomes Model (adapted from Lucelo, Lake and Aiken, 2009).

1.10. SUMMARY OF THE CHAPTER

This chapter introduced the concept of quality care in the nursing profession and the issues within the nursing practice environment that have a detrimental effect on providing such care. All the nuances that play a part in undermining quality care in nursing have received the deepest interest. The problem statement was taken up, especially in the Rwandan context, and the purpose and objectives of the study were determined. Finally, the definitions of the study's concepts and the explanation of the conceptual model underpinning this study closed this introductory chapter. The ensuing chapter is dedicated to the literature review.

CHAPTER TWO: LITERATURE REVIEW

2.1. INTRODUCTION

This chapter is aimed to contextualize the literature review of the empirical and theoretical sources related to quality nursing care. The literature review is an organized written presentation of what has been disseminated on a related topic by other researchers and enables the researcher to gain insight into previous theory on the subject (Burns and Grove, 2009). The literature reviewed included the following electronic databases: CINAHL (Cumulative Index to Nursing and Allied Health Literature), JAMA (Journal of the American Medical Association), Cochrane reviews, Pubmed Journal Database, MEDLINE (Medical Literature on-Line), Health resource: Nursing/Academic Edition, Afrika-wide information and Google Scholar. Key search terms included: "quality", "quality nursing care", "quality improvement", "determinant of quality nursing care", and "nursing practice environment". Then, other documentations deemed to be relevant were also consulted, as displayed in the list of the references. This chapter will take up the conceptualisation of quality nursing care, determinants of quality nursing care and quality nursing improvement.

2.2. CONCEPTUALISATION OF QUALITY NURSING CARE

2.2.1. Quality of care

The Institute of Medicine (Lohr and Schroeder, 1990: 707) has defined quality of care as "*the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge*". According to Booyens (1998), quality of care is the characteristics associated with excellence in accordance with the patient, health professionals, managers and other stakeholders. From this perspective, it is used for assessment, monitoring and evaluation of health services with regard to quality improvement in health care system (Currie et al., 2005).

The concept quality is very complex, multifaceted and multidimensional (Gunther and Alligood, 2002) and its dimensionality is underpinned by accessibility, appropriateness, acceptability, effectiveness, efficiency and equity (Maxwell, 1984). Accessibility means that health services are geared to the extent that they are near the people and that the service delivery is not undermined by distance. Appropriateness refers to the real service or

interventions that are performed, geared to meet the individual or community's needs based on right decisions and fulfilled timeously. Acceptability of services refers to a rational response to the expectations of the patient, family members, community, provider and funders. If you turn it around, acceptability involves not only the legal, ethical and cultural aspect on the behalf of stakeholders, but also includes harm-free interventions, knowledgeable health professionals endowed with outstanding attitudes, skills, competency, and technologically evidence-based interventions. Effectiveness means that a service as well as its entire benefit is implemented as intended by the individual, family or community. Efficiency means that resources are not wasted and that only the best cost-effective services are provided to the patients. Equity means a fair share of care to all human beings without any discrimination while providing health services (Atkinson et al., 2010; Booyens, 1998).

Beside the concept quality, the terms quality assurance and quality improvement are mostly used. Quality assurance means the formal, systematic exercise of problem identification, designing activities to overcome the problems, taking follow-up steps to eliminate new problems and the implementation of corrective steps (Manghani, 2011; Booyens, 1998). The term quality improvement refers to a formal programme to monitor, measure and evaluate whether quality of services is being provided, strategies for improvement have been established and there is a mechanism in place to take remedial steps to maintain improvements and bring about change and transformation. The focus is on the needs of the patient and it is also characterised by participative decision-making of all the relevant role-players. Continuous quality improvement implies that organizational transformation has taken place or that capacity building or empowerment of the individual, group, as well as the organization in terms of the full cycle and process of quality improvement, has been achieved in that particular health care organization (Lynn, Baily, Bottrell, Jennings, Levine, Davidoff et al., 2007; Booyens, 1998).

2.2.2. Quality of nursing care

Quality of nursing care is defined as care that is rendered to patients in accordance with nursing practice standards or hospitals' standards and job requirements (Grujic et al., 1989). According to Kunaviktikul, et al. (2001: 781), "*Quality of nursing care is nursing's response to the physical, psychological, emotional, social and spiritual needs of patients provided in a caring manner, so that the patients are cured, healthy, to live normal lives; and both patients and nurses are satisfied"*. Quality nursing care then refers to the scope of nursing, its view of

reality, its place in and relationship with society and its unique knowledge base. Inquiry into the nature of the quality of nursing care constitutes both an ontological and epistemological venture, as it is the study of the nature of nursing and of nursing knowledge (Gunther and Alligood, 2002).

2.3. OVERVIEW OF QUALITY NURSING CARE

Nursing is considered to be a vital component of the health care delivery system and this is in accordance with its ultimate goal, as a practical discipline, of assisting patients to gain positive health care outcomes (Kunaviktikul et al., 2001). To assist the patients effectively, nurses must be knowledgeable enough to provide nursing based interventions and this knowledge is gained from learning.

2.3.1. Domains of learning in nursing

The wealth of the literature highlights three domains of learning in nursing that underpin the quality of nursing care. Several authors draw on the work of Bloom and Krathwohl (1956) and that of Bloom, Krathwohl and Bertram (1973) to explain that these three domains of learning in the nursing profession are the cornerstone for providing quality nursing care interventions (Lawton, Conner and McEachan, 2009; Miller, 2010; Shephard, 2008; Neumann and Forsyth, 2008; Castle, 2003; Gunther and Alligood, 2002). These domains are the cognitive domain, the psychomotor domain and the affective domain.

2.3.1.1. Cognitive domain

The cognitive domain is related to information and knowledge necessary for providing evidence-based nursing practice (Castle, 2003). According to Miller (2010), through this domain emerges the overall attributes of good nursing practice including communication, teamwork, expression of values and attitudes and informed decision making. Furthermore, Clark (2000), quoted by Gunther and Alligood (2002), argued that cognitive ability entails having and applying empirical knowledge regarding the principles and laws governing the human life process. It therefore involves the ability to comprehend and apply these concepts to specific individual situations while recognizing patterns. In the context of nursing practice, this cognitive domain is frequently applied by nurses as a problem-solving process while implementing the nursing process which includes assessment, nursing diagnosis, planning and evaluation and using a nursing care plan (Gunther and Alligood, 2002).

2.3.1.2. Psychomotor domain

The psychomotor domain is concerned with physical actions or skills including the performance acquired from these motor skills (Castle, 2003). Gunther and Alligood (2002) explained psychomotor skills as those coordinated physical movements evaluated in relation to time, precision and technique. Gunther and Alligood (2002) cited Oermann (1990) to classify these skills into three categories, namely fine motor skills or precision-oriented tasks, manual skills referred as repetitive manipulative tasks and gross motor activities made up of large muscles and body movement. To incorporate the psychomotor domain into nursing practice, Miller (2010) subdivided psychomotor skills into two types, namely technical skills such as doing an injection or dressing and the more personal skills of assisting a patient to bath or clean their teeth (Gunther and Alligood, 2002).

2.3.1.3. Affective domain

The affective domain is related to our values, attitudes, beliefs, behaviours, emotions and values (Neumann and Forsyth, 2008; Castle, 2003). According to Shephard (2008), the affective domain enables nurses to listen to, to respond while interacting with others, to demonstrate balance and consideration and, at the highest level, to display a commitment to principled practice on a daily basis, alongside a willingness to revise judgment and change behaviour in the light of new evidence.

2.3.2. High quality nursing care

Providing high quality nursing care demands one to be knowledgeable of basic life sciences such as chemistry, biology, anatomy and physiology. To be effective while caring for patients, this knowledge should be enhanced by the other knowledge borrowed from health-related disciplines such as nutrition and pharmacology. Furthermore, high quality nursing care asks one to understand and utilize principles from the social sciences, namely psychology, sociology and cultural studies (Dunn and Schmitz, 2005; Gunther and Alligood, 2002). Nurses should also be endowed with high ethical standards enabling them not only to respond to ethical issues, but also to render safe nursing interventions to the patients (Numminen, Leino-Kilpi, van der Arend and Katajisto, 2009). The same authors quote Granot and Tabak (2002) to stress how this ethical knowledge governs nurses' attitudes and behaviours in daily nursing practice. The American College Health Association [ACHA] (2010) displayed fundamental ethical principles which included promoting justice, doing no harm, ensuring respect and autonomy and protecting the privacy of the patients, and stressed

that responsibility in the provision of services and professional responsibility and competence of nurses are necessary to enhance nursing care.

Quality nursing care also involves acquiring theoretical knowledge related to the care of the patient (Cowan, Norman and Coopamah, 2005). It requires that nurses be skilled, which entails using knowledge and dexterity to deliver competent nursing care to the patient (Wysong and Driver, 2009). It is therefore important for nurses to be in possession of interpersonal, critical thinking and technical skills (Laborde and Lee, 2000). To accomplish satisfactory patient care which is evidence-based requires the nurse to be equipped with the communication and interpersonal skills necessary to interact therapeutically and empathically with the patients (Birhanu, Assefa, Woldie and Morankar, 2010). Empathy refers to a therapeutic tool which originated from the work of Carl Rogers (1959), who regarded empathy as one of the building block of his person-centred approach to counselling. According to Rogers (1959), empathy is the state of perceiving the internal frame of reference of another person with accuracy and with the emotional components and meanings that pertain to it, as if one were with the person (Rogers, 1959 in Brunero, Lamont and Coates, 2010). To this end, one can state that there is no therapeutic relationship without empathy and therefore there is no quality nursing care without empathy (Reynolds, Scott and Jessiman, 1999). However, it is equally critical for nurses to possess therapeutic communication skills, not only to care for the patients, but also to maintain their physical and emotional well-being (Jasmine, 2009). Furthermore, Chant, Jenkinson, Randle and Russel (2002) argued that effective communication is of such great value that it has even been considered as one of the determinants of patient satisfaction, compliance and recovery. To conclude, Bolger (2007) reiterated the importance of communication in nursing practice, maintaining that it is one of the core duties of nurses.

To provide current evidence-based nursing interventions to the patient, it is important for nurses of today to be critical thinkers, effective decision-makers and competent (Shepherd, McCunnis and Brown, 2010; Bakalis and Watson, 2005). Critical thinking is concerned with being able to assess and judge issues in order to make reasonable decisions or solve problems, and is a skill for all health professionals to master in an age where they are expected to base their practice on sound evidence (Castle, 2010). Thus, critical thinking is usually used by nurses while collecting data related to the patients' health status, analysing and exploring it with a view to finding out what is known or not in relation to the outcome,

while examining the patients to determine the best intervention to be carried out (Shepherd et al., 2010). Clinical decision making refers to that discriminative thinking applied by nurses in order to choose a specific course of action (Cioffi, 1998). Therefore, effective decision-making skills are required for nurses to render safe nursing care (Paul, 1993). According to Benner, (1984), quality nurse care demands nurses to be competent enough to perform a task with desirable outcomes in any circumstances of the real world. However, as levels of competency may vary from one person to another, Benner (1984) classified competency according to a continuum, ranging from novice, to advanced beginner, to competent, to proficient, to expert (Benner, 1984). Bradshaw (2000) asserted that this competence also incorporates the moral character of the nurse and requires technical knowledge and practical skill necessary to carry out procedures in his daily nursing activities.

2.3.2.1. Succinct description of nursing care activities

Before embarking on the description of typical nursing care activities performed by nurses, it is worthwhile to shed light on methods or models used to organize nursing staff for the purpose of providing patient care.

2.3.2.2. Nursing models for organization of nursing staff for patient care

The delivery of quality nursing care depends on the nurse manager's ability to organize the nursing staff within the service or unit. According to Booyens (2008), eight nursing care delivery models or methods of allocating nurses to patients in the hospital settings have been documented. These include: the functional method, case assignment (total patient care), team nursing, primary nursing, modular nursing, combined methods, nursing case management and disease management. For the purpose of this study, only four models are discussed as they are the most used and credible for providing quality nursing care to the patients.

2.3.2.2.1. Total patient care delivery model

The total patient care model, known as case assignment or the case method (Robinson, 2008; Booyens, 2008), was the primary method of providing care to patients until the 1930s and has made a resurgence in the 1980s (Tiedeman and Lookinland, 2004). This method consists of assigning one competent, skilled and knowledgeable nurse or registered nurse to one patient or group of patients to be responsible for their total nursing care during his or her shift. The role of the nurse manager is to ensure continuity of care to the patients by receiving and giving feedback and assigning patients to the nursing staff (Tiedeman and Lookinland, 2004).

Since this method is recognized to be effective and efficient to patients, it is suggested that it should be used in intensive care units, emergency departments or applied to patients in the post-operative phase (Booyens, 2008). Although this method is credited to be better than team and/ or functional nursing models in terms of quality to patient, it is not rated as high as the primary care nursing method (Tiedeman and Lookinland, 2004).

2.3.2.2.2. Functional care delivery model

This model was introduced in nursing practice as early as the 1800s as a method geared to respond to the increasing demand of nursing care in hospitals (Robinson, 2008). Then, it resurfaced in the 1940s as a response not only to the need of less qualified ancillary health professionals, but also to the need of widening the hospital systems (Fairbrother, Jones and Rivas, 2010; Tiedeman and Lookinland, 2004). According to this model, tasks are allocated to nursing and ancillary personnel in accordance with the complexity of the task in terms of judgment and technical knowledge. To this end, less-skilled workers are given most of the routine tasks whereas the RN carries out the more complex tasks (Fairbrother et al., 2010). Currently, this model is still valuable where nurses, based on their level of education, are allocated to specific duties and functions for all patients who are in need of nursing care in the unit (Booyens, 2008). This author goes on to stress the basic advantage of this model, apart from its efficiency, is that it requires fewer nurses to get the work performed (Booyens, 2008). The weakness, however, is that it is comparatively lower to total patient care or primary nursing in terms of quality of care (Tiedeman and Lookinland, 2004).

2.3.2.2.3. Team nursing care delivery model

This model emerged in the 1950s as a response to changes in the nursing skill mix (Ferguson and Cioffi, 2011). It consists of providing nursing care to a group of patients by a team of nurses and other staff based on their varied levels of education (Registered Nurse (RN), technical personnel and ancillary staff) and skills, spearheaded by a RN known as the team leader (Tran, Johnson, Fernandez and Jones, 2010). This method requires everyone to use their skills and experience and to work collaboratively and cooperatively with shared responsibility, and to some degree accountability, for assessing, planning, implementing and evaluating the patient care (Tiedeman and Lookinland, 2004). This method is good, as stressed by Kalisch, Weaver and Salas (2009), who stated that the more nurses work on effective teams, the higher the level of satisfaction, productivity and reduction in adverse effects and, thus, the higher the quality of care provided to patients. The downside, however,

is that this method is very expensive as it requires a considerable number of nursing staff (Tiedeman and Lookinland, 2004).

2.3.2.2.4. Primary nursing care delivery model

This model was developed in the 1960s (Tiedeman and Lookinland, 2004) as a systematic method of organizing the nursing care in the unit with a view to providing individualized, comprehensive, co-ordinated and continuous patient-centred care (Booyens, 2008). The use of this model requires a nurse manager to allocate nurses to every patient, based on their competences and the individual needs of the patient. It is therefore incumbent on the primary nurse to assume 24-hour responsibility of taking care of the patients of whom they are in charge until their discharge from hospitalization. The nurse manager also has the responsibility and authority to assess, plan, organize, implement, coordinate, and evaluate care in collaboration with the patients and their families. It is up to him/her to decide on the modality of care administration and to be certain on the eventual delivery of care to the patient. In case of his/her absence, the primary nurse delegates the responsibility to an associate nurse to ensure that the patient receives continuity of care in relation to what has already been planned (Tiedeman and Lookinland, 2004).

2.3.2.3. Nursing interventions

Nursing interventions are nursing treatments carried out by nurses with a view to improving patient health conditions based on clinical judgment and knowledge (Muller-Staub, Lavin, Needham and Achterberg, 2006). According to Schubert et al. (2007), these interventions are based on problem-solving and decision-making processes done in a systematic way. This involves assessing the patient situation, identifying the potential problem, planning the intervention according to the need identified, implementing the intervention and then evaluating the care based on nurses' critical observations. Observation is a method used in nursing to identify the nursing interventions required for patients. This method was urged by (2002:50) who stated that '*the most important practical lesson that can be given to nurses is to teach them what to observe - how to observe - what symptoms indicate improvement - what is the reverse - which are of importance - which are of none - which are evidence of neglect - and what kind of neglect*'.

Lucero et al., (2009) have observed that nursing interventions fall into seven major categories: direct care activities controlled by the nurse (e.g. bathing comforting/communicating with patients); direct patient care activities, only partially

controlled by the nurse (e.g. nutrition, treatments and procedures); variable communication (e.g. charting and information exchange); cleaning and specimens (e.g. maintenance of the ward and patient intake and output); non-variable communication (e.g. nurse-to-nurse report and clerical duties); preparations (e.g. gathering equipment and preparing medications); and personal and miscellaneous activities (e.g. student teaching, rest periods, and surveillance of comatose patients). Furthermore, McCloskey and Bulechek (1996) subdivided nursing activities into two groups: direct nursing treatments, that is, those nursing interventions carried out directly with patients (e.g. wound care); and indirect treatments, meaning those activities not conducted directly with patients, but for their wellbeing (e.g. environment care) (McCloskey and Bulechek, 1996).

2.3.3. Nursing practice environment

The concept of the nursing practice environment encompasses all aspects of the real-time practical context in which nurses deliver patient care, and includes such issues as staffing levels, leadership, resource management, interpersonal relations and models of care as well as the built physical environment (Gardner, Woollett, Daly and Richardson, 2009).

2.3.3.1. Nurse-Physician relationships in the delivery of nursing care

The act of communication between nurses and physicians is a central activity in health care, and their failure to communicate has been linked with poor quality and errors in patient care (Tschannen and Kalisch, 2009). This relationship is commonly known as "collegial", which refers to the collaborative nature of the relationship and implies nursing autonomy and status in the organization (Roche and Duffield, 2010; Laschinger and Leiter, 2006). According to Baggs, Schmitt, Mushlin, Mitchell, Eldredge and Oakes (1999: 1991), quoted by Thomson (2009:90), this collaboration means that "*nurses and physician cooperatively working together, sharing responsibilities for solving problems and making decisions to formulate and carry out plans for patient care"*. It has been suggested that nurses and physicians tend to work in isolation and that a higher level of quality care would be provided if they collaborated and interacted as members of the healthcare team (Ihemedu, Omolase, Osere and Betiku, 2010). Research has shown that a poor nurse-physician relationship contributes to the nurse shortage and that 90% of the nurses surveyed witnessed some type of problematic physician behaviours (Wanzer, Wojtaszczyk and Kelly, 2009; Rosenstein, Russell and Lauve, 2002). Ultimately, effective communication and collaboration among nurses and physicians is pivotal for improved patient and professional outcomes (Tschannen and Kalisch, 2009).

2.3.3.2. Leadership in clinical nursing practice

Leadership is defined as a process by which one person influences others to willingly and enthusiastically direct their efforts and abilities towards attaining defined group or organisational goals (Nel, Werner, Haasbroek, Poisat, Sono and Schultz, 2008). It is also a process of influencing the attitudes, beliefs, behaviours and feelings of other people (Curtis, de Vries and Sheerin, 2011). Leadership is the ability to guide others, whether they are colleagues, peers, clients, or patients toward desired outcomes. A leader uses good judgment, wise decision making, knowledge, intuitive wisdom, and compassionate sensitivity to the human condition, suffering, pain, illness, anxiety and grief (Marshall, 2010). According to Carney (2009), leadership refers to the delivery of health services through a collaborative and ethical process that uses advocacy to effect change for the benefit of patient. Thus, a good leader should be guided by a clear vision, have a plan or strategy and be eager to drive their followers and services to a future goal (Mahoney, 2001). It has even been suggested that effective leaders apply problem-solving processes, maintain group effectiveness and develop group identification. To this end, they should be dynamic, passionate, have a motivational influence on other people, be solution-focused and seek to inspire others (Frankel, 2008). Effective leaders are endowed with the ability to instil power in ordinary people so that can achieve extraordinary things when confronted with challenge and change and constantly turn in superior performance to the long-term benefit of all concerned (Charlton, 2000).

In nursing practice, the meaning of leadership is quite often blurred with management (Marquis and Huston, 2009; Murphy, Quillinan and Carolan, 2009). In an attempt to unravel this conceptual confusion, Jooste (2004) argued that leadership simply means legitimate power and control whereas management refers to empowerment and change. To corroborate Jooste, Stanley and Sherratt (2010) underlined that the term leadership was coined to support nurses in management positions to enable them to be efficient in fulfilling their management responsibilities. Since these clarifications are not very convincing, Curtis et al. (2011: 307) drew on Hughes, Ginnett and Curphy (2006) to spell out the distinction between managers and leaders based on their responsibilities, as it is of great value to note that management functions are different from leadership roles. These authors make the following distinctions: (1) managers administer while leaders innovate; (2) managers maintain, whereas leaders develop; (3) managers control, while leaders inspire; (4) managers have a short-term view, whereas leaders have a long-term view; (5) managers ask how and when, while leaders ask

what and why; (6) managers initiate, whereas leaders originate; and (7) managers accept the status quo, whilst leaders challenge it. These distinctions are supported by Frankel (2008) who maintains that management is doing things right, whereas leadership is doing the right things and management is efficiency in climbing the ladder of success, whereas leadership is about determining whether the ladder is leaning against the right wall. According to Frankel, this differentiation suggests that management is intertwined with tasks, whereas leadership is related to perception, judgement, skill and philosophy.

From this conceptual clarification one might believe that it is easier to be a good manager than a good leader. Despite this clear-cut distinction, however, Cook and Leatgard (2004) urged that a nurse leader should not be confused with a clinical leader as a clinical leader is an expert clinician who is involved in providing direct clinical care and influences others to continuously improve the delivery of nursing care. The qualities displayed by a good clinical leader should include creativity, highlighting, influencing, respecting and supporting. Murphy et al. (2009) maintained that good clinical nurse leaders are expected to promote patient safety, professional accountability and clinical excellence in clinical nursing practice.

To be a good leader in the nursing practice environment one needs to be endowed with many skills and the ability to balance the needs of multiple constituencies to satisfy the demands of the nursing staff and also meet the needs of the patients (Houser, 2003). Thus, Jones (2007) conceded that the only available source of these skills and ability is to take inspiration from leadership theories that were put forward many years ago, but are still relevant today (Gifford, Davies, Edwards, Griffin and Lybanon, 2007; Moiden, 2002; House and Aditya, 1997). In this regard, Curtis et al. (2011) credited Spector' s (2006) work to classify nursing leadership theories into the four following categories: trait approach, behavioural approach, contingency approach and leader-member exchange approach. The trait approach associates effective leadership with the personal traits of people (Gifford et al., 2007; Sellgren, Ekvall and Tomson, 2006), the behavioural approach is likened to the trait theory, but they differ in that it views leadership from the perspective of the leader with emphasis on leader behaviours (Gifford et al., 2007) and the contingency approach essentially encompasses Fielder's contingency theory and path-goal theory and believes effective leadership to be related to the interaction between a person (leader), his/ her behaviour and the situation (Sellgren, Ekvall and Tomson, 2008). The leader-member exchange approach involves charismatic or

transformational leadership and is focused on the relationships between subordinate and supervisor (Mallot and Penprase, 2010). For the purpose of this dissertation, it is important to focus on transformational leadership since it is regarded as the best and the most suitable theory for nurse leaders to apply to improve the quality of patient care, nurses' job satisfaction and the performance of health care services (Bamford-Wade and Moss, 2010; Grant, Colello, Riehle and Dende, 2010; Tomey, 2009).

The concept of transformational leadership was coined by James McGregor Burns as early as 1978 and was refined by Bernard Bass in 1985, who traced a line of continuum between transactional and transformation leadership (Marshall, 2010). According to Marshall, transformational leadership is a process of developing the leadership capacity of an entire team. Transformational leaders inspire others to achieve what might be considered extraordinary results. Leaders and followers engage with each other, raise each other and inspire each other. Transformational leadership embraces value systems, emotional intelligence and attention to spiritual aspects. Drawing on Marriner and Tomey (2004), Jones (2007: 37) distinguished transformational leaders from transactional ones. He claimed that transformational leaders direct by role modelling, promoting employee development, providing a stimulating work environment and inspiring optimism. Transactional leaders, on the other hand, lead by being task-focused. They focus on the daily work of the organization, setting goals for the employees and the reward system. According to Jones, even although there are many leadership styles that motivate staff to reach certain goals of the organization, transformational leadership remains highly rated by nurses as it is positively related to their empowerment. It is therefore regarded as intrinsic task motivation.

It has been suggested that nursing leaders who apply the transformational style strain every nerve to creating and maintaining a nursing practice environment which not only promotes positive patient outcomes, but also positively influences teams and individual nurses (Mallot and Penprase, 2010). To achieve this, Frankel (2008) suggests that senior nurse leaders should assume the following responsibilities: making decisions; delegating appropriately; resolving conflict; and acting with integrity. By being emotionally in tune with the staff, they will nurture others and be aware of how people in the team are feeling. It is also important for nurse leaders and managers to find out what motivates their employees and to create a work environment that capitalizes on these motivations for eventual effectiveness of the entire

organization (Jones, 2007). Bearing in mind that the delivery of quality nursing care is to be based on evidence-based care, nurse managers need to promote collaborative learning, which in turn requires effective knowledge-sharing practices from managers and staff members (Lammintakanen, Kivinen and Kinnunen, 2008). According to Frankel (2008), a culture based on continual learning through support and best-practice methods has proved to be a strong strategy to empower and motivate staff. Dynamic clinical leaders and supportive clinical environments are vital to make the clinical nursing environment enticing. To conclude, Jooste (2004) highlighted that nurse leaders and managers must be kept abreast of the new style of leadership, where a leader no longer controls the employees, but acts as a visionary leader, who assist employees to plan, organize, lead and control their activities and empower them so that they act as autonomous individuals leading to high quality of care and performance in clinical nursing practice environment.

2.3.3.3. Value of autonomy in clinical nursing practice

Autonomy refers to the state of being independent, free, and self-directing (Dempster, 1990). In nursing literature, the term autonomy is used frequently as, although the variables are slightly different, it equates to nurses having some form of control over their nursing practice. According to Weston (2008), autonomy means the authority and freedom of the nurse to make nursing care decisions about the content of clinical patient care in an interdependent practice. Weston goes on to define the control over nursing practice as the authority and freedom of nurses to engage in decision making regarding the context of nursing practice involving the organizational structures, governance, rules, policies, and operations. The control over nursing practice may also be explained as having "*a voice in decisions that affect the patient care environment and their ability to deliver quality care"* (Fitzpatrick, 2001:41) Kanter (1977) likened power to autonomy and freedom of action. Being autonomous hinges on a number of factors including the ability to make independent choices, freedom from coercion; rational and reflective thought; adequate information; and knowledge (Skar, 2010). This was stressed by Kramer and Schmalenberg (1993), who regarded competence as a driving force for autonomy and empowerment. It is therefore important for autonomous individuals to have such a competence enabling them to think, decide and act independently (Cajulis and Fitzpatrick, 2007).

In clinical nursing practice, nurses sharpen their autonomy through communication and organization of their work to be certain that they are free to act on nursing decisions informed

by sound clinical judgment (Weston, 2010). The literature reveals that nurses need autonomy to make timely care decisions (Almost and Laschinger, 2002). This was exemplified by Mick and Ackerman (2000) in their study in USA, where they found that the nurses' development of autonomy in medical diagnosing and decision-making was of great value in the delivery of effective and timely care. In this regard, Weston (2008) stated that when nurses are empowered to such an extent that they participate in decision making there is not only an increase in their level of satisfaction, but also in their quality of performance. Furthermore, Currie, Harvey, West, McKenna and Keeney (2005) documented that the value of autonomy in clinical practice included improved staff retention, increased staff morale, reduced costs, increased participation in decision-making, improved clinical skills, improved quality and facilitation of effective multi-disciplinary working. Budd, Warino and Patton (2004) conclude that when organizational autonomy or control over practice reigns in the work environment, nurses feel respected and empowered and this contributes enormously to the delivery of high quality patient care.

2.3.3.4. Participation of nurses in hospital affairs

In last few decades, nursing and organisational experts have advocated and shown the importance of actively involving nurses in decisions related to the delivery of health care services, working conditions and organisational policy (Havens and Vasey, 2003). This suggestion is supported by the vast amount of nursing literature highlighting the nurses' critical role in the provision of high quality patient care and quality care improvement in health systems (Miles and Vallish, 2010; Kunaviktikul, Nantsupawat, Sngounsiritham, Akkadechanunt, Chitpakdee, Wichaikhum et al., 2010; Prybil, 2007). Furthermore, involving nurses in decision making is vital since it has been estimated that nursing staff accounts for around 50% of the health workforce globally, but in low income countries more than 80% of the health professionals are nurses. However, in remote communities, this distribution seems to be extremely inflated (Stark, Nair and Omi, 1999). According to Havens and Vasey (2005), decisional involvement means the pattern of the distribution of authority for the decision and the activities that govern the nursing practice policy and the practice environment. This suggests that for nurses to participate in hospital affairs they must be given the opportunity to be represented at the highest levels of hospital leadership and integrated into hospital decision making (Needleman and Hassmiller, 2009). Moreover, it has been reported that appointing an accessible nurse leader in the senior management structure of the organisation empowers nursing practice as these representatives have the ability to influence

policy decisions and handle issues relevant to nurses (Roche and Duffield, 2010; McClure and Hinshaw, 2002).

Nursing leadership needs to be actively applied at every level of the health sector with a view to providing professional clarity and direction, co-ordinating the professional and strategic management of nursing, contributing to governing boards, to develop and motivate nurses, ensure effective succession planning and, most importantly, to support innovative practice (Hansen, Carryer and Budge, 2007). Montgomery (2007) concurs that strong input from nursing staff is a core element of multi-disciplinary approaches to providing services in optimal healthcare institutions. In a study by Attree (2005), it was revealed that when nurses are unable to influence important decisions that impact on everyday standards, especially in terms of resource allocation, they become frustrated, dissatisfied, and less productive. In contrast, when a participative management and decentralized administration is in place within a given organization, there is an increase in nurses' satisfaction and positive patient outcomes (Jaafarpour and Khani, 2011; Laschinger, Shamian and Thomson, 2001). It is therefore a good idea to hear the voices of nurses as well as physicians and involve them in the hospitals' governance and decision making (Prybil, 2007).

