UTILIZATION OF A STRUCTURED TOOL ON SUPPORTIVE SUPERVISION AMONG NURSES AT THIKA LEVEL 5 HOSPITAL, KIAMBU COUNTY, KENYA

LUCY WAITHIRA WAWERU

DOCTOR OF PHILOSOPHY IN NURSING IN LEADERSHIP AND MANAGEMENT

JOMO KENYATTA UNIVERSITY
OF
AGRICULTURE AND TECHNOLOGY

2026

Utilization of a Structured Tool on Supportive Supervision among Nurses at Thika Level 5 Hospital, Kiambu County, Kenya

Lucy Waithira Waweru

A Thesis Submitted in Partial Fulfilment of the Requirements for the Degree of Doctor of Philosophy in Nursing (Leadership and Management) of the Jomo Kenyatta University of Agriculture and Technology

2026

DECLARATION

This thesis is my original work and has not been presented for a degree in any other University.

Signature……Date: ……

Lucy Waithira Waweru

This thesis has been submitted for examination with our approval as the University Supervisors:

Signature……Date: ……

Prof. Sherry Oluchina, PhD

JKUAT, Kenya

Signature……Date: ……

Dr. Elijah Githinji Mwangi, PhD

JKUAT, Kenya

DEDICATION

I dedicate this work to my husband, Dr. Willy Waweru Mwangi, who was a great inspiration and help during this process.

ACKNOWLEDGEMENT

I thank God for giving me His grace to enable me to accomplish this work. Much thanks to my supervisors for great a sacrifice and wisdom in guiding me during this process. I appreciate the JKUAT school of Nursing for the commitment in seeing that I progress in this work. Much thanks to Dr. Grace Githemo, Dr. Nilufa and Dr. Kawira for their contribution in the customization of the supportive supervision Tool. I appreciate Thika Level 5 Hospital Nursing services Manager and deputy, all Nursing wards' and sections' Managers and their staff for making this study a success.

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

LIST OF APPENDICES

ACRONYMS AND ABBREVIATIONS

FGD	Focused Group Discussion
JKUAT	Jomo Kenyatta University of Agriculture and Technology
KIIs	Key Informants Interviews
KL5H	Kiambu Level 5 Hospital
MLM	Mid-Level Managers
NACOSTI	National Commission for Science, Technology and Innovation
SPSS	Statistical Package for Social Sciences
SS	Supportive Supervision
TL5H	Thika Level 5 Hospital
W.H.O	World Health Organization
RHU	Reproductive Health Unit

DEFINITION OF OPERATIONAL TERMS

Frontline Nurse Manager	Nurse in Charge of a ward/section
Nursing staff	Nurses working in a ward/section managed by Frontline Nurse Manager
SS documents	Documents used by Frontline Nurse Managers to record SS activities and outcome
SS indicators	Measures/evidence of SS practice
Supportive supervision	Monitoring and guidance provided by Frontline Nurse Managers to Ward/section Nursing staff on performance
Key informants	Senior nursing managers in charge of the hospital
SS Structured Tool	A document stating how and when Supportive supervision is done
Ward/section SS	SS done by ward/section Frontline Nurse Manager on Nursing staff
Internal supportive supervision	Supportive supervision by ward/section Frontline Nurse Manager on ward/section nursing staff
External supportive supervision	Supportive supervision by county/ministry supervisors on Frontline Nurse Managers
Level 5 Hospital	County Teaching and referral hospital

ABSTRACT

The Supportive supervision (SS) process aims at improving staff performance through identification of knowledge and skills gaps, giving feedback and on-job-training. Training of managers on SS is therefore required to facilitate this role. Where SS is not done staff performance deteriorate resulting to poor patient care. No study was found on SS at the ward/sections level in Kenya. The objective of this study was to determine the effects of utilization of a structured SS tool among Frontline Nurse Managers at Thika Level 5 Hospital (TL5H) in Kiambu County. The study conducted a baseline survey to determine the level of SS practice among the Frontline Nurse Managers and factors associated with the practice. Baseline results were used to customize and adopt a World Health Organization structured supportive supervision tool. An end line survey was used to evaluate the effects of the intervention which was conducted after training Frontline Nurse Managers on SS and utilizing the structured supportive supervision tool. The study used concurrent triangulation mixed methods where quantitative and qualitative approaches were applied. For quantitative approach, quasi experimental pretest-posttest one group design was used; for qualitative approach, phenomenological design was applied and triangulation of data performed. The study population included the Nursing Services Manager, Frontline Nurse Managers, their deputies, and nursing staff. Census method was applied for sampling Nursing Services Manager, Frontline Nurse Managers and their deputies. Frontline Nurse Managers and their deputies were purposively sampled into Focused Group Discussion (FGD) groups. Nursing staff were sampled through stratified sampling. Questionnaires, FGD guide, Key Informant Interviews (KII) guides and observation checklist were used to collect data. Quantitative data were collected using a semi-structured questionnaire and observation checklist. Qualitative data were collected through (FGDs) and (KIIs). The study used Statistical Package for Social Sciences (SPSS) version 25.0 to analyze quantitative data which were analyzed by use of descriptive and inferential statistics. Quantitative data was presented using frequency distribution tables, and pie charts. Qualitative data were analyzed using NVivo version 12 then presented in themes. Level of practice and associated factors were identified. End line survey were analyzed by use of inferential statistics analyzed using chi-square and paired t-test. Statistical significance was determined using 95% confidence interval and a P-value of 0.05. Dissemination of the results was done through seminars presented to Jomo Kenyatta University of Agriculture and Technology (JKUAT) School of Nursing and Thika Level 5 Hospital (TL5H) Nursing department and publications in different peer review journals. Ethical approval was obtained from JKUAT Research and Ethics Committee and National Commission for Science Technology and Innovation (NACOSTI). Approval to collect data was granted by Kiambu County and TL5H. The study respondents were requested to give informed consent by signing and no names were written to ensure confidentiality and anonymous of the information collected. Frontline Nurse Managers' SS practice, there were no records for SS activities; knowledge on SS did not meet the expectations, and key institutional factors were: the hospital lacked SS schedules, had not trained Frontline Nurse Managers on SS, there was staff shortage, lack of SS tools such as SS observation checklist and facility for recording SS data. The baseline survey results were used to develop the intervention. Training in and utilization of a structured SS tool were effective on improving SS knowledge and practice. The study therefore concludes that there was no SS practice at TL5H and that Frontline Nurse Managers' knowledge did not meet expectation. Furthermore the hospital had no SS system and no SS tool. Both Institutional factors and individual factors contributed to lack of SS practice by Frontline Nurse Managers at TL5H. The study recommends adoption of a customized structured SS tool for use by Front Nurse Mangers in their SS role in TL5H. The study further recommends further training of Frontline Nurse Managers on SS and setting up of SS policy and system in the hospital. Additionally the hospital to address staff shortage.

CHAPTER ONE

INTRODUCTION

1.1 Background to the Study

Supportive supervision (SS) at the ward/section level is the process that aims at improving the performance of staff through problem solving, monitoring and effective communication between supervisor and supervisee. Both the supervisor and the staff set goals based on the professional standards and agree on how they will be followed and what is to be achieved. Supportive supervision takes place during work time as well as specific planned visits (Martin, Kumar, & Snowdon, 2021).

Training of managers on supportive supervision is important to enable them to facilitate the staff on achievement of better results (Nordbøe & Enmarker, 2017). Due to the participatory approach of the supportive supervision process, the supervisor and staff, aim at planning and monitoring of the ward activities together in order to achieve the set goals. This results in high quality performance and staff job satisfaction as well as staff retention. Supportive supervision, therefore, benefits both health institution and the staff through improvement of professional competence (Ndatimana et al., 2022).

Traditionally supervision goal has been taken to be inspection of staff performance rather than providing support to staff due to lack of supervisors' training on the supportive supervisory skills. The practice of supportive supervision is faced with challenges such as staff shortage, lack of health institution policy on the role of supervisors as well as managers' lack of supervisory knowledge and skills (Barle *et al.*, 2016, as cited in *Global Health Science and practice, 2022*).

In a study on 'influence of supportive supervision', done in Australia, the study found that, Nurse Managers were short of supervisory empowerment in terms of knowledge and skills which affected their SS practice. Managers needed empowerment in terms of supportive supervisory skills in order to improve work environment as well as job satisfaction of their staff (Ryu, Buus, Naccarella, Zarb, & Hamilton, 2024).

In Pakistan, the practice of supportive supervision among managers was reported to be between 0%-25% before intervention (Aftab *et al.*, 2021).

Further, in Kyrgyzstan, Central Asia, a study of intervention for supportive supervision by Marzia *et al.*, (2017), concluded that there was great improvement in patient care as a result of training of managers on supportive supervision. The managers' took up the role of supporting nursing staff better after training on SS as compared to when they had not been trained on this role.

In Uganda, a study done by Rachael et al, (2017) rated supportive supervision practice at 38% and recommended for further strategies to improve the competence. A study done in Kenya on factors contributing to nurse high turnover indicated that supportive supervision was incompetently and unsuccessfully done resulting in job discontent (Njoroge et al., 2019). In a study on identifying Kenyan health care providers' training needs at county level, supervisory skills were scored at 8% (Ministry of Health, 2015). Studies on nursing supportive supervision at the ward/section globally were very few while none was found in Kenya.

It was therefore important to identify the determining factors that influenced the practice of supportive supervision among Frontline Nurse Managers and address them for improvement of quality of health care and institutional efficiency.

1.2 Statement of the Problem

Supportive supervision practice at the ward/section level is one of the Frontline Nurse Managers' critical functions. It is a strategy that improves the performance of staff through effective evaluation and nurse manager –staff communication and support. Supportive supervision improves staff performance, retention and quality of care. Despite the fact that Frontline Nurse Managers' supervisory role being included in health institutions' policies, less is known about its practice at the ward/section level.

Globally, the SS practice is said to be a challenge caused by nurse managers' lack of supervisory knowledge and skills. Supportive supervision practice in the clinical area has been reported in many studies as an occurrence that takes place between the top-

level supervising the mid-level health institutions. This leaves out the nursing staff providing daily care inadequately or totally unsupported. Nurse Managers lack supervisory the knowledge and skills necessary for supportive supervision. The reason for this being that the health institutions either put no or less emphasis on lower- level managers' supervisory role.

While the practice of supportive supervision remains pivotal in the outcome of health facilities, the level of supportive supervision skills at county level was identified to be at 8% in Kenya (Ministry of Health, 2015). Lack of or ineffective supportive supervision is perceived as destructive supervision by the supervisees. Supportive supervision requires planning and setting of objectives to be achieved. In most cases, nurse managers find themselves short of time because of their competing roles and end up performing supportive supervision without proper preparation of themselves and that of the supervisees. Such exercise results in supervisees demotivation and the supervisors feeling unfulfilled (Madede *et al.,* 2017).

The study by Roets *et al.,* (2018), in Kenya identified supportive supervision as a gap in the improvement of quality of care at all levels of the health system. There were very few studies conducted on ward/section nurses' supportive supervision globally while none was found in Kenya. The researcher observed through a preliminary study that Frontline Nurse Managers at Thika level 5 Hospitals in Kiambu County had no documented evidence to indicate supportive supervision practice for their nursing staff. This study therefore intends to establish the effects of utilization of a structured supportive supervision tool among Frontline Nurse Managers at Thika level 5 Hospital.

1.3 Justification of the Study

Supportive supervision by the Frontline Nurse Managers improves the quality of patients' care and patients' satisfaction, nursing staff job fulfilment as well as their confidence. Nurse Managers who practice supportive supervision are able to attend to staff performance and patient safety issues and guide the practice to improve quality of nursing practice. Frontline Nurse Managers have many varying competing

responsibilities, which need to be scheduled or planned for them to be successful in their management roles.

Lack of effective SS has negative consequences such as high staff turnover, low morale and staff job dissatisfaction which result to poor patient outcome in health institutions. Notwithstanding the knowledge on the significance of supportive supervision many health institutions acknowledge the idea but continue to pay it diminutive consideration.

The study found very few studies on ward staff supportive supervision globally and of great concern, none was found in Kenya. This study's purpose was to determine level of SS practice and associated factors in the wards/sections. Identifying the Frontline Nurse Managers' supportive supervision to their staff and the challenges they face would provide knowledge and insight on this important component of ward nursing management.

Utilization of a structured tool ensures that SS practice is not only done but the Frontline Nurse Managers follow a standardized tool that enhances use of supervisory skills as well as keeping record of the SS activity and its achievement. The study aimed at improving status from that which was found at baseline survey through intervention. The intervention involved training on SS, and utilization of the W.H.O. SS structured tool.

It was hence imperative to determine and address factors contributing to Frontline Nurse Managers' supportive supervision practices. The baseline survey's findings guided the study in developing an intervention necessary to facilitate Frontline Nurse Managers in improving the quality of supportive supervision in their workplace.

Studies indicate that interventions such as training of nurse managers on SS improve SS practice (Aftab *et al.,* 2021). The study sought to improve supportive supervisory knowledge, skills and practice of Frontline Nurse Managers through use of a structured supportive supervision tool. Utilization of the structured SS tool by Frontline Nurse Managers improved quality of SS since it provided structure and evidence of SS practice. Frontline Nurse Managers are nursing in-charges of wards and sections in

hospitals responsible for supervision of day - to - day care of patients. Improved supportive supervision benefits health institution by improving staff motivation, job satisfaction, safe and quality patient care and patient satisfaction (Regan *et al.*, 2017).

Frontline Nurse Managers, their Nursing staff and Nursing Services Manager and deputy were chosen for the study population since they were considered to have the required information on the practice of SS in this study.

1.4 Research Questions

1. What is the level of supportive supervision practice among Frontline Nurse Managers at Thika Level 5 Hospital, Kiambu County, Kenya?
2. What are the individual factors associated with the supportive supervision practice among Frontline Nurse Managers at Thika Level 5 Hospital, Kiambu County, Kenya?
3. What are the institutional factors associated with supportive supervision practice among Frontline Nurse Managers at Thika Level 5 Hospital, Kiambu County, Kenya?
4. What intervention will the study develop to improve SS among Frontline Nurse Managers at Thika Level 5 Hospital?
5. What are the effects of training on utilization of a structured supportive supervision tool on supervision practice among Frontline Nurse Managers at Thika Level 5 Hospital in Kiambu County, Kenya?

1.5 Objectives of the Study

1.5.1 Broad Objective

To determine the effects of utilization of a structured tool on supportive supervision among nurses at Thika Level 5 Hospital, Kiambu County, Kenya.

1.5.2 Specific Objectives

1. To establish the level of supportive supervision practice among Frontline Nurse Managers at Thika Level 5 Hospital, Kiambu County, Kenya

2. To describe the individual factors associated with SS practice among Frontline Nurse Managers at TL5H, Kiambu County
3. To describe institutional factors associated with supportive supervision practice among Frontline Nurse Managers at TL5H, Kiambu County, Kenya
4. To develop an intervention to improve SS practice among Frontline Nurse Managers at TL5H
5. To evaluate the effects of training on utilization of a structured supportive supervision tool on supportive supervision practice among Frontline Nurse Managers at Thika Level 5 Hospital, Kiambu County, Kenya

1.6 Hypotheses

1.6.1 Null Hypothesis

Ho: There is no significant difference between Frontline Nurse Managers' supportive supervision practice at TL5H before and after training and implementation of structured SS tool

1.6.2 Alternative Hypothesis

Ha: There is a significant difference between Frontline Nurse Managers' supportive supervision practice at TL5H before and after training and implementation of structured SS tool

1.7 Scope of the Study

The study was conducted in one Level 5 hospital in the County of Kiambu County which is Thika Level 5 Hospital. The study population was all Frontline Nurse Managers and their deputies, nursing staff, of the respective wards and sections in the hospital and Nursing services Manager and deputy.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

The chapter looked at literature from studies conducted on supportive supervision in clinical area which is the working environment where nurses provide care and Frontline Nurse Managers provide supportive supervision (SS). A systematic literature search was done using Google Scholar, Medline and the CINAHL database. Peer reviewed journals were preferred for evidence based data. The chapter as well reviewed literature related to the study objectives. In this chapter, a theoretic framework was explained and conceptual framework outlined.

Supportive supervision is a process that improves the motivation and job-satisfaction of health care workers. The practice strengthens the rapport between supervisors and the supervisees, making it easier for them to work as a team. The good relationship builds an environment of trust that enables the supervisor and supervisee to agree on the goal and objectives of care (Barle *et al.*, 2016, as cited in *Global Health Science and practice,* 2022).

The supervisor assumes the role of a facilitator, providing the supervisee with the essential knowledge and skills to enhance the quality of supervisee's performance through training. Monitoring and appraisal of the staff performance, is decided on the bases of earlier set goals and objectives of care. The supervisor plans and schedules time for supportive supervision which the team is made aware of and feedback on their performance is communicated and discussed in a timely manner. Problems in individual performance identified during SS, forms the basis for training for the supervisee. This helps the workers to improve their performance, provide quality care, and prevents bad practice from becoming the tradition in clinical practice (Maryse *et al.,* 2018).

Supportive supervision has four components. The first component is establishing of supportive supervision system. This involves ensuring that supervisors receive

adequate training on the supportive supervisory techniques, and updated with the knowledge and skills of the practice. Appropriate tools for training and updating staff on knowledge and skills are availed. Checklist and forms for writing recommendations during the supervision process are made ready for the process.

Second component of SS involves planning. This becomes an integral part of the supervisors' roles. Schedules on when to do the SS are made, either on daily, weekly or fortnight bases. Finally objectives for SS are set in this second step. The third component is conducting SS. In this step data/information related to staff performance in the health care provision is collected. Problems are identified, and timely feedback and problems- solving strategies are provided here through on-the-job training. The fourth component involves follow-up after SS. In this step, actions that were agreed on during supervision are monitored to see if the staff corrected their mistakes in performance (W.H.O., 2008).

