

**DEVELOPMENT OF A FINANCIAL MANAGEMENT
COMPETENCY FRAMEWORK FOR NURSE
MANAGERS AT SELECTED PUBLIC HOSPITALS IN
KWAZULU-NATAL, SOUTH AFRICA**

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the Faculty of Health Sciences at the Durban University of Technology

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Declaration

This is to certify that the work is entirely my own and not of any other person, unless explicitly acknowledged (including citation of published and unpublished sources). The work has not previously been submitted in any form to the Durban University of Technology or to any other institution for assessment or for any other purpose.

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Dedication

As an expression of my deepest gratitude and appreciation I dedicate this work to my husband, Arnold, to whom I remain forever indebted for the love, patience, support, tolerance and encouragement which inspired and sustained me throughout this research. You ask "Are you done yet?" I can answer you now, "Yes, I am done." To my precious children, Thanisha, Seeni, Tivania and Dhayalan, this work is a dedication to you for your unwavering support and encouragement towards my commitment in achieving a lifetime dream. I pray that I may be an inspiration and support to you as you pursue your own dreams. To my dearest grandchild, Ila Rahi, may this be an inspiration to you that you can achieve anything in life if you believe in it and pursue it. It does not matter how long it takes. Thanks for being part of my life. I love you all.

"For I know the plans I have for you", declares the Lord, "plans to prosper you and not to harm you, plans to give you hope and a future." Jeremiah 29 v. 11.

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Abstract

Background

In the South African context, the Nurse Manager (NM) is responsible for and manages the nursing side of the health care organisation. Public hospitals face the challenges of poor management, underfunding, deteriorating infrastructure and poor standards. The consequences are that NMs have to do more with less. This necessitates that the NMs should have the competencies and skills to enable them to use the existing resources more efficiently and equitably and be able to manage and contain costs within their departments. However, NMs do not necessarily have financial management skills and competencies to manage the current health care financial situation. This then highlights the need for financial preparation of all NMs.

Aim

The aim of the study was to explore the financial management roles of NMs in their current work environments, identify financial management development needs necessary for NM practice, and ultimately to develop a financial management framework to improve the skills of NMs.

Methodology

A qualitative, grounded theory approach was used to explore the financial management skills and competencies and developmental needs of NMs. Nursing Managers, Financial Managers, Operational Managers and Chief Executive Officers of public hospitals in KwaZulu-Natal participated in the study. The data was collected by means of interviews. The sample size for the interviews was guided by data saturation and comprised 18 participants.

Findings

The study findings revealed that NMs are involved in financial management activities within the hospitals. However, they do not necessarily have the requisite financial management skills and competencies to function in their financial roles. From the findings the researcher was able to propose and

develop a framework to improve the financial management competencies of NMs in the public sector.

It was concluded that NMs do indeed practice financial management and therefore require the relevant knowledge, skills and competencies. Recommendations include the development of a financial management training programme to be implemented based on the identified needs of NMs in the public sector. Another recommendation is that undergraduate and post graduate nursing programmes include financial management programmes that would be relevant and applicable to the specific financial management activities that nurses practice daily.

Key words: Competency, financial management framework, Nurse Manager.

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Glossary of Terms

Nurse Manager (NM): A Nurse Manager plays a nursing and executive role and is responsible for functions of the unit or hospital (The Agency for Healthcare Research and Quality 2016: 1).

Financial management: refers to planning, organising, directing and controlling financial activities such as procurement and utilisation of funds of the enterprise. It means applying general management principles to financial resources of the enterprise (Juneja 2016: 1).

Competency: refers to a mix of skills, related knowledge and attributes to produce a job/task to a defined standard; competence, however, relates to the outcomes which would define effective performance, namely aspects of the job at which a person is competent, for example, conducting an internal audit engagement (South Africa 2010 a: 4).

Competency Framework: describes a set of competency standards for employees and makes the expected knowledge, skills and attributes of employees explicit for those within and outside the organisation (South Africa 2017a: 8).

List of Acronyms

Acronym	Full word/sentence
AIDS	Acquired Immune Deficiency Syndrome
ANC	African National Congress
ANM	Assistant Nurse Manager
BAS	Basic Accounting System
CEO	Chief Executive Officer
CFO	Chief Financial Officer
CGT	Classical Grounded Theory
CINAHL	Cumulative Index to Nursing and Allied Health Literature
CNE	Chief Nursing Executive
CNO	Chief Nursing Officer
COE	Compensation of Employees
EXCO	Executive Committee
FM	Financial Manager
GT	Grounded Theory
HIV	Human Immune Deficiency Virus
HR	Human Resource
HRM	Human Resource Management
HTS	Health Technology Services
KZN	KwaZulu-Natal
MFMA	Municipal Finance Management Act
MTEF	Medium-term expenditure framework
NHI	National Health Insurance
NM	Nurse Manager
No.	Number
NSI	Non-Stock Item
NUM	Nursing Unit Manager
OM	Operational Manager
PERSAL	Personnel and Salary Administration System
PFMA	Public Finance Management Act
PHC	Primary Health Care

PN	Professional Nurse
PPPFA	Preferential Procurement Policy Framework Act
SANC	South African Nursing Council
SCM	Supply Chain Management
SOP	Scope of Practice
SWOT	Strengths, Weakness, Opportunities, Threats
TB	Tuberculosis
UN	United Nations
USA	United States of America
WHO	World Health Organisation

CHAPTER 1: OVERVIEW OF THE STUDY

1.1 INTRODUCTION AND BACKGROUND

In the South African context, the Nurse Manager (NM) is responsible for and manages the nursing side of the health care organisation (Baker, Marshburn, Crickmore, Rose, Dutton and Hudson 2012: 24). The role of the NM is critical in the provision of effective and high quality care in any patient care delivery setting. She/he is accountable and responsible for patient safety and quality. In addition, the NM represents the direct caregiver's voice at nursing leadership decision-making tables (Chase 2010: 271).

There have been many changes in health, health care systems and health care organisations in South Africa and worldwide which impact and influence how nursing management is practiced. Advances in technology are enabling and forcing new health care delivery models, funding is decreasing, and new health policies and laws are being introduced (Porter and Lee 2013: 1). In light of these changes, NMs face significant pressure to increase efficiency and deliver quality and compassionate care in a cost-efficient and integrated manner.

Public hospitals are funded by the state and deliver health care to about 80% of the population in South Africa (Ataguba and McIntyre 2012: 3). However, these institutions face the challenges of poor management, underfunding, deteriorating infrastructure and often fall short of the standards necessary for proper health care (Anderson 2016: 1). There are constraints on public health care spending, due to the low rate of economic growth, the need to repay government debt, the pressure to reduce government spending and the competing claims for public resources by other social services like education and social welfare (McIntyre, Bloom, Doherty and Brijlal 2015: 8). The introduction of the National Health Insurance (NHI) proposal with its re-engineered approach to the primary health care (PHC) system, the increasing prevalence of tuberculosis (TB) and human immunodeficiency virus/acquired

immune deficiency syndrome (HIV/AIDS) in the South African population has meant increased pressure on budgeted healthcare allocations (Naidoo 2012: 150). The future implications of these pressures could be that more funds of the total amount allocated to the health care budget will be channelled to these services, leaving a smaller reduced budget allocation to curative and tertiary services like public hospitals (Ataguba and McIntyre 2012: 3). The consequences of this would be that NMs should have to do more with less. This means that the NMs must have the competencies and skills to enable them to use the existing resources more efficiently and equitably and be able to manage and contain costs within their departments. To successfully advocate for the resources needed to staff and operate nursing units, NMs need to become more financially knowledgeable and increase their understanding of finances and healthcare costs (Sherman 2014: 1).

According to the South African Nursing Council (SANC) (1984:1), the NMs work within the legislative framework of the Nursing Act, 2005 (Act 33 of 2005, as amended) and the Scope of Practice (SOP) of nurses who are registered or enrolled (R2598 of 30 November 1984, as amended). The SOP sets out the procedures, actions and processes that nurses are allowed to perform. As the profession of nursing has a single SOP that broadly covers nursing practice related to general and specialty practice, the SOP does not address or specifically delineate financial skills as a competency for NMs. Searle (2004: 117) explains that between the periods 1950 to 1960 research was conducted into the “phenomenon of nursing practice” and the nursing regulations were based on this research. From this research, principles were developed which guided the development of the regulations that formalised the scope of nursing practice in South Africa. Chase (2010: 61) cautions that NMs’ scope and role has changed since 1984 and the competencies listed in the SOP may no longer be adequate and relevant to current practice. Sherman (2014: 1) finds the role has changed significantly over the past decade that the clinical and interpersonal skills that led to the selection of many managers are simply no longer enough to ensure good performance. The NM role is not what it once was, and the competencies needed today are far different from those of a decade ago (Sherman 2014: 1). The SOP has not

given attention to financial management skills. Training programmes and job descriptions for NMs are developed around the specifications and competencies as listed in the SOP, which explains the lack of these critical skills among NMs.

Waxman and Schaefer (2010: 177) confirm that the role of NM is different in today's health care environment compared to 25 years ago. In the past, nurses took care of patients and gave little thought to the financial side of health care. Today every nurse needs to understand that hospitals in both the public and private sector need finances to function. Prudent management and usage of all resources is critical in order to ensure that quality care is maintained.

Barnum and Kerfoot (1995: 197) found that the management of the finances of the nursing department has often been highly centralised. Previously, the only persons who knew the budget for the nursing department were the financial managers (FM) and Chief Executive Officers (CEOs). As the roles of NMs expanded they have been brought into full partnership with the FM in developing and managing the finances of the nursing departments. Often other categories of nurses are left out of this process. The focus of nursing education has been largely on the clinical outcomes and the development of clinical skills. There is some inclusion of financial management in the basic and post-basic nursing programmes, but this has not been given much attention. Barnum and Kerfoot (1995: 197) advocate that nurses should participate fully in financial management and that financial management for nurses should be a course on its own where nurses can be credentialed.

Thew (2015: 1) states that concern for a hospital's finances has traditionally been outside the realm of the professional nurse, but understanding health care costs gives them insight into leadership and management challenges facing the institution, and can improve patient care accordingly. Nurses need to be educated on how their actions can positively or negatively affect the hospital's bottom line (Thew 2015: 1).

Geyer (2016: 51) stresses that the SOP is formulated as a flexible framework in order to make provision for different areas of practice, and to allow for new developments in health, nursing or midwifery care. The broad guidelines set out in the regulations are not restrictive and permit the expansion and development of the nurse or midwife's role in order to keep pace with technology and advances in the health, nursing or midwifery field (Geyer 2016: 51).

The nursing education systems prepare nurses in the basic nursing programmes for clinical skills and nursing leadership, with a component of financial management included. Waxman and Schaefer (2010: 179) state that in nursing school nurses are taught a vocabulary specific to the profession. Nurses must also learn the language of finance to make their jobs easier and gain the respect of financial personnel. There is a need for more education and training to assist NMs in acquiring financial management skills as they do not receive adequate training in this subject, even though they are held accountable for the budget in their areas (Waxman 2008: 3). NMs in many instances do not receive adequate training in financial management principles compared to other industries. Nurses have learnt to care for patients and financial management is not addressed adequately in nursing curriculum (Rundio 2016: 2).

Penner (2015: 1) posits that historically nursing has steered clear of business and finances of a health care organisation and focused on the clinical role. Nurses do not get exposure to financial management in nursing school, and they do not get the necessary experience at work as well. Penner (2015: 1) states that even when nurses are promoted into management, they do not always get training in managing finances. Nurses across-the-board need to have some kind of knowledge and insight into financial management. Penner (2015: 1) adds that few NMs have any background or education in health care finance, and often resist the idea that they need to think about the cost of nursing care. However, in these times of rapid change and ever more scarce resources, it is time for nurses to realise that their performance affects not only their patients' health but the financial health of their institution (Penner

2015: 1). Nurses experience conflict in embracing their roles both as carers and financial management of the healthcare organisation (Douglas 2010: 270).

Specialised training is required to manage a health care organisation and develop the skills and models to support the financial management development of NMs (Harper 2015: 1). In South Africa, there are universities and colleges that offer various diplomas, degree and certificate courses that enable professional nurses (PNs) to specialise in nursing management. On completion of the course PNs can register their qualifications with the SANC. The Diploma in Nursing Management leads to registration with SANC as a Nurse Administrator (Regulation 1501). The Diploma in Unit Management for Registered Nurses (Regulation 203) leads to an additional qualification with SANC in unit management. These programmes provide broad guidelines of the competencies required of candidates that complete the course, which includes the fundamentals of nursing administration and the Principles of Administration and the Practice of Unit Management. Financial management is included as modules in these courses.

Problems and issues challenging the nursing profession as highlighted in the National Strategic Plan for Nurse Education, Training and Practice for South Africa 2012/13-2016/17, include nursing education and training, resources in nursing, professional ethos and ethics, governance, leadership, legislation and policy, positive practice environments, compensation, benefits and conditions of employment and nursing human resources for health. Suitable recommendations are included in the report to address these issues (South Africa, Department of Health 2012a: 4).

In the National Strategic Plan for Nurse Education, Training and Practice for South Africa 2012/13-2016/17, it is acknowledged that NMs are in a critical position to lead the implementation of many proposed health care reforms (South Africa, Department of Health 2012a: 23). However, NMs face several challenges, including numerous competing demands, lack of formal authority and control over resources, lack of or outdated job descriptions, lack of

support from superiors, problematic relationships with doctors and staff absenteeism, among others. NM development is fundamental for good health outcomes and depends on adequate numbers of managers, adequate competencies of managers, functional support systems and enabling work environments. These management competencies should be specified for different levels of the health system and programmes/courses should be multi- and interdisciplinary (South Africa, Department of Health 2012a: 43). The report advocates for empowering nurse leaders through appropriate management programmes including financial management training and business administration to equip them to compete equitably with other disciplines at all levels of management (South Africa, Department of Health 2012a: 69). The report also suggests that a review of the content of nursing management courses and teaching methods and competencies for different levels of nursing management should be articulated, and should include, inter alia, competencies in financial and human resources, care management, quality management, and managing the implementation of complex healthcare reforms. Financial responsibilities and suggestions for inclusion into the nursing education curriculum have been identified (South Africa, Department of Health 2012a: 4).

Trossman (2011: 1) states the NM role has evolved over time, but it has never been easy. The authors found that previously it was common for PNs who were good staff nurses to automatically be offered the next step of becoming a manager. NMs these days must learn a new, even broader skill set. They have to be able to decrease costs, increase access to care, and assure quality at all levels. They also routinely confront issues surrounding ethics, human resources, and ensuring a safe environment. The majority of the NM's education focuses on clinical nursing. Many clinically proficient staff nurses have been promoted to NM without any formal or informal business or financial experience or training. This side of nurse managing is likely to cause the most conflict and warrants the most education (Trossman 2011: 1).

A review of advertisements for NM vacancies in the public sector indicates the focus to be mainly on clinical skills. The requirements include a minimum of 5-

14 years' experience as a PN and 3-5 years in a management position (KwaZulu Natal, Department of Health 2016). Although the requisite skills include aspects of budgeting and financial responsibilities, a qualification in financial management or knowledge and competencies in financial management is not emphasised.

Doherty (2014: 26) postulates that managers are often promoted into management positions because of seniority or length of service, instead of them possessing good leadership and management skills. This view is echoed by Pillay (2010: 141) who finds that the hospitals tend to promote nurses into management positions because of clinical experience, rather than because of managerial expertise. In their new role, they suddenly have to deal with finance and budgeting and are expected to achieve a blend of clinical and financial management with little to no training. In many health care organisations, the NM is part of the Executive Committee (Exco) and consults with other senior managers within the organisation to make financial decisions and discuss matters of strategic importance. The NM cannot be excluded from these discussions due to her/his role in the organisation. It is often required that the NM represents or deputises in the absence of the CEO. The NM then has to continue the same functions of the CEO and make financial and business decisions while maintaining accountability for those decisions.

The core functions of the NM have not changed, namely, to improve quality and patient care and safety, practice cost containment and manage and lead nursing teams, but the competencies and skill sets needed to achieve those aims have (Larson 2015: 1). The pressures and changes in the public sector, such as the introduction of the NHI, the burden of different diseases, reduction in funding and volatile health care environment require a review of how nurse management is practised in South Africa and has intensified the need for NMs to develop a new set of competencies. Traditional management competencies, skills and practices though still relevant and applicable, may no longer be adequate. The role of the NM has changed from a predominantly clinical one-to-one requiring managerial, leadership, clinical and financial management skills (McIntyre *et al.* 2015: 8).

The question that arises is what interventions can be developed to adequately equip NMs with the requisite financial management knowledge and competencies for them to be able to cope in the current health care environment? This study seeks to explore such interventions. The challenges faced by NMs regarding financial management support the need to develop a reconceptualised model for educating and training NMs to respond to the changes of the health care environment so that there is a match between competencies and health priorities. The aim of this study was to develop a financial management framework for NMs that would identify and define the skills, knowledge and competencies required for effective nursing management in the South African health care services context.

1.2 PROBLEM STATEMENT

South Africa's public health sector is in a crisis largely due to reduced budget allocations and economic constraints (Brits 2016: 1; Khan 2016: 1). The challenges in the public sector, which predominantly revolve around finances and funding and the increased emphasis on cost containment, calls for NMs to have the correct and relevant managerial and financial competencies to respond to these challenges. Traditional management skills are no longer sufficient in the demanding public health care environment. NMs in the public sector cannot become complacent and overlook what is happening in their health care environment. They need to take the initiative to challenge and overcome the difficulties by finding innovative ways to manage. NMs in the public sector are generally silent when it comes to talking about business and finances. They rely on and accept financial directives for their practice areas from FMs, CEOs and head offices (Brannagan 2012: 1). Evidence shows that this is due to the lack of knowledge and understanding about finances. Brannagan (2012: 1) is of the view that although there is an increased awareness of the value of nurses who are financially competent, many health care organisations continue to find that financial management is one of the "key deficits" of their NMs. This view is supported by Douglas (2010: 270) who finds that financial skills of NMs are underdeveloped leading to nurses not

being able to understand the language of finance and not taking ownership for the financial performance of their departments.

The financial management role is demanding and challenging, and some of the NMs are not competent or prepared for this role, which highlights the need for financial preparation of all NMs. This is due to them not being adequately trained in financial management or not practising financial management. The problem is compounded by NMs in the public sector being promoted without consideration of competency for the new roles. Financial management is not emphasised as a critical function of the NM in the public sector when considering employment or promotion. However, when the NM assumes the position, she/he is expected to understand and manage the financial side of the nursing sector. Most NMs gain the financial knowledge and skills on the job and through experience. The current SANC basic nursing education and training programmes and curricula are outdated and do not prepare NMs adequately for their role in finance as the focus is largely on caring rather than on financial management. Most of the NMs have been trained in these nursing programmes. However, recent or newer post-basic nursing management programmes have included financial management as a module on its own. Nurses need to have a broader understanding of financial concepts and the connection to health care.

There is a paucity of literature and research conducted within the context of South Africa and worldwide and this may explain why such a crucial part of the role of a NM is underdeveloped. There was a need, therefore, to not only explore the financial management skills of NMs in KwaZulu-Natal (KZN) South Africa; but to also address the gaps in the training of NMs especially in financial management. This was achieved in this study by using the Grounded Theory methodology, conducting interviews and obtaining first-hand information from NMs pertaining to their current financial management competencies and what their development needs are. A framework was drawn up to address the financial management development needs of NMs in the public sector.

1.3 AIM OF THE STUDY

The aim of the study was to explore the financial management roles of NMs in their current work environments, identify financial management development needs necessary for NMs practice, and ultimately to develop a financial management framework to improve the skills of NMs.

1.4 RESEARCH OBJECTIVES

The objectives of the study were to:

- Explore the current roles of the NM with regard to financial management practice in public health care organisations.
- Determine the financial management competencies that NMs in public health care organisations currently possess.
- Explore the training and educational qualifications NMs have with respect to financial management.
- Establish the essential financial management development needs of NMs in public health care organisations.
- Develop a financial management competency framework for NMs.

1.5 RESEARCH QUESTIONS

- What is the current role of the NM with regard to financial management practice in public health care organisations?
- What financial management competencies do NMs in public health care organisations currently possess?
- What training and educational qualifications do NMs have with respect to financial management?
- What are the essential financial management development needs of NMs in public health care organisations?
- What would be an ideal financial management competency framework for NMs?

1.6 SIGNIFICANCE OF THE STUDY

No evidence could be found of research in the South African context on financial management skills of NMs in public hospitals. This research study will provide information regarding the daily financial management activities of NMs in public health care organisations, the current challenges they experience in the workplace and the perceived skills they need to have in order to effectively manage their health care organisation as a business. An awareness of the current financial management challenges that NMs experience can lead towards improvement of future financial management preparation and training of nurses. The study has the possibility to deliver some academic input into the field of nursing education and nursing administration, specifically in financial management. Nursing education programmes can use the results of this study to evaluate curricula and address the key competencies required to prepare future managers to be effective and successful in managing a health care environment.

The study would contribute to the knowledge base of the dual role of NMs, namely, to manage a health care organisation while at the same time ensure that the provision of quality care is delivered in the most cost-effective way. The study also has the potential to contribute to the establishment of effective financial practices in terms of government revenue and expenditure and alignment between organisational strategy and best financial practices. A financial management framework for NMs in the public sector has been developed as a result of this study which can form the foundation for the development of financial management skills for NMs. The framework has been designed to support the development of financial skills of NMs in their posts as well as to support the learning and development of current and future NMs as part of a continuous process of development. The framework can be used by those responsible for developing and delivering education and training to identify appropriate financial education and training for nurses and to design the content of educational programmes. The framework will be presented to the public health sector in order to assist in the financial management development of NMs.

NMs could use the framework to rate themselves and then develop a plan for personal improvement, plan personal careers, or guide job descriptions. Health care users may benefit by receiving improved health care delivery as a result of better financial management by nurses.

1.7 STRUCTURE OF THE THESIS

Chapter 1 provides an overview and background of the study, the research problem, aims and objectives, research questions and significance of the study.

Chapter 2 provides an in-depth review of the literature related to the topic under investigation to give the researcher information on what is published or discussed in the literature about the subject.

Chapter 3 focuses on the overall plan for addressing the research questions and objectives including the research design, research approach, research paradigm, sampling and data collection processes. Measures to ensure rigour and trustworthiness of the study including the ethical considerations are discussed.

Chapter 4 presents the data analysis of the study in the form of themes and sub-themes that emerged from interviews. Participants' responses are produced verbatim.

Chapter 5 comprises a discussion of the key findings and the link between these and the literature.

Chapter 6 presents the financial management framework for NMs in the public sector that was developed from the findings of the current study.

Chapter 7 concludes the study and presents the limitations, conclusions and recommendations and includes the key contributions of the study to knowledge, professional nursing education and practice.

1.8 SUMMARY OF THE CHAPTER

Chapter 1 served as an introduction to the study. It begins with the context, which introduces the research by providing the background that sets the stage for the problem to be investigated. An overview of the changes and challenges encountered by NMs in the public sector health care organisations was presented in the background as well as the financial context in which health care operates. The problem statement, purpose, objectives and significance was discussed. Chapter 2 presents the literature review.

CHAPTER 2: LITERATURE REVIEW

2.1 INTRODUCTION

The literature review focuses on financial management skills of NMs. An overview of the South African health care system is provided. Health care financing and expenditure is discussed in order to understand the business context in which both public and private health care sectors operate. The role of the NM is discussed. The financial management skills required of NMs are identified as well as the deficits both in the education and training and preparation of NMs for their financial management roles. The literature has been reviewed based on the research problem and the research questions.

2.2 STRATEGIES USED FOR LITERATURE SEARCH

The steps and strategies for conducting a literature search as proposed by LoBiondo-Wood, Haber, Cameron and Singh (2013: 97) served as a guide to conduct the literature review. These steps are illustrated in Figure 2.1.

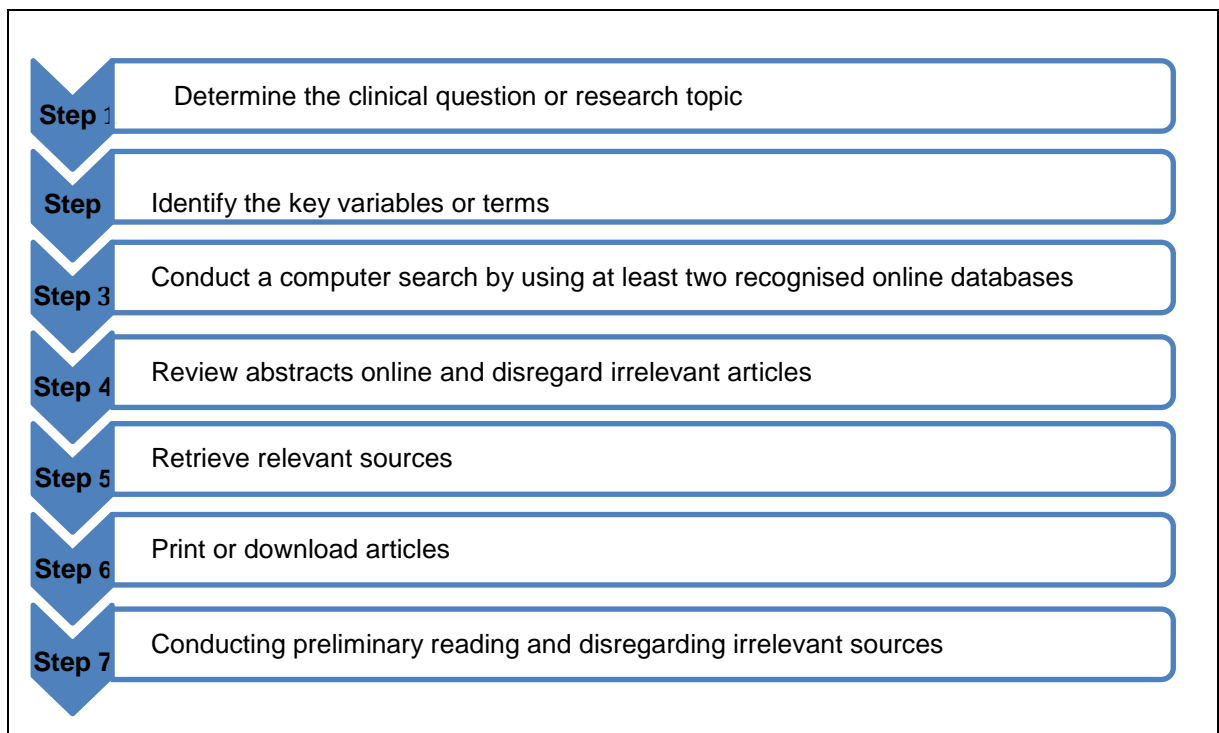


Figure 2.1: Steps for conducting a literature review

Source: LoBiondo-Wood *et al.* (2013: 97)

The first step was to determine the clinical question or research topic (LoBiondo-Wood *et al.* 2013: 97). The recent restructuring of health care services as well as the pressure to deliver high quality, coordinated care at lower costs and under severe financial constraints requires knowledge of financial management. A literature search indicated there has been minimal attention paid to the development of financial management skills for NMs in the South African health care context. International studies and literature indicate that there is an increasing emphasis being placed on the development of financial management skills of NMs. In light of this, it was important to identify the financial management skills of NMs and to develop a framework to improve these skills.

The second step was to identify the key variables or terms (LoBiondo-Wood *et al.* 2013: 97). The literature review examined research conducted on the following variables: (a) South African health care system, (b) current changes and reforms in the health care system, (c) financing and expenditure of health care, (d) health care as a business, (e) financial management, (f) financial management skills, (f) role of NMs, (g) financial management skills of NMs, (h) education and training of NMs.

The third step was to conduct a computer search by using at least two recognised online databases (LoBiondo-Wood *et al.* 2013: 97). The literature review was undertaken by searching the databases Cumulative Index to Nursing and Allied Health Literature (CINAHL), Medline, EBSCO, ProQuest and PubMed.

The fourth step was to review abstracts online and disregard irrelevant articles (LoBiondo-Wood *et al.* 2013: 97). Peer reviewed and full text articles published between 2006 and 2018 were considered. A systematic search protocol was designed to include all empirical studies focusing on financial management skills of NMs. Articles and reports were scanned and abstracts read. Only those articles and reports that were relevant to the study were selected and saved.

The fifth step was to retrieve relevant sources (LoBiondo-Wood *et al.* 2013: 97). All saved literature was reread for relevance and those that were to be used were organised according to the relevant concepts for the study.

The sixth step was to print or download articles (LoBiondo-Wood *et al.* 2013: 97). All articles and literature downloaded was saved in a folder.

Step seven involved conducting preliminary reading and disregarding irrelevant sources (LoBiondo-Wood *et al.* 2013: 97). The critical terms used to identify relevance of the sources included NM, financial management, health care, health care systems, finance, budget, health care reforms, NM competencies, roles and responsibilities. Irrelevant sources were saved in a separate folder for future reference.

Additional information was obtained through select, reputable internet sites. In addition to journals, health care management and business management books, book chapters, acts and legislation, theses, dissertations, selected conference proceedings, newspaper articles, blogs and reports were used. Primary and secondary sources were used during the literature review. Primary sources are materials or documents created during the time under study and directly experienced by the writers (Curley and Vitale 2016: 113). An example of a primary source is an original article written by researchers that summarises the methods and findings of a study carried out by them. Other examples include letters, diaries and speeches. Secondary sources interpret and analyse primary sources such as a news articles announcing a new scientific discovery (Curley and Vitale 2016: 115), which can lead to bias. Curley and Vitale (2016: 115) advocate that it is advisable to use primary sources when seeking evidence for a change in practice. Primary sources were mainly used in this study.

2.3 THE CONTEXT OF THE SOUTH AFRICAN HEALTH CARE SYSTEM IN WHICH NURSE MANAGERS WORK

It is important to examine the context of the South African health care system in which NMs practice. This sets the stage for understanding why NMs require financial management skills to make the appropriate financial and clinical decisions. The South African health care system, as stated in the National Health Act (No. 61 of 2003), is a “national health system within the Republic, whether within the public or private sector, in which the individual components are concerned with the financing, provision or delivery of health services” (South Africa 2003a: 10). An understanding of how health care is delivered across the different structures is essential in identifying the levels of the distribution of finances which impacts on the financial management role of the NM. Relevant literature sources for this topic were obtained by reviewing journal articles, internet sources, books, government publications, legislation, policies and newspaper articles.

2.3.1 Delivery of health care in South Africa

The Department of Health holds overall responsibility for health care, with a specific responsibility for the public sector. The Department of Health derives its mandate from the National Health Act which requires it to provide a framework for a structured uniform health system within South Africa. The Act sets out the functions of the three levels of government as they relate to health services. The Department of Health contributes directly to achieving Government’s desired outcome which is a long and healthy life for all citizens (South Africa 2003a: 1).

According to the Department of Health (South Africa 2012b: 1), health services in South Africa are delivered across three levels of government: national, provincial and local. In terms of the Constitution of the Republic of South Africa (South Africa 1996), both national and provincial governments have concurrent jurisdiction over health as a service delivery area, namely., both make decisions and have a duty to deliver services (South Africa 1996:

87). According to the National Health Act, in practice, the role of the National Department of Health focuses on legislation, policy, norms and standards, and ensuring equity, while the role of the provincial departments of health is focused on the planning, budgeting and delivery of health services at the coal face. Local government is responsible for the delivery of municipal health services (South Africa 2003a: 28).

The National Health Act outlines that the framework for the health system is based on a decentralised model (South Africa 2003a: 2). This means that power, authority and functions shift away from the National Department of Health to the provincial departments and then to the health districts (South Africa 2003a: 34).

2.3.2 The National Health System

The African National Congress (ANC) (1994: 1) developed the National Health Plan based on the PHC approach. The policy outlined that the state, being the major provider of services, is responsible for creating the framework within which health is promoted and health care is delivered. According to the ANC (1994: 2), a single comprehensive, equitable and integrated National Health System was created and legislated for. A single governmental structure coordinates all aspects of both public and private health care delivery and all existing departments are integrated (ANC 1994: 2). The provision of health care is coordinated among local, district, provincial and national authorities. Authority over, responsibility for, and control over funds, is decentralised to the lowest level possible that is compatible with national planning, administration and the maintenance of good quality care. Rural health services were also made accessible with particular attention given to improving transport (ANC 1994: 1).

a) National health

According to the National Health Act the Health Minister has the overall responsibility for health care in South Africa. The Health Minister's

responsibilities include protection, promotion, improvement and maintenance of the health of the population by determining policies that will ensure the provision of essential health services (South Africa 2003a: 18). This includes making regulations which ensure that adequate facilities are available for the training of human resources. The National Department of Health also has a duty to distribute information on available health services (including the type and availability of service, the timetables for visits, the procedures for access and for laying complaints and the rights and duties of patients and health care providers (South Africa 2003a: 18).

The National Health Act outlines the Director-General's function as overseeing the implementation of policies and liaising with health departments in other countries to promote adherence to health standards, services and training. The Director-General also sets national health goals and plans, which comply with national health policy, coordinates services during national disasters, promotes community participation in the planning and provision of health services, and facilitates pollution control (South Africa 2003a: 28).

b) Provincial health

South Africa is divided into nine provinces, which have, according to the Constitution, their own individual administration. The National Health Act reports at the provincial health level. Each province provides specialised hospital services, oversees the funding and support of district health councils, conducts relevant research into health services and manages the development of human resources. Provincial legislation provides for the functioning of district health councils (South Africa 2003a: 34). Provincial health departments provide and manage comprehensive health services, through a district-based, public health care model. Local hospital management has delegated authority over operational issues, such as the budget and human resources, to facilitate quicker responses to local needs. (South Africa 2003a: 34). The NM is part of the hospital management team that oversees and manages comprehensive health services within the hospital and various clinics that provide these services at district level. The current

study was conducted in the KZN province and the health sector is administrated by the KZN Department of Health.

c) The District health system

The health system is further divided into various health districts and sub-districts, whose boundaries coincide with district and municipal boundaries. The health districts are managed by district health councils, whose function is to promote co-operative governance and to ensure coordinated planning by drawing up district health plans (South Africa 2003a: 36). There are 11 health districts in the KZN province which are represented in the study. Tembani, van Rooyen and Strumpher (2003:64) clarify the role of the NM within the services provided by the District health system. NMs are responsible for the supervision of a number of clinics. The supervisory functions of the NM includes supporting the nurse in charge of the clinic in many ways by updating her/him on changes and developments regarding policies and practices, assisting her/him with problem solving, facilitating the acquisition of the necessary skills and providing her/him with a written report after every visit.

d) Health services provided by municipalities

As outlined in the National Health Act, all municipalities provide the appropriate health services in their areas. The relevant province and each municipality draws up a service level agreement, outlining which services the municipality must provide, which resources the state will make available to the municipality, and the standards by which services will be monitored (South Africa 2003a: 38).

2.4 PRIVATE AND PUBLIC HEALTH SECTOR IN SOUTH AFRICA

Ataguba and Akazili (2010: 74) mention that South Africa, like many other developing countries, have both private and public health sectors co-existing. Public health care is usually provided by the government through national health care systems. Private health care can be provided through 'for profit' hospitals and self-employed practitioners, and 'not for profit' non-government

providers, including faith-based organisations (Basu, Andrews, Kishore, Panjabi and Stuckler 2012: 2). Relevant literature sources for this topic were obtained by reviewing journal articles, internet sources, books, government publications and relevant legislation.

2.4.1 Private health sector

Matsebula and Willie (2007: 160) state that private hospitals have a significant role in the health system. The private sector is run largely on business lines and provides services to middle- and high-income earners who are generally members of medical schemes (Matsebula and Willie 2007: 160). Private hospital services cost more than services at public hospitals and are accessible to wealthy households and those with private health insurance. Private hospitals comprise the single largest component of expenditure by medical schemes followed closely by expenditure on medical specialists, which is not unusual due to the nature and intensity of services offered in these settings (Matsebula and Willie 2007: 160). The majority of private hospitals in South Africa can be classified as short-stay hospitals, where most patients are admitted for less than 30 days. The average size of a private hospital is small with an average number of beds below 200 (Matsebula and Willie 2007: 160).

The private health care sector provides health care services for an estimated 28% to 38% of the South African population. It was estimated that 37% of General Practitioners, 59% of specialists and 38% of nurses work in South Africa's private sector (Econex 2013: 2). As reported, the private sector covers 16.2% of the population. A large proportion of its funding is acquired through medical schemes, various hospital plans and out-of-pocket payments. This funding provides cover to private patients who have purchased a benefit option linked to a scheme of their choice, or as a result of their conditions of employment. It benefits the employed, which are subsidised by their employers in the state and private sector (South Africa 2017b: 16).

2.4.2 Public health sector

The South African public sector health system is split into 42 health regions and 162 health districts. Since 1994, more than 1600 clinics have been built or upgraded. There are 376 public hospitals in the country; 143 in urban areas and 233 in rural areas (Brand South Africa 2012: 1). The public sector covers 84% of the population and is funded through the fiscus (South Africa, Department of Health 2011: 7).

Edmeston (2015: 10) notes that the overwhelming majority of South Africans rely on the public health sector. This is confirmed by a report by Brand South Africa (2012: 1) indicating that the state contributes around 40% of all health care expenditure and the public health system serves just over 80% of the population. Public health uses around 11% of the government's budget, which is allocated to the nine provinces. This means that in many ways the public sector forms the cornerstone of the national health system (Edmeston 2015: 10).

Tibane (2016: 254) reports in the South African Yearbook 2015/16 that there are 4 200 public health facilities in South Africa. The number of people served per clinic is 13 718, exceeding the World Health Organisation (WHO) guidelines of 10 000 per clinic. Provincial hospitals offer treatment to patients with or without medical aid cover. Patients are classified as hospital patients if they cannot afford to pay for treatment. Their treatment is then partly or entirely financed by the particular provincial government or the health authorities of the administration concerned (Tibane 2016: 254). Provincial hospital patients pay for examinations and treatment on a sliding scale in accordance with their income and number of dependants. Patients with medical aid are charged a private rate that is generally lower than the rate charged by private hospitals (Tibane 2016: 254). The public sector has faced the challenges of transformation and re-organisation, budget reform, enhancing quality of care and human resource management. The private sector on the other hand has faced cost escalations with stagnant coverage of the medical aid population (Yach and Kistnasamy 2007: 18).

2.4.3 Public hospitals in South Africa

Public hospitals are managed by the provincial Departments of Health. Currently all state hospitals fall under the remit of the Department of Public Works, while the running of the facilities is the responsibility of the Department of Health. This creates huge challenges for those who are put in charge of running the hospital. Hospital managers in the public sector have to refer the problems and issues to the relevant government departments. The role of the Department of Health is to develop policy and channel funding to the provincial departments. Public hospitals in South Africa are categorised as district, regional and tertiary, central and specialised hospitals. These hospitals, which offer different levels of service, are also called level 1, 2 and 3 hospitals (South Africa, Department of Health 2012a: 4). The information for this section was obtained from publications of the Department of Health as the information is very specific to and contained within the South African context.

2.4.4 Categories of public hospitals in South Africa

a) District hospital (Level 1)

A district hospital is defined as a facility at which a range of outpatient and in-patient services are offered. It is open 24 hours a day and 7 days a week. The hospital has between 30 and 600 beds. A district hospital provides services for the needs of the defined population being served. Services include a 24-hour emergency service, paediatric health services, obstetrics and gynaecology, internal medicine and general surgery. This is the first level of referral and has general practitioners and clinical nurse practitioners providing primary health services. Basic diagnostic and therapeutic services, such as X-rays and basic laboratory tests are available. Support to district hospitals is provided from general specialists based at regional hospitals (South Africa, Department of Health 2012a: 5). District hospitals were included in the current study.

b) Regional hospitals (Level 2)

Regional hospitals are level 2 facilities and have between 200 and 800 beds. They provide services to a defined regional set of the population and receive referrals from several district hospitals within the region. Care requiring the intervention of specialists and general practitioners is provided on a 24-hour basis. A hospital providing a single specialist service would be classified as a specialised level 2 hospital. A general level 2 hospital provides care in at least five of the following eight basic specialties: surgery, medicine, orthopaedics, paediatrics, obstetrics and gynaecology, psychiatry, diagnostic radiology and anaesthetics. Regional hospitals are often the most overburdened of all levels of hospitals, bearing the brunt of the many inadequacies in the district hospitals. For example, district hospitals that are unable to perform basic operations such as Caesarean sections because of staff shortages refer their patients to regional hospitals, which are only supposed to deal with more complicated health problems. Outreach and support to regional hospitals is provided by tertiary hospitals (South Africa, Department of Health 2012a: 5). Regional hospitals were also part of the study.

c) Tertiary hospitals (Level 3)

Tertiary hospitals are Level 3 facilities which provide specialist and sub-specialist care. Tertiary hospitals have between 400 and 800 beds. These hospitals receive patients from, and provide sub-specialist support to, a number of regional hospitals. Intensive care services are not limited by provincial boundaries. Level 3 care provides the expertise of clinicians working as sub-specialists or as specialists in rarer specialties, for example urology, neurosurgery, plastic surgery and cardiothoracic surgery (South Africa, Department of Health 2012a: 6).

d) Central hospitals

A central hospital has a maximum of 1200 beds and provides tertiary hospital services, central referral services and national referral services, namely, it receives patients referred to it from more than one province. Research is

conducted at these hospitals which must be attached to a medical school as the main teaching platform. Central referral services are provided in highly specialised units that require unique, highly skilled and scarce personnel. National referral services refer to super-specialised national referral units with extremely specialised and expensive services for example, heart and lung transplant, bone marrow transplant, liver transplant, cochlear implants (South Africa, Department of Health 2012a: 7).

e) Specialised hospitals

A specialised hospital provides specialised health services like psychiatric services, tuberculosis services, infectious diseases and rehabilitation services, and has a maximum of 600 beds. There are a wide a range of possible specialties that could be focused on in such a hospital, including spinal injuries, maternity, heart, infectious diseases and so on. Two common specialised hospitals catering for high incidence chronic conditions that are found nationally are psychiatric hospitals that provide long-term in-patient care for patients with chronic psychiatric conditions, and TB hospitals that provide long-term in-patient care for patients with chronic TB (South Africa, Department of Health 2012a: 7).

2.4.5 Challenges for Nurse Managers working in private versus the public sector

Pillay (2009:495) informs that South Africa's health system is made up of a large public sector and a smaller, well-developed and better resourced private sector. The public sector facilities are often labelled as being inefficient and ineffective. In contrast, the private sector compares favourably with the best in the world. The public sector comprises less than 30% of doctors and just over 50% of nurses. Brophy (2015: 12) states that the one of challenges experienced by NMs in the public sector relate to staff shortages of nurses. The currently employed state nurses are overworked, as there are, on average, too many patients per nurse. Nurses experience stress, burnout, a lack of recognition, long working hours and excessive workloads. Pillay (2009:

496) finds there is a continuous migration of nurses from the public to the private sector due in part to the public sector nurses' dissatisfaction with their pay, the work load and the resources available to them. This statement is supported by Egerdahl (2009: 11), who agrees that in South Africa, migration of nurses was mainly from the public sector to the private sector.

Another challenge in the public sector is the nurses' decline in morale due to a lack of career advancement unsatisfactory environmental working conditions a lack of job satisfaction, being constantly under pressure and poor communication, amongst themselves, their management, their patients and members of the public (South Africa 2011b: 59).

Pillay (2009: 496) concluded that state nurses were more dissatisfied in their daily work environment than private sector nurses and that the state nurses' experiences in the public sector work climate were worse than the working experiences of nurses in the private sector. The lack of adequate resources such as medicines, medical equipment, and malfunctioning or non-working medical equipment, medical supplies, and linen for example, sheets, pillow cases beds and furniture has added to the stress and decrease in morale for nurses.

State nurses in South Africa are challenged by the non-productive use of resources and there was evidence of the lack of adequate human and financial resources in state hospitals (Mack 2011: 37). There are vast differences in resource allocations in the public and private health institutions and the limited allocation of resources in the public health sector is a cause for concern. Causes for the lack of resources were blamed on the unequal distribution of personnel in the public and private sectors (Dookie and Singh 2012: 67). Makie (2006: 2) adds that the reduced budget to some of the institutions is a big challenge for NMs, leaving them with not enough money to buy or repair equipment.

2.5 FINANCING OF HEALTH CARE IN SOUTH AFRICA

Total health expenditure is defined as the sum of public and private health expenditure. It covers the provision of health services (preventive and curative), family planning activities, nutrition activities and emergency aid designated for health but does not include provision of water and sanitation (World Bank 2016: 1). In South Africa, health care expenditure is derived from three main sources: public sector expenditures financed out of general revenue, private sector expenditures financed through medical schemes and out-of-pocket payments (South Africa 2017b: 15). Public health in South Africa consumes around 11% of the government's total budget, which is allocated and mostly spent by the nine provinces. How these resources are allocated, and the standard of health care delivered, varies from province to province (Brand South Africa 2012: 1). Relevant literature sources for this topic were obtained by reviewing national and international journal articles, internet sources, books, government publications, government guidelines, legislation, policies and dissertations.

According to Ataguba and McIntyre (2012: 3), the public source of finance is mainly allocations from general taxes such as through income tax, value-added tax (VAT), and other taxes while private sources include private health insurance contributions and out-of-pocket payments. The bulk of health sector funding comes from the National Treasury (South Africa, Department of National Treasury 2017: 58). Public health budgets remain under pressure as a result of increased personnel costs, higher expenditure on the antiretroviral programme and currency depreciation. In the 2017/18 budget allocation, the health sector was allocated R187 483 billion (South Africa, Department of National Treasury 2017: 58). The central hospital services received R35.9 billion, provincial hospital services R32.3 billion, district health services R83.6 billion (which included an allocation of R17. 6 billion for comprehensive HIV and AIDS and a TB grant), Emergency Medical Services R7.3 billion, facilities management and maintenance R9.9 billion, health science and training R5.5 billion, National Health Laboratory Service R7 billion and National Department of Health R5 billion (South Africa, Department of National Treasury 2017: 58).

As indicated by Gray, Vawda and Jack (2011: 30), South Africa's fragmented and inequitable healthcare system is still focused on expensive curative approaches, underscored by inadequate adherence to referral systems.

2.5.1 Financial regulatory framework

Financial management in public health organisations in South Africa is governed by the Constitution, the Public Finance Management Act (Act 1 of 1999) (PFMA) (South Africa 1999) and the generic principles of corporate governance (Muller, Jooste and Bezuidenhout 2015: 416). In terms of this study, financial management for NMs fall under a remit of a regulating framework which includes policy regulations (National Treasury Guidelines), legislation (Public Financial Management Act), the Basic Accounting System (BAS) and procedures and operational aspects of BAS such as business reporting and controlling) (South Africa 2000a: 1-6).

2.5.1.1 Public Financial Management Act

The PFMA was passed by the South African parliament in 1999. The PFMA sets the framework for accountable financial budgeting and financial administrative activities in Departments. The Act's preamble states that it aims to "ensure that all revenue, expenditure, assets and liabilities (of government) are managed efficiently and effectively" (South Africa 1999: 2). It is one of the measures drawn up by the National Treasury to try to manage spending in the public sector and to align spending to outcomes. Financial decision-making is in theory decentralised down to managers who best know and understand the priorities and realities of their local situations. Managers are given the authority to manage their finances within their organisations, for which they must also assume responsibility (South Africa 2000b: 13). The PFMA also aims to eliminate waste and corruption in the use of public assets. The PFMA positions the accountability for finances used for the delivery of health care in the hands of the head of the organisation or accounting officer concerned. In the hospitals under study, the CEOs were the accounting officers who maintained the responsibility for the finances of the organisation.

The PFMA, as part of a larger scheme aimed at improving financial management in the public sector, allows the accounting officer to prepare the departmental budget (specified in terms of measurable objectives) for the Minister or Member of an Executive Committee (Exco) to approve and present to the legislature for voting. The accounting officer is then responsible for implementing and managing the budget (South Africa 2000b: 26). All public hospitals in this study apply the PFMA. NMs give input into the budget for their nursing sections. Most managers at the hospitals where the research was conducted cited that training was required on the PFMA and its application to their practice. They viewed the PFMA as one of the most important pieces of legislations that guided their financial management roles and responsibilities. In most of the hospitals the dialogue around the PFMA was at the executive hospital management level and very little filtered down to the nursing management and staff.

2.5.1.2 Basic Accounting System

Together with the PFMA, the BAS is used as the accounting system to control and monitor financial expenditure. The intention was to find a system where the facilities should be of a basic nature, operational by all government departments and as user-friendly as possible. The BAS was developed with improved financial control in mind. In addition, it was built to support the capacity-building drive within government, by providing the user with a simple-to-use graphical user interface. This improved user interface makes it easier to absorb new employees by reducing the time to learn the system (South Africa 2010b: 16).

The BAS functions in terms of the main principle of the PFMA, namely, to ensure efficient and effective management of public resources. As implied, the BAS covers the indicators related to personnel, administration, pharmaceutical, procurement and professional expenditures, which are relevant to, and appropriate for public hospitals (South Africa 2010b: 8). All hospitals have accounting officers. They are normally the Head of the Department or CEO and their responsibilities include resourceful, cost-effective and visible use of revenues, expenditures, assets and liabilities. The

accounting officer has to apply appropriate internal control, apply risk management, implement suitable disciplinary measures and provide the national treasury with accurate management of their budgets (South Africa 2000b: 8). Many role players add to the financial management of institutions. These role players need to be competent (in terms of knowledge, skills and attitude) and familiar with the legislative framework and policy structures in order to implement and administer their allocated responsibilities effectively (van Der Heever 2009: 23). To this effect NMs play a very important role as they control the largest part of the hospital budget and the application of prudent financial principles is critical.

2.6 CURRENT REFORMS IN THE HEALTH CARE SYSTEM THAT IMPACT ON THE NURSE MANAGER ROLE

As reported in the South African Yearbook 2014/15 by the Government Communication and Information System, the Department of Health implemented a two-pronged approach to overhaul the health system namely by having the health system focus on PHC and by improving the functionality and management of the health system and by revitalising and restructuring the South African health care system (South Africa 2015a: 225). Nurses need leadership skills and competencies to become partners with physicians and other health professionals in redesigning and reforming efforts across the health care system. Information for this topic was obtained by reviewing journal articles, internet sources, books, government publications and guidelines, legislation and policies.

2.6.1 The National Health Insurance scheme

South Africa has introduced a new system of healthcare financing which impacts on the health of South Africans. The NHI, which will be phased-in over a period of 14 years, will ensure that everyone has access to appropriate, efficient and quality health services. As directed in the National Health Insurance in South Africa Policy Paper of 2011, this will entail major changes in the service delivery structures as well as administrative and

management systems (South Africa 2011: 4). The NHI aims for every South African to have a right to, and access to, comprehensive healthcare services free of charge at the point of use at accredited health facilities such as clinics, hospitals and private health practitioners. The services will be delivered closest to where people live or work (South Africa, Department of Health 2015: 24). The funding for NHI will be through a blend of different compulsory pre-payment sources, principally based on general taxes (South Africa, Department of Health 2015: 24).

It is predicted that the NHI will better and more efficiently utilise and control the key financial resources in the health sector and boost and strengthen the under-resourced and strained public sector (South Africa, Department of Health 2015: 21). The objective of the NHI, as stated in the White Paper on National Health Insurance, is to provide improved access to quality health services for all South Africans (South Africa, Department of Health 2015: 21). This will be based on a 'Re-engineered PHC System' approach that will focus mainly on community outreach services using a set of comprehensive primary care package services. PHC services will be delivered through three streams according to the NHI policy document (South Africa, Department of Health 2015: 21). The health system will be organised into three areas of health care service delivery namely, PHC Services, Hospital and Specialised Services, and Emergency Medical Services.

The PHC services include health promotion, disease prevention, curative (acute and chronic clinical) services, rehabilitation and palliative services. PHC starts in the communities and is the first level of contact with the health system by individuals, the family and community. In addition, the multidisciplinary clinics and networks of practices in the private sector will form part of the first level of contact. The expansion of preventive PHC services will aim at reducing the need for costly tertiary and quaternary services (South Africa, Department of Health 2015: 13). This has implications for NMs in the public hospitals as the focus on PHC will result in cutbacks in the funding of curative and tertiary care which could place hospitals under substantial financial strain.

2.6.1.1 The objectives of the NHI

The objectives of the NHI are to:

- Improve access to quality health services for all.
- Pool risks and funds in order to achieve equity and social solidarity.
- Procure services on behalf of the entire population and to efficiently mobilise and control key financial resources.
- Strengthen the public health sector so as to improve health systems performance (South Africa, Department of Health 2011: 18).

Dhai (2011: 48) contends that major reforms in health financing is required if these objectives are to be realised. In 2005, member states of the WHO committed to develop their health financing systems so that the goals of universal coverage can be achieved. The WHO identified three fundamental, inter-related problems that restrict countries from moving closer to universal coverage (Dhai 2011: 49). The first is the availability of resources. Even the richest of countries have been unable to guarantee that everyone has direct access to all technology and interventions that may improve their health. The second problem that poses as a barrier to universal coverage is related to the over-reliance on direct payments at the time that people need care (Dhai 2011: 49). Even where some form of health insurance is available, patients may still need to contribute, for example, in the form of co-payments or deductibles. Many are prevented from receiving health care because of the need for direct payments (Dhai 2011: 50). The third obstacle hindering the path towards universal coverage is the inefficient and inequitable use of resources (Dhai 2011: 50). A conservative estimate places the wastage of health care resources at 20% to 40%. In South Africa, corruption could be added to this list as a fourth hurdle. Corruption erodes 10% of all health expenditure in South Africa, and within the private sector this is estimated to be between R5 and R15 billion annually (Dhai 2011: 50).

2.6.1.2 Hospitals and specialised services under the NHI

The NHI will cover various hospital health services and the population will access these services through referral from PHC level providers. Certified and accredited hospitals and specialised services in the private sector will be contracted to address the health needs of the population in line with the requirements of NHI (South Africa, Department of Health 2015: 36). One of the factors that greatly contributes to poor quality of health care in the public institutions is inept or poor management.

Management of public hospitals is characterised by over-centralisation where they are administered by provincial health department head offices, rather than being actively managed at facility level. This results in hospital managers having almost no authority to manage their own institutions (South Africa, Department of Health 2015: 36). This has led to under-development of management systems and capacity at hospital level and demoralisation of hospital managers, exacerbated by poor remuneration, limited training and support and inadequate career paths for managers. This makes it difficult for the public system to attract and retain skilled managers. Over centralisation has also undermined the legitimacy and functioning of hospital boards, diminishing public accountability and trust in the hospital system (South Africa, Department of Health 2015: 36).

2.6.1.3 Strengthening leadership development in the health system

As reported in the National Development Plan 2030, the health system requires competent leaders and managers at all levels from clinic to tertiary hospital (South Africa 2010c: 336). From a governance perspective, competent leaders are required in all structures from district to national level. Anyone who does not meet the competency requirements for a job should be replaced. People who lead institutions must have the required leadership capability and high-level technical competence in a clinical discipline (South Africa 2010c: 336).

Under the NHI the roles, functions and responsibilities of management and governance structures for the district, regional, tertiary and specialised hospitals will have to change. Hospitals will be contracted to render quality health services in accordance with the norms and standards as determined by the Office of Health Standards Compliance and in line with benefits as determined by the NHI Benefits Advisory Committee (South Africa, Department of Health 2015: 39). In order to improve accountability, quality of health services, performance and effectiveness, managers will be provided with more decision-making responsibility in critical management domains such as the management of human resources, finance and supply chain/procurement. Strengthened management will also be vital in the areas of facility management, cost-centre management, management and maintenance of essential equipment and infrastructure. This will be achieved through a process of enhancing management competencies in these areas and strengthening the role of hospital boards. For establishment of minimum competency requirements and continuous professional development of health managers, all health facility managers will be required to have a health management qualification. The delegated authority assigned to each category of hospital will be commensurate with the capacity to exercise the appropriate responsibilities and functions that can be delegated (South Africa, Department of Health 2015: 39).

In the initial phases of implementation of NHI, apart from central hospitals, these hospitals will be afforded semi-autonomy. The delegations afforded to these hospitals will be in line with the PFMA and the Public Service Act, 1994 (Act No. 103 of 1994). As the NHI matures, hospitals will be authorised as semi-autonomous entities to provide services funded by the NHI Fund. They should be capable of providing quality services, operating as viable units with capacity to utilise their available resources. Hospitals will be required to assume increasing degrees of managerial autonomy in preparation for NHI but also to improve the efficiency and effectiveness of public hospital services in general (South Africa, Department of Health 2015: 39).

2.6.2 Rising cost of healthcare

The cost of healthcare is rising worldwide largely driven by the heavy and growing burden of non-communicable diseases including mental health disorders, ageing societies, innovations of expensive treatments and techniques, and increasing demands of clients (De la Maisonneuve and Martins 2013: 2). The rising cost of healthcare is placing a heavy financial burden on health systems and populations globally. Costing information is important for the planning and decision-making process on how to do better within the constraints of financial, human and other resources. It is prudent to make best use of available resources. Nurses, as the single largest component of the health workforce, are well positioned to do more with less while providing quality care and optimal patient outcomes. It is imperative that nurses develop a proper understanding of health care financing, budgeting, resource allocation and strategic planning. Such competencies will facilitate nurses' participation in policy making and resource allocations in order to lead from the frontline as the force for change and as cost-effective and care-effective professionals (De la Maisonneuve and Martins 2013: 2).

2.7 HEALTH CARE AS A BUSINESS

Fiegenbaum (2016: 1) reports that hospitals are businesses concerned with revenues and expenses like any other business. The flow of revenues can affect not only how patient care is delivered but also the health of the hospital itself. McIntyre *et al.* (2015: 8) state that the major challenge facing the health sectors is to contain the rapidly rising cost of health care. Public health care organisations are financed almost entirely out of general tax revenue. However, there are severe constraints on health care spending. This is related to the low rate of economic growth, the need to repay government debt, pressure to reduce government spending and the competing claims for public resources by other social services like education and social welfare (McIntyre *et al.* 2015: 8). A review of local and national sources indicate that there is agreement that healthcare revolves around finances and that business principles should be applied irrespective of whether in the public or private

sector. The literature review includes sources such as peer reviewed journal articles, dissertations and internet sources.

Powell and Hodges (2009: 1) propose that health care is a business. Health care spending continues to rise sharply. This creates tremendous pressure for NMs to manage their organisations more effectively than many other businesses (Powell and Hodges 2009: 1). Operating efficiently and generating a return on investment is crucial for all hospitals, regardless of ownership, in order to be able to provide replacement equipment and new technology to keep up with the demands of consumers (Powell and Hodges 2009: 1). According to Powell and Hodges (2009: 1), for some hospitals efficient operations include making interest payments on bonds and other indebtedness or making dividend payments to shareholders, while for other hospitals, especially rural facilities, efficient operations simply equates to survival.

Powell and Hodges (2009: 1) assert that the characteristic that distinguishes hospitals from most other businesses is that hospitals are guided by a mission and a focus on the community. This requires today's NMs to be able to strike a balance between making solid business decisions and providing services or programmes for the community. With limited resources, NMs often must choose carefully how resources are used and which needs the hospital can reasonably meet (Powell and Hodges 2009: 1).