2.3.3.5. Staffing and resources in the delivery of health services

Nurse staffing is the process used to determine and deploy the acceptable number and skill mix of personnel needed to meet the care needs of patients in a programme, unit or healthcare setting (Thungjaroenkul, Kuaviktikul, Jacobs, Cummings and Akkadechanunt, 2008). Decisions about staffing levels in hospitals must balance personnel costs with the intensity of care required by the population of patients served by each hospital (Blegen, Vaughn and Vojir, 2008). Staffing has been shown to affect the outcomes of care for patients who were admitted to general hospital units, as well as to special units, such as intensive care units (ICUs) (Thungjaroenkul et al., 2008). As Rafferty, et al. (2007) recently showed, if hospital staffing levels are appropriate, then patients' deterioration can be detected early and death may be avoided. This study also points to the importance of ensuring the existence of adequate material resources, such as the supplies and equipment needed in patient care. This has been connected to nurses' satisfaction and empowerment, a key staff outcome in Magnet hospitals (Tervo-Heikkinen, Kiviniemi, Partanen and Vehvilainen-Julkunen, 2009; Upenieks and Abelew, 2006). In this view, Buchan (1999) found out that in magnet hospitals emphasis is put on administration, professional practice and staff development leading to the delivery

of quality nursing care. Graven and DuHamel (2003), in corroboration, argued that professional development is vital in the delivery of quality nursing care as nurses are not only kept abreast of the evidence-based practice about new technology in the provision of quality nursing care and standards of practice, but is also regarded as a strategy for retaining the experienced health professionals. This professional development could be therefore carried out through continuing education, distance learning, in-service training, mentorship, and clinical supervision (Gould et al., 2007, Mensah et al., 2007, Wallen, Mitchell et al., 2010; Bondas, 2010; Brunero and Stein-Parbury, 2008).

2.4. DETERMINANTS OF QUALITY NURSING CARE

Determinants mean those factors that facilitate or impede actual change (Fleuren, Wiefferink and Paulussen, 2004). In the context of this study, the determinants refer to the factors affecting or influencing the improvement of quality nursing care. In this regard, Mrayyan (2006) documented that the factors that determine quality nursing care are adequate nurse staffing endowed with nursing skills reflected through caring attitudes and interpersonal communication. In the view of Mrayyan, efficient organizational and management systems within the care environment are critical in delivery of quality nursing care. Along the same lines, the literature points out that nurses' autonomy in respect of assessment, planning and implementing nursing interventions to be vital as far as the determinants of quality nursing care are concerned (Hall and Doran, 2007; Pearson, Lee, Chang, Elliot, Kahn and Rubenstein, 2000). Subsequently, quality of care is determined by the knowledge and skills of the nurse's assessment. In order to deliver high quality nursing care, the nurse must be able to perform effectively and must be competent in the application of theory and skills in the clinical situation. This requires possession of the necessary knowledge as well as mastery in psychomotor, cognitive and affective skills (Hogston, 1995a).

Specific factors within the practice environment that have been consistently linked to better outcomes include positive collegial relationships between doctors and nurses; strong nursing leadership; adequate access to education and professional development; participation of nurses in the operation of the organization; and sufficient staffing and resources (Roche and Duffield, 2010; Aiken et al., 2008; Lake and Friese, 2006; Lake, 2002).

2.5. FACTORS AFFECTING QUALITY NURSING CARE

The factors that have been documented to affecting quality nursing care include: limited resources among others insufficient infrastructures, money, and equipment; shortcoming of health professionals involving lack of trained, skilled, and motivated workers (Peabody et al 2005, Jukkala et al. 2010; Casey and Moscovice, 2004). To this point, Lucero et al. (2010) found out that new technology, numerous providers' treatment recommendations, and patients' illness severity to be prone to the delivery of poor nursing care. Concurrently, Carney (2009) asserted that quality nursing care is undermined by ineffective leadership skills reflected through lack of vision, clear philosophy, and poor goal settings. According to Pazargadi, et al. (2008) lack of clinical nursing indicators and standards of practice are important factors for not delivering quality nursing care to patients. Along the same line of thought many nurse researchers point out that lack of appropriate standards in clinical nursing practice environment, implicit duties, heavy workload, lack of job descriptions, unclear and inflexible processes, unsupportive management, lack of fringe benefits, lack of time and stressful work environment (Chiang and Lin, 2008; Alleyne and Jumaa, 2007; Ulrich et al., 2005; Aiken et al., 2002b). Additionally, lack of accreditation laws referred to as the requirements for hospitals to provide basic requirements to patients is suggested to undermine quality nursing care (Pomey, Lemieux-Charles, Champagne, Angus, Shabah, and Contandriopoulus, 2010).

2.6. QUALITY IMPROVEMENT IN CLINICAL PRACTICE

Quality improvement is defined as the combined and unceasing efforts of everyone; healthcare professionals, patients and their families, researchers, payers, planners and educators, to make the changes that will lead to better patient outcomes (health), better system performance (care) and better professional development (learning) (Batalden and Davidoff, 2007:2). Improving quality is to ensure that everyone is doing their best to make healthcare safer, more effective, patient-centred, timely, efficient, equitable and sustainable (Atkinson et al., 2010).

According to Manghani (2011), leaders and managers need to ensure that systems of quality control and quality assurance are in place in the workforce, thus enabling health care providers to implement quality improvement activities. Concurrently, Booyens (1998) argued that the quality improvement activities should be organized in a systematic manner and make provision for risk management, an infection control programme, clinical quality improvement

activities, and the monitoring, measurement and evaluation of quality health care within the organization. In similar vein, Atkinson et al. (2010) argued that it is not possible to talk about quality improvement without talking about change as well as action based on experience. However, every change is not necessarily an improvement (Muntlin, 2009:14). This suggests that quality improvement as a science needs to be evidence-based and it is therefore important to improve quality of care based on sound interventions (Davidoff, Batalden, Stevens, Ogrinc and Mooney, 2008). To conclude, Leape et al. (2006) proposed that those who are responsible for quality improvement should not only be guided by the Plan-Do-Study-Act cycle model put forward by W Edwards Deming to make quality improvement activities sound, but should also be guided by the standards of practice.

2.6.1. Standards and criteria

Although the concepts standards and criteria have become blurred with respect to quality improvement to such an extent that they are used interchangeably, they may, however, be clearly clarified. Standards are statements of what good healthcare should be (Booyens, 2008). In other words, a healthcare standard is a description of the desired level of performance for judging the quality of healthcare. In nursing practice, standards are referred to with respect to the scope of nursing practice, and encompass both various aspects of the nurse' role, such as assessment, planning and evaluation; and standards of professional performance, such as aspects of the nurse's role in quality assurance and research (Arries, 2006). Arries goes on to state that standards are cardinal in the delivery of quality nursing care since within them emerge criteria against which various aspects in the delivery of care are measured for the purposes of quality improvement. According to Booyens (2008), criteria are defined as descriptive statements of performance, behaviour, circumstances or clinical status that represent a satisfactory, positive or excellent state of affairs. However, **c**riteria are related to the standard in that they serve as detailed indicators of the standards and thus make the standard work. Therefore, criteria serve as a practical measurement scale to assess the quality of care (Booyens, 2008).

2.6.2. Nursing clinical indicators

Clinical indicators give an indication of the quality of the patient care that is being delivered. They must comply with high-quality standards and should be constructed in a careful and transparent manner. Indicators must be relevant to the important aspects of quality of care and be sufficiently evidence-based so that the recommendations formulated lead to clinical

effectiveness, safety and efficiency (Wollersheim, Hermens, Hulscher, Braspenning, Ouwens, Schouten et al., 2007). Curtis et al. (2006) suggested that those undertaking a quality improvement programme should adopt the use of Donabedian's tripartite model, which is made up of three classic quality of care components: structure, process and outcome. This model further serves as a guide to the American Nurses Association (1996), where it has been used to identify nursing clinical indicators to inform nursing practice in an attempt to improve nursing quality care.

Firstly, the nursing clinical indicators falling under the structure standards are ratio of nursing staff per patients, RN and nursing staffing, RN staff qualifications, total nursing hours per provided per patient, staff continuity, RN overtime and nursing staff injury. Secondly, the nursing clinical indicators related to process standards involve nurse satisfaction, assessment and implementation of patient care requirements, pain management, discharge planning, assurance of patient safety and responsiveness to unplanned patient care needs. Finally, those related to outcomes include mortality rate, length of stay, adverse incidents, complications, patient/family satisfaction with nursing care and patient adherence to discharge plan (American Nurses Association, 1996).

2.6.3. Strategies for fostering nursing continuous quality improvement

Draper, Felland, Liebhaber and Melichar (2008) have documented the strategies that could be implemented by the health care settings as far as quality nursing improvement is concerned. These strategies include supportive hospital leadership, which is actively engaged in the work; setting expectations for all staff, not just nurses, that quality is a shared responsibility; holding staff accountable for individual roles; inspiring and using physicians and nurses to champion efforts; and providing ongoing, visible and useful feedback to engage staff effectively. These authors also suggest to tackle the challenges faced by nurses related to their active involvement in quality improvement involves having adequate nursing staff when resources are scarce; engaging nurses at all levels, from bedside to management; facing growing demands to participate in more, often duplicative, quality improvement activities; dealing with the high level of administrative burden associated with these activities; and confronting traditional nursing education that does not always adequately prepare nurses for their evolving role in today's contemporary hospital setting (Draper et al., 2008).

The South African Department of Health (2008) has outlined some strategies to improve quality nursing care which involved appropriate workload, professional leadership and clinical support, ongoing professional education, career mobility and career ladders, and good wages. In Tanzania, Manongi, Marchant and Bygbjerg (2006) found that even although financial incentives are important, they are not sufficient to motivate health workers. They revealed that supportive supervision, performance appraisal, career development and transparent promotion are essential for continuous improvement of quality nursing care. Along the same line of thought, Pomey, Lemieux-Charles, Champagne, Angus, Shabah, and Contandriopoulos (2010) suggest that accreditation is also necessary to improve quality and safety in health care system delivery. In Rwanda, Muller, Murenzi, Mathenge, Munana, and Courtright (2010) documented that emphasis is put on training nurses in good patient interaction skills and providing adequate material, monitoring and evaluation of health services. It is also imperative to empower nurses in decision-making in health service management (Meessen, Musango, Kashala and Lemlin, 2006) and adopt a performance-based financing (PBF) in health as a strategy to improve quality of care (Rusa, Ngirabega, Janssen, Bastelaere, Porignon and Vandenbulcke, 2009). Furthermore, the Ministry of Health of Rwanda is striving to increase the number of health care providers to such an extent that ten (10) physicians and twenty (20) nurses will take care for 10.000 inhabitants (Ministry of Health, 2011).

To sum up, quality improvement in nursing implies that nurses attend effectively and efficiently to patients' needs and are aware of and take into consideration all factors influencing the patients' satisfaction (Johansson, Oléni and Fridlund, 2002).

2.7. NURSES' ROLE IN CONTINOUS QUALITY IMPROVEMENT

Nurses have many roles to play in the delivery of quality nursing care to patients. According to Aiken et al. (2002a), the vital role to be played by nurses is to keep on observing patients, detecting, and preventing them from suffering from side effects. Concurrently, Suner, Juvinya, Bertran, Graboleda, Brugada and Garcia (2010) asserted that monitoring and evaluation of care provided to patients while delivering quality nursing care are critical in quality care improvement. However, it is important to be guided by nursing performance indicators while monitoring and evaluating nursing care delivery (Needleman, Kurtzman and Kizer, 2007) (See page 32). To do this, nurses are required to carry out the nursing process whereby they are suggested to make thorough assessment of patient, planning, implementing

and evaluating the care of the patient using a nursing care plan (Schubert et al., 2007). In this regard, Murphy (2007) goes on to stress the value of care planning in that it help patients meet their individual needs be it physical, psychological, spiritual and social needs of the patients. According to Bjorvell (2003), in their daily nursing activities, nurses are called upon to use care planning as it is essential to document the care and communicate the current status of the patient's individual needs and response to care. Furthermore, Nursing and Midwifery Council (NMC) (Nursing and Midwifery Council, 2002) urged nurses to provide skilled care and maintain safety of patients through adequate nursing documentation and recordkeeping resulting in quality improvement. This is true since through documentation communication among health professionals, provision of evidence in case of litigation, research, statistical evidence, education, clinical audit and quality assurance, even care planning are made possible (Benbow, 2011).

According to Zacharova and Gulasova (2011) nurses also should be able to interact therapeutically with the patients and help them express their emotions and feelings. Similarly, Sprinks (2011) revealed that nurses are accountable for treating all people as individuals and respecting their dignity, and making them feel comfortable in their environment. Nurses are also suggested to increase the health literacy of the patients through health education so that the latter may become knowledgeable regarding their role in illness management (Lamiani and Furey, 2009; Freda, 2004). To conclude, one can state that nurses' knowledge, skills and attitudes are utmost importance for the delivery of evidence-based nursing interventions in a safe and caring manner resulting in continuous quality nursing improvement (Grotle et al., 2010; Miles and Vallish, 2010; Salzer et al., 1996).

2.8. SUMMARY OF THE CHAPTER

This chapter has extensively discussed what is implied by quality nursing care in the health care system, and perceptions of quality nursing care in relation to the nursing practice environment have been outlined. A description of the determinants of quality nursing care ensued and finally the chapter ended by providing insight into nursing quality improvement. The next chapter is devoted to the methodology aimed to guide this study.

CHAPTER THREE: METHODOLOGY

3.1. INTRODUCTION

This chapter presents the research methods that were used while conducting this study. According to Polit and Beck (2008), methodology refers to the techniques used by the researcher to structure a study and collect and analyse information in a systematic manner. Thus, the research paradigm and approach, research design, research setting and study population, and the data collection procedure will be highlighted.

3.2. RESEARCH PARADIGM

A paradigm is a set of assumptions and practices that structure inquiry within a discipline by providing lenses, frames and processes through which investigation is performed (Weaver and Olson, 2006). For the context of this enquiry, the positivist paradigm was deemed relevant for exploring the nurses' perceptions of quality care as it assumes that truth is absolute and that there is a single reality that one may discover whenever reliable measurements are applied (Burns and Grove, 2009).

3.3. STUDY DESIGN

The study design is referred to as the structured approach undertaken by the researchers to address a particular research question, involving specifications for maximizing the control over the study's integrity (Polit and Beck, 2008; Joubert and Ehrlich, 2007). A quantitative non-experimental exploratory descriptive study design was used.

3.4. RESEARCH SETTINGS

This study was conducted in two district hospitals in Rwanda. One research setting is located in the Southern Province while the other is located in the Kigali City Province. These district hospitals are fairly close to one another and were purposively selected by the researcher because of time constraints. The first one is a subsidiary hospital providing promotional, preventive, curative and rehabilitation services to patients and has 384 beds. The current nursing staff consists of 120 nurses, among which 18 are registered nurses (female: 12, male: 6), 100 enrolled nurses (female: 76; male: 24), 2 auxiliary nurses (female: 2; male: 0) and 18

physicians of whom 2 are specialists. There is an average of 1200 patients per month. This hospital is made up of 11 services: emergency, paediatric, radiology, surgery, internal medicine, laboratory, nutrition, mental health, physiotherapy, ophthalmology, maternity and dentistry. This hospital accommodates 14 health centres. The second one is a governmental hospital with 186 beds that is mandated to provide primary health care and to deliver quality care to its target population. It accommodates 9 health centres. There are 122 nurses working in this hospital including 1 who has a Masters degree in nursing (A0) (Female), 47 registered nurses with advanced diplomas (A1) (female: 27, male: 20), 71 enrolled nurses (female: 65, male: 6) and 3 auxiliary nurses (Female: 3, male: 0). There are also 22 physicians, of whom 2 are specialists. There is an average of 750 patients per month. This hospital is made up of 3 services including: gynaecology, paediatrics, and VCT/ ARV, and has 7 units including radiology, physiotherapy, dentistry, dermatology, mental health, nutrition and a laboratory

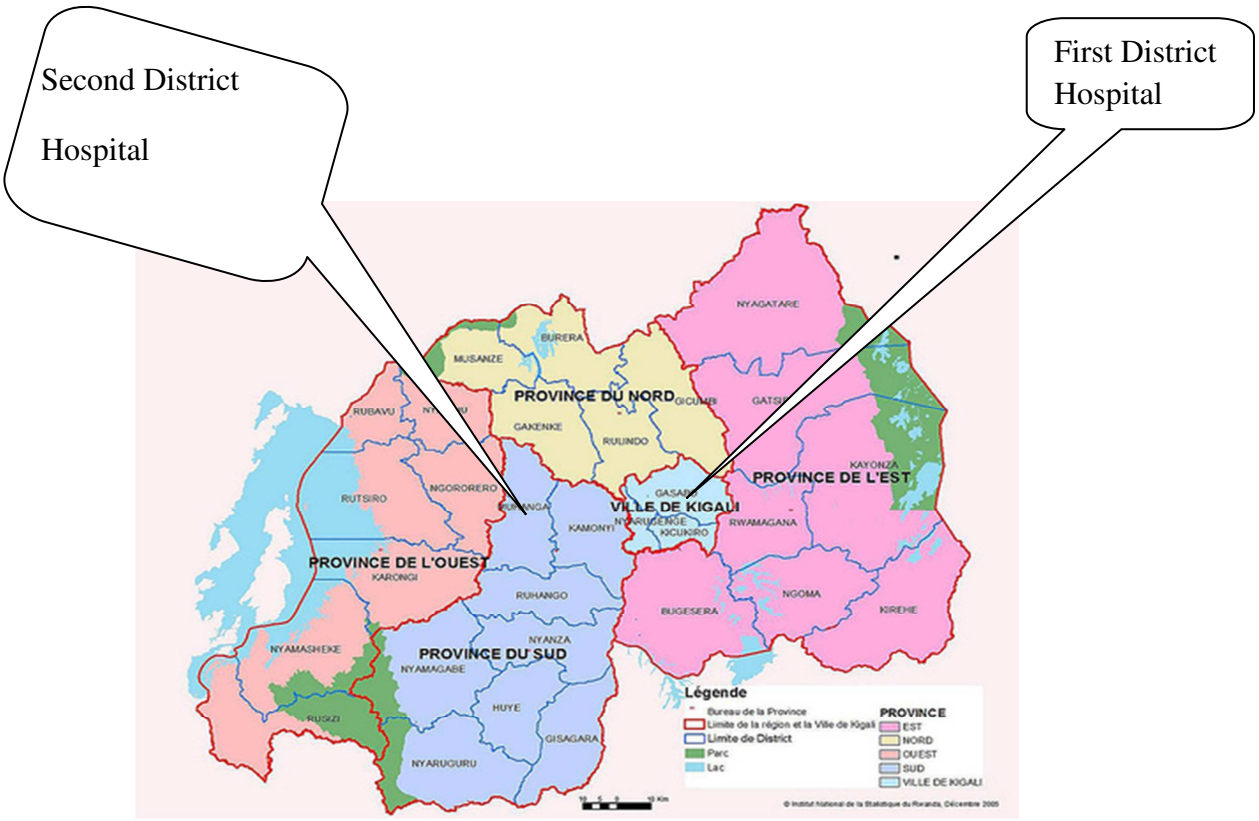

Figure 2 1 Localisation of two District Hospitals on Map of Rwanda

3.5. STUDY POPULATION

The target population for this study are all registered nurses working in the two district hospitals: (N=237) only as five (5) auxiliary nurses were not included in the study. To this end, there were: Masters (n=1), registered nurses (n=55) and enrolled nurses (n=181).

3.6. SAMPLE AND SAMPLING

A sample is a subset of a larger set that represents the population of interest chosen by the researcher to partake in the investigation, while sampling means the researcher's process of selecting the sample from a study population for obtaining information related to the phenomenon under investigation (Brink, 2006). In this study, the researcher has used the purposive convenience non-probability sampling approach to select nurses who were available for the study.

3.6.1. Inclusion criteria

The following inclusion criteria were implemented:

- Participants had to be either enrolled nurses or registered nurses;
- Participants had to be currently working full-time in one of the two district hospitals;
- Participants had to have had at least 6 months full-time work experience in nursing in either of the two district hospitals; and
- Participants had to be on duty during the data collection period.

3.6.2. Exclusion criteria

The following exclusion criteria were implemented:

- Auxiliary nurses were not included in the study;
- Participants who had less than 6 months work experience were not included; and
- Part-time nurses (enrolled or registered) were excluded from the study.

3.7. DATA COLLECTION INSTRUMENT

The research instrument was a self-report questionnaire based on three different instruments. The first one was designed in Ireland by Murphy (2007) and measures the nurses' perceptions of quality of care, the second is the Basel Extent of Rationing of Nursing Care (BERNCA,) which was developed by (Schubert, Glass, Clarke, Aiken, Schaffert-Witvliet, Sloane et al., 2008) and is geared to measure the necessary nursing interventions which were not carried out due to inadequate time, staffing level and/or skill mix commonly known as implicit

rationing of nursing care (Schubert et al., 2008). The third is known as the Practice Environment Scale of the Revised Nursing Work Index and was developed by several scholars (Aiken, Clarke and Sloane, 2002a; Lake, 2002; Aiken, Havens and Sloane, 2000) from the Center for Health Outcomes and Policy Research, University of Pennsylvania, to measure the quality of the nursing practice environment. Permission to use these instruments has been received from the authors (see appendices 5.1, 5.2, 5.3 and 5.4 on pages 127-130 respectively).

The questionnaire comprised of the following four sections.

- Section A is concerned with the demographic variables and is made up of 4 items including age, gender, qualification and work experience respectively. This demographic data will serve a double purpose. Firstly, the information will enable the description of the sample and determine its representativeness (gender and qualification). Secondly, it will be used during analysis and interpretation of data as it will be associated with participants' responses for the exploration of eventual associations;
- Section B consists of 32 items on a 5-point Likert-type scale and measures the nurses' perceptions of quality nursing care. The participants were invited to rate each item ranging from extremely important to definitely not important (see appendices 1.1 and 1.2 on pages 112 and117 respectively);
- Section C corresponds with the 14 items from the BERNCA instrument and are related to basic nursing tasks. These tasks are grouped into 4 categories involving attitudes towards the implementation of nursing care interventions related to activity of daily livings (ADLs) (1a, b, c, d), caring and support (2a, b), rehabilitation, instruction and education (3a, b), monitoring and safety (4a, b, c), and documentation (5a, b, c). The participants were required to rate each item on a 4-point Likert-type scale ranging from never (0), rarely (1), sometimes (2), or often (3) (see appendices 1.1: 113; appendix 1.2: 119); and
- Section D encompasses 32 questions related to nursing practice environment including: nurse participation in hospital affairs (items 5,6,11,16,18,23,25,29), nursing foundations for quality of care (items 4,15,19,20,24,27,28,31,32), nurse manager ability, leadership, and support of nurses (items 3,10,14,22), staffing and resource adequacy (items 1,8,9,12), and collegial nurse-physician relations (items

2,7,13,17,21,26,30). Each item is scored on a 4-point Likert-type scale ranging from strongly disagree (1), somewhat disagree (2), somewhat agree (3) and strongly agree (4). The higher scores heralded the agreement upon the existence of the item in the work environment (see further Appendix 1.1: 114; appendix 1.2: 120).

Regarding translation, sections A and B of this instrument were translated by the researcher and verified by the Department of Language of the University of KwaZulu-Natal (See Appendix 5.5: 131). Section C, the BERNCA instrument, was designed and translated by the researchers (Schubert et al., 2007) and while the PES-NWI-R in section D was designed in English by Aiken et al., at the Center for Health Outcomes and Policy Research, University of Pensylvania, US, it was translated into French by the University of Basel, Switzerland, (2009).

3.8. DATA COLLECTION PROCEDURE

Once ethical approval had been obtained from the University of KwaZulu-Natal Research Ethics committee and the Kigali Health Institute Institutional Review Board (Appendix 5.7: 133; Appendix 5.8: 134), the Directors of the two hospitals gave permission for the researcher to proceed with data collection (Appendix 5.6: 132; Appendix 5.9: 135; Appendix 5.10: 136). The Chief Nursing Officers of both hospitals were approached to discuss the data collection procedure and through collaboration with the ward managers a suitable time for data collection was determined. Potential participants were met on an individual basis to explain the purpose of the study, the data collection process and informed consent was obtained from them.

Questionnaires were distributed by hand and completed questionnaires were posted by participants in a safe box. Participants were requested to not divulge the content of questionnaire to colleagues during the 2 week data collection period, from 16 to 28 October 2011, in an attempt to avoid influencing participants' responses, specifically with respect to perception items.

3.9. VALIDITY AND RELIABILITY

Brink (2006) explained the validity as the ability of instrument to measure the variable that it is supposed to measure. The reliability of an instrument, on the other hand, refers to the

extent of the consistency or dependability with which a measurement measures a variable (Polit and Beck, 2008).

With regard to validity and reliability, firstly, the instrument measuring the nurses' perceptions of quality which was used as section B of this instrument has proved its validity and reliability and Cronbach's alpha of the whole instrument was between 0.72 to 0.95 (Murphy, 2007).

Secondly, the BERNCA which was used as section C of this instrument has proved its validity and reliability in two previous studies (Schubert et al., 2008; Schubert et al., 2007). This instrument was reliable to the extent that the internal consistency was extremely good as reflected by Cronbach's alpha that equalled 0.93.

Thirdly, the PES-NWI-R, which made up section D of this measurement, has demonstrated good psychometric properties and has been applied in a number of studies since its establishment and revision (Roche and Duffield, 2010; Aiken et al., 2008; Friese, Lake, Aiken, Silber and Sochalski, 2008; Lake and Friese, 2006). Of note is that this instrument has been adopted in the United States as a measure of quality nursing care in organizations (National Quality Forum, 2004). Its internal consistency has been scrutinized by researchers yielding good results not only for each item, but also for the whole instrument with Cronbach's alpha ranging between 0.71 and 0.98 (Roche and Duffield, 2010; Manojlovich and Laschinger, 2007).

Fourthly, as displayed in Table 3.1, the content validity, which means the extent to which the research instrument encompasses all the aspects related to the concepts being measured (Burns and Grove, 2009), is displayed by matching the instrument to research objectives, and conceptual and measurement items.

Finally, a pilot study was performed using 2 enrolled nurses and 3 registered nurses who met the inclusion criteria, but who were not surveyed anew when the study started. This was necessary to ensure that the participants understood the questions and were able to fill in the questionnaire correctly. Input from the pilot group led to minor modification of the instrument. Taking into account these minor modifications and alterations made while

adapting these instruments, Cronbach's alpha was computed yielding the following results: Murphy's instrument scored .89, BERNICA .90, while PES-NWI-R scored .92.

Table 3 1 : Content validity

S/N	Research objectives	Conceptual framework	Content validity	Questionnaire items
1.	Explore the nurses' perceptions of quality nursing care among nurses in two district hospitals.	Care environment Process of care Patient variables Outcomes	(Murphy, 2007)	Section B: 4,13,16 Section B: 3,5,6,12,14,15,17, 19,20,21,22,23,24,25,26,27,28,29, 30,31 Section B: 1,2,7,8,10,10,11 Section B: 9,18,32
2.	Explore the nurses' perceptions of their role in continuous quality improvement in two district hospitals.	Process of care	(Schubert et al. 2007; Schubert et al., 2008)	Section C: 1. (a), (b), (c), (d), 2.(a), (b); 3.(a), (b); 4.(a), (b), (c); 5. (a), (b), (c).
3.	Describe the factors affecting the quality nursing care in two district hospitals	Care environment	(Aiken et al, 2008).	Section D: 1,2,3,4,5,6,7,8, 9,10, 11, 12, 13,14,15,16, 17,18,19,20, 21,22,23,24,25,26,27, 28, 29, 30, 31, 32.

3.10. DATA ANALYSIS

The questionnaires were coded to facilitate data analysis. Data analysis was done using the Statistical Package for the Social Sciences, version 19.0. Descriptive statistics were used to summarize and present the data. Associations were calculated between demographic data and participants' perception scores. An independent -samples t-test was used to test if the perceptions scores differed according to gender. A one-way analysis of variance (ANOVA) was used to test if the perception scores differed according to participants' qualifications and

nursing experience. Spearman's rho correlation was used to test if there is any linear relationship between years of experience and perceptions of quality nursing care (Pallant, 2007).

3.11 ETHICAL CONSIDERATIONS

Ethical approvals were obtained from the Research Ethical Committee of the University of KwaZulu-Natal (Appendix 5.7: 133) and the Kigali Health Institute, Rwanda (Appendix 5.8: 134). Permission to collect data was obtained from the Directors of both district hospitals (Appendix 5.6: 132; Appendix 5.9: 135; Appendix 5.10: 136) and potential participants through informed consent (Appendix 2.1: 123; Appendix 2.2: 124; Appendix 3.1: 125; Appendix 3.2: 126). Permission to adapt and use the instruments was sought from the authors (appendix 5.1:127; appendix 5.2: 128; appendix 5.3: 129, appendix 5.4: 130). The questionnaire was translated into French to help participants feel at ease while eliciting information (Appendix 1.2: 117).

The risk to participants was minimised in the following ways. Their rights to full disclosure were addressed by an information and consent sheet that outlined the purpose of the study, the procedure for data collection and explanations that anonymity would be preserved throughout the process of handling and storage of raw data and dissemination of findings. Participants were given the right to decline to participate in the study. However, it was explained that the data was not identifiable as belonging to specific participants and that once it had been collected participants could not remove their data from the study.

3.12. DATA MANAGEMENT

On completion of data collection the researcher enclosed the raw data in sealed envelopes and brought them back to UKZN where they were opened by the researcher and data entered into SPSS. Then, the raw data have been submitted to the supervisor to be stored for 5 years by the researcher's supervisor, according to UKZN policy as it serves as the primary data for the study. After this period the hard copies will be destroyed and soft copies will be deleted not only from the programme files in computer but also from the recycle bin.

3.13. DISSEMINATION OF THE FINDINGS

A copy of the marked final report will be submitted to the School of Nursing, Faculty of Health Sciences UKZN, where it will be accessible to UKZN library. A final copy will also be submitted to the Institutional Review Board of KHI and to the two Directors of the two district hospitals. In collaboration with the supervisor, the findings from this study will be published in an accredited nursing journal.

3.14. SUMMARY OF THE CHAPTER

This section has outlined the methodology used to guide this study. The research paradigm and approach as well as study design and research setting have been presented. The data collection instrument has been described and the extent to which the measurement is credible was displayed through the validity and reliability. Ultimately, the discussion of the data collection procedure, data analysis, ethical considerations and data management closed this chapter. The following chapter is devoted to data presentation.

CHAPTER FOUR: PRESENTATION OF THE FINDINGS OF THE STUDY

4.1.INTRODUCTION

This chapter presents the findings of the study, the purpose of which was to explore the perceptions of quality nursing care among nurses working in two district hospitals in Rwanda in order to inform realistic driven continuous quality improvement. A total population of 237 nurses working in two district hospitals were targeted to participate in the study. However, some nurses were not available during data collection while others were not willing to participate. Therefore, the researcher distributed the self-report questionnaires to 150 nurses who were available during data collection and received a worthwhile return rate of 110 (73%) completed questionnaires.

The findings from this study are presented according to the objectives. Descriptive statistics are presented in the form of frequencies and associations between demographic variables and participants' perceptions of quality nursing care. Frequencies will be described first, followed by associations between scores and demographic data. Measures of central tendency used in the analysis included mean, range, and standard deviation.

4.2. DEMOGRAPHIC CHARACTERISTICS OF THE SAMPLE

The four demographic variables of this study included age, gender, highest professional nursing qualification and nursing work experience of the participants.

