BASIC NURSING TRAINING AND LEADERSHIP PREPAREDNESS OF NURSE MANAGERS IN SOUTH RIFT AND SOUTH NYANZA, KENYA

BY

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DECLARATION

CANDIDATE

This thesis is my original work and has not been presented for a degree in any other university. No part of this work may be reproduced without the prior written permission of the author and or Moi University.

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DEDICATION

I dedicate this work to my husband Philip Towett and our three children, Faith, Mercy, and Ezra, for their encouragement and support.

ABSTRACT

Background: Effective leadership and management are vital for strengthening global health systems, yet they remain under-prioritized in low- and middle-income countries (LMICs). Despite the essential role of nurse leaders in maintaining service delivery amid evolving epidemiological demands, training deficiencies often leave them feeling underprepared for managerial responsibilities. In Kenya, Mid-Level Nurse Managers (MLNMs) are central to hospital unit operations; however, significant knowledge gaps exist regarding whether basic nursing training sufficiently prepares them for these leadership roles.

Objectives: The objectives were to assess nurse managers' level of preparedness for MLNMs' leadership role, determine the level at which basic nursing training prepares nurses for MLNMs' leadership roles**,** assess the contribution of role-induction programs to MLNMs' leadership role preparedness, and determine MLNMs' training needs for leadership role preparation.

Methods: The study was grounded on Henri Fayol's management theory and Frederick Taylor's principles of scientific management. A mixed-methods study design employing a descriptive, cross-sectional approach was conducted in 9 hospitals and 4 Diploma nursing training institutions selected in South Rift and Nyanza, using a multi-level sampling process. The study population involved 68 purposively selected MLNMs and 7 Nursing Directors (NDs). Data was collected using pretested instruments adapted from validated tools, including self-administered questionnaires, Focus Group Discussions (FGDs), Key Informant Interviews (KII), and a document review checklist. Quantitative data was analyzed using frequency tables, percentages, mean, and mode, while Qualitative data was analyzed thematically.

Results: More than half (56.9%) of the MLNMs perceived their level of preparedness for leadership roles as above average, 24.6% excellent, 15.4% average, and 3.1% below average. About 57%, 41%, and 2% of respondents rated their satisfaction with nursing training for leadership roles as satisfied, somewhat satisfied, and dissatisfied, respectively. This is largely due to a focus on theory (65%) through lectures, a change in assessment focus, and a one-month clinical rotation in leadership. Role induction programs contributed to leadership role preparation as follows: formal leadership training (M=4.84, SD = .412, Skw -2.502), Mentorship (M=4.69, SD = .499, Skw -1.196), Supportive supervision (M=4.66, SD = .565, Skw -1.430), 'On-the-job (M=4.60, SD = .552, Skw -.955), and Preceptorship (M=4.35, SD = .734, Skw -.899). Nurse managers stated that formal leadership training, on-the-job training, mentorship, and supportive supervision significantly contribute to preparedness for the leadership role. They noted being appointed to leadership directly or through progressive promotion without structured leadership role preparation. Managers felt least prepared for budgeting and expressed a need for formal training in resource management.

Conclusion: Majority of the respondents rated their leadership preparedness as suboptimal. Basic nursing training was inadequate due to overemphasis on theory, a shift in assessment focus, and limited clinical experience. Formal leadership training, on-the-job training, mentorship, preceptorship, and supportive supervision play a significant role in improving leadership readiness. To effectively fulfill their leadership roles, MLNMs require formal leadership training, resource management training, particularly in budgeting, and training in emotional intelligence.

Recommendation:

Hospital management teams (HMTs) should develop strategies to enhance the leadership preparedness of MLNMs. Nursing training institutions should reassess the leadership and management aspects of basic nursing programs, focusing on budgeting content and the length of clinical rotations for leadership training. Moreover, HMTs should introduce formal leadership training, structured role-induction programs, and training in emotional intelligence to build the capacity of their MLNMs.

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OPERATIONAL DEFINITION OF TERMS

Adequacy: State of being enough or satisfactory for a particular purpose.

Basic Nursing Training: Certificate, diploma, or bachelor's degree programs for entry-level nurses.

Conceptual Framework: An analytical tool with several variations and contexts that can be applied in different categories of work where an overall picture is needed. It is used to make conceptual distinctions and organize ideas to achieve a research project's purpose.

First-Level Nursing Staff : Nurses who directly provide nursing services where they are most needed

Leadership Role: The action or process of social influence, which maximizes the efforts of others, towards the achievement of goals in an organization.

Management: The process of forecasting, followed by planning, organizing, coordinating, commanding, and controlling the activities of others.

Managerial competencies: comprise knowledge, skills, attitudes, and behaviours that an individual requires to facilitate effectiveness in various managerial positions in varied organizations

Mentorship: The relationship between two parties in which an individual with more experience and knowledge provides guidance to a less experienced individual within a specific field.

Mid-Level Nurse Managers: Refers to registered nurse professionals who are responsible for overseeing first-level nursing staff, together with heading and having 24-hour accountability for the management of nursing service units within the health care institutions.

Nyanza Region: Constitutes the region which is home to four counties, namely Homa Bay, Migori, Kisii, and Nyamira counties.

On-the-Job Training: Hands-on method of teaching the skills, knowledge, and competencies needed for employees to perform a specific job within the workplace, whereby training takes place within the employee's normal job environment and may occur as he or she performs their actual work.

Organizational Structure: A way or method by which organizational activities are divided, organized, allocated, coordinated, supervised, and directed toward the achievement of organizational goals

Perceptions: The manner in which something is regarded, understood, or interpreted.

Preceptorship: A period that provides opportunity for nurse leaders to teach, share leadership expertise, monitor, and guide in order to support new nurses to make the transition into the new role and develop their practice further.

Role Preparedness: Quality or state at which someone has been adequately equipped for a specified function.

Role-Induction program: a structured process that introduces new employees to their workplace or job roles to help them transition quickly and integrate into their new environment or role.

South Rift Region: the southern area of the former Rift Valley province in Kenya. It comprises the following counties: Kericho, Bomet, Narok, Kajiado, and Nakuru.

ABBREVIATIONS AND ACRONYMS

ANOVA: Analysis of Variance

CDOH: County Department of Health

CHMT: County Health Management Teams

FGDs: Focus Group Discussions

FLNM: Front-Line or First-Line Nurse Managers

HIC: High-Income Countries

HSS: Health System Strengthening

IREC: Institutional Research and Ethics Committee

KII: Key Informant Interview

LMIC: Low- and Middle-Income Countries

MLNMs: Mid-Level Nurse Managers

NACOSTI: National Commission for Science, Technology & Innovation

NAKAEB: Kajiado County, known as the Narok Kajiado Economic Block

NVivo: qualitative data analysis software used in qualitative & mixed methods research

OJT: On-the-Job Training

PHC: Primary Health Care

POSDCORB: planning, organizing, staffing, directing, coordinating, controlling, and budgeting.

NDs: Nursing Directors

NUM: Nurse Unit Manager

RA: Research Assistants

SPSS: Statistical Package for Social Sciences

SSA: Sub-Saharan Africa

WHO: World Health Organization

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CHAPTER ONE

INTRODUCTION TO THE STUDY

1.0 Introduction

This chapter presents a comprehensive overview of the study's background, articulates the statement of the problem, and delineates the objectives of the study. It also poses pertinent research questions, presents the study justification, and the significance of the study. Additionally, the chapter outlines the underlying assumptions as well as the limitations and delimitations pertaining to the research study.

1.1 Background

Effective leadership and management are widely recognized as essential foundations for strengthening health systems and ensuring the sustainability of health service delivery globally (Nzinga et al., 2018). Within this framework, nurses, who constitute the largest professional cohort in healthcare, are uniquely positioned to spearhead innovation, empower their staff, and significantly improve patient outcomes (Salvage et al., 2019). Their extensive skill set, combined with their daily interactions with patients, equips them to identify challenges, propose creative solutions, and advocate for allocation of resources for use to improve patient care (Vos, 2017). Recognizing this pivotal role, it becomes imperative for healthcare institutions to strategically invest in the development of nursing leaders. This investment should encompass comprehensive training programs, mentorship opportunities, and supportive environments that encourage professional growth. By cultivating leadership skills among nurses, organizations can transform institutional performance, fostering a culture of collaboration and accountability. Consequently, these

strong leadership frameworks enable healthcare systems to adapt proactively to the rapidly evolving technological and social dynamics, ensuring that they remain responsive and resilient in the face of future challenges (Turner, 2019; Daly et al., 2020).

Mid-Level Nurse Managers (MLNMs) and Front-Line Nurse Managers (FLNMs) play pivotal roles within the healthcare management framework, serving as essential links between the top management and frontline clinical staff. These nurse leaders are tasked with a demanding, continuous cycle of accountability that spans 24 hours a day, addressing various aspects of unit operations, strategic staffing, and compliance with clinical protocols (Bryant & Stone, 2022). The primary responsibilities of MLNMs and FLNMs include overseeing day-to-day clinical operations, ensuring the effective allocation of nursing resources, and fostering a collaborative environment that promotes adherence to evidence-based practices. Their role extends beyond operational oversight; they are instrumental in cultivating a culture that prioritizes patient-centered care. By serving as the "voice of the patient," MLNMs create a critical feedback loop that informs clinical practices and enhances patient outcomes (Richey & Waite, 2019; Klaes, 2018).

Empirical evidence underscores the significance of effective management in nursing. Research conducted by Nurmeksela et al. (2021) and Vos (2017) demonstrates a positive correlation between competent management practices and various indicators of staff satisfaction, including job satisfaction, retention rates, and overall morale. This body of research suggests that when nurse managers are equipped with the necessary leadership skills and support, they can significantly influence staff behavior and, consequently, clinical decision-making. Enhanced managerial competency not only fosters a positive

work environment but also leads to improved patient care outcomes, highlighting the importance of strong leadership in nursing contexts (Richey & Waite, 2019). This is demonstrated by the research findings by Bryant & Stone (2022), which portrayed that direct care nurses and other health professionals working under competent nurse managers exhibited higher fulfillment with their jobs, minimal turnover, improved effectiveness in personal care skills, and were better equipped to make decisions, as well as an improved ability to use research findings in their practice. This means that the more competent the nurse managers in a particular organization, the better the satisfaction and retention of the nursing staff, which would hence translate to better patient care outcomes as well as the overall organizational performance and sustainability.

The role of middle-level nursing managers (MLNMs) is increasingly recognized as vital in shaping the quality of healthcare delivery, particularly in settings characterized by complex challenges (Rahman & Mabrouk**,** 2017). However, a significant gap persists in their professional transition, resulting in many MLNMs entering managerial positions without the requisite competencies necessary for effectively leading direct-care professionals. According to research by Bryant and Stone (2022), this deficiency can weaken both the operational efficacy and the overall morale of healthcare teams.

The competencies that are deemed essential for effective managerial performance encompass a universal set of functions, which include planning, organizing, staffing, directing, and controlling. These foundational elements are critical for the efficient management of healthcare services and the organization of team dynamics (Marquis & Huston, 2021). For MLNMs, possessing expertise in these areas is vital not only for the day-to-day management of healthcare teams but also for fostering a culture of collaboration

and accountability among staff. In low- and middle-income countries (LMICs), particularly within the context of sub-Saharan Africa, the situation is aggravated by a prevailing under-prioritization of clinical leadership development. Structural investments in healthcare leadership training are often inadequate, resulting in a workforce that is ill-equipped to address the unique challenges faced by public hospitals in these regions. As highlighted by Johnson et al. (2021) and Nzinga et al. (2018), this disregard leads to significant operational shortcomings, manifesting in poor patient outcomes, inefficient resource allocation, and high staff turnover rates. The implications of inadequate training and support for MLNMs are profound, impacting not only individual career paths but also the broader healthcare systems in which they operate. Addressing these gaps through targeted educational initiatives and investment in leadership development programs is essential for enhancing the capabilities of MLNMs, thereby improving healthcare delivery in LMIC contexts.

Kenya's devolved healthcare system consists of six distinct levels of care, ranging from community health service units that offer essential health interventions (RoGGKenya, 2019) to advanced national referral hospitals that provide specialized, advanced medical treatments (World Health Organization, 2017). Mid-Level Nurse Managers (MLNMs) emerge as a pivotal leadership group in this context. These skilled professionals bridge the gap between health care providers and administration, ensuring that the flow of care is seamless and that patient needs are met effectively. This study focuses on these vital levels of leadership, including nurse unit supervisors, nurse department heads, and frontline nurse managers (FLNMs). Owing to the varied nursing organizational structures within the particular hospitals under study, the researcher involved both the MLNMs and FLNMs as the study participants because they have identical roles, differing only in the hierarchical

scope of units they oversee. Their unique position allows them to influence both strategic decision-making and the quality of patient care.

Fig. 1, below, is an illustration that highlights the specific MLNMs under examination in this study.

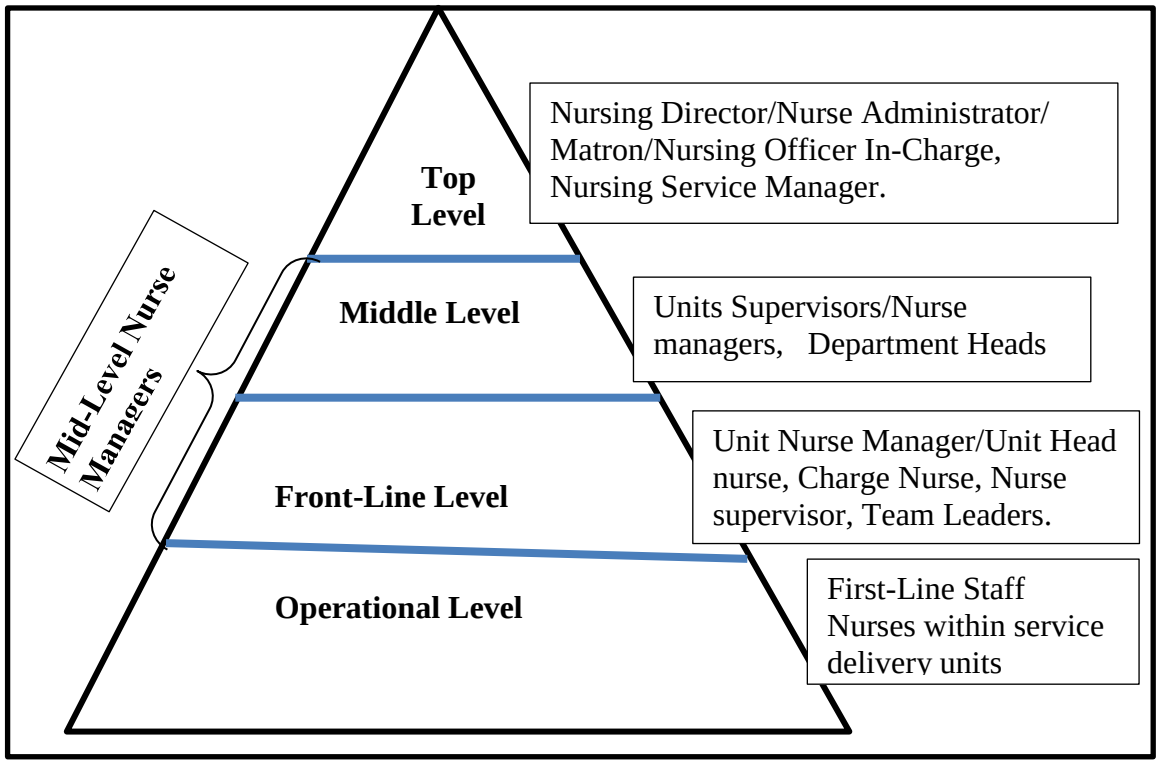

Figure 1: Illustration of the Operational Definition of Mid-Level Nurse Managers
Source: Own Illustration from Literature Review

By skillfully bridging the gap between executive decision-making and the realities of daily healthcare operations, MLNMs play an indispensable role in upholding and enhancing both the quality and efficiency of healthcare delivery. This essential function is particularly critical within County Referral Hospitals (CRHs) and other holistic service facilities, where the seamless integration of various services is fundamental to patient care and outcomes.

1.2. Statement of the Problem

The Nursing Council of Kenya Scope of Practice (NCK, 2020) stipulates that basic nursing education prepares graduates for leadership and management roles upon their completion of training. Mid-Level Nurse Managers (MLNMs), comprising the largest segment of leadership within the healthcare system, play a vital role in maintaining patient care safety, quality, and efficiency (Johnson et al., 2021; Bryant & Stone, 2022). Thus, establishing high standards of leadership, management, and accountability is an essential prerequisite for contemporary nursing practice (Maia et al., 2019).

Despite these professional requirements, a notable gap persists between the educational preparation of nursing professionals and the leadership demands encountered in clinical settings. While basic nursing programs effectively impart essential clinical skills, they often fall short in cultivating sufficient leadership competencies necessary for success in increasingly complex healthcare settings (Frasier, 2019; Ortega et al., 2018). Consequently, MLNMs are obligated to navigate an evolving healthcare environment that is characterized by changing epidemiological trends and increasing regulatory demands, without the necessary managerial preparation and competencies (Daly et al., 2020).

Inadequate leadership preparation among mid-level nurse managers (MLNMs) poses significant challenges within Kenya's healthcare system, negatively affecting various critical aspects of care delivery. The persistence of this gap is critical because, without adequate preparation, MLNMs face increased professional burnout and suboptimal performance, which directly compromises the quality of nursing care and organizational effectiveness (Ullrich et al., 2020; Kim & Lim, 2022).

Clinically, inadequately prepared nurse managers face challenges in coordinating care effectively, thereby intensifying the risk of adverse patient outcomes and compromising patient safety. On an organizational level, ineffective leadership creates a negative work environment, leading to employee dissatisfaction and increased attrition among nursing staff. High turnover disrupts team dynamics and care continuity, straining the healthcare system (Al-Yami et al., 2024). Economically, ineffective management results in higher operational costs due to increased turnover, ongoing training needs, and potential malpractice claims related to patient safety (Bae, 2022; AONL, 2024).

While existing literature has addressed broader nursing leadership challenges in Kenya, a significant gap remains in empirical research on the capacity of basic nursing training to prepare MLNMs for leadership within the regional clusters of Bomet, Kericho, Narok, Kisii, and Nyamira Counties. Failure to bridge this localized knowledge gap threatens the performance and leadership efficacy of the healthcare systems in these regions. Therefore, this study examined nurse managers' level of leadership preparedness, satisfaction with basic nursing training in terms of course content, clinical experience duration, and the effectiveness of leadership practical assessments, and the contribution of role induction programs to leadersdhip leadership preparedness. It also sought to determine thenurse managers' training needs for leadership preparation. Understanding the gaps in nursing training and nurse managers' readiness for leadership is crucial for developing strategies for enhancing leadership capabilities, improving patient outcomes, staff satisfaction, and healthcare efficiency.

1.3 Purpose of the Study

The purpose of this study was to assess the training and leadership preparedness of nurse managers in the South Rift and South Nyanza Regions of Kenya.

1.4 Objectives of the study

The specific objectives of this study were to:

1. Assess the level of leadership preparedness for MLNMs' role among the nurse managers in selected hospitals in Bomet, Kericho, Narok, Kisii, and Nyamira counties, Kenya.
2. Determine the extent to which basic nursing training prepares nurses for MLNMs' leadership roles in selected hospitals in Bomet, Kericho, Narok, Kisii, and Nyamira counties, Kenya**.**
3. Assess the contribution of role-induction programs to MLNMs' leadership role preparedness among the Nurse Managers in selected hospitals in Bomet, Kericho, Narok, Kisii, and Nyamira counties, Kenya.
4. Determine MLNMs' training needs for leadership role preparation in selected hospitals in Bomet, Kericho, Narok, Kisii, and Nyamira counties, Kenya.

1.5 Research Questions

1. What is the level of preparedness for MLNMs' leadership role among the nurse managers in selected hospitals in Bomet, Kericho, Narok, Kisii, and Nyamira counties, Kenya?
2. What is the extent to which basic nursing training prepare nurses for MLNMs' leadership roles in selected hospitals in Bomet, Kericho, Narok, Kisii, and Nyamira counties, Kenya?

3. What is the contribution of role-induction programs to MLNMs' leadership role preparedness among the nurse managers in selected hospitals in Bomet, Kericho, Narok, Kisii, and Nyamira counties, Kenya?
4. What are MLNMs' training needs for leadership role preparation among nurse managers in selected hospitals in Bomet, Kericho, Narok, Kisii, and Nyamira counties, Kenya?

1.6 Justification of the Study

The justification for this study is grounded in the disconnect between the expectation that basic nursing education produces competent entry-level nurse managers, as outlined in the Nursing Council of Kenya's Scope of Practice (NCK, 2020), and the empirical reality that basic nursing training curricula remain disproportionately focused on developing clinical psychomotor skills. This creates a significant deficiency in leadership competencies, threatening the stability of the healthcare system (Ortega et al., 2018).