According to Powell and Hodges (2009: 1), another area that distinguishes hospitals from most other businesses is the number of stakeholders involved. These include many other businesses that provide services to customers (patients) as ordered by independent practitioners and paid for by a third party. Many of the supplies used by hospitals are dictated by the preferences of physicians who have no responsibility for the cost of those supplies. Other stakeholders include the employed caregivers, the lenders, the owners, the vendors and the community. These various relationships create a complex operational environment not found in other businesses (Powell and Hodges 2009: 1).

Gandolf (2013: 1) concurs with Powell and Hodges (2009: 1) by stating that “healing is an art, medicine is a profession, but health care is a business”. Due to the changes in the health care environment, hospitals, medical groups and individual providers have increasingly been dealing with tough business issues. Gandolf (2013: 1) asserts that health care has become a business, and health care managers have accepted the situation and are seeking business training to learn how to cut costs and improve the quality of health care.

The view of health care functioning as a business is further supported by Sherman and Pross (2010: 1) who found that although health care is built around care, it is also a business that needs to be managed. It is difficult to build healthy work environments in health care settings that are not financially stable. Health care reforms in the USA have focused on the cost of care and have placed increasing pressure on leaders to operate organisations that are more efficient while continuing to improve quality and patient outcomes (Sherman and Pross 2010: 1).

Further assertions on health care being an intensely competitive business climate is confirmed by Burns, Bradley and Weiner (2012: 321). NMs have been trained to provide care, and many of them have internalised it as their chosen vocation and not just a job. Efforts to change the health care system using business practices imported from the outside have repeatedly come up short.

2.8 FINANCIAL MANAGEMENT SKILLS

Financial management means planning, organising, directing and controlling financial activities such as procurement and utilisation of funds of the enterprise. It means applying general management principles to financial resources of the enterprise (Juneja 2016: 1). Financial managers oversee and direct the financial activities for an organisation. They analyse financial trends in their respective industries, create reports and budgets, and make financial

decisions for the organisation. Financial managers need the right education, experience, skills and qualities to be successful (Luther 2018: 1).

According to Danna (2013: 1), financial management skills include proficiency in reading and understanding organisational budget reports, and being able to develop a basic unit budget and recognise the different line items and categories that are included in the budget. Financial management skills also require knowledge of basic financial terminology and definitions. According to a report by the Inter-Departmental Working Group (South Africa 1995: 3), financial management in the public sector is directed by a chief financial officer (CFO) and consists of all results and actions of management because these influence and control the utilisation of limited financial resources assigned to accomplish specific and agreed strategic outputs. The information for this topic is very limited especially when it applies to nursing. Sources for this literature review included journal articles, internet sources, government publications and guidelines.

2.9 THE NURSING MANAGER

2.9.1 Definition of Nurse Manager

Buchbinder and Shanks (2012: 4) define management as comprising social and technical functions and activities occurring within organisations for the purpose of accomplishing predetermined objectives through humans and other resources. Managers work through and with other people carrying out technical and interpersonal activities in order to achieve desired objectives of the organisation. A manager is anyone in the organisation who supports and is responsible for the work performance of one or more persons (Buchbinder and Shanks 2012: 5).

The Agency for Healthcare Research and Quality (2016: 1) defines the NM as embodying a nurse and executive role who is responsible for functions of the unit or hospital. Regan and Rodriguez (2011: 101) state that NMs are the frontline leaders for nursing staff in acute-care hospitals.

The person that is responsible for nursing activities throughout the organisation and reports directly to the CEO or Medical Officer of Health/Senior Management Team as a senior member of executive-level decision-making management is known as the Chief Nurse Executive (CNE) or Chief Nursing Officer (CNO). This person is involved in significant decisions dealing with the day-to-day operational management of the organisation or institution (Registered Nurses' Association of Ontario 2011: 1).

Nurse executives are the most senior nurses in a health care organisation. Their titles include director of nursing, president or vice president of nursing or CNO. Their specialty is the management and administration of nursing within the organisation (Greenwood 2015: 1). In the South African context, the person overall in charge of the nursing section of the organisation is called NM, Senior NM, Senior Nursing Services Manager, Nursing Service Manager or Nursing Director. For the purposes of this study, the term NM will be used to refer the person overall in charge of the nursing activities of the health care organisation.

2.9.2 Nurse Managers' role in the health care organisation

Trossman (2011: 1) finds that the NM is one of the most essential roles in the hospital, because they have control over how care is delivered and patient outcomes. Trossman (2011: 1) reports that NMs tend to focus primarily on managerial and administrative duties for their entire unit. Their responsibilities include hiring of nursing staff and coordinating training, conducting employee evaluations and professional development programmes, and creating work and shift schedules. Other responsibilities include providing nursing quality assurance, developing policies and procedures, creating departmental budgets, tracking of monthly expenses and purchase of equipment and supplies (Trossman 2011: 1).

Baker *et al.* (2012: 25) state that NMs frequently attend meetings with other medical staff and collaborate with them to plan and implement programmes for patient care. Some of their managerial tasks influence patient care, such

as developing specific unit objectives, identifying and planning new programmes, and reviewing policies and procedures to ensure that standards are being met. NMs may also: provide nursing consultation to other staff members and patients; monitor patient care for ethical, legal and safety standards; ensure the safety of equipment and work environments; and resolve patient care issues (Baker *et al.* 2012: 26).

Cipriano (2011: 24) argues that NMs usually start out as PNs and therefore need to have general nursing skills and knowledge, which includes medical procedures and patient rights. As managers, they also need to have strong leadership skills. Cipriano (2011: 25) highlights that the NM must be able to properly monitor and assess nursing care given to patients. Excellent written and verbal communication skills as well as effectiveness in motivating, selecting and disciplining staff are an important task of the NM. Further skills that are deemed important in the role of the NM is the ability to plan and implement new programmes, good record-keeping and budgeting skills, strong time management and delegation skills, and the ability to give detailed written and oral instructions (Cipriano 2011: 29).

2.10 NURSE MANAGER'S FINANCIAL MANAGEMENT SKILLS

2.10.1 Reasons for Nurse Managers requiring financial management skills

According to Danna (2013: 1), mastery of basic financial management skills is essential for NMs to be successful in today's health care environment. This highlights the need for the financial management preparation of NMs. They must have the knowledge necessary to make sound decisions integrating clinical and financial aspects of health care (Danna 2013: 1). Financial management skills are vital to surviving and thriving in the NM role as incumbents must possess administrative confidence, appropriate educational preparation and skills to manage financial deals, broad clinical expertise and a thorough understanding of financial principles (Chase 2010: 3).

Harper (2015: 1) states that NMs are required to work beyond their clinical training and become experts in the fundamentals of financial management. This requires specialised training to develop the skills and models to support the development of effective NMs.

Llewellyn (2014: 1) highlights that, in addition to the clinical side of health care, understanding the financial side of health care is important for career progression. Management and nurse executives are under tremendous pressure to ensure their organisations are meeting the clinical, regulatory and financial requirements pertinent to health care. As a result, many nurses are looking at financial programmes to ensure that they have the competencies to meet the requirements needed to perform their role (Llewellyn 2014: 1). Golden (2008: 42) notes that despite the need to become more financially oriented, NMs fail to understand the impact of nursing activities and staffing on the revenue of a health care agency. If nurses are unable to see the financial ramifications and costs of decisions, they will be less successful in advocating for the resources needed to successfully staff and operate units (Golden 2008: 42).

Douglas (2010: 270) emphasises the need for deeper understanding of financial management among NMs. NMs control the largest part of a hospital labour budget, in some cases the largest part of the overall budget. The effectiveness of overseeing this responsibility can mean the difference between an organisation's financial stability and financial turmoil (Douglas 2010: 270). NMs well versed in financial management seem to be more the exception than the rule. The author questions why such a fundamental part of the role of NMs is so underdeveloped. There could be many reasons but whatever they may be, today's environment, more than ever before, demands that NMs be competent financial and business leaders (Douglas 2010: 270). These sentiments are echoed by Hartley (2013: 1) who cautions that the economic climate for the future of health care is uncertain and with increasing competition for funds, financial resources are becoming scarce. The nursing department budget can account for as much as half of a hospital's total expenses, so there will be significant pressure upon nursing to increase

efficiency and effectiveness, therefore managers at all levels must become proficient in managing their departments as businesses (Hartley 2013: 1).

2.10.2 The type of financial management skills essential for Nurse Managers

Morgan (2015: 1) states that, in addition to the clinical knowledge gained during nursing school, the NMs need knowledge of business, finance and health care administration principles to excel in the position. Morgan (2015: 2) further adds that NMs should be able to: create departmental budgets; prepare budget reports and present them to nursing executives; monitor the use of supplies in the unit; train nurses and other unit staff members; coach nurses who need improvement; interview nurses for open positions and create work schedules to ensure adequate unit coverage (Morgan 2015: 2).

Danna (2013: 1) states that financial management skills include proficiency in reading and understanding organisational budget reports and being able to develop a basic unit budget and recognise the different line items and categories that are included in the budget. According to Danna (2013: 1), financial management skills also require knowledge of basic financial terminology and definitions. Similarly, Greenwood (2015: 1) posits that the basic business management skills required in the health care environment are financial management and experience in areas such as human resources, strategic planning and systems thinking. The NMs usually have financial and budgeting responsibilities (Greenwood 2015: 1). All executives should have business skills, and the NM is no exception. She must understand healthcare financing, which is much more complex than developing or balancing budgets (Greenwood 2015: 1).

2.10.3 Benefits of Nurse Managers having financial management skills

Hunt and Laughon (2011: 1) assert that the benefits of NMs having financial management skills include them being able to evaluate new services and products (cost-benefit analysis) using economic decision-making approaches.

Financial management skills also enable NMs to calculate staffing levels to maximise labour efficiencies, anticipate and forecast the impact of changes in care and practice, and use expert strategies to maintain and/or reduce expenses. NMs with financial management skills are able to communicate confidently with executives in order to defend and advocate for their departments' budgets (Hunt and Laughon 2011: 1). Knowledge of financial management skills enable direct care staff to be able to engage in financial decisions because they understand financial imperatives and the organisation's mission, as well as write effective funding proposals to secure the resources their departments need (Hunt and Laughon 2011: 1).

Harper (2015: 1) asserts that within the hospital and specialised clinic setting a synergy between business practice and clinical practice is vital to the success of the organisation. Hospital administrators believe that NMs are essential for a hospital or health clinic to function and to maintain a high quality of care (Harper 2015: 1). The administrators also expressed concerns that NMs did not understand what their job role was. This perception may not be due to a lack of clinical expertise but more a lack of financial management skill and understanding of expectations from the NMs' point of view (Harper 2015: 1).

2.10.4 The gap in financial management preparation of Nurse Managers

Waxman (2013: 1) states that with the current reforms and rising cost of health care hospitals and health care systems need to find a way of delivering care at the lowest possible cost. According to Waxman (2013: 1), nurses are not adequately educated in financial management in nursing even though they are held accountable for the budget in their areas. Waxman (2013: 1) therefore, advocates that more education and training be arranged to assist NMs in acquiring the financial management skills they need for success.

Harper (2015: 1) emphasises that NMs have come to be regarded as one of the most important assets within healthcare. Harper (2015: 1) highlights the gap in management and financial preparation among NMs as an area that can

be improved. Nurses bring a unique perspective to the health care cost conversation, so they must be included in the discussions and utilised as active participants in the fight against rising health care costs.

Wallingford (2013: 1) concurs that nurses are not usually integrated into the cost containment discussion. This creates a challenge for NMs, as on one hand they are required to cut costs while on the other they are not included in business decisions and business management functions of the health care organisation. This may be a contributing factor as to why NMs lack the financial skills required to manage the health care organisation as a business. The NM has the responsibility and accountability for the nursing budget aspect of the overall health care organisation budget. Ntlabezo (2004: 140) asserts that previously hospital budgets and finances were handled by hospital administrators. Now high-ranking nurses are responsible for containing budgetary costs. These responsibilities might be a new experience for many NMs and might pose real challenges which need to be addressed. Providing NMs with financial management training will give them the confidence to handle the finances of their relevant sections (Ntlabezo 2004: 140).

Oliver (2016: 1) reports that historically, the best clinical nurses became managers. The role of the NM has evolved into a very different position from that of head nurse, and additional skills are required. In today's health care environment, NMs must also be able to access, evaluate and interpret data on quality measures, patient satisfaction and other areas that reflect the changes in the health care delivery system (Oliver 2016: 1). The ability to understand and be comfortable with financial data is also a growing concern of NMs.

Oliver (2016: 1) indicates that the role of the NM has been evolving rapidly but they have not always been provided with the education and skills required to fulfil this role. This is true of formal education programmes as well as hospital-based in-service programmes. Nursing leaders within academia should consider adding core courses to academic programmes that address these needs, just as they have modified curricula to respond to the expansion of the

roles of case managers and nurse practitioners. Ideally, academic programme leaders should collaborate with hospitals to determine the nature of the needs of NMs, who are important figures in clinical operations (Oliver 2016: 1).

Douglas (2010: 270) posits that the reasons for the gap between nursing and financial management skills are that the nursing education systems do not prepare nurses to become part of leadership in the business of health care. According to Douglas (2010: 271), the role of the NM has evolved to require greater business and financial skills yet many do not have the requisite skills. NMs are not oriented or educated in financial management when they are promoted into positions with greater financial responsibilities.

2.11 EDUCATION AND TRAINING OF NURSE MANAGERS IN FINANCIAL MANAGEMENT SKILLS

2.11.1 Educational paths to becoming a Nurse Manager

Nursing education and training in South Africa is under the control of the SANC (Mellish, Oosthuizen and Paton 2010: 50). The SANC provides the guidelines and regulations that serve as a basis for nursing education and training in South Africa. The Nursing Act 33 of 2005, prescribes that the SANC must register all nursing qualifications, both basic and additional qualifications of persons registered under the Nursing Act (SANC 2005: 30). All NMs must undergo basic nursing training in order to become a professional nurse. Professional nurse qualifications are currently obtained through the basic nursing education programmes. The four-year nursing course (Regulation R 425), which leads to the registration as a general nurse, psychiatric nurse, community nurse and midwife, was introduced in April 1986 (SANC 1985b: 1). One of the objectives of the programme is that the nurse on completion must be able to manage a health service unit effectively. A professional nurse qualification is also accessed through the bridging course for enrolled nurses leading to registration as a general nurse or a psychiatric nurse (Regulation R 683). The course includes Ethos and Professional Practice, Ward

Management and Clinical Teaching, which is spread over two academic years (SANC 1989: 1).

The programme's objectives include one which states that on completion the professional nurse must be able to apply the principles of management in a nursing unit. Financial management content is included in programmes. Aspects of financial management include budget and the budgeting process, managing expenditure control, financial management monitoring, cost containment, financial statements and remuneration systems (Marx 2016 in Booyens, Jooste and Sibiyi 2016: 107). Prior to 1986, students required three years to become registered general nurses and after that one year for midwifery, psychiatry and community nursing respectively, implying that a minimum of six years was required to obtain the four qualifications (Khoza 1996: 51). Many NMs that participated in this study trained during that period.

2.11.2 Programmes in which Nurse Managers learn finance

2.11.2.1 Post graduate nursing management programmes

The SANC approved nursing management programmes include the Diploma in Nursing Administration (Government Notice Number (No.) R. 1501) and the Diploma in Unit Management for Registered Nurses (Government Notice No. R. 203). The objectives of these courses are to enable a nurse to manage a health service unit effectively. The curriculum for the Diploma in Nursing Administration (Government Notice No. R. 1501) consists of the following four subjects and is taught at an applied level throughout the course (SANC 1985a: 1):

- (a) The scientific foundations of the nursing administration process;
- (b) The health care system in South Africa;
- (c) Fundamentals of nursing administration I; and
- (d) Fundamentals of nursing administration II.

Financial management principles are included as part of the fundamentals of nursing administration modules. The Diploma in Unit Management for

Registered Nurses (Regulation R203 of 1987) offers a registration of an additional qualification in unit management. The Principles of Administration and the Practice of Unit Management module included in this programme incorporate financial management (SANC 1987: 1).

NMs are able to access on-line, full-time and distance learning financial management programmes through various universities, colleges and business schools. These are usually provided by the non-nursing faculties and the qualification is not registered or recognised by SANC.

A website search was conducted to ascertain which post graduate programmes are offered that include financial management for NMs. Post graduate nursing management courses are offered as certificate, diplomas or degree programmes. The prospectuses and curricula of several universities and colleges were reviewed. Business management and/or financial management are offered as core modules in all postgraduate nursing management programmes.

Universities offer a basic, four-year, full-time undergraduate nursing degree that prepares students in four career fields, namely general nursing, community nursing, psychiatric nursing, and midwifery. Clinical (practical) nursing experience is obtained at hospitals and other health service providers during the four years of study. Universities also offer post-basic qualifications at diploma, degree, masters and doctoral levels. There are public and private nursing colleges, and the most common courses they offer are: a four-year diploma leading to registration as a nurse (general, psychiatric, community or midwifery); a two-year bridging course; one-year courses; and post-basic diplomas (Mellish, Brink and Paton 2003: 61).

Douglas (2010: 271) affirms that in the United States of America the majority of the NM's education focuses on clinical nursing. Many clinically proficient staff nurses have been promoted to becoming a NM without any formal or informal business or financial experience or training. This side of nurse managing likely causes the most strife and warrants the most education

(Douglas 2010: 271). Similarly, Ritchie and Yen (2013: B) find that in Australia, promotion into management positions is linked to seniority and clinical expertise without formal preparation for the managerial role. The managers focus on clinical issues and may not adopt a corporate management perspective as their pre-service clinical education does not including the level of education that the managerial roles require (Ritchie and Yen 2013: B). The managers are then expected to learn the necessary managerial competencies on the job. The effectiveness of the learning for their new roles is reduced as the demands and nature of the NM role surpasses learning needs.

The promotion of clinical nurses to NMs has many educational implications (Ritchie and Yen 2013: B). The transition needs to take place in such a way that clinical nurses can function effectively in the managerial capacity. Education plays a significant role in this transition as it provides the resources for the development of the knowledge and skills required to perform management functions. Ritchie and Yen's (2013: B) study focused on a health service management syllabus which was grounded in the need to develop the management skills of clinicians moving into management roles. A total of 17 Master's degree programmes were examined. The study identified differences in the core foundation of health service management qualifications and that there were differences in the core knowledge areas. The authors found that health services management programmes exist in isolation and suggested that more research be conducted into the educational requirements of NMs. The study found that though resource management is a fundamental management function, this was lacking specifically in the areas of finance, human resources and information in the programmes examined (Ritchie and Yen 2013: D).

Douglas (2010: 271) is of the view that nursing education systems need to adjust their curricula to address this gap in preparation and to better assist PNs in meeting the demands of today's nursing realities. Hospitals should invest more in business and financial education for nurses as they are promoted into positions requiring financial management skills (Douglas 2010:

270). Noh and Lim (2015: 154) state to obtain financial competency, the development of financial management programmes is necessary for both nurses and NMs. The programmes would ideally provide nurses with greater financial oversight as well as strengthen the relationship between hospitals' nursing departments and finance departments.

2.11.2.2 New nursing qualifications

The SANC has approved new nursing qualifications for inclusion in the National Qualifications Framework. These qualifications are aligned to the higher education framework and the SANC is currently developing policies and guidelines for the programme, Bachelor's Degree in Nursing and Midwifery. On successful completion of this qualification, the learner will be eligible for registration with the relevant statutory body, currently the SANC, as a professional nurse and midwife. Successful registration will license nurses to practise as a professional nurse and midwife. In order to manage health care facilities, the graduate will be prepared comprehensively and appropriately according to the health needs of the country. The course will enable the graduate to effectively manage the health care unit and health facility with the understanding of the roles and relationships within the multidisciplinary team, establish and promote cost-effective and efficient service delivery within a health care unit and apply management processes strategically and systematically to manage resources effectively within a health care unit (SANC 2013: 2). The programme is still in its development phases and curricula are being currently drawn up and finalised.

2.12 CHAPTER SUMMARY

From the above discussion, it can be stated that there is a gap between the current skills of NMs and financial management. Health care, both in private or public sectors is run on business principles. The role of the NM has changed to require greater financial management skills. NMs lack knowledge of financial management skills. Another gap identified is that the current nursing education systems prepare nurses for clinical skills and nursing

management, while financial management does not get the attention it deserves. It is relevant to identify the skills and competencies that are perceived to be important for effective health care financial management in South Africa. Chapter three discusses the research design and methodology.

CHAPTER 3: RESEARCH DESIGN AND METHODOLOGY

3.1 INTRODUCTION

The previous chapter focused on the literature review. This chapter presents an overview of the methods that were used in the study in keeping with the constructivist grounded theory (GT) approach, which allowed for flexibility and assumed an emergent approach to the data. The discussion in this chapter is structured around the research methodology and design, research paradigm, setting population, sampling, data collection and data analysis. Measures to ensure rigour of the study and ethical considerations are also discussed.

3.2 RESEARCH PARADIGM

Before the commencement of a research project, the researcher must take into consideration their philosophical worldview and the theoretical design that will support the research questions. The methods of data collection, analysis and interpretation must also be decided (McInnes, Peters, Bonney and Halcomb 2017: 36). Individual inquirers adopt the paradigm that best represent their relationship to that worldview and helps legitimise the practice of their research (Guba 1990: 18). It is the selection of the paradigm that decides the aims, inspirations and prospects for the research. Without selecting a paradigm as the initial phase, there is no foundation for ensuing options of research design and methodology.

Saunders, Lewis and Thornhill (2009: 118) define paradigm as a way of examining social phenomena from which specific understandings of these phenomena can be achieved and explanations attempted. It is a way of looking at natural phenomena that incorporates a set of logical assumptions and that guides one's approach to inquiry (Polit and Beck 2008: 14).

3.2.1 Characteristics of paradigms

Polit and Beck (2008: 13) outline the basic philosophical questions by which paradigms for human inquiry are often characterised as follows:

- Ontological: What is the nature of reality?
- Epistemological: What is the relationship between the inquirer and that which is being studied?
- Axiological: What is the role of values in the inquiry?
- Methodological: How should the inquirer obtain knowledge?

Guba (1990: 18) further states that research paradigms can be characterised through their ontology (what is reality), epistemology (how do you know something) and methodology (how do you go about finding it out). These will be achieved through presenting ways that the axioms and operational characteristics of naturalistic inquiry were applied to the research (Lincoln and Guba 1985: 36-46).

3.2.2 Types of paradigms

Two broad paradigms known as the positivist paradigm and naturalistic paradigm are described by Profetto-McGrath, Polit and Beck (2010: 10).

3.2.2.1 Positivist paradigm

Profetto-McGrath, Polit and Beck (2010:10) state that within the positivist paradigm, research activity largely focuses on understanding the primary causes of natural phenomena. Positivists believe in objectivity and use of systematic, well-organised procedures with rigid controls over the research situation to prove intuitions about the nature of phenomena being studied and relationships among them. Positivism is widely used in nursing research (Profetto-McGrath, Polit and Beck 2010: 10).

3.2.2.2 Naturalistic paradigm

Profetto-McGrath, Polit and Beck (2010: 12) state that in the naturalistic paradigm (sometimes called the constructivist paradigm), reality is not a fixed entity but rather a construction of the individuals participating in the research. Reality exists within a context and many constructions are possible. The naturalistic paradigm assumes that knowledge is increased when the distance between the researcher or investigator and the participants in the study is decreased or reduced. The interpretations of those under study are central to understanding the phenomenon of interest and personal interactions are the primary way to access them. The findings from a naturalistic inquiry are the result of the relations between the inquirer and the participants (Profetto-McGrath, Polit and Beck 2010: 12).

According to Profetto-McGrath, Polit and Beck (2010: 12), naturalists who stress that all inferences are filtered from people's prior experience and biases believe that people build or construct their understanding of the external world, that is, they interpret it. Naturalist researchers accept that researchers, as well as research subjects, make interpretations and that it is neither possible nor desirable for the researcher to eliminate all biases or expectations. Because they cannot eliminate their own experiences and expectations, researchers need to be careful not to force their expectations on interviewees and should remain aware of how their expectations affect what they see and hear (Profetto-McGrath, Polit and Beck 2010: 12).

3.2.3 Theoretical elements of naturalistic paradigm

This study was guided by the naturalistic paradigm (Creswell 2014: 39). This type of study required several perspectives on the financial management competencies and the financial management developmental needs of the research participants. It was understood that individuals have the ability to construct their own realities and do so based on their own personal ontology and epistemology. For this reason, the foundational paradigm for this study was based on Lincoln and Guba's (1985) theoretical elements of the

naturalistic inquiry. Naturalistic inquiry allowed for multiple perspectives and realities to be obtained in this research. The naturalistic paradigm offered the correct method for gaining the detailed, information necessary to understand the financial management roles and practices of NMs, as it is experienced in the hospital settings. Such an understanding was critical during the data analysis phase as it helped with the development of financial management competency framework for NMs. The theoretical elements of naturalistic inquiry, as defined by Lincoln and Guba (1985: 39) are built upon five axioms or basic beliefs as presented in Table 3.1. Lincoln and Guba (1985: 37) devised these to differentiate naturalistic inquiry from other paradigms (McInnes et al. 2017: 39).

Table 3.1: Five axioms of naturalistic paradigm

Axioms	Naturalist Paradigm
The nature of reality (ontology).	Realities are multiple constructed and holistic.
The relationship of knower to the known.	Knower and known are interactive, and inseparable.
The possibility of generalisation.	Statements are time- and context-bound.
The possibility of causal linkages.	It is impossible to distinguish causes from effects.
The role of values.	Inquiry is value-bound.

Source: Lincoln and Guba (1985: 37)

3.2.4 Compliance of the research study to the five axioms

Lincoln and Guba (1985: 251) state that the inquirer must adopt a stance suggested by the axioms of the naturalistic paradigm. The axioms are an inseparable, combined set and must be adopted as such. Mix and match strategies are not allowed, nor are accommodations and compromises. The axioms of naturalistic inquiry are presented in relation to how it is applied to the study.

3.2.4.1 Axiom 1: The nature of reality (ontology)

The first axiom is based on the ontological assumption that multiple realities cannot be understood in isolation from their contexts and must be studied holistically (Lincoln and Guba 1985: 39). The researcher sought to understand the data within the context of the interviewees' immediate working context. The hospitals were already in existence and functional which provided a natural context- rich setting. There were different categories of people working in the hospitals that were included as research participants (NMs, ANMs, OMs, FMs and CEOs) and each party saw and interpreted reality through their own eyes. Participants were free to respond to the questions based on his or her own experiences. Due to this diversity, it was reasonable to conduct this study within the naturalistic paradigm where the perceptions and experiences of each person's subjective realities were accepted and greatly valued. The interview method of data collection allowed for a better understanding of the information that emerged with regards to the financial management roles and competencies of NMs as well as their developmental needs. Participants' comments were used to illustrate the findings that emerged from the interviews.

3.2.4.2 Axiom 2: The relationship of knower to the known

The second axiom relates to the epistemological relationship between the researcher and participants (Lincoln and Guba 1985: 37). The relationship is interactive and inseparable. In this naturalistic study the researcher was also a participant in the research process. Data was collected in participants' natural settings or contexts and the researcher interacted with the participants during data collection. A semi-structured interview guide was used to conduct face-to-face interviews for the purpose of data collection. This approach provided the opportunity for the researcher to use prompts and clarify responses. The researcher was known to the participants due to interactions in the professional capacity.

3.2.4.3 Axiom 3: The possibility of generalisation

The third axiom identifies the possibility of generalisation where statements are time- and context-bound. The researcher aimed to gain an understanding from rich, thick descriptions of the participants of their financial management roles, competencies and developmental needs and in their natural settings. The goal was to describe particular processes from the perspectives of the participants. Participants shared their views and opinions about their financial management roles, competencies and developmental needs based on their own individual experiences, personal biases, years of experience and their own personal and professional abilities and development. As indicated by Lincoln and Guba (1985: 38), the aim of an inquiry is to develop knowledge from individual cases or events. The study centred on individual experiences as reported by the participants which was subsequently analysed and blended to form themes. These themes are not generalisable across different contexts but will be important for further investigation of the topics discussed in other health care contexts or settings.

3.2.4.4 Axiom 4: The possibility of causal linkages

The fourth axiom states it is complex to differentiate causes from effect and therefore all interactions must be examined holistically in their natural contexts (Lincoln and Guba 1985: 38). The interviews were conducted in the participants' natural settings which were hospitals. Face-to-face interviews allowed for the building of a relationship between the researcher and the participants. The research approach using GT also provided further information as required due to theoretical sampling.

3.2.4.5 Axiom 5: The role of values

The fifth axiom relates to the inquiry being influenced by the researcher's values and beliefs. The inquiry process is manipulated by four factors: the values of the inquirer, the beliefs or axioms that inspire the theory, the methodology, and the values of the context in which the inquiry is undertaken (Lincoln and Guba 1985: 43). The researcher was aware that values play a role in the inquiry and the dangers of researcher bias. How researcher bias was eliminated is stated later in this chapter. The participants presented value

based accounts related to their experiences of financial management. All these affected the type of data that was presented and how it was analysed. This aspect is dealt with in the section of trustworthiness and credibility.

3.2.5 Operational characteristics of naturalistic inquiry

Recognising that naturalistic research necessitates more elements than addressing the five axioms, Lincoln and Guba (1985) offered an additional set of 14 operational characteristics to guide a naturalistic inquiry. Although each characteristic is dependent on the five axioms, they demonstrate a rational interdependence (Lincoln and Guba 1985: 39). These characteristics provide the structure for the development of the study and the application in the study of each operational characteristic is discussed.

a) Natural setting

The first characteristic finds that realities are wholes and must be understood in their natural settings or context (Lincoln and Guba 1985: 39). Individual face-to-face interviews were conducted in the participants' natural setting, this being their work place. This was done to develop a rich understanding of the participant's perspectives in their original context.

b) Human instrument

Humans are to be used as primary data gathering instruments as opposed to pen and paper instruments (Lincoln and Guba 1985: 39). The researcher conducted all interviews and analysed all data. The researcher was very adaptable as a data collection instrument and observed and interacted with the participants. The researcher adjusted to the changes that occurred during the study and modified data collection procedures as necessary.

c) Utilisation of tacit knowledge

Intuitive knowledge as legitimate in addition to planned knowledge (Lincoln and Guba 1985: 39). All members of the research team had expertise in nursing. The researcher ensured that her intuition and observations helped

develop a rich understanding about participants and the study in the natural setting.

d) Qualitative methods

Qualitative methods must be chosen because they can be adapted to deal with multiple realities (Lincoln and Guba 1985: 40). The diverse nature of the participants and research settings supported a qualitative study and the multiple realities that were generated from participants. The researcher used qualitative data collection methods and analysis instead of quantitative methods.

e) Purposeful sampling

Purposeful sampling increases the extent or scope of data (Lincoln and Guba 1985: 40). Purposeful sampling was used to gain access to a full range of participants that met the criteria and to obtain the participants experiences and perspectives.

f) Inductive data analysis

Inductive analysis is more likely to identify multiple realities in the data (Lincoln and Guba 1985: 40). An inductive process of analysis was used in the interpretation of data. Important leads were identified in the early phases of data analysis and pursued by asking new questions. Analysis began after the first interview and after each subsequent interview which provided the opportunity for the significant aspects of the phenomenon under study to begin to emerge. In this way, the researcher built more data on the data collected with each interview.

g) Grounded theory

Substantive theories emerge from the data (Lincoln and Guba 1985: 41). Constructivist GT was used and the researcher engaged in thematic analysis of the data to allow the themes to emerge rather than base them on preset or preconceived theories or ideas.

h) Emergent design

The research design is allowed to emerge rather than be constructed in advance (Lincoln and Guba 1985: 41). As there was a paucity of research into financial management for NMs, it was suitable to adopt an emergent design. Patterns within the data were allowed to surface without any predetermined expectations.

i) Negotiated outcomes

Meanings and interpretations are negotiated with the people from whom the data have chiefly been drawn (Lincoln and Guba 1985: 41). Member checking was done as part of this study. After the data was transcribed, transcripts were sent to the participants to verify that what was transcribed was a true reflection of their accounts and experiences.

j) Case study reporting mode

Case study reporting mode is preferred over the scientific or technical report (Lincoln and Guba 1985: 42). Direct quotes from participants are presented in the findings. The researcher provided many excerpts from the actual data collected from the participants. This was done to give the reader sufficient information for understanding the research outcomes.

k) Idiographic interpretation

Idiographic means pertaining to or involving the study or explication of individual cases or events (Collins Advanced English Dictionary 2017: 1). The researcher is inclined to interpret data as unique sources rather than generalisable cases (Lincoln and Guba 1985: 42). The findings were reported as they pertain to the natural setting and no generalisation was done. By reaching consensus, the research team ensured interpretations were consistent with the participants' experiences and did not generalise findings to settings outside of those they occurred.

l) Tentative application

The naturalist is likely to be hesitant about making broad application of the findings (Lincoln and Guba 1985: 43). The researcher communicated the provisional nature of the findings that was unique to the particular situation in the natural setting. Less definitive terms such as 'may' and 'possible' were used during the interpretation and reporting of findings.

m) Focused determined boundaries

Multiple realities define the focus rather than the inquirer's preconceptions (Lincoln and Guba 1985: 43). Maintaining a clear focus in the study was guided by the research questions. The researcher was conscious of the influence her prior knowledge and expertise might have on the interpretation and presentation of data. Regular discussions among the research team helped improve any presumptions.

n) Special criteria for trustworthiness

Criteria to assess trustworthiness (credibility, transferability, dependability and confirmability) are adopted (Lincoln and Guba 1985: 43). The procedures and criteria for addressing trustworthiness and rigour was identified, applied, presented and discussed in detail later in this chapter.

3.3 RESEARCH DESIGN

Mouton (2011: 55) defines research design as a plan that is used to describe how the research will be conducted. It focuses on the kind of study that is planned and the results that one hopes to achieve for the study and what evidence will show that the research problem has been addressed appropriately. The research design must connect the philosophical worldview, strategy of inquiry and the research method (Mouton 2011: 56).

Polit and Beck (2010: 74) state that the research design is the general plan for finding answers to the questions being studied and for addressing different challenges to the significance of the study evidence. In designing the study, researchers choose which particular design will be adopted and what they will

do to reduce bias and enhance the interpretability of results. Research designs also indicate other aspects of the research, for example, how often data will be collected, what types of comparisons will be made, and where the study will take place. Mouton (2011: 56) adds that the research design focuses on the type of study that is intended and the results that one hopes to achieve for the study as well as what evidence will show that the research problem has been addressed appropriately. The research design must connect the philosophical worldview, strategy of inquiry and the research method (Mouton 2011: 56). This has been explained in the relevant sections. The GT approach as proposed by Charmaz was adopted for this study.

3.4 GROUNDED THEORY APPROACH

GT is described as a flexible, qualitative, inductive approach which is comprehensive, integrated and highly structured and follows a set of procedures based on the constant comparative method (Glaser and Holton 2004: 1). There are three major approaches to GT namely classical GT, constructivist GT and Straussian GT as detailed in the sections below.

GT is sometimes referred to as the constant comparative method because every piece of coded data is compared with every other piece of data, with concepts and categories and with all levels of abstraction as the developing theory begins to take form (Glaser and Holton 2004: 1). GT works in an opposite manner to the traditional scientific method where theory is generated from the data. Instead of proposing a hypothesis and gathering data to support it or proving a theory, data collection is done first without any preconceptions (Glaser and Strauss 1967: 36). The main point in data collection is the coding, which groups the data into similar concepts or categories. These categories become the basis of a theory (Glaser and Strauss 1967: 36). The coding process is performed in different steps, according to the different scholars of GT.

3.4.1 Defining components of grounded theory

The following are the defining components of GT as verified by the three proponents of GT, namely Glaser, Strauss and Charmaz:

- Data collection and analysis occurs concurrently (Glaser and Strauss 1967: 48; Strauss and Corbin 1990: 6; Charmaz 2014: 7).
- Analytic codes and categories are constructed from data, and not from preconceived, logically deduced hypotheses (Glaser and Strauss 1967: 10; Strauss and Corbin 1990: 6; Charmaz 2014: 7).
- The constant comparative method, which involves making comparisons during each stage of the analysis (Glaser and Strauss 1967: 101; Strauss and Corbin 1990: 9; Charmaz 2014: 7).
- Advancing theory development during each step of data collection and analysis (Glaser and Strauss 1967: 251; Strauss and Corbin 1990: 11; Charmaz 2014: 7).
- Memo writing to elaborate on categories, specify their properties, define relationships between categories and identify gaps (Glaser and Strauss 1967: 251; Strauss and Corbin 1990: 10; Charmaz 2014: 7).
- Sampling aimed towards theory construction, not for population representativeness (Glaser and Strauss 1967: 108; Strauss and Corbin 1990: 8; Charmaz 2014: 7).
- The literature review is conducted after developing an independent analysis (Glaser and Strauss 1967: 36; Strauss and Corbin 1990: 6; Charmaz 2014: 7).

These processes were followed and their application is illustrated throughout the study.

3.4.2 Approaches to grounded theory

The three major versions of GT fit into different paradigms. Glaser and Strauss's (1967) original version fits within the post positivist paradigm and is also known as classical GT. Charmaz's (2006) version is known as constructivist GT and Corbin and Strauss's (2008) version fits with the interpretivist paradigm, known as Straussian GT (Holton 2008: 67).

3.4.2.1 Post positivist paradigm – classical grounded theory

Sociologists, Glaser and Strauss originally developed GT methods in 1967 from a research project where they observed how dying occurred in a variety of hospital settings (Charmaz 2014: 8). In Glaser and Strauss's book, *The Discovery of Grounded Theory* (1967), they proposed that theories should be grounded in collected data that would reflect the actions, interactions and social processes rather than assuming testable hypotheses from existing theories (Charmaz 2014: 8). All collected data, fieldwork notes as well as other literature are included in the process. However, a literature review is not conducted first as in other research methods as this may create a bias (Glaser 1992: 16). There are two types of coding in classical GT, namely substantive coding and theoretical coding.

In substantive coding, the researcher breaks down and analyses data directly, initially through open coding for the emergence of a core category and related concepts and then through theoretical sampling and selective coding of data to theoretically saturate the core and related concepts (Holton 2007: 265). Theoretical coding occurs at the last stage and conceptualises how the substantive codes may relate to each other and is used to formulate the theory (Glaser 1978: 164). Substantive codes break down while theoretical codes bring the story together into an organised whole theory (Glaser 1978: 165).

3.4.2.2 Straussian grounded theory approach

Glaser and Strauss separated professionally and developed differing versions of GT (Coleman and O'Connor 2007: 4). Glaser remained with the original principles of GT while Strauss and Corbin developed their own guide to conducting GT (Charmaz 2014: 11). Strauss and Corbin's (1990) interpretation of GT is more methodical and concerned with coding and structuring of qualitative data. This method is often referred to as Straussian GT (Charmaz 2014: 11).

Differences between Straussian GT and classical GT include that Straussian GT supports the concept that the researcher brings the idea of the phenomenon to be studied, while classical GT insists that it should emerge from the data and not be initiated by the researcher (Lawrence and Tar 2013: 31). Theoretical sampling in classical GT begins with initial data collection and analysis which generates initial codes that stimulate further data collection. Once a core category is identified, theoretical sampling then focuses data that is relevant to the core category. The Straussian approach is more structured, leading to a much more rigid coding structure for analysis. Strauss and Corbin (1990) added more procedures on how to code and structure the data. They used a three stage coding methodology of open coding, axial coding and selective coding (Lawrence and Tar 2013: 30). Another difference between Straussian theory and classical GT is in the use of literature. CGT believes that the literature review should only occur when the emergent theory is satisfactorily developed to allow the literature to be used as supplementary data, while the Straussian approach recommends a literature study prior to collecting the data (Heath and Cowley 2004: 143).

3.4.2.3 Constructivist grounded theory approach

Charmaz is the creator of constructivist GT and this approach was used in this study (Charmaz 2014: 13). Constructivist grounded theorists seek to understand the difference and variation among research participants and to co-construct meaning with them (Charmaz 2014: 13). The importance of carrying out data collection and analysis concurrently, using constant comparison, memo writing, and theoretical sampling is highlighted by Charmaz, with a few differences. Charmaz (2008: 133) finds that with constructivist grounded theorists, a connection exists between the researcher and the participants. From a research perspective, the idea of a shared reality is discovered by the researcher through the interview process with research participants (Charmaz 2006: 14). The coding process for constructivist GT uses open, focused, and theoretical coding (Charmaz 2006: 14) (discussed in section 3.11), while classical GT uses substantive and theoretical coding, and Straussian GT uses open, axial and selective coding.

3.4.3 Rationale for adopting the grounded theory approach

One of the roles of NMs that is not completely understood is that of financial management. The importance of this role is beginning to be acknowledged by researchers, as there is a small number of studies conducted and available in the literature. Although there are studies conducted on NM competencies which include aspects of financial management, there is very little published research to date that focuses exclusively on the financial management roles, knowledge and developmental needs of NMs. This study was developed in response to this gap in the literature. GT was an appropriate methodology to adopt in the study as its focus is on social processes (Glaser and Strauss 1967: 21). It was also appropriate for the type of research questions being investigated as GT questions are more aligned towards action and process (Strauss and Corbin 1990: 38). As illustrated in the introductory sections of this study, financial management competencies of NMs are poorly understood, and GT was useful to the current study in clarifying aspects relevant to these competencies. Lehane (2014: 11) asserts that the GT framework is valuable when little research has been conducted on a topic. Strauss and Corbin (1990: 23) state that in GT one starts with a field of study, and what is applicable to that field is allowed to emerge, as opposed to starting with a theory and aiming to prove it. The contribution this study offers through the generation of a framework, grounded in the data, is beneficial for the development of financial management competencies of NMs.

3.4.4 Rationale for using constructivist grounded theory

A GT approach was selected because little is empirically known on what financial management competencies NMs have and what their developmental needs are. Research on NMs financial management competencies is limited. Studies conducted on NM competencies are based on existing theories and frameworks such as the Chase Nurse Manager Competency Instrument (Chase 2010) and the American Organisation of Nurse Executives (2005) Competency Framework, and not on their own experiences. Using GT allowed for the creation of a theoretical framework that was developed from

the actual work experiences of NMs. An exploration of the financial management roles and development needs that NMs verbalised generated ways of a better exploration and analysis than would have been achieved with the closed-ended questions that might be asked in questionnaires.

The constructivist GT approach was used to address the two main research questions of the study: (1) what financial management competencies do NMs in public health care organisations currently possess? (2) What are the essential financial management developmental needs of NMs? One of the strengths of GT is that it does not prescribe a data type or method of data collection (Glaser and Holton 2004: 3). This means that grounded theorists can use the research design that best fits the needs of their study. The current study was grounded in the experience of NMs from public hospitals where data was obtained from in-depth interviews.

The flexibility of the constructivist approach afforded the opportunity to interact with the participants and ask for clarification and examples in order to understand the different perspectives. According to Charmaz (2014: 14), the constructivist approach provides a more flexible approach than the rigid classical GT which provides a more positivist approach. It was important to gather rich data from the NMs which are “detailed, focused and will provide solid material for building a significant analysis” (Charmaz 2014: 23). Rich data discloses participants’ views, feelings, intentions and actions as well as the contexts and structures of their lives. Obtaining rich data means seeking ‘thick’ descriptions such as writing extensive field notes of observations, collecting respondents’ written personal accounts, and/ or compiling detailed narratives such as from transcribed tapes of interviews (Charmaz 2014: 23).

Charmaz (2006: 26) advises that a few broad, open-ended questions can be formulated for a GT study. The interview questions can attract a detailed discussion of the topic. By creating open-ended, non-judgemental questions the interviewer allows for unforeseen statements and stories to surface. Charmaz (2014: 65) finds that the constructivist would extract the participant’s definitions of terms, situations, and events and try to draw on his or her

assumptions, inherent meanings, and unstated rules. The GT approach can only easily start without a unit, by starting with a substantive area. Doing GT can mean starting with a unit, but the researcher soon leaves it to look for other data and comparative groups as the theory develops and theoretical sampling takes over. 'All is data' means leaving time and place behind, so that the researcher can go anywhere to find any form of data (Glaser 1992: 11). In the current study the NMs, ANMs, OMs, CEOs and FMs were interviewed and gave their own account of financial management roles, competencies and developmental needs. In the constructivist approach, the truth comes from the participants' perspectives as well as from the researcher's interpretation (Charmaz 2006: 130). In this study, the researcher conducted the interviews and interacted with the participants throughout the study. When compared with the other two GT approaches, constructivist GT emphasises the importance of the researcher's relationship with the study participants to get more concrete data (Charmaz 2014: 31).

The constructivist GT approach was practical and provided a useful and meaningful product in the area of study (Charmaz 2000: 524). A framework was developed following the study that would serve as a guide for NMs to improve their financial management competencies. Hence, the pragmatic approach was important in this study. The main reasons for choosing the constructivist approach in this study were due to its flexibility, reflexivity and practicality.

Classic grounded theorists such as Glaser and Strauss (1967: 37) encourage delaying the literature review until after completing the analysis (Charmaz 2014: 306). Constructivist GT allows for a review of the literature, which serves to discover what has been done in the study area so that the study problem can be identified and addressed. Charmaz (2014: 306) acknowledges that a literature review is required for the research proposal phase and states that it is important for the researcher to begin by positioning his or her study within the relevant literature. In addition, Charmaz (2014: 306) emphasises that the literature review should include an argument that may form the foundation of the discussion in the writing stage of a study. A

literature review was conducted in the current study in order to learn whether any similar research has already been conducted in this field and to satisfy the requirements of the research proposal as prescribed by the study institution.

3.5 RESEARCH SETTING

The study was conducted in KZN which is one of the nine provinces in South Africa. The KZN province is located in the south-east of South Africa bordering the Indian Ocean. It also borders on the Eastern Cape, Free State and Mpumalanga provinces, as well as Lesotho, Swaziland and Mozambique. The total area of KZN is 94 361 square kilometres, the country's third-smallest province. It takes up 7.7% of South Africa's land area and has the second-largest population, estimated at 10.6-million people in 2010 (KZNONLINE 2016: 1). The KZN province is divided into one metropolitan municipality, eThekweni Metropolitan Municipality and 10 district municipalities, which are further subdivided into 50 local municipalities. The KZN province is divided into 11 health districts as depicted in Figure 3.1. All 11 health districts were included in the study in order to ensure geographic representativeness, as well as the inclusion of urban, semi-urban, rural and semi-rural public hospitals. The 11 health districts were categorised according to their geographical regional location in KZN being north, south, midlands and central regions (KZNONLINE 2016: 1).

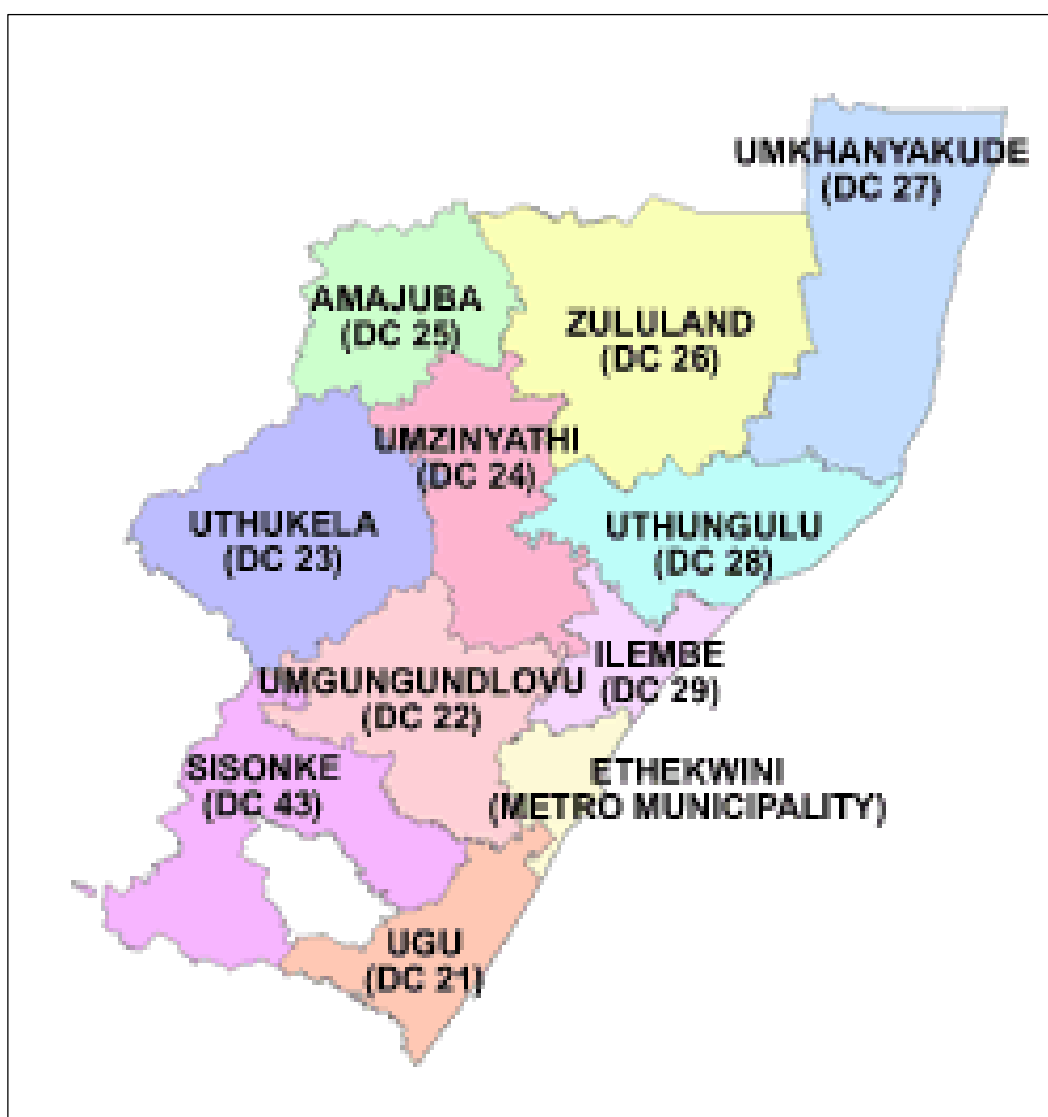


Figure 3.1: Map showing KZN Health Districts

Source: EThekwinI Investment Maps (2018: 1)

The 11 health districts and the number of public hospitals in each district are depicted in Table 3.2 below. There are 72 public hospitals in the eleven districts and there is a combination of urban, semi-urban, rural and semi-rural hospitals within each geographical region.

Table 3.1: Number of public hospitals per geographical location

Geographical location	Health districts	Number of public hospitals	Types of hospital
NORTH	Zululand	7	Rural, semi-rural
	UMkhanyakude	5	Rural, semi-rural
	UThungulu	8	Urban, rural, semi-rural and semi-urban
	ILembe	4	Urban, rural, semi-rural and semi-urban
	TOTAL	24	
SOUTH	UGu	5	Urban, rural, semi-rural and semi-urban
	Sisonke	6	Urban, rural, semi-rural and semi-urban
	TOTAL	11	
CENTRAL	EThekwini	18	Urban and semi-urban
	UMgungundlovu	9	Urban, rural, semi-rural and semi-urban
	TOTAL	27	
MIDLANDS	UThukela	3	Urban, rural, semi-rural and semi-urban
	UMzinyathi	4	Rural and semi-rural
	Amajuba	3	Urban, rural, semi-rural and semi-urban
	TOTAL	10	
Total number of public hospitals		72	

3.5.1 Sampling of hospitals

The first stage of the selection involved the sampling of those hospitals that met the study criteria as being regional or district hospitals and having 200 beds or more in KZN. The researcher then purposively selected hospitals according to their geographical location and health districts. Some hospitals are situated in urban areas and some in rural areas. It is often supposed that urban health services are better resourced than rural services (Sibiya 2009: 62). For this reason, it is important to analyse both rural and urban hospitals to identify differences in the financial management competencies and development needs of NMs. Of the 72 public hospitals in KZN, a total of 32 hospitals met the criteria for inclusion in the study and were purposefully sampled. All these hospitals have 200 beds or more and are either medium or

large district or regional hospitals. In the North 10, South 6, central 8 and midlands 8 hospitals met the criteria (Table 3.3).

Inclusion criteria

- Medium or large district or regional hospitals as these hospitals provide similar health care services on a 24-hour basis. Regional hospitals operate both as district hospitals in the districts where they are located and as referral hospitals for the other districts of their region (South Africa, Department of Health 2012a: 3-6).
- Hospitals with more than 200 beds. Medium district hospitals have between 150 and 300 beds and regional hospitals have 200 beds or more (South Africa, Department of Health 2012a: 4). For consensus and uniformity purposes only those hospitals that have 200 beds or more were included in the study.

Exclusion criteria

- Speciality, tertiary and central hospitals were excluded as their financial needs differ according to the type of service they provide. Speciality hospitals provide care only for certain specialised groups of patients. These include chronic psychiatric and TB hospitals, as well as specialised spinal injury and acute infectious disease hospitals (South Africa, Department of Health 2012a: 1). Tertiary and central hospitals provide specialist level services (South Africa, Department of Health 2012a: 4). The exclusion of these hospitals occurred as it was unclear when planning the study if the NMs of these hospitals may have the same financial management roles as the NMs of district and regional hospitals. Some financial management processes and activities may be different in each hospital due to the diversity of the services offered.
- Small and medium district hospitals and regional hospitals with less than 200 beds were excluded. Bed states in small and medium hospitals can range from 60 beds. These hospitals were excluded as they may be administrated by larger hospitals and may not have staff such as FMs and CEOs who were required to answer the research questions.

Table 3.3 shows the number of public hospitals that met the study criteria.

Table 3.2: Public hospitals that met the study criteria

Number of health districts	Number of public hospitals	Number of public hospitals that met the study criteria	Name of hospitals that met the study criteria
4	24	10	Benedictine, Hlabisa, Ekombe, Eshowe, Manguzi, Mosvold, Nkandla, Nkonjeni, Vryheid
2	11	6	Christ the King, GJ Crookes, Murchison, Port Shepstone, Rietvlei, St Andrews
2	27	8	Addington, Edendale, Mahatma Gandhi, Northdale, Prince Mshiyeni, RK Khan, Wentworth, Osindisweni
3	10	8	Charles Johnson Memorial, Dundee, Church of Scotland, Greytown, Estcourt, Ladysmith, Madadeni, Newcastle
11	72	32	

3.6 RESEARCH POPULATION

Burns and Grove (2009: 343) define the research population as all elements, individuals, substances or objects which meet specific criteria to be included in the study. The population in this study comprised NMs, FM, ANMs, OMs and CEOs of the selected hospitals.

3.6.1 Inclusion and exclusion criteria for study participants

The initial target population selected for the study was senior or chief NMs who were overall in charge of the nursing section of the hospitals at the time of the study from 1 October 2016 to 31 December 2017. However, with the nature of the study being GT, the researcher anticipated that this population could change as the study progressed depending on the study findings. This became more evident after the pilot study was conducted when there was an indication that more information on financial management competencies and financial development needs was required. The population that was identified that could also provide valuable information in answer to the research

questions were the ANMs, FMs, OM and CEOs of the hospitals under study. Therefore, all these were subsequently added as participants of the study.

The senior or chief NMs from the 32 hospitals that met the inclusion criteria (presented in Table 3.3) were invited to participate in the study. For confidentiality and anonymity purposes, the names of hospitals are not revealed in the study report. The hospitals were alphabetically coded, for example Hospital A, Hospital B.

Inclusion criteria

- Chief or senior NMs who are overall in charge of the nursing section of the hospital and have been working in the NM position for a year or longer.
- ANMs working in the position for a year or longer.
- FMs who have been working in the position for a year or longer.
- OM who were permanently employed and have been working in the OM position for a year or longer.
- CEOs who have been working in the position for a year or longer.

The above inclusion criteria were set as the researcher wanted to choose participants with the characteristics that would enable them to share their experiences with regard to financial management. The study required accounts from participants that were 'information rich' about the research phenomenon. A minimum of one year of working in the relevant position would enable participants to have some experience with financial management of their departments and therefore be able to provide the answers sought by the researcher and so contribute to the understanding of the research phenomenon.

Exclusion criteria

- All other NMs who did not meet the inclusion criteria.
- FMs who had less than one year of experience.
- ANMs who had less than one year of experience.

- OMs who had less than one year of experience.
- CEOs who had less than one year of experience.

These restrictions necessarily limited the sample. As explained above, in order to meet the objectives of the study it was important to recruit participants who had the required experience and were familiar with the research phenomenon.

3.7 SAMPLING PROCESSES

Keen (2013: 4) asserts that sampling is an emergent process in GT. Sampling decisions cannot all be determined prospectively from the outset of the study. Sampling, data collection and data analysis are concurrent activities. Sampling decisions should be driven by the emergent analysis and end when theoretical saturation is reached (Keen 2013: 4). GT studies are characterised by theoretical sampling, but this requires some data to be collected and analysed. Sampling must thus begin purposively, as in any qualitative study (Sbaraini, Carter, Evans and Blinkhorn 2011: 2).

In line with all of the above, the researcher did not select all the participants at the onset of the study but could only identify the NMs as the group of individuals with some common defining characteristic. Subsequently the ANMs, FMs, OMs and CEOs were added in the sample.

Purposive sampling was used in the initial stages of this study to recruit NMs who had a diversity of educational, social and professional backgrounds and also had exposure to the financial aspects of their job. Purposive sampling is widely used in qualitative research for the identification and selection of information-rich cases related to the phenomenon of interest (Brink, van der Walt and van Rensburg 2012: 141). The qualitative researcher using this method does not know in advance how many participants are needed; he/she samples continuously until data saturation occurs, that is, the point at which new data no longer emerges (Brink, van der Walt and van Rensburg 2012:141). This method is based “on the assumption that the investigator

wants to discover, understand and gain insight and therefore must select a sample from which the most can be learned” (Merriam 2009: 77).

3.7.1 Sampling of Nursing Managers

NMs were purposively chosen as participants because they were both ‘information rich’ and possessed knowledge based on their positions and roles within the selected public hospitals (Merriam 2009: 77). The available population size of NMs was 32 participants. The names of the NMs were obtained from the CEOs office in some hospitals and the KZN Department of Health website where the information is available and accessible.

3.7.2 Theoretical sampling

Charmaz (2014: 192) indicates that the logic of theoretical sampling distinguishes GT from other types of qualitative inquiry. Criteria for initial sampling differ from those of theoretical sampling. Initial sampling in GT gets ‘one started’ while theoretical sampling guides ‘where one goes’ (Charmaz 2014: 197). Theoretical sampling is not the same as purposeful sampling. Theoretical sampling is a form of purposive sampling and is the sampling method used in GT after the initial sample is selected and the initial data collection and analysis has been undertaken (Polit and Beck 2010: 321). Theoretical sampling involves decisions about what data to collect next and where to find this data to develop an emerging theory optimally. The basic question in theoretical sampling is: “What groups or subgroups should the researcher turn to next?” (Glaser 1978: 46). Groups are chosen as they are needed for their relevance in furthering the emerging conceptualisation. These groups are not chosen before the research begins, but only as they are needed for their theoretical relevance in developing further emerging categories (Polit and Beck 2010: 321). The objective of theoretical sampling is to discover categories and their properties and to offer new insights about interrelationships that occur in the substantive theory (Polit and Beck 2010: 321).