4.2.1. Age and gender

The results of the variables within the sample demographics as related to age and gender are displayed in Table 4.1. It indicates a higher number of female participants (83.3%, n=90) than male participants (16.7%, n=18). The average age was ±32.9 [95% CI: 31.6-34, 2] years, with the youngest being 21 and the oldest 53 years old, with a median of 31 years and a standard deviation of 6.7 (SD=6.7). Of the participants, 48.2% (n=52) ranged between 20 and 30 years old, 37% (n=40) were between 31 and 40 years old, 13.9% (n=15) were between 41 and 50 years old, whereas only 0.9% (n=1) was over 50 years old. Forty three (43) females and 9 males fell into the 20 to 30 years old age group, 35 females and 5 males fell into the 31

to 40 years old age group, 11 females and 4 males fell into the 41 to 50 years old age group and there was only 1 female who was older than 50.

Table 4 1 Age and gender of the participants

Demographic variables			**Frequency**	**Percentage %**
Age	20-30 years	female (43) male (9)	52	48.2%
	31-40 years	female (35) male (5)	40	37%
	41-50 years	female (11) male (4)	15	13.9%
	50 + years	female (1) male (0)	1	0.9%
Gender	Female		90	83.3%
	Male		18	16.7%

4.2.2. Highest professional nursing qualification of the participants

The highest nursing qualification means the level of training dispensed to the participants in nursing education. In this study sample, the majority of participants (65.7%, n=71) were trained at secondary level (enrolled nurse) against 34.3% (n=37) who were at diploma level (registered nurse), as depictured in figure 4.1.

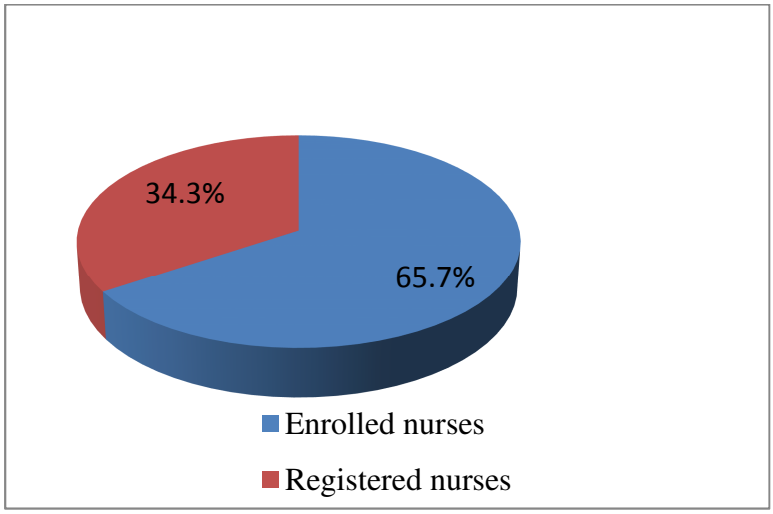

Figure 4 1 Highest nursing qualification of participants

4.2.3. Nursing work experience of the participants

The participants were invited to indicate their work experience in nursing. The working experience refers to the number of years in which a participant has worked as a nurse in

clinical nursing practice. It is important to note that the work experience of participants who have worked for over 6 months was rounded up to one year to facilitate data analysis. The findings showed that the majority of the participants had a mean of 7.7 years of working experience with a median of 6 years. In this sample, almost half of the participants (47.2%, n=51) had working experience of between 6 months to 5 years, 34.3% (n=37) had practised for between 6 and 10 years, 13.9% (n=15) had worked between 11 and 20 years and 4.6% (n=5) had working experience of more than 21 years. According to gender distribution, 43 females and 8 males fell into the category of 6 months to 5 years, 31 females and 6 males fell into the category of 6 to 10 years, 11 females and 4 males fell into the category of 11 to 20 years, while only 5 females with 0 male were in the category of more than 21 years. These findings are portrayed in table 4.2.

Table 4 2 Nursing work experience of the participants

Variable	Years	Gender	Frequency	Percentage %
Nursing work experience	6 months - 5 years	Female (43) Male (8)	51	47.2%
	6-10 years	Female (31) Male (6)	37	34.3%
	11-20 years	Female (11) Male (4)	15	13.9%
	21+ years	Female (5) Male (0)	5	4.6%

4.3. THE NURSES' PERCEPTIONS OF QUALITY NURSING CARE

The perceptions of quality nursing were explored based on the nurses' understanding and perceptions on the delivery of quality nursing care. Of note is that in order to ease the reading of the findings, the figures have been combined in such a way that ratings of extremely important and important have been grouped together to mean an adequate understanding of quality nursing care while neutral, not important and definitely not important have been grouped to illustrate a lack of understanding of quality nursing care.

4.3.1. Nurses' understanding of quality nursing care

Table 4.3 displays the definition of quality nursing care from the views of the participants.

The majority of participants (98.1%, n= 101) maintained that good nursing care should be patient centred in contrast to 2% (n=2) who disagreed. The majority of the participants (97.1%, n=101) regarded good nursing care as holistic care, meaning that care is responsive

to the physical, psychological, social and spiritual needs of the patient, while 2.9% (n=3) did not rate it as important. A considerable number of the participants (87.7%, n=92) believed that quality nursing care should be based on a nurse-patient relationship, against 12.4% (n=13) who felt that a nurse-patient relationship was not important. The concept that good nursing care is provided by nurses who are competent in technical skills was supported by a total of 96.3% (n=104) of participants with only 3.7% (n=4) finding it not relevant. A total of 76.9% (n=80) of the participants supported the statement that good nursing care is individualized care, while 23% (n=24) were in disagreement. The majority of participants 92.4% (n= 97) agreed that good nursing care is well co-ordinated, while 7.7% (n=8) indicated that it was not important for the patient. The concept that quality nursing care should be sensitive to a patient's spiritual needs was supported by 77.1% (n=81) of participants, while 22.9% (n=24) rated that it is not important. More than half percent of participants 66.9% (n=71) agreed that quality nursing care involves knowing the patient as a person, but 33% (n=35) felt it was not necessary. Helping the patient integrate socially and meaningfully in the community was perceived as good nursing care by the majority of participants (83.2%, n=89) in contrast to 16.8% (n=18) who disagreed. A large number of participants (91.5%, n=97) agreed that good nursing care is based on respect for the patient, while 8.4% (n=8) believed that it is not important. Most of the participants (72.9%, n=78) felt that sensitivity towards the patients was important, with only 27.1% (n=29) rating it as not important. The majority of participants 76.7% (n=82) agreed that nursing care should be provided by nurses who have good interpersonal skills with only 23.4% (n=25) regarding it as not important. The concept that quality nursing care is guided by good nursing leadership was supported by most of participants (83.3%, n=90), while 16.6% (n=18) viewed it as not being important. The majority of the participants (91.5%, n=95) agreed that helping the patient meet their potential was a component of good care while 8.3% (n=9) claimed that it was not important. That good nursing care can be regarded as thorough and systematic care to the patients was supported by 85.9% (n=91) of the participants, with 14.2% (n=15) disregarding it as being important for the patient and 82.3% (n=88) of the participants agreed that quality nursing care should be evidence based, whereas 17.8% (n=19) viewed it as not important.

Table 4 3 Nurses' understanding of quality nursing care

Variable	Extremely important	Important	Neutral	Not important	Definitely not important	Total
1.Patient centred	80(77.7%)	21(20.4%)	0(0%)	1(1%)	1(1%)	103(100%)
2.Holistic care	84(80%)	18(17.1%)	2(1.9%)	1(1%)	0(0%)	105(100%)
3.Based on nurse-patient relationship	66(62.9%)	26(24.8%)	4(3.8%)	8(7.6%)	1(1%)	105(100%)
4.Provided by skilled nurses	73(67.6%)	31(28.7)	2(1.9)	1(0.9)	1(0.9)	108(100%)
5.Individualized	49(47.1%)	31(29.8%)	10(9.6%)	7(6.7%)	7(6.7%)	104(100%)
6.Well co-ordinated care	68(64.8%)	29(27.6%)	1(1%)	4(3.8%)	3(2.9%)	105(100%)
7.Sensitive to a patient's spiritual needs	42(40%)	39(37.1%)	6(5.7%)	7(6.7%)	11(10.5%)	105(100%)
8.Based on knowing the patient as a person	38(35.8%)	33(31.1%)	10(9.4%)	13(12.3%)	12(11.3%)	106(100%)
9.About helping the patient integrate socially	58(54.2%)	31(29%)	8(7.5%)	1(0.9%)	9(8.4%)	107(100%)
10.Based on respect for the patient	71(67%)	26(24.5%)	1(0.9%)	3(2.8%)	5(4.7%)	106(100%)
11.Sensitive to patients' preferences	41(38.3%)	37(34.6%)	10(9.3%)	8(7.5%)	11(10.3%)	107(100%)
12.Provided by nurses who have good interpersonal skills	48(44.9%)	34(31.8%)	2(1.9%)	9(8.4%)	14(13.1%)	107(100%)
13.Guided by good nursing leadership	55(50.9%)	35(32.4%)	9(8.3%)	5(4.6%)	4(3.7%)	108(100%)
14.About helping a patient meet their potential	59(55.1%)	39(36.4%)	4(3.7%)	1(0.9%)	4(3.7%)	107(100%)
15.Thorough and systematic care	66(62.3%)	25(23.6%)	7(6.6%)	6(5.7%)	2(1.9%)	106(100%)
16.Knowledge based	60(56.1%)	28(26.2%)	9(8.4%)	2(1.9%)	8(7.5%)	107(100%)

4.3.2. Nurses' perceptions of the delivery of quality nursing care

Table 4.4 demonstrates the nurses' perceptions with regard to the delivery of quality nursing care. The following aspects were considered:

Listening to the patient: The majority of participants (98.1%, n=105) felt this was important, while only 1.9% (n=2) disagreed.

Meeting the emotional needs of patients: 67.3% (n=72) of the participants agreed it was important, while 32.7% (n=35) disagreed.

Demonstrating kindness to patients: This aspect was highlighted by a large majority of participants (96.3%, n=104) whereas only 3.8% (n=4) disagreed.

The provision of the recreational and social activities for patients: 81.5% (n=88) of the participants agreed it was important while 18.5% (n=20) felt it was not important.

Facilitating the choice of the patient: More than half of the participants (67.3%, n=72) rated this aspect as important, with 32.7% (n=35) rating it as not important.

Meeting physical needs of the patients: This was supported by 85.1% (n=86) of participants, while 14.9% (n=15) disagreed.

Teaching and informing patients and families: 96.3% (n=103) of the participants stated that this was important, while 3.8% (n=4) found it not important.

Promoting health of the patients while rendering nursing care: This was supported by a total of 95.1% (n=103) of participants, whereas 4.7% (n=5) disagreed.

Valuing the views of the patient: 76.7% (n=82) of the participants agreed that this was an important aspect, in contrast to 18.7% (n=25) who disagreed.

Making the patient feel comfortable in caring environment; 93.4% (n=99) of the participants agreed with this aspect, while 6.6% (n=7) disagreed.

Maintaining privacy of the patients; 93.5% (n=100) of participants indicated that they perceived this as being important, while 6.6% (n=7) rated it as not important.

Paying attention to the personal needs of the patient; 86.1% (n=93) of the participants rated this aspect as important, but 14% (n=15) disregarded it; and

Nursing care should be provided by multidisciplinary teamwork; A large majority (98.2%, n=106) of participants agreed with this aspect with only1.8% (n=2) disagreeing.

Advocating for the patient: 82.2% (n=83) of the participants perceived this to be part of quality nursing care, but17.8% (n=18) disagreed.

Involving the family members: Sadly, less than half 49% (n=51) of the participants rated it as important while 50.9% (n=53) rated it as not important.

Maintaining the independence of the patients: 65.8% (n=71) of the participants agreed that this was an aspect of quality nursing whereas 34.2% (n=37) disagreed

Table 4 4 Nurses' perceptions of the delivery of quality nursing care

Variable	Extremely important	Important	Neutral	Not important	Definitely not important	Total
1.Listening to patient	93(86.9%)	12(11.2%)	0(0%)	2(1.9%)	0(0%)	107(100%)
2.Meeting patients emotional needs	26(24.3%)	46(43%)	10(9.3%)	8(7.5%)	17(15.9%)	107(100%)
3.Kindness to patients	77(71.3%)	27(25%)	0(0%)	2(1.9%)	2(1.9%)	108(100%)
4.Providing recreational and social activities for patients	39(36.1%)	49(45.4%)	9(8.3%)	3(2.8%)	8(7.4%)	108(100%)
5.Facilitating patient choice	19(17.8%)	53(49.5%)	10(9.3%)	14(13.1%)	11(10.3%)	107(100%)
6.Meeting physical needs	47(46.5%)	39(38.6%)	6(5.9%)	5(5%)	4(4%)	101(100%)
7.Teaching and informing patients and families	74(69.2%)	29(27.1%)	2(1.9%)	2(1.9%)	0(0%)	107(100%)
8.Promoting health	86(79.6%)	17(15.5%)	2(1.9%)	3(2.8%)	0(0%)	108(100%)
9.Valuing the views of patient	45(42.1%)	37(34.6%)	9(8.4%)	9(8.4%)	7(6.5%)	107(100%)
10.Making patient comfortable in environment	65(61.3%)	34(32.1%)	2(1.9%)	3(2.8%)	2(1.9%)	106(100%)
11.Giving patients privacy	86(80.4%)	14(13.1%)	3(2.8%)	2(1.9%)	2(1.9%)	107(100%)
12.Paying attention to the patient's personnel needs	54(50%)	39(36.1%)	6(5.6%)	3(2.8%)	6(5.6%)	108(100%)
13.Good multidisciplinary teamwork	84(77.8%)	22(20.4%)	0(0%)	1(0.9%)	1(0.9%)	108(100%)
14.Being an advocate on patient's behalf	41(40.6%)	42(41.6%)	8(7.9%)	6(5.9%)	4(4%)	101(100%)
15.Family centred	12(11.5%)	39(37.5%)	17(16.3%)	16(15.4%)	20(19.2%)	104(100%)
16.Maintaining patients independence	34(31.5%)	37(34.3%)	20(18.5%)	8(7.4%)	9(8.3%)	108(100%)

4.3.3. Composite score for nurses' perceptions of quality nursing care

4.3.3.1.Score for nurses' understanding of quality nursing care

The frequencies of total scores for nurses' understanding of quality nursing care were computed and this composite score comprised of items 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16 in section B of the instrument. This represented a total possible score of variables related to adequate understanding of quality nursing where extremely important scored five (5); important, four (4); neutral, three (3); not important two (2); and definitely not important, one (1). The total scores were divided by the number of variables, i.e. 16. The scoring of the questionnaire was structured in such a way that higher scores were indicative of better understanding of quality nursing care, as portrayed in Table 4.5

Table 4 5 Frequency of scores for nurses' understanding of quality nursing care

Score		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	2.6	2	1.9	1.9	1.9
	2.8	2	1.9	1.9	3.7
	3.0	1	.9	.9	4.6
	3.1	2	1.9	1.9	6.5
	3.2	2	1.9	1.9	8.3
	3.4	1	.9	.9	9.3
	3.5	3	2.8	2.8	12.0
	3.6	4	3.7	3.7	15.7
	3.7	3	2.8	2.8	18.5
	3.8	12	11.1	11.1	29.6
	3.9	4	3.7	3.7	33.3
	4.0	4	3.7	3.7	37.0
	4.1	9	8.3	8.3	45.4
	4.2	4	3.7	3.7	49.1
	4.3	8	7.4	7.4	56.5
	4.4	10	9.3	9.3	65.7
	4.5	1	.9	.9	66.7
	4.6	9	8.3	8.3	75.0
	4.7	8	7.4	7.4	82.4
	4.8	5	4.6	4.6	87.0
	4.9	8	7.4	7.4	94.4
	5.0	6	5.6	5.6	100.0
	Total	108	100.0	100.0	

Measures of central tendency, displayed in Table 4.6, of the total understanding scores were equally calculated. There was a negative skewness as denoted by the skewness statistic (-.675) which is twice the size of the Standard Error of skewness (.233). This negative

skewness reflected that the majority of participants have a good understanding of quality nursing care, even although a few of them lacked such understanding (Weinbach and Grinnell, 2010). To this end, the total scores equal 86.1, and the range, known as the difference between the participants' highest score and lowest score was 2.4 (5.0-2.6= 2.4) as demonstrated in the table hereunder.

Table 4 6 Measures of central tendency of scores for nurses understanding of quality nursing care

N	Valid	108
	Missing	0
Mean		4.183
Median		4.300
Std. Deviation		.5741
Skewness		-.675
Std. Error of Skewness		.233
Range		2.4
Minimum		2.6
Maximum		5.0

4.3.3.2.Score for nurses' perceptions of the delivery of quality nursing care

The frequencies of total scores for nurses' perceptions of the delivery of quality nursing care were calculated, and this composite score comprised of items 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32 in section B of the instrument. This represented a total possible score of variables related to the appropriate provision of quality nursing where extremely important scored five (5); important, four (4; neutral, three (3); not important, two (2); and definitely not important, one (1). The total scores were divided by the number of variables, i.e. 16. The scoring of the questionnaire was structured in such a way that higher scores were indicative of better perception of the delivery of quality nursing care, as shown in Table 4.7.

Table 4 7 Frequency of scores for the delivery of quality nursing care

Score		Frequency	Percentage	Valid Percentage	Cumulative Percentage
Valid	2.1	1	.9	.9	.9
	2.6	1	.9	.9	1.9
	2.9	1	.9	.9	2.8
	3.0	1	.9	.9	3.7
	3.1	2	1.9	1.9	5.6
	3.2	1	.9	.9	6.5
	3.3	3	2.8	2.8	9.3
	3.4	6	5.6	5.6	14.8
	3.5	2	1.9	1.9	16.7
	3.6	6	5.6	5.6	22.2
	3.8	5	4.6	4.6	26.9
	3.9	9	8.3	8.3	35.2
	4.0	3	2.8	2.8	38.0
	4.1	8	7.4	7.4	45.4
	4.2	6	5.6	5.6	50.9
	4.3	11	10.2	10.2	61.1
	4.4	8	7.4	7.4	68.5
	4.5	2	1.9	1.9	70.4
	4.6	10	9.3	9.3	79.6
	4.7	6	5.6	5.6	85.2
	4.8	6	5.6	5.6	90.7
	4.9	7	6.5	6.5	97.2
	5.0	3	2.8	2.8	100.0
	Total	108	100.0	100.0	

Measures of the central tendency of the total scores for the nurses' perceptions of the delivery of quality nursing care were computed and are displayed in Table 4.8. There was negative skewness as evidenced by the skewness statistic (-.761) being twice the size of the standard Error of skewness (.233).. This negative skewness suggests that the majority of participants have a good perception of the aspects which contribute to the delivery of quality nursing care, despite some of them who did not perceive the meaning of the appropriate delivery of quality nursing care. Thus, the total scores equal 87.9, and range was 2.9 (5.0-2.1= 2.9).

Table 4 8 Measures of central tendency of scores for the delivery of quality nursing care

N	Valid	108
	Missing	0
Mean		4.137
Median		4.200
Std. Deviation		.5763
Skewness		-.761
Std. Error of Skewness		.233
Range		2.9
Minimum		2.1
Maximum		5.0

4.4. NURSES' ROLE IN THE DELIVERY OF QUALITY NURSING CARE

The role of nurses in the delivery of quality nursing care was explored with regard to their workforce environment. This presentation has been simplified by condensing the components of the scale by grouping never and rarely together, as they were an indication that the participants had not failed to provide the necessary care to patients. Sometimes and often were also grouped together, as they were an indication that participants had failed to render the necessary nursing care to patients. Participants were asked to indicate whether they were able to deliver the following care to the patients in the light of their lack of time and excessive workloads. As shown in Table 4.9, slightly more than half of the participants (55%, n=59) indicated that they were able to assist the patients to have bath despite the lack of time and excessive workload, with 44.8% (n=47) indicating that they were not able to do so. Less than half (42.9%, n=45) of participants were able to provide dental hygiene to the patients

against 57.2% (n=60) who were unable. Forty-nine percent (49%, n=51) revealed that they were able to change the position of the patients whereas 51% (n=53) were not. With regard to changing dirty bed linen, 47.1% (n=49) revealed that they had changed the linen, while 52.9% (n=55) responded that they had not. Slightly more than half of the participants (55.7%, n=59) felt they were able to assist the patients psychologically, while 44.3% (n=47) did not. Few participants (46.7%, n=49) revealed that they had time to converse with the patient and/ or care provider against 53.3% (n=56) who did not. A total of 47.2% (n=50) of participants revealed that they were able to educate the patients and their care providers while 52.8% (n=56) were not able to educate the patients**.** Less than half the participants (46.2%, n=48) indicated that they were able to prepare the patients or their family members for discharge from the hospital, whereas 53.8% (n=56) were not. Few participants (37.8%, n=39) reported having monitored the patients as recommended by the physician or where needed against 62.2% (n=64) who had not. Few participants (36.8%, n=45) agreed that physicians do come on time during the sudden change in the health status of the patients, whereas 63.2% (n=67) disagreed. Few participants 42.8% (n=45) asserted that they were able to respond promptly to the call of the patient for any assistance, whereas 60.5% (n=60) were unable. Few participants (32.1%, n=33) went over the patients' documentation at the beginning of their work in contrast to 68% (n=70) who did not. Only 42.3% (n=44) were able to plan the nursing care for the patients, with 57.7% (n=60) responding that they were not. Few participants 41.3% (n=41) indicated that they were able to document the care rendered to the patients, while 58.6% (n=61) were not.

Table 4 9 Role of nurses in the delivery of quality nursing care

Statement	**Never**	**Rarely**	**Sometimes**	**Often**	**Total**
1.Bathing a patient	21(19.8%)	38(35.2%)	29(27.8%)	18(17%)	106(100%)
2.Provision of dental hygiene to patient	19(18.1%)	26(24.8%)	34(32.4%)	26(24.8%)	105(100%)
3.Change the position of a patient	36(34.6%)	15(14.4%)	22(21.2%)	31(29.8%)	104(100%)
4.Putting clean sheets on a dirty bed	31(29.8%)	18(17.3%)	24(23.1%)	31(29.8%)	104(100%)
5.Provision of psychosocial support to a patient	25(23.6%)	34(32.1%)	19(17.9%)	28(26.4%)	106(100%)
6.Maintaining a necessary conversation with a patient	28(26.7%)	21(20%)	31(29.5%)	25(23.8%)	105(100%)

7.Teaching and/ or educating a patient and/ or their family about their necessary self-care	25(23.6%)	25(23.6%)	17(16%)	39(36.8%)	106(100%)
8.Preparing a patient or their family for his/ her hospital discharge	37(35.6%)	11(10.6%)	20(19.2%)	36(34.6%)	104(100%)
9.Monitor a patient as closely as prescribed by a physician or as was necessary	19(18.4%)	20(19.4%)	29(28.2%)	35(34%)	103(100%)
10.Coming in person on time by a physician after giving him a call due to an acute or sudden change in a patient's condition	17(13.2%)	25(23.6%)	30(28.3%)	37(34.9%)	106(100%)
11.Keeping a patient who had called for a nurse waiting longer than 5 min	16(15.2%)	29(27.6%)	25(23.8%)	35(33.3%)	105(100%)
12.Having enough time to go over the patient documentation	15(14.6%)	18(17.5%)	28(27.2%)	42(40.8%)	103(100%)
13.Setting up to date care plan	30(28.8%)	14(13.5%)	24(23.1%)	36(34.6%)	104(100%)
14.Documenting performed nursing care for a patient	28(26.9%)	15(14.4%)	25(24%)	36(34.6%)	104(100%)

Table 4 10 Measures of central tendency of scores for Nurses' role in quality care delivery

N	Valid	108
	Missing	0
Mean		2.554
Median		2.500
Mode		2.4
Std. Deviation		.8184
Skewness		-.304
Std. Error of Skewness		.233
Range		4.0
Minimum		.0
Maximum		4.0

As shown in Table 4.10, the measures of central tendency for nurses' perceptions of their role in the delivery of quality nursing care were calculated. There was a negative skewness as evidenced by the skewness statistic (-.304) being twice the size of the Standard Error of Skewness (.233). This negative skewness suggests that more than half participants were able to accomplish their role (mean score: 2.554) with a SD of .81. The minimum score obtained by the participant was .0 while the maximum was 4.

4.5. FACTORS AFFECTING THE DELIVERY OF QUALITY NURSE CARE IN NURSING PRACTICE

The presentation of findings related to the factors affecting the delivery of quality nursing care in the participants' clinical practice environment is presented according to five areas of nursing care environment as suggested by Aiken (2002). These areas include the participation of nurses in hospital affairs; nursing foundation of quality of care; nurse manager's ability, leadership, and support of nurses; staffing and resources; and nurse-physicians relationship. In the context of this dissertation, the results have been condensed and the answers strongly agree and somewhat agree have been grouped together to indicate the participants' agreement of the presence of those factors in their clinical practice environment. On the same lines, strongly disagree and somewhat disagree have been grouped to indicate that those factors were not present in their work environment.

4.5.1. Nurse participation in hospital affairs

As shown in Table 4.11, more than half (58.1%, n=61) of the participants were satisfied with the career development in their workforce environment, with 41.9% (n=44) being dissatisfied. Less than half of the participants (40.3%, n=61) were satisfied with the involvement of registered nurses in policy decisions, against 59.6% (n=62) who were not. The majority (77.8%, n=84) of participants were satisfied with the visibility and accessibility of the chief nursing officer, while 22.2% (n=24) were not. Only 45.8% (n=49) of participants were satisfied with the equality in power and authority to other top level hospital executives, whereas 54.2% (n=58) were not. More than half of the participants (61.3%, n=65) were satisfied with the opportunities for advancement in contrast to 38.6% (n=41) who disagreed.

.

Table: 4. 11. Nurse's participation in hospital affairs

Statement	Strongly disagree	Somewhat disagree	Somewhat agree	Strongly agree	Total
1.Career development/ clinical ladder opportunity	18(17.1%)	26(24.8%)	34(32.4%)	27(25.7%)	105(100%)
2.Opportunity for registered nurses to participate in policy decisions	38(36.5%)	24(23.1%)	30(28.8%)	12(11.5%)	104(100%)
3.A chief nursing officer who is highly visible and accessible to staff	7(6.5%)	17(15.7%)	34(31.5%)	50(46.3%)	108(100%)
4.A chief nursing officer is equal in power and authority to other top level hospital executives	26(24.3%)	32(29.9%)	26(24.3%)	23(21.5%)	107(100%)
5.Opportunities for advancement	17(16%)	24(22.6%)	32(30.2%)	33(31.1%)	106(100%)
6.Management that listens and responds to employee concerns	16(14.8%)	14(13%)	37(34.3%)	41(38%)	108(100%)
7.Registered nurses are involved in the internal governance of the hospital (e.g., practice and policy committees)	25(23.4%)	13(12.1%)	29(27.1%)	40(37.4%)	107(100%)
8. Registered nurses have the opportunity to serve on hospital and nursing committees.	18(17%)	23(21.7%)	45(42.5%)	20(18.9%)	106(100%)

More than half of the participants (72.3%, n=78) were satisfied with the way in which the management listened to and responded to their concerns, against 27.8% (n=30) who were not A considerable number of participants (64.5%, n=69) were satisfied with the way registered

nurses were involved in the internal governance of the hospital, while 35.5% (n=38) were dissatisfied. Of the participants, 61.4% (n=65) were satisfied with the way registered nurses had the opportunity to serve on hospital and nursing committees, against 38.7% (n=41) who were dissatisfied.

Measures of central tendency of total score for nurses' participation in hospital affaires were computed. There was negative skewness as shown by the skewness statistic (-.385) being twice the size of the Standard Error of skewness (.233). This negative skewness indicates that the majority of participants were involved in hospital affairs (mean score: 2.6 with a standard deviation of .7). The minimum score obtained by the participant was .9 whereas the maximum was 4, as shown in Table 4.12.

Table 4 12 Measures of central tendency of scores for nurses' participation in hospital affairs

N	Valid	108
	Missing	72
Mean		2.669
Median		2.600
Std. Deviation		.7028
Skewness		-.385
Std. Error of Skewness		.233
Range		3.1
Minimum		.9
Maximum		4.0

4.4.2. Nursing foundation for quality of care

Table 13 shows that the majority of the participants (73.9%, n=79) agreed that there was active staff development and continuing education programmes for nurses, with only 26.2% (n=28) who disagreed. The majority of the participants (75.5%, n=77) indicated that the managers expected high standards of nursing care, against 24.5% (n=25) who disagreed. The majority of the participants (72.4%, n=76) accepted that there was a clear philosophy of nursing that pervades the patient care environment, whereas 27.4% (n=29) denied this. The majority of the participants (77.2%, n=81) agreed that they worked with nurses who are

clinically competent, in contrast to 22.8% (n=24) who disagreed. The majority of the participants (74.3% (n=78) agreed that there was an active quality assurance programme, with only 25.7% (n=27) who disagreed. The majority of the participants (72.9%, (n=78) confirmed that there was a preceptor programme for newly hired nurses in their workforce environment, against 27.1% (n=29) who disagreed.

Table 4 13 Nursing foundation for quality of care

Variable	Strongly disagree	Somewhat disagree	Somewhat agree	Strongly agree	Total
1.Active staff development or continuing education programs for nurses	11(10.3%)	17(15.9%)	48(44.9%)	31(29%)	107(100%)
2.High standards of nursing care are expected by the management	11(10.8%)	14(13.7%)	34(33.3%)	43(42.2%)	102(100%)
3.A clear philosophy of nursing that pervades the patient care environment	13(12.4%)	16(15.2%)	4.3(41%)	33(31.4%)	105(100%)
4.Working with nurses who are clinically competent	6(5.7%)	18(17.1%)	34(32.4%)	47(44.8%)	105(100%)
5.An active quality assurance program	13(12.4%)	14(13.3%)	38(36.2%)	40(38.1%)	105(100%)
6.A preceptor program for newly hired nurses	10(9.3%)	19(17.8%)	38(35.5%)	40(37.4%)	107(100%)
7.Nursing care is based on a nursing rather than a medical model	9(8.3%)	19(17.6%)	30(27.8%)	50(46.3%)	108(100%)
8.Written, up-to-date care plans for all patients	6(5.6%)	11(10.3%)	30(28%)	60(56.1%)	107(100%)
9. Patient care assignments that foster continuity of care (i.e., the same nurse cares for the patient from one day to the next day).	8(7.5%)	17(16%)	30(28.3%)	51(48.1%)	106(100%)

The majority of the participants (74%, (n=80) asserted that the nursing care was based on a nursing rather a medical model, whereas 25.9% (n=28) disagreed. Most of the participants (84.1%, n=90) agreed that there were written, up-to-date care plans for all patients in contrast to 15.9% (n=17) who disagreed. The majority of the participants (76.4%, n=81) agreed that there was a patient care assignment that fosters continuity of care, while 23.5% (n=25) disagreed

Measures of central tendency of the total score for nursing foundation of quality were calculated. There was a negative skewness as shown by the skewness statistic (-.388) being twice the size of the Standard Error of skewness (.233). This negative skewness indicates that there were strategies to maintain quality of care in the workplace (mean score: 3, SD of .7, Md of 3.1). The minimum score obtained by a participant was 1.4 while the maximum was 4, as displayed in Table 4.14.