The necessity of this study is articulated through the following four tenets: First, the mitigation of risk related to nursing workforce sustainability. This is because Mid-Level Nurse Managers (MLNMs) represent the largest leadership cohort within the health system, commanding greater influence on healthcare outcomes (Johnson et al., 2021). According to Nzinga et al. (2018), to effectively support and supervise the large nursing workforce, MLNMs must possess the necessary leadership competencies acquired through training. Consequently, inadequate preparation for this role is a primary driver of workplace stress, managerial burnout, and high staff turnover (Ullrich et al., 2020; Kim & Lim, 2022). By investigating the root causes of this underpreparedness, this study seeks to

safeguard the sustainability of the nursing workforce through enhanced preparation of nurses for leadership roles, resulting in improved satisfaction and retention.

Secondly, there is an urgent need to link leadership preparation directly to patient safety. This is because inadequately prepared nurse managers are less effective at implementing safety protocols and overseeing clinical leadership, a failure that directly correlates with increased patient outcomes (Bryant & Stone, 2022). This study is justified by the need to establish leadership competency as a mandatory component of high-quality patient care. Thirdly, it is for the resolution of the geographical knowledge gap, which is informed by the fact that while localized research, particularly in the Kenyan coastal region, has identified minimal formal preparation among nurse managers (Nyikuri et al., 2015), there is an absence of empirical data concerning MLNMs in the South Rift and South Nyanza regions. By focusing on Bomet, Kericho, Narok, Kisii, and Nyamira counties, this study addresses a critical localized knowledge gap, ensuring that health policies and governance strategies within these regions are grounded in context-specific evidence that can then be extrapolated to other counties.

Lastly, it informs structural appointment processes and curriculum reform, since to navigate the complex demands of modern healthcare, structured leadership training is vital (Nzinga et al., 2018). This study is prudent for determining specific deficiencies in the basic nursing training curriculum and institutional leadership role induction processes. The outcomes will provide a foundational guide for transitioning from unstructured forms of appointments based on clinical experience and seniority (Ocho et al., 2021), to proactive, evidence-based capacity-building programs that ensure managers are fully equipped to discharge their leadership and management duties upon appointment.

1.7 Significance of the study

The findings will provide evidence-based insights into the leadership development of nurses, offering substantial benefits to the following stakeholders:

Significance to the policy makers, regulatory bodies and educators. This study is of paramount significance to the Nursing Council of Kenya (NCK), the Ministry of Health, and nursing training institutions, as it provides the empirical evidence necessary to bridge the gap between educational preparation and clinical leadership demands. By providing data-driven insights into the efficacy of current basic nursing curricula, the findings serve as a critical prompt for curriculum review and national policy reform. Specifically, this research informs the integration of strong, context-relevant management training modules into national training standards, ensuring that future nurse leadership preparation is commensurate with the complex operational and governance requirements of modern healthcare systems.

To the County Health Management Teams (CHMTs) and Hospital Management Teams (HMTs). This study provides a vital problem-solving framework for healthcare leadership in Bomet, Kericho, Narok, Kisii, and Nyamira counties to objectively assess the leadership readiness of their nursing workforce. By identifying specific leadership preparation gaps, the research offers a strategic outline for the implementation of structured role-induction programs, mentorship frameworks, and preceptorship models. Furthermore, the findings serve as an organizational and economic justification for these interventions, demonstrating their potential to mitigate leadership transition difficulties, enhance operational efficiency, and improve staff retention, thereby reducing the high costs associated with managerial turnover and suboptimal unit governance.

Significance to Mid-Level Nurse Managers (MLNMs). This study serves to strengthen the professional voices of MLNMs by validating their lived experiences of leadership transition difficulty and the complex challenges inherent in their roles. By formally documenting their perceived training needs, the study advocates for the institutionalization of structured leadership preparation frameworks. Such formalization is significant as it provides a clearer, evidence-based pathway for career progression, significantly enhancing managerial self-efficacy. Ultimately, the findings aim to reduce the psychological burden and professional burnout associated with underpreparedness, empowering managers to cultivate more collaborative, innovative, and resilient clinical work environments.

Significance to the patients and the general public. Ultimately, this study serves the broader public interest by advocating for a healthcare environment anchored in proficient and well-prepared nursing leadership. The research emphasizes the direct correlation between managerial competence and the delivery of high-quality, safe, and efficient health services. By identifying the pathways to enhance leadership readiness, the study aims to foster institutional standards characterized by improved patient safety, superior quality of care, and optimized resource management. These improvements lead to enhanced healthcare outcomes and greater system accountability for the community at large.

1.8 Scope of the Study

This study involved the Mid-Level Nurse Managers from nine selected hospitals in South Rift and Nyanza regions, namely: Kaplong Mission Hospital, Longisa County Referral Hospital, Litein Mission Hospital, Kapkatet Hospital, Kericho County Referral Hospital, Kericho Nursing Home, Narok County Referral Hospital, Kisii Teaching and Referral and Nyamira County Referral Hospital. This selection was based on the fact that they are the

hospitals that provide both Out-Patient and In-Patient services and their health facility physical structures are divided into service delivery units. This therefore provides a wider range of unit nurse managers as the target population to obtain the information to inform this study. These were also the facilities that offered clinical rotation sites for nursing students, both from their own counties as well as those from other counties. These clinical rotations provided by the study sites included rotations for the nursing leadership from the management sections. Furthermore, out of the nine study sites, six have nurse training institutions within the selected counties, which provided an opportunity for the researcher to obtain data from reviewing the curricula from these nurse training institutions in order to gain information on the leadership and management section of the curriculum.

1.9 Limitations and Mitigation Measures

The following limitations may impact the findings of the study:

Generalizability bias, because while the study provides deep insight into the South Rift and South Nyanza regions, the findings may not be fully generalizable to the private healthcare or urban settings like Nairobi, where resource allocation and training opportunities may differ from those in the study sites.

Also, its narrow geographical and institutional focus, concentrating on nine hospitals in the South Rift and South Nyanza regions. This limited sample may affect the generalizability of the findings to the broader nursing leadership population in Kenya. To enhance data richness, nurse managers with at least two years of leadership experience were engaged, ensuring valuable insights. A mixed-methods approach was used to triangulate quantitative data with qualitative experiences, providing a comprehensive exploration of leadership preparedness despite the localized sample.

Another limitation of the study is self-reporting bias. This is because this study sought the perceptions of the mid-level nurse managers regarding their preparedness for leadership roles. This poses a risk of social desirability bias, where participants may feel pressured to appear more capable than they feel, resulting in either overstating their preparedness or being reluctant to criticize their training and institutional support. To mitigate social desirability bias inherent in self-reported data, the researcher employed several strategies. Firstly, anonymity was guaranteed to dissociate personal identity from professional evaluation. Secondly, methodological triangulation was utilized by pairing quantitative surveys with qualitative interviews; the researcher was able to cross-verify perceptions against lived experiences.

Another limitation is the cross-sectional constraint – This study captured data on preparedness at a particular point in time. It cannot account for how leadership competence evolves over a longitudinal period as a manager gains years of on-the-job training experience. This was mitigated by first using experience as a covariate. Since the researcher could not watch them grow over time, their current years of experience in practice and in a leadership role were used as key variables in the analysis. Secondly, by leveraging the qualitative depth, because qualitative data provides the story behind the cross-sectional data.

Finally, the limitation of the sampling is a result of the use of non-probability sampling techniques, particularly purposive sampling. This was mitigated by the use of the maximum variation strategy, whereby, within the purposive framework, the researcher sought to include managers from various units, for example, Maternity, Medical-Surgical,

critical care units, and also different counties to capture a broader range of administrative experiences and institutional cultures.

1.10 Assumptions

The study was based on the assumptions that were identified by the researcher prior to conducting the research, as well as those that emerged in the course of the research process. First, the study assumed that the participants would be truthful and willing to provide relevant information to the research question. The study was narrowed down to ensure appropriate data for the research objectives were obtained by ensuring that the inclusion criteria were set to focus on the Mid-Level nurse managers as the main respondents, and the interview questions were related to the level of leadership role preparedness concerning the basic nursing training that the Mid-level nurse managers received.

Secondly, the study was based on the assumption that in Kenya, all counties have comparable health delivery system structures from level 1 to level 5 facilities. It was also deemed that the private and faith-based organizations would have similar health delivery system structures, except for minimal variations in certain faith-based hospitals and training institutions. This would then justify the fact that the results of the study from the selected facilities within the five counties would be generalizable to all the counties in Kenya.

Thirdly, the study was based on the assumption that at the end of the basic nursing training, nurses were expected to be adequately prepared to take up leadership roles within different healthcare settings. It was also assumed that all the diploma nursing training institutions designed their individual curricula in compliance with the core curriculum guidelines provided by the Nursing Council of Kenya (NCK), which is the regulatory body for nursing

training and practice. This, therefore, would also provide reason for utilizing the results from the 4 reviewed curricula in the study to generalize to the entire population of diploma nursing training programs. In reviewing the basic nursing training curriculum, the questions in the document review checklist focused on the leadership section of the curriculum only to explore the extent to which the nurse managers perceived their level of leadership role preparedness, having undertaken a basic nursing training.

Lastly, the study was also based on the assumption that the nursing directors would provide meaningful information regarding the preparedness of Mid-Level Nurse Managers for their leadership roles because they constantly provide supervision and evaluation of their performance. This then justifies the reason for obtaining data from the Nursing directors and the key informants for the study, yet the study focused on the preparedness of the Mid-Level Nurse Managers' competencies.

CHAPTER TWO

LITERATURE REVIEW

2.0 Introduction

This chapter presents a literature review of available, relevant, and current research related to the study topic and objectives. The literature for this study has been organized according to the following subheadings: the level of leadership preparedness for MLNMs' role among the nurse managers, the extent to which basic nursing training prepares nurses for MLNMs' leadership roles, the contribution of role-induction programs to MLNMs' leadership role preparedness among the Nurse Managers, and MLNMs' training needs for leadership role preparation. Further, it discusses the theoretical and conceptual frameworks for the study.

2.1 Level of leadership preparedness for the Mid-Level Nurse Managers role among the nurse managers

Nurse managers play a pivotal and multifaceted role within healthcare organizations. Their responsibilities include leading and overseeing service delivery units, coordinating care, collaborating with multidisciplinary teams to ensure wide-ranging patient care, and making considerable contributions to the overall quality of service for patients. This implies that nurse managers must possess a wide range of knowledge, capabilities, and skillfulness to make them competent to efficiently and effectively lead different teams ranging from small groups to larger groups; harmonizing the activities of these various teams as well as providing a conducive working environment that fosters quality nursing services to patients (Zendrato, Hariyati & Afriani, 2019). Owing to this complexity and the dynamics involved in the role, it is important to understand the perceived level of leadership role preparedness of the MLNMs as lived experience because their perceptions influence their experience

and performance, thus impacting patient and organizational outcomes (Manion, Griffin, & Van Dam, 2021).

According to the study by Hughes (2018) regarding the barriers to effective nurse leadership, numerous factors contribute to nurses perceiving themselves as underprepared to undertake leadership roles. Some attributed this to the time constraints and time pressure at work, consequently leading to difficulties maneuvering the work-life balance, owing to the complexities involved in the nurse manager's role, while others cited limited organizational leadership development opportunities. Other barriers included a lack of formal preparation for leadership before undertaking the leadership role. These barriers contributed to nurse managers who participated in the study feeling that they were ill-prepared in their current leadership roles. While Hughes (2018) provides a foundational understanding of the barriers to effective nurse leadership, the study presents limitations in terms applied to the current research context of Mid-Level Nurse Managers (MLNMs) in Kenya.

First, there is the contextual and geographical limitation. The findings by Hughes (2018) are predominantly entrenched in Western healthcare standards where organizational structures and resource allocations differ significantly from Low- and Middle-Income Countries (LMICs). For example, the "time pressure" identified by Hughes (2018) may be intensified in the Kenyan context by extreme nurse-to-patient ratios and the administrative burden of a devolved health system. Therefore, while Hughes identifies what the barriers are, this study is required to explore how these barriers manifest in a resource-constrained environment like the South Rift and South Nyanza regions. Secondly, the scope of the definition of leadership by Hughes (2018) focuses broadly on "nurse leadership," which

can be an ambiguous term spanning from bedside clinical leadership to executive governance. In contrast, the current study narrows the focus to Mid-Level Nurse Managers (MLNMs). This is a critical distinction because MLNMs face a unique pressure balancing the strategic directives of senior management with the operational realities of frontline staff, which is a dynamic that Hughes' broader study does not fully explore. Lastly, there is a methodological gap regarding leadership preparedness versus execution of the management function. This is because Hughes (2018) effectively highlights that nurses feel underprepared. However, the study relies heavily on the perceptions of barriers rather than measuring the specific level of preparedness in concrete management functions like budgeting, staffing, and coordinating. The current study addresses this gap by not only identifying that managers feel underprepared but also quantifying their preparedness across the seven universal management functions: planning, organizing, staffing, directing, coordinating, controlling, reporting, and budgeting (POSDCoRB).

There is considerable variation in the transition of nurse managers into leadership roles across organizations, even as the role of nurse managers is growing increasingly intricate. Many nurse managers are appointed to leadership and management positions without the necessary knowledge, and then they are expected to acquire it through experience as they perform in the leadership role (Warshawsky, Caramanica, & Cramer, 2020). The prevailing perceptions among nurse managers regarding their unsatisfactory preparation for leadership roles raise significant concerns. Inadequate leadership competencies and suboptimal preparedness can lead to adverse outcomes for both patients and staff. Consequently, these circumstances underscore the necessity of establishing a well-structured recruitment process for nurse managers, one that is based on the assessment of

relevant skills and capabilities. This approach is essential in fostering effective leadership within nursing, ultimately enhancing the quality of care and organizational effectiveness (Paarima *et al.*, 2022). The study by Warshawsky et al (2020) highlights that managers are expected to learn "on the job." While this is a global phenomenon, the authors do not sufficiently address the cost of this learning curve in resource-constrained environments. In high-resource settings like the US, where their study was based, learning by doing is often mitigated by administrative support staff and digital management systems. In the Kenyan context, an MLNM lacks these safety nets; thus, the lack of prior knowledge does not just cause role stress, but it can lead to systemic failures in staffing crises and poor patient health outcomes. Additionally, the study by Warshawsky et al. (2020) assumes a linear path, indicating that managers will eventually acquire knowledge through experience and performance. This study challenges that assumption by questioning whether experience alone is sufficient to master complex functions like budgeting and strategic planning. Without a formal baseline of preparedness, experience may simply reinforce inefficient or trial-and-error management practices rather than fostering true competency.

Research studies have shown that nurse managers often begin their leadership roles without prior preparation and that they are consistently ill-prepared for their leadership roles (Bryant & Stone, 2022). This is attributed to the lack of training and support during their transition into their roles, which has contributed to their suboptimal performance both at the individual level and at the organizational level (Ullrich et al., 2020). These assertions are reinforced by the findings in the study by Al Sabei et al. (2024) regarding factors influencing nurses' willingness to lead, which showed that fifty-three percent of the nurses were willing to undertake leadership responsibilities given the adequacy of the leadership

role preparation before being appointed to the position. The study by Al Sabei et al (2024) presents a limitation emphasize that willingness to lead is contingent upon the adequacy of preparation. While this is a vital psychological insight, the study fails to define what adequate preparation actually looks like in practice. For a Mid-Level Nurse Manager (MLNM) in Kenya, adequate may go beyond clinical leadership to include navigating procurement laws or devolved county budgets. By focusing primarily on the intent to lead, Al Sabei et al. (2024) leave a gap regarding the functional competence required once the leadership role is assumed. All three studies, Bryant & Stone (2022), Ullrich et al. (2020), and Al Sabei et al. (2024), provide a generalized view of unpreparedness. They do not dissect the level of preparedness for the specific administrative functions (Planning, Organizing, Staffing, Directing, Controlling, Coordinating, and Budgeting) that are the focus of this thesis. While they tell us that managers are ill-prepared, they do not tell us which specific function, for example, Budgeting versus Directing, is the most neglected. This thesis fills that gap by providing a functional breakdown of the competency deficit.

Organizations frequently promote clinical staff to nurse management positions without adequately preparing them for their new roles. The decision to promote is often based on factors such as the candidate's extensive experience in nursing, exceptional clinical skills, or seniority. However, without improved recruitment, selection processes, and ongoing development, these new nurse managers may feel overwhelmed and ill-prepared to handle the wide range of interpersonal issues and constantly evolving priorities that come with the role (Gunawan, Aungsuroch & Fisher, 2020). This was supported by the findings of the study on ‘managerial and leadership competencies of front-line nurse managers in Mikkah City’, which revealed that all the FLNM who participated in the study had not attained the

competent level in terms of leadership and managerial roles and responsibilities. Findings from the same study further showed that the hospital had not put in place the protocols, standards, or strategies for appointment of nurses into FLNM positions. FLNMs held the trust that their appointment into a leadership role was done according to: outstanding clinical experience in nursing practice (55%), due to scarcity of senior FLNMs (31%) and educational qualifications (14%). Subsequently, this contributed to the assertion that FLNM, who were appointed into leadership and managerial positions, were ill-prepared, evidenced by the lack of the necessary leadership competencies to execute their responsibilities effectively (Alomairi, Seesy & Rajab, 2018)

This has been identified as a critical factor that significantly influences the overall operational effectiveness of these organizations (Ocho *et al.*, 2020). The multifaceted nature of the NUM's responsibilities, encompassing clinical, administrative, and leadership duties, underscores the significance of ensuring that these professionals receive comprehensive training and ongoing support to effectively fulfill their roles. Without adequate preparation, NUMs find themselves ill-equipped to handle the complexities and demands of their positions, potentially compromising the delivery of high-quality patient care and the overall efficacy of healthcare units (Josefina, 2018). The study implies a deterministic relationship, indicating that lack of preparation equals compromised care. While this is often true, it overlooks the adaptive capacity of nurse managers in resource-limited settings who often innovate or rely on informal peer support networks to maintain quality despite a lack of formal leadership training. By focusing solely on the ill-equipped nature of the manager, Josefina (2018) misses the opportunity to explore how existing informal competencies might mitigate the absence of formal preparation, a gap this study

explores within the Kenyan context. Additionally, there is also a methodological limitation because Josefina (2018) discusses the overall efficacy of healthcare units as a consequence of leadership preparedness, but does not provide a strong empirical framework to measure that efficacy. Efficacy remains a broad, qualitative term in her work. This thesis seeks to move beyond this by framing leadership preparedness as a dependent variable that has a measurable relationship with specific operational effectiveness indicators in terms of capacity to execute the management functions in County Referral Hospitals.

According to a qualitative study done in two Kenyan hospitals involving eight mid-level clinical managers complemented with 51 front-line workers by Nzinga et al (2018), findings presented various perceptions and experiences that could be grouped into three main categories, namely: those who were willing, those reluctant and those who were ambivalent to enact leadership and managerial roles. Those who were willing expressed that taking the leadership role is an opportunity for exposure to realize problems faced by juniors, being a role model, solving issues, having authority to influence behavior, as well as presenting a chance for research on leadership. The group also indicated that taking a leadership role is an opportunity to be innovative and further stated that they received support and encouragement from senior managers during their transition, which distinguished the importance of having mentors and role models who motivated them during their transition into the new roles. The second group reluctantly displayed no desire to learn how to manage because they felt that leadership is a big responsibility, an extra burden on top of their already demanding clinical roles, and that they were hard-pressed into the role. They also expressed that the multifaceted dynamics involved in the role, such as supervision of nurses and interns, orienting, providing technical advice, and at the same

time being required to give holistic care, led to tension and a feeling of being demoralized. The third group, who were ambivalent, exhibited fluctuations from time to time, having discouragements from managing conflicting expectations from senior managers, peers, and juniors to the point of even wishing to resign from their responsibilities, but sometimes they felt that they accepted the responsibility.

A quantitative descriptive survey by Vos (2017) aimed at assessing and analyzing the complexity of the Front-line Nurse Managers' role was conducted in the state of California and revealed that the role of frontline nurse managers goes beyond their basic professional training. This is because they are constantly required to balance competing priorities, including clinical, managerial, and financial responsibilities. Despite the importance of the role that the MLNMs play in healthcare settings, nurse managers often do not commence their careers with proficiency in terms of the skills and competencies they need to lead and support direct care professionals (Bryant & Stone, 2022)

2.2 The extent to which basic nursing training prepares nurses for the Mid-Level Nurse Managers' leadership role

This study assessed the preparedness of nurse managers for leadership roles in selected hospitals across Bomet, Kericho, Narok, Kisii, and Nyamira counties, addressing the limited research on this topic in Kenya. It examines nurse managers' satisfaction with basic level nursing training in terms of course content, clinical experience duration, and the effectiveness of assessments. As the dynamics of healthcare continue to evolve, it becomes imperative to enrich nursing education programs, which incorporate comprehensive training that fosters leadership skills and equips future nurses with the necessary competencies to thrive in these demanding roles (Frasier, 2019). Understanding the gaps

in nursing training and nurse managers' leadership readiness is crucial for developing strategies for enhancing leadership capabilities, improving patient outcomes, staff satisfaction, and healthcare efficiency

Nurse training is the systematic process of equipping entry-level nurses with the theoretical knowledge and practical experience needed to develop professional competencies and readiness for leadership roles. Adequacy measures how well this training prepares nurses with the necessary knowledge, skills, and competencies for effective leadership (Purabdollah et al., 2023).