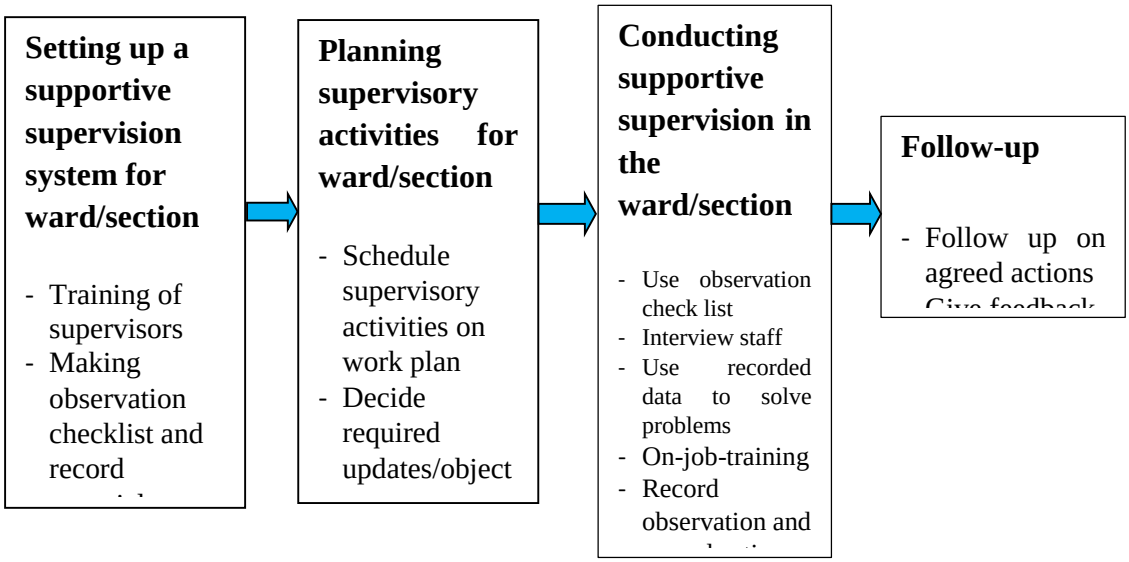

Figure 2.1: Supportive Supervision Structured Tool

Source: (W.H.O., 2008)

There are a number of factors associated with supportive supervision. Traditional supervision has been associated with the evaluation of staff performance, where supervisor's focus is on identifying mistakes and what has not been done. On the

contrary, SS focuses on facilitating the workers in improving their job. To achieve this, SS ensures that performance goals and objectives are set and agreed upon by both the supervisor and the supervisee based on standard procedures and guidelines. Monitoring of performance is done with the aim of identifying problems that workers face in order to solve them. Staff are empowered through positive feedback and on-the-job training to correct mistakes identified during SS. The supervisee and supervisor work together in decision-making, ensuring that set objectives are met and that standards and guidelines are followed (Ministry of Health, 2020).

Supportive supervision is known to build confidence, trust, and motivation to participate in the improvement of the quality of care. Timely feedback prevents bad practice from becoming routine, especially when internal SS is practiced. When SS is internally conducted, planning and scheduling are easier as it does not require funding; but rather the ward/section nurse managers do it as part of their routine responsibility (Avortri *et al.,* 2018).

The impact of supportive supervision provides a systematic way of identifying gaps in care provision among health care providers. Gaps identified are addressed through mutual understanding where supervisors are seen as facilitators of knowledge and skills to the staff, and not fault finders. The positive environment the supervisors create while carrying out the supervision enables the staff to appreciate the exercise rather than fear it. Both the supervisors and supervisees are objective and understand the purpose of the SS as a process that improves the standard of care as staff performance improves (Kisakye *et al.,* 2017).

Staff with poor attitudes and low performance grades in health service delivery are assisted to perform at their highest capacity through SS. This comes as result of accurate identification of practice gaps and on-job training by the supervisors. High-performing staff are motivated by positive results of their services and those being served gain confidence in the healthcare services provided (Anoke *et al,* 2021*).*

A study done by Purity *et al,* (2017) indicated that, training and empowering managers on their role of supportive supervision eases SS process. Knowledge and skills on use

of SS structured tools and guides have a great impact on managers' Supportive Supervision practices.

2.2 Supportive Supervision Practices

Supportive supervision in the clinical area has been recorded in many studies as an event that occurs between the top-level supervising and the mid-level health institutions. The activity is therefore aimed at helping the mid-level managers, but not directly at helping Frontline Nurse Manager in the ward or section. Supervisions are usually planned quarterly in a year. This leaves out the nursing staff providing daily care inadequately supported. Nurse Managers ought to have efficient mandatory supervisory knowledge and skills and if they don't, they inadequately provide SS to the workers under them (Avortriet *et al,* 2018). In most cases, the reason for nurse managers' inadequate SS practice is that, health institutions either put no or less emphasis on lower- level managers' supervisory role to their staff (Avortri *et al.*, 2018).

The ward/section Frontline Nurse Managers have many different competing responsibilities which need to be scheduled or planned if they are to be fruitful in their supervisory role. Ward/section Frontline Nurse Managers are answerable for health care outcomes such as the length of stay for clients, which implies on cost, staff job gratification and retention, quality of care as well as hospital processes that indicate its quality of output. It is therefore necessary for the top managers to clarify and emphasis the specific roles and responsibilities of ward and section Frontline Nurse Managers (Royal College of Nursing, 2016).

There are two main strategies of supportive supervision applied by majority of health systems globally. These include: external top-level supportive supervision and internal or ward/section supportive supervision. For the external top-level supportive supervision, top-level managers visit health facilities and conduct supportive supervision of the performance of the staff based on a schedule. The internal or ward/section supportive supervision is a continuous daily activity carried out by the immediate supervisor in the ward or section (*Onuka, et al,* 2015).

While both strategies are important, many studies have shown internal supportive supervision to have yielded better patient outcomes. This is because the supervisor and supervisee work and identify supportive supervision needs together. Staff learn and gets support in time before a practice of poor standards becomes a routine. The external supportive supervision has limitation of time and frequency since plans and schedules have to be made for the facility visits. Follow up of identified needs takes a long time and corrective measures agreed upon may not be timely evaluated (Onuka *et al*, 2015).

The supportive supervision practice is not an event to be carried out occasionally but a process. The process' goal is improvement staff performance. Standards of performance and desired goal are identified and agreed on. This forms the bases for monitoring and evaluation of the achievement of the agreed goal. Supportive supervision therefore requires gathering of information to inform decision making. The data collected informs the supervisor of the strength and weakness of the staff and areas that needs to be corrected. This is a systematic process that requires to be structured (W.H.O., 2008).

Health care workers in United State of America reported that they lacked supportive supervision from their managers which resulted in mental health issues. They reported that their supervisors did not engage them positively on work issues but rather they felt harassed. Health workers did not trust their managers' in-terms of getting guidance on their personal performance improvement (Nigam et al., 2023).

In a study done in Lebanon on health institutions' SS by Chami-Malaeb, (2021), the study established that SS eased nurses' burnout. Nurses reported that the supportive supervision they received from their managers was positive and it enhanced their personal efficacy in their work.

A study done in Mozambique reported that, the practice of SS is understated and where it was done, its focus had been inspection and not on support of workers' performance. The study further indicated that SS in most low-income countries is unsuccessfully done due to such factors like managers' competing roles and lack of time (Tavares *et al.*, 2017).

Time availability constraints SS in most clinical areas and where it is performed, it is insufficiently done. Coaching and mentorship is poorly considered and this attribute to limited technical capacity in the health care providers. Lack of SS guidelines make supportive supervision appear to be more clinical but less formal. This therefore results in facility-level SS not being directly about improving clinical competence of the practitioners in the care provision and quality. Coaching and mentorship towards enhanced health care workers' performance are reported to be rare. A review of annual and/or quarterly reports in Tanzania on supervision by Tumaini *et al.*, (2021) showed that SS is constrained by a shortage of resources, including supervisors, health care workers, and funds.

In Kenya research work done by Wamunyu, (2016) on health care providers' job fulfillment, the study found that top-level management supportive supervision practice was at 42.9% while at the lower level administration was at 40%. In a report on evaluation of training needs for health care providers by the Ministry of Health, it was established that supervision by the county health management team scored 8% as alleged by the lower level management (MOH, 2015).

2.3 Individual Factors Associated with Supportive Supervision Practice

There are a number of factors that are associated with SS. Knowledge and skills on how to conduct supportive supervision is key for supervisors. It is imperative for supervisors to be aware of their own gaps in supervisory skills so that they may seek training opportunities. Structure or schedule of SS is an important factor for supervisors if they desire to have effective SS. Staff and supervisors work as a team and SS does not happen as a surprise to supervisees. Collaborative setting of SS objectives enhances team work since both supervisors and supervisee have same knowledge on the expected performance of patient care. The supervisors' skills of teaching, appraisal, counselling and feedback are determinants of effective SS. The institutional support for SS and well laid down system of SS is an aspect that cannot be ignored. If the health institution fails to recognize the part played by SS in the quality of health care, there will not be resources to support SS (Avortri, *et al.*, 2018).

There are a number of factors that are thought to influence SS performance among nursing managers. Such factors are: the duration one has worked as a nurse manager, his/her age, gender, and position or rank held in the ward/section one had worked in. Other factors besides social characteristics influencing SS are; whether one has had training on managerial skills, and managers' staff ratio. Adequate staff establishment facilitates managers' to have time off patient workload and take managerial roles such as planning and conducting SS. Health institutions support on SS such as use of SS report to promote staff play part in encouraging SS practice by managers (Lu *et al.*, 2021).

2.3.1 Knowledge

Supportive supervision is a concept and a tool managers apply to facilitate staff to better their knowledge and skills in provision of care resulting in quality performance and job satisfaction. It should not be a one instant thing but an ongoing process and as thus demands that the managers take the responsibility of making it an individual responsibility and role for their daily work (W.H.O, 2008). Supportive supervision is one of the Nurse Managers' function and therefore an integral skill that every Frontline Nurse Manager should embrace in their daily plan of duty. However, support from institution's administration is needed for the Nurse Managers to execute this function (Sana, *et al.,* 2021).

To most of supervisors, monitoring and SS are one and the same thing which they carry out during their managerial roles. Supportive Supervision has been taken to mean patrolling staff to ensure they carry out their expected duties by pointing out the wrong rather than identifying performance gaps and training the staff to do it right. The process of supervision carried out by supervisors during supervision do not indicate the goal and objectives of SS but is more of inspection (Sana, *et al.,* 2021).

It is important for the Frontline Nurse Managers to realize that they are key to the achievement of ward/section's quality standard care and role models to their nursing staff. This calls for individual commitment to managerial knowledge and skills of which supervision is key among others (McKenna, 2018).

In a study done in USA on supportive leadership, inadequacy of Nurse Managers in inter-person communication skills was eminent. The nursing staff whom they supervised expressed dissatisfaction in the way decisions were made and expressed need for the managers to involve them. Communication with staff is key in supportive supervision since it is the only way the manager would ensure that staff understand the objectives of the care they provide. It is through good inter-person communication that the nurse manager would make the required performance standard known to the staff. Communication skill is key to the nurse manager in the performance of the task of effective SS and if this skill lacks, it results in ineffective evaluation and giving feedback to the staff. Thus poor communication results in poor patient outcomes as well as poor staff retention. Supervisors' attitude in supportive supervision counts in SS. Supervisors do not apply equity in staff development and as such, strained relation and make staff feel not valued. This create a distance between the supervisee and the supervisor (Dawson, 2014).

In Kenya, Wakaba *et al.,* (2014, as cited by Gathara et al., 2019), indicated that Frontline Nurse Managers are ill prepared for the managerial functions particularly in specialized care. This results in their inadequacy in supervision of the nursing staff working under them. However this study also noted that nursing council of Kenya has ensured that every nurse taking the registered nursing program (diploma and Bachelor of Science in Nursing) is trained on leadership and managerial skills.

2.3.2 Attitude Associated with Supportive Supervision Practice

Attitude toward work is a key factor affecting people work performance. This is about how people think about work. Attitude toward self, colleagues, workload, work ethics and policies may influence how one relates with colleagues and how one perceives work. Positive attitude results in good relationships and good work outcomes, while negative attitude give poor work performance (Cabrera & Estacio, 2022).

A study done in China on level of nurse supportive supervision indicated that, attitude toward work, and ratio of nurses to supervisors were part of influencing factor to SS (Lin et al., 2023). In South Africa, Frontline Nurse Managers found it easier to do

patient activities than the supervisory roles. This was an attitude that made majority of nurse managers not to engage with supervisory roles. The study further established that nurse managers used only 5% of their time in this role. Nurse Managers found themselves interrupted by other unplanned ward activities such as problem solving and attending to emergencies. These were as a result of lack of planning for supervisory role. Negative attitude towards supervision role resulted in nursing managers neglecting this role and function (Susan *et al.*, 2015).

In Mozambique, it was observed that Frontline Nurse Managers needed to keep a breast with the current knowledge on human management as well as evidence based patient care. The study further suggested that Frontline Nurse Managers require professional knowledge on the role of management as well as time management for them to be efficient in their function as supervisors. Most times nurse managers found themselves constrained with time and ended up not supervising staff for lack of time. Lack of knowledge and skills on their functions and responsibilities resulted in managers neglecting their duty of supervision. The study then suggested that Nurse Managers needed support to improve their knowledge on supervisory role in order to be effective in supportive supervision (Tavares, *et al.*, 2017).

Supportive supervision is negatively affected by attitude of supervisors. Many of supervisors lack commitment to the supervisory role blaming the multiple tasks of managers. Lack of time associated to increased workload and shortage of staff are reported as a barrier to SS (Sana, *et al*., 2021). Some supervisors complain that the SS role is demoralizing since it does not come with incentives such as salary increment. The supervisors see it as an added responsibility that need to be reward (Tumaini *et al.*, 2021).

In Kenya, Aruasa *et al.*, (2019), established that supervisors should establish working relationship with their staff in order to be effective in their role as supervisors. Supervisors that appreciate their staff are well received as they discussed challenges and expected performance with their staff. Respect for employee by supervisors as they provide feedback is considered as a positive attribute of effective supervisors while those who do not respect their staff are considered demotivating.

In conclusion, the individual factors contributing to effective SS are knowledge and skills on the role of supervision, respect for employees, and good relationship with supervisee. In addition, time management and positive attitude towards SS as part of the Nurse Manager's role and responsibility is important in SS. Nurse Managers' perception of patient care role being more important than managerial duties make nurse managers to give less priority to SS.

2.4 Institutional Factors Associated to Supportive Supervision Practice

Health institutions' policies influence supportive supervisions done by their Frontline Nurse Managers. The frequency and level of SS depends on whether the top management and the institution have strategized it as one of their strategies for improving quality care. In most cases, health institutions do not put demands for and, monitor SS of their staff (Marzia *et al*., 2017).

A study done in India indicated great improvement of quality care as a result of supportive supervision. The quality of care improved seven times compared to when supportive supervision lacked. The study concluded health institutions did not emphasis on supportive supervision because, it was perceived to be costly, required planning and that, it was time consuming (Sudharshini & Selvavinayagam, 2018).

Seer *et al*, (2015) in their study in England found that supportive supervision was a function that Nurse Managers were aware of but its implementation was met with challenges. The practice level was found to be at 42% for those who supervised their staff 5 days a week. Some of the ward managers did not know what data to link to supervisory role and therefore not able to accurately point out the findings of their supervisory activity. This made it difficult to make decision on the appropriate action towards the supervised staff. In addition, the staff shortage was identified as the greatest challenge facing supportive supervision practice among Nurse Managers which was sited at 88%. Beside institutional challenges, the nurse managers were found to lack supervisory skills as well as expertise knowledge.

Study done in Kyrgyzstan in Central Asia concluded that policy makers should be involved in monitoring SS by their managers for its effectiveness. This means that SS

should not be left to the individual managers to decide whether to perform it or not. It should be the responsibility of the policy makers to make sure that the concept is included in the institution policy and guidelines and executed in all levels of the organization. The frequency of supportive supervision practice need to be clear and also monitored (Marzia *et al.*, 2017).

Health institution are reported to lack clarity of supervisors' roles and responsibilities. Supervisors are not trained on supervisory skills that would enhance their SS performance. This leads to lack of clarity on the role and responsibilities of supervisors. Supervisors are faced with staff shortage where the patient workload cannot allow them to have time for SS (Sana, *et al*., 2021).

In England, Ward managers identified institutional factors such as lack of support by the hospital administration as barriers to their performing the role of supportive supervision. Part of the complaint and reason for not performing SS was that hospitals did not employ enough staff resulting in the nurse managers running wards with critical staff shortage. Staff shortage forced them to be involved in provision of care in most of their working hours while the little time left, they did critical administrative duties to ensure that the wards were running (Seers *et al.*, 2015).

Administration of institutions do not support the ward managers in training for improvement of their knowledge and skills on the role of supervision, and they do not communicate clearly concerning role expectations. Those institutions that provide administrative support are reported to have had a satisfactory supervisory functions. Effective SS in return results in good staff relation, retention of staff and, improves quality of patient care (Seers *et al.*, 2015).

In Ethiopia setbacks to supportive supervision were shortage of staff and lack of computers for keeping supervisory data. Having few staff made the supervisor do the daily activities of providing care just like his or her staff and therefore denying him/her time to do supervision. Lack of computers limited the data storage and analysis making supervisors inefficient in their follow up of supportive supervision. In addition, the study observed that supportive supervision was not scheduled and therefore not regularly performed (Avortri *et al.*, 2018).

Nurse Managers' encounter challenges in SS practice. Health institutions lack policies and guiding principle on how SS should be conducted. It is challenging for nursing managers to perform supportive supervision without a laid down policy and structured supportive supervision tools. Health institutions' that provide support nurse managers with SS resources and training on SS, they end up with improved support for nursing staff. An enabling atmosphere for managers, play an important role in nurse managers' SS practice. Administrators of institutions should provide adequate human resource so that nurse managers get time for SS practice (Henry *et al.,* 2023).