Table 4 14 Measures of central tendency of scores for nursing foundation of quality

N	Valid	108
	Missing	72
Mean		3.017
Median		3.100
Std. Deviation		.5835
Skewness		-.338
Std. Error of Skewness		.233
Range		2.6
Minimum		1.4
Maximum		4.0

4.4.3. Nurse Manager's ability, leadership and support of nurses

Table 4.15 demonstrates that the majority of the participants (72.4%, n=76) agreed that supervisory staff was supportive of nurses in their workforce environment, against 27.6% (n=29) who disagreed. The majority of the participants (87%, n=94) appreciated the manner in which the nurse managers played their managerial and leadership roles in their workforce environment, whereas 13% (n=14) disagreed. More than half of the participants (66.3%,

n=71) agreed that they were given praise and recognition for a job well done, against 33.7% (n=36) who disagreed. A considerable number of the participants (59.8%, n=61) agreed that the nurse manager supported the nursing staff in the decisions they had made, even if it was in conflict with a physician, in contrast to 40.1% (n=41) who were in disagreement.

Table 4 15 Nurse manager's ability, leadership and support of nurses

	Strongly disagree	**Somewhat disagree**	**Somewhat agree**	**Strongly agree**	**Total**
1.A supervisory staff that is supportive of nurses	14(13.3%)	15(14.3%)	46(43.8%)	30(28.6%)	105(100%)
2.A nurse manager who is a good manager and leader	6(5.6%)	8(7.4%)	36(33.3%)	58(53.7%)	108(100%)
3.Praise and recognition for a job well done	16(15%)	20(18.7%)	38(35.5%)	33(30.8%)	107(100%)
4.A nurse manager who backs up the nursing staff in decision making, even if the conflict is with a physician	18(17.6%)	23(22.5%)	35(34.3%)	26(25.5%)	102(100%)

Measures of central tendency of the total score for nurse manager's ability were calculated. There was a negative skewness, as shown by the skewness statistic (-.547) being twice the size of the Standard Error of skewness (.233). This negative skewness suggests that the majority of the participants appreciated the manager's ability and leadership (mean score: 3, SD of .7, Md of 3). The minimum score obtained by a participant was 1, while the maximum was 4, as displayed in Table 4.15

Table 4 16 Measures of central tendency of scores for nurses' ability and leadership

N	Valid	108
	Missing	72
Mean		2.890
Median		3.000
Std. Deviation		.7066
Skewness		-.547
Std. Error of Skewness		.233
Range		3.0
Minimum		1.0
Maximum		4.0

\

4.4.4. Staffing and resources adequacy

Table 4.16 indicates that the most of the participants (72.8%, n=75) agreed that there were adequate support services allowing nurses to spend time with the patients in their workforce environment, against 27.2% (n=27) who disagreed. The majority of the participants (79.2%, n=84) agreed that there was enough time and opportunity to discuss patient care problems with other nurses in the workforce environment, whereas 20.7% (n=21) disagreed. The majority of the participants (76.7%, n=79) agreed that there were enough registered nurses on the staff to provide quality patient care, with 23.3% (n=24) disagreeing. More than half of the participants (59.8%, n=64) agreed that there was enough staff to get the work done, against 40.2% (n=43) who were in disagreement.

Table 4 17 Staffing and resource adequacy

Variable	Strongly disagree	Somewhat disagree	Somewhat agree	Strongly agree	Total
1.Adequate support services allow me to spend time with my patients	17(16.5%)	11(10.7%)	40(38.8%)	35(34%)	103(100%)
2.Enough time and opportunity to discuss patient care problems with other nurses	5(4.7%)	17(16%)	19(17.9%)	65(61.3%)	108(100%)
3.Enough registered nurses on staff to provide quality patient care	8(7.8%)	16(15.5%)	30(29.1%)	49(47.6%)	103(100%)
4.Enough staff to get the work done	23(21.5%)	20(18.7%)	37(34.6%)	27(25.2%)	107(100%)

Measures of central tendency of the total score for staffing and resources adequacy were calculated. There was a negative skewness as represented by the skewness statistic (-.355) being twice the size of the Standard Error of skewness (.233). This negative skewness suggests that the majority of the participants appreciated the level of staffing and resources available to provide quality nursing care (mean score: 2.9, SD of .76, Md of 3). The minimum score obtained by a participant was .8 while the maximum was 4, as displayed in Table 4.17.

Table 4 18 Measures of central tendency of scores for staffing and resources adequacy

N	Valid	108
	Missing	72
Mean		2.948
Median		3.000
Std. Deviation		.7602
Skewness		-.355
Std. Error of Skewness		.233
Range		3.2
Minimum		.8
Maximum		4.0

Table 4.19 Collegial nurse-physician relations

Variable	Strongly disagree	Somewhat disagree	Somewhat agree	Strongly agree	Total
1.Physicians and nurses have good working relationships	8(7.4%)	13(12%)	30(27.8%)	57(52.8%)	108(100%)
2.Physicians value nurses' observations and judgments	12(11.3%)	26(24.5%)	43(40.6%)	25(23.6%)	106(100%)
3.Physicians recognize nurses' contributions to patient care	7(6.5%)	18(16.8%)	38(35.5%)	44(41.1%)	107(100%)
4.A lot of team work between nurses and physicians	10(9.4%)	10(9.4%)	30(28.3%)	56(52.8%)	106(100%)
5.Physicians respect nurses as professionals	12(11.5%)	23(22.1%)	29(27%)	40(38.5%)	104(100%)
6.Collaboration between nurses and physicians	6(5.6%)	16(15%)	35(32.7%)	50(46.1%)	107(100%)
7.Physicians hold nurses in high esteem	20(19%)	27(25.7%)	38(36.2%)	20(19%)	105(100%)

4.4.5. Collegial nurse-physician relations

Table 4.18 displays that the majority of the participants (80.6%, n=87) agreed that there were good working relationships between physicians and nurses in their workforce environment, against 19.4% (n=21) who disagreed. Of participants, 64.2% (n=68) agreed that physicians value nurses' observations and judgments, while 35.8% (n=38) disagreed. The majority of the participants (76.6%, n=82) agreed that physicians recognize nurses' contributions to patient care, whereas 23.3% (n=25) disagreed. The majority of the participants (81.1%, n=86) agreed that there was a lot team work between nurses and physicians, while 18.8% disagreed. The majority of the participants (65.5%, n=69) agreed that physicians respect nurses as professionals, in contrast to 33.6% (n=35) who disagreed. The majority of the participants (78.8%, n=85) agreed that there was good collaboration (joint practice) between nurses and

physicians in their workforce environment, whereas 20.6% (n=22) disagreed. A considerable number of the participants (55.2%, n=58) agreed that physicians held nurses in high esteem, whereas 44.7% (n=47) disagreed.

Measures of central tendency of the total score for nurse-physicians relationships were calculated. There was a negative skewness as represented by the skewness statistic (-.485) being twice the size of the Standard Error of skewness (.233). This negative skewness suggests that the majority of the participants maintained there was a good relationship between nurse and physician in the workforce (mean score: 2.9, SD of .69, Md of 3). The minimum score obtained by a participant was 1, whereas the maximum score was 4, as shown in Table 4.19.

Table 4 19 Measures of central tendency of scores for nurse-physicians relationships

N	Valid	108
	Missing	72
Mean		2.922
Median		3.000
Std. Deviation		.6910
Skewness		-.485
Std. Error of Skewness		.233
Range		3.0
Minimum		1.0
Maximum		4.0

4.5. ASSOCIATIONS BETWEEN DEMOGRAPHIC VARIABLES AND NURSES PERCEPTIONS OF QUALITY NURSING CARE

Associations were computed between demographic variables and the mean scores of the participants' perceptions of quality nursing care. The perceptions of quality nursing care were divided into two scoring categories: understanding of quality nursing care and the delivery of quality nursing care. The mean scores of both categories were computed, giving the scores of 4.183 for understanding of quality nursing care, and 4.137 for the delivery of quality nursing care. Although there is a slight difference in these mean scores, the findings show that participants agreed more with the perceptions of quality nursing care based on their

understanding, rather than on its delivery. Therefore, independent t-tests were used as they are suggested to be suitable for indicating the difference between two groups as well as comparing the mean scores (Pallant, 2007). Taking into account the categorization of age ranged from 20-30, 31-40, 41-50 and older than 51, and nursing work experience ranged from 6 months to 5, 6-10, 11-20 and more than 21 years, the one-way analysis of variance was used. This test was necessary to ensure that there is no variance (variability in scores) between those groups. In addition, the use of correlation was adopted to check whether there is any linear relationship between demographic variables and participants' perceptions of quality nursing care.

4.5.1. Associations using an independent-samples t-test

4.5.1.1. Association between participants' gender and the understanding of quality nursing care

An independent-samples t-test was conducted to compare the participants' understanding of quality nursing scores for males and females. There was a significant difference in scores for males (M= 3.900, SD=.68) and females (M= 4.240, SD=.54); t (106) = 2.341, p= .021 (two tailed). The magnitude of the differences in the means (mean difference =.34, 95% CI: -.05 to .63) was very small (eta squared= 0.04). This suggests that female participants understand better the meaning of quality nursing care than the male ones.

4.5.1.2. Association between participants' gender and the delivery of quality nursing care

An independent-samples t-test was conducted to compare the participants' perceptions of the delivery of quality nursing scores for males and females. There was little difference in scores for males (M= 4.100, SD=.59) and females (M= 4.144, SD= .57); t (106) = .290, p= .774 (two tailed). Therefore, the magnitude of the differences in the means (mean difference =.0444, 95% CI: -27 to .36) was very small (eta squared= 0.001).

4.5.1.3. Association between participants' qualification and understanding of quality nursing care

An independent-samples t-test was conducted to compare the understanding of quality nursing scores for enrolled nurses and registered nurses. There was little difference in scores for enrolled nurses (M=4.187, SD=.55) and registered nurses (M= 4.176, SD= .62); t (66.789)

=.096, P=.924 (two tailed). Therefore, the magnitude of the differences in the means (mean difference =.0.116, 95% CI: -.22 to .25) was very small (eta squared=0.00008).

4.5.1.4. Association between participants' qualification and the delivery of quality nursing care

An independent-samples t-test was conducted to compare the participants' perceptions of the delivery of quality nursing care scores for enrolled nurses and registered nurses. There was little difference in scores for enrolled nurses (M=4.148, SD=.60) and registered nurses (M= 4.116, SD=.53); t (106) =.270, P=.788 (two tailed). Therefore, the magnitude of the differences in the means (mean difference =.0317, 95% CI: -.20 to .26) was very small (eta squared= 0.007).

4.5.2. Associations using a one way analysis of variance

4.5.2.1. ANOVA between age and understanding quality nursing care score

A one-way between groups analysis of variance was conducted to explore the impact of age on the understanding of quality nursing care. Subjects were divided into four groups according to their age (group 1: 20-30 years old; group 2: 31-40 years old; group 3: 41-50 years old; and group 4: 51 and above). There was no statistical difference at p less than .05 level in understanding score for the four groups: F (3, 100) = .436, p=.728.

4.5.2.2. ANOVA between the age and the delivery of quality nursing care score

A one-way between groups analysis of variance was conducted to explore the impact of age on the nurses' perceptions on the delivery of quality nursing care. Subjects were divided into four groups according to their age (group1: 20-30 years old; group 2: 31-40 years old; group 3: 41-50 years old; and group 4: 51 and above). There was no statistical difference at p less than .05 level in understanding score for the four groups: F (3, 104) = 1.833, p=.146.

4.5.2.3. ANOVA between work experience and understanding of quality nursing care

A one-way between groups analysis of variance was conducted to explore the impact of work experience on the understanding of quality nursing care. Participants were divided into four groups according to their years of work experience (group1: 1-5 years; group 2: 6-10 years; group 3: 11-20 years; and group 4: 21years and above). There was no statistical difference at p less than .05 level in understanding score for the four groups: F (3, 100) = .436, p=.728.

4.5.2.4. ANOVA between the work experience and the delivery of quality nursing care

A one-way between groups analysis of variance was conducted to explore the impact of work experience on the delivery of quality nursing care. Subjects were divided into four groups according to their years of work experience (group1: 1-5 years; group 2: 6-10 years; group 3: 11-20 years; and group 4: 21 years and above). There was no statistical difference at p less than .05 level in understanding score for the four groups: F (3, 100) = .096, p=.829.

4.5.3. Associations using Spearman's rho correlation

4.5.3.1.Correlation between participants' age and understanding of quality nursing care

The correlation between age and understanding of quality nursing score was done, but it did not show any evidence of linear relationship because Spearman's rho r= .160 was above the 0.05 cut-off.

Using a scatter plot, figure 4.2 below displays that there is no linear correlation between age and understanding of quality nursing care because the points are scattered all over the graph.

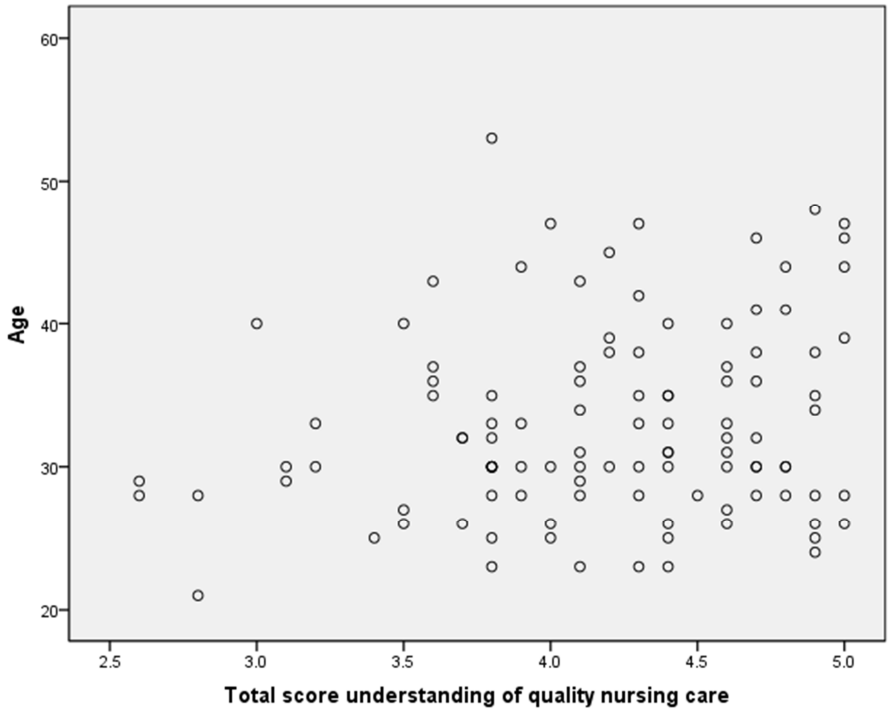

Figure 4 2 Scatter plot of age and perceptions of quality nursing care

4.5.3.2. Correlation between participants' age and delivery of quality nursing care

The correlation between age and the delivery of quality nursing care score was done but it did not show any evidence of linear relationship because Spearman's rho r= .148 was above the 0.05 cut-off.

The relationship between participants' age and delivery of quality nursing care was also measured using a scatter plot. The findings in figure 4.3 display that no linear relationship existed between age and delivery of quality nursing care due to these scattered points representing the values of age and delivery of quality nursing care.

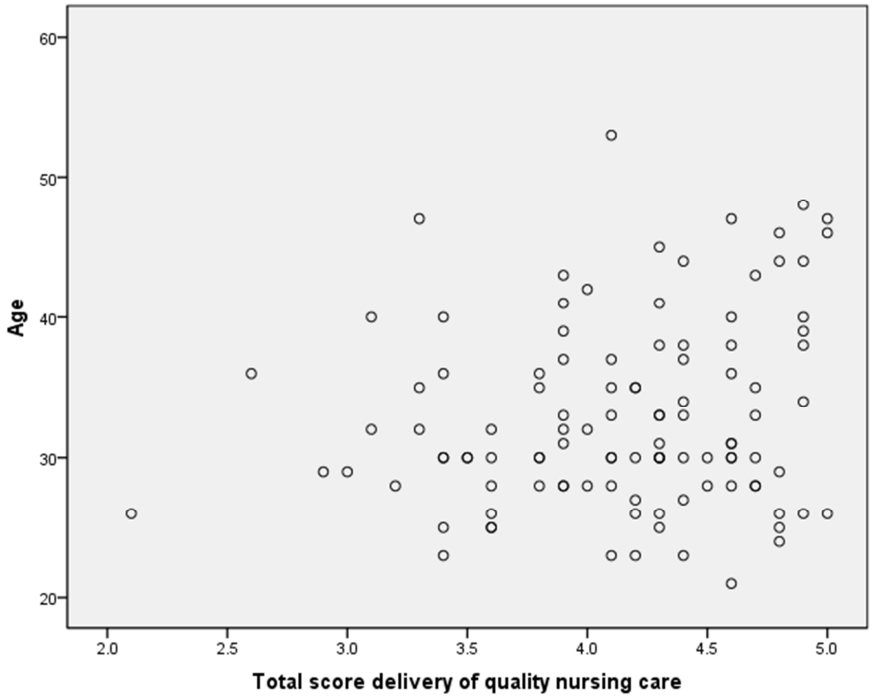

Figure 4 3 Scatter plot of age and delivery of quality nursing care

4.5.3.3. Correlation between participants' work experience and understanding of quality nursing care

The correlation conducted between participants' work experience and understanding of quality nursing care suggests that no linear relationship exists as Spearman's rho r= .148 was above the 0.05 cut-off.

As portrayed by figure 4.4, no linear relationship exists between working experience and understanding of quality nursing because the values are scattered around the graph.

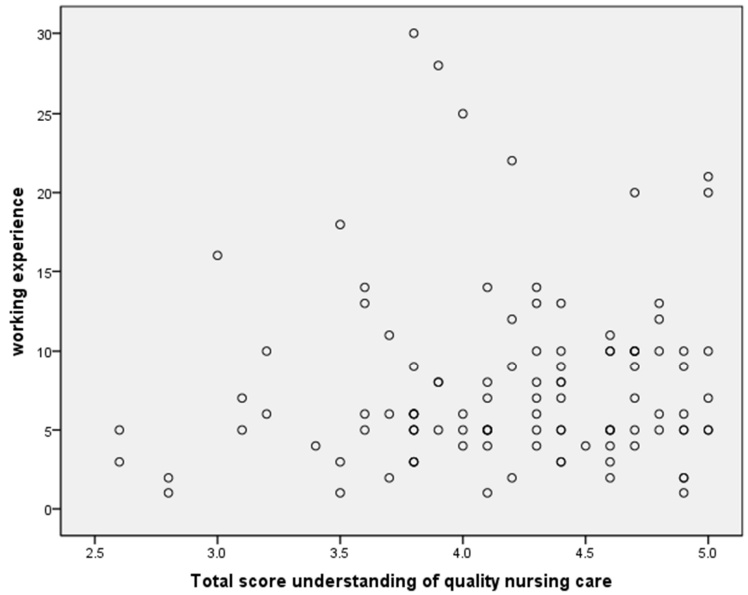

Figure 4 4 Scatter plot of working and understanding of quality nursing care

4.5.3.4. Correlation between participants' work experience and delivery of quality nursing care

There is no linear relationship between participants' work experience and the delivery of quality nursing care since Spearman's rho r= .148 was above the 0.05 cut-off.

As depictured in figure 4.5, no linear relationship exists between working experience and the delivery of quality nursing care because the values are scattered around the graph.

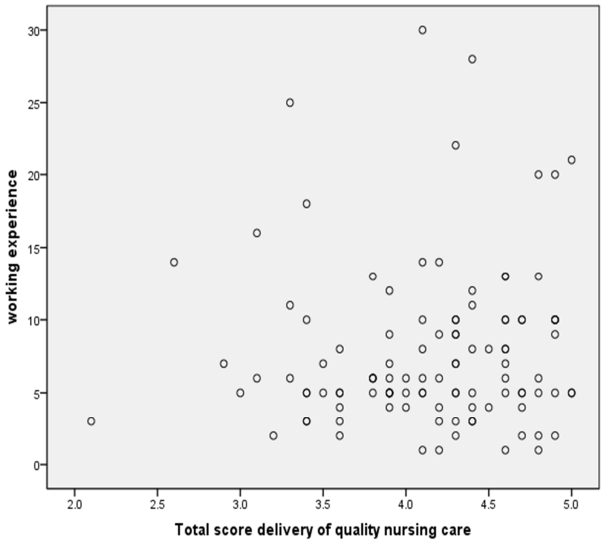

Figure 4 5 Scatter plot of working experience and delivery of quality nursing care

4.6.SUMMARY OF THE CHAPTER

This chapter presented the findings of the study. It is evident from this study that there are more female participants than males. Many of the participants (48.2%, n=52) fell into the 20-30 years old category, while 47.2% (n=51) of them had nursing experience of between 6 months and 5 years. The majority of participants (65.7%, n=71) were trained at secondary level, against 34.3% (n=37) who were at diploma level.

The findings showed that most participants had adequate perceptions of quality nursing care, as displayed by a high mean score of 4.183 (SD of .57) correlating with their understanding of quality nursing care against 4.137 mean scores (SD of .57) which were obtained for the delivery of quality nursing care. Although most participants perceive the meaning of quality nursing care, the results indicated that they experienced difficulty in delivering quality nursing care to patients due to staffing and heavy workload constraints.

Associations conducted between demographic variables and participants' perceptions of quality nursing care have underscored a statistical significant difference between male and female participants in respect of their understanding of quality nursing care (p= .021). It is therefore suggested that female participants understand better the meaning of quality nursing care than the male ones. However, there were no linear relationships between demographic variables and participants' perceptions of quality nursing care. The next chapter is dedicated to the discussion of major findings and recommendations made from this study

CHAPTER FIVE: DISCUSSION AND RECOMMENDATIONS

5.1.INTRODUCTION

This chapter presents the discussion of findings and recommendations. The purpose of the study was to explore the perceptions of quality nursing care among nurses working in two district hospitals in Rwanda. The significant findings will be highlighted and discussed according to the research literature related to quality nursing care. The discussion will be in line with the study objectives and describe the results within the context of the conceptual framework of the study, which is underpinned by the care environment, process of care, patient demographic variables and outcomes. This will be followed by the limitations of the study and the recommendations. The chapter will be closed with a summary.

5.2. STUDY DEMOGRAPHIC DATA

The results of the variables within the study sample demographics indicate; firstly, a predominance of female participants (83.3%, n=90) over males (16.7%, n=18). This gender distribution is quite similar to that reported in a Brazilian study about quality nursing care where 90.5% were female as compared to 9.5% male (Paganin, Moraes, Pokorski and Rabelo, 2008). According to Wilson (2005) gender balance does not currently exist in nursing. This male minority in nursing has been reported even in high income countries to the extent that only 10% and 7.9% of the registered nursing staff in the United Kingdom (UK) and the USA (United States of America) respectively, are men (Roth and Coleman, 2008). This gender-based imbalance is suggested to be related to the historical context of the nursing profession which is perceived internationally as a female gender-predominated profession (Alexander, 2010). Secondly, the average age of the participants was ±32.9 years, 6.7 [95% CI 31.6-34, 2], with the youngest being 21 and the oldest 53 years of age, with a median of 31 years and a standard deviation (SD=6.7). Drawing on this study, just less than half of the participants (48.2%, n=52) ranged between 20 to 30 years old, followed by 37% (n=40) who were between 31 and 40 years old. This study's findings are likened to those of a Chinese study about perceptions of quality nursing care where 68.33% of participants were between 20-30 old (Zhao, Akkadechanunt and Xue, 2008). However, this average is contrasted with that of the USA where the average age of registered nurses is estimated to be about 45.4 years old, with the concern that according to the projections, 40% of the registered nurses are likely to be older than 50 in the next 10 years (Keller and Burns, 2010). The authors suggested,

however, that as the nurses were within the normal age range, they would still be productive in their workforce. This was supported by several authors arguing that older nurses are more skilled, more productive and more committed at work and are thus best to provide quality of care to patients (Keller and Burns, 2010; Sorrell, 2010).

Thirdly, in this study, the majority of participants (65.7%, n=71) were trained at secondary level (enrolled nurse) against 34.3% (n=37) who were at diploma level (registered nurse). This may be due to the fact that before 2007 most Rwandan nurses were trained at secondary level to be recognized as enrolled nurses with few registered nurses being trained at diploma level at Kigali Health Institute. However, this secondary training no longer exists and nursing training is being done at diploma level and Bachelor's level in Rwanda (Roxburgh et al., 2009).

Finally, the findings showed that the largest portion of the participants had a mean of 7.7 years of working experience with a median of 6 years. In this sample, almost half of the participants (47.2%, n=51) had working experience of between 6 months and 5 years, followed by 34.3% (n=37) who had been practising for between 6 and 10 years, 13.9% (n=15) have worked between 11 and 20 years and 4.6% (n=5) have worked for longer than 21 years. The reason that there are so many nurses that are new to the nursing profession may correlate the fact that most of health professionals had been killed or exiled during the genocide in 1994 and that nursing education in Rwanda has only recently been resumed (Ministry of Health, 2008). There can be no doubt, however, that nurses' experience and knowledge of nursing is vital to the delivery of quality nursing care (Sorrell, 2010; Paganin et al., 2008).

5.3. NURSES PERCEPTIONS OF QUALITY NURSING CARE

5.3.1. Nurses' understanding of quality nursing care

Drawing on the findings from this study, 97.1% (n=101) of participants perceived that good quality nursing care is holistic care that is responsive to the physical, psychological, social and spiritual needs of the patients. These findings are similar to those found in a Thai study where nurses perceived high quality nursing care as a comprehensive care whereby psychological, emotional, social and spiritual dimensions of the patients are taken into consideration while providing nursing care to patients (Kunaviktikul et al., 2001). Similar

findings were also reported by William (1998) who suggests that in addition to all of those aspects being met, extra care should be given to the patient. However, it is appalling to hear that many patients are not receiving comprehensive care since the psychosocial aspect is mostly overlooked by nurses (Sanders, Bantum, Owen, Thornton and Stanton, 2010). In this regard, an illustration was made by Hill, Amir, Muers, Connolly and Round (2003), whereby about 43% of patients in UK did not benefit from psychosocial nursing care.

In this study, the majority of participants (87.7%, n=92) believed that high quality nursing care should be based on a nurse-patient relationship. These findings are consistent with those reported in previous studies where it has been documented that communication between nurses and patients is a vital driving force for the delivery of high quality nursing care (Ipsos MORI Social Research Institute, 2010). This was the view of Honzak (1999), referred to by Zacharova and Gulasova (2011), who asserted that a relationship between nurse and patient mediated by communication is necessary, unavoidable and unrepeatable. Zacharova and Gulasiva (2011) go on to highlight the value of communication in nursing care delivery in that it helps implement the nursing process and improve the quality of nursing care. However, maintaining a good nurse-patient interaction is not easy since it is incumbent upon nurses to be responsive, to take time to listen to the patient, as well as to demonstrate the interest and a commitment in contacts with the patient (Milutinovic, Brestovacki and Cvejin, 2010). Bearing this in mind, Bach and Grant (2010) remind their readers that failure to interact effectively and collaboratively between nurses and patients is prone to decreased quality nursing care.

About 76.7% (n=82) of the participants rated nursing care provided by nurses who are endowed with interpersonal skills as optimal nursing care. In line with these findings, Zenobia (2010) argued that nurses who are sufficiently equipped with interpersonal skills are able to build a trustful relationship between themselves and the patients, and by establishing such rapport they help the patients to verbalise and experience their feelings.

It is worthwhile to notice that in this study, the majority of participants (96.3%, n=104) strongly agreed that good nursing care would be provided by nurses who are competent in technical skills. It is documented in nursing literature that nurses' competence and technical skills in the delivery of quality nursing care are not only indicative of professionalism, but are

also an indubitable source of satisfaction of care towards patients (Milutinovic et al., 2010; Johansson et al., 2002).

In this study, a considerable number of participants (76.9%, n=90) asserted that good quality nursing should include individualized care. In line with these findings, Radwin (2000) maintained that individualized care is critical in the delivery of quality nursing care since patients' experiences, behaviours, feelings and/or perceptions are taken into account during the delivery of nursing care. Similarly, Zhao and colleagues (2008) argued that the essence of individualization of nursing care dwells in the valorisation of uniqueness of the patient as a human being leading to high quality nursing care.

About 82.3% (n=88) of the participants asserted that good nursing care should be knowledge-based. When nursing care delivered to individuals and groups through the expertise of professional nurses and this care strives to meet the quality outlined by the best evidence, it can be considered nursing excellence (Spears, Thornton and Long, 2008). This is not always the case, however, as a Grimshaw and Eccles (2004) displayed stating that although evidence based practice is critical to improve patient outcomes, it is not being translated into practice. In this view, Grimshaw and Eccles (2004) reported that about 30% - 40% of patients are cared for using interventions that are not evidence-based, while 20% - 25% of the care rendered is not needed or harmful to patients. Sadly, it is disappointing to hear that only 15% of the available evidence-based practice is being incorporated into practice while delivering nursing care to patients (Shirey, 2006).

5.3.2. Nurses' perceptions of the delivery of quality nursing care

Drawing on the findings from this study, almost all the participants (98.1%, n=105) rated listening to patients as an invaluable way of delivering high quality nursing care. These findings were consistent with those found in a study by Shipley (2010: 125) who regarded listening as a "*critical component of all aspects of nursing care and is necessary for meaningful interactions with patients"*. To corroborate Shipley, Browning and Waite (2010) argued that listening is of utmost importance in the delivery of quality nursing care in the sense that it serves as a potentially powerful tool in designing treatment plans, improving patient compliance, decreasing costs, increasing efficacy and improving nurse-patient interactions.

In this study, about 85.1% (n=86) of participants regarded meeting the physical needs of the patients as a quality nursing care delivery to patients. According to Rafii et al. (2008) meeting the physical needs of patients is the essence of caring in nursing. In a study by Radwin (2000:187) patients explained it as follows: *"It's caring that you're not in pain, caring that you're comfortable, caring that you're clean, caring that you get your medications"*.

Most of the participants (93.4%, n=99) agreed that making the patient feel comfortable in a caring environment was an aspect of quality nursing care. These findings were in keeping with those of a study by the Ipsos MORI Social Research Institute (2010) where nurses perceived the quality nursing care delivery as looking after the patients and being certain that they are comfortable and happy in their environment. According to Rafter (2011), when the caring environment is not comfortable for the patients, quality nursing care may be compromised and patients are susceptible to develop negative outcomes such as pressure ulcers.

Nearly all of the participants (96.3%, n=103) agreed that teaching and informing the patients were of great value in providing high quality nursing care. This is true as suggested by Milutinovic and colleagues (2010), who state that adequate information before hospitalization, during patients' stay in the hospital and immediately before discharge is the constitutive part of the treatment. Hatonen et al., (2010), suggest that nurses should provide health education to patients to the extent that they become empowered to self-care, as this results in improved patient outcomes. Evidence of this has been illustrated by patients who live with chronic diseases. Furthermore, in a study by Koutsopoulou et al., (2010), it was concluded that the role of nurses in information delivery is vital as they provide different types of information and are sometimes better than physicians in giving information.