Research consistently emphasizes the importance of developing leadership skills in newly qualified nurses, as these competencies are closely associated with improved patient outcomes, staff retention, and the overall quality of care. The *AACN Essentials* (2021) establish leadership, quality improvement, and interprofessional collaboration as core competencies for all entry-level nursing graduates, highlighting the expectation that leadership preparation be central to nursing curricula. Researchers further claim that leadership development must be woven throughout training rather than confined to a single course, ensuring that graduates are adequately prepared for the demands of practice (Kukkonen et al., 2023; Miles & Scott, 2019). Structured frameworks such as the 'Nursing Leadership Development Model' provide pathways to foster leadership in pre-licensure students, equipping them to apply these skills in real-world contexts (Miles & Scott, 2019). Globally and across diverse contexts, persistent concerns have been raised regarding the adequacy of entry-level nurse training in preparing graduates for leadership roles. Evidence indicates a discrepancy between the competencies emphasized in nursing training and the demands of clinical practice (Abdul-Rahim et al., 2025). Nurse managers frequently

perceive significant gaps in new graduates' leadership and management skills, particularly regarding the application of current knowledge to practical, real-world scenarios (Kukkonen et al., 2023; Purabdollah et al., 2023). This inadequate preparation is often attributed to entry-level nursing programs prioritizing theoretical instruction over essential practical skill development, leaving graduates ill-equipped for complex managerial responsibilities (Södersved Källestedt et al., 2020). Similar conclusions have been drawn by Nyikuri et al. (2015) and Nzinga et al. (2018), who argue that formal training alone does little to cultivate the leadership attributes necessary for effective professional competence. Collectively, these studies underscore a consistent global challenge: entry-level nursing education remains insufficient for equipping nurses with the leadership skills required to navigate contemporary healthcare systems.

Evidence from multiple studies suggests that entry-level nursing education does not adequately prepare graduates for leadership roles. Hughes' (2018) scoping review highlights persistent deficiencies in foundational preparation, with mid-level nurse managers often seeking additional education and specialized training to compensate for gaps in leadership competence. The transition from student to professional often reveals a significant gap between entry-level training and the leadership readiness expected in practice (Frasier, 2019). Newly qualified nurses and their managers frequently report that graduates feel unprepared for leadership responsibilities, notably struggling with confidence and facing difficulties in prioritizing complex ward tasks (Frasier, 2019). These consistent findings indicate that graduates fall short of the expected performance in leadership positions. Given the increasing complexity of modern healthcare, researchers advocate for the proactive integration of comprehensive leadership training into nursing

curricula to ensure future nurses are adequately equipped to navigate emerging challenges (Frasier, 2019; Salvage et al., 2019).

2.2.1 The extent to which the course content of basic nursing training prepares nurses for leadership roles.

The study by Marcellus et al (2018) on 'The role of education in developing nurse leadership' depicted that nursing students need a strong educational foundation from the start of their training to enhance their leadership skills and gain practical experience throughout their coursework. This requires a curriculum that strikes a balance between theory, coursework, and clinical practice (Abdul-Rahim et al., 2025). Furthermore, according to WHO (2020), nursing curricula must align with current healthcare issues to prepare nurses for effective teamwork and to maximize their skills in diverse roles within the practice environment.

The study by Scammell et al. (2020) depicted that even though BScN programs include instruction on leadership and management in nursing, the evidence is that the level of competence nurse leaders need in the practice environment far surpasses the elementary educational backgrounds for practice. Furthermore, the study revealed that leadership and management content were placed towards the end of the nurse training program during the final year. This implies that this disadvantaged the nursing students because they are left with little time for self-development in the leadership aspect.

The findings underscore a fundamental gap between current undergraduate nursing education and the level of leadership competence required in modern clinical practice. There is a consensus that developing effective nurse leaders requires a strong educational foundation and a curriculum that integrates theoretical knowledge, coursework, and

practical experience from the onset of training (Marcellus et al., 2018; Abdul-Rahim et al., 2025). Furthermore, this curriculum must align with current healthcare issues to prepare graduates for effective teamwork and diverse practice roles (WHO, 2020).

2.2.2 The extent to which clinical experience duration in basic nursing training prepares nurses for leadership roles.

In addition to curriculum design, the duration and quality of clinical experience significantly influence leadership readiness. Evidence shows that leadership and management competencies strengthen progressively with increased clinical exposure, particularly during the transition from education to practice (Alilyyani et al., 2024). Longer clinical placements, coupled with effective supervision, provide opportunities for students to practice decision-making, problem-solving, and team coordination—skills central to nursing leadership (Baharum et al., 2023; Hsieh et al., 2021). This suggests that leadership preparation is most effective when curricula integrate both structured theoretical content and adequate clinical experience, enabling graduates to develop personal attributes, team management skills, and systems thinking essential for leading in complex healthcare environments (Hsieh et al., 2021).

Research strongly supports the idea that a longer, structured, and focused clinical experience is essential for developing leadership skills in nurses, particularly for those transitioning into professional practice. This support is largely based on the positive outcomes linked to formal residency programs and the importance of time spent cultivating core competencies (Abdul-Rahim et al., 2025; Scammell et al., 2020). Nonetheless, research indicates that entry-level nurse training focuses heavily on central clinical skills,

while leadership skill development receives minimal emphasis (Ortega et al., 2018). Additionally, the study by Ocho et al (2021) noted that nurses often graduate and are thrust into leadership roles without adequate preparation or having demonstrated leadership competency in complex practice environments. In reality, Ortega et al (2018) suggested that this lack of leadership skills may stem from insufficient field experience or gaps in academic training related to leadership and management.

Previous research highlights the need for future nurse managers to receive additional training beyond entry-level education to effectively navigate the complex healthcare environment. It emphasizes inspiring prospective nurse leaders to pursue at least a Bachelor of Science in Nursing (BScN) or advanced practice training to enhance their education and leadership skills (Acob et al., 2018).

2.2.3 The extent to which clinical practicum assessments in the basic nursing training prepare nurses for leadership roles

The transition from student to nurse, especially in contexts that necessitate leadership roles, represents a critical area of inquiry within nursing education and workforce development. This shift is essential not only for the individual career trajectories of nursing graduates but also for the overall efficacy and sustainability of health care systems (Abdul-Rahim et al., 2025).

A study by Ahmari et al. (2021) identified two key themes in clinical evaluation challenges faced by nursing instructors and students: a lack of effective clinical education instructors affecting evaluation, and secondly, shifting the responsibility of supervising students onto the ward, coupled with insufficient direct oversight from instructors, can negatively impact clinical education and discourage effective learning.

A study on final-year nursing students' views regarding clinical assessment identified the following key themes: the need for a valid assessment tool, the importance of skilled preceptors, and the necessity of collaboration between academic and clinical settings to support both preceptors and students. It also suggested forming academic-clinical partnerships to review clinical education programs and noted that students were often task-oriented and not fully prepared for professional practice (Wu et al., 2017)

Research highlights significant issues with the relevance and replicability of clinical assessment in nursing education. Nurse mentors note a substantial gap between specified learning outcomes and the actual clinical learning environment, arguing that existing outcomes often fail to reflect the unique features of the nursing profession. For instance, home care nursing mentors specifically require more realistic learning outcomes that capture the distinctiveness of their setting to effectively evaluate student competencies (Christiansen et al., 2021).

2.3 The contribution of role-induction programs to Mid-Level Nurse Managers' leadership role preparedness.

Nurses at all levels require strong leadership skills for them to lead efficiently, enhance patient safety, and improve the quality of care. Owing to their pivotal influence, it is therefore prudent to exercise extensive development of leadership skills among MLNMs (Whitby, 2018). This was further reinforced by Manion et al. (2021), who also argued that the role is commonly acknowledged as intricate and challenging, and individuals entrusted with this responsibility should be equipped with a range of skills and qualities for them to effectively fulfill it.

2.3.1 Formal Leadership Training

According to the executive summary of WHO (2020) in the 'State of the World's Nursing' report, it was emphasized that due to the migration of experienced nurses seeking employment abroad, it has contributed to younger, less experienced nurses being left to run nursing services, and consequently, others being appointed to leadership positions without prerequisite competencies for the role. This report suggests that it is sensible for the health sector and health institutions to establish or plan for leadership training programs to facilitate leadership growth and development in young nurses. This is attributed to the fact that nurse leaders are appointed to leadership positions because of their technical competence earned from their experience but they are deficient in leadership and management competencies (WHO 2020).

The study's findings indicate that Nurse Unit Managers (NUMs) were promoted to their positions by chance rather than through conscious selection or being pre-chosen by management based on their perceived leadership and management skills. Even though NUMs found leadership workshops and short courses to be very helpful, they struggled to put the knowledge gained into practice (Josefina, 2018). This implies that leadership workshops and short courses alone may not be sufficient for developing leadership skills. This, therefore, necessitates the need for formal leadership training for nurses.

The survey results showed that participants perceived a significant improvement in their leadership capabilities after participating in the Developing Leader Programme. Early educational interventions to foster the development of leadership and clinical skills in junior registered nurses can effectively enhance their interaction within the team. Participation of junior registered nurses in a locally designed leadership training program

has shown to be instrumental in helping them develop essential leadership behaviors that they can apply in their daily practice. This hands-on experience provides them with the opportunity to gain valuable skills, increase their confidence, and effectively lead and support their colleagues in providing high-quality care to patients (Paterson, Henderson & Burmeister, 2014)

A cross-sectional study on newly graduated Registered Nurses in Brunei Darussalam, about leadership and management preparedness after completing an induction program, revealed that nurses who had been exposed to a period of clinical experiences were better equipped with knowledge, attitude and practice regarding different leadership and management skills compared to those who were ushered into leadership roles immediately after completion of the basic nursing training. Findings from this study indicated that it is prudent for policymakers and institutional leadership to establish standardized training programs to prepare nursing students and newly graduated nurses with appropriate competencies and skills to competently navigate leadership and management in any healthcare setting (Bakir *et al.,* 2022).

In a Quasi-experimental study by Kim and Lim (2022) on evaluation of 'High-Up' training program for enhancing the leadership competencies for mid-career nurses for preparing them for leadership, the intervention group was offered the 'High-Up ' training program. Within four weeks after implementation of the training, it was determined that the experimental group exhibited improved scores for critical thinking skills as an attribute for nurse managers than the control group (pre-intervention score: 3.48 0.36; post-intervention score: 3.71 0.49; $Z = 1.99$, $p = 0.046$). From these findings, it was established that the training program was capable of developing the competency for nursing leadership and

management, especially for experienced nurses who were aspiring for nurse managers' roles. This further suggests that formal structured leadership training is recommended to nurses prior to being appointed into leadership positions, the the purpose of equipping them the better exercise their leadership responsibilities. In the same study, it was also posited that offering leadership training for nurses before their appointment to leadership not only benefited the nurses to enhance their leadership competencies and performance, but it also contributed to the improvement in the standards and quality of care as well as the overall organizational performance.

Research shows that nurse managers require formal leadership training before or as they begin their leadership and management role. As postulated by Balluck, (2023) the lack of or insufficient leadership training is one crucial factor that contributes to nurse managers' perceived low level of confidence and preparation to take on leadership roles, subsequently causing them to be unenthusiastic to embrace responsibilities when leadership opportunities arise.

The literature provides a strong evidence base for formal training, utilizing diverse research designs including cross-sectional surveys (Bakir et al., 2022) and quasi-experimental interventions (Kim & Lim, 2022). The work of Kim & Lim (2022) is particularly significant because it moves beyond mere perception, providing quantitative proof ($p = 0.046$) that structured training like the 'High-Up' program objectively improves critical thinking, which is a core attribute for nurse managers. This suggests that leadership is a measurable, developable skill rather than an innate trait.

A recurring theme across these studies is the timing of training. Bakir et al. (2022) and Balluck (2023) both emphasize that the involvement or practical method of ushering nurses into leadership immediately after basic training is counterproductive. Balluck (2023) adds a psychological layer to this critique, noting that insufficient training directly correlates with low confidence and professional disinterest. This highlights a critical contradiction because institutions expect nurses to lead, yet by failing to provide prior training, they inadvertently create a culture of reluctant leadership.

The critique extends beyond individual competency to institutional outcomes. Kim & Lim (2022) successfully link individual training to systemic improvements in the standards and quality of care. This suggests that formal leadership training is not merely extra professional development but a strategic organizational necessity that safeguards patient safety and improves overall healthcare delivery.

While the literature, Bakir et al. (2022) and Kim & Lim (2022), provides strong arguments for standardized programs, they present two notable gaps in the context of this thesis: These studies are situated in high-resource or stable healthcare environments. They do not account for the specific pressures of devolved healthcare systems or resource-limited settings found in Kenya, where the cost of low confidence may be much higher due to a lack of administrative support. Additionally, while the literature argues that training is needed, it remains relatively silent on the specifics of financial and budgetary training, which is a major challenge identified in the findings of this study.

While Bakir et al. (2022) and Kim & Lim (2022) provide empirical validation for the efficacy of formal leadership programs, their findings underscore a global systemic failure

in terms of the tendency to appoint nurse managers reactively rather than proactively. This literature supports the current study's argument that the confidence gap identified in Kenyan MLNMs is a direct consequence of this lack of structured, pre-appointment training.

2.3.2 On-the Job-Training

On-the-job training refers to the process by which employees acquire job-related skills and knowledge under direct supervision. This is facilitated through the observation of seasoned employees and practical engagement with the materials, personnel, or machinery pertinent to the job. A proficient trainer is expected to epitomize a positive professional model and allocate dedicated time from their regular job responsibilities to furnish job-specific instruction and guidance to the trainee. This training methodology offers hands-on experience within standard working conditions and allows the trainer, manager, or senior employee to foster meaningful connections with new employees (Agufana, 2022).

During on-the-job training, employees acquire and enhance their skills while carrying out their job responsibilities. This type of training allows employees to learn and develop in real-time, within the context of their everyday work environment. On-the-job training is instrumental in fostering the specific expertise and proficiency required for employees to be successful in their roles (Timsal, Awais, & Shoaib, 2016).

2.3.3 Mentorship

Mentorship is both an art and a science whereby nurses with professional experience and capable of sharing their knowledge and leadership skills are engaged in guiding less experienced nurses. Within the domain of nursing, mentoring has been recognized as a critical leadership strategy. The mentoring relationship may be exercised through direct

supervision or coaching techniques, facilitating the mentee's navigation toward a transformative direction in their career path. Mentors engage in instructive practices that incorporate critical areas such as conflict resolution, performance appraisal delivery, negotiation processes in personnel matters, participation in organizational meetings, daily planning and assessment of supervisory responsibilities, budget preparation, and the development of institutional presentations. During the mentorship process, throughout the workday, mentees collaborate closely with their mentors, gaining insight through observational learning and benefiting from iterative opportunities for inquiry and discussion. This dynamic approach fosters a rich environment for professional development and the acquisition of essential skills necessary for effective nursing practice and leadership (Vitale 2018).

In addition, it was found that time was a significant obstacle to effective mentoring. A mentoring program can help new nurse leaders by providing educational interventions and mentoring support. Developing and implementing a mentoring pilot program can strengthen future nursing leadership and support new leaders in their roles (Hedenstrom *et al.*, 2022)

The global empowerment of nurses through a Global Leadership Mentoring Community is crucial in enhancing leadership capabilities at all levels. This enables nurses to have a stronger influence on nursing and health policy and contributes to improving patient care on a global scale. Recognizing the significance of mentorship, mentors and mentees experience tangible gains in developing leadership confidence and competence. Such a community facilitates the fostering of crucial skills and knowledge that are essential for promoting effective leadership within the nursing profession (Rosser *et al.*, 2020).

According to Rosser *et al* (2023), mentorship has been recognized as being valuable in the growth and development of leadership skills and confidence, especially when it is begun early and at the individual level. Furthermore, this would then translate to developing strategic leaders for the future who would be ready to take up leadership roles at different levels. This resonates with Ocho *et al.* (2020), who posited that mentorship programs have been identified to be very beneficial in transitioning nurses into practice settings, as well as being recognized as an important part in preparing individuals for leadership positions within the organizational level.

The study by Rees *et al.* (2020) revealed that the satisfaction, knowledge, and skills of nurse managers will possibly be enhanced by exposing nurse managers to continuing support and mentorship opportunities to allow them to gain real-life practice in carrying out various aspects of their leadership roles.

A descriptive qualitative study by Holm *et al* (2018) found that FLNM lacked initiative, competence, and ability for decision-making. Moreover, lack of confidence was alluded to as a deterrent to assuming leadership roles, as evidenced by respondents who exhibited a strong desire for more preparation for leadership in the form of mentoring (IntraHealth International, 2019)

Research shows that the value of mentorship for leadership development cannot be underrated. Mentorship has been regarded as a strongly advocated approach to leadership development that not only benefits the mentee but also the mentor through the interactive process (Stedman *et al.,* 2021). This is reinforced by the study that emphasized that as the mentors act as role models for the mentees, they also contribute to the provision of individualized guidance and advice geared toward leadership development (Iheduru-

Anderson & Shingles, 2023; Patterson et al., 2022). Furthermore, having a formal mentorship program has been considered an approach that can potentiate the development of leadership competencies and knowledge among newly appointed nurse managers (Cummings et al., 2021; Shen & Tucker, 2024)

The literature, particularly Vitale (2018), successfully frames mentorship beyond simple supervision, defining it as a transformative relationship. A significant strength of this section is the identification of mentorship as a dual-directional process. Unlike traditional training, which is often top-down, Stedman et al. (2021) and Iheduru-Anderson & Shingles (2023) highlight that both the mentor and mentee gain leadership capital. This suggests that mentorship is not just a preparation tool for new managers, but a sustainability strategy for the entire organization's leadership pool.

A compelling argument in this literature is the use of shadowing as a bridge to administrative competency. Charlotte (2015) highlights that mentorship is uniquely suited to teach the budgeting process, which is an area that the findings of this study identified as a major deficit. This implies that while formal classrooms teach the theory of finance, mentorship provides the mechanisms of how organizational decisions are made through the budgeting process. This practical involvement is essential for shifting a nurse from a clinical mindset to a managerial one.

The literature transitions from individual benefits to global and organizational implications. Rosser et al. (2020) argue that mentorship is the primary vehicle for succession planning. By identifying and nurturing prospective leaders early, organizations can prevent the leadership gap that occurs when senior nurses retire or migrate, which is a

context highly relevant to the Kenyan "State of the World’s Nursing" report cited earlier in this study.

The work of Holm et al. (2018) and IntraHealth International (2019) provides a vital link between mentorship and the psychological readiness of Front-Line Nurse Managers (FLNMs). They argue that a lack of initiative and decision-making ability is often a symptom of low confidence, which mentorship is specifically designed to cure. This supports this thesis's findings that even if a nurse has the clinical know-how, they require the mentorship-derived confidence to enact leadership.

While the literature positions mentorship as an essential art for navigating complex managerial tasks like budgeting (Charlotte, 2015), there is a disconnect between its perceived value and its logistical execution. The findings of Hedenstrom et al. (2022) regarding time constraints serve as a critical warning for Kenyan healthcare settings: mentorship cannot be left to chance; it must be a formalized, implemented, and resource-protected program if it is to successfully bridge the preparedness gap found in this study.

2.3.4. Preceptorship

Preceptorship involves the coupling of a more experienced and skilled nurse preceptor to a newer, less experienced nurse preceptee. Preceptorship offers an individualized learning experience for preceptees in a new clinical area. The preceptor-preceptee pairing offers the opportunity for one-to-one guidance within the wards and allows for learning experiences and outcomes tailored to each preceptor (Quek & Shorey, 2018). According to Araújo et al (2023) preceptorship is considered as an approach for developing both clinical and managerial competencies for nurses.