Data collection in the form of interviews began with the NMs that were purposively selected for the study. Once the interviews were transcribed, initial coding of the data and memo writing, which incites theoretical sampling, commenced (Charmaz 2014: 199). The result of each stage guided the subsequent stage. In the initial coding stage, the data from the interviews was examined and coded (Charmaz 2014: 116). Initial coding used word-by-word coding, line-by-line coding and incident-with-incident coding. Open or initial coding utilised a process of constant comparison which is a simultaneous and concurrent process of coding and analysis (Glaser and Strauss 1967: 102).

As the initial collected data was analysed, some preliminary concepts and categories began to emerge. This data was organised and assembled to form categories that were similar, and all data was included (Glaser 1978: 93). Patterns that led to social processes which were of interest were identified (Glaser 1978: 93). As the categories began to fill, those that were most dense became known as core categories (Glaser 1978: 93). These concepts and categories then guided the next phase of data collection. As the study progressed, the theoretical sampling strategy was used to recruit further NMs, ANMs, OMS, FMs and CEOs who provided the relevant data to develop the emerging themes and framework (Charmaz 2014: 193). The main purpose of theoretical sampling was to expand and refine the categories making up the framework and to continue advancing the properties of the categories until no new properties surfaced. The FMs input was critical in this study as they manage the finances within the hospitals. They provide a support role for the NM by providing financial information that assists the NM with the implementation of policies; promote costing systems and skills in order to support the NM in this regard.

Theoretical sampling continued until the stage where saturation was reached. Saturation was decided by the completeness of all codes when no new conceptual information was available to indicate new codes or the expansion of new codes. According to Glaser (1978: 36), theoretical sampling on any code ceases when it is saturated, elaborated and integrated into the emerging theory. The researcher ultimately achieved a sense of closure by repeatedly

checking and asking questions to contrast and compare the emerging conceptual framework as indicated by Glaser (1978: 39).

3.7.3 Theoretical saturation

Theoretical saturation, the stage at which one terminates data collection, is the stage at which the core categories, identified during the analysis, are supported through relevant and rigorous data and thus the various properties of the categories are established in great detail (Charmaz 2014: 213). Theoretical saturation is achieved by the constant comparison of incidents in the data to elicit the properties and dimensions of each category or code (Evans 2013: 3). Most studies achieve saturation with between 8 and 24 interviews, depending on the topic. In evaluating the credibility of the theoretical sampling, it is important that the researcher understands that there is no definitive checklist for ensuring credibility and that theoretical sampling is different for every theory (Evans 2013: 3). Theoretical saturation is the point at which the researcher has reached the full extent of the data, and, for this reason, “sampling is over when the study is over” (Glaser 1992: 107).

In this study, theoretical sampling ended when no new information was obtained and no further categories emerged from the data. Keen (2013: 4) concurs that data collection should continue until the data collected ceases to inform the data categories and no further themes emerge. Hence, in this study, sample size was determined by theoretical saturation. Sampling is discontinued once a point of saturation has been reached, whereby categories and their properties are considered sufficiently dense and data collection no longer generates new leads (Glaser 1992:107). The criterion for ending data collection is when the properties of theoretical categories are saturated with data (Charmaz 2014: 213). This means that no new properties of these categories are found and that the established properties account for patterns in the data (Charmaz 2014: 213).

3.7.4 Sample size

In terms of obtaining a suitable sample size in GT, the grounded theorist does not decide on the size of the sample population before the study begins. Sample size is deemed to be satisfactory only when the key concepts that have been identified from the collected data have reached saturation point: in other words, when no new data emerges (Glaser and Strauss 1967: 61). These authors further state that in research carried out for discovering theory, the researcher cannot cite the number and types of groups from which he/she collected data until the research is complete. The basic criterion governing the selection of comparison groups for discovering theory is their theoretical relevance for furthering the development of emerging categories. The researcher chooses any group that will help generate, to the fullest extent, as many properties of the categories as possible and which will help relate categories to each other and their properties (Glaser and Strauss, 1967: 49). The final sample size comprised six NMs, two ANMs, five OMs, three FMs and two CEOs. The total sample size was 18 participants.

3.8 PRE-TESTING OF THE DATA COLLECTION TOOLS

Prior to the main study, a pre-test which is a small scale study, is done with a few participants from the study population (Brink, van der Walt and van Rensburg 2012: 174). Pre-testing of the interview guide was conducted with five NMs who fulfilled the inclusion criteria for the population. These participants were not included in the major study. The pre-test followed exactly the same process as the actual interviews. The pre-testing of the interview guide was conducted with the NMs in order to test adequacy of the interview guide, assess whether the research protocol was practical and feasible, and establish whether the sampling frame and techniques were effective (Brink, van der Walt and van Rensburg 2012: 175). The pre-test identified any unclear or ambiguous questions, as well as determined time limits and the clarity of instructions. The non-verbal behaviour of participants in the pilot study gave important information about any embarrassment or discomfort experienced concerning the questioning technique, content or wording of questions (Polit and Beck 2010: 563). Findings

from the pre-testing of the interview guide revealed that NMs answers were vague and they did not provide sufficient information for developing the competency framework. It was found from the data analysed that the NMs indicated that the financial management functions were done by the CEO and FM. This then guided the theoretical sampling that followed to include FMS and CEOs in the main study. One of the objectives of a pre-test is to test a researcher's instrument with the intention of improving the instrument before being used in the final data collection. If there is a change or improvement of the instrument, quality of data collected during pilot study and actual study is different and combining both the data can impact the outcome of the data analysis. For this reason the data gathered during the pre-test was not included in the actual study.

3.9 DATA COLLECTION METHODS

The GT approach allows concurrent data collection and analysis (Charmaz 2014: 22). Charmaz (2014: 23) cautions that the data collected should be assessed for relevancy, quality and quantity. Data collection in this study was done qualitatively using in-depth face-to-face interviews. The data collection and analysis for this study took place simultaneously and was guided by the GT approach. The data collection process was guided by theoretical sampling. In the beginning data was collected from the NMs and subsequently other relevant participants were involved.

3.9.1 Demographic survey

Prior to the interviews, all participants completed a demographic survey. The requested data included identification information: name of facility, age, and gender, length of service, employment history, qualifications and formal education level. This survey took approximately ten minutes to complete. The collection of this demographic data provided a basis to theoretically sample the respondent population. The collection of demographic data also enabled the comparative analysis of interview data between and against various demographics.

3.9.2 Interview method

One of the most widely used data collection techniques in GT is intensive interviewing which probes below the surface of everyday conversation and re-examines earlier events, views and feelings (Charmaz 2014: 56). This technique allowed the researcher to play an active role and to have an in-depth exploration of the topic and interpretation of the responses (Charmaz 2014: 58). Intensive interviews create and open an interactional space in which the participant can relate his or her own experiences. The focus is on research participants' statements about their experiences, how they portray this experience and what it means to them, as they indicate during the interview (Charmaz 2014: 58).

Bhattacharjee (2012: 78) finds interviews are a more personalised form of data collection method than questionnaires and are conducted by trained interviewers. The interviewer has the opportunity to clarify any issues raised by the respondent or ask probing or follow-up questions. However, interviews are time consuming and resource-intensive. Special interviewing competencies are needed on the part of the interviewer. The interviewer is also considered to be part of the measurement instrument, and must proactively strive not to artificially bias the observed responses (Bhattacharjee 2012: 78). In accordance with the methodological approach of constructivist paradigm, it is recommended that the interview processes be open-ended, informal and mutually constructed, to make certain that the required depth, richness and rigour is attained (Alemu, Stevens, Ross and Chandler 2015: 527).

3.9.3 Face-to-face interviews

Saunders, Lewis and Thornhill (2009: 320) espouse that the differentiation between types of interviews can be linked to the nature of interaction between the researcher and those who participate in this process. Interviews may be conducted on a one-to-one basis, between the interviewer and a single participant. Such interviews are most commonly conducted by meeting the

participant face-to-face, but there may be some situations where interviews are conducted by telephone or electronically via the internet or an organisation's intranet. In this study face-to-face interviews were conducted where the researcher met the participants individually in their own venues of choice (Saunders, Lewis and Thornhill 2009: 320).

The advantages of using semi-structured, face-to-face interviews provided the researcher with the opportunity to probe answers, or build on their responses (Saunders, Lewis and Thornhill 2009: 323). This was important as this study adopted a naturalistic research paradigm, where it was necessary to understand the meanings that participants ascribed to various phenomena. Interviewees also used words or expressed ideas in a particular way, and the opportunity to probe these meanings added significance and depth to the data obtained. This approach also led the discussion into areas that were not previously considered but which were significant in addressing the research question and objectives. This method also enabled the collection of rich and detailed data (Saunders, Lewis and Thornhill 2009: 324).

The significance of establishing personal contact was also important as Saunders, Lewis and Thornhill (2009: 323) found that managers were more likely to agree to be interviewed, rather than complete a questionnaire, especially where the interview topic is seen to be interesting and relevant to their current work. In this study the face-to-face interviews provided managers with an opportunity to reflect on events without needing to write anything down. This situation also provided the opportunity for interviewees to receive feedback and personal assurance about the way in which information would be used. The interview questions were of a sensitive nature and it was important to conduct face-to-face interviews to gain trust thereby achieving a higher response rate than using questionnaires (Saunders, Lewis and Thornhill 2009: 324).

3.9.4 Interview guide

A semi-structured interview guide was developed in order to explore the views of the participants. Charmaz (2014: 65) explains that only a few broad questions are required and open-ended questions invited detailed discussions of the topic under study. The questions were developed in accordance with the research objectives and research questions and to fit the participants experience (Charmaz 2014: 65). The interview guide document had two parts. The first part contained the acknowledgement of the interviewee and introduction of the research topic and objectives. The second part of the interview guide had open-ended questions to which follow-up questions were made by way of probing and prompting.

3.10 DATA COLLECTION PROCESS

The data collection process was similar for all participants with the interview guide being modified for each participant based on their positions, experiences and responses. The discussion below describes the processes that were used for data collection. Data collection initially began with the NMs. Following the results of the pilot studies, telephonic and electronic mail (e-mail) permission was secured to conduct interviews with ANMs, FMs, OMs and CEOs at the selected hospitals. Findings generated from the interviews contributed to the development of a financial management competency framework for NMs. The modifications or changes that were made are discussed in the sections pertaining to the relevant participants.

3.10.1 Preparation for the interviews

Charmaz (2014: 59) advocates that researchers learn about and be familiar with the situation they will enter before data collection begins. This aids in being confident of the procedural issues and enables the researcher to engage the research participants and guide the conversation. Prior to conducting the interviews, permission was obtained from the CEOs of the selected public hospitals. Participants were recruited by sending electronic mails (e-mails). The email addresses and contact details for all participants

were obtained from the office of the CEO of the relevant hospitals or through the KZN Department of Health website. Letters inviting people to participate, letters informing participants about the study, the informed consent, the approved research proposal, the approval letters from the study institution and research department of KZN Department of Health, permission letters from the CEOs, the interview guide and other relevant documentation was sent by e-mail with each recruitment of the participants as the study progressed.

As advocated by Elias and Theron (2012: 153), each potential participant was provided with a copy of a formal informed consent form explaining the purpose of the study, who conducted the research and the significance of the study. The principle of informed consent, autonomy and voluntary participation and the right to withdraw from the study at any time was emphasised. Participants were informed of the procedure that was followed when conducting the interview.

Participants were reassured of confidentiality and anonymity and that no individual names would be mentioned when results were published. Findings were disseminated through a research report. Details were provided on how to contact the researcher and supervisor in the case of any clarification needed on any aspect of the study. Based on the information provided, each potential participant decided whether they wished to participate in the study or not.

3.10.2 Conducting the interviews

Constructivist grounded theorists attend to the situation and construction of the interview, the construction of the research participants' stories and silences and the interviewer-participant relationship as well as the explicit content of the interview. A constructivist approach views interviews as emergent interactions in which social bonds may develop (Charmaz 2014: 91).

Once the participants indicated their willingness to participate in the study, an appointment was made with each of them to conduct the interviews at a date, time and a location of their preference. The interviews took place in the offices of the participants or the boardroom in some hospitals. The discussions of the interview sessions were recorded by way of taking notes and using an audio-recorder. The researcher secured permission from the study participants to audio-record the interview sessions in the consent letter which was signed prior to each interview. Utilising an audio-recording device ensured that participant responses to questions were accurately reflected in the data transcript and data analysis. Careful attention was paid to language, tone, verbal and non-verbal cues and expressions and these were noted consistent with the constructivist GT approach (Charmaz 2014: 91). Additional notes were made regarding the place of discussion, situational characteristics and events associated with the interview. These were included when presenting the findings of the study. Research participants were afforded the opportunity to read all interview transcripts and provide the researcher with any further clarification prior to publication (Saunders, Lewis and Thornhill 2009: 204). The interviewer maintained an atmosphere of respect, trust and openness throughout the interview.

The data was collected using semi-structured interviews and was qualitatively factual, to establish what were the financial roles of NMs in the hospital and the training needs with respect to financial management competencies of NMs. The participants could choose to terminate the interview at any time but each interview finished when the participants indicated that they had nothing more to contribute. Interviews of each participant took place only once even though the opportunity existed to have second or subsequent interviews to further explore their perspectives on the findings that may have emerged from the interview process and to allow for clarification. All participants consented to follow-up interviews and their contact information was confirmed at the end of the interview. As interviews progressed they were guided more specifically by emerging theoretical leads. Early interviews generated an interim set of codes and categories, identifying several provisional leads to follow-up in further data collection.

3.10.2.1 Data collection: Nurse Managers

Once the NMs indicated their willingness to participate in the study, an appointment was made with each NM to conduct the interviews at a date, time and a location of their preference. The interviews took place in the offices of NMs or the boardroom in some hospitals. After the formalities, the NMs were handed the letter informing them of the study which they were allowed to read. The interview guide was sent to them previously and was handed to them again to peruse prior to the commencement of the interviews. The demographic questionnaires and consent forms were completed and collected before the interviews began. The interview guide that was constructed at the beginning the study was used initially. In-depth interviews at this phase were informed by the concepts, categories and propositional statements that emerged. Influenced by codes and categories developed for previous interviews, further probing was done with subsequent interviews to obtain in depth information. For this reason, two sets of interview questions are shown in the appendices: Appendix 6a – Interview questions November 2017, and Appendix 7 – Interview questions December 2017. The second set of questions was guided by Charmaz's approach to GT, particularly her chapter on how to phrase interview questions to allow respondents to express their views without constraints (Charmaz 2014: 58).

It was anticipated that at least 10 to 20 NMs would be recruited for the study. However, data saturation was reached after the sixth interview. Polit and Beck (2010: 321) find that there are no rules for sample size in qualitative research as sample size is usually determined based on informational needs. The guiding principle in sampling is data saturation, that is, sampling to the point at which no new information is obtained and redundancy is achieved. The number of participants needed to reach saturation depends on a number of factors. Data quality can also affect sample size. If participants are good informants who are able to reflect on their experiences and communicate effectively, saturation can be achieved with a relatively small sample (Polit and Beck 2010: 321). Furthermore, the application of qualitative rigour provided a surplus of primary data and did not require further interviews of

more NMs in order to develop a framework. Consequently, the researcher focused on the six interviews and that of the participants as guided by theoretical sampling. Interviews lasted one hour to two hours.

3.10.2.2 Data collection: Financial Managers

It became apparent during the interviews with NMs that the FMs worked very closely with them and handled financial matters in the hospitals. In response to some questions such as what are the financial management activities that NMs are involved in, several references were made that the question should be directed to the FM who will be best able to provide the answers.

The FMs were interviewed using the same semi-structured interview guide that was developed for NMs with a few modifications and based on the research questions. Only three FMs responded and all three were interviewed. Attempts to interview more FMs yielded no responses. The interviews took place in the offices the FMs. The interviews lasted between one and two hours each. Sufficient information was gathered from the three FMs as the procedures and processes were similar in all hospitals. Analysis of the data found that no new information emerged with each interview.

3.10.2.3 Data collection: Chief Executive Officers

During the interviews with the FMs and NMs, it was often quoted that the CEO is the accounting officer and maintains responsibility and accountability for all financial management activities and processes within the hospitals. The CEO also supervises the NM and is the person to whom the NM is accountable for the performance and financial management activities of the nursing section. As indicated by the naturalistic paradigm chosen for this study, it was important to obtain multiple perspectives and multiple realities on the research phenomenon. Two CEOs responded to the request and agreed to participate in the study. Further requests to conduct interviews with additional CEOs met with no responses. The interviews were conducted in the office of the CEOs

and lasted between one and two hours. An interview guide was used to collect data (Appendix 8).

Two questions of the semi-structured interview guide developed for NMs were used to obtain the views of the CEOs. The questions were (1) what are the financial management roles and activities in the hospital? and (2) what are the financial management developmental needs of NMs? Follow-up questions were formulated and asked based on the responses of the CEOs. Incidentally both CEOs were former nurses and added valuable perspectives and first-hand experience to the research phenomenon. Analysis of the data after each CEO interview revealed that the financial management roles of the NMs were the same in each hospital and no new information emerged with each interview.

3.10.2.4 Data collection: Assistant Nurse Managers and Operational Managers

The analysis of the interviews of the NMs, FMs and CEOs pointed out that the ANMs and OM s functioned at operational level and were most closely associated with the financial management of each department. Permission was granted by the CEOs and NMs to conduct interviews with the ANMs and OM s. The NM interview guide was used to obtain the views of the OM s and ANMs with regard to their financial management roles, activities and developmental needs (Appendix 6a). A total of five OM s and two ANMs were interviewed in their own offices or the boardroom of the hospitals. Attempts to recruit further ANMs met with no response as many cited they had work commitments or had no interest in the study as they felt they did not play a role in financial management. The purpose and objectives of the research was explained but that did not change their minds. Data saturation was reached after conducting interviews with five OM s as no new information was emerging. The two ANMs were interviewed and the views expressed were similar.

3.11 DATA ANALYSIS

3.11.1 Analysis of data from interviews

In accordance with the GT method, data collection and analysis were done simultaneously. Interviews were transcribed word for word from the audio-recorders within 24 hours of the interviews. The interviews were replayed to ensure accurate transcriptions of the interviews. This approach allowed the researcher to become fully immersed in the data. The audio-recorded transcriptions were further reviewed, identifying wording which correlated to the research questions. Memo writing and comparative analysis were done throughout the study and also assisted the process of open, focused and theoretical coding as suggested by Charmaz (2006: 47).

3.11.2 Memo writing

Memos were written throughout to keep track of thoughts and ideas regarding the data analysis. Memo writing provided the freedom to write down ideas so that these could be sorted, categorised or discarded at some later time (Appendix 11). The writing and reflecting on memos was a crucial step in the development of the final categories based on initial and focused codes (Sbaraini *et al.* 2011: 128).

3.11.3 Constant comparison

The constant comparative method of GT means (a) comparing data from different people (such as their views, situations, actions, accounts, and experiences), (b) comparing data from the same individuals with themselves at different points in time, (c) comparing incident with incident, (d) comparing data with category, and comparing a category with other categories (Charmaz 2006: 259). In this study, the constant comparison method of data analysis was achieved by constantly comparing new information with previously identified information. The constant comparative method allowed for any newly collected data to be compared with previous data that was collected in earlier interviews and helped identify information that was repeatedly present

and relevant to participants. Generating codes enabled the process of making comparisons (Charmaz 2006: 259). The coding process discussed below followed Charmaz's (2014:116-150) techniques of open coding to discover categories, focused coding to further develop and relate the categories, and theoretical coding to integrate and refine the theory.

3.11.4 Open coding

Charmaz (2014: 116) refers to open coding as initial coding which points out that the identified concepts are grounded on the data and the goal is to remain open to all possible theoretical directions and any new concepts indicated by the readings of the data. In initial or open coding, line-by-line analysis was done. After assessing which initial codes appeared most frequently, codes were applied to large amounts of data during a second stage of focused coding. Different categories, concepts or codes were developed from the data that emerged from the study. This process continued as data was collected (Appendix 10).

3.11.5 Focused coding

Focused coding means using the most significant data and/ or frequent earlier codes to sift through large amounts of data (Charmaz 2014: 140). Upon completion of the open coding stage, focused coding of codes and concepts were employed to identify emerging core categories (Charmaz 2014: 140). By comparison, line-by-line coding of field notes was done to stay focused on what patterns emerged and focus on what was important and relevant data.

3.11.6 Theoretical coding

Theoretical coding, the last stage of coding, enabled the saturation of the core categories identified during focused coding. The use of memos and constant comparison between focused codes were important for theoretical coding. During each of these refinement and saturation processes, the analysis moved from mere description to conceptualisation (Charmaz 2014: 150).

Emergent concepts were compared to each other with the purpose of establishing the framework.

3.12 MEASURES TO ENSURE RIGOUR AND TRUSTWORTHINESS OF THE STUDY

Lincoln and Guba (1985: 294) describe trustworthiness as the honesty of data collected from or about the participants. Krefting (1991: 214) confirms that a research project is trustworthy when it reflects the reality and ideas of the participants. Merriam (2009: 209) adds that the research study is trustworthy when there is evidence of rigour in executing the study. Rigour refers to the principle of truth value of the research outcome (Brink, van der Walt and van Rensburg 2012: 97). Rigour is described as involving discipline, focus on detail and scrupulous accurateness in order to aim for excellence in research (Burns and Grove 2011: 39). Rigour refers to the fundamental characteristics of and is emphasised in all the steps of the research process and requires a critical analysis of each step (Brink, van der Walt and van Rensburg 2012: 97). Lincoln and Guba (1985: 294-316) recommend four concepts that increase the conceptual soundness and trustworthiness of findings namely, credibility, transferability, dependability and confirmability. Similar criteria for evaluating GT studies as proposed by Charmaz (2014: 337) include credibility, originality, resonance and usefulness. These criteria accounted for the empirical study and the development of the theory.

3.12.1 Credibility

Credibility involves developing intimate familiarity with the context and focus of the study and engaging in evidence-based procedures of analysis after appropriate data are collected (Priya and Dalal 2015: 69). The sampling strategy adopted for research as well as the analysis process must be explained in detail (Priya and Dalal 2015: 70).

Charmaz (2014: 337) provides the following criteria for evaluating credibility:

- Has the researcher achieved intimate familiarity with the setting or topic?
- Is the data sufficient to merit the claims? Consider the range, number and depth of observations contained in the data.
- Have you made systematic comparisons between observations and between categories?
- Do the categories cover a wide range of empirical observations?
- Are there strong logical links between the gathered data and the argument and analysis?
- Has the research provided enough evidence for your claims to allow the reader to form an independent assessment and agree with the claims?

Credibility was enhanced in several ways in this study. Ensuring that researcher achieved intimate familiarity with the setting or topic was through immersion in the data. To ensure that data was sufficient to merit the claims, data was collected from a number of NMs from different public hospitals with diverse experiences within the nursing profession. Field notes were generated on site during observation to ensure that the researcher recorded the observed information and incidences while still fresh in her mind.

Credibility was enhanced by gathering rich data and seeking depth and variation in the data. Systematic comparisons were made between observations and between categories throughout the study (Charmaz 2014: 337). In order to demonstrate the links between the gathered data and final framework that was developed, extracts from the interviews and insight into the data that informed the development of each of the categories were provided. Interviews, journals, field notes and memos were transcribed verbatim. Staying close to the data by initial, line-by-line coding, facilitated the construction of a framework that reflected the participants' experience (Charmaz 2014: 337). The researcher ensured credibility of data by recording all the interviews with the study participants and using their direct quotations and narratives during data reporting. The extracts allow the reader the chance to form an independent assessment of the study. Keeping raw data, field

notes and memos, provided an audit trail of the various steps, from the raw data to analysis and interpretation of findings (Charmaz 2014: 337).

3.12.2 Originality

Originality addresses the concern about whether the study has helped develop new insights about the phenomena (Priya 2013: 4). It also asks whether the findings challenge, extend, or refine current ideas, concepts, and practices (Charmaz 2006: 182).

The criteria for evaluating originality as proposed by Charmaz (2014: 337) include:

- Are the categories fresh?
- Do they offer new insights?
- Does the analysis provide a new conceptual rendering of the data?
- What is the social and theoretical significance of this work?
- How does your GT challenge, extend, or refine current ideas, concepts and practices?

As there is limited knowledge and information of the financial management competencies and developmental needs of NMs, the categories that were presented in the study report were original and offered new insights into the topic (Charmaz 2014: 337). Most of the studies previously undertaken investigated the management and leadership competencies of NMs, while this study provided an original approach that focused primarily on the financial management competencies (Charmaz 2014: 337). The analysis of the data provided a conceptual rendering of the financial management competencies and developmental needs of NMs in a regional context. Through attaining a better understanding of the financial management competencies and developmental needs of NMs, it was possible to address the issues that contribute to the poor financial management competencies of NMs (Charmaz 2014: 337).

3.12.3 Resonance

Resonance is the concern that the findings should depict the lived experiences of participants and asks whether the findings make sense to the participants themselves (Priya 2013: 4).

The criteria for evaluating resonance as proposed by Charmaz (2014: 337) are as follows:

- Do the categories portray the fullness of the studied experience?
- Have you revealed both liminal and unstable taken-for-granted meanings?
- Have you drawn links between larger collectivities or institutions and individual lives, when the data so indicate?
- Does GT make sense to your participants or people who share their circumstances?
- Does your analysis offer them deeper insights about their lives and worlds?

The resonance of this study was demonstrated through the categories that emerged and the concepts associated with these categories that depicted the views of NMs regarding their financial management competencies and developmental needs. The study revealed that meanings that are taken-for-granted exist in the nursing profession as NMs related their experiences (Charmaz 2014: 337). The work conceptualised and conveyed what is meaningful about the NMs experiences regarding financial management from the perspective of NMs and will make a contribution to the knowledge of this subject (Charmaz 2014: 337). Links were made with the individual experiences of NMs and the wider literature that relates to financial management competencies and the recommendations to improve and enhance these competencies (Charmaz 2014: 337). The study provides the reader with a deeper understanding of the what the financial management roles of NMs are, what competencies they possess and what their developmental needs are (Charmaz 2014: 337).

3.12.4 Usefulness

Usefulness is concerned with the contributions a study has made to the domain of knowledge that may be used by researchers as well as laypersons. The researchers' reflection on wider implications of their findings aids the process of synthesising findings of research conducted in the domain (Priya 2013: 3).

Charmaz (2014: 338) proposes the following criteria for evaluating usefulness:

- Does the analysis offer interpretations that people can use in their everyday worlds?
- Do the analytic categories suggest any generic processes?
- If so, have these generic processes been examined for tacit implications?
- Can the analysis spark further research in other substantive areas?
- How does your work contribute to knowledge? How does it contribute to making a better world?

The analysis presented a framework that the nursing profession and academia can use in an effort to improve the financial management competencies of nurses. The interpretation offered through this study will allow for the revision and integration of financial management into nursing curricula. The analytic categories that were developed in this study suggest generic processes that apply to all NMs and nurses in general (Charmaz 2014: 338). The analysis of the data revealed a number of unspoken implications that were inherent in the generic processes. This study has the possibility to contribute to nursing education as it provides an insight into the issues around financial management competencies and experiences of NMs (Charmaz 2014: 338). This motivates the need for greater attention to be paid to the financial management competencies of nurses. This study will help nurses who aspire to be NMs to have a better idea of what to expect in this role so that they can prepare themselves educationally (Charmaz 2014: 338).

3.13 ETHICAL CONSIDERATIONS

De Vos, Strydom, Fouché and Delport (2011: 114) define ethics in research as “a set of moral principles which is suggested by an individual or group, is subsequently widely accepted, and which offer rules and behavioural expectations about the most correct conduct towards experimental subjects and participants, employers, sponsors, other researchers, assistants and students”.

3.13.1 Obtaining permission to conduct the study

Ethics clearance was granted by the research committee of the study institution (Appendix 1). The study proposal, ethics clearance, letters outlining the purpose of the study and objectives, data collection process as well as the ethical considerations like anonymity, confidentiality, privacy that would be adhered to, was included when sending permission letters to collect data to all District Managers, hospital CEOs, NMs and the KZN Department of Health Research and Knowledge Management. Letters were sent to all 11 Health District Managers in the KZN province, in August 2017 to obtain permission to conduct the study in the hospitals that met the study criteria in each health district (Appendix 3a). Permission was granted by 8 of the 11 health districts (Appendices 3b, 3c, 3d, 3e, 3f, 3g, 3h, 3i). Once the District Managers permission was obtained, letters were sent to the CEOs of the 32 hospitals to obtain permission to conduct the study (Appendix 4a). A total of 11 of the 32 hospital CEOs granted permission to conduct the study (Appendices 4b, 4c, 4d, 4e, 4f, 4g, 4h, 4i, 4j, 4k, 4l). Prior to commencement of the study, permission must be granted by the KZN Department of Health Research and Knowledge Management. This approval is only granted once all gatekeepers' permissions are obtained. The procedure is to submit all gatekeepers' approval letters, as in this study, would be the permission letters from the District Managers and hospital CEOs, to the KZN Department of Health Research and Knowledge Management. While awaiting further permission letters from the hospitals and District Managers, the KZN Department of Health Research and Knowledge Management was contacted to obtain

information on the research approval process (Appendix 2a). It was indicated that there was no need for the gatekeepers' permissions as the KZN Department of Health Research and Knowledge Management, Circular 14/6 of 2008, states the granting of permission to conduct the study is approved by this department if all districts are used (KwaZulu, Natal Department of Health 2008:2). Permission was granted overall by the KZN Department of Health Research and Knowledge Management to conduct the study at all 32 hospitals in all eleven districts (Appendix 2 b). This approval superseded all the district and hospital approvals. As the study used a grounded theory approach, this approval letter also covered the permission to include the additional participants as required. This permission letter was then used to collect data.

The approval letter from the KZN Department of Health Research and Knowledge Management was sent to all District Managers and Hospital CEOs to inform them that permission has been granted to conduct research in their respective hospitals and health districts. It is noted that not all CEOs gave permission to conduct the study in writing. Some permission to collect data was granted over the telephone or via e-mail.

3.13.2 Ethical principles

Ethical principles provide a generalised framework within which particular ethical dilemmas may be analysed (Polit and Beck 2008:120). This study was guided by the ethical principles of beneficence, non-maleficence, the right to self-determination, the right to full disclosure and informed consent, the right to fair treatment and the right to anonymity and confidentiality.

3.13.2.1 Principle of beneficence

Beneficence means 'doing good' (Jooste 2009: 272). The benefits and risks of the study were communicated to participants prior to the study in the form of a letter (Appendix 5a) and explained by the researcher prior to the commencement of the study. No foreseeable risks were associated with the

study. The researcher did not cause subjects undue harm through asking intrusive and sensitive questions and did not use the information gained against participants. The questions were carefully constructed to avoid intrusion of participants' privacy. Participants were provided with the researcher's and study supervisor's contact numbers to allow contact in case the participants had any questions after the data collection. The participants were informed that they could withdraw from the study at any time if they felt uncomfortable with the questions or did not wish to continue, without any penalty.

3.13.2.2 Principle of non-maleficence

The ethical principle of non-maleficence prohibits incurring deliberate harm and demands (Jooste 2009: 272). The participants were not forced to participate in the study. They could withdraw from the study at any time with no consequences. The participants were interviewed in a venue that was comfortable and secure. They were informed that they were free to not answer any questions that caused them discomfort (Appendix 5a). The participants did not verbalise any discomfort with the questions asked and participated until the termination of each interview.

3.13.2.3 The right to self-determination

Self-determination means that prospective participants should not be pressurised into taking part in the study. Participants have the right to decide whether to participate without incurring any penalty (Polit and Beck 2008: 171). Participants had the right to decide voluntarily whether to participate in a study without risking any penalty or prejudicial treatment (Polit and Beck 2008: 171). They also had the right to ask questions, to refuse to disclose information and to withdraw from the study. No participant was forced to participate in the study and participation was totally voluntary (Appendix 5a).

3.13.2.4 The right to full disclosure and informed consent

The researcher explained the nature of the study, the purpose, the type of data to be collected and data collection method to the participants in the form of a letter and prior to conduction of each interview. Participants were informed of their right to refuse participation as this is necessary to make informed, voluntary decisions about participation (Polit and Beck 2008: 172). The participants were handed information letters and consent forms, which the researcher collected prior to the study (Appendices 5a and 5b).

3.13.2.5 The right to fair treatment

According to Polit and Beck (2008: 173, 174), the right to fair treatment is concerned with the equitable distribution of benefits and burdens of research. In this study the researcher selected participants based on the research requirements, not on the vulnerability or compromised position of certain people. NMs that refused to participate by not giving written consent were not treated with prejudice. The researcher demonstrated sensitivity and afforded participants courteous and tactful treatment at all times.

3.13.2.6 The right to anonymity and confidentiality

Anonymity occurs when even the researcher cannot link participants to their data. A promise of confidentiality is a guarantee that any information participants provide will not be publicly reported in a manner that identifies them and will not be made available to others unless permission to do so has been given (Polit and Beck 2008: 171). In this study, no names were disclosed when publishing the findings. The researcher only had access to the research instruments. Anonymity in this study was also adhered to by not attaching names to the interview data; a numerical number was given to each participant (Polit and Beck 2008: 180). To maintain confidentiality questionnaires, audio recordings, transcribed interviews and field notes were locked away in a safe place and will be destroyed after a period of five years.

3.13.3 Elimination of bias

Bias was eliminated from the study by using gender neutral words, not identifying people by race or ethnic group, avoiding language that suggested stereotypes and by not making assumptions about various age groups. Data collection occurred through interviews with the participants, observations, and memos or notes made during the study. The interview process affects the data gathered because as the researcher collects the data, the participant may be answering only as the researcher would like him/her to answer. One way to deal with interviewer bias is to have a third neutral party conduct the interview, but that has the potential to lose the human interaction between researcher and participant (Saunders, Lewis and Thornhill 2009: 335). For this study, the researcher was the interviewer; the bias is accepted to be nominal from the research questions being asked.

3.14 SUMMARY OF THE CHAPTER

This chapter has explained the research methodology, including population, sampling, data collection methods and ethical considerations. In order to understand what financial competencies NMs have and what their developmental needs are, constructivist GT was considered to be a suitable method. This research adopted an inductive approach where concepts and categories were developed from empirical data collected using face-to-face in-depth interviews. Data collection and analysis was done concurrently, and a theory emerged that led to the development of a framework. Chapter 4 presents the study findings.

CHAPTER 4: PRESENTATION OF RESULTS

4.1 INTRODUCTION

The research methodology was discussed in Chapter 3. In this chapter the findings of the study are presented. In GT, the theory develops from the data as it is collected and analysed. The analysis of data commences from the beginning of data collection and continues until the study is completed. The method of analysis used for this study was thematic content analysis. This involved analysing transcripts and identifying themes within the interview data. Following the constant comparison analysis method of GT, the codes and concepts identified in the initial coding analysis were developed and cross-referenced. This chapter first presents a description of the sample and then a presentation of the findings. Data collection involved face-to-face interviews in which participants were asked to reflect on the financial management roles and responsibilities of NMs and the financial management development needs. Insightful probing was done throughout the interviews to extract rich details regarding each NMs financial management experiences.

4.2 SAMPLE REALISATION

The study sites, number of interviews and participants are discussed in the ensuing sections.

4.2.1 Study sites

Permission to conduct the study in all 32 hospitals and 11 health districts in KZN was granted by the KZN Department of Health Research and Knowledge Management. Letters were sent to the NM and CEO of each hospital requesting participation in the study. The responses were very poor and weekly letters were sent requesting permission to conduct interviews with the NMs. Some NMs responded indicating their non-willingness to participate and some provided reasons such as workload commitments and consequently

would not be able to grant an interview. There were no responses from some hospitals. Persistent reminders resulted in NMs of 9 hospitals in KZN consenting to participate in the study. On the day of the interviews, the NMs were not available at three hospitals and attempts to schedule another interview with all three were not successful. This resulted in NMs of only six hospitals being interviewed. It was interesting to note that many NMs that were contacted to participate indicated disinterest as they were of the opinion that this study was not relevant to them because they were not involved in the financial management of the hospital and saw no value in participating in the study. Once the study had progressed and data was analysed, the researcher contacted these NMs to explain how they fitted into the financial management role. The NMs persisted and refused to participate in the study. For these reasons, interviews were conducted in eight hospitals. These were regional and district hospitals selected for the study from the 11 health districts in KZN. Two hospitals were from the uGu District, one from uMgungundlovu District, three from the eThekweni District, one from the Sisonke District and one from uThukela District. For anonymity and confidentiality purposes the names of the participating hospitals were not revealed. Codes were allocated to each hospital as presented in Table 4.1.

4.2.2 Participants

The prime feature of GT designs is theoretical sampling and constant comparison of data with emerging theory. Theoretical sampling indicates that the selection of participants is directed by the data analysis and the information as it emerges (Charmaz 2008: 133). The interviews commenced with a focused sample of NMs that were overall in charge of the nursing section and had a financial management role in the public hospitals. The NMs of all 32 hospitals were invited to participate in the study. The NMs from each institution who indicated their willingness to participate in the study and met the inclusion criteria were selected and interviewed. As is the case with GT, data analysis commenced immediately after each interview. After four interviews and as data emerged, it became apparent that there were other role players in the hospital that were also involved in financial management

together with the NM. There was value in including these participants as they could provide an added perspective to the study in view of their experiences. The study sample proceeded to include ANMs, FMs, OMs and CEOs. Interviews continued with two more NMs and after six interviews, data saturation with the NMs was reached as no new information emerged.

Data collection proceeded to include the FMs and CEOs. An invitation to participate in the study was sent to FMs and CEOs of the 32 hospitals. Only two CEOs responded and agreed to participate in the study. Analysis of the data after each CEO interview revealed that the financial management roles of the NMs were the same in each hospital. Further requests to conduct interviews with additional CEOs met with no responses. After conducting two interviews with the FMs and analysing the data, it was apparent that the financial management role also extended to the OMs and ANMs of the hospitals. A third interview was conducted with one more FM. No new information emerged and data collection proceeded to include the OMs and ANMs. A request for participation of the ANMs and OMs was sent to the NMs and CEOs of all 32 hospitals. The OMs of only three hospitals agreed to participate. After five interviews with the OMs data saturation was reached as no relevant and new information emerged.

The ANMs of only two hospitals participated in the study. The additional ANMs that had agreed to participate in the study was either unavailable on the day of the scheduled interviews or withdrew from the study. Persistent attempts to recruit further ANMs to participate in the study in all 32 hospitals yielded no responses. The information received from the two ANMs were the same and no new information was gathered from each interview. Data saturation was reached after conducting interviews with 18 participants. Confidentiality and anonymity were protected through use of a system of participant coding. The names and identities of the participants were not revealed and each participant was allotted a code. Table 4.1 presents the sample realisation for the entire study.

Table 4.1: Presentation of sample realisation for the entire study (n=18)

Health District	Hospital codes	Number of interviews and participant codes									
		NM	CODE	ANM	CODE	FM	CODE	OM	CODE	CEO	CODE
UGu	H 1	1	NM 1			1	FM 1				
	H 2	1	NM 2			1	FM 2				
EThekwini	H 3	1	NM 3								
	H 4	0		1	ANM 1			1	OM 1	1	CEO 1
	H 5	1	NM 4					2	OM 2 OM 3		
UThukela	H 6	1	NM 5			1	FM 3				
UMgungundlovu	H 7	1	NM 6	1	ANM 2			2	OM 4 OM 5		
Sisonke	H 8									1	CEO 2
Totals=5 health districts	8	6		2		3		5		2	

4.2.3 Number of interviews

The number of interviews conducted was guided by data saturation. A total of 18 interviews were recorded in the eight hospitals. A purposive sample of six NMs, two ANMs, five OM, three FM and two CEOs working in the eight public hospitals participated in the study. The number of interviews conducted was guided by data saturation. The interviews were conducted over a period of 12 weeks. Table 4.1 presents the number of interviews conducted for the study.

4.3 DEMOGRAPHIC DATA FOR ALL GROUPS OF PARTICIPANTS

The sample included n=14 (77%) females and n=4 (33%) males. The NMs, ANMs and OM ages ranged between 44 and 58 years of age. The majority (92%) were 50 years and older while n=1 (8%) OM was under 50 years old. The age of FM ranged between 35-43 years old, while the CEOs were between 44 and 50 years old. Of the 13 NMs, ANMs and OM who participated in the study, n=12 (92%) of the participants had 25 years and more experience in nursing while n=1 (8%) had 16 years of nursing experience. Experience in the NM role ranged from 3 years to 17 years with n=8 (61%) of the NMs and OM having 10 years and more management

experience in their current position, while n=5 (39%) had between 3 and 6 years of experience. The FMs had between 4 and 13 years of experience, while the CEOs had one and a half to 12 years of experience in their current positions. This fits the requirement of the inclusion criteria for the sample where participants had to be employed for more than a year in their current position. The demographic characteristics of the sample are presented in Table 4.2.

Table 4.2: Demographic characteristics of study sample (n=18)

Participant	Gender	Age	Experience in Nursing (Years)	Experience in current position (Years)
NM 1	Female	56	25	6
NM 2	Female	54	33	17
NM 3	Female	52	29	13
NM 4	Female	56	34	12
NM 5	Male	50	28	12
NM 6	Female	51	25	13
ANM 1	Female	53	28	6
ANM 2	Female	58	38	13
OM 1	Female	57	36	4
OM 2	Male	44	16	6
OM 3	Female	55	32	10
OM 4	Female	55	31	13
OM 5	Female	54	30	3
FM 1	Female	38	Not applicable	13
FM 2	Male	35	Not applicable	4
FM 3	Male	43	Not applicable	4
CEO 1	Female	50	Not applicable	12
CEO 2	Female	44	Not applicable	1.5

All (100%) of the NMs and OM s had a basic education and entered the profession with an entry level diploma in basic nursing and midwifery. Only n=6 (46%) of the NMs and OM s had a post graduate Bachelor's degree in nursing. The majority of n=12 (92%) of the NMs held a clinical specialty certification in nursing (Critical Care Nursing Science, Orthopaedic Nursing Science, Operating Theatre Nursing Science, Psychiatric Nursing Science, Community Health Nursing Science Occupational Health Nursing Science, Primary Health Care Nursing Science and Nursing Education). A total of n=11

(61%) of the NMs, OM and CEOs held a certification in Nursing Administration or Health Services Management. None of the NMs had a qualification in Business Administration or Financial Management. All n=3 (100%) FMs had a financial degree qualification. Both CEOs interviewed were formerly nurses. One CEO had a Master's in Business Administration degree. The other CEO was qualified as a medical doctor and has a Diploma in Healthcare Management. The participants' qualifications are depicted in Table 4.3.

Table 4.3: Participants' qualifications (n=18)

Qualification	NM	ANM	OM	FM	CEO	Total
Diploma in Nursing and Midwifery	6	2	5		2	15
Bachelor's Degree in Nursing	4		1		1	6
Diploma in Operating Theatre Nursing Science	2	1				3
Diploma in Psychiatric Nursing Science	1		2		1	4
Diploma in Community Health Nursing Science	3		1		1	5
Diploma in Orthopaedic Nursing Science	1		1			2
Diploma in Critical Care Nursing Science	1		1			2
Diploma in Nursing Education	4				1	5
Diploma in Nursing Administration/ Health Services Management	6	1	2		2	11
Diploma in Primary Health Care	2					2
Master's in Business Administration					1	1
Bachelor of Commerce Degree				3		3
Medical Degree					1	1

4.4 PRESENTATION OF FINDINGS

The research question and sub-questions that were included in the interview guide allowed the exploration of the financial management experiences and development needs of the NMs. Initial interview questions were formulated from the literature review and from the observations of the researcher of the NMs financial management roles and responsibilities in the public sector. It is vital in GT that the researcher becomes immersed in the data from the beginning of data collection (Strauss and Corbin 1998: 295). Hence, data analysis commenced after the first interview and additional questions that

were asked during subsequent interviews were guided by the analysis of each interview.

The functions of management include “planning, organising, leading and control take place at various levels in an organisation and are applied to various focus areas such as finances, human resources, facilities, equipment and supplies, and service deliveries” (Smit, Cronje , Brevis and Vrba 2007: 406). These management functions will now be discussed in terms of financial management. Booyens, Jooste and Sibiya (2016: 11) confirm that the nursing units’ objectives can be achieved by employing the management activities of planning, organising, staffing, directing and controlling.

Analysis of the interview transcripts yielded eight major themes. The themes that emerged in this chapter echo the participants’ experiences of their financial management roles and responsibilities and their developmental needs. The identification of each theme and the sub-theme was constructed from the raw data of the participants’ responses. The main themes and sub-themes that emerged following the process of data analysis will be discussed in relation to the research objectives in the subsequent sections. The presentation of the results is guided by the research objectives set out in Chapter 1. The objectives were to:

1. Explore the current roles of the NM with regard to financial management practice in public health care organisations.
2. Determine the financial management competencies that NMs in public health care organisations currently possess.
3. Explore the training and educational qualifications NMs have with respect to financial management.
4. Establish the essential financial management development needs of NMs in public health care organisations.
5. Develop a financial management competency framework for NMs.

4.4.1 Findings related to Objective 1

The first research objective explored the financial management roles and responsibilities of the NMs, as well as the financial activities that they practice in their current positions. It was important to understand and obtain information from NMs regarding which financial management activities they perform regularly. The major themes and sub-themes that emerged from the responses regarding the financial management roles of NMS in the healthcare organisations is presented and discussed below.

4.4.1.1 Theme 1: Financial planning

One major theme identified with respect to the financial management role of the NM was that of financial planning. The participants reported performing several activities or functions that involved planning. On analysis of these functions, it was apparent that all pertained to financial activities of the organisation. These activities emerged as sub-themes and were then collated to form the broad theme of financial planning. The sub-themes are strategic planning, operational planning, procurement planning, human resource planning and budget structuring and formulation. The themes and sub-themes are presented in Table 4.4 below.

Table 4.4: Theme 1: Financial planning

Theme	Sub-themes
Theme 1: Financial planning	Sub-theme 1.1: Strategic planning
	Sub-theme 1.2: Operational planning
	Sub-theme 1.3: Procurement planning
	Sub-theme 1.4: Human Resource planning
	Sub-theme 1.5: Budget planning

Sub-theme 1.1: Strategic planning

One of the financial management roles of NMs was participation in the strategic management process of the organisation. The participants indicated that they were included in the strategic planning of the hospitals. The findings

revealed that NMs at all three levels namely, top, middle and operational level were involved in strategic planning.

One of the participants confirmed involvement in the strategic plan stated:

“...we attend strategic management workshops and we participate in the planning for the next 2 years based on the budget we have.” (OM 2)

Participation and involvement in strategic planning was further confirmed by a participant as follows:

“...we participate in strategic planning which will be aligned with the Provincial Strategic Plan.” (NM 2)

One of the CEOs further elucidated the role of the NMs in strategic planning as noted in the excerpt below:

“...NMs draw up the procurement plan which is based on the strategic plan in which they participate and the gaps they have identified and involves the total plan.” (CEO 1)

Sub-theme 1.2: Operational planning

NMs are involved in business planning or operational planning. One of the NMs explained her role in operational planning as follows:

“...we also do our business plans. We also involve the OMs and ANMs when doing this every year. The OMs and ANMs, we do it together and then I sit with each component before the plan is forwarded to Supply Chain Management.” (NM 1)

One of the FMs confirmed the NMs role in operational planning by saying:

“...financial management activities of the NM starts with the budgeting, making sure that we do have funds for the activities that we said we are going to do in terms of our operational plans. The operational plan involves all other relevant stakeholders within the hospital. We convert the operational plans to budget. This means that all the activities performed and required resources are financed from the budget. Operational plans and budget are aligned. We start from there. Whatever is financed is based on the planning by NMs. They are responsible for drawing up business or procurement plans.” (FM 2)

One FM further elaborated that the operational plans are collated by the respective managers and presented to the finance department as pointed out in the following excerpt:

“...all operational plans from the different nursing departments are received by the NM. Thereafter all operational plans are consolidated into one operational plan for the entire hospital. It is the NM, for example, from the nursing perspective. The Exco is made up of FM, NM, CEO, Medical Manager, Assistant Financial Manager, and Human Resource Manager. All these managers collect operational plans from their different units and consolidate and present to finance.” (FM 2)

The involvement in operational planning and consolidation of operational plans by NMs was verified by one CEO in the following excerpt:

“...around September, we start with our business planning. The business plan will inform the procurement plan for the following year. The business plan is inclusive of the operational plans which tell us our activities for the following financial year. That is how the procurement plan comes up. Remember the procurement plan is based on the strategic plan and the gaps, the total plan. The NM supervises different wards. The business plan comes from the various wards. Those are the ones that will inform our procurement plan. The role of the NM is to ensure that the business plan is formulated and consolidated as a plan and submitted as a plan that comes from the nursing management section. At the same time, she is supposed to make sure that the process is started.” (CEO 1)

OMs confirmed their participation in drawing up the operational plans for their units. One of the OMs also assisted the NM in drawing up the operational plans as indicated as can be seen from the following excerpt:

“...I assist the NM in drawing up the business plan and procurement plan. I base it on the needs for my department for the next financial year. We don't know the budget as it goes into the big procurement plan for the hospital.” (OM 1)

Another OM confirmed that all wards compile operational plans annually as stated in the following excerpt:

“...every ward does an operational plan where we stipulate what we require on a yearly basis.” (OM 3)

In response to the OMs understanding of the processes involved in drawing up the operational plans, the following responses were received. One OM indicated that she did understand the process as evidenced by the following excerpt:

“...yes, because I am involved and all my requirements are what is in it.” (OM 3)

Another OM confirmed that he did understand the operational plan, the processes involved and how to draw it up as evidenced by the following excerpt:

“...yes, they give us a guide on how to go about filling the documents. In fact the operational plan is firstly that you need to know what you require, how much you are going to use and what type of resources you are going to use for the following year. You base it on the previous usage, like how much you have used in the previous financial year, how much did you order and use.” (OM 2)

One OM expressed her despondency in drawing up the business plan for her unit where she felt it was a futile effort as noted in the following excerpt:

“...yes, we do draw it, but is not effective and goes nowhere because there is no money.” (OM 5)

When asked about the understanding what the processes are once the operational plan has been submitted, the response from an OM was as follows:

“...this is where the problems are. The committees sit and decide the necessity of the items and whether there is a budget available for the item. However we as the end users do not get the items we request.” (OM 3)

Sub-theme 1.3: Procurement planning

NMs though not directly involved in the drawing up of the budget, contribute by the way of procurement plans. Procurement plans are drawn up by each department and submitted to the NM for collation and submission to the FM. One NM explained her role in procurement planning in the following excerpt:

“...every year there is a procurement plan that we have to write. Before you even go there you take the previous one and there you check the equipment that you received and check whether you need that equipment or not. So that’s why all Non-Stock items (NSI) requests must go via my office and be discussed with me. Sometimes you will find that a 40 bedded ward will request 40 footstools. You ask those (OMs), do all 40 patients need a footstool? They realise they don’t. But once you sit there in that committee you understand that a little bit about finance. You will find that in their (OMs) plans they also include things they don’t need. But when you sit with them and ask them, they see that they don’t need this equipment. They just put everything in their plan. But now I know and with the experience I understand everything. As a NM you take overall responsibility and accountability for everything. The Operational Managers and Assistant Nurse

Managers, we do the plan together and then I sit with each component before the plan is forwarded to SCM.” (NM 1)

One NM confirmed the participation of OM's in the procurement process by saying:

“...OM's in each department are asked to submit their procurement plans. Basically it is a wish list of what you would like in the ward for the new financial year. So they would include everything such as new Echo-Cardiograph machines, blood pressure machines. They may not get everything they ask for. The budget gets allocated for the new financial year and they have to prioritise. So there is some involvement and they do have an input eventually into the budget.” (NM 5)

Another NM indicated her involvement in the procurement process as noted in the excerpt below:

“...we are quite involved at this level in procurement and procurement planning. From a personal perspective, I don't have a problem with procurement planning. I have problems from people within the units that don't give me the right plan. I don't have problem with understanding how then committees work within the hospital. When doing procurement plans, nursing staff are collaborating with the doctors and other stakeholders.” (NM 3)

One FM confirmed the statement made by the NM above indicating that there are other stakeholders, mainly the OM's, involved in procurement planning and provided further insight into the role of NM's in procurement planning as evident in the following excerpt:

“...we also do procurement plans which are linked to budgets and operational plans. This includes all the things that we would buy in the financial year. The input comes from different stakeholders, mainly the OM's. They know what is needed. All procurement plans are received and consolidated into one procurement plan for the entire hospital. Finance then consolidates for the whole institution and present to cash flow committee which is chaired by the CEO. Once the procurement process is finalised around mid-February, the buying process commences in April.” (FM 2)

Another FM affirmed the NM's responsibilities in the procurement process by the following account:

“...each and every ward draws their own procurement plans. The OM's draw it up and they combine everything. The NM presents the combined procurement plans at the cash flow committee. She (NM) is involved in all of these things. She is part of cash flow committee She is also responsible for approval of the NSI. When items are presented at cash flow committee for purchase, the end users must validate and provide rationale and good motivations why they require the items.

this where the NM comes in. Once she is presented with the budget available, she needs to meet with the NMs and choose what they require and remove the ones that are not urgent. A slight over expenditure is allowed due to inflation and unanticipated price increases. All NMs become part of the expenditure by stating that they approve of the items on the cash flow committee and we need to pay the suppliers. She is involved in all of that.” (FM 2)

The excerpt below from a NM reflected the problematic nature of the procurement process:

“...if we have an understanding of finances and how the processes work, it would definitely make things easier. Because at times you find that we are frustrated in the ward and when we procure some items, there are processes. You will find that sometimes we have to wait three months as there are processes that have to be followed. We don’t understand that. There is no one telling us what is happening or maybe they are telling you in their terms and they don’t understand what the meaning of that is.” (NM 1)

In response to the question of the understanding of how the procurement process works and the levels it has to go through, the response of one NM was as follows:

“...the lack of understanding of the procurement process had surfaced as one of the reasons for non-receipt of stock. The procurement process at institutional level must be part of this framework. There are many branches of procurement. There are different people responsible for different levels of procurement. For example, equipment procurement is not done at institutional level. This is done by Health Technology Services (HTS). HTS has their own processes and procurement plans. You have your own procurement plan. You might have as your number 1 a piece of equipment. When you send your procurement plan to HTS, your number 1 item becomes number 53 because it’s done as a regional procurement process. Their processes are prioritised differently. By taking that responsibility away from the institutions you are making it difficult. Because you don’t get equipment on time, when something breaks, you find you are in crisis as you don’t have the equipment.” (NM 3)

The above NM went on to state that many procurement processes were centralised and required approval from head office which resulted in delays in obtaining the equipment as noted below:

“...anything beyond R200 000 is centralised. Anything else you need like repairs or replacement of equipment must be authorised by head office. This is a lengthy procedure and often you don’t get the response you require as they are not at ground level. They don’t understand our circumstances as well.” (NM 3)

One ANM also voiced her discontent with the procurement process as follows:

"...we also do the NSI and submit them. Some are approved and some not. These things are required for patient care and service delivery, but they decide what they will give us and what they will not. This is not fair. This is beyond our control. We have to wait for them to procure and send to us." (ANM 1)

Sub-theme 1.4: Human resource planning

One NM identified that resources planning forms a critical part of her financial management role of which human resources planning and management being very important. She also found that when planning for resources she has to take the budget into account and evaluate if additional staff are really needed in the departments. This is evident in the following excerpt:

"...if you think about HR management, management of resources, equipment, time management, these are also part of financial management. But now I think the role is very critical. The roles and responsibilities include everything like HRM, resource management, equipment and the finances. Now you understand why they talk about Compensation of Employees (COE), recruitment that you don't just recruit for the sake of filling the post. You have to identify the need. Do we really need to employ this person, not just to fill the vacant post?" (NM 1)

Another NM identified planning of human resource planning as one of her responsibilities in ensuring effective cost management in the following excerpt:

"...when we talk about financial management, within my component I become responsible to ensure that the utilisation of funds is done cost effectively and efficiently. We start by looking at filling of the posts. We have to weigh the post as it is linked to the budget. We need to monitor that the person is fruitfully and gainfully employed. Absenteeism also impacts on the budget. The staff that are left behind will be overworked as they have to do the activities of this person who is absent. Strict monitoring of absenteeism." (NM 6)

One NM stated that human resource planning and management was stressful as this was a very important part her financial management and control function as evidenced in the following excerpt:

"...that is another stressful thing on us. So you know you were asking what is my responsibilities, we got a responsibility with the HR and be able to place people accordingly even if maybe in your department you not so busy and the other departments are busier. Before I actually get overtime, I must source somebody from your department. So, this constant HR management to make sure that you are controlling your finances." (NM 2)

The role of the NM in human resource planning was highlighted by a FM in the following excerpt:

"...at the beginning of the year HR presents the HR plan which tells us how many employees we have, how many do we anticipate having before the end of the financial year looking at the vacant posts and how much will it cost. How many people are turning 65 in that year and so that we can plan on how much we are paying for retirement. For nursing the NM is very much involved in this part." (FM 3)

The CEO gave input regarding the importance of the NM role in proper human resource planning as a means to prevent litigation. Below is an excerpt from a CEO that supports this view:

"...they can't have people dodging, being absent and borrowing staff from other units, making shortages and ending up in litigation in other units because that is the ripple effect that they need to understand. If you don't manage absenteeism and you have litigation coming from your unit that is financial loss. But now they have to be able to translate practice into monetary value abstractly. So, that will make sense to them." (CEO 2)

Sub-theme 1.5: Budget structuring and formulation

The findings of this study revealed that the NMs do not actually draw a budget, but they do participate in budget development by drawing up procurement plans and operational plans for submission. These plans are then submitted to the FM for planning of the budget. The following excerpt verifies the role of one NM in budget planning:

"...we do not draw the budget for our nursing departments. The nursing components, we draw the procurement plans and incorporate the nursing budget, drawing the maintenance plan so that we have one plan for the whole hospital." (NM 6)

Another NM stated that though they were not fully involved in the budget planning and development, there is a certain level of participation, as indicated in the excerpt below:

"...there is involvement in the budget but in a very subtle way. You are not asked to say how much you want. But right now OMs in each department are asked to submit their procurement plans. The budget gets allocated for the new financial year and they have to prioritise. So there is some involvement and they do have an input eventually into the budget." (NM 5)

Participation and inclusion in the budget planning by NMs is very limited as noted in the following excerpt from a NM:

“...I know that national gets the budget and then gets distributed to each institution according to number of patients, head counts and all of that. When it gets to us, the problem occurs as you get COE, equipment budget. Distribution is not done appropriately as it is left to SCM and we are not part of it. Because we don’t have cost centres we don’t have input. For NSIs when the budgeting is done by SCM, we don’t always know how much things cost. We are not excluded, but we are not included as much as we would like to.” (NM 3)

The role played by OM in budget planning is also very also limited, as reported in the following excerpt by an OM:

“...I am involved in budget planning to a certain extent. Every month we are given a printout of what we have ordered and what it costs. If one month does not tally where the graphs are gone up high or that we did order extra, then we have to compare and see what our downfall was and then look at thefts, lock up systems.” (OM 4)

4.4.1.2 Theme 2: Financial monitoring

NMs are continuously monitoring both the operational and financial activities and functioning of the nursing section and the hospital at large. In their financial management roles, they have to continuously monitor compliance with the financial activities relative to the budget and the strategic and operational plans as discussed in the preceding sections. This is done in order to ensure that they are meeting service delivery standards within the specified and allocated budget. A second theme of financial monitoring was identified with respect to the financial management role of the NM. Monitoring of how the money and budget is spent is reflected in cash flow and regular analysis of the institution’s financial statements for each department. These two monitoring functions encompassed the sub-themes that emerged which include cash flow monitoring and analysis and interpretation of financial statements. This is presented in Table 4.5 below:

Table 4.5: Theme 2: Financial monitoring

Theme	Sub-themes
Theme 2: Financial monitoring.	Sub-theme 2.1: Cash flow monitoring.
	Sub-theme 2.2: Analysis and interpretation of financial statements.