In this study, a considerable number of participants (67.3%, n=72) asserted that meeting patients' emotional needs could be considered as an aspect of quality nursing care delivery. These findings were consistent with those of a study by Lalani et al., (2011), who stated that supportive and non-pharmacological measures should be made an essential part of care and need to be prioritized over the routine aspects of care, especially in a palliative care setting. This was further supported by Jones (2007), highlighting that about 50% of patients who are screened cancer positive, experience symptoms of anxiety and depression, but their psychological needs often go unrecognized and unmet.

Advocating for the patient as delivery of quality nursing care was supported by the majority of participants (82.2%, n=83). In line with these findings, it has been documented that advocacy for patients is an important aspect of current professional nursing care and is considered to be of fundamental value to professional nursing (Hanks, 2010 ; Mahlin, 2010). Therefore, it is incumbent upon nurses to safeguard patient autonomy, acting on behalf of the patients who are not able to act for themselves, and champion social justice (Paquin, 2011; Bu and Jezewski, 2007). Moreover, Hanks (2010) maintained that the effective use of advocacy can potentially decrease communication errors and provide for increased patient safety.

The majority of participants (98.2%, n=106) asserted that a good multidisciplinary team is necessary to deliver quality nursing care. In the light of these findings, Cioffi et al. (2010) documented the benefits of care given by a multidisciplinary team, which included improvement in disease management, adherence to guidelines for chronic illnesses, promotion of self-management programs and client-focused education resulting in continuous quality care improvement.

5.4.ROLE OF NURSES IN CONTINUOUS QUALITY IMPROVEMENT

In this study, nurses were requested to consider the context in which they had been practising during the previous seven days and share their experiences related to the necessary nursing care delivery towards patients. As a result of time constraints and excessive workload, only 55% (n=59) of participants had managed to assist patients to have a bath, 49% (n=51) had changed the positions of the patients and 47.1% (n=49) of participants had changed the patients' dirty bed linen. These findings were consistent with those in UK by Hill (2010) who reported the issues related to the delivery of basic nursing care to patients which included cases of patients who were left in soiled sheets with urine and faeces for considerable periods of time, unbearable standards of care, loss of patient dignity and poor hygiene of practice staff. However, Sprinks (2011) suggested that the provision of good care derives from treating all people as individuals and respecting their dignity.

The findings of this study indicated that few of the participants (46.7%, n=49) conversed with the patient and/or care provider. In line with this, in his study, Hill (2010) found that communication was a big challenge and that nurses failed to listen to patients. In contrast,

Zacharova and Gulasova (2011) argued that good communication helps to carry out the nursing process and improves the quality of nursing care.

In this study, about 47.2% (n=50) of the participants revealed that they educated the patients and their care providers. In line with these findings, the wealth of nursing literature documents that patient education has been broadly regarded as a core component of nursing (Lamiani and Furey, 2009; Freda, 2004). The importance of patient health education is that patients are kept abreast of their diseases and their role in illness management, leading to quality of care. In the same vein, Barrie (2011) argued that patients who are knowledgeable of illness management become empowered. According to Barrie, this involves being sure that patients have the knowledge, skills, attitudes and self-awareness to improve the quality of their lives. As most healthcare professionals provide care to people with chronic pain at some point, it is their responsibility to prepare patients to make informed decisions about their treatment. Empowering patients to self-manage their chronic pain can lead to improved person-centred outcomes (Barrie, 2011). Furthermore, DeMarco and Nystrom (2010) argued that individuals with low health literacy may be unable to make the necessary decisions regarding their health or may not be able to adhere to maintenance guidelines as prescribed by their physicians. The consequences of this poor health literacy have been also reported by DeWalt et al., (2004), who highlight that patients with low health literacy were generally 1.5 to 3 times more likely to experience a poor outcome. It is difficult for nurses to provide health education owing to a number of factors such as heavy workload and lack of time, teaching materials, competence and knowledge (Kalra, 2010; Freda, 2004).

Drawing on the findings from this study, about 46.2% (n=48) of the participants indicated that they had adequately prepared their patients and/or their family members for discharge from the hospital. In support of these findings, Mistiaen et al., (2007) asserted that discharge patient from hospital to home is not an easy process as it requires thorough preparation of the patient. In this regard, the literature highlights that deficits in discharge preparation is associated to several readmissions to the hospitals (Jack, Chetty, Anthony, Greenwald, Sanchez, Johnson et al., 2009; Mistiaen et al., 2007). Unfortunately, many patients and their family members have complained that they had not been sufficiently prepared for discharge and highlighted various problems that they had experienced after discharge suggesting that not adhering to medications and readmissions were linked to lack of adequate information (Weiss, Yakusheva and Bobay, 2011).

The findings from this study revealed that only 37.8% (n=39) of the participants reported that they had monitored the patients as recommended by the physicians. In line with these results, it has been reported that nurses are accountable for patient surveillance for the prevention and early detection of side effects (Aiken et al., 2002a). Adverse patient events have been reported elsewhere and can be extremely life threatening to the patients. For instance, it has been reported that in USA, that between 2.9 - 3.7% of acute care hospitalizations were suffering from adverse events (Lucero et al., 2009), while between 44,000 and 98,000 patients die in hospitals annually, with nearly half because of errors in the delivery of care (Institute of Medicine, 2000). Similarly, an Indian study by Kaur et al. (2011) revealed that a total of 208 adverse drug reactions (ADRs) were reported from 188 patients with cardio vascular diseases (19.5%). Of these 188 patients, 62 patients (33%) were hospitalized, primarily due to the development of ADRs, while 126 (67%) patients developed ADRs during their hospital stay. According to Goode et al. (2011), the need to decrease adverse patient outcomes and increase patient safety is a professional nursing imperative. This is obvious since high quality, safe care that is free from preventable error and harm is an expectation of all patients in healthcare settings (Blouin, 2010; Jukkala, Greenwood, Ladner and Hopkins, 2010).

The findings from this study demonstrated that few participants 41.3% (n=41) were able to document the care rendered to the patients. In light with these findings, Bjorvell (2003) argued that documentation of patient care is a fundamental, yet critical, skill used by nurses to communicate the current status of the patient's individual needs and response to care. Even though the documentation of patient is invaluable in the delivery of quality nursing it is often overlooked in clinical practice due to many reasons, including lack of knowledge, time, and heavy workload (Ammenwerth, Kutscha, Kutscha, Mahler, Eichstadter and Haux, 2001).

In light of the overall findings from this study related to nurses' experience with regard to their role in continuous quality improvement, a USA study by Lucero et al. (2010) revealed that, globally, about 28% or more care was left undone by nurses in hospitals due to nursing environmental factors, mainly lack of time. Lucero and colleagues suggested that more time is needed for nurses to spend more time with patients with a view of not only focusing on the necessary care, but also identifying signs and symptoms of complications resulting in prevention of adverse patient events. To conclude, Haigh and Ormandy (2011) argued that what nurses do depends on the number of nurses available as well as the time at their

disposal, rather than the dependency of the individual patients. Therefore, nurse managers need to streamline the nursing practice environment by taking care of the factors affecting the delivery of the quality nursing care.

5.5. FACTORS AFFECTING QUALITY NURSING CARE

5.5.1. Nurse participation in hospital affairs

In this study, about 58.1% (n=61) of participants were satisfied with their career development while more than half of the participants (61.3%, n=65) were satisfied with the opportunities for advancement in their nursing practice environment. These findings are supported by Beaulieu (1997), who stated that nurses become empowered through career development and opportunities for advancement in the sense that their knowledge, competence and skills are shaped and enhanced. In same line of reasoning, Craven and DuHamel (2003) maintained that career development and opportunities for advancement are not only vital in nursing profession for keeping nurses abreast of the nursing evidence-based practice related to advances technologies, therapeutic modalities, standards of practice, but are also retaining strategies for nurses. This was exemplified by Gould et al. (2007), arguing that continuing professional development has been adopted in UK as a nursing strategy to develop nurses as it has been associated with delivery of safe and effective care, increased nurses' job satisfaction and reduced attrition. In Ghana, Mensah et al. (2007) found out that distance learning for nurses has been opted for training nurses with a view of improving the delivery of quality nursing care to patients. Furthermore, the role of mentorship in developing nurses in clinical practice is credited in nursing literature as a strategy to improve quality of care, nursing staff retention and increased nurses' satisfaction (Wallen, Mitchell, Melnyk, Fineout-Overholt and Miller-Davis, 2010; Block, Claffey, Korow and McCaffrey, 2005). Finally, the literature highlights the value of clinical supervision not only for developing nursing staff and preventing burnout among nurses, but also for improving quality of patient care (Bondas, 2010; Brunero and Stein-Parbury, 2008)

However, lack of career development and opportunities for advancement have various detrimental effects on quality nursing care delivery as nurses are not motivated, become dissatisfied and decide to look for non-nursing jobs (Nasiripour and Siadati, 2011; Manzoor, Daud, Hashmi, Zafar, Khan, Zafar et al., 2010; Cortelyou-Ward, Unruh and Fottler, 2010). For instance, Lynn and Redman (2005) drew on Spratley, Johnson, Sochalski, Fritz, and Sencer (2002)'s work to document that in USA, between 1992 and 2000, roughly 28% of RNs who chose non-nursing jobs

because of dissatisfaction with factors in nursing had lacked career advancement and opportunities for advancement. Similarly, a study by Aiken, Clarke, Sloane, Sochalski and Silber (2002b), in the same country, revealed that about 40% of the nurses they surveyed were planning on leaving the nursing profession in the next year. In Belgium, DeCola and Riggins (2010) also reported that more than half of the nurses were contemplating to quit their job due to same phenomenon. Concurrently, based on the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) reports, Block (2005: 136) documented that *'inadequate orientation and training of nurses is a factor in 58% of serious errors'*.

The findings from this study indicated a small percentage of participants (40.3%, n=61) who were satisfied with the involvement of registered nurses in policy decisions. In line with these findings, the wealth of literature suggests that the quality of patient care is directly affected by the degree to which the hospital nurses are active and are empowered by hospital management in making decisions with respect to the provision of care to patients and by the extent to which they have an active and central role in organizational decision making (Jaafarpour and Khani, 2011; Armstrong and Laschinger, 2006). In this regard, Kunaviktikul and colleagues (2010) claimed that nurses' involvement in decisions making has been widely recognized in influencing health policy development and implementation in Thai health care systems. In contrast, it has been documented that the lack of involvement of nurses in policy decisions impacts negatively on the delivery of quality of care as nurses become frustrated, dissatisfied and less committed to their duties (Alam and Mohammad, 2010; Attree, 2005). Ultimately, Prybil (2007) suggested that nurses' voices be heard by hospital managers and that nurses be involved in hospital governance and decision making for streamlining continuous quality improvement of health care services. To conclude, Leiter and Laschinger (2006: 138) asserted that *"effective nurse leaders are more likely to support and encourage nurses' participation in decisions that affect their practice"*.

The findings from this study indicated that only 45.8% (n=49) of the participants were satisfied with the equality in power and authority to other top level hospital executives. In light with these findings, Beaulieu and colleagues (1997) asserted that power is one of the driving forces for making the nursing practice environment conducive for the delivery of quality nursing care. Beaulieu argues that it is in positions of power that nurse executives gain access to information, resources or supplies, and support necessary to meet the organizational goals, including the provision of quality of care to patients. To this point, in a

British study, Sprinks (2010) found that executive nurses are not given the appropriate authority and resources to ensure that their clinical areas are run effectively, despite the increasing demands of the job. According to Moran and colleagues (2011), the lack of positional power has the potential to make nursing and its influence less visible and accountable. Considering the nurses' role in high quality care delivery, Needleman and Hassmiller (2009) suggested that nurses leaders be represented at the highest levels of hospital leadership and integrated into hospital decision making. This was further supported by Francis (2010: 400) who concluded that '*both nursing and medical, are entitled to effective leadership at every level'*.

5.5.2. Nursing foundation of quality of care

Drawing on the findings from this study, the majority of the participants (74.3%, n=78) accepted that there was an active quality assurance programme. In line with these findings, Manghani (2011) argued that quality assurance should be present in clinical practice not only because it is an integral part of quality management, but also because it ensures that health professionals are practising in accordance with the standards of practice. Along the same line of thought, Larson and Muller (2002) asserted that quality assurance needs to be incorporated into practice as it is a driving force for continuous quality improvement based upon measures of quality. This suggests that without quality assurance it could be difficult, if not impossible, to ascertain whether the patients are receiving appropriate, effective, acceptable, efficient, efficacy, safe and continuity of care (Bilawka and Craig, 2003). To achieve this, it is important for hospitals to comply with regulatory and accreditation requirements (Larson and Muller, 2002) since accreditation is regarded as a method of emphasising the importance of continually improving practice (Garrett and Cowdell, 2010).

It is exciting to notice that the majority of the participants (74%, n=80) asserted that the nursing care was based on a nursing, rather a medical model. Indeed, the nursing literature urges nurses to be guided by the nursing model of care since it is patient-focused while the medical model is disease-focused (Leiter and Laschinger, 2006; Wimpenny, 2002). In a recent Australian study, Duffield, Roche, Diers, Catling-Paull, and Blay, (2010) found that the patient allocation model was the most credited by nurses since with this model not only their level of satisfaction and autonomy increase, but also the quality of patient care.

The findings from this study suggested that the majority of the participants (84.1%, n=90) concurred that there were written, up-to-date care plans for all patients. These findings are contrasted with those found in nursing literature where it has been documented that nursing care plans are mostly incomplete (Laitinen, Kaunonen and Åstedt-Kurki, 2010). For example, in a Brazilian study, Paganin and colleagues (2008) cited Reppetto and Souza (2005) to illustrate how nursing diagnosis was not recorded amongst the components of the nursing care plans although it is a cornerstone of nursing process (Olaogun, Oginni, Oyedeji, Nnahiwe and Olatubi, 2011).

In this study, the majority of the participants (76.4%, n=81) agreed that there was a patient care assignment that fosters continuity of care. These findings are in line with those found in a study by van Walraven (2010) stressing the importance of continuity of care in that it enhances the quality of patient care. Continuity of care is necessary because patients are mostly seen by a great deal of providers resulting in fragmentation of care (Haggerty, Reid, Freeman, Starfield, Adair and McKendry, 2003). Therefore, the care coordination is of great value so that it may be patient centred (Liss, Chubak, Anderson, Saunders, Tuzzio and Reid, 2011). In nursing practice, the primary nursing delivery model is suggested to be the best as it is aimed to provide individualized, comprehensive, co-ordinated and continuous patient-centred care (Booyens, 2008; Tiedeman and Lookinland, 2004). To recap, Haggerty and colleagues (2003) underlined three types of continuity of care which include informational continuity, management continuity and relational continuity. According to Haggerty and colleagues, informational continuity is necessary because every provider needs to be knowledgeable of care of the patient and this information should be shared from one provider to another and from one healthcare event to another. Management continuity is valuable in chronic or complex clinical diseases that require management from several providers who could potentially work at cross purposes. Relational continuity bridges not only past to current care, but also provides a link to future care (Haggerty et al. 2003).

5.5.3. Manager ability, leadership, and support of nurses

Drawing on the findings from this study, the majority of the participants (87%, n=94) appreciated the manner in which the nurse managers played the managerial and leadership role in their workforce environment. These findings are in keeping with those by Pillay (2010) who asserted that the primordial role of nurse managers and leaders is to keep on improving the nursing practice environment to the extent that it can be congruent with the

aspirations and value systems of nurses. This could result in subtle nurses' satisfaction and, in turn, lead to boosted productivity and positive patient outcomes (Mallot and Penprase, 2010). On the other hand, however, in a Slovenian study, Lorber and Savic (2011) argued that nurse managers are often criticized for using an inappropriate leadership style. This was conceded by Bondas (2006) in a Ghanaian study highlighting that a number of first-line nurse managers lack adequate education qualifications to accomplish their jobs effectively. Lorber and Savic (2011) documented that nurse managers and leaders are not equipped with managerial and leadership skills, since most of them had not acquired knowledge before taking up a leadership position, suggesting that they had either acquired it later or that they only improved it with workplace experience. In this stance, Curtis and O'Connell (2011) suggested that a transformational leadership approach be adopted by nurse managers to increase or maintain a motivating work environment. Brooks and Anderson (2004) concluded that education of nurse managers is needed to enable them to recognize nurses for a job well done.

In this study, more than half of the participants (66.3%, n=71) agreed that they received praise and recognition for a job well done. In line with these findings, inspired by the Herzberg theory, Vevoda et al. (2011) suggested that nurse managers might motivate subordinate nurses either through hygiene factors such as salary and infringe benefits or by motivators such as responsibility, promotion and recognition which will lead to better job satisfaction. To this point, Morgan and Lynn (2009) stated that hygienic factors are not as meaningful for today's nurses as they attach more importance to intrinsic satisfiers. To this end, Hayes et al. (2010) documented that the strategies which are most valued by nurses as praise and recognition for work well done included educational opportunities, professional development, empowerment and provision of professional pride. Similarly, Lorber and Savic (2011) reported that acknowledgement, praise, encouragement, feedback, opportunities to take responsibility, consistency and sincerity are important elements of praise and recognition. Failure to praise and recognize nurses for their commitments has been documented to be one of the main reasons for about 36% of nurses migrating from low income countries to the UK. This search for missed praise and recognition in the workforce has inflated the UK's Nursing and Midwifery Council (NMC) register from 2003/4 to 2005/6 (Nichols and Campbell, 2010). To conclude, Fairchild (2010: 353) stated that *"in the context of health care system complexity, nurses need responsive leadership and organizational*

support to maintain intrinsic motivation, moral sensitivity and a caring stance in the delivery of patient care".

5.5.4. Staffing and resources adequacy

Findings of this study showed that a high percentage of the participants (72.8%, n=75) agreed that there were adequate support services which allowed nurses to spend time with the patients in their workforce environment. These findings are contrasted with those found in a study by Peabody and colleagues (2005) who found that health professionals in low income countries are experiencing a lack of adequate support services to such an extent that they are often forced to provide care in uncertain settings. Even in high income countries, studies conducted in rural hospitals documented limited resources, inadequate information technology and small staffing as challenges to the delivery of quality nursing care (Jukkala et al., 2010; Casey and Moscovice, 2004). To this point, Clarke and Aiken (2008: 3317) underlined that *"across countries with different cultures and histories, nursing and healthcare leaders face similar issues with respect to workforce supply, quality and safety of care and financial constraints"*. In light of this, Leiter (2006) found that nurses value work environments that support their ability to provide quality patient care in accordance with the standards of the nursing profession.

Referring to the findings from this study, the majority of the participants (76.7%, n=79) agreed that there were enough registered nurses on staff to provide quality patient care while about 59.8% (n=64) of the participants agreed that there was enough staff to get the work done. These findings are contrasted with those reported by the Ministry of Health of Rwanda (2009) stating that majority of the health workforce is made up of enrolled nurses estimated to be roughly 50% (5,499) while only 4.9% (540) of this staff were RNs with advanced diplomas. Concurrently, Roxburgh et al. (2009: 349) underlined that: '*Rwanda has one of the greatest shortages in Africa of qualified nurses and medical staff*'. According to Aiken, Clarke and Sloane (2002a), the role of nurse staffing in quality improvement is of utmost importance in the sense that nurses should continually monitor the patients for the early detection of adverse occurrences, complications, and errors. In the same study, Aiken et al. argued that to make this monitoring effective, it is important to determine the nurse-to-patient ratios as well as nursing skill mix. Several nursing researchers have revealed that the better the nurses are educated, the higher the quality of nursing care that is delivered. This evidence has been based on recent studies which suggest that better educated hospital nurse workforces

are associated with lower patient mortality (Kendall-Gallagher, Aiken, Sloane and Cimiotti, 2011; Aiken et al., 2008; Tourangeau, Doran, Hall, Pallas, Pringle, Tu et al., 2007; Kane, Shamliyan, Mueller, Duval and Wilt, 2007; Estabrooks, Midodzi, Cummings, Ricker and Giovannetti, 2005; Aiken, Clarke, Cheung, Sloane and Silber, 2003). Despite the aforementioned findings, this study did not display any associations of quality of care with respect to their educational level. However, there was a statistical significant difference with respect to gender regarding the nurses' understanding of quality nursing care (P=.021, 95% CI: -.05 to .63).

Bearing this in mind, one can infer that understaffing constrains the delivery of quality nursing care as it is difficult to maintain the safety of the patients. Therefore, it is important for nurse leaders to constantly make sure that necessary human and material resources are available within the nursing practice environment in the quest for nursing excellence (Leiter and Laschinger, 2006). To conclude, Aiken and colleagues (2008: 223) suggested that *"care environment elements must be optimized alongside nurse staffing and education to achieve high quality of care"*.

5.5.5. Nurse-physician relationships

Drawing on the findings from this study, the majority of the participants (78.8%, n=85) agreed that there was a good collaboration between nurses and physicians in their workforce environment. These findings were supported by those found in an Egyptian study by Sayed and Sleem (2011), who regarded the collaboration and positive relationships between nurses and physicians to be important determinants of positive patient outcomes and quality of care. Similarly, McCaffrey et al. (2010) asserted that effective collaboration and communication do not only improve the patient outcomes, but also boost the nurses' job satisfaction. However, ineffective collaboration and communication between nurses and physicians can lead to medical errors resulting in the death of patients (Robinson, Gorman, Slimmer and Yudkowsky, 2010; Alvarez and Coiera, 2006). To illustrate this situation, Tschannen and Kalisch (2009) credited the Knaus, Draper, Wagner and Zimmerman, (1986)'s work to report a mortality rate 41% lower the predicted number of patient deaths (P=0.001) when there was a good nurse-physician collaboration in hospitals. In contrast, during the inefficiency of such collaboration the predicted number of patient deaths increased by 58%.

In this study, the majority of the participants (65.5%, n=69) agreed that physicians respected nurses as professionals. This concern has been also reported by Street and Cossman (2010) claiming that physicians sometimes are reluctant for nurses to practice independently. Manojlovich and Antonakos (2008) argued that this issue of respect may be related to subordinate role that nurses have played in the nursing profession in the past. To this point, Pullon (2008) found out that respect between nurse and physician is necessary since it may be at the same time a precursor or static factor in establishment of a successful inter-professional nurse-physician relationships.

5.6. LIMITATIONS OF THE STUDY

It is commonly known that any scientific investigation has its limitations, strengths and weaknesses. Hence, this study faced mainly methodological issues articulated as follows. Firstly, this study was conducted in only two of the district hospitals in the whole country and as it is not representative of the estimated 40 district hospitals in Rwanda, it therefore may not be extrapolated. Secondly, even although the researcher was not known to participants and strived to reduce desirability bias through implied consent and a data collection procedure that ensured privacy, it is likely that participants' responses did not represent their actual perceptions.

The strength of this study was that the researcher took the initiative to conduct an investigation related to quality of care, an issue which is not only difficult to explore, but is also underexplored due to its sensitivity.

The weakness of this study was that the purposive non-probability sampling method is suggested to be a weak design in the sense that it only targets the participants who are available during data collection, which could be a source of biases in study data.

5.7. RECOMMENDATIONS FROM THE STUDY

The recommendations of this study are made in relation to nursing administration, nursing practice, nursing education and nursing research.

5.7.1. Nursing administration

Drawing on the findings from this study and concurrently on those from other nursing scholars who informed this study, many factors that detract from quality nursing care have

been underlined. Therefore, for nurses to be motivated and committed to quality nursing care delivery there is a need for organizational leadership to:

- Provide adequate time for patient care by determining rationally appropriate nurse-patient ratios workloads;
- Provide opportunities for nursing career development and advancement through continuing nursing education with a view to upgrading the level of nurses in district hospitals, taking into account that they were still predominantly at secondary level of nursing education;
- Provide opportunities for nurse managers to develop their leadership and managerial skills, considering their role in maintaining a nursing practice environment conducive for the provision of quality nursing care to patients;
- Maintain adequate support by employing nurses with advanced levels of nursing training and increasing the medical staff personnel in the nursing practice environment; and
- Promote collegial, open communication as well as professional autonomy in the nursing practice environment.

5.7.2. Nursing practice

According to the findings from this study, optimal care was not delivered to the patients. Considering that caring is not only the essence of the nursing profession, but also essential for the delivery of quality nursing care, the following suggestions may be helpful:

- Implementation of daily nursing activities towards patients should be prioritized;
- Health education and information towards patients should be encouraged to increase their health literacy resulting in positive patient outcomes;
- Surveillance of the patients could be at the heart of nursing care with a view of providing safe and harm free nursing care towards patients; and
- Timely care towards patients should be enhanced and made through the collaboration of nurse-physicians.

5.7.3. Nursing education

Considering the value of managerial and leadership skills in making the nursing practice environment enticing as highlighted throughout this study, this following suggestion could be important:

- Nurse Managers should be encouraged to help patients receive evidence-based nursing care by regular clinical supervision and mentorship of subordinate nurses as these strategies are regarded as the essence of quality improvement.

5.7.4. Nursing research

In this study, the current state of the utilization of the evidence-based nursing care has been proffered as it is the cornerstone of quality improvement in health care systems. Considering the value of research in refining the extent of evidence-based care, the following suggestions should be of great value:

- Knowledge becomes obsolete when it is not updated. Therefore, it is suggested that despite their overburdened workloads, nurses take opportunities to read and partake in nursing research activities with a view of keeping themselves abreast of evidence-based practice in nursing;
- This topic has been explored using a quantitative approach. To this end, a similar study could be conducted using a qualitative research approach to uncover the meaning of the delivery of quality nursing care from the nurses' perspectives in relation to their workforce environment;
- Considering the influence of the delivery nursing care models in the provision of quality nursing care, it is suggested that other researchers could conduct investigations aimed to explore this phenomenon by finding out which model is suitable for the Rwandan context.
- An exploration of unmet nursing care in district hospitals based on patient documentations and reports could be critical in this journey towards nursing excellence; and
- An investigation about the exploration of the perceptions of quality nursing care from the patients' perspectives in district hospitals should be undertaken.

5.8. CONCLUSION

The purpose of this study was to explore the perceptions of quality nursing care among nurses working in two district hospitals in Rwanda in order to inform realistic context driven continuous quality improvement strategies. The findings from this study suggested that nurses have an appropriate perception of the meaning of quality nursing care, as evidenced by the mean score of 4.183 (SD: .5741) related to nurses' understanding of quality nursing care

with mean score of 4.137 (SD: .5763) for the perceptions of the delivery of quality nursing care. There was a significant statistical difference with respect to gender regarding the nurses' understanding of quality nursing care (P=.021, 95% CI: -.05 to .63). Furthermore, the role played by nurses in continuous quality improvement was evident, but constrained by the factors related the nursing practice environment in which they were operating. This study suggested that the factors affecting the delivery of quality nursing care included, amongst others, nurse understaffing, lack of time to complete nursing care, heavy workloads and few opportunities for advancement. Finally, the influence of the nursing practice environment on the delivery of quality nursing care has been extensively discussed.

REFERENCES

AIKEN, L. H., CLARKE, S. P., CHEUNG, R. B., SLOANE, D. M. & SILBER, J. H. 2003. Educational levels of hospital nurses and surgical patient mortality. *Journal of the American Medical Association* 290**,** 1617-1623.

AIKEN, L. H., CLARKE, S. P. & SLOANE, D. M. 2002a. Hospital staffing, organization, and quality care: cross-national findings. *Nursing Outlook,* 50**,** 187-194.

AIKEN, L. H., CLARKE, S. P., SLOANE, D. M., LAKE, E. T. & CHENEY, T. 2008. Effects of hospital care environment on patient mortality and nurse outcomes. *Journal of Nursing Administration,* 38**,** 223-229.

AIKEN, L. H., CLARKE, S. P., SLOANE, D. M., SOCHALSKI, J. & SILBER, J. H. 2002b. Hospital Nurse Staffing and Patient Mortality, Nurse Burnout, and Job Dissatisfaction. *The Journal of the American Medical Association,* 228**,** 1987-1993.

AIKEN, L. H., HAVENS, D. S. & SLOANE, D. M. 2000. The magnet nursing services recognition program: A comparison of two groups of hospitals. *American Journal of Nursing,* 100**,** 26-36.

ALAM, M. M. & MOHAMMAD, J. F. 2010. Level of job satisfaction and intent to leave among Malaysian nurses. *Business Intelligence Journal* 3**,** 123-137.

ALEXANDER, H. 2010. Upper Secondary Male Students' Perception of Nursing as a Career Choice. *International Journal for the Advancement of Science & Arts* 1**,** 46-62.

ALLEYNE, J. & JUMAA, M. O. 2007. Building the capacity for evidence-based clinical nursing leadership: The role of executive coaching and group clinical supervision for quality patient services. *Journal of Nursing Management,* 15 230-243.

ALMOST, J. & LASCHINGER, H. K. 2002. Workplace empowerment, collaborative work relationships, and job strain in nurse practitioners. *Journal of the American Academy of Nurse Practitioners,* 14**,** 408-20.

ALVAREZ, G. & COIERA, E. 2006. Interdisciplinary communication: An uncharted source of medical error? *Journal of Critical Care* 21**,** 236– 242.

AMERICAN COLLEGE HEALTH ASSOCIATION 2010. General Statement of Ethical Principles and Guidelines. *Journal of American College Health,* 59**,** 61-64.

AMERICAN NURSES ASSOCIATION 1996. *Nursing Quality Indicators: Guide for Implimentation*, American Nurses Publishing, Washington, DC, USA.

AMMENWERTH, E., KUTSCHA, U., KUTSCHA, A., MAHLER, C., EICHSTADTER, R. & HAUX, R. 2001. Nursing process documentation systems in clinical routine—prerequisites and experiences. *International Journal of Medical Informatics,* 64**,** 187–200.

ANDERSON, J. A. 2010. Evolution of the health care quality journey from cost reduction to facilitating patient safety. *The Journal of Legal Medicine,* 31**,** 59-72.

ARMSTRONG, K. J. & LASCHINGER, H. 2006. Structural Empowerment, Magnet Hospital Characteristics, and Patient Safety Culture: Making the Link. *Journal of Nursing Care Quality,* 21 124-132.

ARRIES, E. 2006. Practice standards for quality clinical decision-making in nursing. *Curationis,* 29**,** 62-72.

ATKINSON, S., INGHAM, J., CHESHIRE, M. & WENT, S. 2010. Defining quality and quality improvement. *Clinical Medicine,* 10 537-539.

ATTREE, M. 2005. Nursing agency and governance: registered nurses' perceptions. *Journal of Nursing Management,* 13**,** 387–396.

BACH, S. & GRANT, A. 2010. Book reviews: Communication & Interpersonal Skills for Nurses. *Nursing Management,* 16**,** 9.

BAKALIS, N. A. & WATSON, R. 2005. Nurses' decision-making in clinical practice. *Nursing Standard,* 19 33-39.

BAKER, G. R., NORTON, P. G., FLINTOFT, V., BLAIS, R., BROWN, A., COX, J., ETCHELLS, E., GHALI, W. A., HÉBERT, P., MAJUMDAR, S. R., O'BEIRNE, M., PALACIOS-DERFLINGHER, L., REID, R. J., SHEPS, S. & TAMBLYN, R. 2004. The Canadian adverse events study: the incidence of adverse events among hospital patients in Canada. *The Canadian Medical Association Journal,* 170**,** 1678-1686.

BAMFORD-WADE, A. & MOSS, C. 2010. Transformational leadership and shared governance: an action study. *Journal of Nursing Management,* 18**,** 815–821.