A study done in Tanzania on factors and barriers of SS reported that health institutions lack vibrant policies on supportive supervision and also suffer from deficiency of resources, as well as Council of Health management Team supervisors, health staff, and funds (Tumaini *et al*., 2021).

A study on job satisfaction in Kenya reported that top-down approach of communication used by their supervisors created a gap between them and the supervisee. Top-down communication make feedback to be received negatively and as a result, the expected improvement on staff performance does not happen (Aruasa *et al.,* 2019).

Supportive supervision in institutions or department should be formal for it to yield desired outcome. For supportive supervision to take place, someone should take responsibility for the task. As a matter of fact, supportive supervision is a process and not a single activity, and therefore, it should have a goal and desired outcome that must be measurable. Supportive supervision entails managers guiding, assisting and training staff on set standards of care in order to improve on their performance and achieve high quality care services. Most of the times Nurse Managers working in health institutions unfortunately lack knowledge and skills on how to carry out the SS process (McKenna, 2018).

Supportive supervision is an important role of Nurse Manager in the pursuance of quality care provision. This improves the performance of nurses and student nurses and makes the manager visible as they guide patient care. The manager is viewed as a

team leader and interacts with the staff individually or conducts meeting to share the expected standards of performance with the team (McKenna, 2018).

Supportive supervision main objective is monitoring performance of workers by means of using data collected from individual staff performance. The data is used for decision making and as reference point for follow up. The practice of supportive supervision should be regular and not a response to crisis. Supportive supervision enables managers to create and improve working environment which increase the workers morale and job satisfaction which results in improved quality of care. Health institutions should support SS practice (Ifeoluwapo, 2018).

Literature review analysis done on supportive supervision in South of Sahara countries, it was established that in majority of health facilities, supportive supervision was periodic and was done by external supervisors. The supervisory visits were made by senior supervisors stationed in the administrative health offices who planned the visits periodically. The aim of those supportive supervisions was to improve quality of care. The studies showed that most of the supervisory visits and programs were sponsored by non-governmental organizations and after their withdrawal, the programs collapsed. This meant that though supportive supervision yielded good results in terms of quality of patient care, it was short lived and not sustainable in these countries. This literature analysis suggested change of strategy from external to internal supportive supervision and from periodic to continuous supportive supervision supported by the health institutions rather than external support for sustainability (Avortri*et al.*, 2018).

According to a study by Cheburet & Otieno (2016), supportive supervision practice has been a function of the top-level managers of which they carried out twice or once per year. The supervisory practice was external since the supervisors come from the County health offices. The feedback to the supervisees was not timely and therefore making it difficult to implement the recommendations made. There was no in-site supervision.

2.5 Effects of Training on Utilization of Structured Supportive Supervision Tool on SS Practice

Structured supportive supervision is characterized by setting of a SS system whereby an institution puts in place strategies, schedules, SS guidelines and tools. In a study done on support for managers by training and introduction of supportive supervision system, it was established that, managers improved on their role of supervision of their staff by notable changes such as keeping record of staff files and job descriptions. The study noted job-satisfaction for managers, easier time in supporting and supervising staff as well as improvement on time saving (Purity *et al.*, 2017).

Supporting of managers by training on the skills of supportive supervision, is identified as a tool that improves managers' organizational commitment and their job satisfaction. Training managers on SS makes them knowledgeable and make them appreciate the importance of SS on their staff. Health organization benefits from training managers on SS since managers perceive the organization's support and in return, get committed to the organization (Muhammad *et al.*, 2019).

Supervision training for managers' change attitude and approach towards supervision from that of autocratic controller in nature to one of a mentor. The objective for supervision changes from that of checking whether staff have done it right to that of identification of performance gaps that need to be resolved by on-job training to improve staff performance. Managers improve on frequency of supervision of their staff after gaining knowledge and skills and understanding the purpose for SS (Karuga et al., 2019).

Training of supervisors on knowledge and skills of supportive supervision needs to be coupled with a SS system for it to be effective. Supportive supervision system provides the management with a standard to check the performance of the managers' supervisory role. To set up a SS system is the responsibility of the institution or government. A report from MOH Tanzania, (2022) indicated the impact an SS system which resulted in improvement of SS among hospital and nursing managers.

The setting of the SS system promote accountability in the performance of SS as well as increase in SS performance by the supervisors in the health institutions. Managers trained on the use of SS tools improve on use of data to give feedback and increase in their documentation of their SS activities. The SS system evaluation after establishing SS system indicated that, the supervisors improved on use of SS tools such as observation checklist during supportive supervision; which gave them objectivity in their SS practice (MOH Tanzania, 2022).

2.6 Summary and Research Gaps

Literature on supportive supervision has shown that nurse managers have deficiencies in knowledge and skills on the SS. Studies across different nations have shown that supportive supervision practice is ineffectively done and is affected by institutional factors such as lack of policy on the role of Frontline Nurse Managers and shortage of nursing staff.

Literature gaps identified in SS, globally and regionally are that studies have showed that there is little available information on structured SS for Frontline Nurse Managers' SS practice (that is nurses managing wards and sections in hospitals). Supportive Supervision monitoring and evaluation is not sufficient. Information available on SS is about external SS where the top management from high level health management system supervises the lower level facilitates. There is little information on nursing supportive supervision and how it is carried out.

2.7 Theoretical Framework

Theoretical framework is defined as a guide to a study. The researcher makes use of theories that explains the unique problem under investigation. It shows the road map of the study from definition to the design of the study and how certain concepts of the study relate. Theoretical framework serves as a guide to the researcher in finding the right choice of data to be collected, the tool and how it is analyzed (Joe *et al.*, 2018). This study was guided by the Lewin (1951), Change theory and Humanistic Nursing Theory by Josephine Paterson and Loretta Zderad developed in the 1960s.

Lewin, (1951), change theory describes situation where there is desired level of performance and the actual. The theory explains that one has to identify two types of forces; the driving and the constraining forces. The driving forces are the positive strengths that pushes one to the right direction while constrain forces are the draw backs. For change to take place, one has to take into account the desired direction, identify what is required to push him/her to the desired direct and analyze information acquired in order to make decision on how to overcome constrains for the change to occur. The theory has three steps namely unfreezing, change and refreezing. Lewin used the analogy of ice block and the changes it under goes to change to a cone of ice. In this stage, the individual or institution that desire change has to come to the realization of the need to change. The institution makes people aware of the required change and reason for the change from what they are used to the new desired behavior. Since there is no change that comes easy, the institution applies motivational methods to cause the workers to adjust and embrace the transition (unfreeze). The second stage is the change step. In this stage, members of the institution implement the new adopted behavior. This stage is faced with uncertainty about how to do things in the new way and members need a lot of support. The last step is the refreezing. In this step, people accept the new way of working or behavior. People get established and make the new behavior their way of doing things. In this stage the new practice is translated into a policy (Burnes, 2004).

Application of this theory in this study is that the researcher identified the practice of SS and factors that influence supportive supervision either positively or negatively and analyzed. After understanding the constraining forces and driving forces, the researcher planed for intervention to reduce the constraining forces and have the desired change of behavior established. Participants were made aware of the need for change through training on SS and provision of support on implementing the new SS structured tool.

The second theory that helped in designing and planning this study is Humanistic Nursing theory by Josephine Paterson and Loretta Zderad developed in the 1960s. These theorists focused on interpersonal relationship that improves quality of patient care among nurses. They explained that for nursing interventional strategies to be

effective, there has to be an understanding between nurse colleagues and understanding between nurse and patients. The leader has to seek to understand their own world view and that of the colleagues or patients (Norwich University, 2017).

The theory has four major components: person, nursing, health, and environment. For the person, the theorists believed that each person is unique and should be treated according to their unique experiences. This calls for the nurse managers understanding of their nursing staff and patients under them. For nursing, the theory explains that nursing education should focus on both knowledge and clinical experience. The clinical experience being the relationship between colleagues and that one of the nurse to patient. The third component involves health. This theory looks at health as an essential component in human life. Nursing is perceived by this theory as a profession that has health as its goal of existence. The fourth component is environment. This represent time and space in which nursing experiences take place. This theory focuses on existential and phenomenological of the nursing experience (Norwich University, 2017).

Application of this theory in this study is that dialogue and understanding of personal experience and that of the staff being supervised is important. The study sought to understand the view and experiences of the Nurse Managers in relation to SS of their staff. Gaps identified informed the study intervention.

2.8 Conceptual Framework

Conceptual framework is a diagrammatical expression of the research progression and presents the researcher's ideas on how to explore the problem under investigation. It further explains how the various variables and concepts in the study relate to each other (Joe *et al.,* 2018).

In this study, the researcher explored the current status of supportive supervision practice and the associated factors as evidenced in the empirical studies. The study explored the practice of supportive supervision and both individual and institutional influencing factors among Frontline Nurse Managers at Thika Level 5 Hospital. After baseline survey, the study introduced an intervention based on identified gaps. The

intervention involved training on supportive supervision and providing customized structured SS tool to improve on SS practice among Frontline Nurse Managers at Thika Level 5 hospital. The outcome of the intervention was evaluated after the utilization of the structured SS tool by the Frontline Nurse Managers in this same hospital.

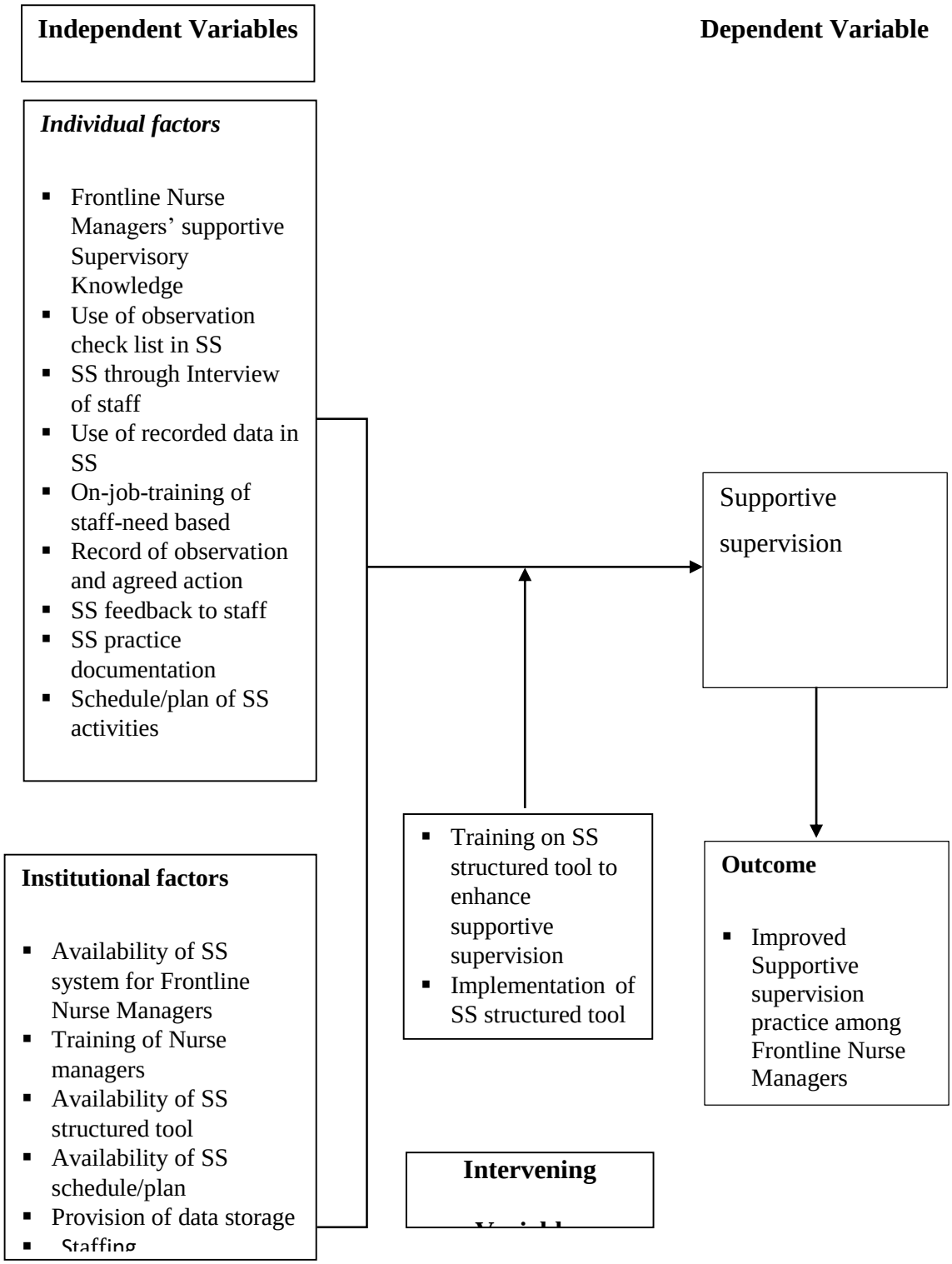

Figure 2.2: Conceptual Framework

CHAPTER THREE

METHODOLOGY

3.1 Introduction

This chapter entails the systematic methods that the study applied in order to investigate the study problem as well as the strategies that were put in place for intervention in order to achieve the study objectives. The chapter described the study area, study design applied, sampling and data collection procedures. The techniques and tools of data collection, data analysis and how data was presented was discussed in this chapter.

3.2 Research Design

Research design is defined as the framework that explains how a study is carried out. It serves the purpose of a guide for the researcher, as it gives the direction the study follows in order to achieve the study's objectives (Kassu, 2019).

The study applied concurrent triangulation mixed method. The quantitative approach applied quasi experimental pretest—posttest design. This design was applied for both baseline survey and post intervention evaluation survey. Baseline survey served as the pretest and the post interventional evaluation survey served as posttest. Qualitative approach applied phenomenological design. All data was collected concurrently baseline and. The mixed concurrent triangulation method was chosen because it allows both quantitative and phenomenological data to be collected giving enriching information about the researcher problem (Creswell & Plano Clark, 2017).

The study had baseline survey phase and interventional phase. Phase I involved baseline survey where concurrent triangulation design was applied. Quantitative and qualitative research designs were applied to collect data for triangulation. Data from this phase informed study intervention in phase III of the study. Phase III was intervention and evaluation of the effects of intervention. Quasi experimental (pretest-posttest one group) research designs was applied after study intervention. The intervention took three months (training and implementing SS tool) after which an

evaluation of the effects of the intervention was carried out to test the study hypotheses. The quantitative data that was collected at baseline survey was used as pre-test data. The same participants who took the pre-test were the same who took the post-test after intervention. The pretest-posttest being the baseline and evaluation surveys respectively.

3.3 Study Plan

The study had three phases. Phase I was a baseline study to establish the level of supportive supervision practice among Frontline Nurse Managers and factors associated with SS practice at Thika Level 5 Hospital. This answered study objectives: one to three. In phase II the study customized World Health Organization (W.H.O.) structured supportive supervision tool for Mid-Level Managers (MLM) to adopt it for Frontline Nurse Managers and implementation of it by the Frontline Nurse Managers.

There were no structural changes made in the W.H.O. MLM tool apart from adopting it to Frontline Nurse Managers' supportive supervision use. The process of adopting a tool as defined by W.H.O required a number of considerations. There had to be involvement of stakeholders, where the tool was to be used. The stakeholders' involvement involved carrying out discussions between the person adopting the tool (in this case the researcher) and the intended users; that is Thika Level 5 hospital Nursing department. Discussions were based on issues concerning the usefulness of the tool. The discussions described the intended users, what needed to be changed in order to fit the purpose for which it was intended to serve, and how it was to be implemented once adopted (W.H.O. Toolkit, 2024).

After the baseline survey, the study results were disseminated to the Nursing services Manager and deputy. The results indicated that: the hospital had no supportive supervision system, and that there was no structured SS tool. Lack of structured SS tool and SS system influenced SS practice of the hospital Frontline Nurse Managers.

In the first step, the researcher presented the structured SS tool to stakeholders that were: Thika Level 5 Hospital Nursing Services Manager and deputy where discussion on the tool was done. Purpose of the tool was discussed. The researcher explained

how to use the tool. The stakeholders and researcher checked the relevance of the structured SS tool and whether it could serve the hospital SS needs for the Frontline Nurse Managers in their function of supportive supervision. The discussion was productive and the stakeholders embraced the tool.

The second step involved discussion of the content in W.H.O. structured SS tool. The stakeholders suggested the areas in the context of SS tool that required to be customized to the purpose of supportive supervision of hospital wards/sections' nursing staff. The researcher adjusted the tool to customize it to the hospital wards/sections' SS purpose as suggested in the stakeholders' discussion. Such changes were; changing from mid-level managers' approach to ward/section managers' approach and changing from periodic schedule to daily schedule approach. This was because ward/section staff need support on daily basis as they provide nursing care services to clients. The study included views from a second set of stakeholders. These were three university faculty members that teach in the department of nursing leadership and management. They contributed in making the content of the tool clearer in terms of objectivity. Contributions suggested by all stakeholders were used to come up with a customized structured SS tool fit for ward/sections' supportive supervision suitable for use by Frontline Nurse Managers.

The third step of adopting the tool was about making decision on how the tool was to be implemented. The researcher with the stakeholders from TL5H held discussion on implementation plan. It was agreed that training of the Frontline Nurse Managers on SS and how to use the structured SS tool be done and thereafter, the researcher to support the Frontline Nurse Managers in its implementation. The implementation took three months after which, an evaluation of the impact of the utilization of the structured SS tool was conducted. The researcher carried out one day training on SS and utilization of structured SS tool. The researcher supported the Frontline Nurse Managers in utilization of the structured tool for three months.

The study applied Cohen's and Fleiss's Kappa Statistics to determine the agreement level among the three university faculty members. The SS structured tool had 4 components: setting of SS system, planning/scheduling SS activities, conducting SS

and follow-up. The experts were asked to give their opinion on how much they agreed on the objectivity of the tool in terms of SS content. The experts rated the components' objectivity using Likert scale of 1-5 where 5 indicated most objective and 1 least objective. Fleiss's Kappa Statistics for overall agreement was 0.789 which indicates substantial agreement. This means that the three experts were in agreement concerning most of the content of the SS tool.