Though preceptorship is meant to prepare nursing students to transition into clinical practice, it has also been recognized as a powerful approach to developing nurses for leadership, particularly for those who take the preceptor role. This is attributed to the fact that as they engage in the preceptorship role, they become more accountable for healthcare delivery and outcomes, improve their communication skills, and exercise management functions to include planning, organizing, delegating tasks, and supervising individuals. This implies that preceptorship helps the nurse preceptors to develop individual leadership styles and skills as they discharge their roles as preceptors (Baylor University, 2022)

2.5 Mid-Level Nurse Managers' training needs for leadership role preparation

The need for training in leadership and management dates back to the time of Henri Fayol, who is regarded as the father of management. This is attributed to his General and Industrial Management Theory (Fayol, 1949). In his theory, Henri Fayol advocated for specialized management training for employees as he postulated that at the end of any basic professional training, the graduates lack the management component and emphasized that these individuals require comprehensive conceptions in the art of planning, organizing, coordinating, and controlling. This is because they are not only being prepared for the service industry, but for leadership positions as well, given the fact that some of them become managers at their workplace. Furthermore, Fayol insisted that even when individuals receive management concepts as part of their basic training, they cannot be entrusted with responsibilities immediately with that knowledge only, however, they require practical experience, which is only possible through ensuring contact and interaction with persons and things within the work environment. He further posited that the theoretical knowledge acquired from a diploma training is only sufficient for

facilitating the employee to assimilate quickly into the details of the particular work for which one has been trained. From this argument, Fayol proposed leadership and management courses to be incorporated in post-primary, diploma, and university education in order to provide foundational knowledge on the concepts that would then be complemented by specialized training and practical experience in the course of professional practice.

Research shows that there have been debates on whether leadership can be taught in an educational setting. Findings from a study by Channing (2020) on ‘How Can Leadership Be Taught?’ provide evidence that leadership can be taught. This is attributed to the fact that the majority of the participants who were leaders (86.36%) reported that they learnt leadership skills through formal leadership training in the form of degrees and specific leadership development programs. They also reported that following these trainings, they experienced improvement in leadership skills, for example, human relations skills, self-reflection skills, and the ability to create a more positive working environment.

In a study by Kumah, Ankomah and Antwi (2016), inadequate training was considered a barrier to Frontline Nurse Managers' fulfillment of their roles because they were subjected to learning through trial and error or on-the-job training, which does not foster effective leadership development. This was reinforced by the findings of the study by Alomairi et al. (2018) on the managerial and leadership competencies of front-line nurse managers, which showed that FLNM were performing tasks outside their scope as nurse managers, which was alluded to as a discrepancy in managerial and leadership competencies. The shortfall in managerial competencies was attributed to the absence of training and

preparation of FLNMs prior to their engagement or during their leadership and management roles.

Ocho *et al* (2020) postulated that for nurse managers to shift into leadership roles, it requires readiness from an individual as well as an institutional standpoint. Furthermore, institutions ought to put in place structures to allow for transitioning nurses into leadership roles. The same study noted that some of the nurse managers were prepared for the leadership roles through training, while others acquired the skills through being assigned to acting capacities as nurse managers. This was maintained by the study, which identified a significant need to empower frontline nurse managers with the requisite knowledge and experience to boost staff engagement, nurture leadership skills, and develop competencies essential for effectively navigating continuous organizational change (Richey & Waite, 2019).

Research shows that nurse managers frequently lack adequate educational preparation regarding leadership skills training that is needed to successfully navigate their expanded roles within healthcare settings. Leadership development programs typically do not sufficiently address the personal and professional developmental needs of nurse managers. Moreover, the pedagogical practices utilized in these leadership development initiatives often fail to provide a necessary balance between assessment, challenge, and support (Gunawan et al., 2020).

The study by Bryant & Stone (2022) portrayed that the registered nurses who participated in the study did not have an acceptable level of preparation to enable them to carry out their leadership roles. It was also evident that those who were appointed to managers' positions excelled in their clinical expertise but they had either minimal training or did not get any

training at all yet such training is necessary to equip them to be able to maneuver through the tough encounters involved in their management roles.

Nurse managers are required to possess a distinct array of knowledge, skills, and attitudes to execute their roles and responsibilities effectively. The demonstration of competence is crucial because well-trained and proficient nursing managers play a pivotal role in guiding nursing staff as well as multidisciplinary teams in the provision of safe, effective, and high-quality care (Abo Jalghef *et al.*, 2023). In addition, nurse managers must develop strong managerial competence to ensure the delivery of high-quality services (Gunawan et al., 2020). According to Zendrato, Hariyati and Afriani (2019) in their study accentuated further that to develop effective nurse managers who can deliver quality nursing services, it is essential to provide opportunities for the acquisition of skills through professional experience as well as leadership training.

The need for training on managerial skills for nurse managers was also affirmed by findings from studies on the implementation of leadership programs for charge nurses, which revealed that leadership practices of charge nurses increased notably following the leadership training program (Manion *et al.*, 2021). .

Owing to the research findings, which show that Front-Line-Nurse Managers need training on managerial skills (Vos, 2017), senior healthcare managers, educators, and policymakers can design appropriate training programs for lower-level managers, identify managers in need of leadership development, and provide training that is relevant to their contexts. This will subsequently have a ripple effect because they benefit immensely from the important role they undertake (Kumah, Ankomah & Antwi, 2016).

Qualitative case studies in different district hospitals in Kenya and South Africa recommended that governments and donors should pay greater attention to strengthening leadership across systems and at different levels (Gilson *et al*., 2017). This was echoed by the recommendation that education in Kenya should develop a curriculum for healthcare professionals that enables them to effortlessly handle their tasks in healthcare systems (Wanza and Mwakesi, 2014). Moreover, findings from the study by Bryant & Stone (2022) suggested that educational institutions offering nursing training should establish leadership training curricula for licensed nurses. This implies that, besides basic nursing training, nurses should be provided with opportunities for additional leadership training.

According to Rehman *et al* (2015), leadership training programs have been attributed to a constructive influence on leaders and leadership performance. Additionally, research has revealed that comprehensive leadership training programs play a vital role in the acquisition of the main skill sets required by nurse managers (McGilton *et al.,* 2020 & Prentice *et al.,* 2017)

The study by Younes, Adam and Abdrabu (2019) about the effects of leadership programs on leadership practice among nurse managers showed that nurse managers demonstrated the lowest leadership knowledge and practice levels at the pre-training stage. The same nurse managers exhibited a significant increase in leadership knowledge immediately after the training. Additionally, after three months of implementation of the leadership training program, and follow-up training phases, the nurse managers had a remarkable increase in leadership knowledge and practice level.

According to the study on the perception of nurse managers' preparedness to act in the leadership role, it was reported that often, nurses felt that they were underprepared and did

not have the confidence to undertake the leadership roles. In the same study, it was, however noted that in occurrences where nurses received training in preparation for the leadership role, nurses exemplified more confidence and level of preparedness for leadership roles. The findings of the same study suggest that to nurture confident, adequately prepared nurses to take up leadership and management roles, a structured, formal leadership training is required (Manion *et al.,* 2021).

A study done in Indonesia on the managerial competence of 247 first-line nurse managers in 18 public hospitals depicted that the FLNM who did not participate in leadership preparation by attending designed leadership and management training did not have optimal managerial competencies compared to those who participated in the management training (Gunawan *et al.,* 2020). Additionally, in a study done in Turkey, where a nurse manager development training program was used as an intervention, it was evident that as a result of training, nurse managers demonstrated a marked increase in nurse managers' leadership and managerial competency self-assessment scores in 21 of the 23 management competency areas. This evaluation was done by comparing the pre-training program and post-training program scores. These findings validate that structured formal training is attributed to the improvement in leadership and managerial competencies of nurse managers (Goktepe et al., 2018)

According to the findings from a systematic review done by Cummings et al (2021), it revealed that nurse managers' roles are quite complex, therefore requiring adequate preparation to ensure that nurse managers are well equipped with the necessary skills to effectively exercise their mandate in their leadership and management roles. From these findings, it is suggested that prospective nurse managers would benefit from formal

leadership training in order to prepare them for their leadership roles. This resonates with the assertions by Ocho *et al* (2021) that the prevailing trend of appointing nurses to leadership positions without a structured preparation process poses significant challenges to nursing leadership. Moreover, as nurses transition from roles as peers to managers, they must nurture emotional intelligence to effectively navigate the intricacies of their new responsibilities. The same findings further emphasized that tailored training interventions, including training on emotional intelligence, are an effective approach for developing nurse managers' leadership skills among the nurses.

This was echoed by the findings by Nghe *et al* (2020) from the study on 'Developing Leadership Competencies in Mid-level Nurse Leadership as an Innovative Approach'. In this study, a training hospital developed a leadership training program for mid-level nurse managers, and the learners who participated identified areas where they had challenges in their nurse managers' roles. From these findings, the same program was recommended for hospitals with numerous mid-level nurse managers, especially during the period when they are new in the leadership role. This corresponds to the assertion by Scott *et al* (2011) that the most appropriate opportunity to facilitate nurses' advancement in their profession is to begin with nurse managers who are already in leadership positions. In the same study, it is proposed that nurse managers should be encouraged to advance their professional education up to at least the undergraduate level because it has been established that the more nurses progress in their professional training, the better they become in their leadership competencies

In a review study on barriers to effective nurse leadership, the nurses who participated in the study identified limited organizational opportunities for upward mobility, which were

perceived as significant barriers to the leadership development of nurses. Furthermore, many nurses indicated that they had not been engaged in formal leadership training and felt that they were inadequately prepared for leadership roles, particularly regarding essential business and management skills (Hughes, 2018). According to a qualitative study involving nurse leaders regarding the challenges they face in financial management, the nurse leaders reported a lack of sufficient training in financial management and nursing economics. The study findings suggested that managerial training for nurse leaders could enhance their financial management skills (Bai *et al*., 2017)

According to Marquis & Huston (2021) in their book on leadership roles and management functions in ursing, it is posited that budgeting is a function that nurse managers are entrusted with and they are expected to actively participate. Nurse managers are responsible for methodically superintend the budgeting process in its entirety including monitoring and evaluation to ensure that expenses are commensurate to the existing budget under implementation. This implies that accountability for prudent and sound financial performance on the part of the nurse manager is overbearing. Furthermore, nurse managers have the obligation of communicating and assigning the budgetary aims to their staff under their their leadership. Consequently with knowledgeable staff members, will enhance their participartion in the management of resources with resultant increased probability of attainment of organization financial goals. This therefore implies that, owing to the immense role that the nurse managers have on financial management of their units, they require the necessary training so that they will be equipped and empowered to effectively and diligently discharge their leadership roles.

In both public and private healthcare institutions, nurse managers at various levels are tasked with financial management, reflecting the extensive nature of their duties. However, research indicates that many nurse managers are often deficient in the essential skills, knowledge, and competencies needed for effective financial oversight, frequently necessitating additional training. This underscores the need for healthcare institutions to implement strategies aimed at enhancing the financial management competencies of nurse managers (Naranjee, Ngxongo & Sibiya, 2019). In addition, according to the 'nurse manager development training program, Goktepe *et al* (2018), the findings indicated that nurse managers portrayed inadequate skills and knowledge regarding budgeting and related finance management matters. Therefore, this implies that sufficient training in financial planning skills is necessary for the development of competent nurse managers. This is affirmed by the findings from a scoping review on 'Nurse Managers' Competencies' in which different competencies were identified, and when ranked in order of significance, financial management was ranked second after communication as a critical competency expected and required of every nurse manager. This is because budgeting is a key function in nursing management (González-García *et al.*, 2021). According to the study by Cabral, Oram & Allum (2019), it is implied that nursing leadership roles are complicated and comprise numerous challenges encompassing time pressure and long work hours, accountability obligations, and competing demands leading to difficulties achieving work-life balance. Frias *et al.* (2021) defined emotional intelligence (EI) as an "individual's capacity to recognize and effectively address emotions within themselves and others, facilitate relationships, and resolve issues". The authors further asserted that EI is deemed to be a robust predictor of leader effectiveness and success, principally within healthcare

settings. These assertions echo the propositions by Tyczkowski et al (2015), who posited that EI is a teachable skill; hence, providing course content, progressive teaching, or professional development opportunities to advance EI in educational institutions and health care systems would enhance the value of leadership and management skills among their nursing students, as well as present and upcoming nurse managers.

The literature provides strong evidence for the impact of formal training. The study by Younes et al. (2019) is particularly vital as it demonstrates that leadership knowledge is not static; the significant increase in scores after three months of follow-up proves that training has a lasting retention effect. This is further validated by Goktepe et al. (2018) and Gunawan et al. (2020), whose comparative studies in Turkey and Indonesia show that managers who participate in formal programs consistently outperform those who rely on random or clinical-based promotion.

A recurring and critical weakness identified across the literature is financial incompetence. Marquis & Huston (2021) and Naranjee et al. (2019) emphasize that while budgeting is a paramount responsibility, most nurse managers are deficient in this area. The ranking by González-García et al. (2021), which places financial management second only to communication, underscores that a nurse manager's inability to navigate nursing financial management (Bai et al., 2017) is a systemic risk. This supports this study's findings that clinical excellence is a poor predictor of budgetary proficiency for nurse managers.

The literature successfully redefines Emotional Intelligence from a soft skill to a strong predictor of success and a very important functional tool (Frias et al., 2021). As nurses transition from clinical practice to managers (Ocho et al., 2021), they face unique

challenges like work-life imbalance and competing demands (Cabral et al., 2019). The analysis here is that basic nursing training fails to treat EI as a teachable skill (Tyczkowski et al., 2015), leaving managers emotionally unequipped for the interpersonal complexities of leadership.

A major strength of this section is the localized focus that provides contextual and curricular implications for Kenya. The recommendations by Gilson et al. (2017) bridge the gap between global theory and the Kenyan context. The argument is that for Kenya's devolved system to thrive, leadership strengthening must happen across systems. This implies that the burden of training should not rest solely on the individual nurse but must be a mandate for policymakers and educational institutions to establish a leadership development path within the diploma and BScN as well as post-graduate curricula (Bryant & Stone, 2022).

The literature establishes a clear competency triad involving managerial skill, financial literacy, and emotional intelligence, which is currently absent from basic nursing education. The evidence from Gunawan et al. (2020) and Younes et al. (2019) proves that while the deficit is universal, it is also highly correctable through structured, contextualized interventions. For the Kenyan MLNM, the implication is clear: to move from an underprepared level to a competent level requires a deliberate move away from clinical seniority as the sole basis for leadership toward a model of continuous professional leadership development (CPLD).

2.6 Theoretical Framework

According to the Oxford English Dictionary (2021), the term “theory” is defined as an explanation of a phenomenon arrived at through examination and contemplation of the relevant facts; a statement of one or more laws or principles generally held as describing an essential property of something. Different researchers have given varied views on the definition of the term theory based on their respective realms of work and perspectives. Mouza (2018) defined theory as interconnected concepts that provide a coherent, systematic understanding of a particular phenomenon. According to the scientists’ perspective, theory is a way of interpreting facts using scientific methods (Hamer & Bradford, 2022).

There are different opinions regarding the functions of theory, particularly in research. A theory facilitates propositions regarding relationships and allows predictive modeling, thereby guiding potential interventions. Employing a theory enables the researcher to define a theoretical framework to guide the systematic collection and analysis of data pertinent to describing, explaining, and predicting particular practice (Aina 2021). Furthermore, it is asserted that it is essential to employ a robust theoretical framework that informs and guides the research process to advance knowledge effectively.

A theoretical framework is a blueprint of the research. It is based on an existing theory in the particular field of inquiry that the researcher adopts and uses as a foundation upon which the research is developed. The theoretical framework is significant for the researcher because it provides a structure that shows how the researcher defines the study. It assists researchers in contextualizing existing theories in their work (Adom, Joe, & Hussein, 2018).

The theoretical framework for this study stemmed from two theoretical frameworks: the works of Henri Fayol's general and industrial management theory (Fayol, 1949) and Frederick Taylor's principles of scientific management theory (Turan, 2015), as discussed below.

2.6.1 General and Industrial Management Theory by Henri Fayol

Henri Fayol's general and industrial management theory (Fayol, 1949) involves three interrelated theories: the Six Industrial Activities, the Five Functions of Management, and the 14 Principles of Management. For this study, the focus was one of these theories, the Five Functions of Management theory.

2.6.1.1 Five Functions of Management by Henri Fayol

Regarding the 'five functions of management,' Henri Fayol established that all managers, regardless of the nature of their organization or their management level in the organization, have essentially the same functions: planning, organizing, directing, coordinating, and controlling. These functions of management were later improved and expanded by Gulick (1937), who, after considering Fayol's six industrial activities, added staffing, reporting, and budgeting to the five functions outlined below:

i. Planning – refers to working out in a broad framework the activities required to be done and the approaches for doing them to achieve the purpose set for the organization.

ii. Organizing – concerns the creation of the formal structure of authority through which work subdivisions are defined, arranged, and coordinated for the defined objective

iii. Staffing - entails the entire personnel function of onboarding and training the staff and sustaining favorable working conditions.

iv. Directing - that is the constant task of decision-making and exemplifying them in specific and general commands, instructions, as well as serving as the leader of the organization.

v. Coordinating - Encompasses all significant duties of interrelating the various portions of the work.

vi. Reporting- refers to keeping those to whom the manager is responsible conversant as to what is going on, which hence comprises keeping himself and his subordinates well-versed through records, research, and inspection.

vii. Budgeting entails all that goes with budgeting in the form of fiscal planning, accounting, and control.

Fayol also asserted that specialization increases efficiency. For this study, by linking Fayol's principles (often expanded as POSDCORB) directly to the managerial competencies of mid-level nurse managers, the study essentially asserts that leadership preparedness is the measurable ability to execute these specific functions.

2.6.1.2 Application of Henri Fayol's expanded POSDCORB Functions of Management to Mid-Level Nurse Managers' Leadership Role Preparation.

This theory informed the study in that from the literature review, seven managerial competencies for Mid-Level Nurse Managers and Front-Line Nurse Managers emerged, namely: Planning, Organizing, Staffing, Directing, Controlling, Coordinating, and Budgeting. These MLNMs' and FLNMs' competencies correspond to the expanded

version of Fayol's functions of management. In theorizing for this study, the level of preparedness of nurse managers to execute the seven functions of management, planning, organizing, staffing, directing, coordinating, controlling, and budgeting, is referred to as exhibiting managerial competencies. To operationalize this to the study, preparation levels for these management functions were considered as the dependent variables that ought to be exhibited among the specific level of authority, which in this study rests with the nurse managers (Averesch, 2017).

The researcher went further to define the meaning of these competencies as they applied to the study by collectively considering the assertions from previous studies as outlined below:

Planning - Ability or skill to decide what to do, when to do it, and how to do it. This translates to nurse managers' role in setting specific objectives and determining the course of action to achieve them **(**Acob et al., 2018). For a mid-level nurse manager, planning involves resource allocation and goal-setting for their unit. In applying to this study, preparedness involves the ability to forecast patient flows, plan for equipment upgrades, and align unit goals with the hospital's broader strategic vision.

Organizing – Ability to make decisions regarding duties and responsibilities of distinct jobs, including the manner in which the obligations should be executed. It entails designing or breaking down a plan into manageable sub-tasks and effectively allocating the required resources to them (Marquis & Huston, 2021). For this study, this function deals with the mobilization of resources both human and material, to achieve the plan. The application implies that prepared manager knows how to design workflows that minimize burnout. It

involves assigning specific roles to nursing staff based on their expertise for example, assigning a senior nurse to a high-acuity patient.

Staffing – The ability of the nurse manager to select appropriate people and assign them to specific roles and tasks, as well as develop them to improve their knowledge, attitudes, and skills to enhance performance **(**Acob et al., 2018). This study emphasizes staffing as a critical competency formid-level nurse managers. In application to this study, staffing function measures the nurse manager's ability to recruit, retain, and develop staff. Leadership preparedness here is seen in how well a manager identifies skill gaps and advocates for professional development in terms of training for their team.

Directing - Directing and channeling human behavior toward the accomplishment of objectives, which involves giving responsibilities, instructions, and guidance to subordinates (Marquis & Huston, 2021). In this study, the application in nursing translates to clinical leadership. Preparedness is measured by how effectively the manager communicates expectations and maintains morale of the frontline nursing staff during high-stress shifts.

Controlling – comprises authenticating whether everything ensues in conformity with the plan adopted, directives allotted, and principles established. The ability of the MLNM to institute performance standards, measure actual performance against the established standards, and monitor progress toward attainment of objectives. Controlling ensures that performance does not deviate from the standards **(**Acob et al., 2018).

In this study, nurse managers' preparedness in controlling involves monitoring performance against standards and making corrections, and this is directly tied to patient

safety outcomes. A manager's preparedness for this function is reflected in how they handle incident reports, audit clinical charts, and ensure adherence to healthcare protocols.

Coordinating - Ability to incorporate the various plans through joint discussion and exchange of ideas, as well as to allocate various activities to subordinates. It involves ensuring the right number of personnel in various positions with the right type of education and skills are taken, which will ensure the right men on the right job (Marquis & Huston, 2021). In this study Mid-level managers are the link between frontline staff and top leadership. Nurse manager's preparedness for this function means assessing the manager's ability to synchronize nursing care with other departments within the healthcare setting, for example, pharmacy, imaging, and laboratory.