BARRIE, J. 2011. Patient empowerment and choice in chronic pain management. *Nursing Standard.,* 25**,** 38-41.

BATALDEN, P. B. & DAVIDOFF, F. 2007. What is ''quality improvement'' and how can it transform healthcare? *Quality and Safety in Health Care,* 16**,** 2-3.

BEAULIEU, R., SHAMIAN, J., DONNER, G. & PRINGLE, D. 1997. Empowerment and Commitment of Nurses in Long-Term Care. *Nursing Economics,* 15**,** 32-41.

BENBOW, M. 2011. Documentation: keeping accurate patient records. *Wound Essentials,* 6**,** 90-92.

BENNER, P. 1984. *From novice to expert: Excellence and power in clinical nursing practice*, Menlo Park, CA: Addson-Wesley.

BILAWKA, E. & CRAIG, B. 2003. Quality assurance in health care: past, present and future *International Journal of Dental Hygiene,* 1**,** 159-68.

BIRHANU, Z., ASSEFA, T., WOLDIE, M. & MORANKAR, S. 2010. Determinants of satisfaction with health care provider interactions at health centres in central Ethiopia: a cross-sectional study *BMC Health Sciences Research,* 10**,** 1-12.

BJORVELL, C., WREDLING, R. & THORELL-EKSTRAND, I. 2003. Improving documentation using a nursing model. *Journal of Advanced Nursing,* 43**,** 402–410.

BLEGEN, M. A., VAUGHN, T. & VOJIR, C. P. 2008 Nursing staffing levels: Impact of organization characteristics and registered nurse supply. *HSR: Health Services Research,* 41**,** 154-173.

BLOCK, L. M., CLAFFEY, C., KOROW, M. K. & MCCAFFREY, R. 2005. The value of mentorship within nursing organizations. *Nursing Forum,* 40**,** 134-140.

BLOUIN, A. S. 2010. Helping to solve healthcare's most critical safety and quality problems. *Journal of Nursing Care Quality,* 25**,** 95-99.

BOLGER, G. 2007. Administering care without empathy is not nursing. *Nursing Standard,* 21 33.

BONDAS, T. 2006. Paths to nursing leadership. *Journal of Nursing Management,* 14**,** 332–339.

BONDAS, T. 2010. Nursing leadership from the perspective of clinical group supervision: a paradoxical practice. *Journal of Nursing Management,* 18**,** 477–486.

BOOYENS, S. W. 1998. *Dimensions of nursing management* South Africa, Juta Publishers

BOOYENS, S. W. 2008. *Introduction to health services management* . Cape Town, Juta Publishers.

BOULT, C., GREEN, A. F., BOULT, L. B., PACALA, J. T., SNYDER, C. & LEFF, B. 2009. Successful models of comprehensive care for older adults with chronic conditions: evidence for the Institute of Medicine's "Retooling for an Aging America" report. *Journal of the American Geriatrics Society,* 57 . **,** 2328-2337.

BRADSHAW, A. 2000. Competence and British nursing: a view from history. *Journal of Clinical Nursing* 9**,** 321-329.

BRINK, H. 2006. *Fundamentals of research methodology for health care professionals,* Cape Town, Oxford University Press Southern Africa: Publishers.

BROOKS, B. A. & ANDERSON, M. A. 2004. Nursing work life in acute care. *Journal of Nursing Care Quality,* 19**,** 269-275.

BROWNING, S. & WAITE, R. 2010. The gift of listening: Just listening strategies. *Nursing Forum,* 45**,** 150-158.

BRUNERO, S., LAMONT, S. & COATES, M. 2010. A review of empathy education in nursing *Nursing Enquiry,* 17**,** 64-73.

BRUNERO, S. & STEIN-PARBURY, J. 2008. The effectiveness of clinical supervision in nursing: an evidenced based literature review. *Australian Journal of Advanced Nursing,* 25 86-94.

BU, X. & JEZEWSKI, M. A. 2007. Developing a mid-range theory of patient advocacy through concept analysis. *Journal of Advanced Nursing,* 57**,** 101–110.

BUCHAN, J. 1999. Still attractive after all these year? Magnet hospitals in a changing healthcare environment. *Journal of Advanced Nursing,* 30**,** 100–108.

BUDD, K. W., WARINO, L. S. & PATTON, M. E. 2004. Traditional and non-traditional collective bargaining: strategies to improve the patient care environment. *Online Journal of Issues in Nursing,* 9.

BUERHAUS, P. I., DONELAN, K., ULRICH, B. T., NORMAN, L., WILLIAMS, M. & DITTUS, R. 2005. Hospital RNs' and CNOs' Perceptions of the Impact of the Nursing Shortage on the Quality of Care. *Nursing Economics* 23**,** 214–221.

BURHANS, L. M. 2008. *What is good nursing care? The lived meaning of quality nursing care for practicing nurses.* Doctor of Philosophy Published Thesis.

BURNS, N. & GROVE, S. K. 2009. *The practice of nursing research: appraisal, synthesis, and generation of evidence* United States of America, Saunders Elsevier.

CAJULIS, C. B. & FITZPATRICK, J. J. 2007. Levels of autonomy of nurse practitioners in an acute care setting. *Journal of the American Academy of Nurse Practitioners,* 19 500-507.

CAMBRIGE ADVANCED LEARNER'S DICTIONARY 2008. 3 ed. New York: Cambridge University Press Publishers.

CARNEY, M. 2009. Public health nurses perception of clinical leadership in Ireland: narrative descriptions. *Journal of Nursing Management,* 17**,** 435-445.

CARSON, P. P., CARRSON, K. D. & ROE, C. W. 1998. Towards understanding the patient's perception of quality. *The health Care Supervisor,* 16**,** 36-42.

CASEY, M. M. & MOSCOVICE, I. 2004. Quality improvement strategies and best practices in critical access hospitals. *Journal of Rural Health,* 20**,** 327-334.

CASTLE, A. 2003. Demonstrating critical evaluation skills using Bloom's taxonomy. *International Journal of Therapy and Rehabilitation,* 10**,** 369-373.

CASTLE, A. 2010 Comparing and contrasting health profiles: one dimension of critical thinking. *International Journal of Therapy and Rehabilitation,* 17 345-352.

CHANT, S., JENKISON, T., RANDLE, J. & RUSSELL, G. 2002. Communication skills: some problems in nursing education and practice. *Journal of Clinical Nursing* 11**,** 12-21.

CHARLTON, G. 2000. *Human Habits of Highly Effective Organisations: The Human Race,* Cape Town, Van Schaik.

CHIANG, H.-Y. & LIN, S.-Y. 2008. Psychometric testing of the Chinese version of nursing practice environment scale. *Journal of Clinical Nursing,* 18**,** 919-929.

CIOFFI, J. 1998. Education for clinical decision making in midwifery practice. *Midwifery,* 14**,** 18-22.

CIOFFI, J., WILKES, L., CUMMINGS, J., WARNE, B. & HARRISON, K. 2010. Multidisciplinary teams caring for clients with chronic conditions: Experiences of community nurses and allied health professionals. *Contemporary Nurse* 36**,** 61–70.

CLARKE, S. P. & AIKEN, L. H. 2008. An international hospital outcomes research agenda focused on nursing: Lessons from a decade of collaboration. *Journal of Clinical Nursing,* 17**,** 3317–3323.

COOK, M. J. & LEATGARD, H. L. 2004. Learning for clinical leadership. *Journal of Nursing Management* 12**,** 436–444.

CORTELYOU-WARD, K. H., UNRUH, L. & FOTTLER, M. D. 2010. The effect of work environment on intent to leave the nursing profession: a case study of bedside registered nurses in rural Florida. *Health Services Management Research,* 23**,** 185–192.

COWAN, D. T., NORMAN, I. & COOPAMAH, V. P. 2005. Competence in nursing practice: A controversial concept-A focused review of literature. *Nurse Education Today,* 25**,** 355-362.

CRAVEN, R. F. & DUHAMEL, M. B. 2003. Certificate programs in continuing professional education. *Journal of Continuing Education in Nursing* 34**,** 14-8.

CURRIE, V., HARVEY, G., WEST, E., MCKENNA, H. & KEENEY, S. 2005. Relationship between quality of care, staffing levels, skill mix and nurse autonomy: literature review. *Journal of Advanced Nursing,* 51**,** 73–82.

CURTIS, E. & O'CONNELL, R. 2011. Essential leadership skills for motivating and developing staff. *Nursing Management,* 18**,** 32-35.

CURTIS, E. A., DE VRIES, J. & SHEERIN, F. K. 2011. Developing leadership in nursing: exploring core factors. *British Journal of Nursing,* 20**,** 306-309.

CURTIS, J. R., COOK, D. J., WALL, R. J., ANGUS, D. C., BION, J., KACMAREK, R., KANE-GILL, S. L., KIRCHHOFF, K. T., LEVY, M., MITCHELL, P. H., MORENO, R., PRONOVOST, P. & PUNTILLO, K. 2006. Intensive care unit quality improvement: A "how-to" guide for the interdisciplinary team. *Critical Care Medicine,* 34**,** 211-218.

DAVIDOFF, F., BATALDEN, P., STEVENS, D., OGRINC, G. & MOONEY, S. 2008. Publication guidelines for improvement studies in health care: Evolution of the SQUIRE Project. *Annals of Internal Medicine,* 149**,** 670-676.

DECOLA, P. R. & RIGGINS, P. 2010. Nurses in the workplace: expectations and needs. *International Nursing Review,* 57**,** 335-342.

DEMARCO, J. & NYSTROM, M. 2010. The importance of health literacy in patient education. *Journal of Consumer Health on the Internet,* 14**,** 294–301.

DEMPSTER, J. S. 1990. *Autonomy in practice: Conceptualization, construction, and psychometric evaluation of an empirical instrument.* Dissertation Abstract International 50(07), 3320A.

DEPARTMENT OF HEALTH OF SOUTH AFRICA. 2008. *Nursing strategy for South Africa 2008* [Online]. Available: http://www.sanc.co.za/pdf/nursing-strategy.pdf [Accessed December 22 2011].

DEWALT, D., BERKMAN, N., SHERIDAN, S., LOHR, K. & PIGNONE, M. 2004. Literacy and health outcomes: a systematic review of the literature. *Journal Of General Internal Medicine,* 19**,** 1228-39.

DONABEDIAN, A. 1966. Evaluating quality of medical care. . *Milbank Memorial Fund Quarterly-Health and Society* 44**,** 166–206.

DONABEDIAN, A. 1988 The quality of care: How can it be assessed? . *Journal of American Medical Association,* 260**,** 1743-1748.

DRAPER, D. A., FELLAND, L. E., LIEBHABER, A. & MELICHAR, L. 2008. The role of nurses in hospital quality improvement. *Research Brief,* 3**,** 1-8.
DUFFIELD, C., ROCHE, M., DIERS, D., CATLING-PAULL, C. & BLAY, N. 2010. Staffing, skill mix and the model of care. *Journal of Clinical Nursing,* 19**,** 2242-2251.
DUNN, S. V. & SCHMITZ, K. 2005. Nurses' perceptions of patients' requirements for nursing resources. *Australian Journal of Advanced Nursing,* 22**,** 33-40.
ESTABROOKS, C., MIDODZI, W., CUMMINGS, G., RICKER, K. & GIOVANNETTI, P. 2005. The impact of hospital nursing characteristics on 30 day mortality. *Nursing research,* 54**,** 74-84.
FAIRBROTHER, G., JONES, A. & RIVAS, K. 2010. Changing model of nursing care from individual patient allocation to team nursing in the acute inpatient environment. *Contemporary Nurse* 35**,** 202–220.
FAIRCHILD, R. M. 2010. Practical ethical theory for nurses responding to complexity in care. *Nursing Ethics* 17**,** 353–362.
FARQUHAR, M., KURTZMAN, E. T. & THOMAS, K. A. 2010. What do nurses need to know about the quality enterprise? . *Journal of Continuing Education in Nursing,* 41**,** 246-256.
FERGUSON, L. & CIOFFI, J. 2011. Team nursing: experiences of nurse managers in acute care settings. *Australian Journal of Advanced Nursing,* 28**,** 5-11.
FITZPATRICK, M. A. 2001. Collective bargaining: A vulnerability assessment: Part 1. *Nursing Management,* 32**,** 41-42.
FLEUREN, M., WIEFFERINK, K. & PAULUSSEN, T. 2004. Determinants of innovation within health care organizations: Literature review and Delphi study. *International Journal for Quality in Health Care,* 16**,** 107-123.
FRANCIS, R. 2010. *Independent inquiry into care provided by Mid Staffordshire NHS Foundations Trust January 2005-March 2009, Volume I* [Online]. Available: http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_113447.pdf [Accessed April 14 2011].
FRANKEL, A. 2008. What leadership styles should senior nurses develop? *Nursing Times,* 104**,** 23-24.
FREDA, M. C. 2004. Issues in Patient Education. *The Journal of Midwifery and Women's Health,* 49**,** 203–209.
FRIESE, C. R., LAKE, E. T., AIKEN, L. H., SILBER, J. H. & SOCHALSKI, J. 2008. Hospital nurse practice environments and outcomes for surgical oncology patients. *Health Services Research Brief,* 43**,** 1145–1163.
GARDNER, G., WOOLLETT, K., DALY, N. & RICHARDSON, B. 2009. Measuring the effect of patient comfort rounds on practice environment and patient satisfaction: A pilot study. *International Journal of Nursing Practice,* 15**,** 287-293.
GARRETT, D. & COWDELL, F. 2010. Practice question: Improving care. *Nursing Older People; Dec, Vol. Issue, p,* 22**,** 12.
GEORGE, J. B. 2002. *Nursing theories: The base for professional nursing practice,* United States of America, Prentice Hall
GIFFORD, W., DAVIES, B., EDWARDS, N., GRIFFIN, P. & LYBANON, V. 2007. Managerial leadership for nurses' use of research evidence: An integrative review of the literature. *Worldviews on Evidence-Based Nursing,* 4**,** 126–145.
GOODE, C. J., BLEGEN, M. A., PARK, S. H., VAUGHN, T. & SPETZ, J. 2011. Comparison of patient outcomes in Magnet and Non-Magnet Hospitals. *The Journal of Nursing Administration,* 41**,** 517-523.

GOULD, D., DREY, N. & BERRIDGE, E.-J. 2007. Nurses' experiences of continuing professional development. *Nurse Education Today* 27**,** 602-609.

GRANT, B., COLELLO, S., RIEHLE, M. & DENDE, D. 2010. An evaluation of the nursing practice environment and successful change management using the new generation Magnet Model. *Journal of Nursing Management,* 18**,** 326–331.

GRIMSHAW, J. M. & ECCLES, M. P. 2004. Is evidence-based implementation of evidence-based care possible? *medical Journal of Australia* 180**,** S50–S51.

GROTLE, M., GARRATT, A. M., KLOKKERUD, M., LØCHTING, I., UHLIG, T. & HAGEN, K. B. 2010. What's in team rehabilitation care after arthroplasty for osteoarthritis? Results from a multicenter, longitudinal study assessing structure, process, and outcomes. *Physical Therapy,* 90**,** 121-131.

GRUJIC, S. D., O'SULLIVAN, D. D. & WEHRMACHER, W. H. 1989. Organizational Control of Hospital Infrastructure Determines the Quality of Care *American Journal of Medical Quality* 4**,** 19-24.

GUNTHER, M. & ALLIGOOD, M. R. 2002. A discipline-specific determination of high quality nursing care. *Journal of Advanced Nursing,* 38**,** 353-359.

HAGGERTY, J. L., REID, R. J., FREEMAN, G. K., STARFIELD, B. H., ADAIR, C. E. & MCKENDRY, R. 2003. Continuity of care: a multidisciplinary review. *BMJ,* 327**,** 1219–21.

HAIGH, C. & ORMANDY, P. 2011. Evaluation of the organisation and delivery of patient-centred acute nursing care. *Contemporary Nurse,* 37**,** 253–264.

HALL, L. M. & DORAN, D. 2007. Nurses' perceptions of hospital work environments. *Journal of Nursing Management,* 15**,** 264-273.

HALL, L. W., MOORE, S. M. & BARNSTEINER, J. H. 2008. Quality and nursing: Moving from a concept to a core competency. *Urologic Nursing,* 28**,** 417-425.

HANKS, R. G. 2010. The medical-surgical nurse perspective of advocate role. *Nursing Forum,* 45**,** 97-107.

HANKS, R. G. 2010 Development and testing of an instrument to measure protective nursing advocacy. *Nursing Ethics,* 17**,** 255–267.

HANSEN, C., CARRYER, J. & BUDGE, C. 2007. Public health nurses' views on their position within a changing health system. *Nursing Praxis in New Zealand,* 23**,** 14-26.

HÄTÖNEN, H., KUOSMANEN, L., KOIVUNEN, M. & VÄLIMÄKI, M. 2010. Patient education practices in psychiatric hospital wards: A national survey in Finland. *Nordic Journal of Psychiatry,* 64**,** 334–339.

HAVENS, D. S. & VASEY, J. 2003. Measuring staff nurse decisional involvement: The decisional involvement scale. *The Journal of Nursing Administration,* 33 331-336.

HAVENS, D. S. & VASEY, J. 2005. The staff nurse decisional involvement scale: Report of psychometric assessments. . *Nursing Research,* 54**,** 376-383.

HAYES, B., BONNER, A. & PRYOR, J. 2010. Factors contributing to nurse job satisfaction in the acute hospital setting: a review of recent literature. *Journal of Nursing Management,* 18**,** 804-814.

HILL, K., AMIR, Z., MUERS, M., CONNOLLY, K. & C., R. 2003. Do newly diagnosed lung cancer patients feel their concerns are being met? *European Journal of Cancer Care,* 12**,** 35–45.

HILL, R. 2010. Compassion, quality and standards of care. *Nurse Prescribing,* 8 98-100

HOGSTON, R. 1995a. Nurses' perceptions of the impact of continuing professional education on the quality ofnursing care. *Journal of Advanced Nursing,* 22**,** 586-593.

HOGSTON, R. 1995b. Quality nursing care: a qualitative enquiry. *Journal of Advanced Nursing,* 21**,** 116-124.

HOUSE, R. J. & ADITYA, R. N. 1997. The social scientific study of leadership: quo vadis? *Journal of Management,* 23**,** 409-473.
HOUSER, J. 2003. A model for evaluating the context of nursing care delivery. *Journal of Nursing Administration,* 33**,** 39-47.
HUBER, D. L. 2010. *Leadership and nursing care management* United States of America, Saunders Elsevier.
HURST, K. 2011. Has nursing quality improved in the past quarter of a century? . *Nursing Standard,* 25**,** 14-15.
HUYCKE, L. & ANITA, C. 2000. Quality in health care and ethical principles. *Journal of Advanced Nursing,* 32**,** 562-571.
IHEMEDU, C. O., OMOLASE, C. O., OSERE, Y. R. & BETIKU, O. B. 2010. Appraisal of Physician-Nurse working relationship in Owo, South West, Nigeria. *TAF Preventive Medicine Bulletin,* 9**,** 569-574.
INSTITUTE OF MEDICINE 2000. *To Err is Human: Building a Safer Health System,* Washington, DC, National Academy Press.
INSTITUTE OF MEDICINE 2001. Crossing the quality chasm: A new health system for the 21st century. Washington, D.C: National Academies Press.
IPSOS MORI SOCIAL RESEARCH INSTITUTE 2010. Perceptions of quality in NHS secondary care: A research report for NHS West Midlands.
JAAFARPOUR, M. & KHANI, A. 2011. The participation of nurses in decision making. *Journal of Clinical and Diagnostic Research,* 5**,** 16-19.
JACK, B. W., CHETTY, V. K., ANTHONY, D., GREENWALD, J. L., SANCHEZ, G. M., JOHNSON, A. E., FORSYTHE, S. R., O'DONNELL, J. K., PAASCHE-ORLOW, M. K., MANASSEH, C., MARTIN, S. & CULPEPPER, L. 2009. A Reengineered Hospital Discharge Program to Decrease Rehospitalization: A Randomized Trial. *Annals of Internal Medicine,* 150**,** 178–87.
JOHANSSON, P., OLÉNI, M. & FRIDLUND, B. 2002. Patient satisfaction with nursing care in the context of health care: a literature study. *Scandinavian Journal of Caring Sciences,* 16**,** 337–344.
JONES, R. A. P. 2007. *Guide to nursing leadership and management: Theories, processes and practice,* Philadelphia, Davis Company: Publishers.
JOOSTE, K. 2004. Leadership: a new perspective. *Journal of Nursing Management,* 12**,** 217–223.
JOUBERT, G. & EHRLICH, R. 2007. *Epidemiology: A research manual for South Africa,* Cape Town, Oxford University Press Southern Africa: Publishers.
JUKKALA, A., GREENWOOD, R., LADNER, K. & HOPKINS, L. 2010. The clinical nurse leader and rural hospital safety and quality. *Online Journal of Rural Nursing and Health Care, vol. , no. , Fall 2010,* 10**,** 38-44.
KABOGORA, P. 2008. *Exploring phenomena overcrowding in the context of CHUK emergency department in Rwanda.* Masters Thesis, University of KwaZu-Natal.
KALINGANIRE, R. 2010. *Developing health infrastructure* [Online]. Kigali. Available: http://tap.pmhclients.com/images/uploads/press/Infrastructure_Fact_Sheet_29JULY10_Final_Version.pdf [Accessed February 28 2011].
KALISCH, B. J., WEAVER, S. J. & SALAS, E. 2009. What Does Nursing Teamwork Look Like? A Qualitative Study. *Journal of Nursing Care Quality,* 24**,** 298–307.
KALRA, S. 2010. Needs and gaps in diabetes self management *Internet Journal of Family Practice,* 8 11-11.

KANE, R. L., SHAMLIYAN, T. A., MUELLER, C., DUVAL, S. & WILT, T. J. 2007. The association of registered nurse staffing levels and patient outcomes: Systematic review and meta-analysis. *Medical Care,* 45**,** 1195–1204.

KANTER, R. M. 1977. *Men and women of the corporation,* New York, Basic Books.

KAUR, S., KAPOOR, V., MAHAJAN, R., LAL, M. & GUPTA, S. 2011. Monitoring of incidence, severity, and causality of adverse drug reactions in hospitalized patients with cardiovascular disease. *Indian Journal of Pharmacology* 43**,** 22-26.

KAYONGA, C. 2007 Towards universal health coverage in Rwanda.

KELLER, S. M. & BURNS, C. M. 2010. The aging nurse: Can employers accommodate age-related changes? *AAOHN Journal,* 58**,** 437-46.

KENDALL-GALLAGHER, D., AIKEN, L. H., SLOANE, D. M. & CIMIOTTI, J. P. 2011. Nurse specialty certification, inpatient mortality, and failure to rescue. *Journal of Nursing Scholarship,* 43**,** 188–194.

KENDALL-RAYNOR, P. 2011. Heavy workloads prevent focus on non-communicable diseases. *Nursing Standard,* 25**,** 10.

KLEINPELL, R. & GAWLINSKI, A. 2005. Assessing outcomes in advanced practice nursing practice: the use of quality indicators and evidence-based practice. *AACN Clinical Issues,* 16**,** 43-57.

KNOX, S. A. & BRITT, H. 2005. The contribution of demographic and morbidity factors to self-reported visit frequency of patients: a cross-sectional study of general practice patients in Australia. *BMC Family Practice,* 5**,** 1-7.

KOUTSOPOULOU, S., PAPATHANASSOGLOU, E. D., KATAPODI, M. C. & PATIRAKI, E. I. 2010. A critical review of the evidence for nurses as information providers to cancer patients. *Journal of Clinical Nursing,* 19**,** 749–765.

KRAMER, M. & SCHMALENBERG, C. 1993. Learning from success: autonomy and empowerment. *Nursing Management,* 24**,** 58-9, 62, 64.

KUNAVIKTIKUL, W., ANDERS, R. L., SRISUPHAN, W., CHONTAWAN, R., NUNTASUPAWAT, R. & PUMARPORN, O. 2001. Development of quality of nursing care in Thailand. *Journal of Advanced Nursing,* 36**,** 776-784.

KUNAVIKTIKUL, W., NANTSUPAWAT, R., SNGOUNSIRITHAM, U., AKKADECHANUNT, T., CHITPAKDEE, B., WICHAIKHUM, O., WONGLIEUKIRATI, R., CHONTAWAN, R., KEITLERTNAPHA, P., THUNGARAENKUL, P., ABHICHARTTIBUTRA, K., SANLUANG, C. S., LIRTMUNLIKAPORN, S. & CHAOWALAKSAKUN, P. 2010. Knowledge and involvement of nurses regarding health policy development in Thailand. *Nursing & Health Sciences* 12**,** 221-7.

KUNKEL, S., ROSENQVIST, U. & WESTERLING, R. 2007. The structure of quality systems is important to the process and outcome, an empirical study of 363 hospital departments in Sweden. *BMC Health Services Research,* 7**,** 1-8.

LABORDE, S. & LEE, J. A. 2000. Skills needed for promotion in the nursing profession. *Journal of Nursing Administration,* 30**,** 432-439.

LAITINEN, H., KAUNONEN, M. & ÅSTEDT-KURKI, P. 2010. Patient-focused nursing documentation expressed by nurses. *Journal of Clinical Nursing,* 19**,** 489-497.

LAKE, E. T. 2002. Development of the practice environment scale of the nursing work index. *Research in Nursing & Health,* 25**,** 176-188.

LAKE, E. T. & FRIESE, C. R. 2006. Variations in nursing practice environments: Relation to staffing and hospital characteristics. *Nursing research,* 55 1-9.

LALANI, N. S., LAKHANI, S. & SHAH, M. 2011. Meeting the social, emotional and psychological needs of patients in a palliative care setting. *Journal of Pakistan Psychiatric Society,* 8**,** 39-40.

LAMIANI, G. & FUREY, A. 2009. Teaching nurses how to teach: An evaluation of a workshop on patient education. *Patient Education and Counseling,* 75**,** 270-273.

LAMMINTAKANEN, J., KIVINEN, T. & KINNUNEN, J. 2008. Human resource development in nursing: views of nurse managers and nursing staff. *Journal of Nursing Management,* 16**,** 556-564.

LANG, N. M. 1976. Issues in quality assurance in Nursing. Issues in Evaluation Research: An Invitation Conference. Kansas City: American Nurses Association.

LARSON, J. S. & MULLER, A. 2002. Managing the quality of health care *Journal of Health & Human Services Administration,* 25**,** 261-280.

LASCHINGER, H. K. S. & LEITER, M. P. 2006. The impact of nursing work environments on patient safety outcomes: The mediating role of burnout/engagement. *Journal of Nursing Administration,* 36**,** 259–267.

LASCHINGER, H. K. S., SHAMIAN, J. & THOMSON, D. 2001. Impact of magnet hospital characteristics on nurse's perceptions of trust, burnout, quality of care and work satisfaction. *Nursing Economics,* 19**,** 209-219.

LAWTON, R., CONNER, M. & MCEACHAN, R. 2009. Desire or reason: Predicting health behaviours from affective and cognitive attitudes. *Health Psychology,* 28 56-65.

LEAPE, L. L., ROGERS, G., HANNA, D., GRISWOLD, P., FEDERICO, F., FENN, C. A., BATES, D. W., KIRLE, L. & CLARRIDGE, B. R. 2006. Developing and implementing new safe practices: voluntary adoption through statewide collaboratives. *Qual Saf Health Care,* 15**,** 289–295.

LEE, P. 2008. Improving in rural Rwanda (part1). Institute for Healthcare Improvement: IHI Open School.

LEITER, M. P. & LASCHINGER, H. K. S. 2006. Relationships of work and practice environment to professional burnout:Testing a causal model. *Nursing Research,* 55**,** 137-146.

LISS, D. T., CHUBAK, J., ANDERSON, M. L., SAUNDERS, K. W., TUZZIO, L. & REID, R. J. 2011. Patient-reported care coordination: Associations with primary care continuity and specialty care use. *Annals of Family Medicine,* 9**,** 323-9.

LOHR, K. N. & SCHROEDER, S. A. 1990. A Strategy for Quality Assurance in Medicare. *New England Journal of Medicine,* 322**,** 707–712.

LORBER, M. & SAVIČ, B. S. 2011. Perceptions of managerial competencies, style, and characteristics among professionals in nursing. *Croatian Medical Journal* 52**,** 198-204.

LUCERO, R. J., LAKE, E. T. & AIKEN, L. H. 2009. Variations in nursing care quality across hospitals. *Journal of Advanced Nursing,* 65**,** 2299-2310.

LUCERO, R. J., LAKE, E. T. & AIKEN, L. H. 2010. Nursing care quality and adverse events in US hospitals. *Journal of Clinical Nursing,* 19**,** 2185–2195.

LYNN, J., BAILY, M. A., BOTTRELL, M., JENNINGS, B., LEVINE, R. J., DAVIDOFF, F., CASARETT, D. & CORRIGAN, J. 2007. The ethics of using quality improvement methods in health care. *Annals of Internal Medicine,* 146**,** 666-673.

LYNN, M. & MOORE, K. 1997. Relationship between traditional quality indicators and perceptions of care. *Seminars for Nurse Managers,* 5**,** 187-93.

LYNN, M. R. & REDMAN, R. W. 2005. Faces of the nursing shortage: Influences on staff nurses' intentions to leave their positions or nursing. *Journal of Nursing Administration,* 35**,** 264–270.

MA, J.-C., LEE, P.-H., YANG, Y.-C. & CHANG, W.-Y. 2009. Predicting factors related to nurses' intention to leave, job satisfaction, and perception of quality of care. *Nursing Economics,* 27**,** 178-202.

MAHLIN, M. 2010. Individual patient advocacy, collective responsibility and activism within professional nursing associations. *Nursing Ethics* 17**,** 247–254.

MAHONEY, J. 2001. Leadership skills for the 21st century. *Journal of Nursing Management* 9**,** 269-271.

MALLOT, T. & PENPRASE, B. 2010. Nursing leadership style and psychosocial work environment. *Journal of Nursing Management,* 18**,** 715–725.

MANGHANI, K. 2011. Quality assurance: Importance of systems and standard operating procedures. *Perspective in Clinical Research,* 2**,** 34-37.

MANOJLOVICH, M. & ANTONAKOS, C. 2008. Satisfaction of intensive care unit nurses with nurse-physician communication. *Journal of Nursing Administration,* 38**,** 237-243.

MANOJLOVICH, M. & LASCHINGER, H. 2007. The nursing worklife model: Extending and refining a new theory. *Journal of Nursing Management,* 15**,** 256-263.

MANONGI, R. N., MARCHANT, T. C. & BYGBJERG, I. C. 2006. Improving motivation among primary health care workers in Tanzania: a health worker perspective. *Human Resources for Health,* 4**,** 1-7.

MANZOOR, I., DAUD, S., HASHMI, N. R., ZAFAR, M., KHAN, M., ZAFAR, J. & BABAR, S. 2010. Reasons for selection of nursing profession in Parkistan *Professional Medical Journal,* 17**,** 728-734.

MARQUIS, B. & HUSTON, C. 2009. *Leadership Roles and Management Functions in Nursing: Theory and Application,* Philadelphia, Wolters/Kluwer/Lippincott Williams and Wilkins.