Table 3.1: Substantial Agreement Experts

Variables	Expert 1	Expert 2	Expert 3
Setting of SS system	4	4	4
Planning/scheduling SS activities	5	5	5
Providing resources	4	4	4
Conduction SS	4	4	4
Feedback after SS	4	4	4
Follow-up	3	3	3

Table 3.2 Fleiss's Kappa Statistics

Overall Agreement						
	Kappa	Asymptotic			Asymptotic 95% Confidence Interval	
		Standard Error	Z	Sig.	Lower Bound	Upper Bound
Overall Agreement	.798	.126	6.322	.000	.790	.806

Phase III of the study involved evaluation of the effects of utilization of the customized structured SS tool on Frontline Nurse Managers' SS practice. The researcher administered same questionnaire that was administered at baseline survey to Frontline Nurse Managers and results for both baseline and post intervention surveys were compared. Study hypothesis was tested. This answered study objective number four.

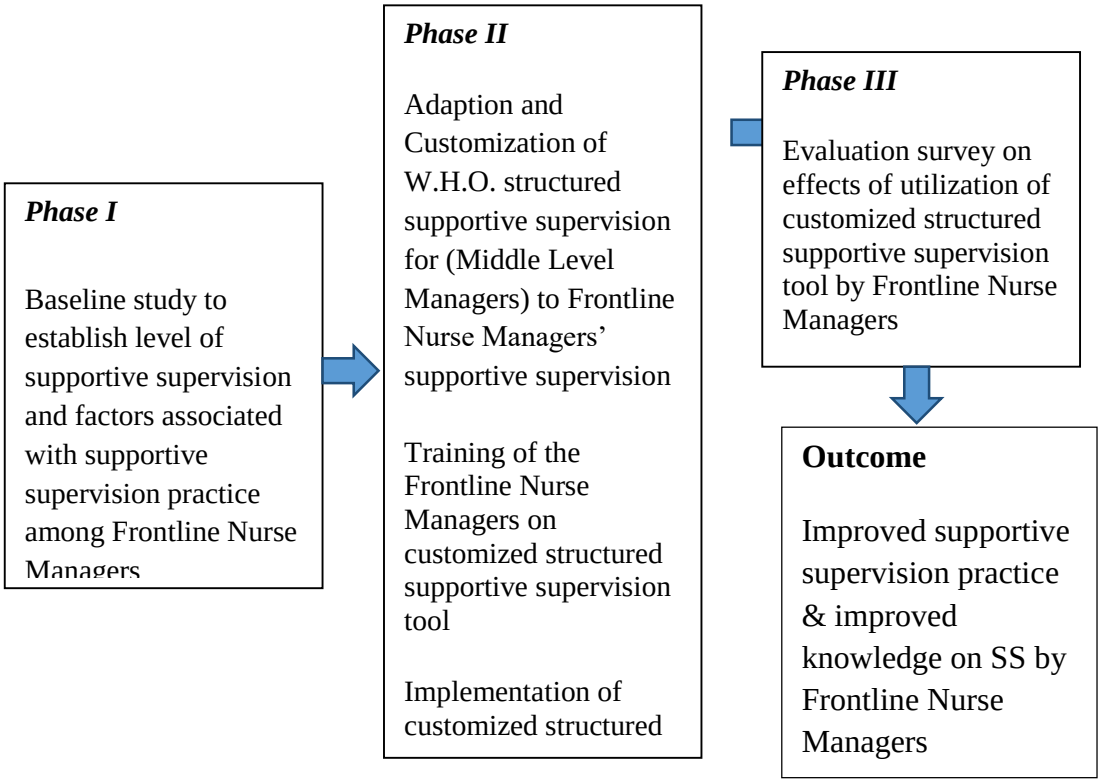

Figure 3.1: Study Plan

3.4 Study Area

The study was done at Thika Level 5 Hospital in Kiambu County, which is in Central region of Kenya. This county has a population of approximately 2.4 million as per 2019 Kenya Population and Housing Census. Thika Level 5 Hospital is a government facility and is one of the Kiambu County referral and training Hospitals. It is within Thika town approximately 40 Kilometers from Nairobi. Annual workload is about 350,000 patients seen as outpatient and approximately 20,000 inpatients (Macharia *et al*., 2017). Catchment population is about 3.5 million people. Total health workers are about 460. The hospital has approximately 228 nurses and having bed capacity of 265 (Onyambu *et al.*, 2016).

Nursing administrative is headed by Nursing Services Manager with one deputy. Under them are twenty Frontline Nurse Managers managing wards/sections with each having one deputy (figure 3.4).

Department of Nursing in this hospital has 4 units namely: Out-patient, Medical, Surgical, and Reproductive health. Under these units are wards and sections which are headed by Frontline Nurse Managers. Thika Level 5 Hospital was preferred because of workload and specialization which is more than other Level 5 Hospitals in the county (Table 3.1).

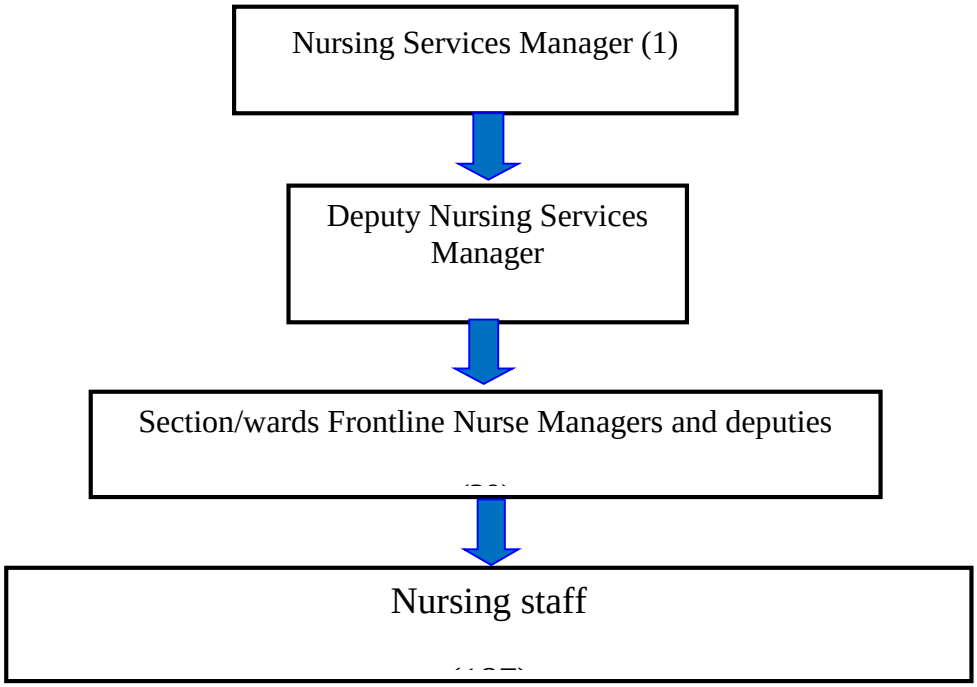

Figure 3.2: Nursing Administrative Structure

Table 3.3: Hospital Nursing Units

S.No.	Unit Name	Number of Nurses	Number of Nursing services Manager, Nursing services Deputy Manager and Frontline Nurse Managers and deputies	Total
1	Administration		2	2
2	Outpatient unit ccc, OP, and Renal	20	6	26
3	Medical unit: (WD 4 & 5 PAED, ICU, EYE- ENT)	50	11	61
4	Surgical unit: 2 Theatres, WD 1&2, casualty	57	12	69
5	Reproductive Health Unit: MCH, Antenatal, Postnatal, Labour Ward, New Born Unit and ward 6	60	10	70
	Total	**187**	**41**	**228**

3.5 Study Population

The study population involved: the Nursing Services Manager, Frontline Nurse Managers and deputies and nurses working under them at Thika Level 5 Hospital.

3.6 Sample Size Determination

3.6.1 Sample size for Nursing Services Manager, Frontline Nurse Managers and Deputies

Sample size determination for Frontline Nurse Managers and Nursing Services Manager and deputies was by census since they were less than 200.

3.6.2 Sample Size for Nursing Staff

The study used Yamane (1967) formula to calculate sample sizes.

With 95% confidence level

P = 0.5

$$n = \frac{N}{1 + N(e)^2}$$

Where:

n = is the sample size

N = is the population size

e = is the level of precision

N = 187

e = 0.05

$$n = \frac{187}{1 + 187(0.05 \times 0.05)} = 127$$

3.7 Inclusion and Exclusion Criteria

3.7.1 Inclusion Criteria

The study included nurses at TL5H who were on permanent or on contract for more than one year and consented to be in the study.

3.7.2 Exclusion Criteria

The study excluded nurses at TL5H that were on internship

3.8 Sampling Procedure

Census sampling method was used to sample all the Frontline Nurse Managers and Nursing Services Manager and deputies since their number was less than 200. For focused group discussions (FGD), the study applied purposive sampling method to sample Frontline Nurse Managers. The researcher picked 20 study participants to represent all the units by purposive method and conducted two FGDs each having 10 participants. Recommended number of participants per GGD being 8-12 (WHO, 2020). For Key Informant Interviews, the study applied purposive sampling method to sample Nursing Services Manager and Deputy.

For the nursing staff, the study applied stratified random sampling method. The nursing department was stratified into 4 strata (4 units) and weighted. Simple random

sampling was used to sample nurses per each stratum. All samples from the strata were added to make the study sample (table 3.4).

Table 3.4: Sample Size for Nurses

S/No.	Units	Number of Nurses	Weighting	Sample size
1.	Outpatient	20	$20/187 \times 127$	14
2.	Medical Unit	50	$50/187 \times 127$	34
3.	Surgical Unit	57	$57/187 \times 127$	39
4.	Reproductive Unit	60	$60/187 \times 127$	41
	Total	**187**		**127**

3.9 Data Collection Tools

The study used mixed methods for data collection. For quantitative data, a self-administered semi-structured questionnaire was used. Observation checklist based on World Health Organization Supportive Supervision indicators was used to collect quantitative data from Frontline Nurse Mangers' practice of SS. Wathorn effect control was achieved since the study had no threats on participants' performance and the idea was quite new. Rating/score of each individual item on the observation check list was adopted from performance management guide for supervisors by Montgomery County Maryland (2023). This rating had five categories as follows: outstanding, above expectation, meets expectations, below expectation and does not meet expectations. Rating was indicated by scoring the items on the scale of 1 to 5; 5 being the outstanding and 1 being does not meet expectations. For qualitative data, the study conducted two FGDs consisting of Frontline Nurse Managers and deputies. The wards and sections were 20 and therefore the study formed two groups FGDs of 10 members each. The rationale for the two FGDs was because of divisibility of 20 participants which fitted better in 10s rather in other lesser numbers (when divided by 3 or 4). For Key Informants Interviews consisted of Nursing services Manager (NSM) and deputy to collect in-depth data.

3.10 Validity and Reliability of Study Tools

Validity in research refers to whether study tools measures what they are intended to measure and if a study accurately assesses what it intends to (truthfulness), while

reliability checks if results are consistent and repeatable under the same conditions that is whether there is consistency in results from research tools (Ahmed & Ishtiaq, 2021).

3.10.1 Validity of Study Tools

The researcher carried out a pre-test of the study questionnaire at Kiambu Level 5 Hospital (KL5H) to test for validity. The researcher pre-tested questionnaire's validity on (10% of study sample) the Frontline Nurse Managers and nursing staff working at KL5H. This population was assumed to be similar to the study population since both institution are government Level 5 Hospital facilities with minimal differences in terms of nursing staff and working structure. The pre-test tested whether the tool could collect the intended data. Concerns raised by the pre-test participants about contents, incompleteness and meaning of terms in the questionnaire were picked and corrected. This addressed the issue of trustworthiness and dependability of the data collection tool.

3.10.2 Reliability of the Study Tools

The researcher carried out a pre-test of the study questionnaire at Kiambu Level 5 Hospital (KL5H) to test for reliability. The researcher tested questionnaire reliability on (10% of study sample) the Frontline Nurse Managers and nursing staff working at KL5H. This tested whether the tool could collect the same information consistently. Cronbach's Alphas was 0.875 for most of the variables, an indication of consistence in the study participants' response as indicated in the table below (table 3.3).

Table 3.5: Cronbach's Alphas

Variables	Number of items	Cronbach's Alpha	Remarks
Level of SS practice	4	0.875	Acceptable
Individual factors	4	0.815	Acceptable
Institutional factors	4	0.875	Acceptable

3.11 Data Collection Procedure

The researcher introduced the study to the study participant and requested them to sign informed consent form if they agree to participate. For quantitative data, the Frontline

Nurse Managers and Nursing Staff were given self-administered questionnaires to fill and submit. An observation checklist was used to observe SS documentation by Frontline Nurse Managers in their respective wards/section. Data from nursing staff added more insight about the SS practice. This data answered study objectives 1-3

For qualitative data the researcher conducted two FGDs of purposively picked Frontline Nurse Managers. Key Informant Interviews were carried out on Nursing Services Manager and deputy to collect in-depth information. The discussions were recorded in audio recorder. This answered study objectives one to three.

To answer objective four, the study collected quantitative data from Frontline Nurse Managers and their deputies through self-administered questionnaire and observation checklist after training of Frontline Nurse Managers on SS and on utilization of structured SS tool.

3.12 Data Analysis

Data collected was scanned through to check for typing errors, validation of data in line with the research questions, incompleteness and accuracy of information. Open ended questions and interview notes were edited for grammar, completeness and then coded ready for entry into the computer. Data was entered into a computer after editing and coding and stored ready for analysis. The study used mixed methods to analyze data. The Statistical Package for Social Sciences (SPSS) version 25 was used for quantitative data analysis. Data analysis for baseline survey for quantitative data was conducted using descriptive statistic. Inferential statistics were used to determine the relationship between the practice level and the associated individual and institutional factors pre and post intervention. Qualitative data was analyzed using content analysis through Nvivo version 12 software and data organized into narrations per the objectives.

The analysis of post intervention data was done using both descriptive and inferential statistics. Descriptive analysis indicated the level of practice of SS before and after intervention. Inferential statistics applied chi-squire and paired t-test to determine the effect of the intervention by testing the hypothesis.

Presentation of the quantitative data was done by use of frequency tables, pie-charts and graphs. Qualitative data was presented through narratives as per the objectives.

3.13 Study Variables

Independent variables: the study independent variables were Frontline Nurse Managers' knowledge on SS. The study sought to identify gaps in knowledge concerning what SS is and process of SS as well as knowledge of SS tools. The study also sought to determine Frontline Nurse Managers' level of practice of SS through an observation checklist which checked for evidence of recorded SS activities in the wards/sections. The other independent variable beside Frontline Nurse Managers' factors that the study checked was the institutional factors. The study sought to know whether the hospital provided the Frontline Nurse Managers with SS schedule and SS tools. The study also determined the institutional support of Frontline Nurse Managers on SS training.

Intervening variables: the study carried an intervention after the baseline survey findings which indicated Frontline Nurse Managers' gap in knowledge and practice of SS. The intervention involved training Frontline Nurse Managers and nursing services Manager on SS and SS structured tools use.

Dependent variables: the study's dependent variable was supportive supervision practice. The study determined the level of SS practice by the Frontline Nurse Managers which was found to be at zero. The outcome after intervention showed improvement on knowledge and practice with *p value of 0.001*.

3.14 Ethical Considerations

Ethical approval and permit were sought from Jomo Kenyatta University of Agriculture and Technology Research and ethics Committee (reference number JKU/IERC/02316/0532) and National Commission for Science Technology and Innovation (NACOSTI/P/22/18086) respectively. Approval to collect data was sought from Kiambu County (Ref. No.: KIAMBU/HRDU/22/07/26/RA_WAWERU) and Thika Level 5 Hospital (reference number MOH/THKAGEN/VOL.V/704).

Study participants were requested to give informed consent by signing and no names were written to ensure confidentiality and anonymous of the information collected. The reason for the study was explained and participants assured that they could choose to remain or leave the study at will without victimization. The study participants were assured that the information collected would be used for academic purpose and was not to be used against them. The study participants were not exposed to any risks or discomfort. There were no direct benefits to the study participants.

3.15 Study Assumptions

The study assumed that the study participants would give genuine information about the state of supportive supervision and that they would be positive to take the training and implement the knowledge acquired to improve quality of care in the hospital.

3.16 Study Limitations

The study involved only one level 5 hospital in Kiambu County because of time and resource limitation. The study could have been done in many county hospitals for generalization purpose in order to benefit more hospitals in Kenya. The findings of the evaluation of effects of the intervention showed an improvement of SS practice by 50%. This was because, though the nursing services Manager and deputy supported the study, it was difficult to influence the appreciation of the implementation of a new tool and new way of SS to their Frontline Nurse Managers without support of the institution.

Response rate for the study was the, 39 out of 39 for Frontline Nurse Managers, making a 100% and Nursing staff, 90 out of 127 making a 70.9%. The participants were issued with the questionnaires, filled and returned. The Frontline Nurse Managers' issuing of questionnaires was not complicated since their shifts were the same, which is morning to evening with exception of a few odd shift hospital covering. Nursing staff shifts were complicated since their shifts were three: morning, afternoon and night and one had to time them for administering of the questionnaire and return.

CHAPTER FOUR

STUDY FINDINGS

4.1 Introduction

Study findings is a significant section of any research since it demonstrates the key results that answers the study purpose (Kumar, 2022). This chapter presents research results as per the study objectives. The study main target population was Frontline Nurse Managers and their deputies. In addition, the study sought further information on SS from nursing staff and Nursing services Manager and deputy. The study sample size for nursing staff was 127, for ward/section Frontline Nurse Managers and deputies 39, and Hospital Nursing Services Manager and deputy were 2. For the Frontline Nurse Managers, 39 out of 39 were issued with the questionnaires, filled and returned, making a 100% response rate. For the questionnaires issued to the Nursing staff, 90 out of 127 were filled and returned making a 70.9% response rate. The response rate for both was satisfactory to make conclusions for the study. Weisberg, *et al.*, (2006) recommended a response rate of 70%. According to Mugenda and Mugenda (2008), a response rate of 50 percent is adequate for analysis and reporting; a response rate of 60 percent is good and a response rate of 70 percent and over is excellent. Based on the assertion, the response rate for the Frontline Nursing Managers was considered to be excellent while that of the nursing staff was adequate to make conclusions on the study on utilization of structured SS tool on supportive supervision among Frontline Nurse Managers at the Thika level 5 hospital in Kiambu County, Kenya.