Budgeting - Competency regarding financial management concerning improving the cost-effectiveness of patient care. Activities include ensuring payment for staff is consistently correct, efficient use of stocks and supplies, and that they are subject to regular monitoring and checks to reduce costs (Marquis & Huston, 2021). Mid-level nurse managers are all the time more responsible for the bottom-line financial management of their units. Preparedness in budgeting involves managing overtime costs, reducing medical waste, and justifying the need for new hires or equipment within a fixed fiscal framework.

2.6.2 Principles of Scientific Management Theory By Frederick Taylor

This theory is allied with Frederick Winslow Taylor, and its focus was to improve productivity and efficiency in the workplace. In this theory, Taylor (1911) concentrated on the supervisory levels of management and the performance of managers and workers at the operational level. He delineated four main principles, namely, a scientific approach to work, scientific selection and training of employees, collaboration between employees and

employers, and division of work and responsibilities among employees. Taylor asserted that these principles are necessary for cultivating workers' initiative and uniformity and ultimately boosting organizational efficiency, as presented below:

i. Development of science for each element of work, not the 'Rule of Thumb' - Each task is systematically analyzed and broken down into a series of distinct tasks. For every task, a rigorous scientific methodology should be established through measurement, standardization, systemization, and the creation of routines (Iwendi, 2016).

ii. Scientifically select, train, teach, and develop the new worker – This involves the establishment of appropriate, meticulous, and precise selection criteria for workers assigned to each task. Recruitment, training, and instruction should be implemented to ensure that each worker is equipped to execute the assigned tasks in a standardized and consistent manner. The worker's scientific education and development implies the development of every worker to his greatest efficiency through training and instruction. This is significant because an organization's effectiveness depends on the competencies and skills of its employees.

iii. Collaboration between employees and employers, 'harmony, not discord.' Taylor encouraged cordial and harmonious relationships between managers and workers. Managers ought to offer support, guidance, and assistance to workers to ensure that the work is done in accordance with the laid-down scientific principles.

iv. Divide the work and responsibility among workers –This refers to the appropriate distribution of work between the managers and the workers, such that the managers will focus their time on planning for the team members, assessing for training

needs, and organizing appropriate training for them. They also provide a conducive environment for the other workers to perform their assigned tasks efficiently.

In summary, Taylor posited that enhancing organizations' productivity and efficiency could be achieved through scientific accuracy in measuring workers' jobs, employing scientific methods during workers' characteristics considered for selection, progressive development of the workers, and ensuring mutual coordination and cooperation between the organization's management and workers.

2.6.3 Application of Frederick Taylor's Principles of Scientific Management Theory to Mid-Level Nurse Managers' Role Preparation.

This theory was used to guide the researcher in gaining an in-depth understanding of what is involved in the Mid-Level Nurse managers' leadership role and what it takes to adequately prepare nurse managers for effective performance in their leadership roles.

2.6.3.1 Development of science for each element of work.

Research shows that the role of the Mid-Level nurse managers is depicted as being multifaceted. The MLNMs' role encompasses serving as valuable resources for staff, managing numerous nursing-related tasks, taking charge of the implementation and evaluation of financial management activities, facilitating patient and family engagement, and upholding and spearheading safety and quality outcomes (Richey & Waite, 2019). Taylor's principle of development of science for each element of work emphasizes the scientific approach to systematic analysis of each element of work, breaking down work into discrete tasks and defining the best way to perform each of the specific tasks. The scientific approach is preferred over the 'Rule of Thumb' because the upharzard approach based on guesswork may be restricted by knowledge and lack of vision (Iwendi, 2016).

This principle applies to this study in that scientific approaches to the analysis of nurse managers' leadership role is valuable for understanding the complexities involved in it in order to inform the development of the most efficient methods and procedures to optimize the productivity of nurse managers to enhance the overall organization's performance.

2.6.3.2 Scientifically select, train, teach, and develop the new worker

Owing to the complexities involved and the challenges that nurse managers experience in their leadership roles, it is essential for nurse managers to posses a wide range of knowledge, capabilities and skillfulness to make them competent to efficiently and effectively lead different teams ranging from small groups to larger groups; harmonizing the activities of these various teams as well as providing a conducive working environment that fosters quality nursing services to patients (Zendrato, Hariyati & Afriani, 2019; Klaes, 2018). Research also reveals that many nurse managers are appointed to leadership positions without prior preparation for the role (Ullrich et al., 2020; Al Sabei et al., 2024). Taylor's theory advocates for scientific selection, training, and development of each worker to be able to perform their assigned tasks efficiently, hence increasing the productivity of the organization (Iwendi, 2021). This theory applied to this study in that it facilitated knowledge regarding the need for structured formal appointment procedures for workers, which in this study refers to the appointment of nurse managers into leadership roles. Furthermore, it also aided in understanding the requirements for progressive development and training needs for leadership role preparedness among nurse managers in the South Rift and South Nyanza regions of Kenya. This principle underscores the significance of training workers for the acquisition of skills relevant for the assigned tasks, as wellas retraining them to restructureand enhance the skills already acquired through the

basic professional training. This theory, therefore, indicates that there is a need for hospital management teams at various health care settings to understand the processes of appointment and to develop strategies for preparing nurse managers for leadership roles, right from recruitment criteria, training, and continuously developing them throughout the service delivery.

2.6.3.3 Collaboration between employees and employers

Literature shows that nurse managers are consistently ill-prepared for their leadership roles because they lack training and support during their transition into their roles, resulting in substandard organizational and role performance (Ullrich et al., 2020; Manion et al., 2021). This theory emphasizes the importance of managers' collaboration in the identification of the nurse managers' training and development needs and facilitating their continuous improvement in their performance.

2.6.3.4 Divide the work and responsibility among workers

Taylor focused on the appropriate distribution of tasks and responsibilities between managers and workers. The emphasis was on separating planning and execution, meaning that managers would concentrate on strategy and support for the workers, while the workers would be engaged in the execution of the specific tasks assigned to them according to their expertise. The basis of this principle is that Taylor's hierarchical model of three levels, with the most powerful workers at the top, supervisors in the middle, and the operational workers at the bottom. Each level has precise responsibilities and instructions, and each level respects the level they report to above it. In this way, work would be done efficiently with less time.

2.7Conceptual Framework

A conceptual framework is a structure that the researcher believes best explains the progression of the phenomenon in question. It brings about the link between the concepts, variables, and theories adopted for the study. It is significant for the researcher because it aids in creating the researcher's worldview regarding the phenomenon in question (Adom et al., 2018).

This study concerns leadership role preparedness among nurse managers; therefore, it is imperative to understand the concepts of leadership and management because they are used interchangeably or in conjunction throughout the study. According to Marquis and Huston (2021), it is implied that there is a difference between leadership and management based on the focus of the leaders and managers as they exercise their mandate. It is further asserted that leaders are futuristic and utilize imaginations of possibilities ahead to guide in setting direction. On the other hand, managers evaluate, monitor, and fine-tune the current activities while frequently checking the past to ensure that the processes conform to the standards and that the current goals and objectives are being achieved. Evidently, to attain sustained success, organizations require both leadership and management skills and aptitudes.

Ocho *et al* (2020) argue that even though leadership and management are differentiated theoretically by definition and by the specific activities of a leader and a manager, they have established that functionally, they are transposable and that they are not effective without each other. When applied to nursing practice, Fowler (2015) underscored that it is difficult for the clinical nurse to distinguish the point in time when one is discharging the mandate as a leader or as a manager, especially given that they are trying to lead and manage teams within a dynamic and challenging environment. This implies that the role of

nurse managers encompasses two concepts exhibited concurrently, forming the framework for the skills and aptitudes expected of an individual to drive team success. This is reinforced further by Marquis and Huston (2021), who articulated that leadership and management are interdependent and coactive in that a nurse is a leader and a manager at the same level and that nursing roles involve leadership and management skills to occur synergistically. It is further stressed that it is prudent for nurses to continue to develop skills for both leadership roles and management functions. Nurses are also urged to incorporate leadership features throughout every phase of their management processes.

This interrelation in their function and application in practice is illustrated by the 'leadership-management continuum' as shown in **Fig. 2.**

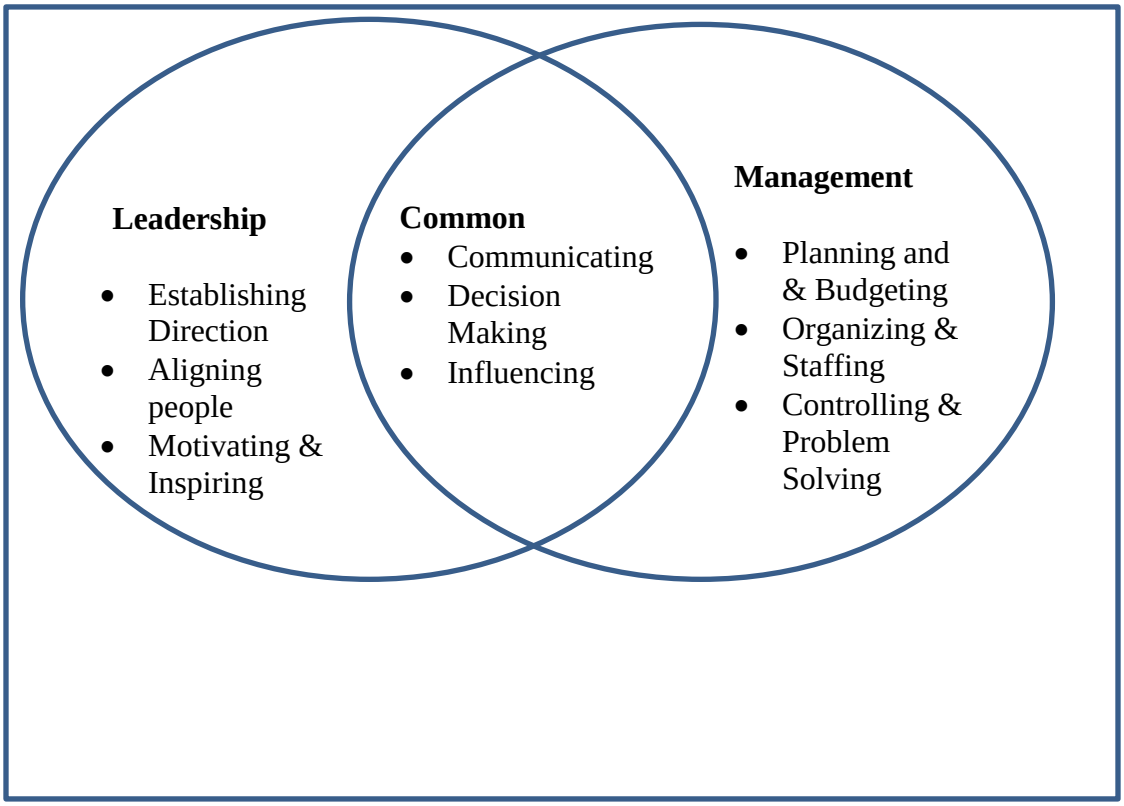

Figure 2: Leadership and Management Continuum. Taken from Morgan, J (2021). Applied Wisdom for Nonprofits. https://www.appliedwisdomfornonprofits.org/leadership-vs-management/

The interrelationship between leadership and management guided the development of the conceptual framework for the study.

In this study, the independent variables are the Role Preparation interventions that drive the change in the nurse manager. These are basic professional nursing training, formal leadership training, on-the-job training, mentorship, and preceptorship. The intervening variables comprise the environmental context, particularly organizational structure and supportive supervision, and psychological context, in this case, the individual attitudes

towards the leadership role. It also includes the demographic characteristics, including age, gender, highest professional qualification, and duration in the current MLNMs' position. These act as control variables to determine if experience or education levels change the impact of the training. These factors can either facilitate or hinder the relationship between preparation and performance. Lastly, the dependent variables represent the outcome, which in this study is the leadership, the effective discharge of leadership roles, measured by the seven classical managerial functions (POSDCORB): planning - setting goals and pathways, organizing - establishing the internal structure, staffing - managing human resources, directing- leading and motivating staff, coordinating- interlinking various nursing units, controlling- ensuring standards are met, and budgeting - financial resource management.

This, therefore, informed the development of the conceptual framework for the study as depicted in **Fig. 3** below.

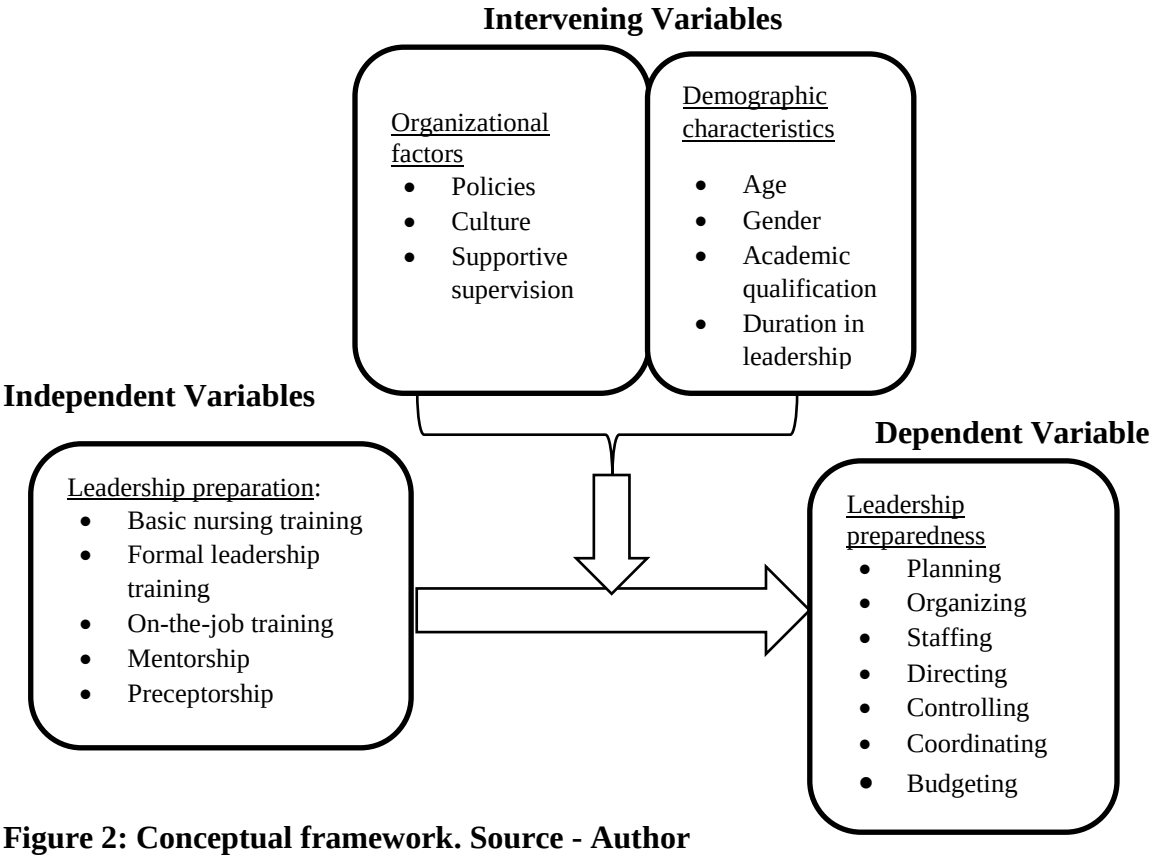

Figure 2: Conceptual framework. Source - Author

The conceptual framework for this study was derived from the literature review, which depicted that for Mid-Level Nurse Managers to be able to discharge their leadership role effectively, they ought to undergo leadership role preparation. The conceptual framework for this study posits that the leadership preparedness of Mid-Level Nurse Managers (MLNMs) is a multifaceted result of collective role preparation interventions, which are the independent variables. It suggests that while formal and informal training in the form of mentorship, On-the-job training (OJT), and basic nursing training provide the necessary skills, the actual effectiveness in managerial functions considered as the dependent variable is not automatic.

This relationship is moderated by intervening variables, which include organizational factors and the individual's own attitude. Furthermore, the framework accounts for demographic characteristics, acknowledging that factors like age, gender, highest professional qualification, and duration in the leadership position may influence how a manager internalizes preparation and executes their duties. Ultimately, the framework maps a path from preparation to effective execution across the seven core domains of management: Planning, Organizing, Staffing, Directing, Controlling, Coordinating, and Budgeting.

2.8 Summary of the Literature Review

This chapter has presented in detail the current and relevant literature regarding the leadership role preparedness level among the Mid-Level Nurse managers.

Current research indicates a significant global trend where nurse managers feel ill-prepared for their roles. Key findings include: Many managers are promoted based on clinical seniority or expertise but are expected to learn leadership "on the job" without formal training (Warshawsky et al., 2020; Gunawan et al., 2020). Common obstacles to preparation for leadership include time pressure, lack of organizational development opportunities, and the struggle to balance clinical versus managerial responsibilities (Hughes, 2018; Vos, 2017). Inadequate preparation often leads to role stress, burnout, and compromised patient care (Bryant & Stone, 2022; Ullrich et al., 2020).

Regarding the extent to which basic nursing training prepares nurses for Mid-Level Nurse managers' leadership roles, research indicates that basic nursing programs often prioritize clinical technical skills over the complex managerial attributes required in contemporary

healthcare, leaving graduates feeling underprepared and lacking confidence in ward prioritization (Frasier, 2019; Södersved Källestedt et al., 2020). Research shows that a significant barrier to preparedness is the structure and timing of leadership education in thebasic nursing curriculum. Leadership content is frequently placed at the end of training programs, which limits the time available for students to internalize these concepts or apply them in a clinical setting (Scammell et al., 2020). Effective leadership development should be woven throughout the entire curriculum rather than treated as an isolated course (Kukkonen et al., 2023). Additionally, the duration and quality of clinical placements are pivotal in transitioning from student to manager. Despite the benefits of longer placements, many programs remain focused on central clinical tasks, providing minimal emphasis on leadership skill development during field experience (Ortega et al., 2018). The effectiveness of practical assessments in preparing nurses for leadership is hindered by systemic challenges, for example, the task-oriented focus whereby practical assessments often prioritize technical tasks over professional practice competencies, leaving students unready for the holistic responsibilities of a manager (Wu et al., 2017). Existing learning outcomes often fail to reflect the actual complexities of the clinical environment, creating a disconnect between academic evaluation and professional requirements (Christiansen et al., 2021).

The contribution of role induction programs to Mid-Level Nurse managers' leadership roles. Research shows that role induction programs, namely, formal leadership training, mentorship, on-the-jobtraining, preceptorship, as well as the contextual factors like supportive supervision, significantly influence leadership role preparation.

The leadership and management training needs for Mid-Level Nurse managers. Literature shows that MLNMs require a three-pronged training competency consisting of formal leadership and management training, financial and budgetary proficiency, and Emotional Intelligence. Study revealed that for effective functioning of the nurse managers in their leadership role, there is a need for formal leadership courses in addition to the basic nursing training.

It has also highlighted the theoretical and conceptual frameworks for the study as a basis for the identification of the variables.

CHAPTER THREE

RESEARCH METHODOLOGY

3.0 Introduction

This chapter describes the procedure employed in conducting the study. This includes descriptions of the research philosophical worldview, research design, research methods, study site, study population, sampling procedures, data collection instruments and procedures, data analysis, and ethical considerations.

3.1 Research Philosophical Worldview

When planning to conduct a study, researchers must carefully consider the philosophical worldview underpinning the research problem or question. This consideration is essential, as it influences the research design that aligns with the identified philosophical worldview. Therefore, researchers must engage in a thorough exploration of their philosophical assumptions before commencing the investigation. This is because such exploration is critical in guiding the choice of appropriate research methods and design, ultimately shaping the integrity and relevance of the study findings (Wright et al., 2016)

Generally, philosophical worldviews refer to the underlying set of beliefs that guide action, while philosophical worldviews in the context of research serve as a fundamental belief system that informs and shapes the inquiry process. According to Walekhwa and Suge (2023), philosophical perspectives play a crucial role by helping us to understand how we think about the world, the reality of nature, and the role that knowledge plays in our lives. Additionally, research is often guided by distinct philosophical worldviews, with the predominant models being positivism or post-positivism, constructivism or interpretivism, pragmatism, postmodernism, and critical theory. Each of these frameworks offers critical

foundations for understanding and approaching research questions as well as shaping the research process and the interpretation of the findings.