MARSHALL, E. S. 2010. *Transformational leadership in nursing: From expert clinician to influential leader,* New York, Springer Publishing Company.

MAXWELL, R. J. 1984. Quality assessment in health. *British Medical Journal* 288**,** 1470–1473.

MCCAFFREY, R., HAYES, R., STUART, W., CASSELL, A., FARRELL, C., MILLER-REYES, C. & DONALDSON, A. 2010. A program to improve communication and collaboration between nurses and medical residents. *; Journal of Continuing Education in Nursing* 41 172-8.

MCCLOSKEY, J. C. & BULECHEK, G. M. 1996. *Nursing Interventions Classification (NIC)*, Mosby, St Louis, MO.

MCCLURE, M. L. & HINSHAW, A. S. 2002. *Magnet hospitals revisited: Attraction and retention of professional nurses,* Washington, DC American Nurses Publishing.

MEESSEN, B., MUSANGO, L., KASHALA, J. I. & LEMLIN, J. 2006. Reviewing institutions of rural health centres: the performance initiative in Butare, Rwanda. *Tropical Medicine and International Health,* 11**,** 1303-1317.

MEILING, M. S. 2009. A proposed framework for evaluating the impact of advanced practice nursing role in Singapore. *Singapore Nursing Journal,* 36**,** 31-34.

MENSAH, J. A., BADU, E. & OSEI, C. 2007. *Addressing educational needs of health workers in Ghana using distance education* [Online]. Available: http://wikieducator.org/images/d/de/PID_323.pdf [Accessed December 26 2011].

MEYER, S. M., NAUDÉ, M., SHANGASE, N. C. & VAN DE NIEKERK, S. E. 2009. *The nursing unit manager,* Johannesburg, Heinemann.

MICK, D. & ACKERMAN, M. 2000. Advanced practice nursing role delineation in acute and critical care: application of the strong model of advanced practice. *Heart & Lung: The Journal of Acute and Critical Care,* 29**,** 210-21.

MILES, K. S. & VALLISH, R. 2010. Creating a personalized professional practice framework for nursing. *Nursing Economics,* ,28**,** 171-189.

MILISEN, K., ABRAHAM, I., SIEBENS, K., DARRAS, E. & DIERCKX DE CASTERLE, B. 2006. Work environment and workforce problems: a cross-sectional questionnaire survey of hospital nurses in Belgium. *International Journal of Nursing Studies,* 43**,** 745-754.

MILLER, C. 2010. Improving and enhancing performance in the affective domain of nursing students: Insight from the literature for clinical educators *Contemporary Nurse,* ,35 2-17.

MILUTINOVIC, D., BRESTOVACKI, B. & CVEJIN, M. M. 2010. Patients` satisfaction with nursing care as an indicator of quality of hospital service. *HealthMed,* 4**,** 461-468.

MINISTRY OF HEALTH. 2008. *Annual health report* [Online]. Kigali, Rwanda. Available: http://www.gov.rw/index.php?option=com_docman&Itemid=13. [Accessed 26 February 2011].

MINISTRY OF HEALTH. 2009. *Annual Report* [Online]. Available: http://medicine.yale.edu/intmed/globalhealthscholars/sites/85679_Final%20MoH%20annual%20report%2027%2001%202011%20(2).pdf [Accessed September 8 2011].

MINISTRY OF HEALTH. 2011. *Human Resources for Health Strategic Plan 2011-2016* [Online]. Available: www.moh.gov.rw [Accessed March 31 2012].

MINISTRY OF HEALTH OF RWANDA. 2009. *Human resources for health strategic plan 2009-2012* [Online]. [Accessed].

MISTIAEN, P., FRANCKE, A. L. & POOT, E. 2007. Interventions Aimed at Reducing Problems in Adult Patients Discharged from Hospital to Home: A Systematic Meta-review. *BMC Health Services Research,* 7**,** 47–65.

MITCHELL, P. H., FERKETICH, S. & JENNINGS, B. M. 1998. Quality health outcomes model. *Journal of Nursing Scholarship,* 30**,** 43-46.

MOIDEN, N. 2002. Evolution of leadership in nursing *Nursing Management,* 9**,** 20-25.

MONTGOMERY, A. 2007. Rewarding Quality Performance: The Role of Nursing. Washington DC: Allied For Health

MORAN, P., DUFFIELD, C. M., DONOGHUE, J., STASA, H. & BLAY, N. 2011. Factors impacting on career progression for nurse executives. *Contemporary Nurse,* 38**,** 45–55.

MORGAN, J. C. & LYNN, M. R. 2009. Satisfaction in nursing in the context of shortage. *Journal of Nursing Management,* 17**,** 401–410.

MOTE, A. & RICHARD, J. 2010. *Strengthening rural heath care in East Africa* [Online]. Available: http://www.apkn.org/health/chapter-6-strenthening-rural-health-care-in-east-africa [Accessed February 26 2011].

MRAYYAN, M. T. 2006. Jordanian nurses' job satisfaction, patients' satisfaction and quality nursing care. *International Nursing Review,* 53**,** 224-230.

MULLER-STAUB, M., LAVIN, M. A., NEEDHAM, I. & ACHTERBERG, T. V. 2006. Nursing diagnosis, interventions and outcomes-application and impact on nursing practice: systematic review. *Journal of Advanced Nursing* 56**,** 514–531.

MULLER, A., MURENZI, J., MATHENGE, W., MUNANA, J. & COURTRIGHT, P. 2010. Primary eye care in Rwanda: gender of service providers and other factors associated

with effective service delivery. *Tropical Medicine and International Health,* 15**,** 529-533.
MUNTLIN, A. 2009. *Identifying and improving quality of care at an emergency department: Patient and healthcare professional perspectives.* PhD Published Thesis, Acta Universitatis Upsaliensis
MURPHY, J., QUILLINAN, B. & CAROLAN, M. 2009. Role of clinical nurse leadership in improving patient care. *Nursing Management,* 16**,** 26-28.
MURPHY, K. 2007. Nurses' perceptions of quality and the factors that affect quality care for older people living in long-term care settings in Ireland. *Journal of Clinical Nursing,* 16**,** 873-884.
MUSONI, E. 2009. *Rwanda: National Council of Nurses and Midwives Established* [Online]. Available: Http://alafrica.com/stories/200909140228.html [Accessed June 25 2011].
NASIRIPOUR, A. A. & SIADATI, S. A. 2011. A propose model for nurses empowerment through characteristics of workplace and management strategies; A study in Iranian hospitals. *Australian Journal of Basic and Applied Sciences,* 5**,** 906-911.
NATIONAL QUALITY FORUM 2004. National voluntary consensus standards for nursing-sensitive care: An initial performance measure set-A consensus report. Washington, DC: Author.
NEEDLEMAN, J. & HASSMILLER, S. 2009. The role of nurses in Improving hospital quality And efficiency: Real-world results. *Health Affairs,* 28**,** w625–w633.
NEEDLEMAN, J., KURTZMAN, E. T. & KIZER, K. W. 2007. Performance measurement of nursing care: State of the science and the current consensus. *Medical Care Research Review,* 64**,** 10S-43S.
NEL, P. S., WERNER, A., HAASBROEK, G. D., POISAT, P., SONO, T. & SCHULTZ, H. B. 2008. *Human resources management* Cape Town, Oxford University Press Southern Africa.
NEUMANN, J. A. & FORSYTH, D. 2008. Teaching in the affective domain for institutional values. *The Journal of Continuing Education in Nursing,* 39**,** 248-252.
NGUYEN THI, P. L., BRIANCON, S., EMPEREUR, F. & GUILLEMIN, F. 2002. Factors determining inpatient satisfaction with care. *Social Science & Medicine,* 54**,** 493-504.
NICHOLS, J. & CAMPBELL, J. 2010. The experiences of internationally recruited nurses in the UK (1995-2007): an integrative review. *Journal of Clinical Nursing,* 19**,** 2814-2823.
NKOMEJE, A. 2008. *Exploring the factors that contribute to job satisfaction among registered nurses at King Faisal Hospital, Kigali-Rwanda.* Masters Thesis, University of KwaZulu-Natal.
NOËL, P. H., PARCHMAN, M. L., WILLIAMS, J. W., CORNELL, J. E., SHUKO, L., ZEB, J. E., KAZ, L. E., LEE, A. F. S. & PUGH, J. A. 2007. The challenges of multimorbidity from the patient perspective *Journal of General Internal Medicine,* 22**,** 419-24.
NUMMINEN, O. H., LEINO-KILPI, H., VAN DER AREND, A. & KATAJISTO, J. 2009. Nursing students and teaching of codes of ethics: an empirical research study. *International Nursing Review,* 56**,** 483-490.
NURSING AND MIDWIFERY COUNCIL 2002. *Guidelines for records and record keeping*, NMC, London.
OLAOGUN, A., OGINNI, M., OYEDEJI, T. A., NNAHIWE, B. & OLATUBI, I. 2011. Assessing the Use of the NANDA-International Nursing Diagnoses at the Obafemi Awolowo University Teaching Hospitals Complex, Ile Ife, Nigeria. *International Journal of Nursing Terminologies and Classifications,* 22**,** 157-161.

PAGANIN, A., MORAES, M. A., POKORSKI, S. & RABELO, E. R. 2008. Factors that inhibit the use of nursing language. *International Journal of Nursing Terminologies and Classifications,* 19**,** 150-157.

PAINTER, D. R. 2010. Nurses' responsibility to improve practice. *Nephrology Nursing Journal,* 37**,** 227.

PALLANT, J. 2007. *SPSS survival manuel: A step-by-step guide to data analysis using version 15* England, The MacGraw-Hill companies.

PAQUIN, S. O. M. 2011. Social justice advocacy in nursing: What is it? How do we get there? *Creative Nursing,* 17**,** 2011.

PAUL, R. 1993. *Critical Thinking: What Every Person Needs to Survive in A Rapidly Changing World*, Foundation for Critical Thinking, Santa Rosa CA.

PAZARGADI, M., TAFRESHI, M. Z., ABEDSAEEDI, Z., MAJD, H. A. & LANKSHEAR, A. J. 2008. Proposing indicators for the development of nursing care quality in Iran. *International Nursing Review,* 55 399-406.

PEABODY, J. W., TAGUIWALO, M. M., ROBALINO, D. A. & FRENK, J. 2005. *Improving the Quality of Care in Developing Countries* [Online]. Available: http://files.dcp2.org/pdf/DCP/DCP70.pdf [Accessed December 29 2011].

PEARSON, A., PALLAS, L. O. B., THOMSON, D., DOUCETTE, E., TUCKER, D., WIECHULA, R., LONG, L., PORRITT, K. & JORDAN, Z. 2006. Systematic review of evidence on the impact of nursing workload and staffing on establishing healthy work environments. *International Journal of Evidence-Based Healthcare,* 4**,** 337-384.

PEARSON, M. L., LEE, J. L., CHANG, B. L., ELLIOT, M., KAHN, K. A. & RUBENSTEIN, L. V. 2000. Structured implicit review: a new method for monitoring nursing care quality. *Medical Care* 38**,** 1074-1091.

POLIT, D. F. & BECK, C. T. 2008. *Nursing research: generating and assessing evidence for nursing practice,* New York, Lippincott Williams & Wilkins Publishers.

POMEY, M. P., LEMIEUX-CHARLES, L., CHAMPAGNE, F., ANGUS, D., SHABAH, A. & CONTANDRIOPOULOS, A. P. 2010. Does accreditation stimulate change? A study of the impact of the accreditation process on Canadian healthcare organizations. *Implementation Science* 5 1-14.

PRYBIL, L. D. 2007. Nursing Involvement in Hospital Governance *Journal of Nursing Care Quality,* 22 1-3.

PULLON, S. 2008. Competence, respect and trust: Key features of successful interprofessional nurse-doctor relationships. *Journal of Interprofessional Care,* 22**,** 133 – 147.

RADWIN, L. 2000. Oncology patients' perceptions of quality nursing care. *Research in Nursing and Health,* 23**,** 179-190.

RAFFERTY, A., CLARKE, S., COLES, J., BALL, J., JAMES, P., MCKEE, M. & AIKEN, L. 2007. Outcomes of variation in hospital nurse staffing in English hospitals: cross-sectional analysis of survey data and discharge records. *International Journal of Nursing Studies,* 44**,** 175-82.

RAFII, F., HAJINEZHAD, M. E. & HAGHANI, H. 2008. Nurse caring in Iran and its relationship with patient satisfaction. *Australian Journal of Advanced Nursing* 26**,** 75-84.

RAFTER, L. 2011. Evaluation of patient outcomes: pressure ulcer prevention mattresses. *British Journal of Nursing* 20**,** S32-S38.

REYNOLDS, W. J., SCOTT, B. & JESSIMAN, W. C. 1999. Empathy has not been measured in clients' terms or effectively taught: a review of the literature. *Journal of Advanced Nursing,* 30**,** 1177–1185.

ROBINSON, C. 2008. *Nursing care delivery systems* [Online]. Available: http://www.bookdev.com/pearson/osborn/dap/chapters/m05_osbo1023_01_se_c05.pdf [Accessed December 4 2011].

ROBINSON, F., GORMAN, G., SLIMMER, L. & YUDKOWSKY, R. 2010. Perceptions of effective and ineffective nurse-physician communication in hospitals. *Nursing Forum,* 45**,** 206-16.

ROCHE, M. A. & DUFFIELD, C. M. 2010. A comparison of the nursing practice environment in mental health and medical-surgical settings. *Journal of Nursing scholarship,* 42**,** 195-206.

ROSENSTEIN, A. H., RUSSELL, H. & LAUVE, R. 2002. Disruptive physician behavior contributes to nursing shortage. *The Physician Executive,* 28**,** 8–11.

ROTH, J. E. & COLEMAN, C. L. 2008. Perceived and real barriers for men entering nursing: Implications for gender diversity. *Journal of Cultural Diversity* 15**,** 148-152.

ROXBURGH, M., TAYLOR, J. & MUREBWAYIRE, M. 2009. Rwanda: A thousand hills, a thousand dreams, a thousand challenges for nurses and midwives and the Millennium Development Goals. *Nurse Education in Practice* 9**,** 349–350.

RUSA, L., NGIRABEGA, J. D., JANSSEN, W., BASTELAERE, S. V., PORIGNON, D. & VANDENBULCKE, W. 2009. Performance-based financing for better quality of services in Rwandan health centres: 3-year experience. *Tropical Medicine and International Health,* 14**,** 830-837.

SALZER, M. S., NIXON, C., SCHUT, L. J. A., KARVER, M. S. & BICKMAN, L. 1996. Quality as relationship between structure, process, and outcome: A conceptual framework for evaluating quality. The 9th Annual Research Conference Proceedings, A System of Care for Children's Mental Health: Expanding the Research Base (February 26-28, 1996). *In:* DEPARTMENT OF EDUCATION, U. S. O. A. (ed.).

SANDERS, S. L., BANTUM, E. O., OWEN, J. E., THORNTON, A. A. & STANTON, A. L. 2010. Supportive care needs in patients with lung cancer. *Psycho-Oncology,* 19**,** 480–489.

SAYED, K. A. E. & SLEEM, W. F. 2011. Nurse – physician collaboration: A comparative study of the attitudes of nurses and physicians at Mansoura University Hospital. *Life Science Journal,* 8**,** 140-146.

SCHUBERT, M., GLASS, T. R., CLARKE, S. P., AIKEN, L. H., SCHAFFERT-WITVLIET, B., SLOANE, D. M. & DE GEEST, S. 2008. Rationing of nursing care and its relationship to patient outcomes: the Suiss extension of the international hospital outcomes study. *International Journal for Quality in Health care,* 20**,** 227-237.

SCHUBERT, M., GLASS, T. R., CLARKE, S. P., SCHAFFERT-WITVLIET, B. & DE GEEST, S. 2007. Validation of the Basel Extent of Rationing of Nursing care instrument. *Nursing Research,* 56**,** 416-424.

SELLGREN, S., EKVALL, G. & TOMSON, G. 2006. Leadership styles in nursing management: preferred and perceived. *Journal of Nursing Management* 14**,** 348–355.

SELLGREN, S. F., EKVALL, G. & TOMSON, G. 2008. Leadership behaviour of nurse managers in relation to job satisfaction and work climate. *Journal of Nursing Management,* 16**,** 578–587.

SHAHIDI TWAHIRWA, I. 2009. *A descriptive study of the structure and process standards in the intensive care unit (ICU) at the University Central Hospital of Kigali (CHUK) in Rwanda.* Masters Thesis, University of Kwazulu-Natal.

SHEPHARD, K. 2008. Higher education for sustainability: seeking affective learning outcomes. *International Journal of Sustainability in Higher Education,* 9 87-98.

SHEPHERD, C. K., MCCUNNIS, M. & BROWN, L. 2010. Investigating the use of simulation as a teaching strategy. *Nursing Standard,* 24 42-48.

SHI, L., SAMUELS, M. E., PEASE, M., BAILEY, W. P. & CORLEY, E. H. 1999. Patient characteristics associated with hospitalizations for ambulatory care sensitive conditions in South Carolina. *Southern Medical Journal,* 92 989-998.

SHIPLEY, S. D. 2010. Listening: A Concept Analysis. *Nursing Forum,* 45**,** 125-134.

SHIREY, M. R. 2006. Evidence-based Practice: How Nurse Leaders can Facilitate Innovation. *Nursing Administration Quarterly,* 30**,** 252-265.

SKAR, R. 2010. The meaning of autonomy in nursing practice. *Journal of Clinical Nursing,* 19**,** 2226–2234.

SORRELL, J. M. 2010. Addressing issues related to geropsychiatry and the well-being of older adults. *Journal of Psychosocial Nursing,* 48**,** 17-20

SPEARS, P., THORNTON, D. & LONG, L. M. 2008. Journey to nursing excellence: Building partnerships for success. *Nurse Leader,* 6**,** 59-66.

SPRINKS, J. 2010. Developing nurses' power to care *Emergency Nurse,* 18**,** 12-15.

SPRINKS, J. 2011. Respect and dignity are vital to quality care provision. *Nursing Older People,* 23**,** 6-7.

STANLEY, D. & SHERRATT, A. 2010. Lamp light on leadership: Clinical leadership and Florence Nightingale. *Journal of Nursing Management,* 18**,** 115-121.

STARK, R., NAIR, N. V. & OMI, S. 1999. Nurse practitioners in developing countries: some ethical considerations. *Nursing Ethics,* 6**,** 273–277.

STICHLER, J. F. & WEISS, M. 2001. Through the Eye of the Beholder: Multiple Perspectives on Quality in Women's Health Care. *Journal of Nursing Quality Care,* 15**,** 59-74.

STREET, D. & COSSMAN, J. S. 2010. Does familiarity breed respect? Physician attitudes toward nurse practitioners in a medically underserved state. *Journal of the American Academy of Nurse Practitioners* 22**,** 431–439.

STURGEON, D. 2010. Have a nice day: consumerism, compassion and health care. *British Journal of Nursing Management,* 19 1047-1051.

SUNER, R. S., JUVINYA`, D. C., BERTRAN, C. N., GRABOLEDA, C. P., BRUGADA, N. M. & GARCIA, M. M. G. 2010. Continuity of care and monitoring pain after discharge: patient perspective. *Journal of Advanced Nursing* 66**,** 40–48.

SZILAGYI, P., SHENKMAN, E., BRACH, C., LACLAIR, B., SWIGONSKI, N., DICK, A., SHONE, L., SCHAFFER, V., COL, J., ECKERT, G., KLEIN, J. & LEWIT, E. 2003. Children with special health care needs enrolled in the State Children's Health Insurance Program (SCHIP): patient characteristics and health care needs. *Pediatrics,* 112**,** 508-520.

TENG, C.-I., HSIO, F.-J. & CHOU, T.-A. 2010. Nurse-perceived time pressure and patient-perceived care quality. *Journal of Nursing Management,* 18**,** 275–284.

TERVO-HEIKKINEN, T., KIVINIEMI, V., PARTANEN, P. & VEHVILAINEN-JULKUNEN, K. 2009. Nurse staffing levels and nursing outcomes: a Bayesian analysis of Finnish-registered nurses survey data. *Journal of Nursing Management,* 17**,** 986-993.

THOMAS, E. J., STUDDER, D. M., BURSTIN, H. R., RAV, E. J., ZYEENA, T., WILLIAMS, E. J., MASON HOWARD, K., WEILER, P. C. & BRENNAN, T. 2000. Incidence and types of adverse events and negligent care in Utah and Colorado. *Medical Care,* 38**,** 261-271.

THOMSON, S. 2009. Nurse-Physician collaboration: a comparison of the attitudes of nurses and physicians in the medical –surgical patient care setting. *MEDSURG Nursing,* 16**,** 87-104.

THUNGJAROENKUL, P., KUAVIKTIKUL, W., JACOBS, P., CUMMINGS, G. G. & AKKADECHANUNT, T. 2008. Nursing staffing and cost of care in adult intensive care units in a University Hospital in Thailand. *Nursing and Health Sciences,* 10 31-36.

TIEDEMAN, M. E. & LOOKINLAND, S. 2004. Traditional models of care delivery: What have we learned? *Journal of Nursing Administration,* 34**,** 291-298.

TOMEY, A. M. 2009. Nursing leadership and management effects work environments. *Journal of Nursing Management* 17**,** 15–25.

TOURANGEAU, A. E., DORAN, D. M., HALL, L. M., PALLAS, L. O. B., PRINGLE, D., TU, J. V. & CRANLEY, L. A. 2007. Impact of hospital nursing care on 30-day mortality for acute medical patients. *Journal of Advanced Nursing,* 57**,** 32–44.

TRAN, D. T., JOHNSON, M., FERNANDEZ, R. & JONES, S. 2010. A shared care model vs. a patient allocation model of nursing care delivery: Comparing nursing staff satisfaction and stress outcomes. *International Journal of Nursing Practice* 16**,** 148–158.

TSCHANNEN, D. & KALISCH, B. J. 2009. The impact of nurse-physician collaboration on patient length of stay. *Journal of Nursing Management,* 17 796-803.

ULRICH, B. T., BUERHAUS, P. I., DONELAN, K., NORMAN, L. & DITTUS, R. 2005. How RNs view the work environment: Results of a national survey of registered nurses. *Journal of Nursing Administration,* 35**,** 389-396.

UPENIEKS, V. V. & ABELEW, S. 2006. The magnet designation process A qualitative approach using Donabedian's conceptual framework. *The Health Care Manager,* 25**,** 243–253.

UWAYEZU, A. 2006. *Exploring the reasons Rwandan nurses change employment status.* . Masters Thesis, University of KwaZulu-Natal.

VAN BOGAERT, P., MEULEMANS, H., CLARKE, S., VERMEYEN, K. & VAN DE HEYNING, P. 2009. Hospital nurse practice environment, burnout, job outcomes and quality care: test of a structural equation model. *Journal of Advanced Nursing,* 65**,** 2175-2185.

VAN WALRAVEN, C., OAKE, N., JENNINGS, A. & FORSTER, A. J. 2010. The association between continuity of care and outcomes: a systematic and critical review. *Journal of Evaluation in Clinical Practice,* 16**,** 947-956.

VÉVODA, J., IVANOVÁ, K., NAKLÁDALOVÁ, M. & MARECKOVÁ, J. Year. Motivation and Job Satisfaction of general Nurses working in out patient hospital departments from the Prespective of Hertzberg's Two-Factor motivation Theory. *In:* Conference Proceedings of the IV. International Conference of General Nurses & Workers Educating Paramedical Staff, 2011. 154-163.

WALLEN, G. R., MITCHELL, S. A., MELNYK, B., FINEOUT-OVERHOLT, E. & MILLER-DAVIS, C. 2010. Implementing evidence-based

practice: effectiveness of a structured multifaceted mentorship programme. *Journal of Advanced Nursing,* 66**,** 2761–2771.

WANZER, M. B., WOJTASZCZYK, A. M. & KELLY, J. 2009. Nurses' perceptions of Physicians' communication practices, satisfaction, and collaboration. *Health Communication,* 24**,** 683-691.

WEAVER, K. & OLSON, J. K. 2006. Understanding paradigms used for nursing research. *Journal of Advanced Nursing,* 53**,** 459-469.

WEINBACH, R. W. & GRINNELL, R. M. 2010. *Statistics for social workers,* Boston, Pearson Publishers.
WEISS, M. E., YAKUSHEVA, O. & BOBAY, K. L. 2011. Quality and cost analysis of nurse staffing, discharge preparation, and postdischarge utilization. *HSR: Health Services Research,* 46**,** 1473-1494.
WESTON, M. J. 2008. Defining control over nursing practice and autonomy. *The Journal of Nursing Administration,* 38**,** 404-8.
WESTON, M. J. 2010. Strategies for Enhancing Autonomy and Control Over Nursing Practice. *Online Journal of Issues in Nursing,* 15.
WHO REGIONAL OFFICE FOR AFRICA. 2009. *WHO Country Cooperation Strategy, 2009-2013 Rwanda* [Online]. Available: http://www.who.int/countryfocus/cooperation_strategy/ccs_rwa_en.pdf [Accessed September 23 2011].
WILLIAMS, A. M. 1998. The delivery of quality nursing care: A grounded theory study of the nurse' s perspective *Journal of Advanced Nursing,* 27**,** 808-816.
WILSON, G. 2005. The experience of males entering nursing: A phenomenological analysis of professionally enhancing factors and barriers. *Contemporary Nurse,* 20**,** 221–233.
WIMPENNY, P. 2002. The meaning of models of nursing to practising nurses. *Journal of Advanced Nursing* 40**,** 346–354.
WOLLERSHEIM, H., HERMENS, R., HULSCHER, M., BRASPENNING, J., OUWENS, M., SCHOUTEN, J. & MARRES, H. 2007. Clinical indicators: development and applications. *The Journal of Medicine,* 65**,** 15-22.
WORLD HEALTH ORGANIZATION. 2009. *World HealtH Statistics: Health workforce, infrastructure, essential medicines* [Online]. Available: http://www.who.int/whosis/whostat/EN_WHS09_Table6.pdf [Accessed October 11 2011].
WYSONG, P. R. & DRIVER, E. 2009. Patients' perceptions of nurses' skill. *Critical Care Nurse,* 29**,** 24-37.
YEN, M. & LO, L. 2004. A model for testing the relationship of nursing care and patient outcomes. *Nursing Economics,* 22**,** 75-80.
ZACHAROVÁ, E. & GULÁŠOVÁ, I. 2011. The level of social communication in nurse-patient interaction. *Conference Proceedings of the IV. International Conference of General Nurses & Workers Educating Paramedical Staff.*
ZENOBIA, C. Y. C. 2010. Supervision of nurses using the five principles on practising listening. *Journal of Nursing Management,* 18**,** 111–112.
ZHAO, S. H., AKKADECHANUNT, T. & XUE, X. L. 2008. Quality nursing care as perceived by nurses and patients in a Chinese hospital. *Journal of Clinical Nursing* 18**,** 1722–1728.
ZIMMERMAN, B. I. 2007. *Comparing Functional and Team Nursing Models of Care Delivery on Patient Outcomes.* Master of Science Nursing Published Thesis, Mountain State University.
ZOSCHAK, E. W. 2010. 10 indicators of excellent nursing care. *The Journal for Hospital Governing Boards [Trustee],* 63 28-30.

APPENDICES

APPENDIX 1.1: QUESTIONNAIRE: ENGLISH VERSION

Thank you for accepting to participate in this research. Please read the following instructions to assist you in completing this questionnaire successfully.

Instructions:

1. Do not write your name anywhere on this questionnaire
2. Please complete all the questions below
3. Indicate your response by placing a √ (tick) in the box directly below your choice

SECTION A:

1. Please indicate your age: …… (in years)

2. Please indicate your gender

Female	male

3. Indicate the highest professional nursing qualification you have completed

Enrolled nurse (A2)	Registered nurse (A1)	Bachelor in nursing (A0)	Masters

4. What is your working experience? …… (in years or months)

SECTION B: PERCEPTIONS OF QUALITY NURSING CARE

Below is a list of potential **elements of quality care** for patient. Please consider each elements of quality of care for patient. Responses range from 'Extremely Important' to 'Definitely Not Important'.

Please, for each element, tick the box, which best represents, your view.

Elements of care: Quality care for the patient should be:	**Extremely important**	**Important**	**Neutral**	**Not important**	**Definitely not important**		**Elements of care**: Quality of care for patient is about:	**Extremely important**	**Important**	**Neutral**	**Not important**	**Definitely not important**
1.Patient centred							17.Listening to patient					
2.Holistic (care which includes a physical, social, psychological and spiritual dimension)							18.Meeting patients emotional needs					
3.Based on nurse-patient relationship							19.Kindness to patients					

4.Provided by nurses who are competent in technical skills							20.Providing recreational and social activities for patients					
5.Individualized							21.Facilitating patient choice					
6.Well co-ordinated care							22.Meeting physical needs					
7.Sensitive to a patient's spiritual needs							23.Teaching and informing patients and families					
8.Based on knowing the patient as a person							24.Promoting health					
9.About helping the patient integrate socially							25.Valuing the views of patient					
10.Based on respect for the patient							26.Making patient comfortable in environment					
11.Sensitive to patients' preferences							27.Giving patients privacy					
12.Provided by nurses who have good interpersonal skills							28.Paying attention to the patient's personnel needs					
13.Guided by good nursing leadership							29.Good multidisciplinary teamwork					
14.About helping a patient meet their potential							30.Being an advocate on patient's behalf					
15.Thorough and systematic care							31.Family centred					
16.Knowledge based							32.Maintaining patients independence					

SECTION C: NURSES' ACTIVITIES AND PRIORITIES

	Please indicate how often in the last 7 days did it happen that…(question 1-5)	Never	Rarely	Sometimes	Often
1	**Activity of daily living (ADLs)**				
1(a)	You could not assist a patient with a necessary sponge bath or skin care?				
1(b)	You could not perform a necessary oral or dental hygiene to a patient?				

1(c)	You were not able to mobilize or change the position of a patient?				
1(d)	You would not put clean sheets on a dirty bed?				
2	Caring-support				
2(a)	You could not offer emotional or psychosocial support to a patient even though you felt it was necessary e.g. dealing with insecurities and fear of his/ her illness, the feeling of dependency?				
2(b)	You could not have necessary conversation with a patient or his/ her family?				
3	Rehabilitation-instruction-education				
3(a)	You could not teach and/ or educate a patient and/ or their family about their necessary self-care e.g. insulin injection, behaviour or coping with illness-specific symptom (hypo-glycemia, dyspnea)?				
3(b)	You could not prepare a patient or their family for his/ her hospital discharge?				
4	Monitoring – safety				
4(a)	You could not monitor a patient as closely as had been prescribed by a physician or as you felt was necessary?				
4(b)	A physician either did not come in person or took a long time to arrive after you called him/ her because of an acute or sudden change in a patient's condition?				
4(c)	You had to keep a patient who had called for a nurse waiting longer than 5 min?				
5	Documentation				
5(a)	You did not have enough time to go over the patient documentation at the beginning of your shift?				
5(b)	You could not set up to date a patient's care plan?				
5(c)	You could not document the performed nursing care for a patient detailed enough?				