4.2 Social Demographic Characteristics of the Frontline Nurse Managers and Nursing Staff

The study findings on socio-demographic characteristics for the Frontline Nurse Managers and their deputies were presented in the same table while those for nursing staff were presented in a different table.

4.2.1 Social-Demographic Characteristics of Frontline Nurse Managers and Deputies

The study sought to establish the socio-demographic characteristics of Frontline Nurse Managers at the Thika level 5 Hospital in Kiambu County. The socio-demographic characteristics of the study respondents included their level of education, gender, age bracket, section/ward of operation and the length of time they had worked in the section/ward.

From the analysis of the findings, the study established that most of the study respondents (n=21, 53.8%) indicated that they had diploma as their highest level of education. This was followed by (n=14, 35.9%) who indicate that they had a degree as their highest level of education. The study also established that (n=4, 10.3%) of the study respondents indicated that they had a master's degree as their highest level of education. Most of the study respondents (n=34, 87.2 %) were females while males were (n=5, 12.8%).

The study showed that (n=17, 43.6%) of the study respondents indicated they were between 41 and 50 years of age, closely followed by (n=14, 35.9%) who indicated that they were between 51 to 60 years old. The study established that (n=7, 17.9 %) of the study respondents indicated that they were between 31 and 40 years old, while (n=1, 2.6%) of the study respondents indicated he/she was between 21 and 30 years old. The section that had majority of Frontline Nurse Managers was Surgical unit (n=19, 48.7%) followed by Reproductive Health Unit (RHU) with (n=9, 23.1%); while the section with the least was Out-Patient Department (OPD) with (n=2, 5.1%). For the length of time one had worked in the current ward/section, (n=20, 51.3%) of the study respondents indicated that they had worked for a period between 0-2 years while (n=7, 17.6 %) indicated that they had been in the current section/ward for more than 9 years. The analysis results are indicated in the Table 4.1 below.

Table 4.1: Socio-Demographic Characteristics of the Frontline Nurse Managers

Variables	Category	Frequency (n)	Percentage (%)
Level of education	Diploma	21	53.8
	Degree	14	35.9
	Masters	4	10.3
	Total	**39**	**100**
Gender	Male	5	12.8
	Female	34	87.2
	Total	**39**	**100**
Age (years)	21-30	1	2.6
	31-40	7	17.9
	41-50	17	43.6
	51-60	14	35.9
	Total	**39**	**100**
Number of Frontline Nurse Managers per department	Surgical	19	48.7
	Medical	6	15.4
	OPD	2	5.1
	RHU	9	23.1
	RenaL/ICU	3	7.7
	Total	**39**	**100**
Length of time worked in ward/section	0-2 yrs	20	51.3
	3-5 yrs	9	23.1
	6-8 yrs	3	8.0
	Above 9	7	17.6
	Total	**39**	**100**

4.2.2 Demographic Characteristics of Nursing Staff

The total questionnaires return was 90 out of 127 (70.9%). Age bracket, education level and time worked in the ward/section were among socio-demographic characteristics that were analyzed. The results were as follows; majority of study respondents were between the age bracket of 31-40 years (n=27, 30 %), while the age bracket with the least respondents was between 51- 60 years (n=16, 17.8%). Study respondents that indicated to have had diploma as the highest level of education were the majority (n=72, 80%) while those who indicated master's degree as their highest education level had the least (n=1, 1.1). Most of the study respondents indicated that they had worked in their current ward/section for a period between 0-4 years (n=70, 77.8%) while (n=4, 4.4%) of the study respondents indicated that they had worked for 15 and above years in the current ward/section. The results are presented in Table 4.2 below.

Table 4.2: Socio-Demographic Characteristics of Nursing Staff

Variables		Frequency	Percentage
Age bracket	21-30	24	26.6
	31-40	27	30
	41-50	23	25.6
	51-60	16	17.8
	Total	**90**	**100**
Level of education	Certificate	4	4.4
	Diploma	72	80.0
	Degree	13	14.44
	Masters	1	1.11
	Total	**90**	**100**
Time worked	0-4 yrs.	70	77.8
	5-9 yrs.	14	15.6
	10-14 yrs.	2	2.2
	15 and above	4	4.4
	Total	**90**	**100**

4.3 Supportive Supervision Practice among Frontline Nurse Managers

The study checked on performance of Frontline Nurse Managers' on various components of SS through an observation checklist and a self-administered questionnaire. The study sought to know whether the respondents performed SS, the frequency of performance of SS per week, and experience of nursing staff on SS in the ward or sections.

4.3.1 Level of Frontline Nurse Managers' SS Practice

The study carried out an observation of evidence of SS activities documentation in the wards/sections using an observation checklist, and scored them according to the following scoring rate: 1=Does not meet expectation, 2=below expectation, 3= meets expectation, 4= above expectation and 5 outstanding. This was adopted from Montgomery County Maryland performance Management Guide for supervisor (Montgomery County Maryland, 2023).

The analyses of results were as follows: there was no evidence to show information form used during SS, use of analysed data after SS, record of identified gaps in staff performance, record of feedback after SS and no record of training staff based on

identified performance gaps. Therefore, all wards and sections scored 1 (did not meet expectation) table 4.3.

Table 4.3: Evidence of Documentation of SS Activities in the Ward/Sections

Variable	Category	Frequency (n)	Percentage (%)
Information form used during SS	Does not meet expectation	20	100
Use of analyzed data after SS	Does not meet expectation	20	100
Record of Identified gaps in staff performance	Does not meet expectation	20	100
Record of feedback after SS	Does not meet expectation	20	100
Record of trained staff on identified performance gaps	Does not meet expectation	20	100
Total		**20**	**100**

4.3.2 Frontline Nurse Managers' Supportive Supervision Performance in Ward/Section

On further exploration, the study used a self- administered questionnaire, to get more data from the frontline Nurse Managers on level of SS practice. The results were as follows: slightly above half (n=20, 51%) of the study respondents indicated that they performed SS in the ward/section, while (n=19, 49 %) said they did not. This was contrary to the observed practice where there was no evidence of documented SS practice (figure 4.1).

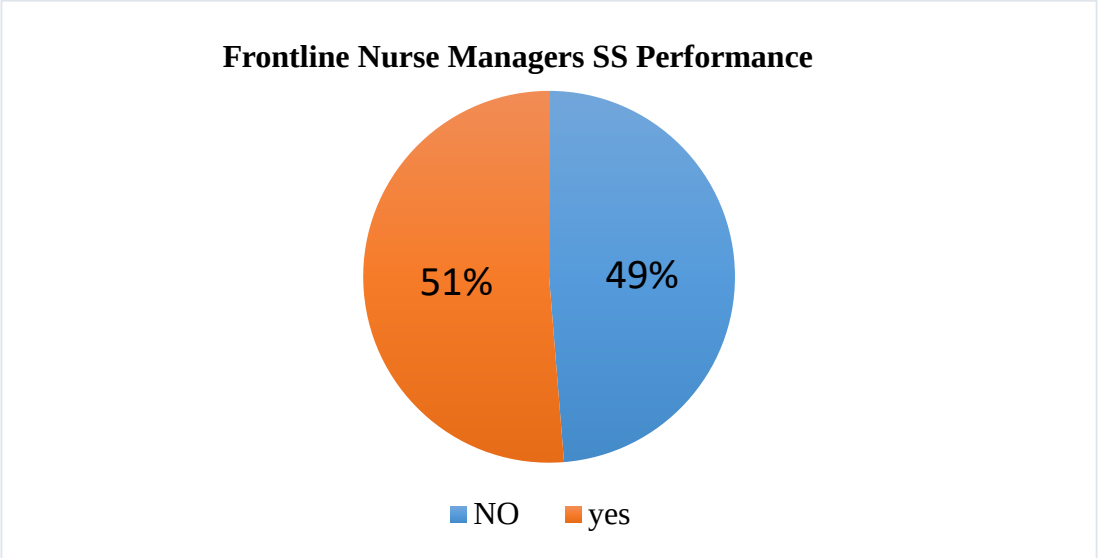

Figure 4.1: Frontline Nurse Managers SS Performance

4.3.3 Frontline Nurse Managers' Frequency of SS Performance per Week

The study further explored on the frequency of SS performance per week from the questionnaire, and majority of study respondents indicated that they performed SS "none of times" per week (n=32, 82%) followed by "1-3 times" per week (n=4, 10%) and (n=3, 8%) indicated "all the times" as indicated in figure 4.2 below.

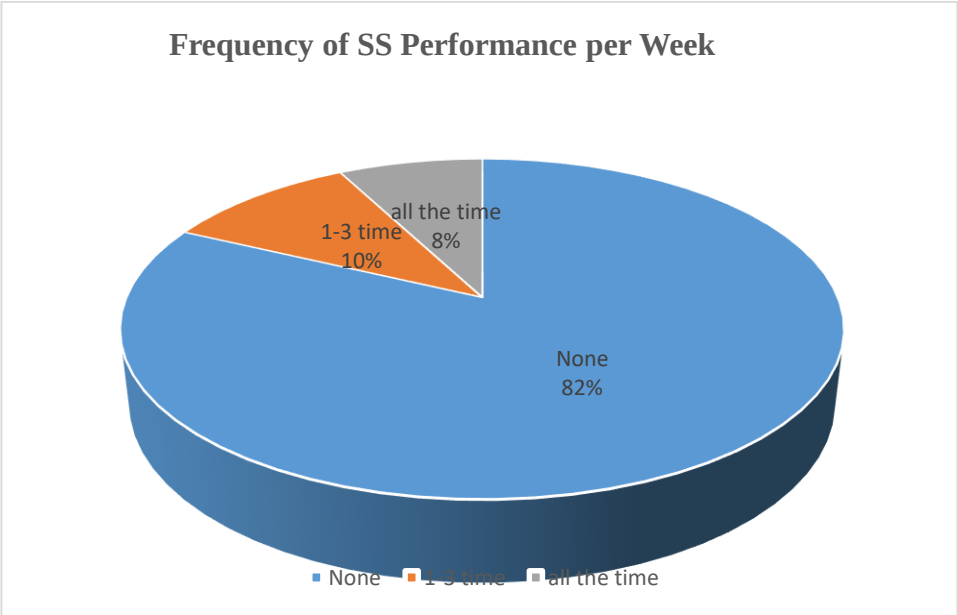

Figure 4.2: Frequency of SS Performance per Week

4.3.4 Practice of SS by Frontline Nurse Managers

Using self-administered questionnaire, the study sought further details on activities that indicate SS practice by asking the study respondents' possession of and use of SS tools where over 70% indicated that they did not possess or utilize SS tools. Majority (n=36, 92.3%) of the study respondents indicated that they did not have SS observation checklist and recommendation forms. Most of the study respondents (n=34, 87.2%) did not allocate time for SS on their nursing staff. On use of SS observation checklist (n=35, 89.7%) of the study respondents reported that they did not use it. About the use of information forms to collect data (n=36, 92.3%) of the study respondents had not used it. Most of the study respondents (n=29, 74.4%) indicated that they did not train their staff based on analysed data from SS. Further upon exploratory on scheduling of on-job- training and giving feedback after SS, (n=33, 84.6%), and (n=30, 76.9%) respectively stated that did not perform those functions (Table 4.4).

Table 4.4: Practice of SS by Frontline Nurse Managers

Variable	Category	Frequency (n)	Percentage (%)
Had SS checklist	No	36	92.3
	Yes	3	7.7
Total		**39**	**100**
Had recommendation forms	No	36	92.3
	Yes	3	7.7
Total		**39**	**100**
Allocates time for SS	No	34	87.2
	Yes	5	12.8
Total		**39**	**100**
Allocated training time	No	34	87.2
	Yes	5	12.8
Total		**39**	**100**
Use SS observation checklist	No	35	89.7
	Yes	4	10.3
Total		**39**	**100**
Use information forms to collect data	No	36	92.3
	Yes	3	7.7
Total		39	100
Training based on analyzed data	No	29	74.4
	Yes	10	25.6
Total		**39**	**100**
Gives feedback after SS	No	30	76.9
	Yes	9	23.1
Total		**39**	**100**
Scheduled on-job training	No	33	84.6
	Yes	6	15.4
Total		**39**	**100**

4.3.5 Nursing Staff Report on SS in the Ward/Section

The study sought to know report from nursing staff on SS by their ward/section Frontline Nurse Managers using self-adminnistered questionnaire. Majority of the study participants indicated that they had resceived supportive supervision (n=64, 71.1%). For the frequency of SS per week, (n=32, 35%) of the study repondents said "none times per week" followed closely by "1-3 times per week" (n=38, 42.2 %) while (n=14, 15%) said "all the time". When asked if the SS was scheduled, majority (n=55, 61.1%) said "no". These findings did not match the Frontline Nurse Managers' finding especially for the frequency of SS where 82% Frontline Nurse Managers said they

performed SS none times opposed to 35% of the nursing staff who reported to have received SS none times per week. Results are presented in Table 4.5.

Table 4.5: Experince of Nursing staff on SS in the Ward/Section per Week

Variables	Category	Frequency (n)	Percentage (%)
SS by ward/section Frontline	Yes	64	71.1
Nurse Managers	No	26	28..9
Total		**90**	**100**
Frequency of SS by ward section	None	32	35.56
in-charge	1-3 times	38	42.22
	4-6 times	6	6.67
	All the times	14	15.55
Total		**90**	**100**
SS scheduled/planned	Yes	35	38.9
	No	55	**61.1**
Total		**90**	**100**

4.3.6 Qualitative data on Frontline Nurse Managers Practice of SS

Theme: Practice of SS

The study conducted two FGDs and Key informants interviews to further explore on Frontline Nurse Managers' SS practice. The study's respondents indicated that ward/section Frontline Nurse Managers did perform SS though not effectively. The reason for the ineffective SS performance were that: they did not schedule SS due to staff shortage and lacked SS tools such as observation checklists and recording facilities. They also did not record SS outcomes and corrective actions. Findings are indicated in the following statements:

One KI, said:

"Yes the ward/section Frontline Nurse Managers do perform SS but they do not have SS tools such as observation checklist or record tools. They do not schedule SS due to acute staff shortage whereby they work with one or two staff per shift" (KI, 1).

Another KI reported that:

"Ward/section Frontline Nurse Managers carry out SS when need arise. This is because of staff shortage. Most of the times, they are the ones carrying out patient care with one or two other staff or sometimes working alone in a shift" (KI, 2).

The report from the FGDs pointed to incorrect SS activities. This was evidenced by the following statements from members of the FGDs:

One study respondent from FGD no.1 attested that:

"SS is supporting others, not separating myself from them. I get involved in that which they are doing, supporting them psychologically and giving them some day offs" (FGD no. 1, group member no. 8).

From FGD no. 2, a study respondent reported that:

"In my SS I do mentorship and work with staff the way I know not what we have been trained on" (FGD 2, Group Member No. 5).

"I provide the material for work such us gloves, syringes… as part of SS" (FGD no. 2, Group Member No. 6).

4.4 Individual Factors Associated to SS among Frontline Nurse Managers

4.4.1 Level of Knowledge on SS of Frontline Nurse Managers

From the self- administered questionnaire the study assessed the knowledge level of Frontline Nurse Managers. The study respondents were asked to indicate "yes" to what they had knowledge and skills of and "no" to what they had no knowledge of in the various components of SS. Most of the study respondents said they were not trained on SS and they did not understand SS setting system requirements (n=26, 67% and n=22, 56%) respectively. Majority of the study respondents (n=22, 56%) stated that they were not trained on scheduling SS and on use of information forms. When asked whether they had skills for analyzing SS data and use of observation checklist, most of the study respondents said no (n=24, 61.5% and n=22, 56%) respectively. Study respondents were asked about training on use of data to resolve problem, (n=22, 56.4

%) said no. Study respondents were asked if they had training on monitoring staff and skills on giving feedback (n=25, 64.1%) and (n=22, 56.4%) said no respectively. When asked about having skills on on-job training and definition of SS (n=20, 51.3%) said no and (n=20, 51.3%) gave wrong answer respectively (Table 4.6).

Table 4.6: Knowledge and Skills of Frontline Nurse Managers on SS

Variable	Category	Frequency (n)	Percentage (%)
Trained on SS	No	26	67
	Yes	13	33
Total		**39**	**100**
Understand SS setting system requirement	No	22	56
	Yes	17	44
Total		**39**	**100**
Trained on SS scheduling	No	22	56.4
	Yes	17	43.6
Total		**39**	**100**
Trained on use of information forms	No	22	56
	Yes	17	44
Total		**39**	**100**
Have skills of using observation checklist	No	22	56
	Yes	17	44
Total		**39**	**100**
Have skills of analyzing SS data	No	24	61.5
	Yes	15	38.5
Total		**39**	**100**
Trained on use of data to solve problem	No	22	56.4
	Yes	17	43.6
Total		**39**	**100**
Trained on monitoring staff	No	25	64
	Yes	17	36
Total		**39**	**100**
Have skills on giving feedback	No	22	56.4
	Yes	17	43.6
Total		**39**	**100**
I have skills on on-job training	No	20	51.3
	Yes	19	48.7
what is SS	Correct	19	48.7
	Wrong	20	51.3
Total		**39**	**100**
I know SS roles	No	21	53.8
	Yes	18	46.2
Total		**39**	**100**

The study did total score of knowledge on all SS items in the questionnaire to determine knowledge level of Frontline Nurse Managers. The answer "Yes" had a score of 1 and "No" a score of zero (0). A respondent's total score on all items on knowledge was summed up for knowledge level. Score of 50% and above was considered knowledgeable and score below 50% not knowledgeable (Gopalakrishnan *et al.*, 2021). Majority (60%, n=23) scored below 50% and were considered not knowledgeable, while 40% (n=16) scored above 50% and were considered knowledgeable (Figure 4.3 below).