Sub-theme 2.1: Cash flow monitoring

The study revealed that cash flow monitoring is done on a monthly basis in the hospitals where senior management meets and discusses expenditure and tracks whether the organisation is maintaining expenditure within the budget. NMs are part of this committee where they monitor and account for the financial performance of the nursing departments. Participation and involvement of the NMs in cash flow monitoring was verified in the following excerpts from NMs:

“...so, I find my financial manager and my CEO, they will say especially during our cash flow meetings, that is where we speak a lot of money and then they will project our spending and how far we are in terms of our money. So you will see and they will be telling us, you are spending a lot on this. You spend too much on this, try and save on this.” (NM 2)

Another NM added the following:

“...at cash flow committee meetings, we monitor how much we are paying for private services such as cleaning. We pay them on monthly basis if it escalates then we query and investigate. We need to be informed so that we move forward. In our cash flow committee meetings, we do have the extended financial management which includes other supervisors and managers of other units. That’s where we hear about the budget and expenditure. We learn about the budget. Most of the time it’s not specific to my nursing components. It’s for the whole hospital. So it’s not easy for me to know if this budget has been controlled. We don’t know how much we are spending. This is a challenge as we do not have cost centres for our nursing units.” (NM 6)

FM verified that the NM is part of the Cash Flow Committee where she monitors and accounts for all expenditure for the nursing section in the following excerpt:

“...in terms of the expenditure, we have to monitor cost drivers. That is part of the cash flow. The whole team is responsible. Cash flow committees normally monitor standing orders. The Department of Health has standard operating procedures which specifies how that should be monitored. The NM is part of all this in terms of monitoring and decision-making.” (FM 3)

A CEO added that the NM is responsible for monitoring the needs of the nursing sections as verified by the excerpt below:

“...the NM supervises different wards. The role of the NM is to ensure that the business plans are formulated and consolidated as a plan and submitted as a plan that comes from the nursing management section. At the same time, she is supposed to make sure the process is started. If in the cash flow committee meetings, an item has been approved, she is the one that tracks whatever the need is.” (CEO 1)

Sub-theme 2.2: Analysing and interpretation of financial statements

According to the NMs, they were required to view and analyse financial statements. Financial statements show financial activities within the different departments and are provided by the finance department. The NMs are required to validate expenditure in the different departments based on the information presented in these statements.

One NM explained that it was critical to analyse financial statements as part of her financial management role. It was difficult initially but with experience and assistance she is able to understand the financial statements. The following quote highlights her views:

“...it is critical to have basic knowledge. Initially it was difficult to understand when they were explaining the financial statements of the institution and where we are, but now they are doing it on a monthly basis, you ask some questions. Now I do understand what they are talking about. It also depends on the people that you are working with. Our FM is very good. He explains at the lowest level so you will understand what he is talking about.” (NM 1)

Another NM also contended that as she retains accountability and responsibility for the nursing section, she has to validate the expenditure presented to her in the financial statements as indicated in the following excerpt:

“...at cash flow meeting for example, you are presented with the COE report; you have to account for why you are paying more salary. Maybe you have employed more staff or you have community service. My role is to investigate reasons for over expenditure in the departments and account for it at the next cash flow meeting. There is a monthly information management meeting where OMs and ANMs attend. Finances are also explained here. OMs are given a print out of their wards and finance sits with them to make them understand. There is a lot of teaching regarding finances going on in this institution.” (NM 2)

Financial reports are reviewed at meetings in order to monitor expenditure and ensure it is within the provisions of the budget as confirmed by a NM in the following excerpt:

“...we do get those reports and at every cash flow that we review, we go through a very short little condensed report just to make sure we are online. We look at what we got to spend, how much we spent and how much we overspent. These issues are discussed at that meeting and we obviously try to balance the books where we can.” (NM 3)

Participants found difficulty with financial terminology in some of the financial reports as confirmed in the following excerpt by a NM:

“...I am familiar with terminology that is used in finance, but if you are not working with it, it might be a different story. You find your way around. When it comes to Auditor General’s reports, some of the terminology is beyond our comprehension. Qualified and unqualified reports. I am becoming familiar with that.” (NM 3)

Another NM indicated that her ability to read financial statements was gained by requesting the FM to teach her as attested in the following excerpt:

“...what they present to me I am assertive and I ask the first time and the next time I remember. There aren’t many financial reports that I don’t know. When they present the financial report every week, so we must know where we are losing out every week.” (NM 2)

Similar to NM 3, another NM found difficulty in understanding the terminology in financial reports as indicated in the following excerpt:

“...they do read financial reports out but we are not familiar with anything, the terminology. At times they talk about the budget and something we don’t know what it is. They have to unpack it and teach us what is important to us. If they don’t unpack it, we are not sure if we are doing the right thing.” (NM 5)

Not all NMs found difficulty with understanding the financial statements as one NM indicated that the expenditure report was presented to her and she was able to analyse and validate her expenditure as verified in the following excerpt:

“...with the expenditure report that we get from stores department SCM. It tells how much we have used this month. It tells us maybe we used excess soap. We go back and check what went wrong for that particular month and then try and reduce. Every month we check and compare. No. With that process we are fully aware. When they have ordered something they come with the expenditure

budget. If we did not receive something we have to check first, they write out of stock, and then this must not be charged.” (NM 6)

FMs also provided their expert input into financial reports and financial statement interpretation and analysis. The input from a FM specified the reports and statements that NMs need to be able to analyse in the following excerpt:

“...NMs control the largest staff component. They need to understand the 5728 report which gives the expenses per person per month. It will help to identify the staff that are currently employed and identify ghost employees. Analysing this report will help verify that the staff are correct. Payroll checking on a monthly basis will help verify all staff that is employed. If the NM is checking these reports it will help to eliminate irregular activities from HR, for example, fraudulent overtime payments.” (FM 2)

The CEOs also concurred with the FMs that the expenditure report, BAS report and Personnel and Salary Administration System (PERSAL) report was important for the NM to understand as stated below:

“...the Basic Accounting System report. This will require her to analyse and come up with solutions on how to spend more and to curb over expenditure. The PERSAL report, we normally give it to her to be able to interpret when you want to check the ghost employees and others. PERSAL reports are given to all EXCO members so that they can check on the people under their care.” (CEO 2)

4.4.1.3 Theme 3: Financial decision-making

The third theme identified with respect to the financial management role of the NM was that of financial decision-making. NMs not only have to make decisions on patient care and nursing related matters but also on financial aspects. The findings indicate that NMs have to approve and make decisions on what will be purchased and from which supplier. This encompasses the decision-making role of the NM from which the sub-theme of approval of contracts and tenders emerged. NMs are often called on to make important financial decisions when acting in the role in the absence of the CEO which emerged as a second sub-theme. NMs do not make decisions on their own but are guided by the prescripts of the financial legislative framework. Hence the third sub-theme of the financial legislative framework as part of the

financial decision-making theme evolved. This is presented in Table 4.6 below.

Table 4.6: Theme 3: Financial decision-making

Theme	Sub-themes
Theme 3: Financial decision-making.	Sub-theme 3.1: Approval of contracts and tenders.
	Sub-theme 3.2: Acting in the CEO role.
	Sub-theme 3.3: Financial legislative framework.

Sub-theme 3.1: Approval of contracts and tenders

In the public sector, NMs are involved in bid committees where decisions are made in terms of how contracts and tenders are awarded. The bid committees are an important element of the supply chain process. Bids are evaluated according to the criteria specified in the bid document. There are three bid committees in which NMs participate and execute their decision-making roles, namely Bid Specification Committee, Bid Adjudication Committee and the Bid Evaluation Committee. NMs highlighted that their financial decision-making function as part of the bid committees in the following excerpts:

“...I am a Cash Flow Committee and Bid Evaluation Committee member.” (NM 6)

“...I sit on Bid Adjudication Committee where we review and award quotes once the end user has specified what they want. The NM usually sits on this committee.” (OM 1)

Further confirmation of the NM financial decision-making role was provided by the CEOs in the following excerpts:

“...you will find that NMs are part of bid awarding committees.” (CEO 2)

“...in terms of bid committees she has to nominate people that are going to be part of those committees. In some of those committees the specification might not be known by SCM but by nursing division. Same as evaluation. Preferably she must be part of the adjudication committee.” (CEO 1)

FMs added that the NM is part of the cash flow where she makes decisions for all expenditure for the nursing section as indicated below:

“...the NM is a part of the Cash Flow Committee where financial decisions are taken in terms of what needs to be procured. The NMs are part of the decision

makers in terms of what's needed in the hospital and which is going to be used for the purpose of giving proper nursing care for the patient. So NM is also involved in all those things because when it comes to the decision-making in the Cash Flow Committee, she is also involved. The NM must make the decision as to what must be purchased according to priority. After she is told at the cash flow Committee, meetings that this is the mandate that is available, she must go back to OMs and coordinate what will be bought with the budget available.” (FM 3)

Sub-theme 3.2: Acting in the CEO role

In the public sector hospitals, the accounting officers are the CEOs. In the absence of the CEO, NMs are called to assume the role and this involves a large amount of decision-making which often has financial implications. NMs indicated that they do act in the role of the CEO but voiced concern as they felt that they had to make financial decisions with little understanding of such.

A NM raised concern that while she acted in the CEO role in his absence, she did not fully understand what she was doing in terms of the financial side as attested to in the following excerpt:

“...at times we act as the CEO. You just sign not understanding fully what are you signing and also the implications. We need detailed explanations but in a simplified manner for NMs, because at the end of the day, you act as a CEO. When the CEO is not around or in an emergency you are expected to sign off like maintenance requests, theatre chillers broken and repairs. You don't wait for the CEO. For some processes they bypass quotations and use delegations. We don't know what this means.” (NM 1)

Another NM also confirmed that she steps into the CEO role when needed but was unsure of whether she was making the correct decisions as highlighted in the following excerpt:

“...my level of experience slows down when it comes to CEO level. If I have to act in the position as a CEO and it happen sometimes, somebody comes to me and say they have an office emergency, please sign this. I will have to do some homework and ensure that I am signing the right thing that is where I will hit a little hump.” (NM 3)

Another NM also confirmed that she acts as a CEO when he is not around, but gets support from the financial team for any financial decisions as noted below:

“...at times I become the acting CEO. Then a lot of information I learn from the FM. I go to the FM and his supervisees and get the financial information I am short of just to manage as expected.” (NM 2)

One CEO who was a NM previously reflected and added her perspective to the role of the NM as a CEO and the lack of financial preparation for this role as noted in the following excerpt:

“...although, in the absence of the CEO the NM will act in that position. But in spite of that the CEO knows more than the NM. The reason being is that there are courses that the CEO has to attend. Therefore CEO has more knowledge. The NM is treated as part of the Exco like the HR managers. Normally the financial course concentrates more on the CEO and FM. That is why we have requested that when we attend these meeting the NM must also be called. They are starting to now include the NM.” (CEO 1)

Sub-theme 3.3: Financial legislative framework

There are various legislative frameworks that influence public sector financial decision-making in South Africa, namely, the Constitution, the PFMA which regulates financial management on the national, provincial and local level of government, and Treasury regulations. These legislative frameworks influence the decision-making processes within the public sector. Managers have to ensure that all decisions taken fall within the prescripts and ambit of the legislation. NMs highlighted the sections and clauses of the legislative frameworks that are applicable and relevant to their practice.

One NM confirmed that part of the role of NMs was to adhere to the prescripts of financial legislation. She highlighted the need for an understanding of the legislation and indicated its importance to NM financial management practice as summed up in the excerpt below:

“...at the end of the day, you are accountable. It’s all here in the PFMA. So we must adhere to the PFMA. From the PFMA we need to pick out all those aspects that are relevant for NM practice. Our CEO likes to quote from this. If she did not then we would not know what’s going on. For each process we have to refer to the relevant section in the PFMA. It’s important as we remain accountable for our actions.” (NM 1)

Another NM highlighted the need for more knowledge of the financial legislation and felt that it was important enough for all NMs to understand its role in financial management as stated below:

“...every manager should be well versed with PFMA. I always refer to the PFMA What I know is what I read because I’m curious and I need to know. I just partly know about Chapter 5 and Chapter 12. In one of the chapters, I think Chapter 12; it talks about measures to control fraud. Those things are never discussed, even as a NM you need to be able to put strategies in place to control fraud. Finance is everywhere and controls everything. Need to put measures in place to control everything.” (NM 2)

Another NM pointed out that the financial legislation was used as guidelines by NMs for cost saving measures as indicated in the excerpt below:

“...secondly, informing, educating or training staff on how to go about ensuring cost saving and cost containment is essential. Unfortunately there has been no formal training given to managers or staff so the information we use is from relevant guidelines like the PFMA and short training or in-services that we may have had regarding cost saving and cost containment. They may be simple but they are effective like simple policies on the use of the telephone, electricity usage, overprescribing like in the gateway clinic. These things can be monitored at a lower level but it has an impact eventually on cost saving.” (NM 5)

The importance of the financial legislation in NM practice was also underscored by one CEO who was once a NM herself as alluded to in the following excerpt:

“...normally what is expected is that the NM is given an overview of the PFMA and what it entails. So that she can understand in totality what PFMA has. She has to be informed on the role of the committees. She is also responsible for asset management and must be updated as it changes from time to time. Those are the information she needs to be given so that she can start doing her job.” (CEO 1)

One FM confirmed that the decision-making for finances in the public sector revolves around the legislation as indicated in the following excerpt:

“...it is the PFMA and other legislation which regulates financial management of provincial and national government.” (FM 2)

In response to a question regarding whether the PFMA had any relevance in the NM practice, a FM responded as below:

“...yes, but only in the South African context. This is a South African Act. However, if they (NMs) have an understanding of the PFMA, it is very low or minimal.” (FM 2)

4.4.1.4 Theme 4: Financial control

The fourth theme identified with respect to the financial management role of the NM was that of financial control. Interviewees in this study pointed out that the responsibility for and control of funds is decentralised to the level of the OMs. A huge part of the NMs role in the hospitals revolves around the control of finances. The sub-themes that emerged from the financial control theme are assets and resources control and expenditure control. This is presented in Table 4.7.

Table 4.7: Theme 4: Financial control

Theme	Sub-themes
Theme 4: Financial control.	Sub-theme 4.1 Assets and resources control.
	Sub-theme 4.2: Expenditure control.

Sub-theme 4.1: Assets and resources control

Asset and resource control was seen to be a large part of the role of all participants in the study who emphasised that it is their responsibility to carefully supervise and control the use of resources. Resources include the management of physical resources, equipment, facilities and infrastructure. The management of resources as part of the NM role was highlighted by one NM in the following comment:

“...on a daily basis we deal with HR, equipment and consumables. If you think about HR management, management of resources, equipment, time management, these are also part of financial management. But now I think the role is very critical. The roles and responsibilities include everything like human resource management, resource management, equipment and the finances.” (NM 1)

One NM spoke about how she retains ultimate accountability and responsibility regarding control and care of equipment as summed up in the following excerpt:

“...so you know you were asking what is my responsibilities, It so huge, because not only among HR but in terms of management of equipment and furniture because if it's broken, it comes right back to this office. I've got to report, write a loss and damage, how it broke, why it broke, what's your plan about it, and people who have broken it must be disciplined accordingly, but now we've got to make sure that they know how to use it so we've got a responsibility with the equipment.” (NM 2)

Another NM stated that she rallies her team together to ensure that equipment is cared and accounted for as illustrated in the excerpt below:

“...the OMs and ANMs are my extended arms who monitor their areas. We have monthly meetings. There is a standing agenda item on equipment and supplies. We discuss how to prevent loss and damage of equipment which costs money. Equipment control involves prevention of loss and damage and breakage. Loss and damage must be reported. Stock in the wards is also closely monitored. We have stock levels that must be ordered. We closely monitor and scrutinise any escalation of costs in each quarter. All escalation in costs at ward level is investigated and validated. We look at the equipment and ensure that all equipment is in the ward and monitored daily by day and night shift. We do inventory control and equipment control.” (NM 6)

Interviews with the FM's further confirmed the important role that NM's play in asset and resource management. It was affirmed by one FM that the NM role includes the management of assets and all request for assets must be authorised by the NM as indicated below:

“...the NM's role is also asset management. They have to check quarterly, broken items must be sent for repairs or condemned and written off. End users must submit their request for assets. For nursing and for patient care, the NM must sign for the recommendation. This is presented at cash flow committee meetings and checked whether there is budget available.” (FM 1)

One FM indicated that nurses are the custodians of assets and resources in their departments as alluded to in the excerpt below:

“...we now come to the issue of asset management which is very important. Nurses have to be custodians of the assets in their departments. The issue of taking care of the equipment they are using. If equipment is not taken care of, it gets broken. This results in repairs. If they are aware of these processes and the financial implications of poor asset management. They need to have this awareness; they will manage their areas as they manage their homes. Everything that is lost and broken will need to be replaced.” (FM 2)

Similar findings from an OM reveal that his financial management roles within the unit is broad and includes the management and control of resources in an economic way as indicated in the following excerpt:

"...my financial management role is broad and includes the economic management of resources, ordering, knowing how much the budget is for the wards, managing both the financial and human resources, staff, ensuring that we keep our stock levels to a minimum, also overstocking which will end up expiring in the department. Using first in first out method. Prevention of expiry of stock." (OM 2)

Although NMs have to control their resources, they have little or no control in obtaining these resources. The challenge that is encountered by one NM in obtaining equipment and resources for patient care is indicated in the following excerpt:

"...when we request for resources we are told that we cannot get this thing in the financial year because of the limited resources and this is what is being allocated. They want to prioritise for us, not knowing what we as nurses need in the institution day and night when they are not there. We are running the institutions 24 hours a day, weekend and holidays. We are the custodians of care. We are at the firing line. So when we cannot provide the things we need for patient care, which is getting pressure from the staff and the public. Sometimes there are no resources, no surgical sundries, nothing to give to patients. Nurses are blamed for the lack of resources and complaints are lodged against the nurses. When I take rounds I have to deal with and attend to the complaints. What is happening is beyond our control." (NM 6)

The centralisation of the procurement of equipment is viewed to be a limiting factor as often the equipment requested is not received in time as attested to by a NM in the following excerpt:

"...sometimes they are able to help, but we are severely limited as a lot of our functions regarding financial management are centralised with regard to equipment / contracts. There is also a lack of contracts. We don't have contracts in place. Everything becomes a non-stock item. That comes with the problem of tendering and not getting the right bids. It becomes difficult to purchase things in time." (NM 3)

Sub-theme 4.2: Expenditure control

NMs play a crucial role in expenditure control within the hospital considering that they manage the largest sections in the hospitals, which are the wards and the nursing staff. This obviously requires a large portion of the budget and

expenditure in the hospital in terms of resources and salaries. The efforts to prevent wastage and control expenditures are not only the function of the NM but that of all nursing department managers as explained by one NM below:

"...in the wards they are expected to apply the first in first out method and to monitor expiry dates. When pharmacy finds drugs that expired in your department you have to be accountable. You find it is wasteful expenditure, you will find that people will be quoting the PFMA and the sections that apply. The OMs and ANMs must also be educated. They will be able to impart the knowledge to the lower categories whenever they are wasting in their departments. But for them it is critical because they are the ones that are ordering stock and monitoring the departments. At the end of the day they are also accountable for whatever is happening in their departments." (NM 1)

One FM felt that nurses do not understand expenditure control processes as indicated in the following excerpt:

"...we try to explain expenditure control processes but in the practical situation they have explanations why they don't as they validate by stating their duties and workload. They are not financially conscious. I inform them that I am accountable for the money allocated to us. Prevention of wastage will result in the money being used for something else." (FM 2)

One CEO felt that if NMs understood finances they would be able to play a critical role in expenditure control as highlighted in the following excerpt:

"...I feel it has to start with us in the institutions. The bulk of the HR in the institution, 80% is made up of nurses. So if expenditure control is treated and understood by nursing, you have half won the battle. If you manage things well, you can actually spread your money and it can go far. Where you are having waste, you are in control. If the NM understands finances, then she can control." (CEO 2)

One OM felt that a lack of control of resources in public hospitals leads to misuse and wastage. He compared the difference in cost containment and expenditure control by nurses in public and private hospitals where there is better control in private institutions. The following excerpt verifies his views:

"...need a change of mind-set. It is nurses who have undergone the same training yet behave differently in the two institutions. The problems arise that in government hospitals there is a storeroom where stock and medication is kept and used for all patients. This can lead to misuse and wastage. In private each patient has their own stock and medication. Everything is accounted for and should anything go missing or is misused the nurses are accountable. There is a lot more control in private hospitals." (OM 2)

In response to the question of a lack of control in public hospitals the OM responded as follows:

“...there is a definitely a lack of control compared to the private. Specifically relating to equipment for example consumables, in private hospitals each patient has their own individual meals. In government they bring a whole lot of food for patients and it ends up being wasted. In government hospitals it is assumed that they we provide everything.” (OM 2)

A similar comparison to the above was echoed by a NM who felt that working in a private hospital made her more cost conscious as summed up below:

“...what also helped me that I wish all OMs were exposed to. I worked for a couple of years in the private sector. In private hospitals they are so good with management of their stock and resources. When you come to a government, you really see the wastage is humongous.” (NM 2)

4.4.2 Findings related to Objective 2

The second research objective addressed the financial management competencies that NMs currently have. In order to develop a financial management framework for the NMs, it was important to understand and establish what competencies and skills they currently have. This would assist to identify areas of development and develop competencies to broaden the financial management skills of NMs. The major themes and sub-themes derived from the responses to the question of NMs financial management competencies are presented and discussed below.

4.4.2.1 Theme 5: Inadequate financial management competencies

The first theme identified with respect to the current financial management competencies of NMs was inadequate financial management competencies. A review of the literature identified the necessary competencies and skills for NMs but the acquisition and development of financial management skills was not extensively explored. The findings reveal that significant challenges exist for NMs as they are often left out of the financial dialogue in some hospitals. These findings led to the first sub-theme of poor involvement in financial management activities. Participants in this study indicated that they did not

have the necessary financial management skills and competencies. This was attributed to the lack of training and in-service education for their roles. This emerged as the second sub-theme. NMs also gave their accounts on how they acquired these competencies which became the third sub-theme of experiential learning. The theme and sub-themes are presented in Table 4. 8.

Table 4.8: Theme 5: Inadequate financial management competencies

Theme	Sub-themes
Theme 5: Inadequate financial management competencies.	Sub-theme 5.1: Poor involvement in financial management activities.
	Sub-theme 5.2: Lack of in- service and financial management training for current role.
	Sub-theme 5.3: Experiential learning.

Sub-theme 5.1: Poor involvement in financial management activities

One NM found that she did not have enough skills and the skills that she had was from attending financial meetings as indicated in the following excerpt:

“...in terms of finances I don’t have enough skills. We also attend cash flow committee meetings where we learn a bit about finances.” (NM 6)

An OM indicated her unhappiness about the financial situation in the hospital and attributed her lack of financial management skills to her not being included in financial tasks and financial decisions as summed up in the following excerpt:

“...maybe if I was involved in financial activities, I would have a better understanding of where the money goes to. We are told that there is no money to fill vacant posts. So I am not happy at all about the things that are going on.” (OM 5)

The need for more skills was emphasised by one OM who indicated that he had a basic knowledge of financial management but no formal skills as indicated in the excerpt below:

“...I have knowledge of financial management but no formal skills. When I was doing orthopaedics we were introduced to financial management in nursing dynamics module. It is sufficient as a basic knowledge but I think one needs to do something that is formal to assist me more.” (OM 2)

Another OM pointed out in terms of financial management competencies that she is not directly involved in the financial part, although she is accountable for a large part of the financial management activities in her unit as noted in the excerpt that follows:

"...in terms of budgeting, ordering, stock control, everything comes to us. We are involved in ways that are not directly involved in the finance part of the budget. We know what amounts we order so that we can control what we order. We have control over medications, surgical sundries, NSI that we order. We don't have control over our procurement plans. We can order but approvals come from management." (OM 3)

The reasons for the poor involvement of nurses in financial management activities was due to the focus of nurses training being on clinical outcomes rather than financial outcomes as alluded to by a CEO in the excerpt below:

"...clinical people understand clinical things but they forget that anything else that they need has a financial connotation to it and as such they have to manage those. For them it's about having the resources for clinical outcomes but the bottom line is how do you get those resources and how do you manage them before you even think about that outcome. Your outcome may be coming at a very expensive end point when it could have been done for much less." (CEO 2)

Another CEO recognised that NMs have minimal financial management skills and attributed it to being more due to a lack of knowledge rather than negligence as indicated in the excerpt below:

"...actually I think the understanding of finances is minimal. It's quite minimal such that sometimes I don't view the non-understanding or the wastage as a matter of negligence. I think it is more of lack of knowledge." (CEO 1)

Sub-theme 5.2: Lack of in-service and financial management training for current role

Participants pointed out that their inadequate or poor financial management competencies were due to the lack of training and in-service for the requirements of their current roles. One NM found that her lack of financial management skills was due to her not having the opportunity to attend financial management training courses as indicated in the excerpt below:

"...I was released to attend a financial management short course. This was in 2012 and I was a NM already. After that there was another financial management course that I was to attend. Unfortunately, the date never came and I am still waiting to attend." (NM 2)

Poor financial management skills were due to the lack of updates and financial management training as indicated by an OM's excerpt below:

"...when we trained some more than 30 years that training is outdated. Now it's 2017. We have not had any updates or any financial management training that would be beneficial as trends have changed." (OM 4)

Sub-theme 5.3: Experiential learning

Most of the study participants revealed that they learnt financial management while on the job. One NM found that attending financial meetings and being involved in financial committees assisted in her gaining financial skills as indicated below:

"...Initially, when you become the NM you have to attend the cash flow committee meetings and other meetings and committees. You learn along the way." (NM 2)

Similarly, another NM indicated that attendance at meetings where finance is discussed has contributed to her learning finance as attested to in the excerpt below:

"...we also attend cash flow committee meetings. That is where we learn. In the beginning of the year we are asked about our cost containment plan. But with budget we do attend the extended management meeting, they tell us about the amount of money we are allocated." (NM 6)

The NM above went on to further state that a basic knowledge of finances is required to manage a ward and that she learnt about finances while she was in charge of a ward as reported below:

"...when you are in charge of the wards, you must have some financial knowledge at basic a level even if you do not have a formal qualification. We need to know the basics of allocating stock in the departments, equipment, furniture, medications. All these things are bought with money, for us to manage all these things we need to have a basic knowledge of how to control it, to keep it under lock and key, to educate staff on how to use and control it. So that is how I learnt about finances. During my Administration Diploma I went through a little bit of financial management which was part of the Diploma. Most of the knowledge was on the job and through experience." (NM 6)

In response to the question of how the financial management content in the Nursing Administration programme empowered her to carry out her financial roles, the NM also indicated and further confirmed that her financial knowledge had been achieved at work as indicated below:

“...the content in my Administration programme was insufficient and most of the knowledge I have was at work, through in-service, experience, meeting with FM and when FM gives us the financial report.” (NM 6)

One NM acknowledged that her financial management knowledge and training was accomplished by her involvement in committees and actually doing the work as indicated in the excerpt below:

“...most of my knowledge and training is being part of a committee and ordering of equipment and other functions. The knowledge I got from the hospital has come through in-service training and attending the odd workshop. But mostly it comes from actually doing the work and trial and error sometimes.” (NM 3)

Learning financial management along the way was confirmed by a NM in the following excerpt:

“...you just learn as you go along. They show you but there is no one that will properly sit down with you and explain that when you are in this committee you are looking at this document before you sign it. These are the important things that you have to look for before you sign.” (NM 1)

Learning of financial management was also acquired on the job and by the years of experience as verified by an OM in the excerpt below:

“...also with the years of experience we pick up, we do graphs, we do stock control and that's how we manage. That is our financial management part at ward level. Most of the skills I received have been on the floor.” (OM 4)

4.4.3 Findings related to Objective 3

The third objective sought to establish the training and educational qualifications NMs have with respect to financial management and in which courses they achieved the qualifications. This question intended to explore what educational courses and programmes are available with respect to NM financial management training. This entailed determining which programmes would best prepare the NM for her/his financial management role. In order to

develop a financial management framework it is essential to establish what knowledge and information is available to avoid duplication. Two themes emerged from the findings, namely, educational preparation for financial management in nursing programmes and support and training for the financial management role.

4.4.3.1 Theme 6: Educational preparation for financial management in nursing programmes

Participants discussed various programmes, modules and courses that they completed in which financial management was included, or that formed part of the curriculum. Most of these programmes were formal, accredited programmes which led to the development of the first sub-theme of formal educational preparation for financial management in nursing programmes. Participants further revealed that though these formal programmes included financial management modules, they were not effective in assisting them gain the requisite skills. The second sub-theme to emerge from these findings was inadequate financial management training in basic and post-basic nursing programmes. The theme and sub-themes are presented in Table 4.9.

Table 4.9: Theme 6: Educational preparation for financial management in nursing programmes

Theme	Sub-themes
Theme 6: Educational preparation for financial management in nursing programmes.	Sub-theme 6. 1: Formal educational preparation for financial management in nursing programmes.
	Sub-theme 6.2: Inadequate financial management training in basic and post-basic nursing programmes.

Sub-theme 6.1: Formal educational preparation for financial management in nursing programmes

NMs' accounts about their financial management education or training both in basic and post-basic nursing programmes are noted in the excerpts below:

"...I have done nursing administration via the university where one of the modules was financial management. It was a basic module." (NM 4)

“...when I was doing the B Cur we did have financial management that was included in some of the courses.” (NM 6)

“...during my nursing administration diploma I went through a little bit of financial management which was part of the diploma.” (NM 5)

One OM found that the introduction to the financial management content in his post graduate modules was very basic and needed more formal courses:

“...in the orthopaedics programme, financial management was covered as a module, but was not sufficient. We need a formal course.” (OM 2)

Sub-theme 6.2: Inadequate financial management training in basic and post-basic nursing programmes

The views of the NM depicting the inadequacy of the financial management content in the training programmes are reflected below. One NM felt that financial management is taught in theory but it is not applied in practice as noted in the following excerpt:

“...in postgraduate training you do financial management, but it is more theoretical. Our training is not productivity driven. It is more quality driven. We talk about increasing our headcount. None of that terminology is included in our training. We don’t come with the mind-set of getting as much done with as little as possible. We are taught economic principles, safekeeping of equipment etc., but it doesn’t help us in practice. I know that’s talk during the curriculum, but in practice it doesn’t translate sometimes. So we have to work on that.” (NM 3)

Another NM stated that financial management was not given importance in the nursing curriculum as reported below:

“...like I said, in our curriculum it was never intense, finances never intensified, we dwelt more on other things, but when it came to finance we just learnt how to be a good nurse, how to be a good practical nurse, but in my general nursing, nobody told me the importance of financial management.” (NM 2)

One NM was of the opinion that various aspects of financial management were included in the nursing education programmes, but was not taught in the context of financial management as verified below:

“...it comes from our training. As explained earlier that there were things we learnt that were related to financial management. Just that we were not told it is financial management. We were taught basic management of resources and everything, that’s financial management. We didn’t understand it in that context. We were not taught the financial impact. In our basic training, though it was not

formal, financial management, it was there. If you think about HR management, management of resources, equipment, time management, these are also part of financial management.” (NM 1)

Financial management should be introduced early in nursing training as it becomes difficult to learn new things when one is older, as attested to by a NM in the excerpt below:

“...when you are older it’s very difficult to grasp new things and information. I think that financial management needs to be introduced in the earlier stages while the nurse is still on training. That where she needs to be groomed early in her training for financial management which she should learn where do we spend money, and include costs ordering, receipt, care and management and maintenance of items. Those things must be started at an earlier stage, not now. They come to us already trained and I don’t think that they have enough experience with the management of finance. They envisage this as a duty of the managers. When you become a manager of people who do not know how to manage something, you need to start afresh teaching them. It becomes frustrating because when you tell, people they tend to forget, you need to work with them, whereas we do not have time.” (NM 6)

Talking from personal experience one CEO stated that the inadequate financial management skills are due to the content of nursing education not focusing on financial management, as noted in the following excerpt:

“...this is a nurse by profession and when you look at the content of the education there is nothing much on the PFMA and all the financial nitty gritty that happens in the process of nurse management. So most of the time, they don’t have enough skills.” (CEO 1)

The sentiments above were also echoed by an OM felt that the financial management preparation in the post graduate diploma was inadequate and did not prepare her for her role as stated below:

“...I completed the Advanced Diploma in Health Services Management and part of it was financial management in nursing. It was basic financial management, calculations. Basically the financial management included things like depreciation, not specifically related to health services, where you are responsible for every cent that you spend. Not adequate. We would appreciate more training in that aspect.” (OM 1)

4.4.3.2 Theme 7: Guidance and training for financial management role

The question asked was related to what support and training NMs receive to assist them in their financial management role. A theme that emerged was that of guidance and training for the financial management role. Participants indicated that they received minimal assistance and attended on site and informal financial management training which led to the emergence of the first sub-theme of informal financial management training for their current role. Participants also reported that they received poor or no support from the Department of Health which became the second sub-theme. Throughout the interviews participants referred to assistance they received from the FMs and CEOs and other stakeholders regarding financial management which led to the third sub-theme of peer support and mentoring or the financial management role. The theme and sub-themes are presented in Table 4.10.

Table 4.10: Theme 7: Guidance and training for financial management role

Theme	Sub-themes
Theme 7: Guidance and training for financial management role.	Sub-theme 7.1: Informal financial management training for current role.
	Sub-theme 7.2: Poor support from Department of Health for current financial management role.
	Sub-theme 7.3: Peer support and mentoring for the financial management role.

Sub-theme 7.1: Informal financial management training for current role

One NM indicated that there has not been much training so just followed guidelines and policies and requested assistance from financial people for any financial matters as stated below:

“...in reality there hasn’t been much. We are going by the contemporary and relevant guidelines in terms of the procurement plan, policies and asking the finance people. But it should be the other way round. There should be some formal training.” (NM 5)

The OM's were provided with opportunities by the Department of Health to attend informal courses on financial management. One OM indicated that she attended onsite training for financial management as noted in the following excerpt:

"...onsite training. There are workshops that are held. We attended one this year. However not everyone gets the chance to go due to the staff shortage and work responsibilities." (OM 3)

Another OM stated that he attended in-service sessions where he was introduced to financial management as reported below:

"...when I started working here we attended in-service where we were introduced to financial management principles at operational level namely, in the wards." (OM 2)

One OM attended a unit management course that taught her financial management early in her position as indicated in the excerpt below:

"...when we were first employed as OM's we were sent on a unit management course that talked about financial management and how to manage. We went for quite a few courses but this was earlier in the position." (OM 4)

Sub-theme 7.2: Poor support from Department of Health for current financial management role

In response to the question on the support from Department of Health for the current financial management role, there was a very noticeable lack of support and training provided by the Department of Health to the NM's. One NM stated that no support was received from the Department of Health for her financial management role and she has not been given the opportunity to attend financial management workshops or training sessions as indicated in the excerpt below:

"...I receive no support for my financial management role. There is in-service but I don't get to go." (NM 4)

Another NM stated that the Department of Health does not provide any financial management training to enable her to better manage finances as noted in the excerpt below:

“...the Department of Health gives us nothing because even the nurse management course that I did was out of my choice. Nurses will choose to go and do a Diploma or something. If only it was in the nursing curriculum at school. But then of course it's not there now. I am not talking about a one week workshop. Something more intense, because the most important thing about the Department of Health, I think is being able to manage finance. Now if you are not giving me a course to empower myself on being a better financial manager, but you still require me to manage your finances well. How am I going to do that? If only the department could offer us something that says, now that you are a manager you have to attend, its compulsory.” (NM 2)

One OM has not had any training or support from the Department of Health for her role and asked for more department involvement in the financial activities. She requested that her voice be heard and for the Department of Health to also invite and consider the ideas of nurses in the financial management aspects as attested to below:

“...I have been in this post for three years; I have never been exposed to any training. Just to involve us in the budget and in the monies. To have that transparency. How much we having and how are we going to use it. Invite our ideas. I know my priorities in the department and what I need in order for my department to function adequately. Just to listen to me.” (OM 5)

Another OM responded to the support received from Department of Health in support of financial management training with the following excerpt:

“...nothing, In fact when you come into a position as an OM, you have to draw your own job description or the ANM draws it up for you. There should be a standard job description for OMs in all institutions. There are no guidelines. You are required to capture stats but there is no training provided. You are required to manage the human and financial management resources of the unit which is very difficult. The administration does not provide adequate guidelines on how to deal with issues. Mismanagement of leave impacts on finances.” (OM 1)

The ANMs experienced the same lack of support and attributed the poor support and training for the financial management role to the lack of finances for training as stated in the excerpt below:

“...even now we are having a problem. They tell us there is no budget. Nurses are resigning and not being replaced, they say we have to use the available resources. They are not supporting us enough. They have to come to the grassroots level and ask how they can support us. I am not happy. Most of the budget goes to salaries. We do attend workshops but it's rare.” (ANM 1)

Sub-theme 7.3: Peer support for financial management role

NMs indicated throughout the interviews that they receive support and guidance from the CEO, FMs and the financial department in any financial related matters that they require assistance. One NM confirmed that she requests assistance from other senior managers for any financial matters but found the centralisation of financial management functions a limiting factor, as noted in the following excerpt:

“...the CEO is chairperson of the Cash Flow Committee and the Quality Assurance Committee. All our financial committees are chaired by senior management. Obviously if there are any issues, or any particular problems I have I can go to the FM or CEO. Sometimes they are able to help, but we are severely limited as a lot of our functions regarding financial management are centralised with regard to equipment / contracts.” (NM 3)

One FM felt that the NM was not sufficiently empowered with financial management knowledge and skills as indicated below:

“...we have not empowered the chief NM as she is just grabbing information on the way. She is exposed to some aspects but not empowered. Empowerment of the chief NM will ensure that she cascades the knowledge to the other nurses. On the job training and an induction programme will help her understand finances.” (FM 2)

One CEO explained the support given to NMs in her hospital was by the FMs and other members of senior management as indicated in the excerpt below:

“...normally what is expected is that the NM is given an overview of the PFMA and what it entails, so that she can understand in totality what PFMA has. She has to be informed on the role of the committee. She is also responsible for asset management and must be updated as it changes from time to time. Those are the information she needs to be given so that she can start doing her job. We give them short courses; formal and informal short courses, in-service education normally given by FM, by district office and by head office at times. At the same time when we talk about the committees, the FM takes that role. He calls the Bid Committee members and briefs them on their roles and responsibilities. At times as management in Exco we have one-to-one in-service education. The FM assists in where the financial management skills are lacking. He provides one-on-one in-service education on the specific aspects she asked for.” (CEO 2)

4.4.4 Findings related to Objective 4

The fourth research objective sought to obtain information directly from the perspective of NMs as to what are their essential financial management development needs in public health care organisations. The theme that emerged from the findings was the need for financial management competency development.

4.4.4.1 Theme 8: Need for financial management competency development

Participants provided information relative to their needs and according to the identified areas of poor financial management skills and competencies. The five sub-themes related to the financial management competency development theme are compulsory financial management training for NMs in the public sector before being promoted or after promotion, training in budget and budgetary concepts, need for NMs to understand financial reports, training in cost centre management and training in financial management legislation. Table 4.11 presents the themes and sub-themes.

Table 4.11: Theme 8: Financial management competency development

Theme	Sub-themes
Theme 8: Financial management competency development.	Sub-theme 8.1: Compulsory financial management training for NMs in the public sector before being promoted or after promotion.
	Sub-theme 8. 2: Training in budget and budgetary concepts
	Sub-theme 8. 3: Need for NMs to understand financial reports.
	Sub-theme 8.4: Training in cost centre management.
	Sub-theme 8.5: Training in financial management legislation.

Sub-theme 8.1: Compulsory financial management training for NMs in the public sector before being promoted or after promotion.

One NM advocated for NMs and managers to be trained in financial management before promotion as reported in the excerpt below:

“...people should come into the post of managers after acquiring that financial information. When you go for the interview they don’t ask you in the interview about the previous. If you haven’t been in-service on financial management, how are you going to know unless you have been working closely with your previous supervisor maybe to equip yourself? They need to acquire that knowledge before they become NMs. After employment, you are expected to perform and they want to see you doing things. You won’t be saying please teach me first.” (NM 6)

Another NM recommended that financial management training for NMs must be presented in a way that can be easily understood as noted below:

“...we need to break down financial management in the way we can understand it. It takes time to understand it. Initially when you attend cash flow meetings you don’t understand anything. But as you go along you learn and ask, there are people who are afraid to ask. If something small and basic can be introduced, then it will be wonderful.” (NM 2)

The notion of compulsory financial management training for all new nurses was supported by a NM as summed up in the following excerpt:

“...I think that the role of the nurse has changed and we are definitely a part of the decision-making body. In order to do that we definitely need the knowledge. Everything revolves around finances, it is a starting point. We need to focus on a compulsory training for new recruits. It is a requirement to have some kind of management course behind. The compulsory training would be good and Department of Health focused. You find that all other financial management courses are generic which does not help you manage in the Department of Health. They present it in a generalised way where you can write it and fall

asleep. But it really doesn't help you practically. So it should be Department of Health current policies and focused on current health issues.” (NM 3)

The FMs concurred with the NMs in their request for compulsory financial management training prior to being promoted or appointed as a manager as evident in the following excerpts:

“...for the newer NMs and OM, as in nursing people often come and go, high turnover, I would say that maybe when a person is being promoted to the position of OM or any management position, they would have to undergo training in this regard. They have to be trained in finance management.” (FM 2)

Another FM proposed that a financial management programme or manual be developed which can be facilitated at institutional level as amplified in the excerpt below:

“...nurses don't have a financial background so they don't understand the concept of the lack of finances. There is a lack of understanding of finances in as much as I try our level best to explain at the extended management meeting our financial management processes and procedures. But I think they should be given financial management training at the level of the OM. I think that the department must design some sort of a manual whereby as finance we are going to handling training for nurses. Design a programme or manual where we can give nurses financial management training or a course that can be done on yearly basis so that we can keep reminding them. Orientation is ongoing and they forget things along the way. If they can design a manual, so that we at finance department can facilitate at institutional level.” (FM 3)

Sub-theme 8.2: Training in budget and budgetary concepts

Participants indicated that they required more training in the budget and the related concepts. One OM expressed that she does not have much knowledge about budgets and would require training as reported in the excerpt below:

“...I still need knowledge as I know virtually nothing as I was never involved. How can I develop a budget if I was never involved? I would like to. However, I need basic financial knowledge first then come to development.” (OM 5)

Another OM indicated that she needed training in understanding financial reports and the budget as detailed in the excerpt below:

“...the cash flow reports. We have our extended management meeting and towards the end of that budget year, our FM does present what happened during the year with regard to budget and where spent. We are given copies to review.

Most of the time we are not able to see where and how the budget was spent due to the lack of understanding and knowing how to read these reports.” (OM 4)

The FMs supported the need for training of the NMs in the budget and called for standardisation in this training as indicated in the following excerpts:

“...NMs need to understand the budget. As much as we explain. If we had a standard manual. We are trying to avoid having the institution doing things differently. If we can have the manual that can be revised and updated every 3 to 5 years as things change every year. The budget cannot be allocated more than what we have provided.” (FM 3)

“...need an understanding of government budget processes, where the money comes from and how it is distributed. These are the critical aspects for the NM in terms of finance.” (FM 2)

Sub-theme 8.3: Need for NMs to understand financial reports

One FM supported the need for NMs to be able to understand financial reports as they have to account for the expenses as indicated in the excerpt below:

“...NMs must understand financial reports. We have meetings with management and they tell us what the breakdowns are. They tell us what our costs are and where we are with the budget. We get regular updates. We get monthly expenditure reports and we query any discrepancies whatever is financed is based on the planning by NMS. They are responsible for drawing up business or procurement plans. The NM must oversee the whole financial processes within the units, so it’s important that she understands the financial processes. A training plan should involve how to link the operational plan, procurement plan, and budget and how to develop and implement these plans.” (FM 2)

One CEO also supported the necessity for the NM to understand financial reports as indicated below:

“...the application of BAS reports in terms of how to read them. The FM will just give the report and e-mail to everyone. It is very important to be equipped with the understanding of how to read this report. We do request the FM to make the report as simple as possible, but if we have not been in serviced specifically on how to read, even if simple, you will miss it.” (CEO 1)

Sub-theme 8.4: Training in cost centre management

The findings revealed that there was a huge call for the implementation of cost centres and for departments to be managed as cost centres. A training

programme is required for NMs to manage their units as cost centres as reflected by one NM in the following excerpt:

“...training is required in cost centre management. There are no cost centres and no history of cost centres. It is quite interesting once they are because we not going to know how much to start with.” (NM 3)

Further clarity was requested on the implications of having cost centres as part of the financial management role of NMs to which the response was as follows:

“...because there are no cost centres it is a case of if it is not on the procurement plan you can't buy it and we don't know how well we doing and we cannot assess our efficiency of utilising what we have. From that level I find planning is difficult. We don't have cost centres but being part of a committee within a hospital you begin to know how much budget is available for different things. It's not a lot for you to manage, for the services according to what you got. If each of the OMs were given their own cost centre there would be better planning and management of the finances.” (NM 3)

Another NM supported the notion that cost centres would increase financial management accountability of NMs and would encourage them to take ownership of their finances as attested to in the following excerpt:

“...I have actually asked our financial manager to make a cost centre for each department. So maybe if we know about cost centres that would also assist and take ownership of our budget. Now we don't take ownership of our budget, we just whatever we need in our departments we order for it and it comes.” (NM 2)

Another NM found that managing expenditure was challenging as there were no cost centres for the nursing units as reported in the following excerpt:

“...we don't know how much we are spending. This is a challenge as we do not have cost centres for our nursing units.” (NM 4)

There was also strong support for cost centres by the CEOs who were interviewed. One CEO added that in terms of financial management, she would like to further empower and felt that the nursing departments should move towards becoming cost centres. This is noted in the following excerpt:

“...the wards should be cost centres. Managing her (NM) nursing components as cost centres will allow her to monitor what is happening in the wards themselves from a financial perspective. If I had a voice, I would say please let's move towards cost centres.” (CEO 1)

The CEO above responded as follows to the comment that throughout the interviews there were a lot of suggestions for cost centres from CEOs and NMs:

“...do you know why? Along with NMs there are ANMs. They have ANMS for each area. If they were managed as cost centres then they will be able to manage their budgets accordingly and inform the NM. This means that the role of the NM can be streamlined.” (CEO 1)

Another CEO felt strongly that cost centre management would bring results-based action as attested to in the following excerpt:

“...cost centres will definitely bring about bring results-based actions. You will look at our benchmarks, utilisation rates, occupancy rates and align to our targets and expenses. It will also allow you to make sense of what you are spending. You will have trends and be able to compare with your expenses. Will also indicate over-expenditure and wastage. This then speaks to your controls and internal systems, which helps to plan and manage. There is a huge place for cost centre management.” (CEO 2)

Further probing was done to establish if NMs were given their own cost centre, would there be better planning and management of the finances? There were challenges verbalised by the respondents and this mainly was the lack of financial management skills and the lack of knowledge of cost centre management. There was a loud call for more training in cost centre management for NMs. One NM believed that with adequate and relevant training and knowledge on finances NMs would be able to manage a cost centre as stated in the following excerpt:

“...if they were given the knowledge and the financial background to a cost centre they would manage. At the moment with the knowledge and skills that they have they won't manage a cost centre, but I think with the necessary training it would improve things they will become more accountable for their environment. That is possible if we give them the training.” (NM 3)

Another NM advocated for cost centres as a way to make NMs accountable for the finances in their departments as noted below:

“...cost centres are the way to go. It is possible in the public sector, but with it goes accountability. This should be taken seriously into consideration when drawing up the Performance Management System of staff. We appreciate that it's important and we are being monitored on it. If they underperform then you score them appropriately. But obviously you start off with the necessary in-service and information they will need for managing a cost centre.” (NM 5)

Some NMs felt that though cost centre management was ideal it was not possible to manage in the public sector as there were other challenges that would hinder the implementation. One ANM felt that cost centres would work if the OMs had some financial knowledge as indicated in the following excerpt:

“...it will work provided you have someone monitoring. But you have to empower OMs with financial knowledge.” (ANM 1)

A second ANM felt that the lack of physical and human resources and the constant changes would make it difficult to run each unit as a cost centre as evident in the following excerpt:

“...I don’t think that will work in our institution. For now, we don’t even see or know how much is being allocated into my department. Things change. We are admitting different diseases and conditions in our wards. Also patients may be admitted to different wards, such as surgical into medical. We may admit patients who require expensive dressing on a long term such as burns. These are things that will not be budgeted for. We don’t get the support and staffing to assist us. This will not work unless they are able to supply the human resources and resources to cope with the increased activities.” (ANM 2)

The OMs also voiced their concerns over managing their departments as cost centres. One OM found that managing the unit as a cost centre was unrealistic at present due to staff shortages as noted below:

“...that can work but it is unrealistic at present. Due to the staff shortages in the unit, I am myself working rendering basic patient care. That can be done provided that we are well staffed and we had the help of the ward clerks. It looks like it is a very time consuming effort. I would need ward clerks with that type of training and adequate staffing so that I then can oversee. As a nurse we have to be on the floor to prevent medico legal hazards.” (OM 4)

Another OM indicated that she would like to manage her unit as a cost centre but the staff shortage presented a reality that would not make it possible as indicated in the following excerpt:

“...that would be ideal situation. Unfortunately in the provincial setting, the reality is that there is such a shortage of staff that I would not be able to take this on my own. This will be a mammoth task. If the staffing was adequate then I would be able to. I would then be able to run the unit as in a private hospital where the OM just focuses on the financial aspects. I would definitely like to manage my own cost centre.” (OM 1)

Another OM lauded the idea of a cost centre and indicated that being given her own budget and managing the unit as a cost centre would give her a sense of ownership. She however felt that the lack of standardised and centralised systems and the correct technology would hamper the management. This is verified in the following excerpt:

“...I would have no problem if we were given that kind of control as I will purchase the equipment I want. Now they are focusing on units where they think that more money is needed and less to others. If I had my own budget, I would then be able to identify my priorities and what can wait for the next financial year. I will get what I need. You have to have a sense of ownership for where you are working and a sense of loyalty and a sense of belonging to that area. It will be fine if we were given a fixed budget per unit. As a cost centre you would have to manage a budget. This is not possible as we do not have computer systems to support us such as having a centralised system of procurement. The budget is for all the units overall not specific.” (OM 3)

Sub-theme 8.5: Training in financial management legislation

A NM indicated that all the financial management activities were guided by the PFMA and providing training of the legislation would assist in understanding how financial management processes work in the public sector as noted below:

“...you find it is wasteful expenditure, you will find that people will be quoting the PFMA and the sections that apply. We have the document but it is a big one. So we need the sections that are relevant and critical for you as a NM. In this book, the person that is doing finance will understand it. For us there are sections that are critical those talks to expenditure. So if someone can just unpack it in the simple language just for us to understand.” (NM 1)

Another NM advocated that all managers should have knowledge of the financial legislation as reported in the following excerpt:

“...I think before you become a manager or even once you become a manager, I think part of your induction and orientation should be a financial somebody to give you in-depth knowledge of the financial act. I would really like to get more knowledge.” (NM 2)

One OM supported the need for training in the PFMA as indicated in the excerpt below:

“...training is needed on the PFMA - guides managers on how to use funds.” (OM 2)

4.5 SUMMARY OF THE CHAPTER

Chapter 4 presented the main themes and sub-themes that emerged in the study. The next chapter discusses the research findings which are supported by literature and findings from other published research.

CHAPTER 5: DISCUSSION OF RESULTS

5.1 INTRODUCTION

The previous chapter presented the results of the study. In this chapter, the discussion of results is presented in order to highlight how the research questions were answered and objectives achieved. The findings of this study are discussed in the context of the literature that was presented in Chapter 2 and the new literature that surfaced as a result of the findings.

The earlier proponents of GT discouraged conducting a literature review prior to the study. These arguments are presented according to the views of the main proponents of GT. Glaser (1992: 31) argues in support of no reading in the field related to the topic to be done prior to the study. He contends that the literature related to the researched area should only be read in later stages of a study (Glaser 1992: 31). Later on, Glaser (1998: 67) expressed that the literature search in the substantive area can be merged into the theory as “more data for constant comparison only when the grounded theory is nearly completed during the analysis and write up.” On the other hand, Strauss and Corbin (1990: 56) acknowledge that it is not only the personal and professional experience that a researcher adds to the research, but also knowledge picked up from literature. They argued that literature read prior to data collection could not for certain hamper the emergence of the theory. The authors recommended that the literature should be used in all phases of the research (Strauss and Corbin 1990: 56).

Charmaz (2006:166) resonates with Strauss and Corbin’s (1990: 56) validation of literature and agreed that the literature should be assembled in a specific literature review chapter and be used all through the study (Charmaz 2006: 166). Charmaz’s (2006: 166) statement is consistent with the naturalistic (constructivist) paradigm chosen for this study which states the assumption that multiple realities cannot be understood in isolation from their contexts and must be studied holistically (Lincoln and Guba 1985: 3). The

study used Charmaz's constructive GT and a literature review was done prior to conducting the study. However, consistent with GT, new concepts emerged during data analysis and new literature was sought during the course of the study.

The discussion of results in this section is based on the five objectives that were identified at the beginning of the study and how they relate to achieving the aim of the study. The objectives were to:

- Explore the current roles of the NM with regard to financial management practice in public health care organisations.
- Determine the financial management competencies that NMs in public health care organisations currently possess.
- Explore the training and educational qualifications NMs have with respect to financial management.
- Establish the essential financial management development needs of NMs in public health care organisations.
- Develop a financial management competency framework for NMs.

5.2 OBJECTIVE 1: CURRENT ROLES OF THE NURSE MANAGER WITH REGARD TO FINANCIAL MANAGEMENT PRACTICE IN PUBLIC HEALTH CARE ORGANISATIONS

The first research objective sought to identify and establish the financial management roles and activities of NMs in their current positions. According to Sherman (2014: 1), the role of the NM has changed radically over the past decade in that the clinical and interpersonal skills that led to the selection of many managers in the first place are simply not enough to ensure good performance. The NM role has a strong business component that needs to be both acknowledged and supported. Sherman (2014: 1) acknowledges that on many levels, the success of a healthcare organisation is extremely dependent on the performance of NMs. A concern raised by Sherman (2014: 1) was that the considerable changes in the role have received little acknowledgement by most health systems and managers often receive little in the way of leadership development and NMs struggle in a role for which they are not

prepared. Taking this into consideration, it was essential to firstly establish what financial management activities were NMs were carrying out in their daily practice. The four major themes that emerged with regards to the current roles of the NM in financial management practice in public health care organisations included financial planning, financial monitoring, financial decision-making and financial control.

5.3 THEME 1: FINANCIAL PLANNING

The findings reveal that generally, managers at all levels in public hospitals are involved to some extent in financial planning. The NMs are not directly involved in the financial management of the hospitals, which is primarily the function of the CFO and the CEO. Nevertheless, they play a critical role by performing various activities that contribute to the financial functioning of the hospital. There is an interdependent function as the CFO and CEO depend on the information provided by the NMs in order to plan finances and the budget. In the public hospitals managers at all levels in the hospital such as the OMs, SCM managers, HR managers are involved in these financial planning activities.

Fiegenbaum (2016: 1) agrees that NMs play a critical role in hospital operations. Nurses provide the majority of in-patient care and are responsible for patient safety and well-being. The NMs have to ensure that their units live up to their responsibilities. At the same time, hospitals are business entities and have financial concerns. The NMs have a financial duty to their organisations and play a key part in ensuring hospitals control and manage their budgets. Hartley (2013: 1) found that poor knowledge about budgeting and finances was a challenge for NMs who were required to manage their departments in a cost-effective manner. The nursing budget comprised more than half of the total hospital budget and pressure is on NMs to increase efficiency and effectiveness (Hartley 2013: 1).

The financial planning role of the NM involves several activities that, in the context of this study, emerged as sub-themes. These sub-themes are (1) strategic planning, (2) operational planning, (3) procurement planning, (4) human resource planning and (5) budget and budget structuring.

5.3.1 Strategic planning

Financial planning in any organisation occurs in different ways and at all levels which includes the setting of organisational goals. This study revealed that part of the financial planning role of the NMs was participation in the strategic planning of the organisation. Booyens, Jooste and Sibiya (2016: 12) state that the strategic planning process involves drawing up of action plans for achieving the objectives of the organisation in terms of the mission statement. The process is applied at three levels in the health care organisation, namely, the top management level (includes the NM), middle management level (ANMs) and at operational or functional level (OMs).

As indicated by the study findings, all NMs and OMs together with the senior managers in the hospital participate in drawing up the strategic plan. The responsibility of the accounting officer of an institution is to prepare a strategic plan for the forthcoming financial period for approval by the relevant executive authority (South Africa 2001: 5). It is stated that a strategic plan must include the measurable objectives, expected outcomes, programme outputs, indicators (measures) and targets of the institution's programmes. In the case of public hospitals, the CEO is responsible for the overseeing and submission of the strategic plan to the provincial offices for approval. The CEO of the institution cannot draw up a strategic plan on his or her own and requires the input of all departmental managers. The NM as head of the nursing section must then provide input into the strategic plan for the nursing side. As indicated earlier, this was done collectively for the nursing section and forwarded to the CEO by the NM for integration into the organisational strategic plan.

Peel (1993) cited by Booyens, Jooste and Sibiya (2016: 73) assert that most organisations only involve senior or top management in strategic planning, but some involve managers at all levels. Strategic planning is done annually in the public hospitals. In this study, NMs at all three levels namely top, middle and operational level were included in the strategic planning of the hospitals.

Muller, Jooste and Bezuidenhout (2015: 436) found that financial management is directly related to the strategic management process of an organisation. The strategic objectives are converted into operational plans, followed by the process of budgeting and subsequent implementation of the plans, applicable in terms of monitoring, reporting, analysis and feedback and final establishment of adherence with the performance indicators.

The findings of the current study revealed that participants were able to correlate the drawing up of the operational plans and procurement plans which were based on the strategic plan. Participants were also able to identify how these plans fitted into the strategic plan and the big plan for the hospital which was eventually integrated into the provincial strategic plan. They did not encounter any problems in formulating strategic plans. Similarly, Asamani, Kwafo and Ansah-Ofei (2013: 27) confirm that middle managers are responsible for tactical planning that translates long-range strategic plans into short-term tactics, usually over one year. Asamani, Kwafo and Ansah-Ofei (2013: 27) found that the level at which planning starts in a hospital's hierarchy can be linked to the type of planning, whether strategic, tactical or operational. Top-level managers, including nurse executives or hospital matrons, usually undertake strategic planning to establish long-term goals to reinforce the hospital's mission (Asamani, Kwafo and Ansah-Ofei 2013: 27).