Positivism or post-positivism is a philosophical worldview emphasizing the significance of empirical evidence and scientific approaches in understanding the world. Positivists search for an objective truth that exists in the world, and it is grounded in the knowledge that science is the only way to learn the existing truth. They hold a limited philosophy founded on vigilant observations and measurements, and they attempt to make interpretations of a general truth (Alakwe, 2017). Although positivism is regarded as an essential concept in social sciences, since it accounts for the development of rigorous methods for observing and measuring natural phenomena, it has received criticism regarding it being too narrow in its focus on observable facts, as well as neglecting the importance of social and cultural factors in determining human behaviour and experience (Walekhwa & Suge, 2023)

Constructivism is a philosophical worldview that stresses the importance of subjective experience, meaning, and context in understanding human behaviour and social phenomena. Constructivists search for subjective truth, created by how human beings see and interpret the world in their respective contexts, meaning that truth is not absolute but comparative, and generalizability is not considered suitable or necessary. Furthermore, constructivists believe that human behaviour is shaped by cultural and social factors and advocate for the consideration of the subjective experiences and interpretations as critical to understanding the particular phenomenon in question. Even though constructivism has been significant in the development of qualitative research methods, for example, interviews and participant observation, particularly for social sciences, critics have argued

that it is too subjective and disregards the importance of objective facts in understanding social phenomena (Walekhwa & Suge, 2023)

Pragmatism is a philosophical perspective that underscores practical experience and action over intangible theory or assumption. The core of pragmatism is the belief that knowledge is a tool for action and that the value of knowledge lies in its ability to guide our actions and solve practical problems. Pragmatists focus more on the research problem and utilize all existing approaches to understand the problem in question, instead of concentrating on the methods. They seek the truth regarding what is practically beneficial and what works at the time. They are not devoted to any philosophical view or reality, and therefore, they use mixed methods in their inquiries (Almeida, 2018)

Pragmatism as an approach arises out of actions, situations, and consequences rather than antecedent conditions and is concerned with what works and solutions to problems (Creswell & Creswell, 2018). Therefore, pragmatism has contributed greatly to the development of mixed methods research. To corroborate the relevance of pragmatism as the appropriate philosophical worldview that guided the research process in this study, the following ideas regarding this study are explained:

This study was concerned with the Mid-Level Nurse Managers' perceptions regarding their leadership role preparedness in relation to their basic nursing training. The question of what works was evident in this research study, and this was grounded on the questions that emanated from the research problem, including: Did the MLNMs perceive that they were well prepared to execute their leadership roles effectively? Did they perceive that their basic nursing training adequately prepared them to fulfil their MLNM's leadership roles? Was there any significance that the role-induction programs for MLNMs within the

different healthcare settings have in preparing them for their leadership roles?. This meant that in whatever form the MLNMs were appointed to their leadership positions, whether they perceived themselves as prepared for the leadership role or not, they somehow found what worked at the time to facilitate them in executing their leadership roles. Therefore, this study adopted pragmatism as a worldview, which affirms that quantitative and qualitative methods are compatible. In this worldview, instead of focusing on methods, researchers emphasize the 'what' and 'how' of the research problem and use all approaches available to understand the problem. This, therefore, justifies pragmatism as a philosophical underpinning for mixed methods studies (Almeida, 2018) as adopted for this study.

3.2 Research Design

Research design refers to the conceptual structure outlining the process of collection, measurements, and analysis of data in conducting research, and its main function is to ensure that the evidence obtained through research allows the researcher to address the research problem well and logically (Shorten & Smith, 2017; Demir & Pismek, 2018). This study adopted a mixed-methods design that employed a descriptive, cross-sectional approach. Mixed methods can be defined as a research framework that employs a comprehensive and dynamic approach, purposefully integrating both quantitative and qualitative research methodologies within a single study. This paradigm allows for a more all-encompassing understanding of research questions by leveraging the strengths of both approaches to provide a richer, more contextualized analysis of a phenomenon under study (Almeida, 2018). This was a convergent-parallel [QUAN + QUAL] approach of the mixed methods design whereby different but complementary quantitative and qualitative data

were collected simultaneously in the same phase of the study, while weighing the two methods together; quantitave and qualitative data were analyzed separately and the interpretation was done together by combining, relating, comparing and contrasting in such a manner that the both quantitative and qualitative data sets informed one another (Edmonds & Kennedy, 2017). In applying this convergent mixed methods design during the process of this study, it means that both quantitative and qualitative data were collected within the same phase of the research process in each of the selected study sites; analyzed separately, and the results were interpreted together (Areia, Taavares & Costa, 2023). However, within the larger quantitative design, the qualitative data were secondary. This means that the findings from the qualitative data were used to reinforce or complement the conclusions that were drawn from the primary data, which in this case is the quantitative data, as asserted by George (2021). The main focus of the study was to determine the level of leadership role-preparedness among MLNMs from nine selected hospitals in Bomet, Kericho, Narok, Kisii, and Nyamira Counties, Kenya. The most appropriate design for this study, therefore, was the Mixed Methods approach because it allowed the researcher to collect a mixture of quantitative and qualitative data that would produce complementary strengths with no overlapping weaknesses, and at the same time provided for triangulation that sought to achieve convergence of findings (Areia et al., 2023)

Because this study was of a parallel Mixed-Methods [QUAN + QUAL] design, it implied that different methods of data collection, different interviews, different times, or different locations and contexts could be used to allow for triangulation of quantitative and qualitative results, as asserted by Almeida (2018). This, therefore, guided the development of the data collection tools in that research instruments, particularly the questionnaires and

key informant interviews, were designed in such a manner that they contained both quantitative and qualitative components. For the quantitative research approach, as proposed by Walekhwa & Suge (2023), the researcher obtained numerical data from participants utilizing standardized instruments to allow for objectivity, replicability, and efficiency, while facilitating statistical inferences in drawing the conclusions about the population of focus in the study, which in this case, was the mid-level nurse managers from the selected sites. The researcher also mainly employed a descriptive research approach, whereby the researcher described the status of leadership role preparedness among the Mid-Level Nurse managers from the selected sites at the time of study, concerning managerial competencies. Owing to the inherent limitations of the quantitative approach, which include its restricted capacity to explore unanticipated variables due to the fixed nature of structured data collection instruments, a notable deficiency in capturing deeper and comprehensive contextual meanings, and a reductionist tendency that simplifies complex phenomena into mere numerical data. To address these challenges and to achieve a comprehensive understanding of the research topic, the researcher opted to employ mixed methods. This approach allows for integration of the qualitative insights, thereby enhancing the richness of the data collected and fostering a more holistic exploration of the subject matter as suggested (Rahman, 2017;Dawadi et al., 2021). Regarding the qualitative approach, the researcher applied both Phenomenological research and narrative research. Phenomenological research can be defined as a form of qualitative approach designed to explore and illuminate the intricacies of human experiences from the perspective of the participants. By emphasizing the subjective interpretation of their lived experiences, this approach allows the researchers to delve into the complexities of individual perceptions,

emotions, and meanings associated with the phenomena under study. Ultimately, phenomenological research fosters a deeper understanding and appreciation of the human condition and enhances the understanding of diverse perspectives within varied contexts (Walekhwa & Suge, 2023). This approach was applicable for this study because the research question was concerning the assessment of the mid-level nurse managers' level of leadership preparedness, given their lived experience in the leadership role. This was operationalized in this study as the researcher investigated, interpreted, and described Mid-Level Nurse Managers' lived experiences. Also, through Focus Group Discussions (FGDs) and key informant interviews, the researcher examined how experiences were narrated by the participants to understand how Mid-Level Nurse Managers perceived and made sense of their experiences in their leadership roles. The quantitative data provided a comprehensive description of the variables under study and were meant to complement the qualitative data.

3.3 Study Sites

The study was conducted in nine selected hospitals and four nursing training institutions from five counties, namely Bomet, Kericho, Narok, Kisii, and Nyamira Counties in the South Rift and South Nyanza regions, Kenya. The specific selected hospitals as study sites from each county included Longisa County Referral Hospital, Kaplong Mission Hospital, Kapkatet Hospital, AIC Litein Mission Hospital, Kericho County Referral Hospital, Kericho Nursing Home, Narok County Referral Hospital, Nyamira County Referral Hospital, and Kisii Teaching and Referral Hospital.

The chosen sites in the South Rift and South Nyanza are at the forefront of health devolution. Nine hospitals were selected to represent the environment in which qualified

nurses, trained in basic nursing, take on leadership roles. Since this study involves Mid-Level Nurse Managers (MLNMs) in Kenya, the choice of sites reflects the 2013 constitutional shift. These regions serve diverse populations with varying socio-economic dynamics. By choosing level 4 and level 5 hospitals that operate under the County Department of Health (CDOH), the study examines how MLNMs navigate the intermediary leadership pressure, translating county-level political mandates into clinical operational realities. Additionally, there is an empirical knowledge gap regarding the preparedness of managers in regional referral centers. By focusing on these specific sites, the study provides geographically distinct data that is more applicable to the majority of Kenyan counties.

The nursing training institutions included AIC Litein Medical Training College (MTC), St. Clare's Kaplong School of Nursing, Kenya Medical Training College (KMTC) Kapkatet Campus, and KMTC Bomet Campus. These training institutions were selected to provide data from both the public medical training colleges and the private and faith-based medical training colleges. The training institutions selected for this study encompass both public medical training colleges and private, faith-based medical training colleges. These institutions provide the context in which leadership is taught and learned. The study aims to assess the curricula regarding content, the duration of clinical rotations, and the structure of clinical practical assessments, specifically focusing on the leadership and management component. The combination of health facilities and training institutions included in this study facilitates a thorough assessment of the training aspect as well as the health facilities involved.

3.3.1 South Rift Region, Kenya

The South Rift region refers to the southern area of the former Rift Valley province in Kenya. It comprises the following counties: Kericho, Bomet, Narok, Kajiado, and Nakuru. The counties that were sampled for the study are Kericho, Bomet and Narok.

3.3.1.1 Kericho County

Kericho County is one of the 47 counties in the Republic of Kenya. It's located in the South Rift of the Great Rift Valley, about 256 km from Nairobi, the capital city of Kenya. The County lies between longitude 35º 02' and 35º 40' East and between the equator and latitude 0 23' South with an altitude of about 2002m above sea level. Uasin Gishu County borders the county to the northwest, Baringo County to the North, Nandi County to the northwest, Nakuru County to the East, and Bomet County to the South. It is bordered to the southwest by Nyamira and Homa Bay Counties and to the West by Kisumu County.

Kericho County occupies a total area of 2,479 sq. Km and is divided into 6 sub-counties, 30 wards, 85 locations, and 209 sub-locations. The county is well positioned to benefit from various markets the neighboring counties provide, as it has robust national and county roads connecting it to the rest of the counties. The county is cosmopolitan and largely inhabited by the Kipsigis sub-tribe of the Kalenjin tribal group. Other notable tribes include the Kikuyus, Luos, Somalis, Indians, Luhyas, and Kisiis, who have enjoyed close relationships with the Kalenjins. The county houses the best Kenyan tea, with vast tea estates. Some of the biggest companies in Kericho County dealing in tea include Unilever Kenya, James Finlay, and Williamson Tea. The most renowned brand from the South Rift region is Ketepa, a favorite of Kenyans.

Kericho County has six constituencies, namely, Ainamoi Constituency, Belgut Constituency, Bureti Constituency, Kipkelion East Constituency, Kipkelion West Constituency, and Sigowet–Soin Constituency. The health facilities that were sampled as study sites include: Kapkatet Hospital, AIC Litein Mission Hospital, Kericho County Referral Hospital,

Kericho Nursing Home, AIC Litein Medical Training College (MTC), and Kenya Medical Training College (KMTC) Kapkatet Campus.

Kericho County Referral Hospital

Kercho County Referral Hospital is a level 5 public health facility managed under the Ministry of Health (MOH). It is located in Kericho town, Ainamoi sub-county, Kapchebor ward. It provides primary health care and specialized care to its residents and those of the neighbouring counties. The hospital has a bed capacity of 250 beds and 20 baby cots. Its departments are categorized according to the services offered. It has 21 service delivery units that are under the leadership of unit nurse managers, meaning that the same 21 Mid-level nurse managers were eligible to participate in the study. The hospital serves as a clinical placement site for nursing students from Kenya Medical Training College, Sigowet campus, University of Kabianga, Kenya Highlands University, Kabarak University, and St. Paul's University.

Kericho Nursing Home

Kericho Nursing Home is a private practice institution situated in Kericho town, opposite Kericho County Referral Hospital. It has 157 beds and 2 baby cots. The hospital comprises 8 service delivery units, each led by a unit nurse manager. This translates to a total of eight mid-level nurse managers who were eligible to participate in the study.

Kapkatet Hospital

Kapkatet Hospital is a Level 4 hospital in Bureti Sub-County, Buret constituency, Kapkatet location, Chemoiben sub-location in Kericho County. It is a public health facility run under the Ministry of Health and has a bed capacity of 227 beds and 17 baby cots. It has twelve distinct service delivery units under the leadership of unit nurse managers who report to the nursing officer in charge of the hospital, making the number of mid-level nurse managers eligible for the study to be 12 in the facility. Kapkate Hospital serves as the main clinical placement site for Kenya Medical Training College, Kapkatet Campus, for their nursing students. It has also been approved as a clinical placement site for Bachelor of Science nursing students from the University of Kabianga and Kabarak University.

AIC Litein Mission Hospital

AIC Litein Mission Hospital is a level 5 rural faith-based organization (FBO) and non-governmental health facility owned by the Africa Inland Church (AIC) and managed through the Hospital Board of Management (HBOM). The hospital lies approximately 6,500 feet above sea level and is located along the Kisii-Sotik-Kericho highway, about 270 km from Nairobi and 40 km from Kericho County headquarters. This makes it convenient for the hospital to provide primary and specialist services to a catchment population of approximately 800,000 people across six counties: Kericho, Bomet, Narok, Nyamira, Kisii, and Nakuru counties in the South Rift region of Kenya.

The hospital has a 240-bed capacity, 8 baby cots, and a 10-bed casualty. Its outpatient department serves approximately 400 patients per day, and about 600 patients are admitted every month, with a bed occupancy of over 80 percent. The hospital is a Medical, clinical officers, and also a Nurses' Internship center. It has 12 distinct service delivery units under

the leadership of unit nurse managers who report to the nursing officer in charge of the hospital. This makes the number of mid-level nurse managers eligible to participate in the study twelve. The hospital has been approved as a clinical placement site for nursing students from AIC Litein Medical Training College for the majority of the clinical experience, University of Kabianga, and St. Paul's University for their Bachelor of Science Nursing students.

AIC Litein Medical Training College (MTC)

AIC Litein Medical Training College is a faith-based institution affiliated with AIC Litein Mission Hospital. It trains nurses and offers a variety of other courses, including medical technical courses. It offers a diploma in Kenya Registered Community Health Nursing (KRCHN) and is approved by the Nursing Council of Kenya to take two intakes in a year, of up to 100 trainees each year. It also offers a diploma in Medical Laboratory Technology and is regulated by the Kenya Medical Laboratory Technicians and Technologists Board for a maximum of 30 students per year. Also, it offers training for diploma in clinical medicine and Surgery, which is regulated by the Clinical Officers' Council of Kenya, and has two intakes up to a maximum of 60 trainees per year. The college uses AIC Litein Mission Hospital as its main clinical placement site.

Kenya Medical Training College (KMTC) Kapkatet Campus.

Kenya Medical Training College, Kapkatet Campus, is one of the two public KMTCs in Kericho County. The college is situated in Kapkatet town, Buret Constituency, Chemoiben Sub-location. The college offers the following courses: Diploma in Kenya Registered Community Health Nursing, Diploma in Clinical Medicine and Surgery, and Diploma in Medical Imaging Sciences. Students' intakes occur twice in a year: March and September.

The college uses Kapkatet Hospital as the main clinical placement site for their nursing students.

3.3.1.2. Bomet County

Bomet County is a county in the former Rift Valley Province with a population of around 875,689 people according to the 2019 census, and covers an area of 1,630 sq. km. Bomet County is a county in the former Rift Valley Province of Kenya. Initially a district, Bomet District was created from the former Kericho District in 1992. It later transitioned to Bomet County under Kenya's new constitution of 2010. The Capital of Bomet County is Bomet Town. The County lies between Latitudes 0º 29′ and 1º 03′ South and between Longitudes 35º 05′ and 35º 35′ East and covers an area of 2507.1 km^2. Bomet County is a multiracial, multi-ethnic county with citizens from diverse socio-economic, religious, and cultural backgrounds.

It is bordered by four counties, namely: Kericho to the North, Nyamira to the West, Narok to the South, and Nakuru to the Northeast. The county is the source of major rivers such as Mara and Itare which flow into Lake Victoria. Bomet County has the following five constituencies: Bomet Central Constituency, Bomet East Constituency, Chepalungu Constituency, Sotik Constituency and Konoin Constituency. The facilities that were sampled to be the study sites included Longisa County Referral Hospital, Kaplong Mission Hospital, St. Clare's Kaplong School of Nursing and Kenya Medical Training College (KMTC) Bomet campus.

Longisa County Referral Hospital

Longisa County Referral Hospital is a public health facility under the Ministry of Health. It is located in Bomet East Constituency, Longisa Ward, along the Bomet-Mulot highway. The hospital has a bed capacity of 144 beds and 6 baby cots. The hospital is composed of

11 distinct service delivery units, which are headed by unit nurse managers who report to the nursing officer in charge of the hospital, making the number of mid-level nurse managers eligible for the study eleven. Some of the services offered in Longisa hospital include Vaccination services, Dental care, Basic Obstetric Care (BMOC), Laboratory and imaging services. Longisa County Referral Hospital is the main clinical placement site for students from Kenya Medical Training College Bomet campus and has also been approved by the Nursing Council of Kenya as the clinical placement site for Legacy College of Nursing, University of Kabianga, and St. Paul's University for their Bachelor of Science nursing students.

St. Clare's Kaplong Mission Hospital

St. Clare's Kaplong Mission Hospital is a faith-based hospital sponsored by the Catholic Church, and it is within the Diocese of Kericho. The hospital is located in the Sotik Sub-county of Bomet County, along the Kisii-Kericho highway at the junction to Bomet town. It started as a health centre to provide health care services to the community; however, over time, it has grown to a level 5 hospital with highly specialized technologies. The hospital provides quality, affordable health care to the local community and those from the neighbouring counties. It has a bed capacity of 220 beds and baby cots. It comprises 8 departments, which are under the leadership of the unit nurse managers, making the eligible mid-level nurse managers eight.

St. Clare's Kaplong School of Nursing

St. Clare's Kaplong School of Nursing is situated in Sotik Sub-County, Bomet County, and is affiliated with St. Clare's Kaplong Mission Hospital. It is well known for its comprehensive approach to nursing training, coupled with strong moral and ethical values

rooted in faith-based learning. The school offers diploma in Kenya Registered Community Health Nursing and is accredited by the Nursing Council of Kenya (NCK). The school of nursing offers high-quality training, hands-on experience, and an excellent environment that fosters nurses who are passionate about healthcare. The students use St. Clare's Kaplong Mission Hospital as their main clinical training site for the majority of their practical experience.

Kenya Medical Training College (KMTC) Bomet campus.

Kenya Medical Training College, Bomet campus is a public health training institution and is one of the 78 KMTCs in Kenya. The college is situated along the Bomet-Narok road, near Longisa market, next to Longisa Level 5 county referral hospital in Bomet County. The college offers both diploma and certificate courses, including a certificate in Medical Engineering, a certificate in Community Health Nursing, a Diploma in Clinical Medicine and Surgery, and a Diploma in Registered Community Health Nursing. The students use Longisa County Referral Hospital as their main clinical site, along with other off-site clinical training sites identified by the college and approved by the Nursing Council of Kenya.

3.3.1.3. Narok County

Narok County is a rich and diverse county in the South Rift. The county comprises 18,000 sq. km and has a population of around 1.2 million people scattered in the County's six constituencies, namely: Narok North Constituency, Narok South Constituency, Narok East Constituency, Narok West Constituency, Transmara East Constituency and Transmara West Constituency.

The County shares an economic block with Kajiado County, known as the Narok Kajiado Economic Block (NAKAEB). The economic block aims to improve various sectors of the economy to increase exports to African countries and abroad. The main economic activities in the county include pastoralism, crop farming, tourism, and trade, among other activities undertaken on a small scale. The famous Maasai Mara Game Reserve, featuring the Great Wildebeest Migration, which is one of the “seven Wonders of the World," is located within the County. The county has a robust ecological system that residents depend on for agriculture, tourism, water, and many other benefits.
According to the UN research for the Kenya Vision 2030, Narok County is marked as one of the key counties for achieving the economic pillar. Key contributions are in the tourism sector through the Maasai Mara National Reserve and the agricultural sector through livestock farming.

The county borders the Republic of Tanzania and six other counties, including Nakuru, Bomet, Nyamira, Kisii, Migori, and Kajiado counties. The facility that was sampled for the study is Narok County Referral Hospital

Narok County Referral Hospital

Narok County Referral Hospital is a level 4 public health facility under the Ministry of Health. It is located in Narok Central Sub-County, Narok Town Ward. It has an in-patient bed capacity of 155 and 15 bay cots. The hospital has nine separate service delivery units under the leadership of nurse in-charges. This means that nine mid-level nurse managers were eligible for the study.

3.3.2 South Nyanza Region, Kenya

The South Nyanza region constitutes the Former South Nyanza District. This district, which existed under the old provincial administration system, is home to four counties, namely Homa Bay, Migori, Kisii, and Nyamira counties.