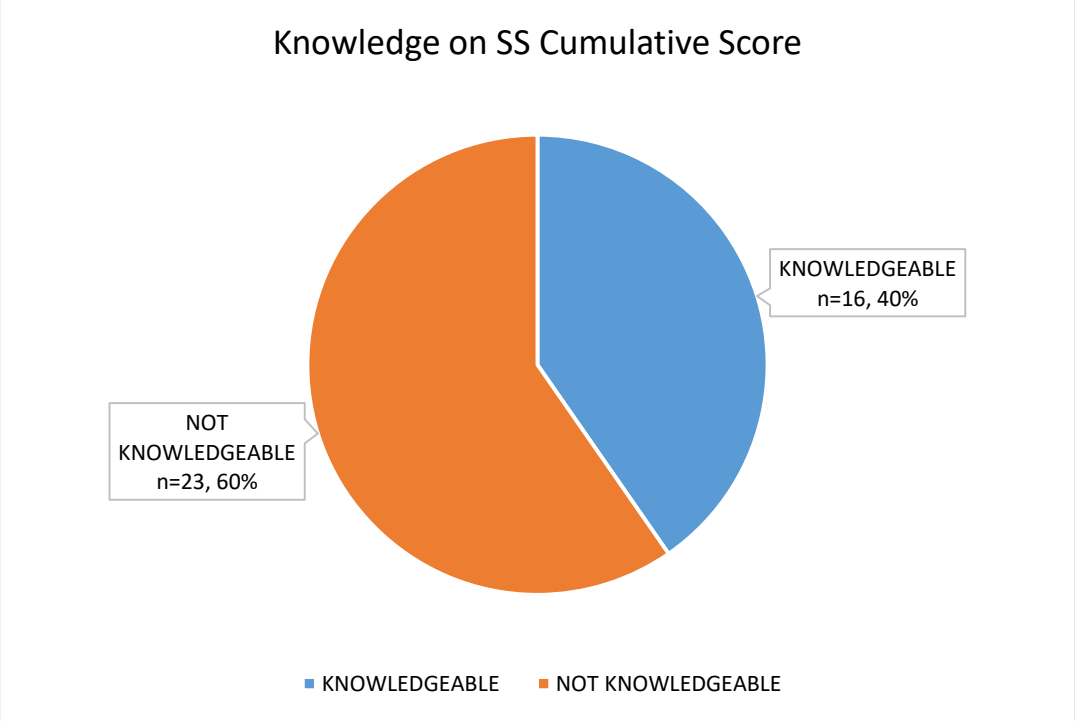

Figure 4.3: Knowledge on SS Cumulative Score

4.4.2 Qualitative Data on Knowledge of Frontline Nurse Managers on SS

Theme: Knowledge on SS

From the focused group discussion with the Frontline Nurse Managers, it was evident that their knowledge and skills of SS was below expectation despite a number of them indicating in the questionnaire that they had knowledge and skills on SS. Three (3) study respondents reported that:

"I am not sure what SS is" (FGD no. 1, group member no. 2, 4 & 8)

Another study respondent said:

"SS is sport checking staff as we perform our duties" (FGD no. 1, group member no. 3)

Also another study respondent attested that:

"SS is inspecting how work is being done" (FGD no. 2, group member no. 6)

4.4.3 Qualitative Data from Questionnaires on Individual Factors Associated with SS among Frontline Nurse Managers

From the open ended questions in the questionnaires, the study sought more information about other factors associated to SS beside knowledge and skills on SS among the Frontline Nurse Managers. Most of the study respondents reported that staff shortage, lack of interest with staff and lack of SS tools were barriers to their SS performance as indicated in the following statements from the questionnaire respondents:

Theme: Individual Perception on SS Barriers

"Attitude is a barrier to supportive supervision" respondent number 24 (from questionnaires).

Respondent number 21 from questionnaire reported that:

"Lack of interest with one's staff influences one's supporting staff"

Respondent number 18 from questionnaire reported that:

"Understating shortage of staff and lack of SS tools is a barrier to SS".

4.5 Institutional Factors Associated with SS Performance among Frontline Nurse Managers

The study sought to explore institutional factors that contributed to the SS practice among Frontline Nurse Managers by checking on SS support that the hospital provided to them on SS. Data from the observation done through observation checklist, found no documented evidence of SS schedule, nor SS tools for Frontline Nurse Managers in all the ward/sections. From the self- administered questionnaire, study respondents were asked whether the hospital provided SS schedule; majority said no (n=36, 92.3%). When asked about hospital providing SS observation checklist, most the study respondent said "no" (n=37, 94.9%). Majority of the study respondent reported that the hospital did not provide SS record facilities or on-job training materials (n=38, 97.4 % and (n= 32, 82%) respectively. The results are indicated in table 4.7 below.

Table 4.7: Institutional Factors Associated with SS Performance among Frontline Nurse Managers'

Variable	Category	Frequency (n)	Percentage (%)
Hospital provides SS schedules	No	36	92.3
	Yes	3	7.7
Total		39	100
Hospital provides SS observation checklist	No	37	94.9
	Yes	2	5.1
Total		39	100
Hospital provides of record facilities for SS	No	38	97.4
	Yes	1	2.6
Total		39	100
Hospital provides on-job training material	No	32	82.0
	Yes	7	18.0
Total		**39**	**100**

4.5.1 Required Support for the Frontline Nurse Managers on SS performance

The study through questionnaire inquired from the Frontline Nurse Managers of the support they would recommend to enhance SS performance in their wards/sections. The study respondents identified three things: 72% (n=28) of the study respondents indicated training on SS, 20% (n=8) recommended SS tools and 8% (n=3) indicated

adequate staff as support they would wish addressed to improve their SS performance (figure 4.4).

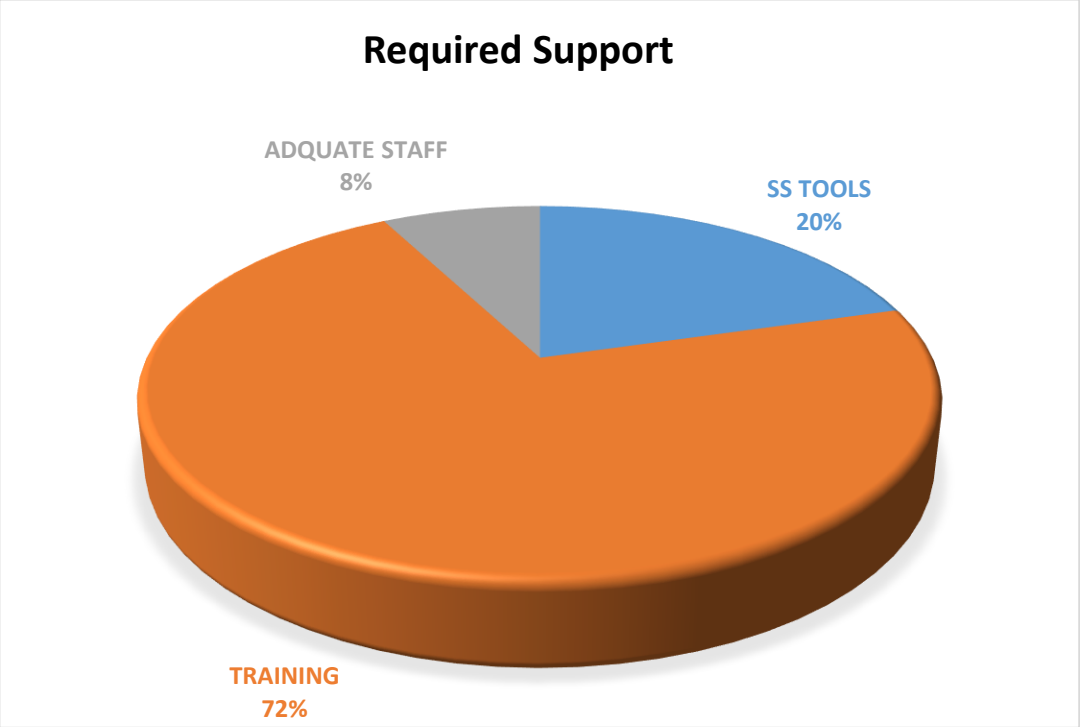

Figure 4.4: SS Required Support for the Frontline Nurse Managers

4.5.2 Qualitative Data on Institutional Factors Associated with Frontline Nurse Managers' Performance of SS

Theme: Hospital Support on SS

The study respondents indicated that the hospital did not have SS schedules, SS observation checklist and had not offered training on SS to Frontline Nurse Managers. These were demonstrated by the following statements:

One study respondent from the FGD no.1 said:

"No, the hospital does not provide SS schedules; it is left to the ward managers because of staff shortage" (FGD 1, Member No. 2).

Another study respondent from FGD noted that:

"No tools, I use patients' file to check if everything was done in the right way and the hospital does not provide SS schedules, it is left to the ward managers because of staff shortage"(FGD 2, Member No.3).

Another study respondent from FGD no.2 attested that:

"I deal with problem as it arises', there are no SS schedules" (FGD 2, Member No. 5).

Key informants also reported that the hospital has no SS schedules nor SS tools:

One of the KI said:

"The hospital has no SS schedules for wards/sections, and it has not provided SS observation checklist or any other SS tools" (KI, 1).

Another KI reported that:

"There are no SS tools in the hospital. The hospital does not provide SS schedule for ward/section Frontline Nurse Managers, they do it when need arises due to shortage of staff" (KI, 2).

4.6 Effects of Training on SS and Utilization of a Structured Supportive Supervision Tool on Supportive Supervision of Frontline Nurse managers

A paired t- test, chi square cross- tabulation and Fisher's exact test were used to determine the difference between pre- and post-intervention level of knowledge and practice of SS among Frontline Nurse Managers at TL5H.

4.6.1 Pre-Test Post-Test Paired t Test Statistics for Observation Checklist Data on Frontline Nurse Managers' SS Practice

Data from observation checklist of the pre-test and post-test on observation done on all 20 ward/sections for Frontline Nurse Managers SS practice proportion who had "not met expectation" at baseline was 100% (n=20) and at post-test was 50% (n=10). Those who had "met expectation" at baseline was 0% (n=0) and at post-test was 50%

(n=10). To test whether the proportion scores differences between the pre- and post-test scores were statistically significant; a paired *t* test was conducted. The result of this test revealed that there was a statistical significant difference in the proportion scores difference of "not met expectation" and "met expectation" in pre-test post-test *t* test (mean =0.500, df =19, *t*= -4.359 and a p-value = <0.001 at 5% significance level); as shown in Table 4.8 below.

Table 4.8: Pre-test Post-test Frequency and t Test table for Observation Checklist Data on Frontline Nurse Managers' SS Practice

	Variable	Frequency	N	%	Mean	95% Conf. interval		*t*	df	p-value
	Meets expectation	**0**	**20**	**0%**	**-0.500**	**Lower**	**Upper**	**-4.359**	**19**	**<0.001**
Pretest	Does not meet expectation	20	20	100%		-0.74009	-0.25991			
Posttest	Meet expectation	10	20	50%						
	Does not meet expectation	10	20	50%						
Total		**20**	**40**	**100%**						

4.6.2 Supportive Supervision Practice of Frontline Nurse Managers for Pre and Post-Intervention Data from the Questionnaire

A paired t-test was carried out on SS practice data from questionnaire for Frontline Nurse Manager's responses for pre and post-test which showed an increase in the mean after intervention as indicated in the following findings: pre-test mean of 2.9744 and a post-test mean of 9.6154. To test whether the mean scores differences between the post- and pre-test scores were statistical significant; a paired samples t-test was conducted. The result of this test revealed that there was a statistical significant difference in the mean score difference of SS practice pre- and post-intervention (t = -7.694, df = 57.7, and p-value = <0.001 at 5% significance level) indicated in table 4.9 below.

Table 4.9: Supportive Supervision Practice from Questionnaire of Frontline Nurse Managers at Baseline and Post Intervention Analyzed using Paired t- Test

Variable	Study period	Total count	Means	*t-test*	Df	Sig. (2-tailed) p-value	Mean Diff.	Std. Error Diff.	95% Confidence Interval of the Difference	
									Lower	Upper
Practice Score	Pre-test	39	2.9744							
	Post-test	39	9.6154	-7.694	57.7	<0.001	-6.6	0.863	-8.37	-4.91

Cross-Tabulation and Chi-Square on Practice for Data from the Questionnaire

Cross-tabulation and Chi-square on practice for various variables, respondents' response during pre-test and post-test from the questionnaire were as follows: for Does not meet expectation pre-test n= 35 (89.7%) and post-test n=10 (25.6%). For the variable "meets expectation pre-test – n= 4 (10.3%) and post-test n= 29 (74.3%). Chi-square value was 32.83, df 1, and a p-value of <0.001 as shown in table 4.10 below.

Table 4.10: Practice Cross-tabulation and Chi-square

Variable	Study period		Total	Chi-square value	Df	95% Confidence Interval		P-value
	Pre-test	Post-test				Lower	Upper	
Does not meet expectation	35 (89.7%)	10 (25.6%)	45					
Meets expectation	4 (10.3%)	29 (74.3%)	33	32.83	1	7.2	89.4	<0.001
Total	39	39	78					

4.6.3 Knowledge Score of Frontline Nurse Managers for Pre and Post-Intervention

The paired t-test was carried out on knowledge score of Frontline Nurse Manager's for pre and post-test which showed an increase in the mean after intervention as indicated in the following findings: pre-test mean of 3.8462 and a post-test mean of 6.2308. To test whether the mean scores differences between the pre- and post-test scores were statistical significant; paired samples t-test was conducted. The result of this test revealed that there was a statistical significant difference in the mean score difference

of knowledge score of (-2.38462) and (t = 3.33, df = 76, and p-value = 0.001 at 5% significance level) Table 4.11.

Table 4.11: Knowledge Score of Frontline Nurse Managers from questionnaire at Baseline and Post Intervention Analyzed Using Paired t- Test Paired

Variable	Category	Frequency	Mean	*t-test*	Df	Sig. (2-tailed) p-value	Mean Diff.	Std Error	95% CI of diff
Knowledge s3core	Pre-test	39	3.8462						Lower -3.80524
	Post-test	39	6.2308	-3.343	76	0.001	-2.38462	0.71328	Upper -0.96399

Chi square cross-tabulation and Fisher's exact test on knowledge of various variables from the questionnaire were tabulated. Study respondents' response during pre-test and post-test were as follows: On whether one was trained on SS, yes was n=13 (33%) at pre-test and n=24 (62%) at post-test: on whether one had understanding of SS requirements "yes" was n=17 (44%) at pre-test and at post-test n=26 (67%) while about having been trained on SS scheduling, yes was n=17 (44%) at pre-test and n= 25 (64%) at post-test. For knowledge on training on use of information forms, yes was n=17(44%) at pre-test and n=26 (67%) at post-test. The respondents' knowledge on use of observation checklist during SS, yes was n=17 (44%) at pre-test and n= 30 (78%) at post-test: while on the question of one having the skills of analyzing SS data: yes at pre-test was n=15 (38%) and n=28 (72%) at post-test. On training on use of data to solve problem yes at pre-test was n=17(44%) and n=23 (59%) at post-test. Study respondents' who said yes on having been trained on monitoring staff at pre-test were n=14 (36%) and n=25 (64%) at post-test and for knowledge on giving feedback on SS to staff, at pre-test yes response was at n=17 (44%) and at post-test, n=31(80%). These who said that they had skills on on-job training were n=19 (49%) at pre-test and n=29 (74%) at post-test. Nine out of ten variables fishers' exact test P-value was < 0.05 with significance level of 5% as indicated in Table 4.12 below.

Table 4.12: Knowledge Score of Frontline Nurse Managers at Baseline and Post Intervention Analyzed Using Cross-Tabulation and Fisher Exact Test

Variable	Study period	No	Yes	Total	Fisher's exact test
Trained on SS	Pre- test	26 (67%)	13(33%)	39	0.011
	Post-test	15 (38)	24 (61%)	39	
Understand SS setting requirements	Pre- test	22 (56%)	17 (44%)	39	0.03
	Post-test	13 (33%)	26 (67%)	39	
Trained on SS scheduling	Pre- test	22 (56%)	17 (44%)	39	0.05
	Post-test	14 (36%)	25 (64%)	39	
Trained on use of information forms	Pre- test	22 (56%)	17(44%)	39	0.03
	Post-test	13 (33%)	26(67%)	39	
Have skills of using observation checklist	Pre- test	22 (56%)	17 (44%)	39	0.00
	Post-test	9 (22%)	30 (78%)	39	3
Skills of analyzing SS data	Pre- test	24(61%)	15(38)	39	0.00
	Post-test	11(28%)	28(72%)	39	3
Trained on use of data to solve problem	Pre- test	22(56%)	17(44%)	39	0.12
	Post-test	16 (41%)	23(59%)	39	9
trained on monitoring staff	Pre- test	25 (64%)	14 (36%)	39	0.01
	Post-test	14 (36%)	25 (64%)	39	1
Skills on giving feedback	Pre- test	22 (56%)	17 (44%)	39	0.00
	Post-test	8 (20%)	31 (80%)	39	1
Have skills on on-job training	Pre- test	20 (51%)	19 (49%)	39	0.01
	Post-test	10 (26)	29 (74%)	39	8

CHAPTER FIVE

DISCUSSION, CONCLUSION AND RECOMMENDATION

5.1 Introduction

This chapter entails discussion of the study findings, conclusion, and recommendations based on the study findings. The discussion follows the study's objectives' results, and compares them with other similar studies conducted locally and globally.

5.2 Discussion

The discussion of the study findings was conducted as per study objectives. The study demonstrated how each finding compared with other findings in other studies conducted elsewhere.