Danna (2013:1) supports the above findings by identifying strategic management as part of the essential business skills that nurse leaders need in their skill set to succeed. The author urges NMs to familiarise themselves with the components of a business plan, have the skills to write a simple business plan and be able to conduct a strengths, weaknesses, opportunities and threats (SWOT) analysis. The NMs should participate in the strategic

planning process for the organisation by providing input into this process and also be able to implement the plan into daily functions. Expertise in writing organisational goals, personal goals and objectives are also a recommendation for NMs (Danna 2013: 1).

5.3.2 Operational planning

Booyens, Jooste and Sibiya (2016: 73) state that business plans are produced by smaller organisations for all their activities. In larger organisations business plans are drawn up for new products or special projects. Business plans serve the purpose of informing investors of the internal and external aspects that influence the organisation. The operational plan is a detailed plan of the objectives and the allocation of resources. Operational plans involve activities such as programmes, projects, budgets, policies, and procedures to achieve the overall goals of planning (Smit *et al.* 2007: 119).

In health care organisations the terms ‘business plan’ and ‘operational plan’ are used interchangeably. In the public sector the term operational plans are used. Visser and Erasmus (2002: 124) confirm that the programmes and projects that have been identified in the strategic plan eventually form the basis of the operational or business plan of the organisation, which would assist in achieving the set goals and objectives. During the interviews it was noted that participants used both terminologies to describe the planning of operations in the departments.

As stated in the Guide for Accounting Officers (South Africa 2000b: 8), the first year of the strategic plan is known as the operational plan. It must provide a sufficiently detailed quantification of outputs and resources, together with service delivery indicators, for the legislature to understand exactly what it is ‘buying’ for the community when it approves the budget. The plan must contain descriptions of the various programmes that the department will follow to achieve its objectives, and for each programme, the measurable objectives, total cost and intended lifespan (South Africa 2000b: 8). The study findings

clearly outlined the understanding and compliance of the participants to the prescripts of the legislation. The NMs followed and drew up the operational plans as directed by the guidelines. Reference was made by a participant that a guide on how to draw up operational plans was made available to them.

Muller, Jooste and Bezuidenhout (2015: 24) contend that operational planning is a medium-term plan developed by senior management and approved by top management. The NM collates the operational plans compiled and drawn up by the OMs of the different departments and units. It was clear in this study that operational plans were drawn up by the OMs and all other relevant managers within the department. Further findings from NMs reveal that the NM was responsible for collating the operational plans and submitting them to the CEO to incorporate into the hospital's total plan. Peel (1993) cited by Booyens, Jooste and Sibiya (2016: 73) states that operational plans depend on factors such as the routine of operations performed and the nature of the services required by the patient. In this study participants were able to draw up their operational plans in line with the suggestions from Booyens, Jooste and Sibiya (2016: 73).

Anderson, Post, Smith, Stinson and Fitzpatrick (2014: 63) assert that when following the requirements of strategic planning, business planning is essential. The use of business plans in health care helps leaders achieve strategic plans by using innovative ideas to ensure achievement of clinical and financial outcomes. Business plans include a current comprehensive market assessment, legal and regulatory elements summary, implementation plans with timelines, resource needs, financial forecasts, and risks, benefits, and exit strategies (Anderson *et al.* 2014: 63). Unlike what Anderson *et al.* (2014: 63) suggest, participants in this study did not or were not able to fully enunciate or identify their operational plans in line with all the strategies as stated. They were able to identify the resources needs only.

Following from the above statement, the OMs in this study indicated that they drew up their operational plans based on the needs of their departments. These findings are in keeping with the statement from Kroon and van Zyl (1995) cited by Wentzel (2008: 58) who found that first-line management (referring to OMs) are responsible for the planning of operational plans. This is done within the framework provided by middle management. It was noted in this study that the NMs as head of the nursing departments indicated that they developed operational plans together with the ANMs and OMs who are the departmental managers. This finding concurred with Wentzel's (2008: 58) study who found that operational managers and supervisors are responsible for managing and planning with their own personnel. Objectives must be set with the personnel and responsibility should be delegated to them.

The first year in the strategic plan is usually an operational plan, which details the operations for the coming financial year. For each of the activities, detailed roles and responsibilities are assigned. A detailed definition of inputs to achieve outputs and outcomes should also be provided in the operational plan. This includes human resources, information technology, information resources and physical resources such as buildings or office spaces. The information on activities, measures and target levels of performance is then used to draw up performance contracts for each of the officials in the organisation (Public Service Commission 2011: 10). The participants in this study did indicate that they compiled operational plans annually, however they did not conform to all the criteria for drawing up the plans.

Smit *et al.* (2007: 119) find that operational planning involves the functional aspects of different departments within the institution and deals with recruiting and training of staff, building and equipping the buildings, and financing. The people involved in drawing up of the operational plans are usually the OMs in institutions, the departmental accountant, budget controller and subordinates who formulate operational plans for the services to be rendered, and those who see to the procurement of supplies and allocation of resources.

5.3.3 Procurement planning

Ambe and Badenhorst-Weiss (2012: 244) define public procurement as the function whereby public sector organisations acquire goods, services and development and construction projects from suppliers in the local and international market, subject to the general principles of fairness, equitability, transparency, competitiveness and cost-effectiveness. It includes many activities that support the service delivery of government entities, ranging from routine items to complex development and construction projects.

Procurement in the public sector is governed by a number of laws. Procurement is regulated in terms of Section 112 of the Municipal Financial Management Act No 56 of 2003 (MFMA) (South Africa 2003b) and Section 76(4) (C) of the Public Finance Management Act 1 of 1999 (PFMA 1 of 1999) and the Preferential Procurement Policy Framework Act No 5 of 2000 (PPPFA). There are also various guidelines that have been developed for managers in the public sector to assist them with procurement practices. One such guideline is the National Treasury Supply Chain Management (SCM) Guide for Accounting Officers. This guideline states that a needs assessment must be conducted prior to procurement of goods and services. The objective is to ensure that goods and services comply with specifications as requested, resources required are delivered at the correct time, price and place, and that the quantity and quality satisfies the needs (South Africa 2003a: 12). It was noted in the findings of this study that NMs and OM's prepare the procurement plan according to the needs of the department. The NMs and OM's indicated that they requested or ordered items based on their departmental needs.

According to Fourie (2009: 62), public managers play a crucial role in the procurement of goods and services as applicants or buyers. In the public service the National Treasury, accounting officers, CFOs, provincial treasury and bid committees are responsible for SCM. Emerging from this context, participants in this study verbalised inclusion and consultation with the interdisciplinary health team when drawing up the procurement plan. NMs, though not directly involved in the drawing up of the budget, contribute by the

way of procurement plans. Procurement plans are drawn up by each department and submitted to the NM for collation and submission to the finance manager.

Handfield, Monczka, Guinipero and Patterson (2011:160) found that centralisation in procurement planning offers advantages such as buying power due to quantity, reducing of duplication of processes involved in buying, enhanced control and developing of expertise of the personnel involved in procurement. Conversely, decentralisation often leads to a quicker response to the purchase, a better understanding of distinctive needs of each organisation, use of suppliers that are local or close and control over the budget (Handfield *et al.* 2011: 162). Contrary to Handfield *et al.*'s (2011: 160) statement about centralisation, the participants of his study found centralisation to be a hindrance and caused delays in obtaining the procured items.

Participants in this study expressed their dissatisfaction with the procurement process. The OMs informed that the items ordered often were delivered to them long after being requested. Some participants articulated that they never received some of the items ordered and no explanations were given for the absence of the items. Similarly, Mothiba's (2013: 106) study identified a lack of transparency in the procurement system when funds were allocated. It was evident that budgets were drawn up and requisitions submitted for particular items. However, the units did not receive their requisitions and no explanations or reasons were provided. Further, if the requisition was purchased it was given to another centre rather than the centre that requested it, without any explanations.

Subsequent to the discussion presented above, Mothiba (2013: 107) concluded that it is evident that there are constraints in procurement practices in the South African public sector. These predicaments can to a large extent be attributed to lack of proper knowledge, skills and capacity. Therefore, the South African government needs to address these dilemmas in order to fully achieve the policy objectives of public procurement.

Tshabalala (2015: 29) concurs that there are several inefficiencies in the procurement process in the public sector. There are various examples of poor public sector practice in the procurement of goods and services, hiring and motivation of staff, and management of systems. This reflects both inappropriate behaviour and systems that are excessively bureaucratic, leading to delays and poor value for money. These issues affect the entire public health system.

Tshamaano's (2012: 3) study found several challenges that were identified in SCM. The backlog of service delivery on SCM is one of the biggest challenges facing South Africa. There is an increasing number projects undertaken by various contractors and service providers hired by government departments which are incomplete. Although there are rules, regulations and policies to be followed by those service providers, there are still service backlogs. Another challenge identified is that often a product of poor quality is bought. This results in equipment which becomes defective within a short time. A similar finding emerged from the study where participants indicated that a reason for the lack of equipment and resources was that inferior quality stock is sent to them which results in breakages and wastage.

Similarly, Wentzel's (2008: 244) study found that participants were dissatisfied with the provision and procurement of equipment which was due to the red tape related to the provisioning and procurement process. For example, quotations have to be requested, expenditure of funds for the purchase must be requested and documentation should be processed with the issuing of an order number. The order number is submitted to the provider and delivery will depend on the availability of stock. Another reason might be that the critical equipment list, which is submitted annually to the Head of Health of the Free State for his approval, had to be revised several times due to a lack of finances. Ultimately, only a limited number of equipment could be purchased which was totally insufficient to address the needs of the clinics (Wentzel 2008: 244).

5.3.4 Human resource planning

Muller, Jooste and Bezuidenhout (2015: 254) defines 'human resource planning' as the process of anticipating and making provision for the movement of people into and out of the organisation. The purpose is to deploy the resources as effectively as possible, when and where they are needed, in order to accomplish the goals of the organisation. Booyens, Jooste and Sibiya (2016: 150) asserts that human resources management is the most important and challenging function of management because the outcomes of a unit or organisation depend largely on the staff.

One of the central responsibilities of the NM as noted in this study was that of human resource planning. NMs indicated that their roles in financial planning included ensuring that there is the appropriate number and mix of nursing to match actual or projected patient care needs. Finkler, Kovner and Jones (2007: 193) find that the largest part of the operating budgets for nursing departments and organisations consists of personnel costs. Justifying the need for a given level of staff requires cautious calculations and a rational argument. NMs must be aware of the substantial resources that should be devoted to nurse staffing. Dunham-Taylor and Pinczuk (2010: 183) add that workload management is an essential concept for NMs. As nursing constitutes the majority of the workforce in health care facilities, NMs are faced with the increasing demand to ensure efficient and effective service delivery.

Similar to the findings of this study where the NM plays a critical role in HR planning, findings that emerged from Courtney, Yacopetti, James, Walsh and Finlayson's (2002: 202) study was that ensuring an adequate and appropriate staff mix and numbers was very difficult for the NMs due to the staffing shortages and the lack of finances to employ more staff and fill vacant posts. This led to NMs moving staff around from departments that were adequately staffed to those that were poorly staffed.

Fiengenbaum (2016: 8) supports this finding by asserting that nursing labour is one of the largest patient-care costs in a hospital. Unlike certain medical services such as rehabilitation therapy, nursing services do not generate a revenue as nursing is considered a cost centre. Therefore, hospitals struggle to maintain enough nurses on duty for proper care and safety while not incurring excessive costs. NMs are charged with figuring out how to responsibly and cost effectively staff their departments through weekly, biweekly and monthly schedules. Booyens, Jooste and Sibiya (2016: 152) maintains that NMs should be responsible for determining the staffing requirements of nursing personnel in their institutions. However, this does not happen in the public hospitals in the current study, as staff appointments are determined at provincial level without NMs involvement.

The findings that emerged from this study indicated that NMs had to do a careful needs assessment to determine whether the employment of staff for the filling of vacant posts was necessary and evaluate if the patient care needs and demands warrant the position. Huber (2010: 714) states that registered nurses can be considered a scarce human resource. Staffing becomes contentious when available resources, especially finances, are limited and consequently the number of posts is restricted.

A further role of the NM in HR planning was ensuring that the staffing levels and salaries are within the budget. Bai, Gu, Chen, Xiao, Liu and Tang (2017: 122) posit that nurses are often seen as one of the largest cost components of any health care system and nursing activity funding accounts for approximately one-third of the total budget of any hospital. NMs who are the leaders of the nursing sections, control labour costs, which is the largest part of the labour budget of a hospital. Therefore, NMs play a major role in realising cost savings and adding to the financial stability of hospitals.

Contrary to the findings of this study where NMs were very much aware of the budget and took the budget and finances into consideration when planning staffing, Wentzel's study (2008: 186) found that most of the respondents indicated that they were not familiar with the budget allocation for human

resources and were not at all conversant with financial matters pertaining to human resources and clinic maintenance. Clinic managers in this study were not directly involved with human resource matters in general. They were mostly involved with human resource matters pertaining to their clinic, including management of leave and absenteeism. Most of the other human resource matters were attended to at the central district office.

The researcher noted that the NMs found HR planning to be a very stressful part of their financial planning role. This was due to the number of posts being restricted by the Department of Health and the high vacancy levels in the hospitals. It was very difficult to staff the departments adequately to ensure reasonable standard of care. Shirey's (2009: 64) study revealed similar findings where human resources and staffing were the biggest cause of stress for NMs. The inability to procure the necessary human resources needed to operate their units was cited as most burdening for NMs. Two NMs discussed difficulties related to people and resources to the extent that it was very stressful just getting enough nurses to take care of patients 12 hours at a time. Added to that was the overwhelming sense that NMs are responsible for everything related to staffing, but do not have all the tools they need. The frustration, as related by the NMs was being the responsible party, but having none of the power to control the situation (Shirey 2009: 64).

Findings from Fleming's (2013: 120) study revealed that frontline managers with developed competencies in financial, human resource and operational management were able to play a vital leadership role within the whole organisation. Increasing participants' competency in human resource management required programme facilitators to teach participants a range of human resource management strategies. Effective rostering and relevant human resource management strategies were taught by expert nursing staff, enabling participants to develop improved expertise in this area within their leadership role (Fleming 2013: 158). The NMs in this study verbalised no formal or informal training and assistance to determine and calculate staffing levels and development in human resource management.

5.3.5 Budget structuring and formulation

Booyens, Jooste and Sibiya (2016: 58) describe a budget as a detailed plan for the acquisition and use of financial and other resources over a specific period of time. It is an amalgamation of expenditure plans and revenue origination plans for the coming year. Budgeting on the other hand is defined by Muller, Jooste and Bezuidenhout (2015: 446) as dealing with income and expenditure for resourcing of the organisation's strategy by drawing up a plan for obtaining resources (planned revenue) and the use of resources in order to achieve the organisations objectives (planned expenditure). This is done according to the type of business ownership, and the legal, professional-ethical and organisational management framework of the health care organisation (Muller, Jooste and Bezuidenhout 2015: 446).

In the public sector a standardised budgeting format has been introduced and is widely used. Budgets are prepared based on the medium-term expenditure framework (MTEF), which provides information on the budgetary implications of current and future programmes two years in advance. At national level, estimates of national expenditure provide information on objectives, policy and outputs. This is a major step towards integrating budgets with policy priorities. Provinces are not all as clear in their statements of planned expenditure. The variable quality of provincial expenditure plans could be resolved through a dedicated budgeting improvement programme (Public Service Commission 2011: 11).

Participants verbalised that they had no idea of how the budget was prepared, approved and allocated. In terms of the PFMA (South Africa 1999: 23), the accounting officer prepares the departmental budget (specified in terms of measurable objectives) for the Minister or Member of the Executive Committee to approve and present to the legislature for voting. The accounting officer is then responsible for implementing and managing the budget. Accounting officers are responsible for the operation of basic financial management systems, including internal controls in departments and any entities they control. They must implement measures to ensure that

departments do not overspend their budgets (South Africa 1999: 23). The National Department of Health receives the overall public allocation for health services from National Treasury and then establishes and allocates funding to provinces. The provincial health departments divide up the health budget between district primary care, hospitals and other health services. They then set the budgets of individual facilities based on submissions from each facility (Ensor, Kruger and Lievens 2009: 18).

Participants in this study expressed the need for more inclusion and consultation in the budget process. Findings reveal that participants want to be consulted in establishing what budget amounts they require for the nursing section prior to the budget submission. Presently, they are not aware of the amounts they are allocated per department as the funds are all combined into one budget for the entire nursing section. Similar to these findings, Wentzel's (2008: 186) study found that the current trend in budgeting is to decentralise the budget process down to the point of service since those rendering the service are more aware of specific circumstances and conditions prevailing in the day-to-day operations of the organisation. The findings of the study indicated that most of the respondents were not conversant with the budget allocation and did not have sufficient knowledge of the clinic budget (Wentzel 2008: 186).

It was evident that the general perception among NMs in the current study was that although they were not fully involved in the budget planning and development, they were involved to a certain level. The findings reveal that NMs do not actually draw up a budget but perform and coordinate various activities that contribute to the formulation of the budget. NMs participation in budget development is limited to the input provided in the procurement plans and operational plans submitted by the various nursing departments. The operational plans and procurement plans are then forwarded to the CEO and FM for collation and integration into the hospitals budget. It was noted in the findings that the role of the finance department is to compile and manage the budget. In order to plan for the budget, assistance and input is required from NMs and various other stakeholders in the organisation. Booyens, Jooste and

Sibiya (2016: 107) posit that input for the budget is essential and must be obtained from health service managers as nursing is the main user of resources in hospitals. The budget is an important aspect of capital and should be managed by managers on all levels of management. Since those rendering the service are usually more aware of the circumstances and conditions prevailing in the day-to-day operations of an organisation, the current trend is to decentralise the budget process down to the point of service delivery (Booyens, Jooste and Sibiya 2016: 107).

The findings above are supported by Andrew (2009: 1) who reports that NMs play an important role in a healthcare organisation's financial planning and management. Traditionally CFOs, though still managing the financial processes, request input from the senior management team mainly the CEO, the CNO and the HR officer for the budgets. This translates to developing a budget that supports the overall strategy of the organisation (Andrew 2009: 1).

One of the shortcomings of the NMs as noted in this study was the lack of knowledge on the budget process and how it is drawn up. Participants expressed that the budget was drawn up on historical and the previous orders from the stores department. The findings are confirmed by Ensor, Kruger and Lievens (2009: 18) who affirm that hospital budgets are not driven by any primary mechanisms or formulae (such as a system of costed norms) but, rather, by annual adjustments to historical levels of spending to take into account, for example, public sector wage increases or general inflation. They might also incorporate budget responses to specific needs that arise from time to time, although hospitals frequently complain that they are required to implement new policies and priorities without additional funding (unfunded mandates). Within the public sector, budgets for hospitals are developed through negotiation between hospitals and provincial health departments during the annual budget round. Budgets are structured around traditional economic line items: staffing, medical supplies, operating costs and capital spending. Facilities and provinces often develop quite detailed plans based on current and assessed future need. However, once budgets are submitted they

are invariably cut back so that, essentially, they reflect last year's budget plus an allowance for inflation (Ensor, Kruger and Lievens 2009: 18).

All participants interviewed reported a sense of despondency with the lack of finances and inadequate budget that did not meet their requirements. In support of these findings, Tshabalala (2015: 22) further confirms that financial departments are generally grossly under-resourced and lack the capacity to draw up or monitor budgets, control costs or expenditure or monitor shrinkage and waste. Budgets bear little relation to operational reality, and there is consensus that budgets are 'meaningless' as they are based on historical allocations rather than operational activity and realities (Tshabalala 2015: 22).

The results of the current study showed that NMs did not receive all the items they requested in their procurement plans as the budget received was way below what was projected. This led to many NMs having to review their procurement plans and prioritise their needs according to the available funds. It was quite evident from the responses that this reduced or limited budget resulted in a lot of frustration among NMs and other staff members. Mothiba's (2013: 110) study found similarities where it was evident that participants do not receive the budget they had requested but were given lesser amounts instead that did not cater for the needs of their departments.

Another common finding that emerged from participants' accounts was the desire to have control over and manage their own budgets and departments as separate independent cost centres. This they felt would give them greater autonomy and control over their department's finances and would enable them to purchase goods and services according to their own individual needs and according to their specifications. The findings on the need for greater involvement and control over the budget are similar to those of Doyle and Williamson (2008: 1) whose study was conducted to identify the knowledge gap and learning needs of clinical/nurse managers posed by devolved budgeting within a changing environment (Doyle and Williamson 2008: 8). Apart from three participants who had prior experience of budgeting, there was a general lack of knowledge of what constitutes a budget. Some

participants expressed anxiety about not being able 'to do budgeting'. All expressed a need for education (Doyle and Williamson 2008: 29).

The idea of decentralisation of the budget was conveyed by NMs and hence these findings point to the conclusion that NMs want to be more active in drawing up the budget for the nursing units. Doyle and Williamson (2008:38) support the idea that devolved budgeting would allow the department managers more control over their budgets so that they could realign priorities on the ward, such as re-organising staff shifts or reviewing medical supplies in the department. Discussions could be held in departments with staff to highlight areas of concern, to look at new ways of operating and ensuring that the staff understand the budgeting process and how it applies to their department. This involvement would ensure that devolved budgeting is an entire departmental responsibility and not just that of the department manager.

According to Smit *et al.* (2007: 107), the budgetary process belongs to the budget holder which is representative of everyone within the organisation that is given a degree of responsibility to make day-to-day operational decisions in view of organisational objectives. Doyle and Williamson (2008: 44) support the involvement of the NM in budgeting by stating that in the future of health service will involve clinical NMs in the budgeting process. NMs have the knowledge and experience to determine, communicate and allocate the needs essential to clinical care. Devolved budgeting would allow the clinical NM to assist in the provision of high quality clinical patient care and help in deciding on the amount of care to be given and the resources required in addition to the way in which it is provided. Devolved budgeting may also assist the hospital to meet its strategic objectives. Such a shift in the role of the clinical NM represents only a part of the change process within the health care sector (Doyle and Williamson 2008: 44).

Another finding that was brought to light in this study was that the NMs found the budget to be rigid and inflexible to the extent that it is not possible to transfer unused funds to purchase other items. Once the allocated budget for

a specific item has been used up there will be no funds for that item until the next budget period. The process to move funds is a very lengthy, tedious process which requires an application and a motivation. Van der Heever (2009: 144) conducted a similar study in public hospitals in South Africa, where he investigated management processes with reference to financial planning, organising, leading and control. The aim was to identify gaps in the management of financial processes and to provide guidelines and strategies to improve these. The major inferences drawn from this study were that the different health care professions have a poor perception of the scope of financial management in terms of financial needs, utilisation of resources, the scope and function of leading and delegation, and applying appropriate financial control methods. Van der Heever's (2009: 144) study found that the three major shortcomings as identified by the participants were the budget being centralised, a lack of transparency and a lack of information around the budgetary process (van der Heever 2009: 144).

It was noted in the findings that the lack of accountability for the finances and budget on the part of nursing staff was attributed to the lack of knowledge of finances. Wentzel's (2008: 186) study confirms that the lack of feedback on budgetary expenditure leads to a lack of insight into budgetary matters. This can be ascribed to the fact that most of the clinics do not operate as separate independent cost centres. The budget of the local area is a general budget, which includes all the clinics located in the specific local area, and it would be impossible for individual clinic managers to identify their expenditure (Wentzel 2008: 186).

5.4 THEME 2: FINANCIAL MONITORING

The second theme to emerge from the findings related to the NM role in financial management was that of financial monitoring. It is reported in the Guide for Accounting Officers (South Africa 2000b: 16), that the most important requirement of the PFMA is to expect accounting officers to act as managers, ensuring that mechanisms for the in-year management of resources are effective. They must monitor progress on the department's

operational plan (which includes the budget), and produce, consider and act on monthly and quarterly reports, which are then submitted to the executive authority and the treasury. Systems and processes already exist for monitoring and reporting monthly budgetary performance, but accounting officers have to scrutinise the financial reports, including data on grants and transfers, before signing off and submitting the required reports. The accounting officer, through the CFO, is responsible for establishing systems, procedures, processes and training and awareness programmes to ensure efficient and effective banking and cash management. The CFO must ensure that the department's systems, records and statements of procedures meet the purposes of sound cash management. He or she must monitor cash management performance and report to the accounting officer, in writing, at least monthly (South Africa 2000b: 16).

The findings in this study illustrated that all senior managers were involved in the monitoring of the finances, budget and operational plans. Overall, participants reported that internal financial monitoring at the institutional level was carried out in two ways. The first mechanism involves attendance of cash flow meetings every month where there is a discussion and monitoring of how the funds are used and to ascertain whether all financial activities are within the prescribed budget. Finkler, Kovner and Jones (2007: 472) state that the NM is currently responsible for the direct operating expense budget for all nursing services and in many cases a high degree of control over this budget.

5.4.1 Cash flow monitoring

It was noted from the data gathered that the NM is responsible for the monitoring of expenditure and ensuring that this is within the allocated budget. The NM monitors orders and approves items ordered or requested. Part of the NM role as found in the study was also monitoring of payments. As revealed in the results, these functions were accomplished by the NM as part of the senior management team through participating in cash flow monitoring. These findings are in keeping with Cole-Ingait (2016: 1) who explain that a health organisation generates transactions from its operational and strategic

activities. The organisation receives or pays money to parties it transacts business with. The cash flow statement summarises these transactions into total receipts and payments as generated by the different activities of the healthcare organisation over a specific period. In this study, participants indicated that cash flow monitoring is done on a monthly basis where senior management meets and discusses expenditure and tracks whether the organisation is maintaining expenditure within the budget.

Finkler, Kovner and Jones (2007: 111) state that the cash flow statement depicts the flow of cash in and out of an organisation and is critical to the NM. The information provided will enable the NM to know if there is enough money to undertake desired projects or purchase equipment and other needs.

5.4.2 Analysing and interpretation of financial statements

A second mechanism mentioned by participants as part of their financial monitoring role is the analysis and interpretation of financial statements. Booyens, Jooste and Sibiya (2016: 122) state that the purpose of financial statements is to monitor how the institution spends income and what the current financial position is. Analysing entails monitoring the institutions financial position to ensure soundness such as the ability to pay short-term debts and profitability. Reading a financial statement should give the reader an impression of the financial performance of the company. Financial statements consist of the following: the income statement, the cash flow statement and the balance sheet (Booyens, Jooste and Sibiya 2016: 122).

Financial statements as stated in the PFMA consist of the following: a balance sheet and an income statement, cash flow statement, any other statements that may be prescribed and any note to these statements (South Africa 1999: 8). Financial statements present a practical basis of financial data and information based on results of all accounting operations for a particular financial period (Ingram and Albright 2007: 595).

Dunham-Taylor and Pinczuk (2010: 564) find that the concluding summary of management's actions is included in the financial statement. Financial statements are required every year and public health institutions must also issue quarterly financial statements. These financial statements consist of the statement of financial position, balance sheet, income sheet, statement of cash flows. In recent years more attention has been focused on the cash flow statement because it is the means of support of the business. To be an informed decision maker one must understand how to use these statements, but do not necessarily need to know how to prepare these financial statements. This is very significant in this study as the aim is not to have NMs draw up these statements, as it is beyond the scope of this study and not the intention.

The result of the findings show that financial reports are reviewed at cash flow meetings in order to monitor expenditure to ensure it is within the provisions of the budget. In support of these findings, Graham (2011: 4) finds that the documents that are commonly used to present financial activity are the public accounts and financial statements. When expenses are matched with the revenue they help external and internal users of financial statements to make better judgements about the financial position and operating performance of the organisation (Graham 2011: 44).

Finkler, Kovner and Jones (2007: 95) add that even non-profit public health care organisations have formal accounting systems that track the financial well-being and financial success of the organisation. The critical job of the FMs are to compile a set of financial reports, officially known as financial statements, to convey information about the organisation's financial condition and the financial results of its activities.

It was noted in the findings of the study that NMs found it critical to analyse financial statements as part of the financial management role. Finkler, Kovner and Jones (2007: 96) support these findings by stating that the information contained in these reports can help NMs know whether the organisation has sufficient resources to provide for the required needs or if there is a need to

cut back on certain expenses. An ability to understand and interpret the financial results of the organisation is critical to ensuring that nursing receives an appropriate share of the available organisational resources. This will provide NMs with the tools necessary for critically analysing the financial status of an organisation (Finkler, Kovner and Jones 2007: 96).

A common finding that emerged in this study was that NMs found difficulty in understanding some of the financial terminology in the financial reports. These findings are supported by Finkler, Kovner and Jones (2007: 96) who state that understanding financial statements is difficult, as the accounting terminology used is generally new to nurses. However, the authors are in strong support of nurses being able to understand these statements and find that basic accounting concepts are critical tools for NMs on two levels: NMs must be able to communicate with FMs of the organisation; and accounting provides information that is of critical value to NMs as they help manoeuvre the overall direction of the organisation. The need to acquire resources for nursing and to work with the organisation to control the use of resources requires the NM to be able to communicate with FMs or at least to some extent, be able to talk some of their language (Finkler, Kovner and Jones 2007: 96). Learning about finances allows the NM to understand why certain things are done, for example, equipment depreciating. In addition, NMs must look beyond their departments to focus on what the organisation as a whole must do to survive and thrive in a difficult economic environment. An understanding of accounting and financial statements is critical to being able to assess the financial position of the organisation (Finkler, Kovner and Jones 2007: 96).

It emerged from the findings that while NMs retain accountability and responsibility for the nursing section, they have to validate the expenditure presented to them in the financial statements. Likewise, Visser and Erasmus (2002: 343) indicate that the reports should make available the necessary information to support if performance and expenditure is line with the approved budget and business plan. Expenditure reports show budget

allocated and expenditure for the particular month and the percentage that is available.

5.5 THEME 3: FINANCIAL DECISION-MAKING

Booyens, Jooste and Sibiya (2016:70) find that nurses are involved in complex decision-making, in diversity of situations and for many different purposes. The decisions that nurses make in their daily duties include those related to financial management decisions. The standard that guides all decision-making for nurses is to achieve the best health outcomes for their clients. Decision-making is therefore defined by Booyens, Jooste and Sibiya (2016: 70), as the process in the selection of a course of action among several options. Similarly, Meyer, Naude, Shangase and van Niekerk (2009: 238) state that decision-making is a management skill that NMs use every day during the implementation of their management functions. Decision-making is a process of selecting the best possible solution from available alternatives to solve a problem. The authors affirm that decision-making is not always related to a problem situation, but is required throughout all aspects of the management process (Meyer *et al.* 2009: 238).

Finkler, Kovner and Jones (2007: 384) propose that NMs must be involved in the specific, long-term financing decisions. The decision must not be left only to the FMs as they may lack vision for the organisation. NMs should not assume that the financing of the organisation is something outside of their management sphere of activity or expertise. A participatory team attitude and approach between nursing and finance is more likely to result in financing decisions that will benefit the entire organisation, including nursing services (Finkler, Kovner and Jones 2007: 384).

Relevant to this study, every decision made irrespective of the context has a financial connotation to it. Nurses make decisions daily with respect to the delivery of the best and quality care for their patients. This in turn results in the patient recovering and returning to society, employment and communities and leading a productive life. This also results in the prevention of litigation as

highlighted earlier in this study, which consumes a large part of the budget with the consequences of lesser funds being available for essential resources required for delivery of care.

5.5.1 Approval of contracts and tenders

Emerging from the context of decision-making, the findings reveal that this role of the NMs encompasses their involvement in bid committees where decisions are made in terms of how contracts and tenders are awarded. Bids are evaluated according to the criteria specified in the bid document. There are three bid committees in which NMs participate and execute their decision-making roles, namely Bid Specification Committee, Bid Adjudication Committee and the Bid Evaluation Committee. The compulsory requirement is that the NM be part of the Bid Adjudication Committee. The findings revealed that bidding policies as promulgated in the PFMA (South Africa, 1999) were implemented in the hospitals.

The Preferential Procurement Policy Framework Act 5 of 2000 (PPPFA) was passed in February 2000. This Act requires all areas of government or state to observe its terms. According to Section 2 of the PPPFA, bids must be evaluated according to the preference point systems. Awarding of points should be clearly specified in the invitation to submit a bid (South Africa 2015b: 8). The SCM policy stipulates three bid committees for the execution of SCM functions. These include: Bid Specification Committee, Bid Adjudication Committee and the Bid Evaluation Committee (South Africa 2015b: 68).

The findings also indicate that the NM makes decisions for all expenditure for the nursing section. The NM is part of the Cash Flow Committee which is where financial decisions are taken in terms of what needs to be procured and what must be purchased according to priority. Sunderland (2013: 1) supports these findings as she highlights the value of NMs being decision makers for procurement. The author finds that the NMs position on the front line of patient care means nurses are uniquely positioned to offer feedback on which

products are best from a patient experience perspective. In so doing, clinical risk is reduced; patient experience and safety is improved; product standardisation becomes much easier; leading to economies of scale and the procurement process becomes more efficient and effective (Sunderland 2013: 1).

Tshamaano's (2012: 53) study, as introduced previously, found that the public officials indicated that tendering and contracting currently is still considered as the only way of procuring goods and services in the government. The respondents further stated that the government only deals with the services that it can render, and all those that they cannot render are given to service providers who tender to do so.

Migiro and Ambe (2008: 230) conducted a study to evaluate whether and to what extent SCM practices in local municipalities are implemented. Of relevance to this study, Migiro and Ambe (2008: 235) found that analysis of the data revealed that 80% of the officials in the SCM directorate lacked skills in SCM and that formation of cross functional committees within the departments for tender specification, evaluation and adjudication was a problem.

Another finding that emerged from participants' responses was the awareness of fraud and corruption present and the part they played in the prevention and control. Decision-making is important in the prevention of fraud and corruption. NMs must take cognisance of the fact that corruption and fraud within the procurement systems is common in South Africa. It is a well-known fact as reported in the Public Sector Supply Chain Management Review (South Africa 2015b: 4), that there are constant allegations of corruption and inefficiency in the public SCM sector. Corruption is not unique to South Africa, but it is one of the country's major challenges. One reason why it continues is that, although the legal framework is strong, laws have not been adhered to or been implemented to their fullest extent (South Africa 2015b: 20). The Guide for Accounting Officers reports that in addition, the award and management of contracts is an area where fraud and corruption has been found in the past

(South Africa 2000b: 40). For this reason, NMs must ensure that the correct decisions are made in the interest of the clients they serve and should reflect this through cost-effective use of control measures, procedures and an ethical culture.

In support of the NMs being involved in the approvals of contracts and tenders and providing input into the procurement process, the Royal College of Nursing (UK) (2015: 1) finds that nursing staff are on the frontline of patient care, using clinical products and equipment on a daily basis. They have the potential to add real value to procurement processes by highlighting other crucial aspects of product suitability besides simply cost, such as usability, safety, quality and patient comfort. Royal College of Nursing (2015: 2) further argues that getting the best value out of procurement remains a challenge for many management committees due to the lack of nursing involvement as often the entire process of selecting and purchasing items has been managed by procurement departments alone. This approach results in staff having to use products they may find inefficient or ineffective. Evidence shows that nursing involvement can be particularly valuable. The position of nurses on the frontline of patient care, using a vast range of clinical products on a daily basis, leaves them uniquely qualified to offer detailed insight into what items do and do not work (Royal College of Nursing 2015: 2).

Fourie (2009: 630) agrees that there is procurement corruption in the public sector. Public managers who are responsible for the procurement of goods and services face many hurdles especially from the political side where there is interference with the administrative duties. Procurement has been criticised by the general public and bidders where the procurement procedures and processes are bureaucratic with vague responsibilities and levels of accountability. Value for money is in most cases destabilised or not evaluated and corruption is rife or unreported in most cases (Fourie 2009: 630).

5.5.2 Acting in the CEO role

The literature review is limited on the topic of the transition from NM to CEO. Most of the studies found are anecdotal interviews conducted or articles in newspapers or website posts. The few studies reviewed and literature reviewed involves CNEs moving into CEO positions. The findings reveal that in the absence of the CEO, NMs are called to assume the role and this involves a large amount of decision-making which often has financial implications. NMs indicated that they act in the role of the CEO but voiced concern as they felt that they had to make financial decisions with little understanding of such.

Smith's (2009: 7) study highlights the complex role of the CEO as the person who is responsible and accountable for leading the organisation and is responsible and accountable for everything. The CEO must meet the present and the future day-to-day operational needs of the organisation. An important finding was that there are operational difference in the roles of NM and CEO. The typical major functions and responsibilities of the CEO include board and governance administration and support, programme, product, and service delivery, financial, tax and risk management, facilities management, human resource management, community and public relations, and fundraising. Core areas of knowledge and skill include basic management and leadership, business planning, organising, leading, and coordinating activities and resources (Smith 2009: 30).

The results reveal that there was a difference in the financial knowledge of the CEOs compared to the NMs, which was mainly attributed to the lack of training in financial matters and the poor inclusion of NMs in financial activities. In a similar finding, Magrath (2016: 1) states that nurses bring a wealth of clinical understanding to the chief executive role, but they have to master business skills and a wider focus if they want to succeed. Magrath (2016: 2) interviewed a Registered Nurse (RN) who was now a CEO at Memorial Hospital West in Pembroke Pines, Florida. The findings of the interview indicate that there was a very big disconnect between the CEO suite

and middle management. There was a completely different skill set to master in order to be a CEO. The CEO represents everyone within the health care organisation namely the clinical side, the dietary side, the environmental side, the construction side and the legal side. There is a whole scope of skills and negotiation abilities one needs to have to balance all of that. As suggested by Magrath (2016: 2), having the experience as well as learning the business end of it will help NMs in their CEO roles.

Findings confirm that NMs act as CEOs, but get support from the financial team for any financial decisions. In support of the findings, Smith (2009: 2) concurs that nurse executives do appear to have the requisite skills, talents and abilities to become CEOs. Yet, preparation as a nurse executive alone may not be sufficient for the task at hand. Critical knowledge includes marketing, running the business, finance, human capital and strategic planning. Educational and experiential preparation of the CNE may lead to the development of some of these competencies but would not necessarily address all of them. Most of the nurse CEOs interviewed in the lay and professional literature stated that lack of financial acumen was one of the largest barriers to their success. Experience and education alone may not be enough to support a nurse executive in the new role as CEO. There are also organisational barriers to successful transition, namely, the perception that the CNE has not always been accepted as a full-fledged member of the senior management team and lack of adequate executive leadership development programmes (Smith 2009: 2).

5.5.3 Financial legislative framework

There are various legislative frameworks that influence public sector financial decision-making in South Africa, namely, the Constitution, the PFMA which regulates financial management in the national, provincial and local level of government and Treasury regulations. These laws influence decision-making processes within the public sector. Managers have to ensure that all decisions taken fall within the prescripts and ambit of the legislation.

The findings reveal that NMs' decision-making regarding finance in the public sector revolves around the relevant laws. It was apparent from the findings that NMs were aware of the sections and clauses of the legislative frameworks that are applicable and relevant to their practice and their role was to adhere to the prescripts of the financial legislation. The PFMA 1 of 1999 was the legislation that participants made reference to and will be discussed in relation to its importance to NM practice. The PFMA is a law that upholds the goals of sound financial management in the national and provincial departments of government. The public hospital sector is governed by the PFMA. The Act sets out to "secure transparency, accountability and sound management of revenue, expenditure, assets and liabilities in the execution of daily operations of these departments" (South Africa 1999: 1). Its objective is to modernise financial management and enhance accountability which is complemented by changes to the procurement system.

The Act allows for financial decision-making to be devolved down to managers who better understand the local realities and local policy and know the needs of their departments and their priorities. However, managers retain accountability for their financial performance (South Africa 2000b: 12). Similarly, findings from the study underlines that the participants understood that they maintain accountability for their financial management practices and highlighted the need for an understanding of the legislation and indicated its importance to NM financial management practice.

In a similar study, van der Heever (2009: 100) asked respondents to indicate if they were aware of the PFMA and its' contents. The majority of respondents were aware of the Act and its contents relating to accountability and sound management of revenue, expenditure, assets and liability matters in the execution of the public hospitals' officials' daily tasks. Although the CFO is accountable to the Department of Health for all financial matters, responsibility lies with management of the institution to apply the PFMA (van der Heever 2009: 101).

5.6 THEME 4: FINANCIAL CONTROL

Van der Heever (2009: 6) explains that the financial transformation process in public hospitals is complex because financial management includes financial planning, financial organising, financial leading and financial control of expenditure patterns. Quinn (2010: 64) states that controlling is where managers monitor what is going on in their area to ensure that the goals and objectives are being met. Most organisations must have financial controls in place. These are widely accepted as being tools that decide on an organisation's financial health. The organisation must have more control mechanisms in place than just financial controls. Control functions ties directly back to the planning function. Planning guides the activities that need to be monitored (Quinn 2010: 64).

5.6.1 Assets and resources control

Asset and resource control was seen to be a large part of the role of all participants in this study who emphasised that it is their responsibility to carefully supervise and control the use of the resources. Resources include the management of physical resources, equipment, facilities and infrastructure. Muller, Jooste and Bezuidenhout (2015: 466) supports this statement by explaining that an organisation's physical resources are its tangible assets such as equipment, buildings, vehicles, stock and supplies. Control systems for these resources involve utilisation of policies and procedures, periodic inspections and stocktaking, condemning and replacement of equipment, tender management, inventory control and utilisation review practices.

Findings reveal that resource control and monitoring was part of the daily task of the NMs in this study. Similarly, Meyer *et al.* (2009: 189) find controlling to be the management functions of monitoring and adjusting the plan, processes and resources to effectively and efficiently achieve goals. Controlling ensures that resources of the organisation are adequately utilised to achieve goals.

Likewise, Wentzel's (2008: 267) study confirms that resources are necessary for effective service rendering and valuable in terms of asset management, therefore resources should be controlled. Control of resources is one of the clinic manager's responsibilities. The respondents considered the following functions important in terms of control of resources: adding newly received equipment/furniture to the inventory, monitoring the correct utilisation of equipment and supplies, and checking the inventory of the clinic monthly.

The nurse plays a key role in the management of material and equipment resources in health services. Booyens, Jooste and Sibiya (2016: 129) assert that nursing staff in the units are at the point of output where care is being delivered and they control a large portion of the resources allocated for health care. It is their responsibility to help the service be cost-effective. Each health care professional should be cost conscious and carefully supervise and control the utilisation of resources. The physical environment in which care is delivered is just as important for cost-effectiveness as the quality of care itself. Health services managers can contribute to a safe and effective environment by looking at features in the unit that they can control. This includes areas that require repair and maintenance such as broken tiles, taps and windows (Booyens, Jooste and Sibiya 2016: 129).

Information received from the participants reflected that they maintain ultimate responsibility for resources and assets regarding control and care of equipment. Booyens, Jooste and Sibiya (2016: 137) observe that the NM's responsibility is to ensure that all health care professionals are taught about the use of the equipment if they are not familiar with the equipment. If they do not know how to use the equipment, it can lead to inefficient and dangerous practices. The environment in which staff members work must be conducive to health care delivery. The team is accountable and responsible for the management of the physical and financial resources (Booyens, Jooste and Sibiya 2016: 235).

It was noted that the participants' responsibilities also included reporting loss and damage of equipment and resources. They had to write reports on how and why equipment, structures and assets were lost, broken or damaged. Booyens, Jooste and Sibiya (2016: 137) confirm that the NM must emphasise to all staff that having the necessary equipment to provide quality requires that they should immediately report any piece of equipment that is broken or damaged. The prescribed procedure must be followed so that it can be sent for repairs or replacement. Booyens, Jooste and Sibiya (2016: 137) also indicate that part of the NM's responsibility is to ensure that the equipment is stored correctly and safeguard against loss and damage.

It was verbalised by NMs that part of their roles in resource management included inventory control. Booyens, Jooste and Sibiya (2016: 137) confirm that the control of equipment is usually performed by keeping an inventory. The NM's responsibility is to ensure that the inventory is up-to-date by comparing the equipment against the list provided by the acquisitions department. All new equipment is first checked for completeness and working order before being added to the inventory list. Wentzel's (2008: 184) study investigated the role of the clinic manager in the checking of inventory as part of asset control management. Respondents agreed that they should be involved in control measures of the inventory of their clinics.

Although NMs have to control their resources they have little or no control in obtaining these resources. Booyens, Jooste and Sibiya (2016: 134) explain that the budgeting committee reviews the requisitions and compiles a list of priorities which is forwarded to head office for approval. The provincial authority decides on the amounts to be granted for a particular fiscal year. Once the institution receives the amount granted, a decision is made about which expensive articles that exceed the fixed limit will be purchased. As a rule, three quotations are obtained before deciding from which firm or tender to buy. NMs are informed of the requisitions that cannot be provided for the fiscal year. Requisitions that have been turned down can be submitted for the next financial year (Booyens, Jooste and Sibiya 2016: 134).

The study also yielded information that part of the financial control function was to monitor and control stock levels in the departments. Participants indicated that they had prescribed minimum and maximum levels of stock to which they had to adhere. This was done to prevent wastage and theft of stock and resources. Booyens, Jooste and Sibiya (2016: 140) indicate that supplies are influenced by the changes in the volume or number of patients. Changes in supply requirements and their consumption can result from changes in patient mix, types of patient, procedures or the use of a new piece of equipment. These amounts of supplies required cannot be accurately determined due to the changes. The systems that must be put in place entail identifying minimum and maximum amounts used in specific time frames. Statistics can be reviewed on bed occupancy rate and volumes of different items ordered in to ascertain the minimum and maximum levels used. Although the actual ordering is delegated to a ward clerk or another designated person, the ultimate responsibility for ordering remains with the NM who is to ensure that there is no overstocking or under stocking of supplies (Booyens, Jooste and Sibiya 2016: 141).

The NM role includes the management of assets and all requests for assets must be authorised by the NM. Booyens, Jooste and Sibiya (2016: 133) state that the role of the NM includes the application for purchasing or acquiring the equipment. A clear motivation is required stating why the item should be purchased. Sherman and Bishop (2012:1) state that sound financial management is important in all healthcare environments, whether for profit, not for profit, or publicly financed. To advocate successfully for the resources needed to staff and operate their units, nurses need to become more financially knowledgeable and increase their understanding of healthcare costs (Sherman and Bishop 2012: 1).

A concerning finding that emerged in this study was that nurses are blamed for the lack of resources and complaints are lodged against the nurses. NMs have to deal with and attend to the complaints. Kirby (2010: 209) agrees that frontline NMs work with patients and families. The author confirms that nurses are faced with a crisis as demand increases and resources are reduced. Of all

the positions in the hospital, the frontline NM is most crucial in managing day to-day patient care activities. They are closest to the patient and family, the direct care staff, physicians, and all the other services that go into providing care. They will become increasingly important as they are forced to find new ways of delivering high quality care efficiently and with fewer resources (Kirby 2010: 209).

In a similar study, Mukuna, Mwaura-Tenambergen and Adoyo (2015: 1) find that nurses can play an important role in helping reduce costs in terms of proper utilisation of consumable materials and by taking care of hospital equipment. The study found that nurses' knowledge of the relationship between supplies and health care cost is generally poor, and that nurses are hardly engaged in planning and budgetary processes of the hospital. It is recommended that nurses be educated on the relationship between supplies and health care cost so as to enable them make more cost conscious decisions. Nurses ought to be engaged in planning and budgetary processes of the hospital so as to improve their knowledge of financial implication of the procedures they carry out in health care delivery (Mukuna, Mwaura-Tenambergen and Adoyo 2015: 1).

5.6.2 Expenditure control

Muller, Jooste and Bezuidenhout (2015: 458) assert that expenditure control is a dimension of financial management and relates to the implementation and control of the approved budget. The NM's role is to control expenditure in the hospital. Booyens, Jooste and Sibiya (2016: 108) state that once the budget has been approved, it becomes the budget holder's responsibility to continuously monitor expenditure against the budget. The ongoing monitoring of expenditure is generally assigned to the manager or budget holder of a cost centre. The NM is the manager of nursing services in the hospitals. Hence the ongoing monitoring of expenditure becomes the responsibility of the NM. Matters such as underspending and overspending negatively influences service delivery.

It was reported by participants that they maintained accountability and responsibility for expenditure control in their departments. Sherman and Bishop (2012: 2) explain that after a unit budget is approved, it must be monitored continuously to ensure expenses stay within projected budgetary limits. The NM gets feedback on actual expenses; data that shows any discrepancies between budgetary projections and actual results are called variances. Unit managers work to modify expenses and thus correct variances, ensuring that each department stays within budget for the year and that expenses are controlled. Goetz, Janney and Ramsey (2011: 173) find that accountability and ownership for attaining financial outcomes in nursing begins with senior leadership. The final and most critical success factor in attaining exceptional financial performance is a personal and collective accountability for achieving outcomes. Nursing assumes primary ownership of budget targets.

The FMs in this study gave a divergent version of how they perceived expenditure control in the hospitals. According to the data gathered from the interviews in this study, FMs perceived that nurses do not understand expenditure control processes and that they lack financial consciousness. It was further found that nurses attribute their lack of expenditure control to the fact that they have a big workload. Penner (2015: 2) adds that nurses are often completely unaware of the costs of care in their in-patient or out-patient settings. Few staff nurses have any background or education in healthcare finance, and often resist the idea that they need to think about the cost of nursing care. However, in these times of rapid change and ever more scarce resources, it is time for nurses to realise that their performance affects not only their patients' health but the financial health of their institution (Penner 2015: 2).

It was also noted in the study that the nurses, being the largest workforce in the hospital, play a critical role in expenditure control (Penner 2015: 1). The NM's role is to investigate and find reasons for the rise in costs. Unauthorised expenditure, as defined in the PFMA, is either overspending or expenditure that is not in accordance with the purpose of a vote or a main division (South

Africa 1999: 7). Accounting officers must implement appropriate mechanisms to prevent such spending.

Participants reported that there was evidence of several mechanisms in place to prevent wastage and control expenditure. Fruitless and wasteful expenditure is expenditure made in vain, which could have been avoided had reasonable care been exercised. NMs are required to report unauthorised, irregular or fruitless and wasteful expenditure to the accounting officer, who must disclose it in the monthly report. The Guide for Accounting Officers (South Africa 2000b: 39) indicates that accounting officers must exercise control over all government expenditure, whether it is incurred directly by a department or takes the form of a transfer payment to another sphere of government or other entity. The PFMA specifically requires accounting officers to exercise all reasonable care to prevent and detect unauthorised, irregular, fruitless and wasteful expenditure. They must implement effective, efficient and transparent processes of financial and risk management, and track expenditure and expenditure commitments against the vote. In addition, monthly and annual reporting requirements are stipulated, and disciplinary sanctions prescribed, should these provisions not be satisfied (South Africa 2000b: 39). These inadvertently impact on the NM, as they are under constant pressure to cut costs and monitor expenditure.

Participants in this study compared expenditure control and cost containment by nurses in public and private hospitals. It was found that a change of mindset was required to manage expenditure in public hospitals as nurses who work in both the private and public sector have undergone the same training. It was evident in this study that there was a lack of control relating to expenditure in public hospitals and wastage was excessive. In a South African study, Pillay (2010: 134) identified the competencies important for effective nursing management and assessed the NMs competencies in both the public and private sector. The findings suggest that despite their seniority, public sector managers still perceive a need for hard management skills such as finance and information systems management as compared to the NMs of the private sector.

5.7 RESEARCH OBJECTIVE 2: CURRENT FINANCIAL COMPETENCIES OF NURSE MANAGERS

The second research question addressed the financial management competencies that NMs currently have. The fundamental role that NMs play regarding financial management in their environments has been addressed in the nursing literature. Financial management skills should be considered as a core competence for NMs (American Organisation for Nurse Executives 2005: 15). Financial competency supports nurses in utilising resources efficiently and in upholding a high standard of nursing practice (Muller and Karstens 2012: 52). NMs should consider financial management skills as a core competency due to their extended responsibilities in enhancing the financial performance of nursing units (Noh and Lim 2015: 153).

Sherman, Bishop, Eggenberger and Karden (2007: 85) support research into NMs' competencies. Although research findings maintain that the NM has a crucial role in influencing all aspects of the nursing environment, recruiting talented staff into these nursing leadership positions has become increasingly more difficult. There is a need to better understand the competencies needed by contemporary NMs and the challenges in the role.

The literature and studies relating specifically to nurses financial management skills and competencies is rather sparse. Although practised, financial management competencies are not found to be an essential prerequisite for NMs in this study. Although a plethora of research has investigated the general management competencies of NMs, only a few studies have examined the need for financial competencies in overseas countries. The interest in assessing the financial management competencies of NMs arose from the fact that there are very few studies done in South Africa and that education and training can improve competencies.

Harper (2015: 1) states that NMs are required to work beyond their clinical training and become experts in the fundamentals of financial management. This requires specialised training to develop the skills and models to support

the development of effective NMs. NMs have come to be regarded as one of the most important assets within health care organisations (Harper 2015: 1).

5.8 THEME 5: POOR OR INADEQUATE FINANCIAL MANAGEMENT COMPETENCIES

The findings indicated that NMs do not have the requisite skills and competencies necessary for their financial management roles and functions in the hospitals. They attributed the poor competencies due to various factors such as lack of involvement and inclusion in financial management activities within the hospital and the lack of in-service training. A further concept emerged where NMs indicated that they mostly attained some financial knowledge and competencies while working in their current roles and positions.

5.8.1 Poor or lack of involvement in financial management activities

Participants reported that the lack of skills and competencies in financial management was due to their poor involvement or inclusion in financial matters, financial tasks and financial decisions. The findings of this study support work done by other researchers who have studied the NM role. Muller and Karstens (2012: 54) observe that when opting to learn the financial vocabulary, leaders embark on the practice of building a common language, bridging the current language gap between nursing and finance. By learning finance, nurse leaders will be better able to manage their departments. This knowledge enhances the dialogue between nurses and the executive management, allowing nurses to better advocate for their units, workspaces, and patient needs. Future nurse leaders can expect to monitor a broader spectrum of financial indicators and by speaking the language of finance, they can remain at the centre of conversations about the strategic direction of their organisation (Muller and Karstens 2012: 54).

Studer (2010: 80) agrees that clinical leaders and financial leaders need to 'speak the same language' to meet the organisation's mission while remaining financially viable, especially in the current economy. Yet, Studer (2010: 80) finds that clinical leaders often lack the skills to demonstrate positive financial impact. An example of a success story is shared by Studer (2010: 81) who demonstrates the value of including nurses in financial matters. Baptist Health Hospital in South Florida has a double-A rating from both Moody's and Standard and Poors and has been ranked in Fortune Magazine's 100 best employer lists for the past 10 years. More importantly and relevant to this study is that Baptist Health sets clinical goals for FM and financial goals for clinical leaders to ensure that everyone has a stake in meeting the organisation's overall goals. All leaders have patient satisfaction and expense management as a goal. Baptist Health has devised a tool where each manager is evaluated against the goals set and a weighting is allocated to the specific goal (Studer 2010: 84). In this way the hospital has shown that including nurses in the financial management of the hospital can greatly contribute to successful cost containment and expenditure management.

Results of this study showed some participants had a basic knowledge of financial management but no formal skills and require more skills for the role. Muller and Karstens (2012: 53) support these findings and state that finance is also a vital knowledge competency for graduate-level prepared specialty nurses and advanced practice RNs. These competencies suggest nurses need to use resources effectively and maintain quality design evaluation strategies that demonstrate cost-effectiveness, cost-benefit, and efficiency factors associated with nursing practice. It is clear that those establishing the profession's nursing practice standards expect nurses to maintain a strong advocacy role for their units, workspaces, and most importantly, future patient needs. This requires nurses to actively pursue, understand and be conversant in finance (Muller and Karstens 2012: 53).

Another finding was that the poor involvement of nurses in financial management activities were due to the focus of nurses training being on clinical outcomes rather than financial outcomes. The result aligns with

findings in the study by Brannagan (2012:1), who found that often, the NM's focus is on quality of patient care and clinical issues, and not on identifying and responding to financial matters. However, in today's healthcare environment, organisations are increasingly recognising the importance of having nurse executives who are fluent in financial language and able to make use of financial tools and techniques to monitor, improve, and report on performance within their area. The potential impact of this combined skill set in NMs can prove to be of tremendous value to the financial status of organisations, and ultimately benefit the patients they serve (Brannagan 2012:1).

It was also reported by participants that there was some involvement indirectly in financial management, as in the planning of activities for the budget, but with no direct input or involvement. This is similar to the finding by Sherman *et al.* (2007:85) whose study found that most nursing leaders cited financial management as their weakest area. They acknowledged that there is constant pressure to justify the nursing staffing budget, which is a critical part of any hospital's operating budget (Sherman *et al.* 2007: 91).

The findings support the call for more inclusion and involvement in financial matters to improve their skills. Douglas (2010: 270) refers to the successes at Northwestern Memorial Hospital where a great number of challenges in nursing were addressed by bridging the gap between nursing and finance. At this hospital, the Associate Chief Nurse Executive reported that there is a sense of accountability and deep ownership of financial performance within nursing. Dr Janney, the vice president of the hospital, found that adopting an approach of inclusion was a key approach that has paid off. Financial education was part of the approach, and getting the NMs on board was mainly accomplished by having them as active participants in each step of the process. In support of this was some basic education in finance and budgets. They found it effective to help managers think about their unit budgets and how to make decisions by relating this responsibility to thinking about how they manage their bank accounts and the running of their personal financial circumstances (Douglas 2010: 271).

5.8.2 Lack of in-service and financial management training for current role

The study findings indicate that inadequate or poor financial management competencies were due to the lack of training and in-service education for the requirements of their current roles. NMs revealed that they were not provided with the opportunity to attend financial management training courses.

A further finding was that poor financial management skills were due to the lack of updates and financial management training. Participants cited that their training was outdated and they had had no updates or training according to the changes and trends for their roles, which mirrors findings in the literature. Bailey (2014: 4) finds that today's hospital administrators have not given attention to the important developmental needs of NMs which are critical to the organisation's continuation. The critical role that NMs play in the organisation has not been valued and the importance of addressing unit nurse leaders' personal needs have been neglected. For example, the trend in nursing has been to promote good clinical nurses and expect them to change into skilled unit managers. This may no longer be acceptable as a different role is required of them. This requires organisations to identify the best practices and environments for best possible patient outcomes and staff performance (Bailey 2014: 4).

Bailey (2014: 55) states that research findings have consistently indicated that unit nurse leaders lack adequate training and development, principally related to financial management competencies. Knowledge deficit of finance among unit nurse leaders appears to be a persistent finding in the literature. Bailey's (2014: 55) study found that leaders stated that they needed training in budgeting and finances and that they had no formal orientation. While most unit leaders were quite satisfied with their role preparation in that they felt they had received sufficient training and were confident in their role, there was evidence that some leaders still felt inadequate in performing their duties, in particular with regard to the areas of budget and finance (Bailey 2014: 80).