Section D: QUESTIONS RELATED TO JOB

1.Please indicate the extent to which you agree that each of the following features is present in your current job		**Strongly disagree**	**Somewhat disagree**	**Somewhat agree**	**Strongly agree**
1.	Adequate support services allow me to spend time with my patients.				
2.	Physicians and nurses have good working relationships.				

3.	A supervisory staff that is supportive of nurses.				
4.	Active staff development or continuing education programs for nurses				
5.	Career development/ clinical ladder opportunity.				
6.	Opportunity for registered nurses to participate in policy decisions.				
7.	Physicians value nurses' observations and judgments.				
8.	Enough time and opportunity to discuss patient care problems with other nurses.				
9.	Enough registered nurses on staff to provide quality patient care.				
10.	A nurse manager who is a good manager and leader.				
11.	A chief nursing officer who is highly visible and accessible to staff.				
12.	Enough staff to get the work done.				
13.	Physicians recognize nurses' contributions to patient care.				
14.	Praise and recognition for a job well done.				
15.	High standards of nursing care are expected by the management.				
16.	A chief nursing officer is equal in power and authority to other top level hospital executives.				
17.	A lot of team work between nurses and physicians.				
18.	Opportunities for advancement.				
19.	A clear philosophy of nursing that pervades the patient care environment.				
20.	Working with nurses who are clinically competent.				
21.	Physicians respect nurses as professionals.				
22.	A nurse manager who backs up the nursing staff in decision making, even if the conflict is with a physician.				
23.	Management that listens and responds to employee concerns.				
24.	An active quality assurance program.				
25.	Registered nurses are involved in the internal governance of the hospital (e.g., practice and policy committees).				
26.	Collaboration between nurses and physicians.				
27.	A preceptor program for newly hired nurses.				
28.	Nursing care is based on a nursing rather than a medical model.				
29.	Registered nurses have the opportunity to serve on hospital and nursing committees.				

30.	Physicians hold nurses in high esteem.				
31.	Written, up-to-date care plans for all patients.				
32.	Patient care assignments that foster continuity of care (i.e., the same nurse cares for the patient from one day to the next day).				

APPENDIX 1.2: **QUESTIONNAIRE: FRENCH VERSION**

Merci beaucoup d' avoir accepté de participer à cette recherche. Pour bien remplir ce questionnaire, nous vous prions de lire les instructions ci-dessous mentionnées:

Instructions:

1. Ne pas écrire vos noms sur ce questionnaire.
2. Veuillez remplir toutes les questions ci-après.
3. Indiquez votre choix de reponse en cochant (√) dans la case appropriée.

SECTION A:

1. Indiquez votre âge:

Moins de 20 ans	21-25 ans	26 -30 ans	31-40 ans	Plus de 40 ans

2. Indiquez votre sexe

Féminin	Masculin

3. Indiquez votre plus haut niveau de qualification en sciences infirmières.

Infirmier A_2	Infirmier A_1	Infirmier licencié (A_0)	Maitrise en sciences infirmières

4. Indiquez votre expérience de travail dans la carrière infirmière, y compris votre expérience actuelle (par exemple, si vous avez 5 ans et 3 mois d' expérience, vous pouvez sélectionner 6-10 ans puis que vous êtes près à atteindre votre expérience de 6 ans).

0-5 ans	6-10 ans	11-20 ans	21-30 ans	Plus de 30 ans

SERIE B: LA PERCEPTION DE LA QUALITE DE SOIN

Le tableau en bas contient les éléments de la qualité de soin. Veuillez considérer tout élément de la qualité de soin. Les réponses sont ordonnées de "Très important" au "Moins important".

S'il vous plaït, pour chaque élément, cochez la case qui représente le mieu votre point de vue.

Elément de soin La qualité de soin pour le malade doit être**:**	**Très important**	**Important**	**Neutre**	**Pas important**	**Moins important**		**Elément de soin** Pour fournir un soin de qualité au malade, if faut**:**	**Très important**	**Important**	**Neutre**	**Pas important**	**Moins important**
1.Centré sur le malade							17.Ecouter le malade					
2.Holistique (soin qui comprend l' aspect physique, social, psychologique et spirituel)							18.Répondre aux besoins émotionnels des malades					
3.Basée sur la relation infirmière-malade							19.Traiter les malades avec gentillesse					
4.Donnée par les infirmier (ères) qui sont compétent(es) techniquement							20.Fournir aux malades des activités récréationnelles et sociales					
5.Individuelle							21.Privilégier le choix du malade					
6.Bien coordonnée							22.Répondre aux besoins physiques du malade					
7.Respectueuse des besoins spirituels du malade							23.Eduquer et informer le malade et sa famille					
8.Basée sur la connaissance du malade en tant qu' être humain							24.Promouvoir la santé du malade					
9. Capable d' aider le malade à s' intégrer dans la société							25.Valoriser les propos du malade					
10.Basée sur le respect du malade							26.Rendre confortable le malade dans son environnement					
11.A l' écoute des souhaits des malades							27.Respecter l' intimité du malade					
12.Donnée par les infirmier(ères) qui ont des compétences interpersonnelles							28.Faire attention aux besoins personnels du patient					
13.Guidée par une bonne gestion/							29.Avoir une bonne équipe soignante multidisciplinaire					

administration infirmière												
14.Capable d' aider le malade à atteindre son potentiel.							30.Pouvoir plaider en faveur du malade					
15.Complète et systématique							31.Rester centré sur la famille					
16.Scientifique							32.Maintainir l' indépendence du malade					

SECTION C: ACTIVITES INFIRMIERES ET PRIORITÉS DES INFIRMIERS

Vous trouverez dans cette partie des questions qui se réfèrent aux mesures ou thérapies infirmières nécessares mais qui n'ont pas pu être effectuées par **MANQUE DE TEMPS, SURCHARGE DE TRAVAIL** ou pour des **RAISONS FINANCIERES** ou qui ont été effectuées de manière insuffisante. Il est également demandé si certains groups de personnes sont davantage touchés par ces mesures. (veuillez cocher les réponses qui conviennent).

A quelle fréquence est-il arrivé durant vos derniers 7 jours de travail que (1-5)

1	**SOUTIEN AUX ACTIVITES DE LA VIE QUOTIDIENNE**	**Jamais**	**Rarement**	**Parfois**	**Souvent**
a)	…vous n' avez pas pu réaliser auprès d' un malade un soin corporel partiel et/ ou un soin de peau NECESSAIRE?				
b)	…vous n' avez pas pu réaliser auprès d' un patient un soin de dents et/ ou un soin de bouche NECESSAIRE?				
c)	…vous n' avez pas pu mobiliser un patient ou le changer de position?				
d)	…vous n' avez pas pu changer les draps sales d' un lit				
2	**DISCUSSION-ACCOMPAGNEMENT-MARQUE D' ATTENTION**				
a)	…vous n' avez pas pu offrir le soutien et l' accompagnement émotionnels et psycho-sociaux nécessaries à un patient, par ex. en relation avec l' incertitude et la peur ou le sentiment de dépendence?				
b)	Vous n' avez pas pu avoir un entretien necessaire avec le patient ou un proche?				
3.	**PROGRESSION-INSTRUCTION-ENSEIGNEMENT**				
a)	…vous n' avez pas pu instruire ou faire l' enseignement auprès des patients ou ses proches par ex. à faire des				

	injections d' insuline, à gérer des symptomes dus a la maladie (hypoglycémie, dyspnée etc)?				
b)	…vous n'avez pas pu préparer suffisamment un patient et/ ou ses proches en ce qui concerne les soins à sa sortie de l' hospital?				
4	**SURVEILLANCE- SECURITE**				
a)	…vous n' avez pas surveillez un patient tel que le médecin l' avez prescript ou qu' il aurait été nécessaire à votre avis?				
b)	…un médecin n' a pas pu venir personnellement ou est arrivé avec beaucoup de retard lors d' un changement aigu ou soudain dans l' état de santé d' un patient				
c)	…un patient qui a appelé a du attendre plus de 5 minutes				
5	**DOCUMENTATION**				
a)	…lorsque vous avez commencé votre tranche horaire, vous n' avez pas eu le temps de vous informer suffisamment sur la situation des patients à l' aide de la documentation de soins?				
b)	… vous n' avez pas pu faire ou actualiser une planification des soins pour un patient?				
c)	…vous n' avez pas pu documenter suffisamment les soins effectués à un patient?				

SECTION D: A PROPOS DE VOTRE TRAVAIL

1.Veuiller indiquer votre niveau d' adhésion sur la présence des propositions suivantes au sein de votre place de travail actuelle					
		En grand desaccord	**Plutot en desaccord**	**Plutot d' accord**	**En grand accord**
1.	Des services logistiques adéquats me permettent de consacrer du temps auprès de mes patients.				
2.	Les médecins et infirmièrs entretiennent de bonnes relations de travail.				
3.	Le personnel de direction soutient les infirmières.				
4.	Des programmes de développement ou de formation continue à l' attention des infirmières.				
5.	Des opportunités d' évolution				

	professionnelle/ d' évolution de carrière.				
6.	Des opportunites pour les infirmières de participer aux décisions politiques.				
7.	Une prise en compte par les médecins des observations et du jugement Clinique des infirmières.				
8.	Du temps et des opportunités suffisantes pour discuter avec les autres infirmières les problèmes de soin rencontrés avec les patients.				
9.	Une dotation infirmière suffisante pour fournir des soins de qualité au patient.				
10.	Un ICUS (l' infirmier chef d' unite) qui est un bon manager et un bon leader pour son équipe.				
11.	Le directeur des soins infirmier est visible et accessible pour son personnel.				
12.	Du personnel en suffisance pour effectuer le traivail requis.				
13.	Reconnaissance par les médecins de la contribution des infirmières dans les soins au patient.				
14.	Des remerciements et de la reconnaissance du travail bien fait.				
15.	Des standards de soin élevés sont attendus par la direction.				
16.	Le pouvoir décisionnel et l' autorité du directeur des soins sont équivalents a ceux des autres dirigeants.				
17.	Beaucoup de travail d' équipe entre les médecins et les infirmières.				
18.	Des opportunités d' évolution professionnelles.				
19.	Une philosophie de soins infirmiers claire qui détermine l' environment de travail et le soin apporté aux patients.				
20.	Un travail avec des infirmières compétentes qui disposent d' une expertise clinique.				
21.	Les médecins considèrent les infirmières				

	comme des professionnels.				
22.	Un ICUS (l'infirmier chef d'unité) qui soutient son personnel dans ses prises de décision, même s' il y a conflit avec un médecin.				
23.	Une direction qui écoute et répond aux inquiétudes de ses employés.				
24.	Un programme d' amélioration continue opérationnelle.				
25.	Les infirmières sont inclues dans des comités décisionnels internes de l' hospital (ex. Expertises et pratiques cliniques).				
26.	Collaboration entre infirmières et médecins.				
27.	Un programme d' intégration et d' encadrement pour les nouvelles infirmières engagées.				
28.	Les soins infirmiers sont basés sur un model infirmier plutot qu' un modèle médical.				
29.	Possibilités pour les infirmières de participer à des colloques ou comités de pilotage.				
30.	Estime élevée des infirmières par les médecins.				
31.	Des plans de soins écrits et mis à jour pour tous les patients.				
32.	Une programmation de soins qui favorise la continuité des soins (ex. Même infirmière d' un jour à l' autre pour le patient).				

APPENDIX 2.1: INFORMATION DOCUMENT: ENGLISH VERSION

Study title: **'EXPLORING THE PERCEPTIONS OF QUALITY NURSING CARE AMONG NURSES WORKING IN TWO DISTRICT HOSPITALS IN RWANDA'.**

Dear Nurse,

I am Gilbert Banamwana, a student in Masters Program of Health Service and Administration at University of KwaZulu-Natal. I am currently conducting thesis research to **EXPLORING THE PERCEPTIONS OF QUALITY NURSING CARE AMONG NURSES WORKING IN TWO DISTRICT HOSPITALS IN RWANDA**. I would very much appreciate your participation in this study.

We do not ask for your name so the information you provide will be anonymous and confidential. The findings from this study will be used to contribute to the existing quality improvement in your daily nursing practice. Enclosed you will find a questionnaire that will last roughly 25-30 minutes for you to fill in. The questionnaire is made up of the sections. You are asked to mark the response that best describes how you feel. There is no coercion to partake to this study, and you are freely allowed to decline or withdraw from the study at any time without any consequence. Your consent to participate in this study will be confirmed by completing the questionnaires. If you have any questions or concerns regarding this research project, please do not hesitate to contact me on mobile phone: (+250) 0788400735/ (+27) 0835536075; e-mail: banagilberto@yahoo.fr, or my supervisor, Ms Nondumiso Shangase at mobile phone: (+27) 0828820284, e-mail: shangasen@ukzn.ac.za.

Thank you for your time and co-operation.

Kind regards,

Gilbert Banamwana

APPENDIX 2.2: DOCUMENT D' INFORMATION: FRENCH VERSION

Intitulé d' étude**: "L' EXPLORATION DE LA PERCEPTION DE LA QUALITE DE SOIN INFIRMIER PAR DES INFIRMIERS (ÈRES) QUI TRAVAILLENT DANS LES DEUX HOPITAUX DE DISTRICT DU RWANDA"**

Cher Infirmier (ère),

Je m' appelle Gilbert Banamwana, étudiant en troisième cycle au Programme de Gestion de Services de Santé à l' Université de KwaZulu-Natal. Actuellement, je suis en train de conduire une recherche pour explorer la perception de la qualité de soin infirmier par des infirmier(ères) qui travaillent dans les deux hopitaux de district du Rwanda. J' aimerais avoir votre participation à cette recherche.

Je vous demande de ne pas écrire votre nom sur ce questionnaire pour que les informations données restent anonymes et confidentielles. Les résultats de cette étude seront utilisés pour contribuer à l' amélioration existente de votre quotidien en ce qui concerne les soins infirmiers de qualité.

Dans ce document d' informations, vous trouverez un questionnaire à remplir qui vous demandera à peu près 25 à 30 minutes de votre temps. Le questionnaire est composé d' une série de questions. Vous êtes prié de cocher (√) la réponse qui correspond le mieux à votre opinion. La participation à cette recherche est volontaire et vous êtes libre de vous retirer de cette recherche à n' importe quel moment sans aucune conséquence. Votre consentement de participation à cette recherche sera confirmé en complétant ce questionnaire. Si vous avez une question à propos de cette recherche, n' hésitez pas à me contacter sur mon télephone mobile: (+250) 0788400735/ (+27) 0835536075; par e-mail: banagilberto@yahoo.fr, ou par mon Directeur, Madame Nondumiso Shangase au numéro de télephone mobile suivant: (+27) 0828820284, e-mail: shangasen@ukzn.ac.za.

Je vous remercie sincèrement de votre temps et coopération.

Gilbert Banamwana

APPENDIX 3.1: INFORMED CONSENT: ENGLISH VERSION

Consent to participate in Research

Study title: EXPLORING THE PERCEPTIONS OF QUALITY NURSING CARE AMONG NURSES WORKING IN TWO DISTRICT HOSPITALS IN RWANDA.

Dear nurse,

You have been asked to participate in a research study. You have been informed about the study by Gilbert BANAMWANA having read the information document which has the details of the study. You may contact me on mobile phone: (+250) 0788400735/ (+27) 0835536075; e-mail: banagilberto@yahoo.fr, or my supervisor, Ms Nondumiso Shangase at mobile phone: (+27) 0828820284, e-mail: shangasen@ukzn.ac.za.

Your participation in this study is voluntary, and you will not be penalized or lose benefits if you refuse to participate or decide to stop. If you agree to participate in this study, you will sign below this document in the space provided as a show of your declaration consent.

DECLARATION OF CONSENT

I…….(full names of participants) hereby confirm that I understand the contents of this document and the nature of the research project, and I consent to participating in the research project. I understand that I am at liberty to withdraw from the project at any time, should I so desire.

SIGNATURE OF PARTICIPANT

DATE

…….

APPENDIX 3.2: DOCUMENT DE CONSENTEMENT: FRENCH VERSION

Consentement de participation à la Recherche

Intitulé d' étude**: "L' EXPLORATION DE LA PERCEPTION DE LA QUALITE DE SOIN INFIRMIER PAR DES INFIRMIERS (ÈRES) QUI TRAVAILLENT DANS LES DEUX HOPITAUX DE DISTRICT DU RWANDA"**

Cher Infirmier (ère),

Il vous a été demandé de participer à une recherche. Vous avez été informé à propos de l' étude de Gilbert BANAMWANA; vous avez lu le document d' information qui donne des informations plus détaillées sur l' étude. Vous pouvez me contacter sur mon télephone mobile: (+250) 0788400735/ (+27) 0835536075; par e-mail: banagilberto@yahoo.fr, ou par mon Directeur, Madame Nondumiso Shangase sur son télephone mobile: (+27) 0828820284, ou par e-mail: shangasen@ukzn.ac.za.

Votre participation à cette recherche est volontaire, et vous ne serez aucunement pénalisé si vous refusez de participer ou que vous décidez de vous retirer. Si vous acceptez de participer à cette recherche, veuillez signer ci-dessous à l' endroit reservé à cette fin pour déclarer votre consentement.

DECLARATION DE CONSENTEMENT

J' atteste ,…….(nom et prénom du participant) par cette déclaration , que je comprends le contenu de ce document et le projet de recherche, et que j' accepte de participer à cette recherche. Je comprends que je suis libre de me retirer du projet de recherche à n' importe quel moment selon ma volonté.

SIGNATURE DU PARTICIPANT

DATE

……

APPENDIX 5.1: PERMISSION TO USE THE BERNCA INSTRUMENT

De : Maria Schubert (maria.schubert@unibas.ch)
À : banagilberto@yahoo.fr;
Date : Mar 29 mars 2011, 12h 41min 18s
Cc :
Objet : Re: Fwd: Request for permission for the use of the instrument

Dear Mr. Banamwana,
thank you for your interest in our research and the BERNCA instrument.

Herewith I give you the permission to use the BERNCA in your project mentioned below. I would like to ask you to cite us as the source (owner) of the instrument in your reports/publications, and to send me the publications, if there are any.

In the meantime also a revised version of the BERNCA instrument is available. We have used the revised version in Switzerland in the context of the RN4CAST study (Nurse Forecasting: Human Resources Planning in Nursing). You will find the English translation of the revised BERNCA instrument in the attachment. Both version of the BERNCA are also available in Swiss French. Please let me know, if you need the French version.

Kind regards,
Maria Schubert

Dr. Maria Schubert, PhD, RN
Scientific collaborator, Project Manager EU Study RN4CAST, Swiss branch
Project leader, Study Mechanical Ventilation and Weaning Responsibilities, Swiss branch
Institute of Nursing Science, Faculty of Medicine, University of Basel
Bernoullistr. 28, 4056 Basel, Switzerland
tel: ++41 (0)61 267 09 54; fax: ++41 (0)61 267 09 55

-------- Original Message --------
Subject: Request for permission for the use of the instrument
Date: Thu, 24 Mar 2011 04:46:08 +0000 (GMT)
From: Gilbert BANAMWANA <banagilberto@yahoo.fr>
To:sabina.degeest@unibas.ch

Dear Sabina,

Good morning,

I am Gilbert Banamwana, a masters student in Nursing Management, at the University of Kwazulu-Natal, School of Nursing. Currently, I am conducting my research project on the nurses' perceptions of the nursing quality care in Rwanda and I greatly appreciate your instrument "Rationing of nursing care and its relationship to patient outcomes: the suiss extension of the international hospital outcomes study" and would like to ask for permission and any related information with regard to its use.

Thank you for your cooperation and consideration

Regards,

Gilbert

APPENDIX 5.2: PERMISSION TO USE RN4CAST Version PES-NWI-R

De : Maria Schubert (maria.schubert@unibas.ch)
À : banagilberto@yahoo.fr;
Date : Dim 3 avril 2011, 10h 40min 45s
Cc :
Objet : Re: Special thanks

Dear Gilbert,
you are welcome.

In the meantime I have asked Dr. Aiken, if I can forward to you also French Version of the PES-NWI-R, which we have used in the RN4CAST study. She agreed with this. You will find the French translation of the instrument in the attachment.
Please do not hesitate to contact me, if you have further questions.

Kind regards,
Maria Schubert

On 02.04.2011 16:50, Gilbert BANAMWANA wrote:

> Dear Dr Schubert,
>
> I cannot know how to express my gratitude to you for your time, consideration and cooperation and I promise you to take care of your suggestions during this study.
>
> With regard to the short Nursing Work Index, it could may be relevant to my study but as I do not know how it is really like comparatively to the first one it is not easy for to decide at the present but once I will get any idea about it I will let you kept informed.
>
> Thank you for your usual cooperation and God may bless you for everything.
>
> Regards,
>
> Gilbert

APPENDIX 5.3: PERMISSION TO ADAPT INSTRUMENT

De : Maria Schubert (maria.schubert@unibas.ch)
À : banagilberto@yahoo.fr;
Date : Ven 15 avril 2011, 12h 18min 59s
Cc :
Objet : Re: Request for information

Dear Gilbert,
in the paper from Lake, I sent you, the different subscales of the PES -NWI-R are described. These subscales most commonly used in the international setting, also from Dr. Aiken and her team.
As you can take from our paper, we have used in the RICH Nursing study, based on our evaluation of the psychometric properties of the NWI-R in the Swiss setting, only three subscales.
You do not need a specific permission for the use of the NWI-R from Dr. Aiken. It is only important that you mention Dr. Aiken and her team as the source (developer of the tool) and our team as the source of the translated version.
I discussed this with her.
Yes, if necessary you can adapt the items on your cultural context. You have probably then to reevaluate the psychometric properties of the tool/s.

I have attached some other papers, which you probalby already know.
Kind regards,
Maria Schubert

Maria Schubert, PhD, RN
Scientific collaborator, Project Manager EU Study RN4CAST, Swiss branch
Project leader, Study Mechanical Ventilation and Weaning Responsibilities, Swiss branch
Institute of Nursing Science, Faculty of Medicine, University of Basel
Bernoullistr. 28, 4056 Basel, Switzerland
tel: ++41 (0)61 267 09 54; fax: ++41 (0)61 267 09 55

On 13.04.2011 10:02, Gilbert BANAMWANA wrote:

> Dear Dr Schubert,
>
> Good morning,
>
> I would like to request for information related to the description of the instrument and the permission to use the PES Nursing work index-revised.
> Regarding the description, I would like to know whether there is any particular description related to subscales and component items, for example item related to nurse-physician collaboration, nursing quality care, staffing, etc.
>
> Concerning the permission, I would like to know whether your permission to use your instrument may cover the use of PES Nursing work index-revised as I will use both instrument (BERNCA questionnaire) and PES-NWI-R (Dr Aiken). Am I allowed to adapt some item to the context of the research setting, for example: item 4 (d) you had to keep a patient who had rung for a nurse.... where in Rwandan context patients or family member (care provider) are used to call rather than ring.
>
> Thank you for your cooperation.
>
> Regards,
>
> Gilbert

APPENDIX 5.4: PERMISSION TO ADAPT INSTRUMENT

De : Murphy, Kathleen (kathy.murphy@nuigalway.ie)
À : banagilberto@yahoo.fr;
Date : Ven 10 juin 2011, 17h 12min 17s
Cc :
Objet : RE: Request for the permission for instrument adaptation

Gilbert
You are welcome to adapt in any way you like.
Kathy

From: Gilbert BANAMWANA [mailto:banagilberto@yahoo.fr]
Sent: 10 June 2011 15:06
To: Murphy, Kathleen
Subject: Request for the permission for instrument adaptation

Dear Dr Kathy,

Good afternoon,

First of all, thank you very much for the validity and reliability of the instrument sent. As the instrument was designed for the long-stay care I would like to ask for the permission to adapt some items of of the instrument to the context of my research.

Thank you for your cooperation, time and consideration.

Have a nice weekend.

Regards,

Gilbert

APPENDIX 5.5: PROOF OF TRANSLATION OF THE INSTRUMEN

TO WHOM IT MAY CONCERN

THIS IS TO CERTIFY THAT I HAVE REVIEWED AND CORRECTED THE TRANSLATION INTO FRENCH OF THE RESEARCH INSTRUMENTS RELATED TO THE RESEARCH OF MR Gilbert BANAMWANA AND THAT THESE DOCUMENTS ARE ACCURATE RENDITIONS OF THE ENGLISH ORIGINALS AS PRESENTED TO ME.

NINON LARCHÉ

French Studies,
Translation Studies,
School of Language, Literature and Linguistics
UKZN, Howard College
Ph: +27 31 260 3705
Fax: +27 31 260 1242

UNIVERSITY OF KWAZULU-NATAL
FRENCH, GERMAN, ITALIAN
AND TRANSLATION STUDIES

APPENDIX 5.6: RESEARCH SETTING ENDORSEMENT

KABGAYI DIOCESE N° .....3107/.....HOP/SRO/gz

MUHANGA DISTRICT
KABGAYI HOSPITAL
B.P: 66 GITARAMA – RWANDA.
E– mail: kabgayihospital@ gmail.com

June 24th ,2011

Gilbert BANAMWANA
University of Kwazulu-Natal
School of Nursing
Howard College Campus
POBOX: 4041 Durban
Phone : + (250) 7835536075
E-mail: banagilbert@yahoo.fr

Dear Gilbert,

Re: Approval to conduct your study

Referring to the above subject matter, it is with great pleasure that I am writing to let you know that your request to conduct the study on understanding the perception of the quality nursing care among nurses working in our Hospital was accepted.

We look forward to receiving your findings and recommendations report that is expected to be a highly appreciated asset to our institution.

Yours faithfully

Dr SEBATUNZI. Osée
Director of Kabgayi Hospital

APPENDIX 5.7: ETHICAL CLEARANCE APPROVAL FROM UKZN

UNIVERSITY OF
KWAZULU-NATAL
INYUVESI
YAKWAZULU-NATALI

Research Office, Govan Mbeki Centre
Westville Campus
Private Bag x54001
DURBAN, 4000
Tel No: +27 31 260 8350
Fax No: +27 31 260 4609
snymanm@ukzn.ac.za

30 September 2011

Mr G Banamwana (209510754)
School of Nursing

Dear Mr Banamwana

PROTOCOL REFERENCE NUMBER: HSS/0943/011M
PROJECT TITLE: Exploring the perceptions of quality nursing care among nurses working in two district hospitals in Rwanda

In response to your application dated 04 August 2011, the Humanities & Social Sciences Research Ethics Committee has considered the abovementioned application and the protocol has been granted **FULL APPROVAL.**

Any alteration/s to the approved research protocol i.e. Questionnaire/Interview Schedule, Informed Consent Form, Title of the Project, Location of the Study, Research Approach and Methods must be reviewed and approved through the amendment /modification prior to its implementation. In case you have further queries, please quote the above reference number.
PLEASE NOTE: Research data should be securely stored in the school/department for a period of 5 years.

I take this opportunity of wishing you everything of the best with your study.

Yours faithfully

.....
Professor Steven Collings (Chair)
HUMANITIES & SOCIAL SCIENCES RESEARCH ETHICS COMMITTEE

cc. Supervisor – N Shangase
cc. Mr S Reddy

APPENDIX 5.8: ETHICAL CLEARANCE APPROVAL FROM KHI

RBC/KIGALI HEALTH INSTITUTE

B.P. 3286 Kigali, RWANDA
Tel: + (250) 572172; +250 571788
e-mail: deanchd@khi.ac.rw

Institutional Review Board

17th October 2011

RBC/KHI/IRB/...08.../2011

To: Gilbert BANAMWANA

Dear Gilbert,

RE: ETHICS CLEARANCE

Reference is made to your application for ethics clearance for the study entitled ***"EXPLORING THE PERCEPTIONS OF QUALITY NURSING CARE AMONG NURSES WORKING IN TWO DISTRIC HOSPITALS IN RWANDA"***

You will be pleased to learn that the ethics clearance has been granted to your study by the RBC/KHI Institutional Review Board (IRB) on behalf of the National Ethics Committee (NEC) in accordance with the authority granted to the IRB by the NEC letter of 13th May 2010.

You shall, be required to submit the progress report and any other major changes made in the proposal during the implementation stage. Also, at the end of the study the Institutional Review Board shall also require to be given a final report of the study.

I wish you success in this important study.

Prof. Kato J. NJUNWA
Chairperson, RBC/KHI Institutional Review Board

CC:
- Rector, RBC/KHI
- Vice Rector, Academics and Research, RBC/KHI
- Chairperson, Rwanda National Ethics Committee
- RBC/IRB Members

APPENDIX 5.9: PERMISSION TO COLLECT DATA FROM KABGAYI

KABGAYI DIOCESE

MUHANGA DISTRICT

KABGAYI HOSPITAL
B.P: 66 GITARAMA – RWANDA.
E– mail: kabgayihospital@ gmail.com

Kabgayi, 18th October 2011

N° ...520.../HOP/S.R.O

Dear Gilbert BANAMWANA

Re: Permission to collect Data.

In response to your letter dated on 17th October, 2011 asking the permission to collect data for a research project entitled: " **Exploring the perception of quality nursing care among nurses working in two District Hospitals in Rwanda"**.

I would like to inform that you are permitted to collect data in Kabgayi Hospital.

I take this opportunity to wish you success in this important study.

Your faithfully.

Dr Osée SEBATUNZI
Director of Kabgayi Hospital.

HOSPITAL KABGAYI DIOCESAIN

APPENDIX 5.10: PERMISSION TO COLLECT DATA FROM MUHIMA

REPUBLIC OF RWANDA

Octobre 24th, 2011

KIGALI CITY
NYARUGENGE DISTRICT
Muhima Hospital District
PO Box: 2456 KIGALI
Tel/Fax: +252 50 37 71

Gibert BANAMWANA
University of Kwazulu Natal School of Nursing
Howard College Campus
P.O.Box: 4041 Durban
Phone: (+27)07835536075/(+250)0788400735

Dear Sir,

Subject: Permission to collecting data at Muhima hospital district

In response to your letter dated June 15th 2011, asking the authorization to collect data related to the study entitled "*Exploring the perceptions of quality nursing care among nurses working in two districts hospital in Rwanda*", I am pleased to let you know that you are allowed to collect data at Muhima Hospital . You will provide a copy of your final report.
The Chief Nursing that I give the copy will guide the students.

Dr. Jules MUSHINGANTAHE
The Director of the Hospital Muhima

CC:
- The Administrator / Muhima Hospital
- Human Resources Management
- The Chief Nursing /Muhima Hospital

APPENDIX 11: PROOF OF EDITING

Editing Declaration

P O Box 531
Hillcrest
3650
KwaZulu-Natal

2012-01-12

TO WHOM IT MAY CONCERN

Thesis Title: EXPLORING THE PERCEPTIONS OF QUALITY NURSING CARE AMONG NURSES WORKING IN TWO DISTRICT HOSPITALS IN RWANDA

Author: Gilbert Banamwana

This is to certify that I have edited the above thesis from an English language perspective only, and have made recommendations to the author regarding spelling, grammar, punctuation, structure and general presentation.

A marked-up version of the thesis has been sent to the author and is available as proof of editing.

I have had no input with regard to the technical content of the document and have no control over the final version of the thesis as it is the prerogative of the student to either accept or reject any recommendations I have made.

Therefore, I accept no responsibility for the final assessment of the document

Yours faithfully

Margaret Addis