5.2.1 Level of Supportive Supervision Practice

To answer this objective, the results from quantitative and qualitative were triangulated. The study established that the level of SS practice by the Frontline Nursing Managers did not meet the expectation as per the definition from W.H.O SS MLM's tool, (2008). This tool recommends SS system to be set by the supervisors for planning and preparing SS goals and tools such as, observation checklist, information forms and on-job training materials. In setting health care goals and scheduling of SS plan, the supervisors and supervisees work as a team. This becomes the basis for SS monitoring and on-job training. The training is done based on identified work performance's gaps, aiming at the improvement of staff health care performance.

The study established by observation that the level of SS practice among Frontline Nurse Managers was at zero since there was no observed evidence of recorded SS activity, nor had any ward/section had SS tools such as SS schedules, SS observation checklist, and SS record forms. Despite there being no evidence of SS, study respondents upon exploration by questionnaire, reported that they performed SS. The study established that the majority of Frontline Nurse Managers stated that they practiced SS although upon further probe on SS activities carried out during SS, most

of the study respondents indicated that they did not. This was clearly shown by questioning on performance such as: whether one performed SS, where 51% of the study respondents said they did but when asked the frequency of SS performance per week 82.1% of the participants indicated that, they did "none times per week".

Majority 92.3% did not have SS observation checklist, 87.2% did not allocate time for SS. This was confirmed by report from FGDs and KIIs that established that SS was inaccurately done since the Frontline Nurse Managers did not schedule SS due to staff shortage, they did not use SS tools and performed SS when need arose. These finding agreed with a study done in Mozambique which showed that, SS practice was ineffectively done (Tavares *et al*, 2017).

5.2.2 Individual Factors Associated with Supportive Supervision Practice among Frontline Nurse Managers

Results from qualitative and quantitative analysis were triangulated in order to answer this objective. The study established that knowledge on SS was a crucial individual factor that influenced SS practice among the Frontline Nurse Managers. The knowledge level was below the expected. Majority, 64% had no SS training, and 51.3% did not understand the requirement for setting SS system. The knowledge level was below 50% and therefore rated as unknowledgeable (Gopalakrishnan *et al*, 2021).

Qualitative data confirmed insufficient knowledge on SS. From the FGDs, it was evident that the Frontline Nurse Managers' knowledge on SS was below expectation. These findings corresponded with a study that established that managers lack supervisory knowledge and skills essential for supportive supervision and therefore inadequately provided SS to their staff (Avortriet *et al*, 2018).

From the qualitative data collected from questionnaires' open-ended questions, the study reported personal perceptions considered as barriers of SS. These were: lack of interest of staff working under one's ward/section, understating staff shortage by the management and negative attitude towards SS performance. A similar observation was made by Susan *et al.*, (2015) where negative attitude towards supervision role was reported to result in nursing managers neglecting SS role and function.

The study established that lack of time and staff shortage hindered Frontline Nurse Managers from performing SS. study respondents reported that staff shortage and lack of time were barriers to their performance of SS role. This was confirmed by report from KIIs. These results were similar to what was established in a study that reported that SS is ineffectively done due to such factors like managers' competing roles and lack of time (Tavares *et al*, 2017). Tumaini *et al*, (2021) study also agreed with these findings in their report on SS where they established that SS was constrained by staff shortage.

5.2.3 Institutional Factors Associated with SS among Frontline Nurse Managers

Institutions support for Frontline Nurse Managers in achievement of health goals is critical. It was evident that the hospital did not make available SS schedules, SS observation checklist, or record facilities such as information forms neither provide on-job training material. This was shown by both qualitative and quantitative data. Data from the observation done through observation checklist, found no documented evidence of SS schedule, nor SS tools for use by Frontline Nurse Managers during SS in all the ward/sections. The Frontline Nurse Managers (92.3%) reported that the hospital did not provide SS schedule. The study respondents (94.9%) reported that hospital did not provide SS observation checklist, and (97%) said that hospital did not provide SS record facilities. This concurred with Avortri *et al., (*2018), who observed in their study that health institutions did not support managers with the required tools such as computers and SS schedules.

Report from FGDs and KIIs confirmed that the hospital did not have SS schedules, SS observation checklist, and that it had not offered training on SS to Frontline Nurse Managers and that there was inadequate nursing staff. These findings were similar to findings by a study by Sana, *et al*., (2021) that established that supervisors faced staff shortage and, that the workload could not allow them to have time for SS.

5.2.4 Effects of Training and Utilization of Structured SS Tool on Frontline Nurse Managers SS

The study's fourth objective was to evaluate the effects of training of Frontline Nurse Managers on SS and utilization of structured SS tool in the role of supportive supervision of their staff. The study stated null and alternative hypotheses which were tested in order to evaluate the effects of training and utilization of structured SS tool.

This study rejects the null hypothesis that "there is no difference between Frontline Nurse Managers' supportive supervision practice at TL5H before and after training and implementation of structured SS tool".

The rejection of the null hypothesis was based on statistical difference between the pretest and posttest on the supportive supervision practice by the Frontline Nurse Managers before and after training and utilization of the structured SS tool. Cross-tabulation and Chi-square on practice for various variables indicated: 50% improvement of those who met SS expectation from 0% after training and utilization of structured tool. Chi-square value was 32.83, df 1, and a p-value of <0.001while *t test* (t = - 7.694, df = 57.7, and p-value = <0.001 at 5% significance level). The paired t test was, pre-test mean of 2.9744 and a post-test mean of 9.6154 demonstrating improvement in SS practice. These findings were similar to a study that was done by Purity *et al*, (2017) that reported an improvement on managers' SS practice through training and empowerment on SS skills.

The study recorded improvement on the knowledge of Frontline Nurse Managers as result of training and utilization of structure SS tool. There was an increase in number of those who improved their knowledge and skills in: understanding of SS setting requirements, giving feedback on SS to staff, and skills on use of observation checklist SS. The study reported Fisher's exact test on knowledge on above various variables as: (t = 3.33, df = 76, and p-value = 0.001 at 5% significance) and fishers' exact test P-value of < 0.05.

The same was echoed by a study that concluded that training managers on SS improves their knowledge and make them appreciate the importance of SS on their staff

(Muhammad *et al*, 2019). These findings also were similar to an evaluation report that indicated that supervisors improve on use of SS tools such as observation checklist during supportive supervision after training them on SS and supportive supervision system, which empowers them to be objective in their SS practice (MOH Tanzania, 2022).

5.3 Conclusion

This study concludes that, Frontline Nurse Mangers' SS practice before training and implementation of structured SS tool did not meet expectation as per W.H.O Mid-level Managers' training manual (W.H.O, 2008) since they did not set SS system, did not have SS schedule, SS observation checklist and did not have any documented evidence of SS practice. The implementation and evaluation results could have been better had the Nursing Services Managers been trained on SS. The office of the Nursing services Manager could not enhanced SS practice despite the training of Frontline Nurse Managers by the researcher, since the hospital had no SS system nor SS practice policy.

On individual factors associated with SS practice among Frontline Nurse Managers: Frontline Nurse Mangers' knowledge on SS was below expectation since they had not been trained on SS. They also reported issues of personal perceptions on supportive supervision such as: lack of time, lack of interest, negative attitude and understating staff shortage.

On institutional factors associated with SS practice among Frontline Nurse Managers: Frontline Nurse Mangers' had ineffective SS practice status since they were not trained on SS. There was inadequate nursing staff, and the hospital had not provided SS schedule, SS tools such as: SS observation check, facility for recording SS data, nor had the hospital provided on-job training material.

On effects of training and implementation of structured SS tool, it was evident that the SS knowledge and practice of Frontline Nurse Managers improved by 50% after training and utilization of a structured SS tool. Therefore the study rejected the null hypothesis. To improve on individual interest in a subject, motivation is required. Had

the hospital had SS policy, the Frontline Nurse Managers would have found the reason to seek to know and practice SS better than the 50% that was achieved by this study.

5.4 Recommendations

The following recommendations were derived from the study:

1. The hospital management to embrace Front Nurse Managers' SS practice as policy.
2. The hospital management to facilitate further training of Frontline Nurse Managers on SS.
3. The hospital management to establish a hospital SS system and schedule for Frontline Nurse Managers, provide SS recording system and address nursing staff shortage.
4. The hospital management to adopt customized SS structured tool for use by Frontline Nurse Managers to improve SS practice.
5. Further study on Frontline Nurse Managers' SS practice in a wider scope is recommended generalization.

REFERENCES

Aftab, W., Piryani, S., and Rabbani, F., (2021). Does supportive supervision intervention improve community health worker knowledge and practices for community management of childhood diarrhea and pneumonia? Lessons for scale-up from Nigraan and Nigraan Plus trials in Pakistan: *Hum Resour Health (2021)* 19:99 https://doi.org/10.1186/s12960-021-00641-9.

Ahmed, I. & Ishtiaq, S., (2021). Reliability and validity: Importance in Medical Research *J Pak Med Assoc. 2021 Oct;71*(10):2401-2406. doi: 10.47391/ JPMA.06-861.

Anoke, C.I., Onuoha H. E., Njoku, E O., Aka, E.O. & Ukemezia, P. O., (2021). Effects of Supportive Supervision on Improved Quality Healthcare Service Delivery: *International Journal of Innovation, Creativity and Change. www.ijicc.net Volume 15, Issue 8, 202*

Aruasa, W. K., Chirchir L. K., & Chebon S. K. (2019). Strategies for Improving Physicians and Nurses' Professional Satisfaction: *Strategic Journals Vol. 6, Iss. 3, pp 216*

Ashley, M. & Jessica, F. (2014). Supportive Supervision in Monitoring and Evaluation: Carolina Population Center 400 Meadowmont Village Circle, 3rd Floor Chapel Hill, NC 27517

Avortri, G. S., Nabukalu J. B., Orem, J.N. (2018) Supportive supervision to improve service delivery in low-income countries: *BMJ Glob Health, 4*, e001151. doi:10.1136/bmjgh-2018-001151

Burnes, B. (2004). Kurt Lewin and complexity theories: Back to the future? *Journal of Change Management, 4*, 309–325

Cabrera, W., & Estacio, D. (2022). Job attitude as a factor on employee's performance. *International Journal of Economics Development Research (IJEDR), 3*(1), 45-58. https://doi.org/10.37385/ijedr.v3i1.254.

Cheburet S., K & Otieno G. W. O. (2016). *Organizational factors affecting data quality of routine health management information system quality*: Case of Uasin Gishu County Referral Hospital, Kenya Ministry of Health, Nairobi, Kenya, P. O. Box 30016-00202 Nairobi Kenya.

Creswell, J. W., & Plano Clark, V. L. (2017). *Designing and conducting mixed methods research* (3rd ed.). SAGE Publications.

Dorsett, A. L. (2016) *Human Resources Department: employee performance rating system supervisor's handbook.*: (3rd Rev ed.)

Faizan, A., Olena C., & Kisang R., (2020). Response Rates in Hospitality Research: *An Overview of Current Practice and Suggestions For Future Research; 62*(1). *https://doi.org/10.1177/19389655209430*

Gathara, D., Serem, G., Georgina, A. V., Obengo, M. A.,Tallam, E., Jackson, D., Brownie, S. & English, M., (2019). Missed nursing care in newborn units: a cross-sectional direct observational study *Volume 29, Issue 1 https://qualitysafety.bmj.com/content/29/1/19*

Global Health Science and Practice, (2022). African Health Initiative Partnership Collaborative for Supportive Supervision and Mentoring. Improving primary care quality through supportive supervision and mentoring: lessons from the African Health Initiative in Ethiopia, Ghana, and Mozambique. *Glob Health Sci Pract*, *10*(Suppl 1): e2100667. https://doi.org/10.9745/GHSP-D-21-00667

Gopalakrishnan L, Nadia DS, Rasmi A, Purnima M, Lia F, Dilys W,*et al*, (2021) Association between supportive supervision and performance of community health workers in India: a longitudinal multi-level analysis: *Human Resources for Health*, ***19***(145)

Henry O, Oscar A O,Regina A, and Christoph S.,(2023). Exploring Supportive Supervision of Nurses in the Health Care Facilities in Volta Region, Ghana June 2023; *Journal of Nursing Research Patient Safety and Practise, 3*(4):2799-1210. DOI:10.55529/jnrpsp.34.1.10

Joe, A., Hussein, E. K.. & Adom D. (2018), Theoretical and conceptual framework: mandatory ingredients of a quality research: *International Journal of Scientific Research;* 7

Kama, G., Nancy, C., Rick, S & Pamela, L. (2004) *Supervising Health care services; improving performance of people*: JHPIEGO, Brown's Warf 1615 Thames Street, Suit 200, Beltimore Maryland 21231-3492 USA

Karuga, R. N., Muturi, M., Mireku, N., McCollum, R., Frederique V., Meghan K., Miriam T., & Otiso L., (2019). Supportive supervision of close-to-community providers of health care. https://doi.org/10.1371/journal.pone.0216444.

Kassu, J. S. (2019). Research Design and Methodology [Online First], Intech Open, *DOI: 10.5772/intechopen.85731.*

Kenya Population and House Census. (2019). *Population by County and Sub-county. Volume 1. Kenya National Bureau of Statistics. 26*(35), 44. *ISBN 9789966102096*

Kisakye, A.A., Kananura, R. M., Ekirapa-Kiracho, E., Bua,J., Akulume, M., G Namazzi & Kiwanuka, S.N. (2017). Effect of supportive supervision on maternal and newborn health services and practices in Rural Eastern Uganda: *Global Health Action.* https://www.tandfonline.com/loi/zgha20.

Kumar, A., (2022) Results: Establishing credibility. *J Indian Soc Periodontol. 26*(4). 303–304. doi: 10.4103/jisp.jisp_249_22.

Lin, L., Liu, X., McGilton, K. S., Yuan, Y., Li, H., Dong, B., ... & Tian, L. (2021). Level of nurse supportive supervision and its influencing factors in long-term care facilities. *Geriatric Nursing, 42*(6), 1316-1322.

Lin, L., Liu, X., McGilton, K. S., Yuan, Y., Li, H., Dong, B., Xie, C., Wang, H., Li, H., & Tian, L. (2023). Level of nurse supportive supervision and its influencing factors in long-term care facilities. *Journal of Nursing Management, 31*(5), 1234-1245. https://doi.org/10.1111/jonm.13789.

Macharia, A. G., Yeri K., Mwaniki, P., & Michael H. (2017). Barriers of Condom Use among HIV Positive Women at Thika Level 5 Hospital, Kenya. *J AIDS Clin Res, 8,* 722. doi: 10.4172/2155-6113.1000722

Madede, T., Sidat, M., McAuliffe, E., Patricio, S. R., Uduma, O., Galligan, M.,Bradley, S. & Cambe, I. (2017). The impact of a supportive supervision intervention on health workers in Niassa, Mozambique: a cluster-controlled trial. *Human Resources for Health, 15*(1), 58.. doi: 10.1186/s12960-017-0213-4 *March, Vol. 5, No. 3.*

Martin, P., Lizarondo, L., Kumar, S., & Snowdon, D. (2021). Impact of clinical supervision on healthcare organisational outcomes: A mixed methods systematic review. *PloS one*, *16*(11), e0260156.https://doi.org/10.1371/journal.pone.0260156

Maryse C K., Fre´de´ rique, V., Olivia T., Meghan, B. K., Aschenaki, Z. K., Robinson, K., Sozinho, D., Ndima, K. C., Sally, T., & Miriam, T. (2018). Does supportive supervision enhance community health worker motivation? *Health Policy and Planning, 33,* 988–998 doi: 10.1093/heapol/czy082.

Marzia, L., Venera S., Marina D., Kubanychbek M., Tatiana K., Yuri A., Maya B., Tea M., Ilya M., Leyla N.B., Elnura B., Aigul K., Martin W. W., & Giorgio T. (2017) improving the quality of hospital care for children by supportive supervision: *Bull World Health Organ. 9*(6), 397–407.

MOH Tanzania, (2022). Afya supportive supervision system impact evaluation report. The united Republic of Tanzania. Cathedral Road PO Box 30016 00100 Nairobi, Kenya. National Alliance of State & Territorial AIDS Directors. (2016). 444 North Capitol Street NW, Suite 339 Washington, D.C. 20001-1512 (202)434-8090. www.NASTAD.org

MOH. (2015). *Report of the Training Needs assessment of Kenya's Health Workforce*: Ministry Of Health, August 2015 Published by: Ministry of Health Afya House

Montgomery County Maryland (2023). Performance management Guide for Supervisors. Office of Human Resources; main office number: 240.777.5000. htt://www.montgomerycountymd.gov.

Muhammad, U. A., Rizwan, Q. D., Hafiz, F. A., Rabia, S., Muhammad, A. & Kashif, N., (2019). European Online Journal of Natural and Social Sciences 2019; www.european-science.com Vol.8, No 1 (s) Special Issue on Advancement of Business and Management Science ISSN 1805-3602.

Ndatimana, D., Mwali, A. K., & Radeny, S. (2022). Building Capacity of Health Workers through Supportive Supervision. Retrieved from https://hsag.co.za › index.php › hsag › article › view.

Nigam, J. A. (2023). Vital signs: health worker–perceived working conditions and symptoms of poor mental health—quality of worklife survey, United States, 2018–2022. *MMWR. Morbidity and Mortality Weekly Report*, *72*. DOI: http://dx.doi.org/10.15585/mmwr.mm7244e1

Njoroge, R. K., Mireku, M., Muturi, N., McCollum, R., Vallieres, F., Kumar, M., ... & Otiso, L. (2019). Supportive supervision of close-to-community providers of health care: Findings from action research conducted in two counties in Kenya. *PLoS One*, *14*(5), e0216444. doi: 10.1371/journal.pone.0216444.

Nordbøe, E., & Enmarker, I. (2017). The Benefits of Person-Centred Clinical Supervision in Municipal Healthcare—Employees' Experience. *Open Journal of Nursing*, *7*, 548-560.