Chase conducted a study in 2010 which built on her previous 1994 study. In Chase's 1994 study, financial acumen was one of the competencies rated in the top five for lowest knowledge and understanding and lowest ability to implement and use. What is conspicuous in the two Chase studies is that the same deficits in learning were still present nearly 16 years later. Chase (2010: 120) recommended having realistic expectations of the role, providing a skills assessment and forming a plan based on competency development, and investment in NM support for development of staffing, financial acumen and compliance at every level.

Similarly, Sherman *et al.*'s (2007: 91) study found that leaders in their study reported financial management as a necessary competence, but that it was "their weakest area" of competence. They also reported having had little or no orientation to their role.

5.8.3 Experiential learning

The findings reveal that NMs learnt financial management on the job and along the way. The findings are corroborated by Brannagan (2012: 2) who finds that many nurse executives and managers have had to learn financial management skills, including planning, controlling, implementing, and analysing departmental budgets, on the job. NMs usually progress from apprenticeships within a technical or specialty area in nursing, and are generally not familiar with financial concepts.

Thew (2015: 1) disagrees with Brannagan (2012) and states that historically the nursing establishment has shied away from discussions about finance in both the academic and clinical settings. The author states that nurses do not get exposure to finance in school and they do not learn this on the job either. Even when nurses are promoted into management, they do not always get this kind of training. Nurses across-the-board need to have some kind of insight on costs and benefits and how to make a business case. Another thing that would help is for hospitals to take a more bottom-up approach around budgeting rather than top-down (Thew 2015: 1).

Thew (2015: 2) goes on to write about her interview with San Francisco General's Chief Nursing Officer, Terry Dentoni. Based on her own experience as both a bedside nurse and nurse leader, Dentoni agrees that when she went into management, she gained financial knowledge through drills with her then Chief Nursing Officer, but she describes her understanding of finance at that time as more of a rote, 'check-the-box' mentality. It was not until 2007 when she completed a course on healthcare financial management that she understood the power that bedside nurses have to improve financial outcomes. Dentoni points out that nurses do not have to choose between being financially responsible for providing quality nursing care. They can do both which will be in their greater interest and benefit patients (Thew 2015: 2).

McKinney, Evans and McKay (2016: 46) presented a model for evaluating and improving current NMs' leadership and management competencies at a community hospital, including development of experiential learning activities based on an evaluation of competency gaps and the resulting competency of NMs following the training. Eighty-six percent reported that they had received no formal leadership development when they first became a NM (McKinney, Evans and McKay 2016: 47). Most of the NMs in this study rated themselves as less than competent in the financial management areas of the science domain. Financial areas included understanding healthcare economics and policy expense, forecasting concepts of capital budgets, and concepts of cost-benefit analysis (McKinney, Evans and McKay 2016: 48). Based on these findings, experiential learning activities were developed that consisted of group work, case studies, and exercises in financial analysis, budget practice, and cost-benefit analysis scenarios. The study demonstrated an increase in NMs' competence as they gain experience (McKinney, Evans and McKay 2016: 49).

5.9 FINDINGS RELATED TO RESEARCH OBJECTIVE 3: FINANCIAL MANAGEMENT TRAINING AND EDUCATIONAL QUALIFICATIONS OF NMs

The third research objective sought to establish the training and educational qualifications NMs have with respect to financial management and in which courses they achieved the qualifications. Financial management skills are vital to surviving and thriving in the NM role as they must possess administrative confidence, appropriate educational preparation and skills to manage financial deals, broad clinical expertise, and a thorough understanding of financial principles (Chase 2010: 3).

5.10 THEME 6: EDUCATIONAL PREPARATION FOR FINANCIAL MANAGEMENT IN NURSING PROGRAMMES

Participants discussed various programmes and courses that they completed in which financial management was included within modules or curriculum. Most of these programmes were formal, accredited programmes.

5.10.1 Formal educational preparation for financial management in nursing programmes

The findings that emerged from this study reveal that NMs had completed post-basic and post graduate programmes through various universities and colleges which included modules of financial management. In this study, 92% of the NMs had a post-basic or postgraduate specialty or qualification and 61% had a nursing management or nursing administration certificate. SANC approved nursing management programmes include the Diploma in Nursing Administration (Government Notice No. R.1501) and the Diploma in Unit Management for Registered Nurses (Government Notice No. R.203). The objectives of these courses are to enable a nurse to manage a health service unit effectively. Financial management principles are included as part of the Fundamentals of Nursing Administration Modules. The Diploma in Unit Management for Registered Nurses (Regulation R. 203 of 1987) offers a

registration of an additional qualification in unit management. The Principles of Administration and the Practice of Unit Management module included in this programme incorporate financial management (SANC 1987: 1).

Contrary to the findings of Courtney *et al.* (2002: 202), the NMs in this study did not indicate any challenges with accessing formal qualifications. NMs from both urban and rural hospitals had postgraduate qualifications. Courtney *et al.* (2002: 205) highlighted the findings from their study where there were differences in career enhancing opportunities for nursing executives employed in different locations. Metropolitan respondents were able to utilise more career enhancing opportunities than any other group, which poses questions of equity. Metropolitan nursing executives were also the most likely to hold postgraduate tertiary qualifications, which may reflect access to educational institutions.

McFarlan (2015: 10) finds that nursing leadership roles and titles are not standardised across the industry which creates a hurdle in relation to educational preparation. There are many names for frontline managers and no standard educational expectations. Similarly, Noh and Lim (2015: 152) found that in Korea financial issues and contents are not sufficiently dealt with in undergraduate and graduate nursing curriculums. For example, Korea currently has over 200 nursing schools, however only three colleges include a financial course as part of their graduate programme. Due to the shortage, there is a need to develop a financial management education programme for Korean nurses.

5.10.2 Inadequate financial management training in basic and post-basic programmes

The study found that the introduction to the financial management content in postgraduate modules was very basic and more formal courses were needed to supplement the information. Likewise, the examples of NM competency development mentioned in some of the articles and literature sources reveal that the NMs who completed formal education programmes were still not

prepared for financial management. Participants further revealed that though the formal programmes included financial management modules, they were not effective in assisting them gain the requisite skills. Similarly, Yoder-Wise, Scott and Sullivan (2013: 327) found that postgraduate and further education was important to facilitate the necessary changes in healthcare and recommended that NMs should be prepared at the master's level in nursing administration.

Likewise, Murphy, Scott and Pawlak (2013: 431) found that the financial management content in the baccalaureate programmes in nursing was not sufficient and lacked the information necessary for NM practice. Their findings support that NMs should be prepared at the master's level to prepare them for finance, business, change management and leadership.

Further findings that emerged from the study was that various aspects of financial management was included in the nursing education programmes, but was not taught in the context of financial management. Omoike, Stratton, Brooks, Ohlson and Storfjell (2011: 323) evaluated the University of Illinois, Chicago's academic medical centre NM certificate programme, which was founded on competencies in line with the Nurse Manager Leadership Partnership. They measured pre- and post-education self-perceived competence as well as importance of each area of competence. NMs rated unit level competencies at a higher level of importance than system level ones, but rated their competence with financial management lower than all other areas. Omoike *et al.* (2011: 326) highlighted the need for administrative support for the development of frontline leaders.

Another finding that emerged was that financial management should be introduced early in nursing training as it becomes difficult to learn new things when one is older. In support of these findings, Baxter and Warshawsky (2014: 46) point out that development of skills critical for success is often overlooked and new NMs struggle during their role transition from a clinical provider to nursing leadership. Although the review of the literature emphasised defining the necessary competencies and skills demonstrated by

successful NMs and less on the acquisition and development of these important skills, NMs and executives alike agreed that significant challenges existed for the new NM. Those challenges were the vast responsibilities of the NM role, the lack of knowledge and skills of new NMs to achieve success, and the constant competing priorities and demands on the NM's time. Baxter and Warshawsky's (2014: 49) findings highlight that the highest perceived competency was clinical practice and the lowest was financial management, performance improvement, technology and strategic management. These data illustrate that although many clinically strong nurses are promoted to NM roles, clinical expertise does not prepare the new NM for the wide range of competencies required for success.

McFarlan (2015: 20) contends that there is support for ongoing education and competency based development of NMs as financial management competencies present the largest challenge and can have the greatest impact on healthcare organisations. NMs are responsible for the largest workforce in healthcare and need to understand how to manage efficiently to sustain healthcare organisations. Therefore, NMs need this type of knowledge and ability to engage in the planning of initiatives at all levels of healthcare organisations. NMs have the ability to directly impact outcomes and the bottom line and should be involved in redesigning care processes and making positive changes throughout their organisations (McFarlan 2015: 20).

Emerging from this study was the finding that financial management is taught in theory but it is not applied in practice and financial management was not given importance in the nursing curriculum because the focus was on clinical skills. Similarly, Douglas (2010: 270) finds that pressure should be placed on nursing education systems to adjust their curricula to address this gap in preparation and to better assist PNs in meeting the demands of today's nursing realities. Encouraging hospitals to invest more in financial education for nurses as they are promoted into positions requiring financial oversight can be helpful, as can be building stronger relationships between the nursing and finance departments. One of the best ways to learn, move forward and overcome challenges is to learn from each other (Douglas 2010: 270).

Congruent with the study findings, Bai *et al.*'s (2017: 125) study revealed that there was insufficient training and education on financial management and nursing economics. Participants in the study argued that no opportunities are available for them to attend training or education programmes on financial management. It was found that there were many clinical nursing management training courses but no existing courses focusing on financial management. The hospitals only provided once off lectures or training administered by the financial section. The hospital provided poorly designed training because of the limitation of time and expenditure. Furthermore, it was established that there is a shortage of educators who have the interdisciplinary background of nursing and economics. The suggestion was that nursing schools should add related courses which would develop cost management consciousness. The findings also reveal that financial management skills have not been considered as essential components in leadership development among head nurses (Bai *et al.* 2017: 126).

5.11 THEME 7: GUIDANCE AND TRAINING FOR FINANCIAL MANAGEMENT ROLE

The question asked was what support and training do NMs receive to assist them in their financial management role. A theme that emerged was that of guidance and training for the financial management role.

5.11.1 Informal financial management training for current role

The study findings reveal that there has not been much training in financial management provided by the hospitals or outside sources for nursing. Participants followed guidelines and policies and requested assistance from financial staff for any financial matters. Douglas (2010: 271) highlights the Northwestern Memorial Hospital approach of including NMs in financial decision making. While education was part of the approach, getting the NMs on board was mainly accomplished by having them as active participants in each step of the process. In support of this was some basic education in finance and budgets. They found it effective to help managers think about

their unit budgets and how to make decisions by relating this responsibility to thinking about how they manage their bank account and the running of their personal financial circumstances. Making a link to personal experiences and ownership can facilitate a transition into mastering the business size of operations (Douglas 2010: 271).

It was noted from the findings that some managers were provided with opportunities by the Department of Health to attend informal courses on financial management but these were not useful. McKinney, Evans and McKay (2016: 46) found that many hospitals have poorly designed NM orientation and professional development programmes, or none at all. The primary reason many NMs are not prepared to successfully lead in the current healthcare environment is a lack of formal leadership training. Often, RNs who demonstrate outstanding clinical skill, knowledge, and behaviour are promoted to NM positions despite a lack of formal leadership and management preparation. McKinney, Evans and McKay (2016: 46) is of the opinion that good clinical nurses do not necessarily develop into good NMs.

Brennan, Hinson and Taylor (2008: 90) found that both finance departments and nursing departments agree that nursing and finance are critical to each other's success in maintaining financial viability and providing high-quality care. The authors share the success story of Yavapai Regional Medical Centre, in Prescott, Arizona. With funding cuts and staff shortages, finance and nursing departments viewed it as their responsibility to work as a team, not as opposition. Both departments recognised they are critical to each other's success and worked together to accomplish much more for financial viability and care delivery (Brennan, Hinson and Taylor 2008: 91). To make finance more approachable, Yavapai Regional Medical Centre developed and offered classes on introduction to budgeting and finance for nursing directors, clinical coordinators and assistant directors.

Brennan, Hinson and Taylor (2008: 94) state that it can be challenging for people who work on the clinical side to appreciate the financial implications of delivering care, but it is important for nursing and other staff to understand

that they do have a responsibility to make the most of available resources. The authors concluded that both nursing and finance leaders at Yavapai Regional Medical Centre have worked in each other's environments where these departments have battled. Now, they have established a more respectful relationship that makes the work more rewarding and, more importantly, the hospital, more productive. The partnership between nursing and finance will only increase in importance. Finance and NMs are on the same team with the same objective, maintaining a viable organisation that creates a healthier community (Brennan, Hinson and Taylor 2008: 94).

5.11.2 Poor support from Department of Health for current financial management role

The findings that emerged from this study indicated that there was a very noticeable lack of support and training provided by the Department of Health to the NMs for the current financial management role. Participants were not given the opportunity to attend financial management workshops or training. Congruent to this finding was the study of McFarlan (2015: 52) who notes that NMs do not consistently receive education and support from their superiors to gain knowledge and competence with financial management. Even with years of experience, many NMs do not reach competence or proficiency with financial management. McFarlan's study (2015: 52) illustrated that the education offered in the evidence-based project that was presented, improved NMs knowledge and self-assessed competence with financial management, however they still did not assess themselves at the competent level. McFarlan (2015: 55) finds that education programmes are recommended to develop NM financial competency.

Of special concern in this study were the findings that the Department of Health does not have the finances to provide any financial management training. Similarly, Bai *et al's* (2017: 126) study attributed the absence of financial management training within institutions to the limitations of time and funding. Sangweni (2008: 55) views the organisation's training budget as a major factor in determining whether or not employees will have the skills and

knowledge necessary to help the organisation succeed, especially when those requirements change to keep pace with the business. Organisations that apply best practices establish the costs and benefits of investing in employee training as part of the budget process so that they will have critical information to determine how much money is needed to bring new expertise into the organisation or to remedy workforce inadequacies.

5.11.3 Peer support for financial management role

A positive finding as reported by participants was that they receive support and guidance from the CEO, FMs and the financial department in any financial related matters with which they require assistance. The Guide for Accounting Officers supports the CFO's providing independent, professional advice to improve the quality of decision making within the organisation (South Africa 2000b: 27). This is done in the form of peer support.

Similarly, Peregrina's (2009: 61) study found that Nursing Unit Managers (NUMs) received support from line managers and colleagues. There was not much support from upper management but there were supportive peers. In contrast, some participants clearly identified the minimal support from the organisation with one participant feeling that she either "sinks or swims" in her role due to the lack of support. The NUMs gave examples of the minimal support they receive where support is available but is only offered if and when the NUM raises concerns. New NUMs are told to seek mentors. Formal education and training and support are definitely lacking (Peregrina 2009: 61).

Rohatinsky (2012: 3) found that peer mentoring was essential for knowledge sharing between staff, and that it was a method for fostering knowledge creation in the workplace. According to managers, the whole organisation and senior leadership support played a key role in establishing, encouraging, and sustaining mentorships on the nursing unit. Employees who felt supported by their organisations, such as in the case of organisation-derived formal mentoring programmes, displayed higher job performance, greater organisational commitment, and reduced turnover (Rohatinsky 2012: 120).

5.12 FINDINGS RELATED TO RESEARCH OBJECTIVE 4: FINANCIAL MANAGEMENT DEVELOPMENT NEEDS OF NMs

The fourth research objective focused on exploring the essential financial management development needs of NMs in public health care organisations. The theme that emerged from the findings was the need for financial management competency development.

5.13 THEME 8: NEED FOR FINANCIAL MANAGEMENT COMPETENCY DEVELOPMENT

Noh and Lim (2015: 152) support the need to identify the educational needs and relevant knowledge that is lacking among nurses before developing a financial management education programme. Congruently, Fleming (2013: 5) finds that to meet the leadership development requirements of frontline managers, it is necessary to understand the two major aspects of their role. These are the clinical leadership role of coordinating expert nursing care, and the generation of positive work environments within the practice environment. A consistent approach is required to identify the effective leadership practices and business competencies needed to successfully fulfil these responsibilities. Not only are they responsible for the clinical coordination of nursing care within the wards, but now they are also responsible for the operation of these as business units within hospitals. However, NMs are often less well prepared to manage these business responsibilities than they are to manage their clinical responsibilities. Clinical nurses who are promoted to nurse unit manager roles are usually poorly prepared for the extent of administrative responsibilities, and the business-oriented reality of ward-based operations. To be effective in the nurse unit manager role, a range of business and operational competencies are required, which were not addressed within the job satisfaction and leadership literature. Currently, there is a gap in the literature on how this leadership development content can be taught to effectively develop nurse unit manager as leaders, as teaching strategies were less well described within the literature reviewed (Fleming 2013: 6).

5.13.1 Compulsory financial management training for NMs in the public sector before being promoted or after promotion

It was noted in the findings that there was a need for NMs and managers to be trained in financial management before and after promotion. The participants indicated that the person being promoted should assume the managerial position after acquiring the essential financial management training and competencies. Managers are not provided with financial management training but are expected to perform related functions hence the need for compulsory and mandatory training for their roles.

The findings of the study that was conducted by McCallin and Frankson (2010: 319) suggest that role preparation for NMs should include postgraduate education and business management training. The authors support that there should induction and a formal organisational management trainee programme and ongoing support for developing the business management competencies of NMs. Overall, the profession needs to review ways to overcome these challenges that NMs encounter with financial and business management (McCallin and Frankson 2010: 325).

Emerging from this context was a further proposal that financial management training be presented in a basic way that is practical, relevant and can be easily understood by NMs. Sangweni (2008: 3) supports the above findings by advocating that organisations must select a delivery medium for training according to the subject matter and learning objectives. Failing to follow this approach can ultimately undermine the effectiveness of training because it is greatly dependent on ease of communication and the level of interaction required with both the subject matter and an instructor. Most corporate trainers agree that some topics are more suitable for particular delivery mediums than others.

It was also noted that there was a proposal for a financial management programme or manual to be developed which can be facilitated at institutional level. The researcher noted that FMs were prepared to facilitate some form of financial management training and orientation for NMs provided that they had standardised guidelines.

The senior managers that underwent training in the study by Sangweni (2008: 39) reported that although the courses had met their objectives and were practical, they did not cover as much as they would have liked. They were also disappointed that training material was not customised or adapted for their environments. Sangweni (2008: 40) adds that training service providers may use generic material, and not take the time to understand the public sector context. They may therefore not deliver courses drawing on and relating to the public sector experience, as well as the demands and dynamics specific to each department and province.

The findings of this study diverges from the traditional financial content found in text books and financial management courses, as NMs identified the activities that they perceived were the important financial management activities that they participated in. Brannagan (2012: 1) concurs that teaching NMs finance skills necessitates a targeted approach to the selection of course content. It may not be practical or even necessary to cover the spectrum of topics presented in a traditional introductory finance or accounting course. The content that is chosen should be relevant and current as it relates to the issues healthcare managers are likely to encounter. The American Association of Colleges of Nurses offer recommendations for programme content at all levels of educational preparation, and may be used as a guide. Additionally, financial skill sets may differ according to each individual and this must be taken into account when planning financial management educational programmes.

A South African study conducted by van der Heever (2009: 110) found that it is noted in the literature that managing institutional resources requires the understanding of financial processes, requests for financial finances, applying

financial regulations, utilising budgets and resources consumed at different operational levels within the institution. Asamani, Kwafo and Ansah-Ofei (2013: 26) found that drawing up plans is the first and perhaps most important step in the management process. Their findings indicate that although the practice of planning was almost universal, half of the participants had no knowledge of the process, and this knowledge gap was traced to a lack of educational preparation before their appointment. In-service training, support from management and staff, and funding were identified as major factors influencing effective planning at ward level. The authors recommend that prospective NMs have educational preparation before they take up these positions and NMs already in the post have capacity-building training in planning (Asamani, Kwafo and Ansah-Ofei 2013: 28).

5.13.2 Training in budget and budgetary concepts

Based on the financial development needs assessment, the findings reveal that participants required more training in budgeting and related concepts. Participants reported that they have a lack of understanding of the budget process and budgeting and attributed this need to the lack of involvement in the budget development and consultation process.

Doyle and Williamson's (2008: 39) study found that the majority of respondents believed that devolved budgeting should be an integral part of undergraduate education and unanimously believed that all hospital staff should have an awareness of devolved budgeting. A majority stated that additional resources would be necessary and rated education and training as the most important additional resource. The majority were of the view that devolved budgeting would lead to greater accountability and that senior management support was important. The majority identified education and knowledge of budgeting as the main difficulty personally and to their department. Staffing issues were identified as the main difficulty for the hospital. A competency based education programme was suggested by some participants. The study identified strong support for the need for education in devolved budgeting and highlighted and confirmed particular areas of

educational need such as education in costs and budgeting (Doyle and Williamson 2008: 39).

Similar to the previous findings there was support for training of NMs in budgetary concepts as indicated by the FMs. The FMs also requested for standardisation of training throughout all institutions in the public sector. There were also suggestions for a training manual that can be revised and updated regularly and as processes change. Emerging from this context the study conducted by Bailey (2014: 83) found that unit leaders were asked to enter objective and subjective thoughts on how prepared they felt they were for their role. Three leaders expressed that their training was inadequate. Five leaders stated that they needed training in budget and finance and one leader expressed that she had no formal orientation, noting, "I have had to learn things as I go, having a handbook for leaders and knowing who to contact would have been helpful". While most unit leaders were quite satisfied with their role preparation in that they felt they had received ample training and were confident in their role, there was evidence that some leaders still felt inadequate in performing their duties, in particular with regard to the areas of budget and finance (Bailey 2014: 83).

5.13.3 Need for Nurse Managers to understand financial reports

Financial statements as defined in the PFMA consist of the following: a balance sheet, an income statement, cash flow statement, any other statements that may be prescribed, and any note to these statements (South Africa 1999: 8). Booyens, Jooste and Sibiya (2016: 122) state that the purpose of financial statements is to observe how the institution spent income and what the current financial position is. Analysing entails assessing the institutions financial position to ensure soundness such as the ability to pay short-term debts and profitability. Reading a financial statement should give the reader an impression of the financial performance of the company. Financial statements show financial activities and sum up the financial situation of the institution which consists of the following: the income statement, the cash flow statement and the balance sheet.

Dunham-Taylor and Pinczuk (2010: 563) state that the final summary of management's performance is contained in the financial statement. Financial statements are required every year and public health institutions must also issue quarterly financial statements. NMs do not have to prepare these statements but will benefit from being able to understand them.

The American Organisation for Nurse Executives (AONE) (2005: 15) nurse executive competencies delineates that NMs in America are involved in various financial management activities including being involved in business models, analysing financial statements, managing financial resources and educating nurses to use their financial knowledge.

The findings indicate that the participants needed training in understanding financial reports as they were given copies to review by the FMs. Generally, they are not able to see where and how the budget was spent due to the lack of understanding and knowing how to read these reports. Finkler, Kovner and Jones (2007: 109) find that understanding the general financial status of the organisation can help managers to better focus their department's efforts to help the overall organisation. Nurses want to become part of major decisions and to do this requires them to be able to interpret and get involved in the bigger issues than the management of a department. It is necessary to be able to interpret and analyse information about the financial status of the organisation (Finkler, Kovner and Jones 2007: 109).

A further finding was that participants had to understand financial reports as they have to account for the expenses. They found it necessary that a training plan include analysing and understanding these reports and financial statements. Similar to these findings, Noh and Lim's (2015: 153) study found that the development of the educational programme included comprehension of financial management, application of financial ratios and the analysis and interpretation of financial statements as one of the key components of financial education for nurses (Noh and Lim 2015: 154).

5.13.4 Training in cost centre management

Muller, Jooste and Bezuidenhout (2015: 554) describe cost centres as units in the budget structure in which managers may conduct resource allocation and exercise control over finance and resource utilisation. Cost centres may be designed for institutions, functions, line items, client groups, speciality or diagnostic related groups.

Cost centre management is outlined in the context of the legal framework of South Africa. According to the Constitution and the PFMA, South African government departments receive funds from the National Revenue Fund. The South African National Treasury prescribes measures to ensure that transparency and expenditure are accounted for by the appointed accounting officer as stipulated in the PFMA. As set out in the National Treasury (South Africa, Department of National Treasury 2017: 17), one of the objectives is to increase the management capacity of central hospitals to strengthen local decision-making and accountability to facilitate semi-autonomy of central hospitals through training, coaching and mentoring and the implementation of cost centre management, over the medium term. The researcher noted that currently there are no cost centres in the public hospitals that were studied. The findings of this study however indicate that a training programme is required for NMs to manage their units as cost centres.

There was strong support from all participants for cost centres which they felt would bring about results based actions and compare trends with expenses. In contrast the findings reveal that there were challenges to the implementation of cost centres mainly due to the lack of financial management skills and the lack of knowledge of cost centre management. There was a loud call for more training in cost centre management which would empower nurses to manage their departments.

Wentzel's (2008: 90) study highlights that clinics are not regarded as cost centres therefore the clinic manager is not informed about financial matters. This results in frustration for both the clinic manager and local area manager

and is considered a serious deficiency as financial management is regarded as an important business function. To render an effective service, it is crucial to have financial resources available. The research has confirmed that the consequences of a lack of finances could result in essential equipment not being purchased, no vacant or critical posts being filled, and stringency measures being put in place. All these would have a negative impact on clinic service.

The findings of this study reveal that though participants felt that cost centre management was ideal it was not possible to manage. The lack of physical and human resources especially the staff shortages would hinder the implementation of such and would make managing and monitoring of cost centres difficult. The findings indicate that cost centres can work if they have the necessary resources and staffing. It was observed by the researcher that the OM also works in the wards rendering basic nursing care and is not able to focus on the financial side of the department. Similar to these findings, Mothiba's (2013) study found, in a hospital in Limpopo Province, that since the introduction of cost centre management (CCMT) in the financial year 2005-2006, no formal training in CCMT or management of their dual role was provided to the appointed Cost Centre Managers (CCMs). The study highlighted the personal and professional distress that CCMs encountered in managing the units as cost centres. This led to the development of a framework for a context-specific training programme in cost centre management (Mothiba 2013: 106).

A further finding was that cost centres would increase financial management accountability of NMs and would encourage them to take ownership of their finances. At present managing expenditure is challenging as there are no cost centres for the nursing units. Warmer (2002, cited by Mothiba 2013: 2) concurs that cost centres are an important part of the management system as this makes the manager accountable for every expense that is incurred. These managers, however, must receive training to manage the cost centre in order to be effective.

Another finding that emerged was that the centralisation of processes and the lack of technology and computerised systems will make cost centre management a challenge. Tshabalala (2015: 22) agrees with this finding and states that in several of the hospitals, management is working towards disaggregating costs and allocating them to operational units, most often wards and/or pharmacy. Although this is described as working towards cost centres, this is not truly the case since the fragmented management structures prevent the allocation of accountability for controlling costs. Moreover, most management staff acknowledge that cost allocation and recording is still extremely weak and partial, particularly because information systems are so weak or even non-existent. In most cases, financial systems are manual rather than digital, which makes real-time cost control and financial management impossible. Conversely, the researcher did not note any reports or mention of the possibility of implementation of cost centres within the public sector hospitals under study.

5.13.5 Training in financial management legislation

All departments of the government including the public hospital sector are governed by the PFMA. The objective of the Act is to “secure transparency, accountability and sound management of revenue, expenditure, assets and liabilities in the execution of daily operations of these departments” (South Africa 1999: 1). Research is very limited in this section as this is a South African Act and only operates within the South African context.

The participants identified the important role played by financial legislation and that all the financial management activities were guided by the PFMA. The findings indicated that providing training on the relevant legislation would assist in understanding how financial management processes work in the public sector. The researcher observed that many participants had a copy of the PFMA booklet available and would page through the relevant sections while talking during the interviews. Participants requested a simple explanation of the relevant sections of the PFMA. It was found that senior managers often quoted applicable clauses from the PFMA which NMs did not

understand. Participants indicated that that all managers should have knowledge of the financial legislation and there was support for the need for training.

Van der Heever's (2009: 99) study sought information on respondents' knowledge and awareness of the PFMA and its contents as applied in the public hospital. The findings of the study revealed that the majority of respondents who answered the question were aware of the Act and its contents relating to accountability and sound management of revenue, expenditure, assets and liability matters in the execution of the public hospitals official's daily tasks. Although the CFO is accountable to the Department of Health for all financial matters, responsibility lies with management of the institution to apply the PFMA. The study reported that only 28.02% of the respondents correctly indicated that hospital management is responsible for applying the PFMA (van der Heever 2009: 99).

Moagi's (2009: 1) study analysed and assessed the implementation and execution of the PFMA and evaluated the compliance by the Department of Labour in Limpopo Province to the Act. The researcher asked the participants if they have attended any formal or informal financial training and the extent of their knowledge of the PFMA. It transpired from the investigation that officials were trained formally on the following courses: financial management for non-financial managers, PFMA training, SCM and asset management, budgeting, supply chain, treasury regulations and economics.

Moagi (2009: 98) found it is vital that the Department of Labour in Limpopo ensures that all officials are aware of the objectives of the Act. These can be achieved by fostering transparency and making the act available at a conspicuous place where all the employees can have access. The national Department of Labour used facilities of technology to allow access of various legislations and policies. Most of the policies, including the PFMA as researched, are posted on the intranet of the Department of Labour. Though the PFMA is availed to the officials, nothing is being done to ensure that it becomes part of a working manual for all employees since all officials are

accountable and responsible for their actions (Moagi 2009: 121). The researcher has noted that the Department of Health website has several links to other websites including that of other laws. These can be retrieved if participants have the available technology and resources available.

5.14 SUMMARY OF THE CHAPTER

This chapter discussed the findings relating to the financial management roles, competencies and developmental needs of NMs. The responses of the participants were analysed and interpreted and compared with the available literature. The discussion of the findings was based on the themes and related sub-themes that emerged in relation to the objectives of the study. It is suggested from the findings that clearly there is a lack of financial management skills, competencies and knowledge among NMs and more training and education is required. This then necessitates the development of a framework which will act as a guide for NMs to develop their financial management competencies. The next chapter will propose a financial management competency framework for NMs.

CHAPTER 6: NURSE MANAGER FINANCIAL MANAGEMENT COMPETENCY FRAMEWORK

6.1 INTRODUCTION

In the previous chapter, the findings of the study were discussed and the related literature was presented. In this chapter, the financial management competency framework that was developed for NMs is presented. The development of the framework was the fifth research objective that was proposed and the main aim of the current study.

6.2 APPLICATION OF GROUNDED THEORY TO THE DEVELOPMENT OF THE FRAMEWORK

There have been very few studies of this nature and the literature was very limited. This influenced the decision to use the GT approach which would not limit the study to start with and would provide the opportunity to obtain as much information as possible. The intent of this study was to use GT to develop a framework to improve the financial management competencies of NMs' working in the public sector. The data gathered was coded and the researcher then began to apply the rigour of GT to the data. Then, once theoretical saturation of categories was reached, the themes were developed on which the framework is founded.

The first stage in Charmaz Constructivist GT is that of open coding. This involves reviewing the data that has been gathered line-by-line, word-by-word, to gain an insight into what participants are stating (Charmaz 2014: 116). The purpose of this phase is to generate as many codes as possible which resulted in a very large number of codes emerging. This resulted in undertaking several rounds of further coding while frequently completing constant comparative analysis on the data and linking it with areas already covered. Memos were made repeatedly throughout this process. This involved comparing codes with other codes and seeing similarities as well as

comparing the emergent categories. The next stage was that of focused coding which involved using frequent or earlier codes to sift through large amounts of data (Charmaz 2014: 140). Lastly, theoretical coding enabled the saturation of the core categories identified during focused coding (Charmaz 2014: 150). Emergent concepts were compared to each other with the purpose of establishing the framework.

6.3 PURPOSE OF THE FRAMEWORK

An effective competency framework underpins all the human resource development systems operating in an organisation namely recruitment and selection, performance management, training and development, career planning, and succession management. An effective competency framework also facilitates self-management and empowerment as it allows officials to assess their knowledge, skills and attributes (competencies) against the agreed standard of performance required for the relevant position (South Africa 2010a: 3).

Competencies are measureable and should not be confused with the term 'competence'. It is important to understand the meaning of the word 'competency' in order to contextualise the principles of a competency framework. 'Competency' refers to a mix of skills, related knowledge and attributes to produce a job/task to a defined standard. 'Competence', on the other hand, relates to the outcomes which define effective performance, namely aspects of the job at which a person is competent, for example, conducting an internal audit engagement (South Africa 2010a: 4). People demonstrate competence by applying their competencies within the work setting. A competence framework describes the range of knowledge, skills and performance levels required to help nurses provide safe, effective and accountable practice (South Africa 2010a: 4).

The framework will support the use of a planned and integrative approach to NM financial management orientation and development. The framework was designed to support the NMs in their current financial management roles and

responsibilities. Most of the leadership and management development programmes are not well defined and are based on current leadership theories in business and healthcare. This framework provides a structured approach to the development of financial management skills, knowledge and competencies specific to the unique needs of NMs in the public sector. The framework can be used for self-assessment by NMs in all organisations and for ongoing competency development. Furthermore, the framework can be used to guide financial management development programmes. Academic institutions may find financial benefit in developing programmes designed to build successful financial management competencies for the NM role. In view of the financial constraints and reductions in funding for health care, there is a need for a different approach and way of thinking, and for NMs to recognise that their roles focus not only on clinical outcomes but to a very large extent on financial outcomes.

6.4 RATIONALE FOR THE FRAMEWORK

The PFMA brings about a critical change in the method of handling public finances, as it moves the emphasis away from a highly centralised system of expenditure control by treasuries, and places the liability of managing the finances in the hands of the Head of the Department concerned (South Africa 1999: 1). These changes have created a need for all staff to be financially knowledgeable and to use funds prudently.

Information gathered from the NMs reveal that there is very little or no training being done to develop the financial competencies of the staff. Adherence to the PFMA and the cost cutting policies and processes of the Department of Health increase the high demand for the NMs and all senior managers to be financially conscious and knowledgeable. NMs have come from various training backgrounds and there is no generic financial management programme that delineates the critical competencies that are required of all NMs in the public sector. Evidence presented in the preceding chapters indicate that many NMs are currently ill-equipped to perform the tasks expected of them especially with regard to financial matters. For this reason, a

competency framework is necessary to address the financial management training and gaps of NMs, not only for the present time but for the future.

6.5 PROCESS OF DEVELOPING THE FRAMEWORK

The preceding chapters presented information based on the first four objectives of the study which were to:

- Explore the current roles of the NM with regard to financial management practice in public health care organisations.
- Determine the financial management competencies that NMs in public health care organisations currently possess.
- Explore the training and educational qualifications NMs have with respect to financial management.
- Establish the essential financial management development needs of NMs in public health care organisations.

These objectives were set with the aim of eventually drawing up a framework for the development of NMs' financial management competencies. The interview questions were structured and asked in order to obtain the relevant information for the development of the framework. The information gathered during the interviews in the form of responses of the participants and observations were taken into account during the framework development. The framework was developed in relation to the eight major themes and 25 sub-themes that emerged from the findings of the study.

Prior to the compilation of the framework there were a number of questions that needed to be answered. The questions were as follows:

- Who is the target group for this framework?
- What are the relevant competencies that have been identified?
- Who is responsible for the development of the competencies?
- What resources are available for competency development?
- How will competencies be assessed?

These questions have been addressed and included as part of the components of the framework in the latter part of this chapter.

6.5.1 The framework development process

The development of the framework was guided by the findings of the study and followed a series of steps. The first step was selecting the GT approach to explore NMs' financial management competencies. The next step was to conduct a literature review and search for the available information and other researcher's findings on the phenomenon. A search was also conducted to find out if there are any similar frameworks that have been formulated in order to avoid duplication. The third step included the identification of a financial management competence gap among NMs. An analysis was conducted with NMs to identify their financial management competency development needs for inclusion in the framework. Following the development of the framework, it was forwarded to a panel of experts for verification and input. These steps in developing the framework are explained in the discussion below, and outlined in Figure 6.1.

Step 1: Grounded theory approach to explore Nurse Managers' financial management competencies

Interviews based on the constructivist GT approach were used to obtain information on the financial management competencies of NMs. The findings revealed that NMs did not have the requisite skills, knowledge and competencies.

Step 2: Literature search

A literature search was conducted to identify the gaps in the financial management knowledge and competencies of NMs. It was found that there were many studies conducted internationally on NMs financial management competencies. Only a few studies related to financial management skills and competencies of NMs in the South African context. The majority of studies evaluated the generic competencies of NMs of which business or financial management skills were only a small component. There were no studies of

that looked at the financial management skills of NMs in the public sector. There was a gap in the literature and knowledge of the financial management competencies that NMs have.

Step 3: Identification of a financial management competence gap among Nursing Managers

Literature sources revealed the increasing need for NMs to be financially literate and be well versed in financial matters of the organisation. The study findings indicate that NMs were not prepared for their financial management role and called for more training and education in financial education to prepare and assist them in their roles. There is also evidence that there is very little support and assistance for NMs in their present roles especially related to finance. Furthermore, the problem is exacerbated by the lack of attention given to financial management in the nursing curriculum. NMs are faced with funding cutbacks, staff shortages and limited resources and are expected to deliver high quality care. NMs are told to monitor and control expenditure. Often NMs are excluded from the financial matters of the organisation. This raises the concern of how the NM can possibly manage and control the financial side of the nursing sector if she or he does not have the necessary knowledge and experience. It is envisaged that if the NM has the necessary financial management skills, knowledge and competencies, then she or he would be able to make a knowledgeable impact on the financial functioning of the organisation and contribute to cost saving efforts and expenditure control.

Step 4: Conduct training needs analysis

Based on the financial management competency gaps identified, a competency needs analysis was conducted with NMs. The competency needs identified are incorporated into the framework. The competency needs include aspects of financial planning, financial decision-making, financial monitoring, and financial control.

Step 5: Development of the framework

The framework was developed based on the competencies, financial management roles and needs as verified by the NMs who participated in the study.

Step 6: Verification of the framework by experts

Once the framework was developed, it was forwarded to a panel of experts, being NMs and nurse educators who reviewed the content and outcomes for comprehensiveness, importance and relevance to the financial management practice of NMs. The panel included a NM, an OM, one lecturer who teaches post graduate Health Services Management at a university and one lecturer who teaches unit management and professional practice in the basic nursing programme. The study supervisor and co-supervisor who was previously a NM also reviewed the framework and provided input. The panel of experts met on three occasions and reviewed the framework based on the current financial management practices of NMs and the health services management curricula. Final improvements were made to the framework based on comments by these experts.

Step 7: Final improvement based on comments by experts

Final improvements to the framework were effected according to the suggestions made by the reviewers.

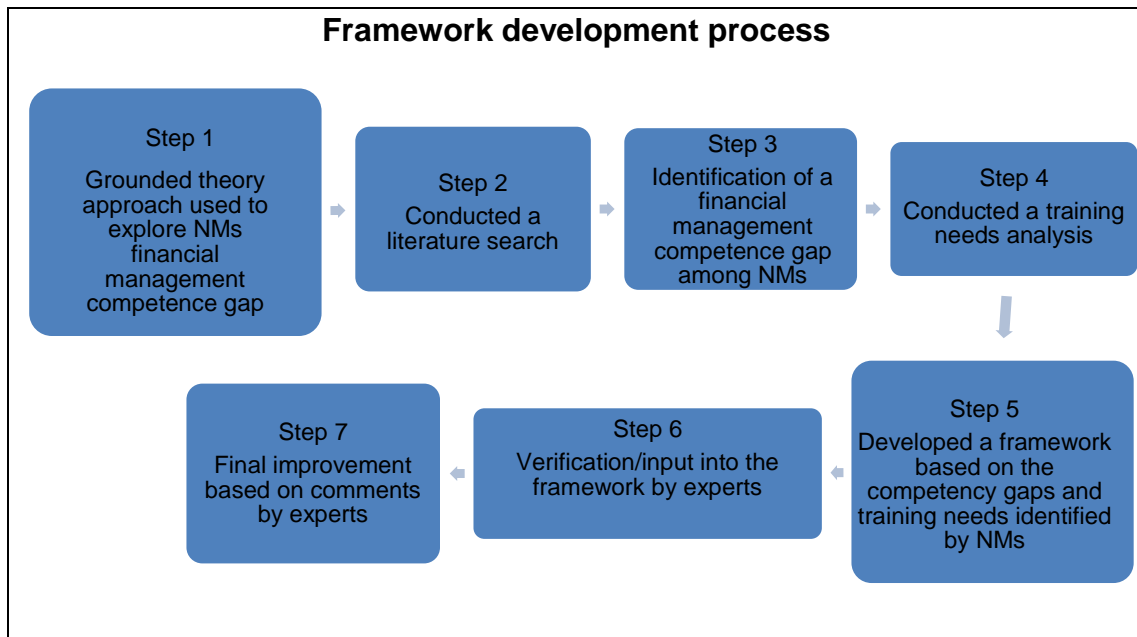


Figure 6.1: Framework development process

6.5.2 Components of the Financial Management Competency Framework

6.5.2.1 Introduction

A competency framework describes a set of competency standards for employees and makes the expected knowledge, skills and attributes of employees explicit for those within and outside the organisation (South Africa 2017a: 8). The intention of developing a framework is to make it simple to apply and for it to be able to be used to identify areas for improvement. This will allow development to be focused on specific areas of need. This NM Financial Development Competence Framework has been developed to encapsulate the level of financial skills and knowledge that are key to the roles and functions of NMs in the public sector. The framework will not replace any competency frameworks that are already in place in the public sector. Instead, it will complement them, focusing on the financial skills which are applicable to all NMs in the public sector. The framework will support NMs to identify learning and development needs and provide access to appropriate learning and development activities.

6.5.2.2 The target group

For the purposes of this study the NM Financial Management Competency Framework is directed at NMs, ANMs and OMs. However, all nurses and any public servant working in the public sector and connected in some manner to the financial processes of government can also use this framework. In addition to the staff currently employed, new staff that are recruited can use this framework to develop their competencies based on the required level of performance.

6.5.2.3 Competencies of Nurse Managers

During this study the gaps between the existing financial management competency levels of NMs and those that are considered necessary was established. There is no baseline data about the current level of financial management competencies of NMs. This baseline must be determined if requirements are to be prioritised and relevant training delivered.

6.5.2.4 Training providers

If the relevant organisation contains the internal expertise or resources to provide best possible learning experiences for the NMs, these can be used. If not, the organisation can outsource the entire training and development function to external training providers. Training providers can be independent trainers, universities, Technikons, Technical Colleges and private sector institutions. Some staff may also undertake formal or distance learning programmes and hence their needs will be met through that system.

6.5.2.5 Resources for competency development

The Department of Health has a website where all the legislation, guidelines, acts and reports are published. Most hospitals have access to the internet and intranet and can retrieve the necessary information. The Department of Health also makes available e-books, online journals, research publications, magazines and other informational sources to all staff. Individual

organisations will need to provide the additional resources that they identify as necessary for the financial management competency development of NMs.

6.5.2.6 Assessment of competencies

In the public sector the NM is accountable to the CEO for her/his actions and functions. ANMs and OMs report to the NMs. The assessment of competencies should be done by the immediate line manager. The competencies should also form part of the performance management process in the public sector. Tools for self-assessment and developmental planning have been included in the framework. The framework will be handed to the Chief Nursing Officer in KZN Department of Health to possibly include and use as part of the NMs financial management competency assessment and development.

6.5.2.7 Content of the Competency Framework

In order to effectively and efficiently perform the financial management role, the nursing management function requires specific competencies that are developed through suitable knowledge and experience. Accordingly, this framework consists of the following components: strategic planning, operational planning, procurement planning, human resources planning and budget planning as part of the financial planning role. The financial monitoring role includes the following components: income and expenditure monitoring, and analysis and interpretation of financial statements and reports. The financial decision-making and financial control roles include the following components: contracts and tender awarding, assets and resources control, and cost centre management. Financial legislation and expenditure control pervade all competencies and are integrated into every aspect of nursing management and is depicted by the arrow in the figure below. The components are shown in Figure 6.2 below.

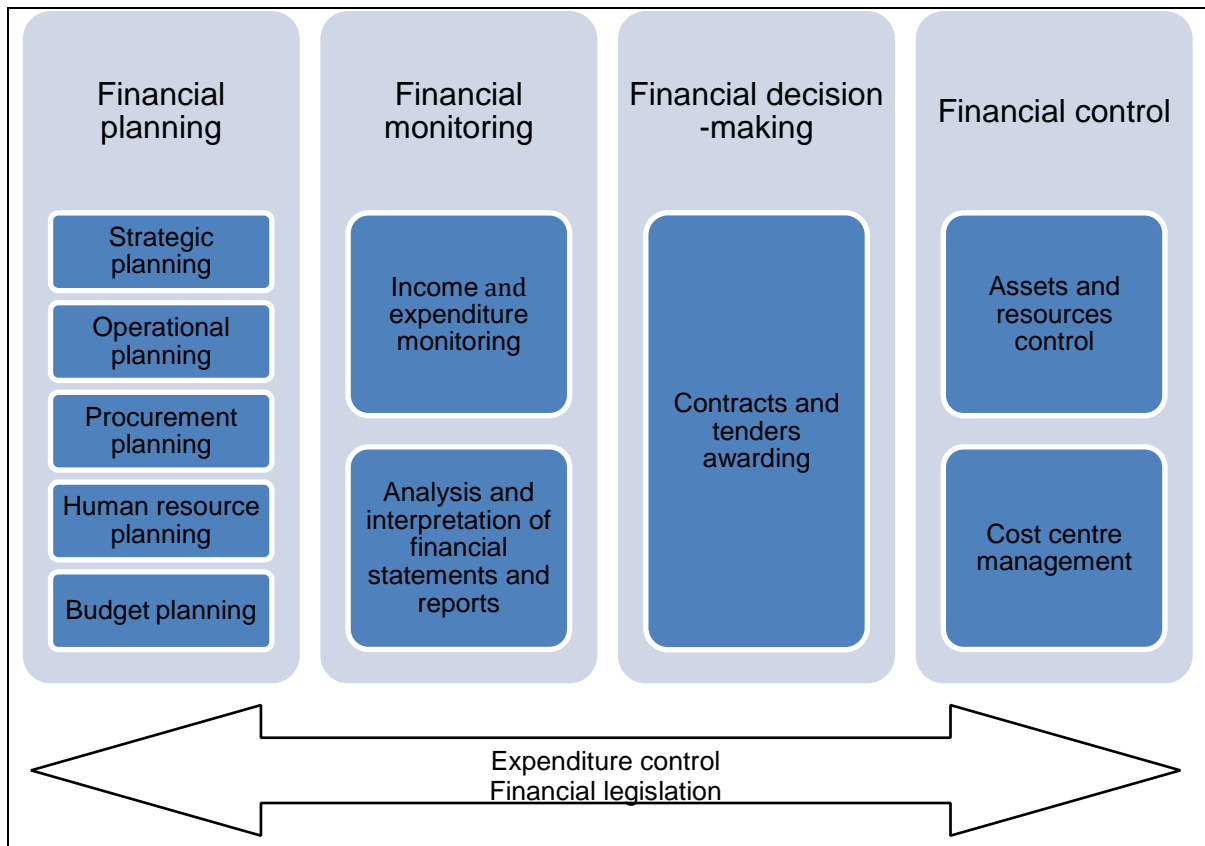


Figure 6.2: Content of competency framework

6.5.2.8 Structure of the competency framework

Definition of concepts used in the framework

Behavioural indicators are a behaviour that an observer can see or expect to see. They integrate the knowledge, skills and attributes components of competencies so that they make the competency come “alive” in the context of how the job is performed (South Africa 2017a: 9). The desired attributes identify the qualities of character required to be an effective and successful performer in a specific job. For example, professionalism in conducting an internal audit engagement would constitute an attribute in this context (South Africa 2010a: 4).

Skills are the inherent or learnt ability to accomplish pre-set results consistently with the minimum expense of time, energy, or both. For example, the ability to deal with complex numbers in accountancy would constitute a skill in this context (South Africa 2010a: 4).

Knowledge is the theoretical and/or practical understanding of a subject namely, facts and information. For example, being familiar with particular provisions of the PFMA relevant to the task would constitute knowledge in this context (South Africa 2010a: 4).

The following guiding principles underpin the Competency Framework:

- Learning is a life-long process – officials are encouraged to foster a culture of life-long learning aimed at individual and organisational growth and development.
- Individual and organisational needs are agreed upon in conjunction with the identification of personal development needs; officials and government institutions are jointly responsible for the development of individuals; people development interventions are evaluated on a continuous basis to determine their effectiveness in improving job and organisational performance (South Africa 2010a: 5).

The structure of the framework is presented in Table 6.1 and includes:

- The financial management role as described by NMs.
- A description of each financial management competency.
- The behavioural indicators required for each competency.
- The knowledge and skills required for each competency.
- The suggested learning and development resources.

A competency assessment form has been developed (Table 6.2) where NMs can assess their financial management competencies based on the basic, intermediate and advanced levels. Based on the proficiency levels, a development plan (Table 6.3) is included which the NMs can use to plan their financial management competency development.

Table 6.1: The Financial Management Competency Framework

Role	Competency	Behavioural indicators	Knowledge and skills	Suggested learning and development resources
Financial planning	<p>Strategic planning.</p> <p>Definition: A strategic plan sets out an institution's policy priorities, programmes and project plans for a five-year period, as approved by its executive authority, within the scope of available resources.</p> <p>Purpose: The strategic plan focuses on strategic outcome oriented goals for the institution as a whole, and objectives for each of its main service delivery areas aligned to its budget programmes and, where relevant, also its budget sub-programmes.</p>	<ol style="list-style-type: none"> 1. Analyses strategies and converts them into the requirements and services that the nursing departments must provide. 2. Breaks down the strategic directive into activities to be implemented. 3. Prioritises or re-prioritises objectives, activities and services to be undertaken by the nursing departments based on the interpretation of the strategic directives to be implemented. 4. Ensures that the nursing departments are structured appropriately in order to implement the required strategic initiatives. 5. Implements any changes required in work unit's services resulting from changes in strategy or strategic priorities. 6. Develops proposals for additional resources required by changes in strategic objectives. 7. Understands and communicates the vision and mission, role and objectives of the department and work unit. 	<ol style="list-style-type: none"> 1. Demonstrate understanding of the term 'strategic planning'. 2. Analyse the benefits of a strategic approach to management and nursing. 3. Analyse the tasks involved in the strategic planning process. 4. Use key management tools to analyse the current situation of the organisation, for example, SWOT analysis 5. Demonstrate the ability to draw appropriate conclusions from SWOT analysis. 6. Explain why organisations must be capable of change and revitalisation. 7. Evaluate various ways in which organisations plan for change. 8. Distinguish between each level of planning: strategic, tactical and operational levels. 9. Be able to conduct the following: <ul style="list-style-type: none"> • Strategy analysis. • Strategy development. • Strategy execution. • Strategy review. 	<ol style="list-style-type: none"> 1. Intranet policies/ procedures. 2. Government publications. 3. The Framework for Strategic Plans and Annual Performance Plans (South Africa: National Treasury 2010a, b). 4. National Department of Health Strategic Plan 2015/16-2019/20 (South Africa, Department of Health 2014). 5. Textbooks. 6. Developmental courses. 7. Internet sources. 8. Chapter 5 and 30 of the Treasury Regulations and Part 3B of the Public Service Regulations set out the legal requirements for Strategic Plans.

Role	Competency	Behavioural indicators	Knowledge and skills	Suggested learning and development resources
Financial planning	<p>Operational planning.</p> <p>Definition: An operational plan can be defined as a plan prepared by a component of an organisation that clearly defines actions it will take to support the strategic objectives and plans of upper management. However, to fully understand operational plans, one should first look at the overall planning process within a business.</p> <p>Purpose: The purpose of the operational plan is to provide organisational personnel with a clear picture of their tasks and responsibilities in line with the goals and objectives contained within the strategic plan.</p>	<ol style="list-style-type: none"> 1. Analyses and understands organisational goals and strategies. 2. Understands business basics in the health care environment and incorporates them into decision-making. 3. Understands how the work of own department fits within the broader organisational context. 4. Effectively sets priorities with an appropriate sense of what is most important. 5. Correctly analyses the operational issues and identifies appropriate action. 6. Acquires additional information to resolve specific operational issues and inform decisions. 7. Anticipates obstacles realistically. 8. Effectively handles multiple demands and competing priorities. 	<ol style="list-style-type: none"> 1. Demonstrate understanding of the term 'operational planning'. 2. Analyse the benefits of operational planning to management and nursing. 3. Analyse the key targets and key activities involved in the operational planning process. 4. Set clear objectives for the department. 5. Identify the strategies and activities that must be undertaken. 6. Specify the staffing and resources needed and persons who have responsibility for each of the strategies/tasks. 7. Indicate the timelines in which strategies/tasks must be completed. 8. Determine the amount of financial resources provided to complete each strategy/task (including budget) requirements. 9. Set up a process for monitoring progress. 	<ol style="list-style-type: none"> 1. Intranet policies/ procedures. 2. Government publications. 3. The Framework for Strategic Plans and Annual Performance Plans (South Africa: National Treasury 2010). 4. Textbooks. 5. Developmental courses. 6. Internet sources. 7. National Department of Health Strategic Plan 2015/16 - 2019/20 (South Africa, Department of Health 2014).

Role	Competency	Behavioural indicators	Knowledge and skills	Suggested learning and development resources
Financial planning	<p>Procurement planning.</p> <p>Definition: Procurement planning is the process of deciding what to buy, when and from what source. During the procurement planning process, the procurement method is assigned and the expectations for fulfilment of procurement requirements determined.</p> <p>Purpose: The purpose of the procurement planning is finding, agreeing on terms and then acquiring goods, services or works from an external source, often via a tendering or competitive bidding process.</p>	<ol style="list-style-type: none"> 1. Analyses and understands organisational goals and strategies. 2. Effectively sets priorities with an appropriate sense of what is most important. 3. Understands that supply and logistics is a system of organisations, people, technology, activities, information, and resources involved in moving a product or service from supplier to customer. 4. Possesses basic knowledge of supply chain activities 5. Recognises the ways that supply chains link value chains. 	<ol style="list-style-type: none"> 1. Demonstrate understanding of the term procurement planning. 2. Analyse the benefits of procurement planning to management and nursing. 3. Analyse the key targets and key activities involved in the procurement planning process. 4. Identify the need for the products, whether from internal or external sources. 5. Determine the specifications of the product. 6. Source options and determine where to obtain the product. 7. Investigate all relevant information to determine the best price and terms for the product. 8. Complete and submit purchase order. 9. Once the sending company delivers the product, the recipient accepts or rejects the items. 10. Invoice approval and payment. 	<ol style="list-style-type: none"> 1. Intranet procurement policies/procedures. 2. Government publications. 3. Textbooks. 4. Developmental courses. 5. Internet sources. 6. All relevant legislation of the country for example, the Constitution. 7. Laws regulating the Supply Chain Management System for example, PPPFA. 8. All applicable financial legislation for example, PFMA.

Role	Competency	Behavioural indicators	Knowledge and skills	Suggested learning and development resources
Financial planning	<p>HR Planning</p> <p>Definition: HR planning is the process of predicting and providing for the movement of people into, in and out of the organisation.</p> <p>Purpose: A major purpose of HR planning and provision is to identify future human resource demands and to develop programmes to eliminate any discrepancies in the best interests of the individual and organisation</p>	<ol style="list-style-type: none"> 1. Demonstrates and applies human resources terminology, tools, policies, principles and practices, as relevant for the efficient delivery of health care. 2. Possesses a sound knowledge of current and emerging human resources processes and applies this knowledge in the workplace. 3. Keeps up-to-date with relevant statutory and regulatory requirements, and the Department of Health's human resources policies. 4. Understands the objectives of the regulations governing the delivery of human resources within the Department of Health and the country. 5. Promotes an organisational culture that supports the building of collaborative relationships. 6. Contributes to the development of long-term human resources plans, initiatives and strategies. 	<ol style="list-style-type: none"> 1. Demonstrate understanding of the nature of human resource planning and management 2. Identify the phases of human resource planning. 3. Forecast human resource demands and human resource supplies. 4. Develop human resource goals and objectives. 5. Design and implement human resource policies, programmes and practices. 6. Conduct job analysis. 7. Draw up job descriptions and job specifications. 8. Conduct job evaluations according to institutional prescriptions. 9. Conduct recruitment, selection and appointment of employees. 10. Conduct induction and orientation of employees. 11. Management of quality of work life and productivity 12. Management of absenteeism and turnover. 13. Understanding of remuneration systems and payroll. 	<ol style="list-style-type: none"> 1. Intranet / Internal HR policies/procedures. 2. Government publications. 3. Textbooks. 4. Developmental courses. 5. Internet sources. 6. All relevant legislation of the country for example, the Constitution. 7. Laws regulating the HR management for example: affirmative action. 8. All applicable financial legislations for example, PFMA.

Role	Competency	Behavioural indicators	Knowledge and skills	Suggested learning and development resources
Financial planning	<p>Budget planning.</p> <p>Definition: A budget is a financial plan for a defined period of time, usually a year. It may also include planned sales volumes and revenues, resource quantities, costs and expenses, assets, liabilities and cash flows.</p> <p>Purpose: The purpose of budgeting includes the forecast of income and expenditure (and thereby profitability) and serves as a tool for decision-making.</p>	<ol style="list-style-type: none"> Analyses and comprehends organisational goals and strategies. Understands business fundamentals in the health care environment and incorporates them into budget planning. Understands how the work of own division or group fits within the broader organisational context and budget planning. Effectively sets priorities with an appropriate sense of what is most important. Possesses basic knowledge of budget activities, including internal control policies and processes in line with the Public Finance Management Act. Analyses the business issues and identifies appropriate action. Ability to understand how to read, interpret and use budgets and projections. 	<ol style="list-style-type: none"> Demonstrate understanding of the term budget planning. Analyse the key targets and key activities involved in the budget planning process. Analyse the objectives and benefits of budget planning to management and nursing. Demonstrate understanding of the principles of budgeting. Demonstrate understanding of the public service budgeting cycle and process. Analyse the types of budgets. Differentiate between the costing approaches. Explain the process of performance budgeting. Demonstrate the ability to draw up and present a budget. Demonstrate ability to link budgeting process to forecasting and strategic planning process. Ensure conformity with PFMA and auditing requirements. 	<ol style="list-style-type: none"> Intranet policies/ internal procedures on budgeting. Government publications. Textbooks. Developmental courses. Internet sources. Legal requirements and guidelines. Chapter 4 of the PFMA and Chapter 6 of the Treasury Regulations set out the legal requirements for annual budgets. Section 53 of the PFMA deals with the legal requirements for annual budgets and the MTEF budgets of public entities.