3.3.2.1Kisii County

Kisii County is located in southwestern Kenya, with its capital and largest town being Kisii. A hilly topography with several ridges and valleys characterizes Kisii County. It can be divided into three main topographical zones. The first zone covers areas lying below 1,500m above sea level, located on the western boundary, and includes parts of Suneka, Marani, and Nyamarambe. The second zone covers areas between 1500-1800m above sea level in the Western parts of Keumbu and Sameta divisions, Eastern Marani and Gucha River basins. The third zone covers areas above 1800m above sea level in eastern and southern Keumbu, Masaba and Mosocho.

The most notable features of these topographical zones are hills of Sameta (1970m), Nyamasibi (2170m), Kiong'anyo (1710m), Kiamwasi (1785m), Kiongongi, Kiombeta, Sombogo, Nyanchwa and Kegochi hills. The general slope of the land is from east to west. The county is dissected by permanent rivers which flow westwards into Lake Victoria. Among the notable ones are Kuja, Mogusii, Riana, and Iyabe rivers. There are also depressions and valleys.

Kisii Teaching Referral Hospital

Kisii Teaching and Referral Hospital is a leading public hospital in the South Nyanza region, Western Kenya. The Facility was established in 1916 during the colonial period as a centre for treating injured soldiers during World War I. In November 2007, the hospital

achieved a significant milestone when it was upgraded to Level 5 status, which was considered a testament to its commitment to providing comprehensive healthcare services to its community. Subsequently, in 2014, through the Kisii Teaching and Referral Hospital Act, the hospital attained the esteemed status of a Teaching and Referral Hospital. The hospital has twenty distinct service delivery units, meaning that the mid-level nurse managers who were eligible for the study were also twenty.

3.3.2.2. Nyamira County

Nyamira is one of the 47 counties in Kenya that covers most of the highland area of the former Nyanza province. The county borders Homabay to the north, Kisii to the west, Bomet to the southeast, and Kericho to the east.

The county covers an area of 899 km2, and administratively, the County has 5 districts, namely Nyamira, Nyamira North, Borabu, Manga, and Masaba North, with 13 divisions, 33 locations, and 88 sublocations. Politically, the county has four constituencies, namely, West Mugirango, North Mugirango, Borabu, and Kitutu Masaba.

The county`s topography is mostly hilly, the `Gusii highlands`. The Kiabonyoru, Nyabisimba, Nkoora, Kemasare hills, and the Manga ridge are the most predominant features in the county. The two topographic zones in the county lie between 1,250 m and 2,100m above sea level. The low zones comprise swampy wetlands and valley bottoms, while the upper zones are dominated by hills. The high altitude has enabled the growth of tea, which is the major cash crop and income earner in the county. The permanent rivers and streams found in the county include Sondu, Eaka, Kijauri, Kemera, Charachani, Gucha (Kuja), Bisembe, Mogonga, Chirichiro, Ramacha, and Egesagane. All these rivers and several streams found in the county drain their water into Lake Victoria. The major types

of soil found in the county are red volcanic (Nitosols), which are deep, fertile, and well-drained, accounting for 75 percent, while the remaining 25 percent are those found in the valley bottoms and swampy areas suitable for brick-making. To the north is Kisii County, to the west, Bomet County, to the southeast, and Kericho County to the east.

Nyamira County Referral Hospital

The facility that was sampled for the study is Nyamira County Referral Hospital. It is located in and provides a comprehensive range of medical services. It is run by the County Government of Nyamira. It is a level 4 health facility located in the West Mugirango constituency. The hospital serves as a referral facility for the sub-county hospitals in Nyamira County. The hospital has a total bed capacity of 355 beds and 10 cots, comprising 290 general outpatient beds, 40 maternity beds, 5 emergency casualty beds, 5 intensive care unit beds, 5 high dependency unit beds, and 10 isolation beds. It has two surgical theatres and one general surgical theatre, and a maternity theatre.

3.3.3 Selection of the study sites

The selection of study sites was categorized into regional selection indication the selection of South Rift and South Nyanza from all the other regions in Kenya, and county-level selection, indicating the selection of five counties from the 47 counties in Kenya. The next category is the selection of the level 4 and level 5 hospitals using predetermined criteria in line with the objectives of the study. The final category is the selection of the medical training colleges that offer basic diploma nursing training within the five selected counties.

3.3.3.1 Regional and County Selection

The first level of selection of study sites for this study comprised convenience sampling for both regional and county selection. This implies that South Rift and South Nyanza regions were selected from the five Kenyan regions, namely: Eastern, Central, Western, North Eastern, and Nairobi, as these were the regions without data regarding nursing leadership preparedness. Also, these were the regions within the reach of the researcher.

Furthermore, convenience sampling was also used to select the five counties, namely, Kericho, Nyamira, Kisii, Bomet, and Narok, from the South Rift and South Nyanza regions. In addition to the fact that these were the counties within the reach of the researcher, these counties were deemed to be representative of the 47 counties because in Kenya, all counties have analogous health delivery system structures from level 1 to level 5 health facilities (Zeng *et al.,* 2021).

3.3.3.2 Selection of Hospitals and Nurse Training Institutions.

To facilitate the process of selection of the study sites, the researcher compiled a series of tables, one for each county, showing the distribution of level 4 and level 5 hospitals with their respective bed capacities, and nurse training institutions, as per the counties.

The following section presents the distribution in **Table 3.1a, 3.1b, 3.1c, 3.1d, and 3.1e**

Table 3.1a. Narok County Distribution of Level 4 and 5 Hospitals and Nurse Training Institutions

County	Sub-Counties	Sub-county and Large private hospitals offering inpatient services	Bed Capacity	Hospitals with ≤ 60 beds)	Nurse Training Institutions
Narok	Trans Mara East	None	None	None	None
	Trans Mara West	Trans Mara West Sub-County Hospital	126	√	None
	Narok North	Narok County Referral Hospital	400	√	None
	Narok East	None	None	None	None
	Narok South	Narok Cottage Hospital	30	NA	None
	Narok West	Baraka Hospital	37	NA	Baraka Nursing School

Table 3.1b. Bomet County Distribution of Level 4 and 5 Hospitals and Nurse Training Institutions

County	Sub-Counties	Sub-county and Large private hospitals offering inpatient services	Bed Capacity	Hospitals with ≤ 60 beds)	Nurse Training Institutions
Bomet	Sotik	St. Clare's Kaplong Mission Hospital,	220	√	Kaplong Nursing School √
	Bomet Central	Tenwek hospital	361	√	Tenwek Hospital College of Health Sciences
	Bomet East	Longisa County Referral Hospital	144	√	KMTC Bomet √
	Chepalungu	None	None	None	None
	Konoin	None	None	None	None

Table 3.1c. Kisii County Distribution of Level 4 and 5 Hospitals and Nurse Training Institutions

County	Sub-Counties	Sub-county and Large private hospitals offering inpatient services	Bed Capacity	Hospitals with ≤ 60 beds)	Nurse Training Institutions
Kisii	Etago	Etago Sub-County Hospital	14	NA	None
	Gucha	Gucha Sub-County Hospital	50	NA	None
	Gucha South	Tabaka Mission Hospital	250	√	Tabaka Nursing School
	Kenyenya	Kenyenya Sub-County Hospital	40	NA	None
	Kisii Central	Kisii Teaching and Referral Hospital	650	√	KMTC Kisii
		Christamarianne Mission Hospital	170	√	None
		Hema Mission Hospital	168	√	None
		Mediforte Hospital	100	√	None
	Kisii South	None	None	None	None
	Kitutu Central	None	None	None	None
	Marani	Marani Sub-County Hospital	100	√	None
	Masaba South	Masaba South Sub-County Hospital	34	NA	None
	Nyamache	Nyamache Sub-County Hospital	55	NA	None
	Semeta	None	None	None	None

Table 3.1d. Nyamira County Distribution of Level 4 and 5 Hospitals and Nurse Training Institutions

County	Sub-Counties	Sub-county and Large private hospitals offering inpatient services	Bed Capacity	Hospitals with ≤ 60 beds)	Nurse Training Institutions
Nyamira	Nyamira North	Nyamusi Sub County Hospital	50	NA	None
		Ekerenyo Sub County Hospital	18	NA	None
	Nyamira South	Nyamira County Referral Hospital	242	√	KMTC Nyamira
	Borabu	Kijauri Sub-County Hospital	6	NA	None
	Masaba North	Masaba Sub-County Hospital	34	NA	None
	Manga	Nyangena Sub-County Hospital	227	√	None
		Manga Sub County Hospital	24	NA	None

Table 3.1e. Kericho County Distribution of Level 4 and 5 Hospitals and Nurse Training Institutions

County	Sub-Counties	Sub-county and Large private hospitals offering inpatient services	Bed Capacity	Hospitals with ≤ 60 beds)	Nurse Training Institutions
Kericho	Belgut	None	None	None	None
	Bureti	Kapkatet Hospital,	227	√	KMTC Kapkatet √
		AIC Litein Mission	220	√	AIC Litein MTC √
	Kericho East	Kericho County Referral,	250	√	None
		Siloam Hospital	78	√	None
		Kericho Nursing Home	157	√	None
		Unilever Central Hospital	85	√	None
		St. Leonard's Hospital	77	√	None
	Kipkelion	None	None		None
	Londiani	Londiani Hospital	50	NA	None
	Soin Sigowet	Sigowet Hospital	90	√	KMTC Sigowet

The sampling process for the specific level 4 and level 5 health facilities, together with nursing training institutions were selected for the study using multi-level sampling, as presented in **Fig. 4** below.

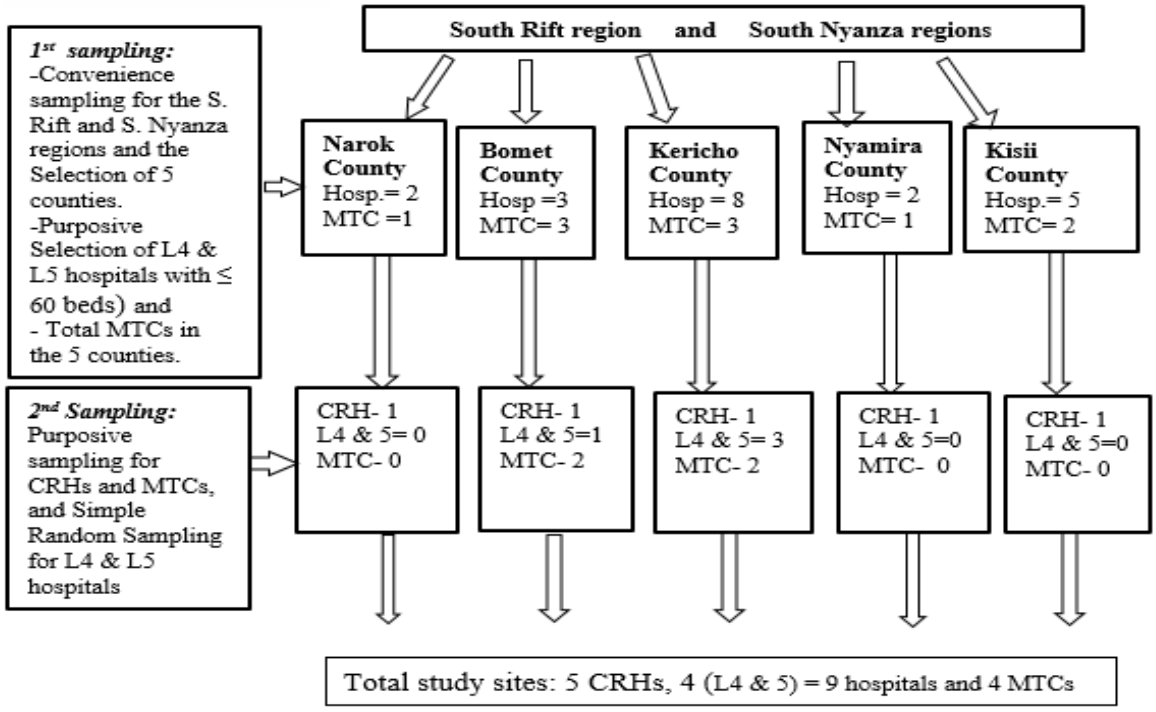

Figure 4: Schematic illustration of the Multi-Level Sampling process

The process of selecting level 4 and level 5 facilities comprised three levels of sampling. In the first sampling level, the list of all five counties with their respective county referral hospitals (CRHs) for each was generated. Additionally, purposive selection of large teaching and referral hospitals, both private and faith-based, with a bed capacity of 60 and above, were included, as noted by Nzinga et al. (2018). This criterion of selecting facilities with a bed capacity greater than 60 was utilized for the study to ensure a sufficient number of mid-level nurse managers in relation to the number of service delivery units. Also, the researcher listed all the public, private, and faith-based medical training colleges (MTCs) that train nurses within the five selected counties. This level of selection yielded a total of

20 level 4 and level 5 public, private, and faith-based hospitals, and 10 nursing training institutions distributed within these five counties.

The second level of sampling involved purposive sampling for county referral hospitals and medical training colleges, and a simple random sampling technique using a lottery method was used for L4 & L5 hospitals, as presented in **Table 3.2**.below.

Table 3.2: Hospitals with (≤ 60 beds) and Sampling Results

County	**No.**	**Hospital**	**No. of Beds**	**Purposive sampling of County Referral Hospitals**	**A random sampling of Level 4 and Level 5 Hospitals**
NAROK	1.	Transmara West Sub-County Hospital	126		No
	2.	Narok County Referral Hospital	400	√	NA
BOMET	1.	Kaplong Mission Hospital,	361		Yes
	2.	Tenwek hospital	361	Excluded due to conflict of interest	NA
	3.	Longisa County Referral Hospital	144	√	NA
KISII	1.	Tabaka Mission Hospital	250		No
	2.	Mediforte Hospital	100		No
	3.	Kisii Teaching and Referral Hospital	650	√	NA
	4.	Christamarianne Mission Hospital	170		No
	5.	Hema mission Hospital	168		No
NYAMIRA	1.	Nyamira County Referral Hospital	242	√	NA
	2.	Nyangena Sub County Hospital	227		No
KERICHO	1.	Kapkatet Hospital,	227		Yes
	2.	AIC Litein Mission	240		Yes
	3.	Kericho County Referral,	250	√	NA
	4.	Siloam Hospital	78		No
	5.	Kericho Nursing Home	157		Yes
	6.	Unilever Central Hospital	85		No
	7.	St. Leonard’s Hospital	77		No
	8.	Sigowet Hospital	90		No

The researcher purposively selected each of the county referral hospitals from each of the five counties, as these were the major referral points of care within the respective counties, and also, they were the larger facilities with different inpatient units led by MLNMs. Correspondingly, these county referral hospitals were used as the main clinical rotation sites for nursing students during their leadership and management clinical practice placement, which was the area of focus in this study. Next, for the simple random sampling lottery technique for level 4 and level 5 private and faith-based hospitals, the researcher assigned numbers to the remaining fifteen hospitals after excluding the five CRHs already sampled purposively. The numbers were recoded in slips of paper, folded similarly, put in a container, mixed thoroughly, and drawn at random by scooping with a spoon. This technique was done to ensure an equal probability of selection. This selection process resulted in four randomly drawn hospitals, in addition to the five CRHs, making a total of nine selected study sites for the study. The researcher also performed purposive sampling of the nursing training institutions, two from public medical training colleges (MTCs) and two from private faith-based medical training colleges. This was done to provide representation for the public, faith-based, and private training institutions. Based on the selection process applied in this study, at the completion, it generated a list of 9 hospitals that were selected for the study.

3.4. Population

In research, the term “population” refers to the comprehensive set of elements, which can be either persons, objects, or other similar entities that share specific common characteristics pertinent to the study. The characteristics that define this population are determined by the researcher based on the specific focus and objectives of the study. The

researcher must understand the population for the particular study because this comprehension forms the foundation of the research design and influences the sampling method, data collection processes, and eventually the interpretation of the results, consequently yielding meaningful findings that can be extrapolated to larger applicable groups or settings. This population comprises the target population and study population (Willie, 2022; Hossan, Mansor & Jaharuddin, 2023). According to the definition by Bhandari (2023), the population refers to the whole group that the researcher desires to draw inferences about. Also, the population is defined further as the total group or set of all the units of the target subjects or phenomenon that possess variable attributes under the study, for whom the results of the study would be generalized. The population has to be well defined up front by the researcher before commencing the research activities (Shukla, 2020). This is because when the population is appropriately defined, it will help the researcher to determine the appropriate sample size that would provide a suitable representation of the entire population of interest. This plays a critical role in guaranteeing the validity, reliability, and generalizability of the study findings (Thomas, 2023). Different scholars have a comparable understanding that the study population does not always refer to people or persons only, but rather, anything can be taken as a unit of study depending on the objectives of the particular study in question. A unit of study can range from living to nonliving things, including persons, animals, objects, events, and phenomena (Ahmad, Alias & Razak, 2023; Bhandari, 2023; Thomas, 2023 & Shukla, 2020). Owing to the diverse aspects involved in the definition of the population forming the unit of study in research, the researcher utilized this comprehension to define the scope of the population for this study.

3.4.1Target Population

In research, the term “Target population” refers to the particular group or segment of individuals within the larger population that is the primary focus of the study. It is the group that the researcher wishes to generalize the study findings to. The target population possesses specific characteristics or meets certain criteria for inclusion in the study, and it is ascertained based on the research question or objectives (Willie, 2023). The target population for this study comprised all the Mid-Level and Front-Line Nurse Managers and Nursing Directors from all the level 4 and 5 health facilities; and nursing curricula from all the public and private diploma nurse training institutions within the selected hospitals in Bomet, Kericho, Narok, Kisii, and Nyamira Counties, of South Rift and South Nyanza regions, Kenya.

3.4.2 Study Population

In research, the study population, also known as the sample population, refers to elements chosen for participation in a study. It is a subset of the target population.

The sample population included the Mid-Level, Front-Line Nurse Managers and Nursing Directors from the nine level 4 and 5 selected hospitals facilities; and nursing curricula from two selected private and two public diploma nurse training institutions within Bomet, Kericho, Narok, Kisii, and Nyamira Counties, of South Rift and South Nyanza regions, Kenya, who met the eligibility criteria.

The selected hospitals in each of the counties and the number of MLNMs in each are illustrated in **Table 3.3** below.

Table 3.3. The selected Hospitals in each of the counties, with their respective number of MLNMs, ND, and Diploma nurse training curricula

	County	**Hospital**	**No of MLNMs**	**Nursing Directors**	**Nurse Training Curriculum**
1.	Bomet	Longisa County Referral	11	1	
2		KMTC Bomet Campus			1
3.		St. Clare's Kaplong Mission Hospital	8	1	
4		St. Clare's Kaplong School of Nursing			1
5.	Kericho	Kapkatet Hospital	12	1	
		KMTC Kapkatet Campus			1
6.		AIC Litein Mission Hospital	12	1	
7		AIC Litein MTC			1
8		Kericho County Referral Hospital	21	1	
9		Kericho Nursing Home	8	1	
10	Narok	Narok County Referral Hospital	9	1	
11	Nyamira	Nyamira County Referral Hospital	12	1	
12	Kisii	Kisii Teaching and Referral Hospital	20	1	
		TOTAL (N)	113	9	4

3.4.2 Inclusion Criteria

- Mid-Level Nurse Managers (MLNM) with at least two years of experience in heading nursing service delivery units within the nine selected hospitals.
- Mid-Level Nurse Managers (MLNM) who voluntarily consented to participate in the study.
- Nursing Directors (ND) from each of the nine selected hospitals who voluntarily consented to participate in the study.

- Diploma nurse training curricula, which were made available for review by the Principals of the respective training institutions.
- Diploma nurse training curricula from the selected medical training colleges that were available for review at the time of the data collection.

3.4.3 Exclusion Criteria

- Mid-Level Nurse Managers with at least two years of experience in heading nursing service delivery units within the nine selected hospitals, who were away from the selected facility during the data collection period.
- Mid-Level Nurse Managers declined to consent for participation in the study.
- Nursing Directors from each of the nine selected hospitals who declined to consent for participation in the study.
- Diploma nurse training curricula, which were unavailable for review at the time of data collection.

3.5 Sampling Procedures

A sample is a segment of the population selected for investigation, while sampling is the process of selecting a subset of individuals with similar features to the underlying population as a representative of the total population to make certain observations of elements and conclusions regarding the entire population (Bhandari, 2023). This study employed a multi-level sampling procedure, utilizing both selected probability and non-probability sampling methods at different sampling levels (Zimano & Chilunjika, 2019). Purposive sampling technique was used for mid-level nurse managers because the drive of purposive sampling was to address specific initiatives related to the research question, and therefore, the selection of cases was deemed to be most informative regarding the research

question [in this study, Mid-level or unit-level nurse managers] were selected by virtue of their leadership positions. Additionally, the total number of participants (MLNMs) from the nine selected hospitals was one hundred and thirteen (113), allowing for probability sampling. This is because probability sampling requires a study population that would offer a study sample that is large enough to establish representativeness (Hall and Roussel, 2014). The remainder of the participants (Nursing Directors) were purposively sampled. In purposive sampling, the researcher selects participants with rich information regarding the central focus of the study. Since the number of Nursing Directors is nine, the number is manageable without sampling. Therefore, this implies that the total number of participants was 113 MLNMs and 9 NDs.