Norwich University. (2017). Humanistic Nursing Theory: Norwich University 158 Harmon Drive Northfield, VT 05663158.

Nyamhanga, T. M., Frumence, G., & Hurtig, A. K. (2021). Facilitators and barriers to effective supervision of maternal and newborn care: a qualitative study from Shinyanga region, Tanzania. *Global Health Action*, *14*(1), 1927330. DOI: 10.1080/16549716.2021.1927330

Oathokwa.,N. Mash, R., Wojczewski, S., Kutalek, R., & Phaladze, N. (2016). How to create more supportive supervision for primary healthcare: lessons from Ngamiland district of Botswana: co-operative inquiry group. *Global health action, 9*(1), 31263.*doi: 10.3402/gha.v9.31263. eCollection 2016.*

Onuka, O., Madukwe, O., Chukwueme, N., Gidado, M., Emperor, U., Agbaiyero, K., & Adeleke, O. (2015). Use of smartphone for supportive supervision in Nigeria. *I-Business*, *7*(2), 75. http://dx.doi.org/10.4236/ib.2015.72009.

Onyambu, Masese, C, Tenambergen, W. M., & Muiruri, L. (2016). Utilization of Service Charters in Public Hospitals in Kenya: A Case of Thika Level 5 Hospital, Kiambu County.

PATH, (2003*). Children's Vaccine Program at PATH. Guidelines for implementing Supportive Supervision:* A step-by-step guide with tools to support immunization. Seattle: PATH (2003).

Purity, M., Eilish, M., Ogenna, U., Honorati, M., & Henry, M. (2017). The impact of supportive supervision on the implementation of HRM processes; a mixed-methods study in Tanzania. *Health Systems and Policy Research*, *4*(01). doi: 10.21767/2254-9137.100066

Rachael, H., Lynda, N., Anita, K. W., Martha, E., & Birna, T. (2017). Competency in supportive supervision: a study of public sector medicines management supervisors in Uganda. *Journal of Pharmaceutical policy and practice*, *10*(1), 33. DOI 10.1186/s40545-017-0121-y

Regan, P. J., & Shillitoe, S. (2017). The supervisory ward manager's role: progress on Compassion in Practice action area four. *Nursing Management, 24*(6). 2732. ISSN 13545760

Roets, L., Chelagat, D., & Joubert, A. (2018). Strategies to improve postnatal care in Kenya: A qualitative study. *International journal of Africa nursing sciences*, *9*, 62-67.

Royal College of Nursing. (2016). Frontline nurse leadership: an international perspective: *RCN Policy and International Department; Policy briefing 02/16.*

Ryu, H., Buus, N., Naccarella, L., Zarb, L., & Hamilton, B. (2025). Factors that influence the clinical supervision implementation for nurses: A scoping review. *Journal of Advanced Nursing*, *81*(11), 7297-7310.doi: 10.1111/jan.16390

Sana, T., Yasmeen, S., DureSamin, A., Lubna, B., & Faraz, K. (2021). Strengthening supportive supervision: A case study of the Expanded Programme on Immunization in Sindh, Pakistan. *Journal of Global Health*, *11*.

Seers, K., RI, R., Staniszewska, S., & Tutton, L. (2015). A survey to provide baseline activity in relation to ward sister/charge nurse supervisory roles.

Subramaniam, S., & Selvavinayagam, T. S. (2018). Supportive supervision as an effective intervention in improving water, sanitation and hygiene facilities in government health facilities of Tamil Nadu. *International Journal of Community Medicine and Public Health*, *5*(3), 1082.

Susan, J. A.,Laetitia, C., Rispel., & Loveday, P-K. (2015). The activities of hospital nursing unit managers and quality of patient care in South African hospitals: a paradox?. *Global health action*, *8*(1), 26243.

Tavares, M.,Mohsin, S., Eilish, M., Sergio, R.P.,1 Ogenna, U., Marie, G., Susan, B.,& Isabel, C. (2017). The impact of a supportive supervision intervention on health workers: *Journal of Human Resource in Health v.15; 2017*

W.H.O. (2008). Supportive supervision: Training for mid-level managers (MLM)

W.H.O. (2020). Focus group discussion guide for communities. *https://www.unicef.org › media › file*

Wakaba, M., Mbindyo, P., Ochieng, J., Kiriinya, R., Todd, J., Waudo, A., ... & English, M. (2014). The public sector nursing workforce in Kenya: a county-level analysis. *Human resources for health*, *12*(1), 6.

Wamunyu, S. (2016). Factors Influencing Health Workers' Job Satisfaction in Public Hospitals: A Case of Kiambu Level Four Hospital in Kiambu County, Kenya. *Kenya (Doctoral dissertation, University of Nairobi)*.

WHO/IVB/08.04 (W.H.O Toolkit, 2024). – accessed on 6th September 2024: qualityhealthservices.who.int/quality-toolkit/about-toolkit

APPENDICES

Appendix I: Consent Form

Introduction : I **Lucy Waweru,** postgraduate student doing Doctor of Philosophy in Nursing Leadership and Manager at Jomo Kenyatta University of Agriculture and Technology, I am conducting a study on Utilization of structured supportive supervisory tool among front line Nurse Managers at Thika Level 5 Hospital. I am kindly requesting to recruit you into the study. Your participation will involve you allowing me to access part of your personal information like age, and religion.

Broad Objective: To determine effects of utilization of structured supportive supervisory tool among front line Nurse Managers at Thika Level 5 Hospital.

Voluntariness of Participation: Your participation in this study is based on your free will and should you wish to withdraw from the study at any point then you will be at liberty to do so.

Confidentiality: Your participation in the study will be kept confidential and the information you give will be coded in such a way that it is not identified by your name or anything that can reveal your identity. The handling of the information will also be limited to as minimum people as possible.

Benefits: The benefits of taking part in the study will be direct as the study aims at improving the supportive supervisory among front line Nurse Managers at Thika Level 5 Hospital.

Risks: There are no risks from you getting involved in this study. The study findings will not be used for any financial gains.

Right to Withdrawal: Should you decide to withdraw from the study at any point, you will not be subjected to any discriminatory treatment.

Participant's Statement

I have read this consent form and I have had the chance to discuss this research study with a study researcher. I have had my questions answered in a language that I understand. The risks and benefits have been explained to me. I understand that my participation in this study is voluntary and that I may choose to withdraw any time. I freely agree to participate in this research study.

I understand that all efforts will be made to keep information regarding my personal identity confidential

By signing this consent form, I have not given up any of the legal rights that I have as a participant in a research study.

I agree to participate in this research study: **Yes/ No**

Participant signature ……..… Date…….……..…

Researcher's statement

I, the undersigned, have fully explained the relevant details of this research study to the participant named above and believe that the participant has understood and has willingly and freely given her consent.

Researcher's
Name:……..…….

Signature……..… Date……..……

Appendix II: Questionnaire for Frontline Nursing Managers

Section A: Demographic Information

1. Level of education:

   Diploma ☐ Degree ☐ Master's Degree ☐ PhD ☐

2. Gender: Male ☐ ☐male
3. Age bracket in years : 20-30 ☐ 30-40 ☐ 40-50 ☐ 50-60 ☐
4. Your unit/ward of operation?
5. Length of time you have worked in this ward/unit?

Section B: Knowledge on supportive supervision

S/No	Statements	Yes	No
1.	I have been trained on supportive supervision		
2.	I understand the requirement for setting supportive supervision schedule		
3.	I have the skills on how to schedule supportive supervision for my ward		
4.	I have been trained on how to use information forms to collect data		
5.	I have the skills of collecting data using observation check list during supportive supervision of my ward		
6.	I have skills on how to analyze data for my ward supportive supervision		
7.	I have been trained on how to use data to solve staff problems		
8.	I Have been trained on how to monitor staff performance		
9.	I have skills on how to give feedback to my staff after supportive supervision		
10.	I have skills to perform on-job training based on supportive supervision		

Section C: Practice on Supportive Supervision

i) Practice on Supportive Supervision

S/No.	Statements	Yes	No
1.	I have supportive supervisory checklist		

2.	The ward has forms to fill recommendations after supportive supervision		
3.	I allocate time for supportive supervision and follow up of agreed		
4.	I perform supportive supervision on my staff		
5.	I allocate time for training staff on identified gaps		
6.	I use observation check list to collect data during supportive supervision		
7.	I use information forms to collect data for supportive supervision		
8.	I base staff training on analyzed data		
9.	I give feedback after supportive supervision		
10.	I schedule on-job training for my staff		

1. What is supportive supervisory?

.....

.....

2. Do you perform supportive supervision in your ward …….

3. If Yes to No. 3 above, how many days in a week? ……

4. What are the barriers of supportive supervision to your staff

.....

5. What support do you need to perform supportive supervision duties?

.....

.....

ii) Observational Checklist for Supportive Supervision

Key: **1** = Does not meet expectation (20 % and), **2** = Below expectations (40%), **3** = Meets expectation (60%), **4** = Above expectations (80%), **5** = Outstanding (100%). ***(Tick the number appropriate for the item's score)***

S/No.	**Statements**	**1**	**2**	**3**	**4**	**5**

1	Use of plan and schedule for ward/section supportive supervision					
2	Use of supportive supervision observation check list					
3	Use of information form during supportive supervision					
4	Analyzes data after supportive supervision					
5	Identifies gaps in the staff performance					
6	Gives feedback to staff after supportive supervision					
7	Trained staff on identified performance gap					
	Total score					

Scoring adopted from Employee Performance Rating System Supervisor's Handbook (Dorsett, 2016)

iii) Institutional Factors

1. Does the hospital provide schedules for ward supportive supervision by the ward Nurse Managers?

   Yes ☐ No ☐

2. Does the hospital provide observation check list for supportive supervision

   Yes ☐ No ☐

3. Does the hospital provide record facilities for recording the outcome of supportive supervisions?

   Yes ☐ No ☐

4. Does the hospital provide on-job training materials for supportive supervisions?

   Yes ☐ No ☐

5. What help do you suggest for the hospital to provide for improvement of supportive supervision in your ward?

   .....

   .....

   .....

   .....

Appendix III: Focused Group Discussion Guide

1. In your own words what would you say supportive supervision is?
2. How would you describe your status of being empowered to perform supportive supervision on your staff
3. Describe activities you carry out during your ward/section staff supportive supervision
4. What would you say about the supportive supervision tools provided by the hospital?
5. How would you describe the supportive supervision schedules the hospital provides for the ward/section managers to perform supportive supervision?
6. Describe your motivation on performance of supportive supervision to your staff

Appendix IV: Key Informant Interview Guide

1. Do the Frontline Nurse Managers carry out supportive supervision in their wards/section?
2. Do they use SS tools such as SS observation checklist
3. Do they schedule SS
4. Has the hospital trained Frontline Nurse Managers on SS?
5. Does the hospital provide SS schedule and SS tools for the Frontline Nurse Managers?

Appendix V: Questionnaire for the Ward/Unit Nursing Staff

1. Level of education:

   Certificate ☐

   Diploma ☐

   Degree ☐

   Master's degree ☐

   PhD ☐

2. Age Bracket:

   21-30 ☐

   31-40 ☐

   41-50 ☐

   51-60 ☐

3. How long have you worked in this ward/unit?

   .....

4. What is supportive supervision?

   .....

   .....

5. Have you had supportive supervision from your ward in charge?

   .....

6. If yes, how many times in a week?

   .....

7. Is the ward supportive supervision planned and scheduled? Yes ☐ No ☐
8. Did you get feedback of the supportive supervision? Yes ☐ No ☐
9. Did the ward in charge provide on-job training on the identified gap?

   Yes ☐ No ☐

10. If the answer is Yes for No. 7 above, what was your experience of the Supportive Supervision?

.....

.....

11. Does Supportive Supervision motivate you in your care supervision?

Yes ☐ No ☐

12. If Yes, how

.....

.....

13. If No, which explanations would you give?

.....

.....

Appendix VI: Ethical Approvals

REPUBLIC OF KENYA

NATIONAL COMMISSION FOR SCIENCE,TECHNOLOGY & INNOVATION

Ref No: **392245**

Date of Issue: **22/June/2022**

RESEARCH LICENSE

This is to Certify that Ms.. Lucy Waithira Waweru of Jomo Kenyatta University of Agriculture and Technology, has been licensed to conduct research in Kiambu on the topic: UTILIZATION OF A STRUCTURED TOOL ON SUPPORTIVE SUPERVISION AMONG NURSES AT THIKA LEVEL 5 HOSPITAL - KIAMBU COUNTY for the period ending : 22/June/2023.

License No: **NACOSTI/P/22/18086**

392245

Applicant Identification Number

Director General
NATIONAL COMMISSION FOR SCIENCE,TECHNOLOGY & INNOVATION

Verification QR Code

NOTE: This is a computer generated License. To verify the authenticity of this document, Scan the QR Code using QR scanner application.

JOMO KENYATTA UNIVERSITY OF AGRICULTURE AND TECHNOLOGY
P.O BOX 62000(00200) NAIROBI, Tel:(067) 58700001-4
(Office of the Deputy Vice Chancellor, Research Production and Extension Division)

JKUAT INSTITUTIONAL ETHICS REVIEW COMMITTEE

REF: JKU/2/4/896B Date: 28th March 2022

LUCY WAITHIRA WAWERU
SCHOOL OF NURSING, JKUAT

Dear Ms. Waweru,

RE: UTILIZATION OF A STRUCTURED TOOL ON SUPPORTIVE SUPERVISION AMONG NURSES AT THIKA LEVEL 5 HOSPITAL-KIAMBU COUNTY

This is to inform you that JKUAT Institutional Ethics Review Committee has reviewed and approved your above research proposal. Your application approval number is **JKU/IERC/02316/0532.** The approval period is **28th March 2022** to **27th March 2023**.

This approval is subject to compliance with the following requirements;

i. Only approved documents including (informed consents, study instruments, MTA) will be used
ii. All changes including (amendments, deviations, and violations) are submitted for review and approval by JKUAT IERC.
iii. Death and life threatening problems and serious adverse events or unexpected adverse events whether related or unrelated to the study must be reported to JKUAT IERC within 72 hours of notification
iv. Any changes, anticipated or otherwise that may increase the risks or affected safety or welfare of study participants and others or affect the integrity of the research must be reported to JKUAT IERC within 72 hours
v. Clearance for export of biological specimens must be obtained from relevant institutions.
vi. Submission of a request for renewal of approval at least 60 days prior to expiry of the approval period. Attach a comprehensive progress report to support the renewal.
vii. Submission of an executive summary report within 90 days upon completion of the study to JKUAT IERC.

Prior to commencing your study, you will be expected to obtain a research license from National Commission for Science, Technology and Innovation (NACOSTI) https://oris.nacosti.go.ke and also obtain other clearances needed.

Yours sincerely

Dr Patrick Mburugu
Chair, JKUAT IERC

INSTITUTIONAL ETHICS REVIEW COMMITTEE
28 MAR 2022
APPROVED
P.O. Box 62000-00200 NAIROBI
www.jkuat.ac.ke
J K U

COUNTY GOVERNMENT OF KIAMBU

DEPARTMENT OF HEALTH SERVICES

Telephone: +254722106797
Email address: thika15hospital@gmail.com

When replying please quote:

Ref; MOH/TKA/GEN/VOL.V/704

THE MEDICAL
SUPERINTENDENT
P. O. BOX 227 – 0100
THIKA

Date: 29th July, 2022

APPROVAL TO CARRY OUT RESEARCHI

PRINCIPAL INVESTIGATOR: LUCY WAITHIRA WAWERU

RE: UTILIZATION OF A STRUCTURED TOOL ON SUPPORTIVE SUPERVISION AMONG NURSES AT THIKA LEVEL 5 HOSPITAL

Following deliberations by Thika Level 5 Hospital's Training, Research and Ethics Committee (TREC), and subject to provision of all the necessary licenses and ethical approvals, your proposal to carry out the above referenced research, at this facility, has been approved.

This approval is subject to the following mandatory conditions:

1. You shall submit a copy of the abstract of the final report, through the above contact details.
2. Where called upon, you shall be expected to make a feedback presentation to the hospital's Training, Research and Ethics Committee.
3. You shall maintain ethical consideration and the research subjects' confidentiality as outlined in your proposal.
4. Any patient confidential information that you may access during your research should not be used without consent.
5. You shall make payments of applicable research fees to the hospital before commencing research activities.

This letter is valid up to December, 2022.
For any queries feel free to contact the committee chair through the Medical Superintendent's office or Training, Research and Ethics Committee Office.

Thank you and all the best.

Dr. Catherine Munyendo
Chairperson, Training Research & Ethics Committee,
THIKA LEVEL 5 HOSPITAL

COUNTY GOVERNMENT OF KIAMBU
DEPARTMENT OF HEALTH SERVICES

All correspondence should be addressed to HEAD
HRDU – HEALTH DEPARTMENT
Email address: [redacted]
Tel. Nos: 0721641516
0721974655

HEALTH RESEARCH AND DEVELOPMENT
UNIT
P. O. BOX 2344 – 00900
KIAMBU

Ref. No.: KIAMBU/HRDU/22/07/26/RA_WAWERU Date: 26th July 2022

TO WHOM IT MAY CONCERN

RE: CLEARANCE TO CONDUCT RESEARCH IN KIAMBU COUNTY

Kindly note that we have received a request by Ms. Lucy Waithira Waweru of Jomo Kenyatta University of Agriculture and Technology to carry out research in Kiambu County, the research topic being on "**Utilisation Of A Structured Tool On Supportive Supervision Among Nurses At Thika Level 5 Hospital – Kiambu County**"

We have duly inspected her documents and found that she has been cleared by NACOSTI to carry out the research for a period ending 22nd June 2023. She thus does not need any further clearance with another regulatory body in order to conduct research within the county of Kiambu.

However, it is incumbent upon the institution where she is carrying out research to ensure that she receives adequate supervision during the process of conducting the research. This note also accords her the duty to provide a feedback on her research to the county at the conclusion of her research.

DR. MWANCHA KWASA
COUNTY CLINICAL RESEARCH OFFICER
KIAMBU COUNTY