Role	Competency	Behavioural indicators	Knowledge and skills	Suggested learning and development resources
Financial monitoring and control	<p>Income and expenditure monitoring and control.</p> <p>Definition: Income and expenditure monitoring entails showing the amounts of money coming into and going out of an organisation, during a particular period of time.</p> <p>Purpose: The primary purpose when monitoring expenditure against income is to ensure that expenditure does not exceed the available income. When monitoring expenditure against budget, the first problem is how to identify which sources of funds are showing significant surpluses or deficits.</p>	<ol style="list-style-type: none"> 1. Analyses and comprehends organisational goals and strategies. 2. Understands business fundamentals in the health care environment and incorporates them into budget planning. 3. Understands how the work of own division or group fits within the broader organisational context and budget planning. 4. Possesses basic knowledge of budget activities, including internal control policies and processes in line with the Public Finance Management Act. 5. Understands how to read, interpret and use budgets and projections. 	<ol style="list-style-type: none"> 1. Demonstrate understanding of the terms income and expenditure. 2. Analyse the key activities involved in the budget planning process. 3. Identify sources of funding in health care organisations 4. Explain sources of income/revenue and revenue collection processes. 5. Analyse the funding allocation mechanisms in public health sector. 6. Demonstrate an understanding of purchasing mechanisms in public health sector. 7. Monitor the processing of payments. 8. Monitor actual income and expenditure and compare this to the budget, through regular financial reporting and corrective action when needed. 9. Identify key trends in the revenues and expenditures of health care organisations. 	<ol style="list-style-type: none"> 1. Intranet policies/ internal procedures financial management. 2. Government publications. 3. Textbooks. 4. Developmental courses. 5. Internet sources. 6. Legal requirements and guidelines. 7. PFMA. 8. National Treasury Regulations. 9. MTEF Guidelines.

Role	Competency	Behavioural indicators	Knowledge and skills	Suggested learning and development resources
Financial monitoring	<p>Analysis and interpretation of financial statements.</p> <p>Definition: Summary report that shows how a firm has used the funds entrusted to it by its stockholders (shareholders) and lenders, and what is its current financial position. The three basic financial statements are the (1) balance sheet, which shows firm's assets, liabilities, and net worth on a stated date; (2) income statement (also called profit & loss account), which shows how the net income of the firm is arrived at over a stated period, and (3) cash flow statement, which shows the inflows and outflows of cash caused by the firm's activities during a stated period.</p> <p>Purpose: The general purpose of the financial statements is to provide information about the results of operations, financial position, and cash flows of an organisation. This information is used by the readers of financial statements to make decisions regarding the allocation of resources.</p>	<ol style="list-style-type: none"> Analyses and comprehends organisational goals and strategies. Understands business fundamentals in the health care environment and interprets them in the financial statements. Understands how the work of own division or group fits within the broader organisational context. Effectively sets priorities with an appropriate sense of what is most important. Possesses basic knowledge of financial terminology, including internal control policies and processes in line with the Public Finance Management Act. Analyses the business issues and identifies appropriate action. Understand how to read, interpret and use financial statements. 	<ol style="list-style-type: none"> Demonstrate an understanding of basic accounting terminology. Analyse financial statements and financial data to guide decision-making. Design a system of financial ratios and other performance indicators appropriate for a specific nursing unit or situation. Analyse the impact of inflation or other macroeconomic factors on the hospitals and nursing units' reported financial results. Calculate and interpret the meaning of various financial ratios Demonstrate an understanding of basic financial statements: <ul style="list-style-type: none"> Recording and reporting process. Audit reports. Balance sheets and operating statements. Statement of cash flows. 	<ol style="list-style-type: none"> Intranet policies/ internal financial management procedures. Government publications. Textbooks. Developmental courses. Internet sources. Legal requirements and guidelines. Section 40 of the PFMA and Chapter 18 of the Treasury Regulations set out the legal requirements for Departments' annual reports. Section 55 of the PFMA and Chapter 28 of the Treasury Regulations set out the legal requirements for public entities' annual reports.

Role	Competency	Behavioural indicators	Knowledge and skills	Suggested learning and development resources
Financial decision-making	<p>Contracts and tenders.</p> <p>Definition: To tender is to invite bids for a project, or to accept a formal offer such as a takeover bid. Tender usually refers to the process whereby governments and financial institutions invite bids for large projects that must be submitted within a finite deadline.</p> <p>Contracts are written or spoken agreements, especially one concerning employment, sales, or tenancy that is intended to be enforceable by law.</p> <p>Purpose: Written contracts provide individuals and businesses with a legal document stating the expectations of both parties and how negative situations will be resolved. Contracts are legally enforceable in a court of law.</p>	<ol style="list-style-type: none"> 1. Analyses and understands organisational goals and strategies 2. Effectively sets priorities with an appropriate sense of what is most important. 3. Understands that supply and logistics is a system of organisations, people, technology, activities, information, and resources involved in moving a product or service from supplier to customer. 4. Possesses basic knowledge of bid committee functioning 5. Recognise the ways that supply chains link value chains. 	<ol style="list-style-type: none"> 1. Demonstrate understanding of the concepts 'awards' and 'tenders'. 2. Analyse the benefits of contracts and tenders to the organisation and Department of Health. 3. Analyse key activities involved in the contacts and tender process 4. Analyse the functions of the various bid committees. 5. Specify the information and documents that should be requested from bidders. 6. Analyse how to deal with price adjustments in tender documents. 7. Discuss ways to investigate and handle fraud on the part of bidders. 8. Demonstrate an understanding of decisions to award a tender. 9. Explain when and how should the decision to make an award be recorded and communicated. 10. Identify the laws relating to the procurement of goods and services in the public sector. 	<ol style="list-style-type: none"> 1. Intranet procurement policies/procedures. 2. Government publications 3. Textbooks. 4. Developmental courses. 5. Internet sources. 6. All relevant legislation of the country for example: the Constitution. 7. Laws regulating the Supply Chain Management System for example, PPPFA. 8. All applicable financial legislations for example, PFMA.

Role	Competency	Behavioural competencies	Knowledge and skills	Suggested learning and development resources
Financial control	<p>Cost centre management.</p> <p>Definition: A cost centre in a hospital setting is an identifiable department, for example a nursing care unit, which has been practically assigned an account number in the hospital accounting system (Mothiba 2013).</p> <p>Purpose: The purpose of a cost centre is to control clinical and administrative costs, as well as accumulated expenses by that identified department.</p>	<ol style="list-style-type: none"> 1. Understands the Department of Health's and the institution's budgeting and financial regulations and processes. 2. Understands one's responsibility for the careful use and protection of financial resources and assets under one's control. 3. Adheres to budgets as assigned. 4. Provides correct financial information as required. 5. Monitors departmental expenditures. 6. Analyses the internal and external factors that impact financial resource availability. 7. Ensures compliance with legislation, policies and practices applicable to the appropriate and effective use of financial resources. 	<ol style="list-style-type: none"> 1. Identify the relevant sections of South African legislation that guide cost centre management in health care institutions and nursing units. 2. Identify and apply the relevant guidelines, policies and procedures of the Department of Health cost centres management. 3. Analyse roles and responsibilities of cost centre managers. 4. Identify challenges in the current health care environment that impact on the functioning of the nursing units as cost centres. 5. Propose strategies to minimise these challenges. 6. Identify and describe the key practices and business management processes used in cost centre management. 7. Monitor and review the monthly financial reports that detail expenses and revenues to verify the accuracy of the data contained in the reports and to identify any discrepancies. 8. Monitor cost and expenses and ensure that they are within budget. 	<ol style="list-style-type: none"> 1. Intranet and internal policies/procedures. 2. Government publications. 3. Textbooks. 4. Developmental courses. 5. Internet sources. 6. Related legislation. 7. The Constitution of the South Africa, Chapter 13. 8. PFMA, Section 38.

Role	Competency	Behavioural indicators	Knowledge and skills	Suggested learning and development resources
Financial control	<p>Asset and resource control.</p> <p>Definition: In financial accounting, an asset is an economic resource. Anything tangible or intangible that can be owned or controlled to produce value and that is held by a company to produce positive economic value is an asset. Current assets include inventory, while fixed assets include such items as buildings and equipment.</p> <p>Purpose: To ensure the effective and efficient control, utilisation, safeguarding and management of assets.</p>	<ol style="list-style-type: none"> 1. Understands the Department of Health's and the institution's asset management, and supply chain management processes. 2. Understands one's responsibility for the careful use and protection of financial resources and assets under one's control. 3. Monitors departmental assets. 4. Ensures compliance with legislation, policies and practices applicable to the appropriate and effective use of financial resources. 	<ol style="list-style-type: none"> 1. Demonstrate understanding of the definition of assets and resources. 2. Identify the different type of assets and resources in organisations. 3. Analyse systems of internal control of assets, including an asset register 4. Evaluate the Department of Health's policies and procedures, including the acquisition plans regarding the purchase of capital assets. 5. Describe processes for recording of all assets received. 6. Establish mechanism for appropriate safeguarding and protection of assets from inappropriate use or loss. 7. Describe appropriate control over the physical access to assets. 8. Conduct regular asset verification to ensure losses have not occurred, any known losses are immediately reported to the CFO. 9. Evaluate the procedures for the movement of assets from one user to another, for maintenance, or disposals outside the organisation 10. Monitoring of capital assets utilised for the purpose for which they were acquired. 11. Analyse the current strategies for the Management of the physical environment and facilities management for appropriateness. 12. Draw up unit specific policies for the management of stock and supplies. 	<ol style="list-style-type: none"> 1. Intranet and internal policies/procedures, Government publications. 2. Textbooks. 3. Developmental courses. 4. Internet sources. 5. Related legislation 6. The Constitution. 7. Local Government Capital Asset Management Guideline, 2008. 8. Treasury Regulations for departments, constitutional institutions and public entities Issued in terms of the Public Finance Management Act, 1999 (National Treasury, South Africa 2001).

Table 6.2: Competency assessment

COMPETENCY ASSESSMENT			
Competency	Proficiency levels		
	Basic: Some knowledge with the ability to apply the competency in limited situations.	Intermediate: Basic understanding of ability to apply the competency in routine situations.	Advanced: Good understanding of and consistently applies the competency in most situations.
Strategic planning.			
Operational planning.			
Procurement planning.			
Human resource planning.			
Budget planning.			
Understanding and application of financial legislation.			
Income and expenditure monitoring and control.			
Analysis of financial statements and reports.			
Contracts and tenders.			
Cost centre management.			
Assets and resource control.			

Table 6.3: Development plan

DEVELOPMENT PLAN
Identify areas for development based on your identified competency proficiency levels
Which competencies do you wish to develop?
Why is it necessary to develop these competencies?
Action plan to develop these competencies
What support do you need to achieve these competencies?
When do you wish to achieve the desired competencies? Time frame

6.5.3 Analysis and evaluation of the Competency Framework

The aim of the study was to develop a framework that can be used as an instrument to develop the financial management competencies, skills and knowledge of NMs in the public sector. In order for the framework to be applicable and relevant to NM practice and competency development, it needs to go through an appraisal process. The Appraisal of Guidelines Research and Evaluation (AGREE II) Instrument was designed to assess the process of guideline development and the extent to which the process is reported. The instrument can be used by guideline developers to follow a structured and rigorous development methodology, to conduct an internal assessment to ensure that their guidelines are sound, or to evaluate guidelines from other groups for potential adaptation to their own context (Brouwers, Kho, Browman, Burger, Cluzeau, Feder, Fervers, Graham, Grimshaw, Hanna, Littlejohns, Makarski and Zitzelsberger 2017: 4). The

framework was evaluated against the six domains proposed by Brouwers *et al.* (2017) namely scope and purpose, stakeholder involvement, rigour of development, clarity of presentation, applicability and editorial independence.

6.5.3.1 Scope and purpose

Scope and purpose is concerned with the overall aim of the guideline, the specific health questions, and the target population. This domain deals with the potential impact of a framework on society and populations of patients or individuals. The framework met the stipulated criteria of this domain. The overall objectives of the framework are described in detail in relation to the research problem and research objectives. The expected benefits and value of the framework is clearly explained. The population, which are the NMs, to whom the framework applies, is specifically described. The study was conducted in the public sector only and the framework is directed at NMs in the public sector. Clear and specific inclusion and exclusion criteria were set for participants in the programme (Brouwers *et al.* 2017: 11).

6.5.3.2 Stakeholder involvement

Stakeholder involvement focuses on the extent to which the framework was developed by the appropriate stakeholders and represents the views of its intended users. Stakeholder involvement refers to the professionals who were involved at some stage of the development process. This criterion was realised as the framework development group included the researcher, the study supervisors and the panel of experts who checked and verified the framework. The views and preferences of the target population were considered as the framework is based on the input from NMs regarding their competency development needs. The target users of this framework, namely, NMs, ANMs, OMs and all nurses are clearly defined in the framework and they will be able to immediately determine if the framework is relevant to them (Brouwers *et al.* 2017: 15).

6.5.3.3 Rigour of development

Rigour of development relates to the process used to gather and synthesise the evidence, and the methods used to formulate the recommendations and to update them. The criteria of using systematic methods to search for evidence was achieved as the details of the GT approach used and the steps used in the literature review are clearly explained in the preceding chapters. The search strategy was very comprehensive and executed in a manner free from potential biases and sufficiently detailed to be replicated. The methods for formulating the framework are clearly described. The competencies included in the framework are realistic and achievable and are supported by existing evidence in the literature findings. The framework has been externally reviewed by experts prior to its publication. The framework can be changed and adapted to suit the needs of the NMs (Brouwers *et al.* 2017: 19).

6.5.3.4 Clarity of presentation

Clarity of presentation deals with the language, structure and format of the guideline. The recommendations made in this study for improving NMs financial management competency development are clearly stated and specific to the competency gaps identified in the study (Brouwers *et al.* 2017: 28). The framework clearly outlines and explains the definitions, purpose, behavioural indicators, knowledge and skills and suggested learning and development resources for each competency

6.5.3.5 Applicability

Applicability pertains to the likely barriers and facilitators to implementation, strategies to improve uptake, and resource implications of applying the framework. The framework describes barriers and facilitators to its application. The framework includes recommendations on training providers and educational paths that NMs can follow to achieve the recommended competencies. The framework provides a section on suggested learning and development resources and refers NMs to the tools, laws and resources to

consult to assist with competency development. Evaluation documents for NMs to assess their competencies and developmental plans to be drafted have been included in the framework (Brouwers *et al.* 2017: 32).

6.5.3.6 Editorial independence

Editorial independence is concerned with the formulation of recommendations not being unduly biased with competing interests. There were no external influences or competing interests in developing this framework. The researcher drew up the framework based on the factual, subjective information provided by the participants based on their own financial management competency developmental needs (Brouwers *et al.* 2017: 37).

6.6 SUMMARY OF THE CHAPTER

This chapter provided a detailed discussion of the framework that was developed to improve NMs financial management competencies. The framework was also supported by the AGREE II evaluation criteria that validated its applicability and usefulness. Chapter 7 will conclude the study and present a summary of the findings, limitations, conclusions and recommendations.

CHAPTER 7: SUMMARY OF THE FINDINGS, LIMITATIONS OF THE STUDY, RECOMMENDATIONS AND CONCLUSION

7.1 INTRODUCTION

This chapter contains the summary of the research findings, the conclusions, and limitations, recommendations for nursing practice, nursing education and further research. The ultimate aim of the study was to develop a framework to improve the skills of NMs. The use of a GT approach and the constructivist naturalistic paradigm allowed for the development of the framework from the actual work experiences of NMs.

7.2 THE AIMS AND OBJECTIVES OF THE STUDY

The aim of the study was to explore the financial management roles of NMs in their current work environments, identify financial management development needs necessary for NMs practice, and ultimately to develop a financial management framework to improve the skills of NMs. The following objectives were developed in order to achieve the aim of the study:

- Explore the current roles of the NM with regard to financial management practice in public health care organisations.
- Determine the financial management competencies that NMs in public health care organisations currently possess.
- Explore the training and educational qualifications NMs have with respect to financial management.
- Establish the essential financial management development needs of NMs in public health care organisations.
- Develop a financial management competency framework for NMs.

7.3 SUMMARY OF THE RESEARCH FINDINGS

7.3.1 Demographic profile of participants

The demographic profiles of the participants reveal that all NMs were between the ages of 50 and 58 years while the OM's ages ranged from 44 to 57 years. Any training the current NMs and OM's receive will still be a good investment, considering that the retirement age is 65. The ages of the current NMs indicate that the majority will be retiring in the next few years thereby creating many promotion opportunities for the PNs that are below them in the public sector. This then raises the issue of the need for the framework and extending the competencies to the PNs in preparation for their future roles as NMs.

With regards to the number of years of experience, all NMs had 25 to 38 years of experience in nursing, while the OM's had 30 to 36 years except one who had only 16 years. The findings revealed that the NMs felt that their basic nursing training did not prepare them for their current financial management roles and not enough attention was paid to the financial side of nursing in their original training. This has implications for curriculum developers and nursing education where attention must be paid to the fact that all nurses need to understand that there are financial implications in every nursing action. Regarding the years of experience in the current management position, the NMs had 6 to 13 years of experience, while OM's had 3 to 13 years. Though NMs had indicated in the study that they learnt financial management on the job and through experience, they still indicated the lack of understanding of financial management, did not feel fully competent, and required more formal training.

Seven NMs and two OM's had postgraduate qualifications in nursing management, while none held a financial management or business management qualification. Having a qualification in nursing management or financial management is not a mandatory requirement for appointment as a NM. This was highlighted in Chapter 1 where it was noted that the provincial vacancy circulars for appointment as a NM were based on years of experience. It has been highlighted in this study that nurses have sometimes

been promoted to management positions because they are good clinical nurses and they meet the years of experience criteria. However, in this study the qualifications did not make a difference as all NMs indicated that they were not competent in financial management and the postgraduate nursing management qualifications did not prepare them adequately for their roles.

7.3.2 Financial management roles and responsibilities of Nurse Managers

Contrary to the view of many nurses, that financial management belongs to the financial department (Bai *et al.* 2017: 123), NMs were very clear in defining what exactly they do in terms of their financial management roles. Participation in strategic planning, procurement planning, operational planning, human resource planning and budget planning were identified as the financial management roles of NMs. They identified their generic management function of planning and aligned their functions and participation in each of the preceding activities in the context of financial planning. Further roles in financial management included income and expenditure monitoring and control and analysis of financial statements and reports. The NMs identified that their decision-making, especially in financial management, was influenced by the financial legislative framework which set out the guidelines on how each financial activity should be carried out. Part of the financial decision-making role also included the involvement in the awarding of contracts and tenders. This was also guided by the directives and legislation relevant to these specific activities. The financial control function of NMs included the assets and resources control, expenditure control and cost centre management. Despite their years of experience and regular performance of the activities, NMs still found difficulty in understanding these functions and indicated the need for more training.

The findings of this study differ from other studies on financial management for NMs in the sense that they do not suggest that NMs must learn all the finer details of financial management. NMs must be able to apply financial management concepts to NM practice. The NM does not need to move into

the CFO's office, but needs to be able to understand the relevant aspects of financial management applicable to practice. If he or she is required to practice financial management then he or she needs to have the requisite knowledge and skills to do so.

7.3.3 Financial management competencies of Nurse Managers in the public sector

Even after years of experience and training, many NMs still did not feel confident about, and lacked the financial skills and knowledge needed for, their role. NMs who have been in practice for a long time and those who have undergone postgraduate courses and financial management training courses did not feel that they were competent in financial management. The poor involvement of NMs in financial management tasks and functions in the public hospitals has been a contributory factor to the poor financial management competencies. NM participants learnt about finances along the way and by asking their peers and financially knowledgeable people. NMs reported having very little support in the workplace for their financial management roles. It was further alluded to that the poor competencies were due to the lack of training and updates on financial management. In line with the demands of the NM's changing role and function which requires greater financial skills and abilities, the findings of this study support the need to review and reconstruct the role. This can be done by conducting a job analysis of the NM role in the public sector organisations. It is evident that NMs have a difficult position, in that they are accountable for quality care and productivity in their departments but do not have the control over their finances.

7.3.4 Training and educational qualifications Nurse Managers have with respect to financial management

The basic nursing programmes included some aspects of the financial functions such as strategic planning and budgeting, however it was very ineffective. The aspects were taught in the clinical context and not emphasised as a financial management function. Further, the basic nursing

programmes are taught by nurse educators who are nurses themselves and would have had the same lack of exposure to financial management. Postgraduate nursing management programmes are accessible in South Africa and are offered at several universities and Technikons either at full time, part time or distance learning programmes. There is a noticeable lack of standardisation and no consensus on content in these programmes which results in different educational experiences for the NMs. Financial management modules have been included in the postgraduate management programmes but were found to be ineffective and did not adequately prepare the NMs for their roles. Financial management educational programmes need an interdisciplinary approach where the subject matter experts teach the content rather than nurse educators. In general, nursing curricula do not satisfactorily address the financial management competency gaps and needs of NMs, which leads to deficiencies in knowledge and skills. Even though NMs complete postgraduate programmes outside the organisation there is not enough support with mentoring programmes and resources from within the organisation and the Department of Health.

Training opportunities are not provided and exacerbated by the lack of finances for training and development programmes. The importance of financial knowledge and financial literacy for NMs has not been given much attention and the important role that NMs play in the finances of the hospitals has been overlooked. NMs are mandated to become proficient in financial management which frequently is beyond their education and experience. To address these issues, training and support should be provided and frameworks or models designed to support the development of NMs. As a part of support for NMs, more formal education beyond their education and training programmes is needed, and continuous development strategies should be developed to increase their skills. The Department of Health also does not play their part in assisting the NMs in the financial management role as they largely overlook the significant role that NMs play in the hospitals and as part of the senior management team.

7.3.5 Financial management development needs of Nurse Managers

The NMs called for financial management training to be provided before and after promotion to a senior position as they do not come into the position with these skills but are expected to function straight away in a financial capacity. When taking into account the ages of the participants, many have trained more than 30 years ago where financial management was not given recognition and nurses concerned themselves more with clinical outcomes rather than financial outcomes. Research studies also focus more on generic management competencies and leadership styles and skills. Some studies include components of financial management, but in small and insignificant parts. The need for training in financial management stems from the lack of research into the financial management skills and competencies of NMs as this aspect has not been given enough attention. Poor recognition has been paid to the role that NMs play in finance. Very few studies have delved into the actual activities and tasks of NMs. NMs are not seen as part of the financial team or the financial sphere and their roles have not been clearly understood or defined.

A contributing factor for why nurses shy away from finances is that they do not understand finance nor see the roles they play in relation to it. It has always been the 'them and us' between finance and nursing. Nurses hear every day that they have to cut costs, manage expenditure and yet are not shown how to do it. Generally, nurses perceive that they do not play any role in finances.

Finance has always been a foreign language to nurses, hence a practical and simple approach to teaching nurses finance must be applied, rather than inundating them with difficult financial terminology and unnecessary financial jargon. Consideration must also be given to the timing and extent of the training. It is important and most effective to provide training to nurses when they are most ready for the information. Consideration must also be given to who will deliver the training, which must be adapted to the needs of the nurse. Financial management means many things to different professions. In this instance NMs' financial needs and roles differ from the conventional methods

or financial management content. It needs to be understood that their financial management roles are complementary and contributory to that of the CEO and CFO.

Budget training was also seen to be important as NMs indicated that their non-involvement in the budget development process apart from the contribution in the form of the procurement, operational and resources planning. They called for a better understanding of and more inclusivity into budget development and the distribution and devolvement of the budget. Coupled with the cost centre management training, NMs indicated that training would give them more control over the finances of their departments. The desire of NMs was to be given a budget for them to plan, manage and spend according to the needs of their departments.

Nurses have realised that the lack of understanding of finances added to them not being able to handle financial matters of their departments. Poor understanding of finances rendered them unable to read financial statements and account for expenditure. NMs find the need to be able to review financial statements or reports and be able to validate or query transactions and to be able to understand the salient points that are critical to their practice and their roles. This will give them a sense of empowerment and ownership over their finances.

Management of their departments as cost centres will enable NMs to direct and control all financially related activities and more power to manage expenditure. The current lack of financial knowledge causes them to be dependent on the financial personnel. Knowledge of cost centre management would enable them to make their own decisions for their departments. However, the current shortage of staff and resources may hamper the implementation of cost centre management. Managing the department as a cost centre requires attention and continuous monitoring and control of expenditure and costs. This is not possible at present given that there are challenges with technology, insufficient staff trained in financial management, and not enough nurses to carry out clinical duties. The departmental manager

would need to be hands on with the monitoring and management of finances. Instead it is found that the OMs are working in the wards carrying out clinical activities and nursing duties due to the lack of staff.

Centralisation remains a problem as NMs have no control over the items or equipment they receive. Bulk purchases are made at central level and distributed to different departments. Cost centre management will give them better control over their procurement and obtaining the supplies according to their department needs.

NMs concluded that all financial activities revolved around the prescripts of the legislation governing financial practice. They found that they did not fully understand the legislation with special reference to the PFMA. It is therefore, critical that they understand the legislation that is applicable to their practice and what is required of them in terms of financial management.

In conclusion the objectives of the study were addressed and achieved by exploring the views of NMs regarding their financial management roles and responsibilities, competencies and their developmental needs. The descriptions from the NMs allowed insight into the poorly understood financial management roles of NMs and led to the development of a financial management competency framework.

7.3.6 Methodology

The reasons for conducting this study were to establish the financial management roles and responsibilities and competencies of NMs in the public sector. The question was raised whether if NMs were empowered with sufficient financial knowledge and competencies, would this improve the current state of health care in the public sector? The study entered an unknown territory as there was very little information and previous exploration of this area. The decision was to undertake a qualitative study to identify the financial management competencies NMs possess and what are their

developmental needs. The intention was to develop a framework that would assist them to develop and improve their competencies.

During the review process by the University Ethics Committee prior to approval of the study, the question was asked if NMs stated that they did not have any financial management skills, what would the next step be and how would the study proceed? GT is useful when there has been little research in the substantive area, as was the case in this study, so it was a suitable tool to advance nursing knowledge. Having little knowledge of what would be found during the interviews, the constructivist GT method set within a naturalistic (constructivist) paradigm was chosen to enable the research questions and aims to be addressed. This methodology provided the framework for guiding data collection and analysis.

Due to the lack of information on this topic, the realities emerged from the participants' perspectives as well as from the researcher's interpretation (Charmaz 2006: 130). In the constructivist paradigm, knowledge is generated from the data. These data reflect the meaning of phenomenon, which is constructed by the study participants. The researcher's interpretation is considered the tool to understand this meaning. To achieve this goal, the researcher needs to enter the participants' world. For the researcher to make sense of the data that was collected, a practical, pragmatic approach was provided by the use of constructivist GT (Charmaz 2000: 524).

At the beginning of the study, it was not known who the sample would include and what the sample size would be. In GT, theoretical sampling is used to identify participants who can contribute to emerging themes. It was not known at this stage who would be interviewed in order to have answers to the research questions. Sample size, participant selection, and type of data sampled are not predetermined in GT research, because they are dependent upon the emerging theory and whether theoretical saturation has been reached (Glaser and Strauss, 1967: 40). Initial sampling was purposive, because Glaser and Strauss (1967: 40) suggested participants are initially chosen based on a general evaluation of their ability to speak to the subject

area. As the categories and theory emerged during the study, the sampling transitioned into theoretical sampling. Glaser and Strauss (1967: 45) define theoretical sampling as the “process of data collection for generating theory whereby the analyst jointly collects, codes, and analyses the data and decides what data to collect next and where to find them, in order to develop the theory as it emerges” Theoretical sampling which is a distinctive feature of GT allowed for the inclusion of FM, ANMs, OMS and CEOs into data collection to add to the information gathered through earlier interviews.

Interviews were used and as suggested in GT, data collection progressed and theoretical sampling occurred, and interview questions were adjusted to reflect theoretical sampling and sensitivity. The interview questions became more specific to the phenomenon under study.

One of the most unique features of GT data analysis is that sources of data are analysed after each interview. Glaser and Strauss (1967:43) state that data collection, coding and analysis of data should be done concurrently which allows the researcher to be open to emerging themes and not impulsively come up with an analysis. The framework that was developed was constructed from the findings during the data collection.

7.4 LIMITATIONS OF THE STUDY

According to Grove, Gray and Burns (2012: 198), limitations are restrictions or problems in a study that may weaken the generalisation of the findings. There were several limitations in this study. One limitation was the small sample size of NMs. It was observed that there was a lack of interest in participation in the study. The researcher had to request the participation of the NMs several times before any responses were received. Potential participants were telephoned and still refused to participate. Another limitation was the misconception and misunderstanding of the study topic as many NMs felt that they played no role in financial management and would not be able to participate as it was not applicable to them. Attempts by the researcher to explain the aims of the study met with continued resistance and the refusal to

participate. The participants were all managers and did not include other categories of ward staff. Glaser (1998: 32) posits that GT focuses on meaning instead of the number of participants to ensure the trustworthiness of the results. Therefore, even though these research findings cannot be generalised across all health care organisations, it has offered an insight into findings within the study hospitals and can be used as a basis for development of financial management competencies for NMs.

A further limitation was that interviews were the only method of data collection. Given the limited sample size, the findings noted in this study may not fully reflect the views of other NMs who are employed in the public sector. A potential to overcome this would have been to consider using an additional method of observing NMs in their daily tasks and role in their own work environment. Some participants gave inadequate information to some of the questions, which affected the strength of the analysis.

The study was limited to one province only. Perceptions about the NM financial management role, competencies and financial management developmental needs could be different in other provinces and countries. The study was also conducted in the public hospitals and not extended to private hospitals and other health sectors. The study cannot be generalised to all NMs, so inferences can only be made to NMs from hospitals with comparable characteristics. The competency framework developed as a result of this research has not been tested. Regardless of the limitations, these study findings presented an overall depiction of the financial management development needs of NMs and the need to address these needs in the public health care sector.

7.5 RECOMMENDATIONS

The major intention of this study was to develop a competency framework for NMs to improve their financial management skills, knowledge and competencies. In order to do this, participants were asked to describe their roles, responsibilities, current knowledge and financial management

competencies and their training and developmental needs related to financial management. The findings yielded several gaps in both the practice area and NM levels of competence which requires attention and some form of action and response. The following recommendations are made in relation to the findings of the study under nursing practice, nursing education and further research.

7.5.1 Recommendations for nursing practice

Review of Nurse Manager's roles and functions

A review of the NMs roles and functions should be carried out to identify the financial management functions and activities performed. Based on this analysis, outdated job descriptions can be redesigned and aligned to reflect the actual tasks and activities performed by NMs. The NM must be included in all discussions and financial management activities and decision-making with the organisation.

Standardisation of processes in the public sector

All public hospitals in KZN are governed by the same authority, namely, the KZN Department of Health. There needs to be standardisation of all processes such as procurement planning, SCM practices and budget planning and development. A standardised guideline or manual should be drawn up for reference purposes for NMs with the relevant information needed for financial management practice. This would also assist the future NMs who will be promoted.

Implementation of cost centres

All departments should be run as cost centres. This gives the NMs authority over the budget and expenditure and will increase their accountability, especially regarding managing the finances of their departments.

Availability of technology and resources

Currently there is a lack of resources available for NMs to refer to when they need assistance in financial management matters. The Department of Health

must make available the necessary technology such as computers and internet access which NMs can use for reference purposes to assist them in the financial management roles. The necessary tools such as books, manuals, reference guides and the legislation are to be on hand to use for reference.

Visibility of finance personnel in the nursing departments

It is recommended that the finance personnel make themselves available in the nursing departments to observe and assist NMs accomplish their goals, advise and provide guidance in the units, and support NMs to maximise their potential and develop the appropriate financial management skills.

Review of the promotion criteria for Nurse Managers

It is recommended that the current promotion criteria for NMs be reviewed against the changing requirements of the NM role. Clinical expertise and years of experience is not sufficient to support NMs in their new roles. A different set of skills, knowledge and competencies are required. NMs are no longer bedside nurses but boardroom executives. For this role they must have the requisite financial management skills so that they can validate their nursing department's activities. Hence, financial management should be a prerequisite for promotion. That being said, there must be an induction and orientation programme tailored to meet the financial management needs of NMs on promotion.

7.5.2 Recommendations for nursing education

Training and development needs analysis

Given that the NMs trained a long time ago, their knowledge and skills may be outdated and inadequate for the current health care climate. A training and development needs analysis should be conducted among all nurses to identify their training needs regarding finances. A training programme should be implemented based on the identified needs.

Interdisciplinary team approach to Nurse Manager financial education

It is recommended that there be an interdisciplinary approach when it comes to teaching finance to NMs. This cannot be done by nurse educators who themselves have little knowledge of finance. Financial experts can be used or educators from the economics and financial departments can assist with the financial education the NMs.

Curriculum review

Most NMs trained more than 30 years ago and the curricula are outdated. The basic nursing programmes do not give enough attention to financial management and even when these aspects are taught, it is in the clinical rather than the financial context. All curricula including basic, undergraduate, post-basic and postgraduate programmes must be reviewed to reflect a realistic view of the expected competencies of NMs rather than based on clinical outcomes.

Standardisation of financial management training

NMs often complete nursing management programmes through various educational institutions. There is no standardisation or agreement on the content of these programmes. It is recommended that accreditation bodies set criteria for approval and standardisation of content in all nursing management programme so that candidates who complete these programmes would exit with the same knowledge and learning outcomes.

More financial management courses or programmes to be developed

There is a paucity of financial management programmes that are specifically designed for nurses. The programme design requires a collaborative undertaking which would include all stakeholders such as NMs, nurses, FMs, CEOs and other financial decision makers or financial authorities. The programme must be designed according to what NMs want and what is relevant to them. Teaching NMs information that they do not see the value of will result in a lack of interest. Financial management programmes must be simple and avoid the financial language that would scare away the NM. It is

recommended that suitable teaching strategies such as technology be used to improve the skills of NMs.

7.5.3 Recommendations for further research

The study was conducted in one province only and within the public sector. It is recommended that the study be extended to all provinces and nurses in all health care sectors to elicit their views on their skills and competencies and developmental needs. This study used NMs and OMs but can be opened out to include all categories of nurses to obtain their views on financial management. The study should be repeated to learn if there are any other financial management roles that are carried out by the NM and what other competency development do NMs require. Once the framework has been implemented research can be conducted to improve, amend or add to the competencies of NMs.

7.6 CONCLUSION OF THE STUDY

The role of the NM has been transformed and has moved from the bedside to the executive suite. The NMs functions and responsibilities have changed and have evolved into a very strong financial role. The intention of this study was to bring to light the fact that nurses play a very big part in the financial management of the organisations. It is important that the NMs understand financial management concepts and principles before any of the other nursing staff do. Therefore, this study focused on NMs only. If they know how to manage the organisation's finances, they would then be able to cascade the information down to all nurses and lead by example. The intention of using GT in this study was to develop a framework and this has successfully been accomplished. This study is the first of its kind in South Africa and it is hoped that future research will continue to develop this field so that more and newer information will emerge. The study has ignited a flame and it is hoped that continuous research will fuel the fire of this topic and keep it burning.

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APPENDICES

Appendix 1: University ethical clearance



1 November 2017

IREC Reference Number: **REC 69/17**

Ms N Naranjee
28 Protea Road
Vyebank
Kloof
3640

Dear Ms Naranjee

Development of a financial management competency framework for Nurse Managers at selected public hospitals in KwaZulu-Natal, South Africa.

The Institutional Research Ethics Committee acknowledges receipt of your gatekeeper permission letter.

Please note that Full Approval is granted to your research proposal. You may proceed with data collection.

Any adverse events [serious or minor] which occur in connection with this study and/or which may alter its ethical consideration must be reported to the IREC according to the IREC SOP's.

Please note that any deviations from the approved proposal require the approval of the IREC as outlined in the IREC SOP's.

Yours Sincerely,

Professor J K Adam
Chairperson: IREC



Appendix 2a: Letter of permission to the KwaZulu-Natal Department of Health

28 Protea Road
Wyebank, Kloof
3640

Health Research and Knowledge Management
KZN Department of Health
330 Langalibalele Street Natalia Building South Tower 10-102
Pietermaritzburg
3200

Dear Sir/Madam

REQUEST FOR A PERMISSION TO CONDUCT A STUDY

I am registered for a Doctoral Degree at the Durban University of Technology Department of Nursing. The topic of my research study is: *Development of a Financial Management Competency Framework for Nurse Managers at selected public hospitals in KwaZulu-Natal, South Africa*. The aim of this study is to explore the financial management roles of Nurse Managers in their current work environments and identify financial management development needs necessary for Nurse Managers practice and ultimately to develop a financial management framework to improve the competencies of Nurse Managers at public hospitals in KwaZulu-Natal.

I hereby request your permission to conduct a research study at the following selected public hospitals in your district that have 200 beds or more: Addington, Edendale, Mahatma Gandhi, Northdale, Prince Mshiyeni Memorial, RK Khan, Wentworth, Osindisweni (Central hospitals), Benedictine, Hlabisa, Ekombe, Eshowe, Manguzi, Mosvold, Nkandla, Nkonjeni, Vryheid, Stanger (North hospitals), Christ the King, GJ Crookes, Murchison, Port Shepstone, Rietvlei, St Andrews (South hospitals), Charles Johnson Memorial, Dundee, Church of Scotland, Escourt, Greytown, Ladysmith, Madadeni and Newcastle (Inland hospitals).

The study will be conducted using in-depth face-to-face interviews with the Nurse Managers from the selected hospitals in order to explore their roles and experience in financial management and what their financial management development needs are. The interviews will be conducted in a private room at each hospital or in a location and venue of choice of the Nurse Manager. The interview will be audio recorded. Participation in this study is entirely voluntary and the Nurse Managers may at any time withdraw from the study without prejudice or providing reasons for the decision.

The information provided during the interview will remain strictly confidential. Data collected will be coded so that there is no link to any names. The identities of the participants and the hospitals will not be revealed while the study is being conducted and on completion of the project.

Your permission to conduct the study at your hospital will be highly appreciated. I hereby enclose the summary of the proposal, letter of information, consent and data collection tools. The supervisor of this project is Prof M.N. Sibiya and could be contacted on 031-373 2606, or email: nokuthulas@dut.ac.za

Sincerely

Ms Nellie Naranjee

Student no: 21647914

Email: naranjeen@gmail.com

Appendix 2b: Approval letter from Health Research and Knowledge Management, Department of Health, KwaZulu-Natal



health

Department:
Health
PROVINCE OF KWAZULU-NATAL

030 Langaile street,
Private Bag X9051 PMB, 3200
Tel: 033 395 3189/3183 Fax: 033 394 3782
Email: hrkm@kznhealth.gov.za
www.kznhealth.gov.za

DIRECTORATE:

Health Research & Knowledge
Management (HRKM)

Reference: HRKM372/17
KZ_201709_051

23 October 2017

Dear Mrs N Naranjee

(Durban University of Technology)

Subject: Approval of a Research Proposal

1. The research proposal titled '**Development of a Financial Management Framework for Nurse Managers at Selected Public Hospitals**' was reviewed by the KwaZulu-Natal Department of Health (KZN-DoH).

The proposal is hereby **approved** for research to be undertaken at only the selected facilities as per research proposal.

2. You are requested to take note of the following:
 - a. Make the necessary arrangement with the identified facilities before commencing with your research project.
 - b. Provide an interim progress report and final report (electronic and hard copies) when your research is complete.
3. Your final report must be posted to **HEALTH RESEARCH AND KNOWLEDGE MANAGEMENT, 10-102, PRIVATE BAG X9051, PIETERMARITZBURG, 3200** and e-mail an electronic copy to hrkm@kznhealth.gov.za

For any additional information please contact Ms G Khumalo on 033-395 3189.

Yours Sincerely

Dr E Lutge

Chairperson, Health Research Committee

Date: 23/10/17

Fighting Disease, Fighting Poverty, Giving Hope

Appendix 3a: Sample letter of permission to the District Manager

28 Protea Road
Wyebank, Kloof
3640

The District Manager
EThekweni Health District
Highway
House
83 Jan Smuts Highway
Mayville
Durban
4001

Dear Sir/Madam

REQUEST FOR PERMISSION TO CONDUCT A STUDY

I am registered for a Doctoral Degree at the Durban University of Technology Department of Nursing. The topic of my research study is: *Development of a Financial Management Competency Framework for Nurse Managers at selected public hospitals in KwaZulu-Natal, South Africa*. The aim of this study is to explore the financial management roles of Nurse Managers in their current work environments and identify financial management development needs necessary for Nurse Managers practice and ultimately to develop a financial management framework to improve the competencies of Nurse Managers at public hospitals in KwaZulu-Natal.

I hereby request your permission to conduct a research study at the following selected public hospitals in your district that have 200 beds or more:

- (1) Addington Hospital
- (2) Mahatma Gandhi Hospital
- (3) Osindisweni Hospital

- (4) Prince Mshiyeni Memorial Hospital
- (5) RK Khan Hospital
- (6) Wentworth Hospital.

The study will be conducted using in-depth face-to-face interviews with the Nurse Managers from the selected hospitals in order to explore their roles and experience in financial management and what their financial management development needs are. The interviews will be conducted in a private room at each hospital or in a location and venue of choice of the Nurse Manager. The interview will be audio recorded. Participation in this study is entirely voluntary and the Nurse Managers may at any time withdraw from the study without prejudice or providing reasons for the decision.

The information provided during the interview will remain strictly confidential. Data collected will be coded so that there is no link to any names. The identities of the participants and the hospitals will not be revealed while the study is being conducted and on completion.

Your permission to conduct the study at the hospitals will be highly appreciated. I hereby enclose the summary of the proposal, letter of information, consent and data collection tools. The supervisor of this project is Prof M.N. Sibiya and could be contacted on 031-373 2606 or email: nokuthulas@dut.ac.za

Sincerely

Ms Nellie Naranjee
Student no: 21647914
Email: naranjeen@gmail.com
Mobile: 0825776126

Appendix 3b: Approval letter from the eThekweni Health District Office



health

Department:
Health
PROVINCE OF KWAZULU-NATAL

DIRECTORATE: CORPORATE SERVICES

83 King Cetshwayo Highway
Mayville, Durban, 4001
Tel: 031 240 5155 Email: avashni.harrichandparsad@kznhealth.gov.za
www.kznhealth.gov.za

ETHEKWINI HEALTH DISTRICT OFFICE

19 September 2017

Dear Ms N Naranjee

Re: Permission To Conduct Research at eThekweni District Facilities.

This letter serves to confirm that your application to conduct the research study titled, "*Development of a Financial Management Competency Framework for Nurse Managers at selected public hospitals in KwaZulu-Natal, South Africa.*", in the eThekweni district at the following health care facilities has been recommended:

- (1) Addington hospital
- (2) Mahatma Gandhi hospital
- (3) Osindisweni hospital
- (4) Prince Mshiyeni hospital
- (5) RK Khan hospital
- (6) Wentworth hospital

Kindly upload this letter together with your application as required to the Health Research and Knowledge Unit for the KZN Department of Health for Approval.

Please also note the following:

1. This research project should only commence after final approval by the KwaZulu-Natal Health Research and Knowledge Unit, and full ethical approval, has been granted.
2. That you adhere to all the policies, procedures, protocols and guidelines of the Department of Health with regards to this research.
3. All research activities must be conducted in a manner that does not interrupt clinical care at the health care facility.
4. Ensure that this office is informed before you commence your research
5. The District Office/Facility will not provide any resources for this research
6. All logistical details must be arranged with the CEO/medical manager /operational manager of the facility.
7. You will be expected to provide feedback on your findings to the District Office/Facility

Yours sincerely

Dr. A. Harrichandparsad
pp Ms. T. P. Msimango
Chief Director (Acting)
eThekweni Health District

Fighting Disease, Fighting Poverty, Giving Hope

Appendix 3c: Approval letter from the uGu Health District Office



health

Department:
Health
PROVINCE OF KWAZULU-NATAL

Physical Address: 41 Bisset Street, Nelson Mandela Drive
Postal Address: P/Bag X 735 Port Shepstone 4240
Tel: 0396883000 Fax: 0396826296 Email: ntokozi.mkhize@kznhealth.gov.za
www.kznhealth.gov.za

DIRECTORATE:

UGU HEALTH DISTRICT OFFICE

Enquiries: Mrs N.C Mkhize

Date: 19/09/2017

To:

Ms Nellie Naranjee

PERMISSION TO CONDUCT REASERCH IN UGU DISTRICT


Dear Ms Naranjee

I have the pleasure in informing you that permission has been granted to you by Ugu District office to conduct research on "Development of a Financial Management Competency Framework for Nurse Managers at selected public hospitals in KwaZulu-Natal, South Africa."

Please note the following:

- a) Please ensure that you adhere to all the policies, procedures, protocols and guidelines of the Department of Health".
- b) Please ensure that this office is informed before you commence with your research
- c) The District Office/ Facility will not provide any resources for this research
- d) You will be expected to provide feedback on your findings to the District Office/ Facility

Thank you


Mrs N.C Mkhize
Ugu District Director

Appendix 3d: Approval letter from the Umzinyathi Health District Office



health

Department:
Health
PROVINCE OF KWAZULU-NATAL

34 Wilson Street, Dundee, 3000
Private Bag X2052, Dundee, 3000
Tel: 03429991000 Fax: 0342124800 Email: charlotte.vanross@kznhealth.gov.za
www.kznhealth.gov.za

DIRECTORATE:

Umzinyathi District Office

Enquiries: Mrs. G.C. Shabangu
Date: 21st September 2017

Ms. N. Naranjee
Durban University of Technology

RE: PERMISSION TO CONDUCT RESEARCH AT UMZINYATHI DISTRICT FACILITIES

This letter serves to confirm that your application to conduct the research study titled, "*Development of a Financial Management Competency Framework for Nurse Managers at selected public hospitals in KwaZulu-Natal, South Africa.*" In the UMzinyathi District has been recommended.

Please also note the following:

1. This research project should only commence after final approval by the KwaZulu- Natal Health Research and Knowledge Unit, and full ethical approval has been granted,
2. That you adhere to all the policies, protocols and guidelines of the Department of Health with regards to this research.
3. All research activities must be conducted in a manner that does not interrupt clinical care at the health care facility,
4. Ensure that this office is informed before you commence your research,
5. The District Office / Facility will not provide any resources for this research
6. All logistical details must be arranged with CEO/ Medical Manager/ Operational Manager of the facility,
7. You will be expected to provide feedback on your findings to the District Office / Facility.

Yours sincerely



Mrs. G.C. Shabangu
Acting District Manager
Umzinyathi District Office DC 24

Fighting Disease, Fighting Poverty, Giving Hope

Appendix 3e: Approval letter from the uThukela Health District Office



health

Department:
Health
PROVINCE OF KWAZULU-NATAL

32 Lyell Street, Ladysmith, 3370
Private Bag 9958, Ladysmith, 3370
Tel: 036 631 2202 Fax: 036 631 0530 Email: Thandeka.zulu@kznhealth.gov.za
www.kznhealth.gov.za

DIRECTORATE:

Uthukela District Office

19 September 2017

Ms Nellie Naranjee

RE: APPLICATION FOR SUPPORT TO CONDUCT A STUDY ON DEVELOPMENT OF A FINANCIAL MANAGEMENT COMPETENCY FRAMEWORK FOR NURSE MANAGERS AT SELECTED PUBLIC HOSPITALS IN KWAZULU-NATAL, SOUTH AFRICA.

1. Your request received on the 10 August 2017 refers.
2. Uthukela District must ensure adherence to all the policies, produces, protocols and guidelines of the Department of Health with regards to this research.
3. Your research will only commence once this office has received confirmation of the approval by HOD from the provincial Health Research Committee in the KZN Department of Health.
4. However your research is hereby supported.
5. Inconveniences are highly regretted.

Yours faithfully

DR M T ZULU
DISTRICT DIRECTOR
UTHUKELA HEALTH DISTRICT

Appendix 3f: Approval letter from the uMkhanyakude Health District Office



health

Department:
Health
PROVINCE OF KWAZULU-NATAL

364 Ntshinde Road, Josani, 3909
Pietermaritzburg, 3909
Tel: 035 512 1327 Fax: 035 512 1245 Email: hervy.williams@kznhealth.gov.za
www.kznhealth.gov.za

DIRECTORATE:

District Clinical Specialist Team
Umkhanyakude Health District Office

**Enquiries : Dr CH Vaughan Williams
Telephone : 035-5721327 Ext 114**

17 August 2017

Dear Nellie Naranjee

I have pleasure in informing you that permission has been granted to you by the District Office to conduct research on in this district, entitled:

'Development of a Financial Management Competency Framework for Nurse Managers at selected public hospitals in KwaZulu-Natal, South Africa'

Please note the following:

1. Please ensure that you adhere to all the policies, procedures, protocols and guidelines of the Department of Health with regards to this research.
2. This research will only commence once this office has received confirmation from the Provincial Health Research Committee in the KZN Department of Health.
3. Please ensure this office is informed before you commence your research.
4. The District Office will not provide any resources for this research.
5. You will be expected to provide feedback on your findings to the District Office.

Sincerely,

C H Vaughan Williams
Family Physician, Umkhanyakude Health District Office

Appendix 3g: Approval letter from the Harry Gwala (Sisonke) Health District Office



health
Department:
Health
PROVINCE OF KWAZULU-NATAL

111 Main Street/Jonah
Private Bag X462, Tloko 3297
Tel: 039 834 8286 Fax: 039 834 1301 Email: Lindwe.zuma@kznhealth.gov.za
www.kznhealth.gov.za

HARRY GWALA HEALTH DISTRICT

Enquiries: Miss Z. Cele
Date: 23/08/2017
Ref: 2/6/3

Dear Nellie Naranjee

28 Protea Road
Wyebank, Kloof
3640

RE: REQUEST FOR PERMISSION TO CONDUCT RESEARCH ON DEVELOPMENT OF A FINANCIAL MANAGEMENT COMPETENCY FRAMEWORK FOR NURSE MANAGERS

I have pleasure in forming you that permission has been granted to you by the District research committee to conduct research on Development of a Financial Management competency framework for nurse managers.

Please note the following:

1. Please ensure that you adhere to all the policies, procedures, protocols and guidelines of the Department of Health with regards to this research.
2. This research will only commence once this office has received confirmation from The Provincial Health Research Committee in the KZN Department of Health.
3. Please ensure this office is informed before you commence your research.
4. The District office /Facility will not provide any resources for this research.
5. You will be expected to provide feedback on your findings to the District Research Committee and the District Management Team.

Thanking you.
Sincerely

MRS G.L.L. ZUMA
CHAIRPERSON: HARRY GWALA HEALTH DISTRICT RESEARCH COMMITTEE

Fighting Diseases, Fighting Poverty, Transforming Lives

Appendix 3h: Approval letter from the Zululand Health District Office



health

Department:
Health
PROVINCE OF KWAZULU-NATAL

Physical Address: King Dinuzulu Highway, Administration Building, Ulundi 3838
Postal Address: Private Bag X 81, Ulundi 3838
Tel: 035 874 0610 Fax: 035 874 0662 Email: vus.vilakazi@kznhealth.gov.za
www.kznhealth.gov.za

DIRECTORATE:

ZULULAND DISTRICT OFFICE

Reference:

Date: 22 August 2017

Nellie Naranjee
Durban University of Technology


RE: PERMISSION TO CONDUCT RESEARCH AT ZULULAND FACILITIES

I have pleasure in informing you that permission has been granted to you by the Zululand District to conduct research on *"Development of a Financial Management Competency Framework for Nurse Managers at selected public hospitals in KwaZulu, South Africa"*.

Please note the following:

1. Please ensure that you adhere to all the policies, procedures, protocols and guidelines of the Department of Health with regards to this research.
2. This research will only commence once this office has received approval of your study from the Provincial Health Research and Ethics Committee (PHREC) in the KZN Department of Health.
3. Please ensure this office is informed before you commence your research.
4. The District Office/Facility will not provide any resources for this research.
5. You will be expected to provide feedback on your findings to the District Office.
6. You are required to contact this office regarding dates for providing feedback when the research has been completed.

Sincerely,


Mr. SV Vilakazi
District Director
Zululand District Office

Fighting Disease, Fighting Poverty, Giving Hope

Appendix 3i: Approval letter from the King Cetshwayo (Uthungulu) Health District



health

Department:
Health
PROVINCE OF KWAZULU-NATAL

DIRECTORATE:

District Management

Physical Address: No. 2 Cornet Lord Avenue & Chrome Crescent, Empangeni, 3910
Postal Address: Private Bag V20034, Empangeni, 3910
Tel: 035 787 6205/6319 Fax: 035 787 0644 Email: Phakama.dlwati@kznhealth.gov.za
www.kznhealth.gov.za

Date: 24/08/2017
Enquiries: Ms. PPT Dlwati
Ref: 25/1

To: Ms Nellie Naranjee
Student no: 21647914
Email: naranleen@gmail.com
Mobile: 0825776126

Cc: 1. Dr. Elizabeth Lugta
Manager: Research Unit KZN DOH
2. Mr. JN Shabane: CEO Nkandla District Hospital
3. Mr. PN Sangweni: CEO Eshowe District Hospital
4. Dr. BP Zungu: Ekhombe District Hospital

RE: PERMISSION TO CONDUCT A STUDY ON "DEVELOPMENT OF A FINANCIAL MANAGEMENT COMPETENCY FRAMEWORK FOR NURSE MANAGERS AT SELECTED PUBLIC HOSPITALS IN KWAZULU-NATAL, SOUTH AFRICA".

1. I have pleasure in informing you that permission has been granted to you by King Cetshwayo District (uThungulu) to conduct research on the "Development of a Financial Management Competency Framework for Nurse Managers at Selected Public Hospitals in Kwazulu-Natal, South Africa".

2. This research will only commence once this office has received confirmation from the provincial Health Research Committee in the KZN Department of Health.

3. Please ensure this office is informed in writing before you commence your research.

4. The King Cetshwayo District (uThungulu) will not provide any resources for this research.

5. You will be expected to provide feedback on your findings to the District Office.

Yours Sincerely,


Ms. PPT Dlwati
Acting Director: DHO
King Cetshwayo District

Appendix 4a: Letter to the CEO of XXX Hospital requesting for permission to conduct the study

28 Protea Road
Wyebank, Kloof
3640

The CEO
XXX Hospital
XXXX
XXXX
XXXX

Dear Sir/Madam

REQUEST FOR A PERMISSION TO CONDUCT A STUDY

I am registered for a Doctoral Degree at the Durban University of Technology Department of Nursing. The topic of my research study is: *Development of a Financial Management Competency Framework for Nurse Managers at selected public hospitals in KwaZulu-Natal, South Africa*. The aim of this study is to explore the financial management roles of Nurse Managers in their current work environments and identify financial management development needs necessary for Nurse Managers practice and ultimately to develop a financial management framework to improve the competencies of Nurse Managers at public hospitals in KwaZulu-Natal.

I hereby request your permission to conduct a research study at your hospital. The study will be conducted using in-depth face-to-face interviews with the Nurse Managers in order to explore their roles and experience in financial management and what their financial management development needs are. The interviews will be conducted in a private room at your hospital or in a location and venue of choice of the Nurse Manager. The interview will be audio recorded. Participation in this study is entirely voluntary and the Nurse Managers may at any time withdraw from the study without prejudice or providing reasons for the decision.

The information provided during the interview will remain strictly confidential. Data collected will be coded so that there is no link to any names. The identities of the participants and the hospitals will not be revealed while the study is being conducted and on completion of the project.

Sincerely

Ms Nellie Naranjee

Student no: 21647914

Email: naranjeen@gmail.com

Appendix 4b: Approval letter from R K Khan Hospital Ethics Committee



health

Department:
Health
PROVINCE OF KWAZULU-NATAL

Physical Address: R.K. Khan Circle
Physical Address: CHATSWORTH
Tel: [031] 4596001 Fax: [031] 4011247 Email: Sharon.gounden@kznhealth.gov.za
www.kznhealth.gov.za

DIRECTORATE:

R.K. KHAN HOSPITAL
OFFICE OF THE CEO

ENQUIRIES : DR P.S. SUBBAN

17 August 2017

Ms Nellie Naranjee
Student No. 21647914
Department of Nursing
Durban University of Technology [DUT]

Dear Madam

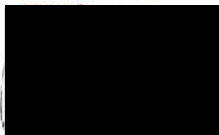
**RE: PERMISSION TO CONDUCT RESEARCH: DEVELOPMENT OF A FINANCIAL MANAGEMENT
COMPETENCY FRAMEWORK FOR NURSE MANAGERS**

Permission is granted to conduct the study at this institution.

Please note the following:

1. Please ensure that you adhere to all the policies, procedures protocols and guidelines of the Institution with regards to this research.
2. Please ensure this office is informed before you commence your research and your University's Ethics approval must be attached.
3. You will be expected to provide feedback on your findings to this institution.
4. You will be liaising with : Mrs F.J. Ngidi
Nurse Manager
Tel : [031 – 4596384]

Yours faithfully



DR P.S. SUBBAN
CHIEF EXECUTIVE OFFICER



Appendix 4c: Approval letter from the Addington Hospital Ethics Committee



health

Department:
Health
PROVINCE OF KWAZULU-NATAL

ADDINGTON HOSPITAL

P.O. BOX 977
DURBAN
4000
Tel: 031-327-2970 Email: reshma.boodhai@kznhealth.gov.za
www.kznhealth.gov.za

OFFICE OF THE CHIEF EXECUTIVE OFFICER

Reference: 9/2/3/R

Date: 19th September 2017

Principal Investigator:

➤ **Ms Nellie Naranjee**

**PERMISSION TO CONDUCT RESEARCH AT ADDINGTON HOSPITAL:
"DEVELOPMENT OF A FINANCIAL MANAGEMENT COMPETENCY FRAMEWORK
FOR NURSE MANAGERS AT SELECTED PUBLIC HOSPITALS IN KWAZULU-NATAL,
SOUTH AFRICA"**

I have pleasure in informing you that permission has been granted to you by Addington Hospital Management to conduct the above research.

Please note the following:

1. Please ensure that you adhere to all the policies, procedures, protocols and guidelines of the Department of Health with regards to this research.
2. This research will only commence once this office has received confirmation from the Provincial Health Research Committee in the KZN Department of Health.
3. Please ensure this office is informed before you commence your research.
4. Addington Hospital will not provide any resources for this research.
5. You will be expected to provide feedback on your findings to Addington Hospital.



**DR M NDLANGISA
HOSPITAL MANAGER
ADDINGTON HOSPITAL**

Appendix 4d: Approval letter from the Edendale Hospital Ethics Committee



Physical Address: No 89 Selby Msimang Road, Pietermaritzburg, 3216
Postal Address: P/Bag X 509, PLESSISLAER, 3216
Tel: 033 395 4040 Fax: 033 395 4087 Email: info@kznhealth.gov.za
www.kznhealth.gov.za

DIRECTORATE: CHIEF EXECUTIVE OFFICER

EDENDALE HOSPITAL

Enquiries: Ms. Mkhize
Ext: 4040
Date: 18 September 2017

Ms N. Naranjee
28 Protea Road
Wyebank
Kloof
3640

Dear Ms Naranjee

**RE: REQUEST TO CONDUCT RESEARCH ON DEVELOPMENT OF A FINANCIAL
MANAGEMENT COMPETENCY FRAMEWORK FOR NURSE MANAGERS AT
SELECTED PUBLIC HOSPITALS IN KZN, SA.**


Your above request is acknowledged and refers.

I have pleasure in informing you that permission has been granted to you by Edendale Hospital to conduct study on **"Development of a Financial Management competency framework for Nurse Managers at selected public hospitals in KZN, S A.**

Please note the following:

1. Please ensure that you adhere to all the policies, procedures, protocols and guidelines of the Department of Health with regards to this research.
2. Please ensure this office is informed before you commence your research.
3. The Hospital will not provide any resources for this research.
4. You will be expected to provide feedback on your findings to Edendale Hospital.

Yours Sincerely


Mrs ZSI Ndwandwe
Chief Executive Officer
Edendale Hospital

Appendix 4e: Approval letter from Nkandla District Hospital Ethics Committee



health
Department:
Health
PROVINCE OF KWAZULU-NATAL

DIRECTORATE:

NKANDLA DISTRICT HOSPITAL
P/BAG X 102 NKANDLA 3955
Tel: 0358335001 Fax: 0358330283 Email: info@nkandla.hosp.za
0613390817 / 0358688907
www.kznhealth.gov.za

DISTRICT HEALTH SERVICES - NKANDLA DISTRICT
HOSPITAL

OFFICE OF THE CEO

Date: Monday, 18 September 2017

Enquiries: Mr JN Shabane

Ref: Permission to conduct research

Attention:

Ms Nellie Naranjee
28 Protea Road
Wyebank, Kloof
3640

Dear Ms Naranjee,


**RE: PERMISSION TO CONDUCT RESEARCH ON " DEVELOPMENT OF A FINANCIAL MANAGEMENT
COMPETENCY FRAMEWORK FOR NURSE MANAGERS AT SELECTED PUBLIC HOSPITALS IN KWAZULU-
NATAL, SOUTH AFRICA".**

I have pleasure in informing you that permission has been granted to you by Nkandla District Hospital, Department of Health, to conduct a study on "Development of a financial management competency framework for nurse managers at selected public hospitals in Kwazulu-Natal, South Africa".

Please ensure this office is informed in writing before you commence your research. This letter must be carried with you at all times so that you may have easy access at security entrance. The hospital will not be able to provide assistance to you with regards to the research except making available time and research subjects for you to collect data and conduct interviews.

You will be expected to provide feedback on your findings to this institution as a matter of courtesy and as to the findings of your research so we may learn from them.

Thanking you.


Chief Executive Officer

Nkandla District Hospital

Fighting Disease, Fighting Poverty, Giving Hope

Appendix 4f: Approval letter from Prince Mshiyeni Memorial Hospital Ethics Committee



health

Department:
Health
PROVINCE OF KWAZULU-NATAL

Mangosuthu Highway, Private Bag X 07
MOBENI
Tel: 031 907 8317/8304 Fax: 031 906 1044 Email: myint.aung@kznhealth.gov.za
www.kznhealth.gov.za

DIRECTORATE: Senior Medical Manager

Prince Mshiyeni Memorial
Hospital

Enquiry: Dr. M AUNG
Ref No: 49/RESH/2017
Date: 14/11/2017

TO: Dr Avashri Harrichandparsad

RE: LETTER OF SUPPORT TO CONDUCT RESEARCH AT PMMH

Dear researcher;

I have pleasure to inform you that PMMH has considered your application to conduct research on **“Development of a Financial Management Competency Framework for Nurse Managers at selected public hospitals in KwaZulu-Natal, South Africa”** in our institution.

Please note the following:

1. Please ensure that you adhere to all the policies, procedures, protocols and guidelines of the Department of Health with regards to this research.
2. This research will only commence once this office has received confirmation from the Provincial Health Research Committee in the KZN Department of Health.
3. Please ensure this office is informed before you commence your research.
4. The institution will not provide any resources for this research.
5. You will be expected to provide feedback on your finding to the institution.

Should the following requirements be fulfilled, a Permission/ Approval letter will follow.

- Full research protocol, including questionnaires and consent forms if applicable.
- Ethical approval from a recognized Ethic committee in South Africa

Thank you.



MYINT AUNG

Senior Medical Manager & specialist in Family Medicine
MBBS, DO(SA), PGDip in HIV (Natal), M.Med.Fam.Med (natal), PhD
Tel: 031 9078317
Fax: 031 906 1044
myint.aung@kznhealth.gov.za

Fighting Disease. Fighting Poverty. Giving Hope

Appendix 4g: Approval letter from Eshowe Hospital Ethics Committee



health

Department:
Health
PROVINCE OF KWAZULU-NATAL

40 Kangelia Street Eshowe, 3815
Tel: 035 473 4500 Fax : 035 474 4914 Email: Nhlanhla.sangweni@kznhealth.gov.za
www.kznhealth.gov.za

Eshowe District Hospital

18 September 2017

Enquiries : Mr PN Sangweni
Reference:1/2017

To : Ms Nellie Naranjee
Student No L 21647914
Email : naranjee@gmail.com
Mobile : 0825776126

RE – Permission to Conduct Study on “Development of a Financial Management Competency Framework for Nurse Managers at Selected Public Hospitals in KwaZulu-Natal, South Africa”

1. I have pleasure in informing you that permission has been granted to you by Eshowe District Hospital to conduct research on **“Development of a Financial Management Competency Framework for Nurse Managers at Selected Public Hospitals in KwaZulu-Natal, South Africa”**
2. This research will only commence once this office has received confirmation from the Provincial Health Research Committee in the KZN Department of Health.
3. Please ensure this office is informed in writing before you commence your research.
4. You will be expected to provide feedback on your findings to Eshowe District Hospital.


Yours Sincerely



Mr PN Sangweni
CEO
Eshowe District Hospital



Appendix 4h: Approval letter from Newcastle Hospital Ethics Committee

 **health**
Department:
Health
PROVINCE OF KWAZULU-NATAL

Physical Address: Hospital Street No.4 Newcastle 2940
Postal Address: Private Bag x 6653, Newcastle 2940
Tel: 034-326 0026 Fax: 034- 326 022 Email: Thabisa.sakyi@kznhealth.gov.za
www.kznhealth.gov.za

NEWCASTLE REGIONAL HOSPITAL


To	: Ms. N.Naranjee
From	: Mrs. TBT Sakyi
Date	: 23 rd August 2017
Subject	: Permission to conduct research at Newcastle Hospital

I have pleasure in informing you that permission has been granted to you by the facility to conduct research on "The development of a financial management competency framework for Nurse Managers at selected public hospitals in KwaZulu Natal, South Africa".

Please note the following:

1. Please ensure that you adhere to all the policies, procedures, protocols and guidelines of the Department with regards to this research.
2. This research will only commence once this office has received confirmation from the Provincial Health Research Committee in the KZN Department of Health.
3. Please ensure that this office is informed before you commence your research.
4. The hospital will not provide any resources for this research.
5. You will be expected to give feedback to the hospital.

Thank you,


Mrs. T.B.T. Sakyi
CHIEF EXECUTIVE OFFICER
NEWCASTLE REGIONAL HOSPITAL

2017/08/23
DATE

uMnyango Wezempilo . Departament van Gesondheid
Fighting Disease, Fighting Poverty, Giving Hope

Appendix 4i: Approval letter from Northdale Hospital Ethics Committee



DIRECTORATE: OFFICE OF THE CEO



DATE	22 AUGUST 2017
TO	DR N NARANJEE
FROM	MRS BC MAPHANGA:CEO
RE:	PERMISSION TO CONDUCT RESEACH AT NORTHDALE HOSPITAL: DEVELOMET OF A FINANCIAL MANAGEMENT COMPENTENCY FRAMEWORK FOR NURSE MANAGERS

I have pleasure in informing you that permission has been granted to you by Northdale Hospital to conduct a research study at Northdale Hospital.

Please note the following:

1. Please ensure that you adhere to all policies, procedures, protocols and guidelines of the Department of health with regards to this research.
2. This research will only commence once this office has received confirmation from the Provincial Health Research Committee in the KZN Department of Health.
3. Please ensure that this office informed before you commence your research.
4. Neither the District Office nor the KDHC will provide any resources for this research.
5. Your attention is drawn to the maintenance of confidentiality with respect to staff records/ files.
6. You will be expected to provide feedback on your findings of KDHC



MRS. BC MAPHANGA
CEO: NORTHDALE HOSPITAL

Appendix 4j: Approval letter from Madadeni Hospital Ethics Committee



health

Department:
Health
PROVINCE OF KWAZULU-NATAL

F0001, Section 6, Madadeni
Private bag X 6642, Newcastle, 2940
Tel: 034 328 8042 Fax: 034 374 9227 Email: jabu.duze@kznhealth.gov.za
www.kznhealth.gov.za

DIRECTORATE:

OFFICE OF THE CEO
MADADENI PROVINCIAL HOSPITAL

Reference: Permission for research
Enquiries: Dr. JJN Duze
Telephone: (034) 328 8257
Date: 23/08/2017

Ms. Nellie Naranjee
28 Protea Road
Wyebank
Kloof
3640

**RE: PERMISSION TO CONDUCT RESEARCH AT MADADENI HOSPITAL:
"DEVELOPMENT OF A FINANCIAL MANAGEMENT FRAMEWORK FOR NURSE
MANAGERS AT SELECTED PUBLIC HOSPITALS IN KWAZULU NATAL, SOUTH
AFRICA"**

I have pleasure in informing you that permission has been granted to you by Madadeni Hospital-Department of Health to conduct research on **"DEVELOPMENT OF A FINANCIAL MANAGEMENT FRAMEWORK FOR NURSE MANAGERS AT SELECTED PUBLIC HOSPITALS IN KWAZULU NATAL, SOUTH AFRICA"**

Please note the following:

1. Please ensure that you adhere to all the policies, procedures, protocols and guidelines of the Department of Health with regards to this research.
2. This research will only commence once this office has received confirmation from the Provincial Health Research Committee in the KZN Department of Health.
3. Please ensure this office is informed before you commence your research.
4. Madadeni Hospital and the Department of Health will not provide any resources for this research.
5. You will be expected to provide feedback on your findings to the Madadeni Hospital -Department of Health.

Thank you.

Yours faithfully



Dr. JJN Duze
C.E.O Madadeni

Fighting Disease, Fighting Poverty, Giving Hope

Appendix 4k: Approval from Ekombe Hospital Ethics Committee

Request for permission to conduct a research study at Ekombe Hospital

[Inbox](#)

[Nellie Naranjee](#)

Wed, Aug 16, 2017 at 2:36 PM

Thu, Aug 17, 2017 at 10:17 AM

Luthuli Happiness

<Happiness.Luthuli@kznhealth.gov.za>

To: "naranjeen@gmail.com" <naranjeen@gmail.com>

[Reply](#) | [Reply to all](#) | [Forward](#) | [Print](#) | [Delete](#) | [Show original](#)

Good morning

Medical manager Dr. B.P Zungu approves your request to conduct research on our institution.

Please find email address: Bonginkosi.Zungu@kznhealth.gov.za

Dr. B.P Zungu

Medical Manager - CEO

Appendix 4I: Approval from Osindisweni Hospital Ethics Committee



health

Department:
Health
PROVINCE OF KWAZULU-NATAL

Physical Address: Osindisweni Hospital, Oakford Road, Verulam
Postal Address: Private Bag x 15, Verulam - 4340
Tel: 032 5419201 Fax: 032 5410340 Email: ntombenhle.ngcobo@kznhealth.gov.za
www.kznhealth.gov.za

OFFICE OF THE CHIEF EXECUTIVE OFFICE

Enquiries: Mrs. N.P Ngcobo

Date: 20 August 2017

Ref: OSI/ R

Ms N Naranjee
28 Protea Road
Wyebank
Kloof
3640

Dear Ms Naranjee

RE: PERMISSION TO CONDUCT RESEARCH A STUDY AT ETHEKWINI DISTRICT -OSINDISWENI HOSPITAL

This institution gives permission to you to conduct a research at this facility, research study titled, "Development of a Financial Management Competency Framework for Nurse Managers at selected public hospitals in Kwazulu Natal, South Africa", in the e Thekwini district at this facility has been approved.

Please note the following:

- This research project should only commence after final approval by the Kwazulu-Natal Health Research and Knowing Unit, and full ethical approval, has been granted,
- That you adhere to all the policies, procedures, protocols and guidelines of the Department of Health with regards to this research.
- All research activities must be conducted in a manner that does not interrupt clinical care at this health care facility.
- This hospital will not provide any resources for this research.
- All logistical details must be arranged with the CEO/medical manager /operational manager of this facility.
- You will be expected to provide feedback on your findings to the institution when your research is completed.

Yours Faithfully

MRS N.P NGCOBO
CHIEF EXECUTIVE OFFICER

Fighting Disease, Fighting Poverty, Giving Hope

Appendix 5a: Letter of information for Nurse Manager



Thank you for agreeing to participate in this study. Your input is highly appreciated.

Title of the Research Study: *Development of a Financial Management Competency Framework for Nurse Managers at selected public hospitals in KwaZulu-Natal, South Africa.*

Principal Investigator/s/researcher: Ms Nellie Naranjee, D Nursing Student
Co-Investigator/s/supervisor/s: Prof MN Sibiya. D-Tech: Nursing (Supervisor) and Dr. TSP Ngxongo: D Nursing (Co-supervisor).

Brief Introduction and Purpose of the Study: The aim of this study is to explore the financial management roles of Nurse Managers in their current work environments and identify financial management development needs necessary for Nurse Managers practice and ultimately to develop a financial management framework to improve the competencies of Nurse Managers.

Outline of the Procedures: You will have to understand what the study is about before you sign the consent form to participate. You will be asked few questions in a private room at your hospital or in a venue of your choice. Permission is requested to use the audio recorder during the interview.

Risks or Discomforts to the Participant: The study and the procedure involve no foreseeable risk and discomfort to you.

Benefits: The results from this study will be used to develop a framework to support Nurse Managers in developing the financial management skills necessary for their practice in public hospitals in KwaZulu-Natal.

Reason/s why the Participant May Be Withdrawn from the Study: Your participation in this study is entirely voluntary. You may at any time withdraw from the study without prejudice or providing any reason to your decision.

Remuneration: Please note that there will be no monetary or remuneration given to the participants.

Costs of the Study: You will incur no costs for participating in this study.

Confidentiality: The information you provided during the interview will remain strictly confidential. Data collected will be coded so that there is no link to your name. Your identity will not be revealed while the study is being conducted and on completion while the results are being reported in a scientific journal. Data that will be collected during the study will be stored in a secure locked area.

Research-related Injury: There is no foreseeable form of injury that could take place during the study.

Persons to Contact in the Event of Any Problems or Queries: Please contact me the researcher, Ms Nellie Naranjee at 031-327 2848 (office hours) or Mobile 082 577 6126, my supervisor, Prof MN Sibiya during office hours at 031-373 2606 and my co-supervisor, Dr TSP Ngxongo during office hours at 031-372 2748 or the Institutional Research Ethics administrator on 031-373 2900. Complaints can be reported to the Director: Research and Postgraduate Support, Prof S Moyo on 031-373 2577 moyos@dut.ac.za

Appendix 5b: Consent



Statement of Agreement to Participate in the Research Study:

- I hereby confirm that I have been informed by the researcher, Ms N. Naranjee about the nature, conduct, benefits and risks of this study - Research Ethics Clearance Number: _____,
- I have also received, read and understood the above written information (Participant Letter of Information) regarding the study.
- I am aware that the results of the study, including personal details regarding my sex, age, date of birth, initials and diagnosis will be anonymously processed into a study report.
- In view of the requirements of research, I agree that the data collected during this study can be processed in a computerised system by the researcher.
- I may, at any stage, without prejudice, withdraw my consent and participation in the study.
- I have had sufficient opportunity to ask questions and (of my own free will) declare myself prepared to participate in the study.
- I understand that significant new findings developed during the course of this research which may relate to my participation will be made available to me.

_____	_____	_____	_____
Full Name of Participant	Date	Time	Signature / Right
Thumbprint			

I, Ms Nellie Naranjee herewith confirm that the above participant has been fully informed about the nature, conduct and risks of the above study.

_____	_____	_____
Full Name of Researcher	Date	Signature

_____	_____	_____
Full Name of Witness (If applicable)	Date	Signature

_____	_____	_____
Full Name of Legal Guardian (If applicable)	Date	Signature

Appendix 6a: Interview guide for Nurse Manager

Date----- Participant code:

Institution code:

SECTION A: GRAND TOUR QUESTION

1. What financial management competencies do you currently possess?
2. What are your financial management development needs for your practice as a Nurse Manager in a public health care organisation?

SECTION B: SUB-QUESTIONS

1. What is your current role regard to financial management practice in your institution?
2. What training and educational qualifications do you have with respect to financial management?
3. What suggestions can you offer that will assist to improve financial management competencies of Nurse Managers in public health care organisations?
4. Any other probing questions following the participants' responses will be used to facilitate the discussion.

Appendix 6b: Demographic questionnaire for Nurse Manager

Dear Participant

Please complete the attached questionnaire and hand to the interviewer.
Please do not write your name.

Date----- Participant code

Institution code

1. Gender _____

2. Age _____

3. In which year did you complete your undergraduate nurse training?

4. How long have you been in your current management position?

5. Please list your educational and professional qualifications?

Thank you for completing this questionnaire

Appendix 7: Additional interview questions for Nurse Managers

1. How important is the knowledge of financial management for your role?
2. What changes need to be made to the nursing curriculum in respect of financial management preparation of nurses?
3. What do you find are the essential business and financial management skills of a Nurse Manager?
4. What would you suggest as guidelines and recommendations to include in a competency framework?
5. What steps should be taken to improve the financial management role of NM?
6. How is the role of NM changing?
7. What support in respect of financial management do you receive?
8. What support and training would you like to receive in respect of financial management?
9. How would NMs knowledge of financial management benefit or improve the health department and health care?

Appendix 8: Interview guide for Financial Managers and CEOs

Date: _____

Participant code: _____

Institution code: _____

- 1) What are the common financial management activities in the hospital?
- 2) What are the financial management roles of Nurse Managers in the hospital?
- 3) What do you perceive as the training needs with respect to financial management skills of Nurse Managers and Nurses in general?
- 4) How would Nurse Manager's knowledge of finance contribute to the improvement of finances and the general management of the public sector?
- 5) How would Nurse Manager's knowledge of finance contribute to the improvement of service delivery in the public sector?
- 6) What do you propose as essential financial management knowledge and competencies that should be included in a competency framework for Nurse Managers?
- 7) What kind of financial reports does the Nurse Manager need to understand and why?
- 8) What role will the NM play in financial management in the future and changing health care environment?
- 9) Any other probing questions following the participant's responses will be used to facilitate the discussion

Appendix 9a: An example of an interview transcript of a Nurse Manager

Interviewer	Good Morning Mam. How are you?
Participant	I am well thanks and you
Interviewer	Well and very blessed.
Participant	Good to hear.
Interviewer	Mam, I want to say thank you so much for agreeing to this interview and participating in my study. I am very grateful.
Participant	It's a pleasure. I am glad that I can help.
Interviewer	Mam, I sent you the documents, have you had the chance to look at the documents and interview guide.
Participant	I did, briefly.
Interviewer	The information letter I sent you outlines the study. Let us look at it and feel free to ask questions and clarify anything.
Participant	Thanks will do.
Interviewer	Do you have any questions?
Participant	Not yet.
Interviewer	May I please ask if you could kindly sign the consent form and demographic questionnaire
Participant	Certainly
Interviewer	Thanks for the consent. Before we proceed with the interview, mam, please may I have your permission to record the interview? As explained the recording is purely for recording purposes, so that I can give you my full attention. Please take note that everything we say is confidential and no one will have access to these recordings apart from myself.
Participant	Ok. I give permission to record the interview.
Interviewer	May we proceed with the interview?
Participant	Yes we can.
Interviewer	Please outline your roles and activities regarding financial management
Participant	When we talk about financial management. Within my component I become responsible to ensure that the utilisation of funds is done cost effectively and efficiently. We start by looking at filling of the posts. We have to weigh the post as it is linked to the budget. The person will need to be paid. Is this person really needed? If the person is really needed then we do motivations and check the budget if the person can be made for the next 12 months. We need to monitor that the person is fruitfully and gainfully employed.
Interviewer	Ok.
Participant	There are also cost containment measures. We look at the equipment and ensure that all equipment is in the ward and monitored daily by day and night shift. We do inventory control. Equipment control. Prevention of loss and damage and breakage.
Interviewer	Are these all part of financial management?
Participant	Yes. The OMs and ANMs are my extended arms who monitor their areas. We have monthly meetings. There is a standing agenda item on equipment and supplies. We discuss how to prevent loss and damage of

	equipment which costs money. Stock in the wards is also closely monitored. We have stock levels that must be ordered. We closely monitor and scrutinise any escalation of costs in each quarter. All escalation in costs at ward level is investigated and validated.
Interviewer	Alright
Participant	At cash flow we monitor how much we are paying for private services such as cleaning. We pay them on monthly basis if it escalates then we query and investigate. We need to be informed so that we move forward.
Interviewer	Yes.
Participant	We also focus on attitudes and behaviour. Negative behaviour can lead to complaints from the public and at the end we find we did something wrong. Then the person is suing the department.
Interviewer	Yes
Participant	Cleanliness and prevention of nosocomial infection is important and must be stressed as it will eat into the budget should a patient get an infection. The term ALOS (average length of stay) will affect the budget if the patient stays for a long time due to our negligence. The prolonged stay and investigations due to the infection will cost more money. We need to speed up the recovery of the patient.
Interviewer	Are you involved in drawing the budget for the nursing side?
Participant	The nursing components we are to draw the procurement plan and incorporate the nursing budget. Drawing the maintenance plan so that we have one plan for the whole hospital. If there is something that needs to be done to the infrastructure within the units it enters into the maintenance plan. Procurement plan takes us back to the equipment. We are responsible for the equipment and we need to know for the next financial year what equipment we need to include for procurement.
Interviewer	Do they ask you: what is the budget amount you require for the nursing section?
Participant	The time we become aware is when the budget has already come. We are not told how much we have. We are told that the budget is not adequate and that we will not get some of the items we ordered. We would have to prioritise. This is very difficult as we need our equipment. Everything with us is a priority.
Interviewer	If you were given the opportunity to draw the budget would you be able to?
Participant	In our cash flow, we do have the extended financial management which includes other supervisors and managers of other units. That's where hear about the budget and expenditure. We learn about the budget. Most of the time it's not specific to my nursing components. It's for the whole hospital. So it's not easy for me to know if this budget has been controlled. We don't know how much we are spending. This is a challenge as we do not have cost centres for our nursing units.
Interviewer	If nursing departments were run as a cost centre would there be a better control over the finances?
Participant	Gakulu, Gakulu, when I was the in charge in one of the wards in another hospital, I was also controlling the pharmaceuticals. At the end of each day they would give us our expenditure on medication for the day. I will query if

	I had time and check what I had ordered. With the help of the FM I can draw the budget. If I am told that I have only maybe 3 million rands for my components. We will come together as a team with the ANMS and OMs. We will prioritise what we need. If we had support from the finance team it is possible
Interviewer	Do OMs and other nurses fully understand how the finances of the hospital work?
Participant	I would say they do understand as I shared with you that in this hospital we do have meetings where we are informed about the budget and expenditure. So they are informed about how much we spend on each objective. They know about COE, how much we spend.
Interviewer	Do nurses understand the procurement plan, supply chain management and other processes in the hospital?
Participant	They do understand as they often have to look after the ward in the absence of the OM. If we teach the person the correct knowledge and skills then they will be able to continue.
Interviewer	What financial management competencies do you possess?
Participant	Initially when you become the NM you have to attend the cash flow. You learn along the way. You then attend all meetings for cash flow. Secondly you identify your PDP, as per EPMDs. Then I was released to attend a financial management short course. This was in 2012 and I was a NM already. After that there was another financial management course that I was to attend. Unfortunately the date never came and I am still waiting to attend. Anyway I am coping with knowledge I have and skills. At times I become the acting CEO. Then a lot of information I learn from the FM. I go the FM and his supervisees and get the financial information I am short of just to manage as expected.
Interviewer	What did the short course include?
Participant	It was just budgeting, allocation of the budget and the processes in the cash flow- cash in and cash out, approval.
Interviewer	Did the knowledge you got from the workshops help you?
Participant	Yes, especially as a manager you must know the procedures. There are various committees such as specification committees, evaluation committees. Adjudication committees. You learn a lot about how to be a member of those committees. Also the ordering of medical and non-medical equipment. The writing of the NSI and approval. That's what you learn.
Interviewer	What financial management training did you have in your basic and post basic studies?
Participant	Though my training is very old, what I have learnt is that there are many changes in DOH. There are many new things that have come but we still hold on to the old things. There are many changes set out by the Department of Health. We have to abide with the new way of doing things.
Interviewer	What support do you receive from DOH to assist you with your financial management role?
Participant	I attended women in management recently which was very beneficial. It also incorporated some information on financial management. It was very

	helpful. It also included people management
Interviewer	What would you like to see in a financial management framework NMs?
Participant	Risk management because whatever wrong thing that could happen would lead to the institution losing money. Recruitment costs money. Acts, prescripts, SANC rules and regulations that support nurses - the need to be reminded of that. Negligence costs us money. We can refer to the regulations. Management of personnel and our supervisory role. Effective management and utilisation of staff in the units. Prevention of negative incidents. Cost centre, financial statements, PFMA.
Interviewer	Anything else for the framework?
Participant	Equipment care and control. Need to understand the process from ordering to receipt. We also know how to differentiate between the different levels of hospitals. Equipment bought must be for the level of services that is delivered. We need to learn about staff and personnel management, equipment management, risk management and also to develop staff. Financial skills to manage with the staff we have to ensure smooth running and efficient management of patient care.
Interviewer	That's interesting.
Participant	Policies need to be included to guide staff. What do we do in case of loss, damage, negligence? We need to understand the importance of taking care of equipment and assets, inventory control.
Interviewer	You say at the other hospital you were managing the unit as a cost centre. Are they still running units as cost centres?
Participant	I heard that they are no longer doing it.
Interviewer	Ok.
Participant	Patient management is also important. If the patient absconds and doesn't return the relatives will sue the hospital. Everything is money.
Interviewer	How would nurses, if financially empowered be able to impact service delivery?
Participant	It will contribute a lot. I did indicate that from the OM within the unit becomes responsible to ensure that each and everything item in the ward is taken care of and not damaged. She must know how much each item costs. That is when she will take care of everything. Equipment must be properly handled and serviced and she must understand why it is necessary.
Interviewer	Why do nurses not understand finance?
Participant	When you are older it's very difficult to grasp new things and information. I think that financial management needs to be introduced in the earlier stages while the nurse is still on training. That where she needs to be being groomed early in her training for financial management which she should learn where do we spend money, and include costs, ordering, receipt, care and management and maintenance of items. Those things must be started at an earlier stage, not now.
Interviewer	Do you think that it should be made compulsory that all NMs undergo financial training before being promoted or after promotion?
Participant	I agree that they should come into the post of managers after acquiring that information. When you go for the interview they don't ask you in the

	interview about the previous. If you haven't been in service on financial management, how are you going to know unless you have been working closely with your previous supervisor maybe to equip yourself? They need to acquire that knowledge before they becomes NMs. After employment, you are expected to perform and they want to see you doing things. You won't be saying please teach me first. Labour, the prescripts, they tell us after employment you must identify the learning needs of this new person and ensure you provide training as per the learning needs.
Interviewer	Would you advise that we have OMs and ANMS on the programme?
Participant	Yes, for succession planning. When I am not there, there must be continuity. The person deputising of me must be able to perform the same functions as me
Interviewer	Is there any other suggestions /input?
Participant	We need to improve on personnel development especially for empowerment of supervisors so that they will be able to perform their management functions and be able to make financial decisions with confidence and without fear.
Interviewer	Are there any questions you want to ask?
Participant	No nothing
Interviewer	Do you have any further input
Participant	No
Interviewer	Thank you very much mam. We will now terminate the interview. I want to say thank you for your time and sharing so warmly and openly with me. I truly appreciate your valued input
Participant	You welcome Nellie. All the best. I hope that something can be done for us as Nurse Managers to help us with finance.
Interviewer	This study will certainly open the door and create awareness. Let us see what emerges from this study.
Participant	Thank you. All the best.
Interviewer	Thank you once again.

Appendix 9b: An example of an interview transcript of a Financial Manager

Interviewer	Good Morning Sir. How are you?
Participant	Very good and you.
Interviewer	Very happy and excited to be here.
Participant	Please sit down.
Interviewer	Sir, I am very grateful to you for taking the time to willingly give me your valued input into the financial management roles of nurse managers.
Participant	It's fine. I'm very happy to see that someone is paying attention to something like this as it is very much needed.
Interviewer	Did you read the documents I sent you?
Participant	Yes, I did and I made some notes.
Interviewer	The information letter I sent you outlines the study. Let us look at it and feel free to ask questions and clarify anything.
Participant	Ok.
Interviewer	Do you have any questions?
Participant	No.
Interviewer	May I please ask if you could kindly sign the consent form and demographic questionnaire?
Participant	Ok.
Interviewer	May I have your permission to record the interview?
Participant	Yes.
Interviewer	May we proceed with the interview?
Participant	Yes.
Interviewer	What are the common financial management activities within the hospital especially the ones that involve NMs.
Participant	Everything actually, let me put it this way, because everything that we do here involves the NMs, reason being that everything that we do here is specifically for the benefit of the patients and the person who is responsible for the patients is the NM to see to it that they are getting the proper nursing care, nurses have all the supplies to provide and perform for certain procedures and to ensure that patients have the necessary items they need for the healing process.
Interviewer	That's interesting.
Participant	The NM is a part of the cash flow committee where financial decisions are taken in terms of what needs to be procured. The NMS are part of the decision makers in terms of what's needed in the hospital and which is going to be used for the purpose of giving proper nursing care for the patient. We start with surgical items that will be used for performing procedures. There is also cleaning services for the purposes of infection control and prevention of infection to our patients. We also look at security for the safety of our patients in the institution. We also look at food services which are also for the healing of our patients and the dietary preferences of our patients. There is also the maintenance part of it where she is the decision maker where the NM makes sure that the equipment used for patients is in proper conditions so it does not give am wrong

	results. The maintenance of equipment is in proper condition so at the end of the day it gives correct indication. Also the servicing of equipment and in certain areas where certain temperatures need to be maintained for example, in theatre there is a certain temperature that must be maintained and autoclaves where equipment is being sterilised.
Interviewer	Are these all part of financial management?
Participant	The other areas she is responsible for is SCM. SCM is for procuring all items that are needed.
Interviewer	Alright.
Participant	We have items that are on stock that we have to procure from time to time. We have our ordering levels, reordering levels. We have items that are supposed to be in stock. For these items we write replenishment and then every expenditure we have is presented in the cash flow. The cash flow consists of managers of all the components including the NM. The replenishments are for items that are on stock and SCM must check for levels and order accordingly. For anything that is not a stock item, we have something that is called a NSI. A NSI form is filled in by the end user for any item that is not on stock. It is presented in the cash flow. On the cash flow when it is presented we check. It is presented to SCM. It starts by being presented to the evaluation committee. We have 3 committees in SCM. Specification committee is where they will decide how they want the item to look like at what do they want it to be. In the specification committee we have someone from nursing or the quality person. The PHC manager, pharmacy manager, maintenance manager is also present on that committee.
Interviewer	These are the Bid Committees.
Participant	The adjudication committee is made of the Systems managers, CEO, FM and NM and someone from SCM where we decide this is what the specification committee has recommended. This is the prices and if we are comfortable with the prices and then we buy. We sign and confirm that we have adjudicated and the purchase is confirmed. The NM is part of that committee.
Interviewer	Does it have to be the chief NM or ANM?
Participant	This is the NM. The person from SCM is that to prepare the documents. The NM is part of that decision making. The order is then awarded to the company.
Interviewer	OK
Participant	Assets management - they have to check quarterly, broken items must be sent for repairs or condemned and written off. End users must submit their request for assets. For nursing and for patient care, the NM must sign for the recommendation. This is presented at cash flow and checked whether there is budget available.
Interviewer	Alright.
Participant	The budget is provided to us by the department which is separated into COE - Compensation of employees which pays salaries and wages and allowances and overtime. The other part is for goods and services (G & S). G and S include assets, surgical items and soft goods, include

	everything. Items that are used for maintenance is also included. With COE - it mainly determined by what you are earning. Therefore 65 % - 70 % of the budget goes to COE.
Interviewer	That's a big amount.
Participant	At the beginning of the year HR presents the HR plan which tells us how many employees we have, how many do we anticipate having before the end of the financial year looking at the vacant posts and how much will it cost. How many people are turning 65 in that year and so that we can plan on how much we are paying for retirement. For G & S everyone has to submit their procurement plan for all the items that they will need for the next financial year. For nursing the NM is responsible for the procurement plan. The nursing departments need medication, patient food etc. The procurement plan includes things that are not stock items. We use NSI to buy. We have standing orders which are monthly orders that we have to pay every month such as electricity, water security, blood test accounts, NHLS, blood bank, contractors such as photocopiers, catering services. This is where the larger part of the budget goes to.
Interviewer	What is the NMs role in this?
Participant	NSI - we align the budget with the procurement plan. We request all the end users to come and verify their orders and prioritise the items. NMs always find that everything that they want is a priority.
Interviewer	Why do you feel that NMs always regard everything is a priority.
Participant	Due to patient care and nursing patients in totality, nurses regard everything as a priority. This is to prevent litigation which is massive amounts. To reduce child mortality rates for example, we need incubators, so this becomes a priority. We can compromise on items such as stationery such as pens. There are some things that are requested such as TVs, BP machines etc. The NM must make the decision as to what must be purchased according to priority. After she is told at the cash flow that this is the mandate that is available, her PP costs more and she must go back to OMs and coordinate what will be bought with the budget available.
Interviewer	Does the NM understand the procurement plan?
Participant	She is involved in all of these things. She is part of cash flow. All the items I mentioned such as the standing orders, she is a part of it. She is also responsible for approval of the NSI. When items are presented at cash flow for purchase, the end users must validate and provide rationale and good motivations why they require the items. This where the NM comes in. Once she is presented with the budget available, she needs to meet with the nursing managers and choose what they require and remove the ones that are not urgent.
Interviewer	What is the NMs role in this?
Participant	A slight over expenditure is allowed due to inflation and unanticipated price increases. All NMs become part of the expenditure by stating that they approve of the items on the cash flow and we need to pay the suppliers. She is involved in all of that.
Interviewer	Who draws the procurement plan for nursing?

Participant	Each and every ward draws their own procurement plan. The OMs draw it up and they combine everything. The NM presents the combined procurement plan at the cash flow.
Interviewer	Are there any other financial management roles of the NM?
Participant	In terms of the expenditure, we have to monitor cost drivers. That is part of the cash flow. The whole team is responsible. Cash flow normally monitors standing orders. The DOH has SOPs which specifies how that should be monitored. The NM is part of all this in terms of decision making. The MTEF committee, the NM is also part of this. In this committee we look at funds. Once we have spent the allocated money on the items we require, we then look at what's left over and decide what we can spend it on. In the DOH it is a charge to overspend or under spend, where we can do so by 2%. The statistics must talk to the expenditure and orders. The head count of patients differs and the orders must align accordingly.
Interviewer	Where does the lack of understanding of finances stem from?
Participant	Nurses don't have a financial background so they don't understand the concept of the lack of finances. They feel that I am refusing to spend the DOH money. If there is no money there is nothing to give.
Interviewer	So what you are saying is that they don't fully understand the financial procedures.
Participant	They don't understand financial procedures. So it becomes our duty to that every time we do financial presentations, we need to highlight monthly expenditure reports at the extended management meeting which is attended by all supervisors of all departments. The NM is the manager but OMs are the supervisors and manage the units. During the extended management meeting we present the budget vs. the expenditure and they will know what we are faced with. Sometimes when we return NSIs, it's not because we want to but we don't have the funds to pay for it.
Interviewer	Do the nurses understand this?
Participant	No, they don't because there are certain programmes that don't take place. They blame it on finance and SCM. The assessments are done by National Core Standards. If they fail, they blame finance, but whereas our hands are tied in terms of expenditure.
Interviewer	Where financial education should be given, at which level?
Participant	At the level of the OM. The NM understands. There is a lot of wastage. Instead of ordering the correct equipment such as tourniquet for taking bloods they use gloves which are wastage. They also have standing orders and they order for rainy days. They don't order according to their needs. They order in case our stores department run out of the items, they will still have and can continue with the service. During stocktaking monthly and quarterly, we take it and redistribute. When ordering they do not look at usage. They order irrelevant items that they will not use. They continue to order the same levels. These results in items expiring in the store rooms. They also do not do stock rotation using FIFO method.
Interviewer	Why is this so?
Participant	Nurses don't think that taking care of assets is part of their responsibility. Equipment that is broken is not accounted for and not reported to loss and

	damage. It all becomes a finance problem as the people who are responsible for the care of the equipment is not doing their part. If a machine is broken the OM must make the nurse to write the statement and present to the loss and damage committee. They will investigate for negligence and the person must pay for the damages. If they don't do this then it becomes fruitless and wasteful expenditure.
Interviewer	Is there anything else that can be included in the framework?
Participant	They need to know how SCM works as everything starts with SCM. They need to understand how to take care of items they order and take responsibility for it. I think that the department must design some sort of a manual whereby as finance we are going to handling training for nurses. Design a programme or manual where we can give nurses financial management training or a course that can be done on yearly basis so that we can keep reminding them. Orientation is ongoing and they forget things along the way. If they can design a manual, so that we at finance department can facilitate at institutional level.
Interviewer	Does it come from institutional level or should all nurses and NMs attend structured financial management programmes?
Participant	All managers must go for the programme first then finance will do it for the institution. The managers will get an overview then finance will do the training for all nurses at all levels and wards and different departments.
Interviewer	Is there anything else that should be included?
Participant	They need to understand the budget. As much as we explain. If we had a standard manual. We are trying to avoid having the institution doing things differently.
Interviewer	What type of financial reports would nurses have to understand?
Participant	Budget vs. expenditure so that will not order unnecessary items. They need to understand expenditure.
Interviewer	Any other type of reports of financial statements?
Participant	Financial statements is not done at institutional level. SCM processes, asset processes, maintenance processes, fruitless and wasteful expenditure reports, stock take and inventory control, irregular expenditure
Interviewer	How do you think that nurses understanding of finances will improve the service delivery?
Participant	Attitude change is the first thing we need to change and be financially conscious. That will change and improve our service delivery and finances. If we give them financial management training they will become financially conscious. When we are financially conscious we will not have wastage. We are going to do our part in monitoring of all the usage and nothing goes to waste and expire.
Interviewer	Thank you for that. Is there anything else you want to say?
Participant	Yes. When is this framework coming? We need it desperately and looking forward to it.
Interviewer	As soon as it is approved, I will inform you.
Participant	It will very much assist us and the nurses desperately need it. Hopefully it will change their way of thinking.
Interviewer	I am very positive that it will. I have started something by creating the

	awareness that nurses are also responsible for financial management. It can only improve from here on.
Participant	Thank you very much. Good luck for your studies.
Interviewer	Thank you. I am really grateful for your most valuable input.
Participant	Take care.
Interviewer	Goodbye.

Appendix 10: Sample coding process for Constructivist GT

<i>Participants words/ expressions</i>	<i>Open coding</i>
7) What is your financial role in the hospital and what are the critical activities that you are involved with daily	
In our basic training, though it was not formal, financial management. It was there. If you think about HR management, management of resources, equipment, time management, these are also part of financial management. But now I think the role is very critical. The roles and responsibilities include everything like HRM, resource management, equipment and the finances. Now you understand why they talk about COE, recruitment that you don't just recruit for the sake of filling the post. You have to identify the need. Do you really need this person looking at the finances because every year when the budget is being allocated, now we are being told for HR this is what is allocated? Every quarter we are told that we are here maybe they project that we will overspend or under spend. Now we really understand that. Whatever we are doing is based on that to identify the need first. Do we really need to employ this person, not just to fill the vacant post?	<p>HR management</p> <p>Management of resources,</p> <p>Equipment management</p> <p>Finance management</p> <p>Management of staff vacancies</p> <p>Recruitment</p> <p>Budget</p> <p>Expenditure control</p> <p>Plan to identify priorities</p>
Also with the equipment, it's the same thing. Every year there is a procurement plan that we have to write. Before you even go there you take the previous one and there you check the equipment that you received and check whether you need that equipment or not. Operational plan is also done	<p>Equipment control</p> <p>Procurement plan</p> <p>Equipment monitoring and control</p> <p>Operational planning</p>
When we talk about financial management. Within my component I become responsible to ensure that the utilisation of funds is done cost effectively and efficiently. We start by looking at filling of the posts. We have to weigh the post as it is linked to the budget. The person will need to be paid. Is this person really needed. If the person is really needed then we do motivations and check the budget if the person can be made for the next 12 months. We need to monitor that the person is fruitfully and gainfully employed.	<p>Cost control</p> <p>Expenditure control</p> <p>Recruitment</p> <p>Human resource management</p> <p>Budget adherence / control</p>
There are also cost containment measures. We look at the equipment and ensure that all equipment is in the ward and monitored daily by day and night shift. We do inventory control.	<p>Cost control</p> <p>Expenditure control</p> <p>Stock control</p>

Equipment control. Prevention of loss and damage and breakage.	<ul style="list-style-type: none"> Asset control Monitoring Resource control Equipment monitoring and control
The OMs and ANMs are my extended arms who monitor their areas. We have monthly meetings. There is a standing agenda item on equipment and supplies. We discuss how to prevent loss and damage of equipment which costs money. Stock in the wards is also closely monitored. We have stock levels that must be ordered. We closely monitor and scrutinise any escalation of costs in each quarter. All escalation in costs at ward level is investigated and validated.	<ul style="list-style-type: none"> Monitoring Equipment and supplies Prevention of loss and damage Stock control Monitoring of expenditure and costs Validation of costs
At cash flow we monitor how much we are paying for private services such as cleaning. We pay them on monthly basis if it escalates then we query and investigate. We need to be informed so that we move forward.	<ul style="list-style-type: none"> Monitoring Cash flow Monitoring of contracts Expenditure monitoring
I would say in a hospital, the nurses are the core, I am going to say nurses are the core managers of resources in a hospital, so you will find if there is wastage it is always directed to the nurses if there is as sudden saving, it is always directed to the nurses, so I find my financial manager and my CEO, they will say especially during our cash flow meetings, that where we speak a lot of money and then they will project our spending and how far we are in terms of our money so you will see and they will be telling us, you'll spending a lot on this. You spend too much on this, try and save on this. And then I just recently said to my financial manager, because there's a lot of things we need to save on and I just said to him, I think the best thing we need to do is to be able to do procurement plan from the operational level. That has never really been done. You know that. We do procurement plans only on medical equipment and furniture, but in terms of procurement plan on the stock you going to use for the year in your department	<ul style="list-style-type: none"> Resource management Cash flow Cost control Procurement plan Operational plan

<p>Operational aspects in terms of I am going to use so much bandages for the year so much gloves. that procurement as such has never been done. It just made me think how difficult finances are. I need to do some sort of a business plan for my house. The financial manager and CEO say, Nursing you'll are wasting Maybe we need to do procurement plans from the operational aspect. If we sit and we look at how much we spent for the year, so we can see and project for the future year, we have been given too little money for what we've got. That is what procurement and budgeting is about. That is another stressful thing on us. They say watch, don't have too much overtime and then on the other hand you've got a shortage of human resource., so you know you were asking what is my responsibilities, It so huge, humongous, because not only among HR but in terms of management of equipment and furniture because if its broken, it comes right back to this office, I've got to report, write a loss and damage, how it broke, why it broke, what's your plan about it, an people who have broken it must be disciplined accordingly, but now we've got to make sure that they know how to use it so we've got a responsibility with the equipment, we got a responsibility with the HR and be able to place people accordingly even if maybe in your department you not so busy and the other depts. Are busier. Before I actually get overtime, I must source somebody from your dept. So, this constant HR management to make sure that you controlling your finances.</p>	<p>Procurement planning Prevention of waste Cost control Forecasting and budget planning Human resource planning and management Resource and equipment management Financial forecasting Financial planning Operational planning Financial control</p>
<p>4) What are your financial management roles within the unit?</p>	
<p>It's broad, for example. the economic management of resources, ordering, knowing how much the budget is for the wards, managing both the financial and human resources, staff, ensuring that we keep our stock levels to a minimum, also overstocking which will end up expiring in the dept. Using FIFO method. Prevention of expiry of stock</p>	<p>Resource management and control Procurement Stock and supplies management and control Human resource management Expenditure control Prevention of wastage</p>

<p>we know the amount that is allocated to the wards for equipment overall. For us it is knowing what we need and drawing our business plans for the year. In fact the BP is firstly that you need to know what you require, how much you are going to use and what type of resources you are going to use for the following year</p>	<p>Drawing up business plans Planning for resources</p>
<p>1) What are the common financial management activities within the hospital especially the ones that involve NMs</p>	
<p>The NM is a part of the cash flow committee where financial decisions are taken ITO what needs to be procured. The NMS are part of the decision makers ITO what's needed in the hospital and which is going to be used for the purpose of giving proper nursing care for the patient. There is also the maintenance part of it where she is the decision maker where the NM makes sure that the equipment used for patients is in proper conditions so it does not give wrong results.</p>	<p>Cash flow Make financial decisions Procurement Decision making Equipment maintenance and control</p>
<p>So NM is also involved in all those things because when it comes to the decision making in the cash flow she is also involved in how much medication do we need so that we don't run out of meds.</p>	<p>Makes decision s for stocks, stores supplies Participates in cash flow meeting</p>
<p>The other areas she is responsible for is SCM. SCM is for procuring all items that are needed. We have items that are on stock that we have to procure from time to time. We have our ordering levels, reordering levels. We have items that are supposed to be in stock. For these items we write replenishment and then every expenditure we have is presented in the cash flow. The cash flow consists of managers of all the components including the NM. The replenishments are for items that are on stock and SCM must check for levels and order accordingly. For anything that is a not a stock item, we have something that is called a NSI. A NSI form is filled in by the end user for any item that is not on stock. It is presented in the cash flow. On the cash flow when it is presented we check. It is presented to SCM. It starts by being presented to the evaluation committee. We have 3 committees in SCM. Specification committee is where they will decide how they want the item to</p>	<p>Procurement Presentation of expenditure at cash flow Bid evaluation committees Bid specification committee where they will decide how they want the item to look like at what do they want it to be Decision making</p>

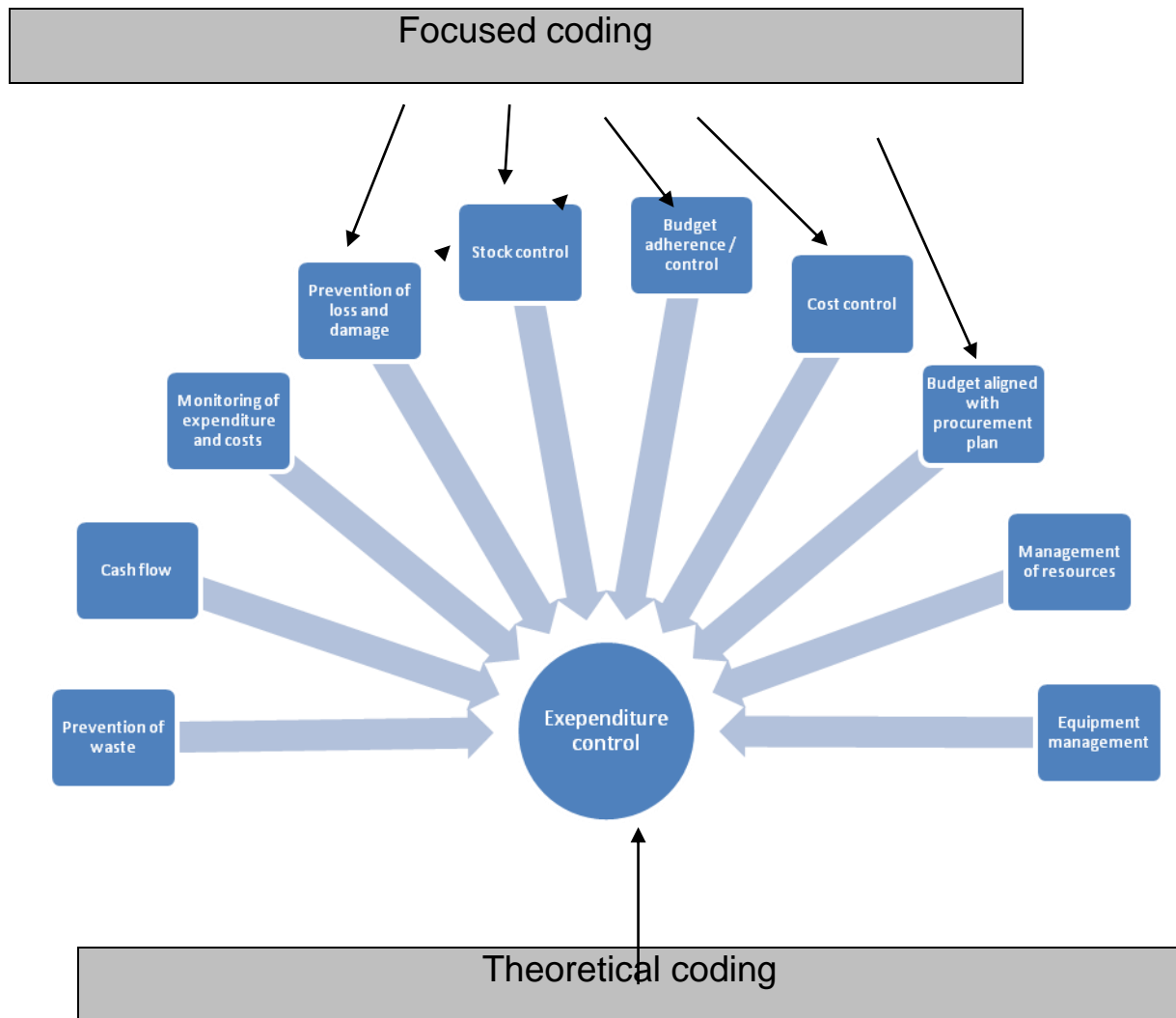
look like at what do they want it to be. In the specification committee we have someone from nursing or the quality person. The PHC manager, pharmacy manager, maintenance manager is also present on that committee.	
There is evaluation committee which evaluates the quality of equipment vs. the prices and see which one the end users are more comfortable with. Medical, monitoring and evaluation (nursing), SCM and finance personnel are represented on this committee.	<p>Bid evaluation committees</p> <p>which evaluates the quality of equipment vs. the prices</p> <p>Monitoring and evaluation</p>
The adjudication committee is made of the Systems managers CEO, FM and NM and someone from SCM where we decide this is what the specification committee has recommended, this is the prices and if we are comfortable with the prices and then we buy. We sign and confirm that we have adjudicated and the purchase is confirmed. The NM is part of that committee.. The NM is part of that decision making. The order is then awarded to the company.	<p>Bid adjudication committees</p> <p>Sign and approve</p> <p>Decision making</p> <p>Contracts and tenders</p>
Assets management - they have to check quarterly, broken items must be sent for repairs or condemned and written off. End users must submit their request for assets. For nursing and for patient care, the NM must sign for the recommendation. This is presented at cash flow and checked whether there is budget available.	<p>Asset management</p> <p>Cash flow</p>
At the beginning of the year HR presents the Hr plan which tells us how many employees we have, how many do we anticipate having before the end of the financial year looking at the vacant posts and how much will it cost. How many people are turning 65 in that year and so that we can plan on how much we are paying for retirement. For G & S everyone has to submit their PP for all the items that they will need for the next financial year. For nursing the NM is responsible for the PP. The nursing depts. need medication, patient food etc. The PP includes things that are not stock items. We use NSI to buy. We have standing orders which are monthly orders that we have to pay every month such as electricity, water security, blood test	<p>Procurement planning</p>

accounts, NHLS, blood bank, contractors such as photocopiers, catering services. This is where the larger part of the budget goes to.	
NSI - we align the budget with the PP. We request all the end users to come and verify their orders and prioritise the items. NMs always find that everything that they want is a priority.	Budget aligned with procurement plan
Starts with the budgeting -making sure that we do have funds for the activities that we said we are going to do in terms of our operational plans (OP). The OP involves all other relevant stakeholders within the hospital. We convert the OP to budget. This means that all the activities performed and required resources are financed from the budget. OP and budget are aligned. We start from there. That is where finance comes in. Immediately thereafter, once we receive the budget from Provincial Office, we commence with the utilisation of the budget. This includes buying or procurement of what we need. We also do procurement plans which are linked to budgets and OP. This includes all the things that we would buy in the financial year. The input comes from different stakeholders, mainly the OMs. They know what is needed. All Ops are received and consolidated into one OP for the entire hospital	<p>Budget planning</p> <p>Operational planning</p> <p>Procurement planning in line with budget</p>
It is the NM, for example, from the nursing perspective. The EXCO is made up of FM, NM, CEO, MM, AFM, and HRM. All these managers collect from their different units and consolidate and present to finance. Finance then consolidates for the whole institution and present to Cash flow committee which is chaired by the CEO. Once the procurement process is finalised around mid-February. The buying process commences in April.	Nm presents the procurement plan for all nursing departments
The OMs are referred to as end users, as they are the consumers of the items that we purchase. We request them to raise the NSI. They complete the forms requesting the same items that they put in their procurement plans. All these forms are now tabled with the Cash Flow committee again.	OMs procurement planning

<p>There is the issue of specification of the items that we have to buy. This will have to come from the end -user as they, the OM, play a very important role in determining exactly what they require. They have to come with the specifications, which will then go to SCM office. They will forward to the specification committee which will verify the specification is correct and approve. This committee is made up of members from different disciplines within the hospital, of which nursing is represented. Usually a nurse manager sits in this committee and has insight into what has been requested. They check that the specification is correct and approves. Thereafter SCM will get the 3 quotes and so forth.</p>	<p>OM make decisions on what is required - equipment, stock items</p>
<p>Two committees, Quotation Evaluation Committee (QEC) and Quotation adjudication committee (QAC). These committees also include representation from all disciplines. The QEC will evaluate the quotation received. A minimum of three or more quotations is required. The end user will verify that the item requested is exactly what required. Thereafter, the recommendations are submitted to QAC is. This is formed by CEO as chairperson, deputy chairperson, FM; the NM is also part of the committee, MM and systems manager. This is to ensure that that the item to be purchased is given the approval by the relevant manager. The FM has to be present to approve as well. The decision rests with the CEO as the chairperson with the input of all committee members.</p>	<p>Nm part of the Bid adjudication committee Approval of items Decision making</p>
<p>16) What are the financial management roles of NMs?</p>	
<p>Whatever is financed is based on the planning by NMS. They are responsible for drawing up business or procurement plans. They need to submit NSI timeously, usually in September in order to get their equipment on time. Good stock management is required and management of stores in the wards. Prevention of waste and loss especially WRT expired stock. They need to apply the FIFO method. The NM must oversee the whole financial processes within the units, so it's important that she understands the financial processes</p>	<p>All finances based on planning by NM Draw business plans Procurement plans Expenditure control and prevention of waste Oversee financial processes in nursing units</p>

A training plan should involve how to link, OP, proc plan, and budget and how to develop and implement these plans.	Link operational plans, procurement plans to budget
Need to understand of GOVT budget process, where the money comes from and how it is distributed SCM processes. Inventory and asset management. These are the critical aspects for the NM ITO finance.	Need to understand government budgeting process Budget allocation and distribution Inventory control Asset control and management

Coding process – Constructivist grounded theory



Focused coding	Theoretical coding
Prevention of waste	Expenditure control
Cash flow	
Monitoring of expenditure and costs	
Prevention of loss and damage	
Budget adherence / control	
Cost control	
Budget aligned with procurement plan	
Management of resources	
Equipment management	

Appendix 11: Memo writing

INTERVIEW TRANSCRIPT	
DATE: 06 DECEMBER 2017	
TIME: 08H00	
DISTRICT: ETHEKWINI	
TYPE: REGIONAL HOSPITAL	
HOSPITAL: HOSPITAL 3	
INTERVIEWER: NELLIE NARANJEE	
INTERVIEWEE: NURSE MANAGER 3	
POSITION: NURSE MANAGER	
<i>1) What financial management competencies do you possess?</i>	
I am able to do financial planning within the budget that we are given, however we don't have cost centers	<p>Able to do financial planning</p> <p>Budget is allocated – has to work within the budget</p> <p>Absence of cost centres</p>
<i>You say we don't have cost centers</i>	
We don't have cost centers but being part of a committee within a hospital you begin to know how much budget is available for different things. It's not a lot for you to manage, for the services according to what you got.	<p>Part of cash flow committee where budget is discussed</p> <p>Budget is inadequate for the needs of the services</p> <p>Has to manage finances according to the budget allocated to nursing sector</p>
<i>2) May I just ask on the cost center aspect. If each of the OMs were given their own cost centre would there be better planning and management of the finances</i>	
They would if they were given the knowledge and the financial background to a cost centre. At the moment with the knowledge and skills that they have they won't manage a cost centre, but I think with the necessary training it would improve things. They will become more accountable for their environment. That is possible if we give them the training.	<p>Ideal for each unit to be managed as a cost centre</p> <p>Lack the financial management skills to manage a cost centre</p> <p>Need the knowledge and training to manage cost centres</p> <p>Cost centres would give greater accountability and control over finances</p>

<p>3) When you look at your training all those years ago. What financial training did you have in your basic training or post graduate training.</p>	
<p>In post graduate training you do financial management, but it is more of a theoretical. Most of my knowledge and training is being part of a committee and ordering of equipment and other functions. The knowledge I got from the hospital has come through in-service training and attending the odd workshop. But mostly it's come from actually doing the work and trial and error sometimes.</p>	<p>Financial management training in post graduate programmes is theoretical, not practical. Knowledge acquired through experience and on the job. In-service training and workshops provided. Acquired skills by trial and error.</p>
<p>We are quite involved at this level in procurement and procurement planning.</p>	<p>Procurement planning part of the financial management role of the NM. Extensive involvement.</p>
<p>4) Do you get any support from govt, DOH or anyone in terms of assisting you with your financial activities and for your financial management role?</p>	
<p>I was to attend a workshop recently on financial management which I did not get to go as it was cancelled. It was the financial for non- financial managers. It was a good course. Our MM was on it and said it was very helpful. This expands your knowledge on how to do, more of a financial overview. I would still be happy to attend that and I hope to get the opportunity.</p>	<p>Lack of workshops and training provided by Department of Health. Would like the opportunity to attend more workshops and training.</p>
<p>5) What support do you get from the financial manager / CEO for your financial management role?</p>	
<p>The CEO is chairperson of the cash flow committee and the QAC. All our financial committees are chaired by senior management. Obviously if there are any issues, or any particular problems I have I can go to the FM or CEO /. Sometimes they are able to help, but we are severely limited as a lot of our functions regarding financial management are centralized with regard to equipment / contracts</p>	<p>Part of the cash flow committee and quality assurance committees. Gets support for financial management role from FM and CEO. Centralisation of financial management functions pose problems.</p>

Appendix 12: Letter from the professional editor

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**Doctoral thesis: A FINANCIAL MANAGEMENT FRAMEWORK FOR
NURSE MANAGERS IN KWAZULU-NATAL, SOUTH AFRICA**

I confirm that I have edited this thesis and the references for clarity, language and layout. I am a freelance editor specialising in proofreading and editing academic documents. I returned the document to the author with track changes so correct implementation of the changes in the text and references is the responsibility of the author. My original tertiary degree which I obtained at the University of Cape Town was a B.A. with English as a major and I went on to complete an H.D.E. (P.G.) Sec. with English as my teaching subject. I obtained a distinction for my M.Tech. dissertation in the Department of Homeopathy at Technikon Natal in 1999 (now the Durban University of Technology). During my 13 years as a part-time lecturer in the Department of Homeopathy at the Durban University of Technology I supervised numerous Master's degree dissertations.

Dr Richard Steele

18 June 2018

per email