3.6 Sample Size Determination

The determination of the sample size for this study was guided by the mixed methods design, which is quantitatively oriented. When using this method, the researcher aimed at producing a sample that would offer meaningful information as well as one that was representative, as asserted by Hall and Roussel (2014). Furthermore, the sample size determination was dependent on the purpose of the study and what the researcher desired to learn; hence, it did not have a single fixed rule. Following this argument, the researcher did purposive sampling for the MLNMs in each of the selected hospitals. This was followed by total coverage for the nine (9) Nursing Directors from the nine selected hospitals in Bomet, Kericho, Narok, Kisii, and Nyamira Counties. This sample size is informed by the fact that the number of MLNMs in each of the selected hospitals is equivalent to the number of service delivery units headed by nurse managers and that each of the hospitals has one nursing director.

To establish the minimum required number of participants for this study, the researcher utilized the Taro Yamane formula (Uniproject Materials, 2016), which is presented as follows:

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

Where: n = sample size required, N =Number of people in the population [in this case, the 113 MLNM], e = allowable error (%) - 0.05.

Substituting in the formula:

$$n = \frac{113}{1 + 113\ (0.05)^2} = 88$$

n= 88

Taro Yamane's formula assumes a 95% confidence level and a degree of variability of the attribute of interest that is present in the population (P) of 0.5 (Israel, 2003). In the study, the attribute of interest was taken to be the Mid-Level Nurse Managers' perception level of the adequacy of the basic nursing training in preparing them for leadership roles. This study will, therefore, assume that the proportion of nurses reporting adequate preparation by their nursing training for leadership roles is 50%.

To determine the proportional number for MLNMs for each of the nine selected study sites, n= 88, obtained from substituting the Taro Yamane formula, was used to calculate as illustrated in **Table 3.4** below

Table 3.4. Population and Sample Size Determination

	County	**Hospital**	**Total No of MLNM**	$\boldsymbol{sample(n)}$ **MLNM**
1.	Bomet	Longisa County Referral	11	$\frac{11}{113} \times 88 = 8.5$
2.		Kaplong Mission Hospital	8	$\frac{8}{113} \times 88 = 6.2$
3.	Kericho	Kapkatet Hospital	12	$\frac{12}{113} \times 88 = 9.3$
4		Litein Mission Hospital	12	$\frac{12}{113} \times 88 = 9.3$
5		Kericho County Referral Hospital	21	$\frac{21}{113} \times 88 = 16.3$
6		Kericho Nursing Home	8	$\frac{8}{113} \times 88 = 6.2$
7	Narok	Narok County Referral Hospital	9	$\frac{9}{113} \times 88 = 7.0$
8	Nyamira	Nyamira County Referral Hospital	12	$\frac{12}{113} \times 88 = 9.3$
9	Kisii	Kisii Teaching and Referral Hospital	20	$\frac{20}{113} \times 88 = 15.5$
		TOTAL (N)	113	87.6
Total Sample Size = 88 MLNMs				

The target population is 113 MLNMs and 9 NDs from the 9 selected study sites. From **Table 3.4** above, the sample size for MLNMs was 88, in addition to the 9 Nursing Directors 9, making a total of 97 participants. Also, 4 purposively sampled curricula from diploma nurse training institutions were reviewed to provide data on the course content, clinical rotation, and the structure for the practical assessment for the leadership and management component of the basic nursing training.

3.7 Data Collection Methods

The procedure used to collect data was influenced by the research design and the research instruments. For the quantitative data, the researcher utilized self-administered questionnaires for the 88 Mid-Level Nurse Managers and a document review checklist for the nursing training curricula from the four nursing training institutions. Regarding the qualitative data, the researcher employed verbal face-to-face interviews with key informants, including the nine Nursing Directors, from the the 9 selected hospitals. The researcher also obtained qualitative data by conducting a total of eight Focus Group Discussions (FGD) in 8 of the nine selected hospitals. Each of the FGD groups comprised 7 to 9 MLNM or FLNM, having served in the current position for at least two years or more, and were willing to participate in the discussion.

3.8 Research Instruments

The research instruments that were used in the study to collect data include: Self-administered questionnaires, Key Informant Interview (KII) schedules, Focus Group Discussion (FGD) Guides, and Document Review Checklist.

3.8.1 Questionnaires

Questionnaires are forms containing systematic collections of questions, distributed to respondents in order to secure responses to particular research questions directly from them (Kirui &Too, 2016). Research postulates that results from questionnaires tend to be dependable and reliable because the respondents have the time to give a well thought out answer, making it the appropriate data collection tool for descriptive studies. Additionally, the use of self-administered questionnaires independently of a researcher offers anonymity and a lack of interviewer pressure, which encourages more truthful and well considered

disclosures on sensitive or intricate topics (Mari, 2024;Tombs & Strange, 2024). Therefore, it was the preferred choice for this proposed study. When developing the questionnaire, the researcher applied the guidelines whereby the objectives of the study form the basis for the organization of the questions contained in the instrument (Kabir, 2016 & Litza *et al.,* 2019). For this study, the researcher adapted a questionnaire that had already been validated through a previous study by Suza and Siregar (2020) by drawing the variables of managerial competencies, namely: planning, organizing, staffing, controlling, coordinating, and budgeting; and incorporating them into the questionnaire. These variables were drawn from the improved version of Henri Fayol's theory of managerial functions as these form the scope for management functions of both Mid-Level Nurse Managers and Front-Line Nurse Managers who were the key respondents in the study (Davis, 2024). For this study, the researcher utilized the questionnaire containing both close and ope ended questions to obtaine quantitative data which was employed to provide nueric description of the perceptions of mid level nurse managers regarding their level of leadership preparedness, to establish the extent to which the basic nursing training prepared nurses for leadership roles as well as to ascertain the association between role induction programs and leadership role (Channing, 2020).

The researcher began the modification of the questionnaire by creating logical sections such that the questionnaire was presented in five parts, which would facilitate concomitant collection of both quantitative and qualitative data from the same sample participants within the same time frame (Edmonds & Kennedy, 2017). The first part represents demographic data. The questions in each of the other four sections were organized in such a manner as to address each of the four specific objectives of the study. The researcher

chose to use both structured and open-ended questions for this study. Section A of the questionnaire contains the demographic data, and the researcher used eight structured questions to seek personal information from the participants. The variables that were considered for this section include: Age, gender, highest professional qualification, current leadership position held, years served in current leadership position, current place of work, years worked in the current institution, and work history of other institutions worked before the current institution.

Section B of the questionnaire relates to the first objective of the study. The researcher designed the questions to assess the the Mid-Level nurse managers' level of leadership role-preparedness in relation to their basic nursing training. The researcher developed five questions in this section. The first question was inquiring from the participants to list other other leadership roles the participants may have been involved in before the current role, the second was asking description of their entry or appointment process into the current leadership role, the third question was presented in a five-point Likert scale where respondents were asked to rate their level of agreement on six key functions of management namely planning, organizing, staffing, controlling, coordinating and budgeting. The researcher designed the question by use of a five-point Likert scale to obtain responses regarding how each of the nurse managers would rate their level of preparedness for their current leadership role. In closing this section of the questionnaire, participants were asked to present any challenges that they faced during the lived experience of their leadership role.

Section C of the questionnaire relates to the second objective of the study, and the researcher designed the questions to determine the level to which basic nursing training prepares nurses for leadership roles. The researcher developed three questions in this section that would facilitate the respondents' ability to rate the level to which their basic nursing training prepared them for leadership roles. In the first question of this section, the researcher designed the question using a five-point Likert scale, whereby the participants were asked to rate the level of agreement for each of the following statements regarding leadership role preparedness in relation to basic nursing training levels, namely: Diploma Kenya registered nurse training, Higher Diploma registered nurse training, and Bachelor's degree nursing training. The second question in this section asked respondents to rate their satisfaction level of preparation adequacy by nursing training on leadership roles as satisfied, somewhat satisfied, or dissatisfied, respectively. Regarding the third and last question in this section

In the section, the participants were asked to give reasons to support the level of satisfaction adequacy in accordance with the response as presented in the preceding question above.

Section D in this questionnaire corresponds to the third objective of the study, which sought to assess the contribution of role-induction programs to nurse managers' leadership role preparedness. The researcher designed two questions, aimed at obtaining information from participants to ascertain whether there are other leadership role-induction programs within the work environment settings apart from the formal basic nursing education, and the degree to which each would influence the leadership role preparedness among the nurse managers. The first question required the participants to provide a list of the available role

induction programs for nurse managers within their work settings. The researcher developed the second question in this section in a manner that would provide an opportunity for the participants to rate the extent to which each of the identified role-induction programs contributed to their leadership development.

Section E of the questionnaire relates to the fourth objective of the study, which is aimed at determining Mid-Level Nurse Managers' perceived training needs for leadership role preparation. The researcher designed one open-ended question for this section. Participants were asked to give suggestions on the perceived training needs for Mid-Level Nurse Managers to enhance their leadership role preparedness.

During the development of the questionnaire, the researcher organized the questionnaire such that it begins with an introduction section indicating the purpose of the study and specifies the sections and the number of questions involved, together with the estimated time it would take to complete the questionnaire. The items for each objective are arranged logically in order for the respondents to make sense of them within a short time. The researcher used bold prints for the headings of each section, font size 12, double spacing throughout the document, use of page numbers, and ensuring that the answer space is right below each question. The researcher ensured that each of the sections began with a statement that gave instructions to the respondents and also outlined the content and purpose of the particular section.

The questionnaires were distributed to the Mid-Level Nurse Managers from the nine selected hospitals who were willing to consent and to participate in the study. All one hundred and thirteen (113) sampled respondents were involved in the study.

3.8.2 Key Informant Interviews (KII)

The Key Informant Interview schedule is a document that has an outline script consisting of a list of open-ended questions pertinent to the topic under inquiry. Key Informant Interviews (KIIs) are used to collect qualitative data that offers select insights from individuals with extensive knowledge or experience in a specific field. It was used by the interviewee to guide the discussion and to ensure that all the relevant questions were covered and responded to at the end of the interview (Kibuacha, 2024). When developing the interview schedule, the researcher ensured that all the components were covered, which included the introduction, Key questions, probing questions, and closing questions (UCLA, n.d). Regarding the KII for this study, the researcher used the total coverage of study participants involving nine (9) nursing directors of the nine selected hospitals because there is only one nursing director for each study site. Although the research question was focused on perceptions of the Mid-Level and Front-Line nurse managers, the nursing directors were interviewed so as to obtain their views as the custodians and participants of the intervening variables of the proposed study, namely organizational structure and supportive supervision for the MLNM and FLNM. In this study, the consideration of the nursing directors as the key informants was informed by the assertion that when conducting applied qualitative health research, key informants are referred to as the group sampled based on their expert role or expertise using purposive sampling strategies (Pahwa, Cavanagh & Vanstone, 2023). For this study, the researcher focused on the objectives of the study to define the scope of where the interview questions arose from. Just as in the case of the questionnaire, the first three questions of the KII schedule were composed of questions that sought to obtain participants' personal information. The variables involved were: the

institution of current employment, how long they have been working in the current institution, and a list of other institutions where the participant has worked before the current institution.

The researcher designed the remainder of the nine questions in such a manner that it would facilitate ascertaining of the information from the supervisors' perspective regarding the following: The understanding of the nursing directors about the role of MLNM, appointment processes into the MLNMs position, the role induction modalities that were in place for the purpose of preparing Mid-Level Nurse Managers for their roles, the extent of role preparedness achieved through basic professional nursing training, the challenges experienced by MLNM in their roles, the involvement of nursing directors in the development of MLNM for their roles as well as the supervisors' rating for the level of leadership-role preparedness for the MLNM under their supervision. The researcher designed the closing question in such a manner that it gave the nursing directors opportunities to give suggestions on how leadership-role preparedness for MLNM would be improved. This section also provided the opportunity for the respondents to give their overall views, comments, recommendations, or possible solutions to the problem under inquiry.

3.8.3 Focus Group Discussions (FGD) Guides

The Focus Group Discussion guide is a document that is used for qualitative data collection to administer a pre-determined semi-structured interview. It is used to aid the researcher in gaining a deeper understanding of an issue than what can be accessed through a survey (Eeuwijk, & Angehrn, (2017). When developing the FGD guide for this study the scope of the questions was guided by the objectives of the research study and the researcher

applied the concept espoused by Prasad and Gracia (2017) where the number of questions is kept as reasonable as possible, simple, short and clear while ensuring use of permissible question types to include; probing questions, follow-up questions, and exit questions. For this study, the researcher kept the questions to a maximum of nine but ensured that they sufficiently covered the four objectives of the study. Unlike in the case of the questionnaire and KII schedule, the researcher did not include the demographic data at the beginning of the FGD guide, but instead, the participants' personal information was captured in the attendance register for the FGD.

3.8.4. Document review checklist

Documentation Review Checklist is a methodically organized form that assists the researcher in conducting a meaningful review of documents (Martine, 2014). It was used for this study to obtain information regarding the basic diploma nursing training curriculum with emphasis on the leadership and management section of the course content as well as students' clinical rotations.

When developing the document review checklist for this study, the researcher was guided by the second objective of the study, which facilitated the determination of the scope, content, and organization of the questions in the research tool. The researcher explored the possible questions that would unveil the information regarding the extent of adequacy to which basic professional nursing training prepares nurses for leadership roles.

The researcher began with the first three questions that would establish the commonalities among the nursing curricula from KMTCs, faith-based training institutions, and Universities associated with the selected hospitals for the study. This is because nurses who

are appointed to leadership positions may not have all been trained in the institutions included in the study.

The remainder of the questions were designed according to the three main parameters, namely: leadership and management section course content, examining the learning process, and examining the assessment of learning. When developing the question regarding the leadership and management course content and objectives, the researcher considered attributes including knowledge, skills, attitudes, and values while determining the percentage content, resources, assessments, and objectives allocated to each. When examining the learning process, the researcher designed the questions in such a manner that they explored the opportunities provided for learning experiences and how learning was delivered to the nursing students. Regarding examining and the assessment of learning, the researcher explored the ratings for assessment attributes such as knowledge, skills, attitudes, practical, and oral assessments.

The last three questions in the checklist were designed by the researcher such that they would obtain information on formal review of the curriculum, including the process followed and the modifications made for the leadership and management course as the area of focus.

3.9 Validation of the instruments

Validation is a process comprising gathering and analyzing data to measure the accuracy of a research instrument. It refers to the determination of the extent to which the instrument actually reflects the construct being examined (Biddix, n.d). In order to fulfill this process, the researcher constructed the instruments and discussed them with supervisors and

experts. Furthermore, the researcher subjected the instruments to pilot testing after obtaining approval from the Institutional Research and Ethics Committee (IREC).

3.9.1 Validity of the instruments

The validity of an instrument refers to the determination of the extent to which a research instrument reflects the concept being examined (Gray & Grove, 2024). The instruments for this study adopted the variables from an already validated questionnaire by Suza and Siregar (2020). Because this was an already facilitated questionnaire, the researcher adopted it while constructing the instruments for this study, and, therefore, it did not require a rigorous process of validation. However, in order to ensure the reliability and validity of the adoption of the variables and format for the instruments, the researcher subjected the instruments to discussion by supervisors and experts and conducted a pretest. Content validity was measured by ensuring that all possible items in the questionnaires were provided per the study objectives (Mugenda and Mugenda, 1999). External Validity was ascertained through ensuring that the sample population for this study was an accurate representation of the Mid-Level Nurse population because this would allow for the generalizability of the findings of this study (Biddix, n.d). The research instruments were pretested to establish their validity.

Using the data from the pretest, the validity of the instrument was authenticated by considering the findings against the specific objectives of the proposed study. The researcher confirmed and ensured that the responses answered the research questions and achieved the study objectives with respect to the study instruments. Any data that was deemed not to be relevant to the study objectives was used to guide in modifying the study instruments to ensure that they collected data that was relevant to the study.

3.9.2 Reliability of the Instruments

The reliability of the instruments refers to the consistency of a measure and may be defined as the degree to which the measure of a construct is consistent or dependable (Price, Jhangiani, and Chiang, n.d). The term construct refers to the skill, knowledge, attitude, or attribute that is being investigated by the researcher. For this study, the items that were included in the questionnaire were ascertained using Cronbach's alpha coefficient, which is used in research to determine internal consistency between items contained in an instrument (Kubai, 2019). To establish the internal consistency of the research instrument, Cronbach's alpha coefficients were calculated for each managerial competency. The six items used to measure nurse managers' preparedness to execute management functions were subjected to internal consistency testing. **Table 3.5** presents the item-level descriptive statistics used in the computation.

Table 3.5: Item Variances Used in Cronbach's Alpha Computation

Management Function Item	**SD (sigma_i)**	**Variance (sigma_i^2)**
I am adequately prepared to execute the Planning function of management	0.802	0.6432
I am adequately prepared to execute the Organizing function of management	0.719	0.5170
I am adequately prepared to execute the Controlling function of management	0.665	0.4422
I am adequately prepared to execute the Coordinating function of management	0.617	0.3807
I am adequately prepared to execute the Staffing function of management	0.844	0.7123
I am adequately prepared to execute the Budgeting function of management	0.981	0.9624
Sum of item variances (sum sigma_i^2)		**3.6578**

Step-by-Step Computation of Cronbach's Alpha

The formula applied was: **alpha = (k / k-1) x (1 - sum sigma_i^2 / sigma_total^2)**

Where:

k = number of items = 6

sum sigma_i^2 = sum of item variances = 3.6578

sigma_total^2 = variance of composite total scores = 18.4024

N = 65 respondents (conservative estimate based on lowest valid N)

Substituting into the formula:

alpha = (6 / 6-1) x (1 - 3.6578 / 18.4024)

alpha = (6 / 5) x (1 - 0.1988)

alpha = 1.2000 x 0.8012

alpha = 0.961

Results and Interpretation

The Cronbach's Alpha coefficient for the six role-preparedness items was 0.961. This value exceeds the threshold of 0.70 recommended by Nunnally (1978) and falls in the excellent reliability range (above 0.90), as proposed by George and Mallery (2003). This confirms that the six items measuring nurse managers' preparedness to execute management functions are internally consistent and reliably measure the same underlying construct.

Specifically, the items covering the planning, organizing, controlling, coordinating, staffing, and budgeting functions of management collectively form a reliable scale. The high alpha value indicates that respondents interpreted and responded to all items in a consistent manner, strengthening confidence in the composite score as a valid indicator of overall role-preparedness.

Table 3.6: Reliability Statistics

Cronbach's Alpha	N of Items	Reliability Level
0.961	6	Excellent

Source: Field Data (2024)

To ensure consistency and standardization in data extracted from the nursing training curriculum, the researcher designed and pretested a data extraction form and presented it to the expert for review. Information on the data extraction form included: the method of teaching, specific learning opportunities and outcomes relevant to nursing training on the leadership and management section, and assessments, both theory and practical. The data extraction form was aimed at establishing whether assessments are aligned to the learning outcomes (Rohwer, Schoonees, and Young 2014)

The reliability of the instruments was validated by considering the responses from the participants and verifying whether they were consistent. The researcher was also keen on checking whether the instrument was understood the same way all the time by different participants, and if it elicited consistent responses all the time it was used.

3.9.3 Pretesting of the Instruments.

The pretest of the instrument is the first step of testing a survey, questionnaire, or interview guide on a small sample of the target population before full-scale use. It identifies faults in question wording, flow, and understanding, ensuring the tool is reliable, valid, and user-friendly. This is carried out before the actual study is done and is done by subjecting the research instruments to a smaller number of respondents with similar characteristics to those of the sample population for the study (Polit & Beck, 2017). For this study, pretesting of the instruments was undertaken by the researcher by using 10% of the sample size (Mugenda and Mugenda, 1999). The pretest was done to find out if the instruments were relevant, satisfactory, acceptable, covered the intended scope within the estimated time, and whether appropriate wording was used. The identified errors or gaps were adjusted accordingly. In order for the researcher to establish the validity of the FGD guide, a pretest

of the FGD guide was carried out in a group of 6 MLNM and one nursing director from Tenwek Hospital. Also, a pretest of the document review checklistwas performed using the nursing training curriculum from Tenwek Hospital College of Health Sciences wasconducted in order to ascertain the validity and reliability of the document review checklist. The results were discussed with supervisors and experts. Changes and modifications were made according to their feedback and what was identified from the pilot study results.

3.10. Data Collection Procedures

Since this proposed study is of a parallel Mixed-Methods [QUAN + QUAL] design, both qualitative and quantitative data were collected concurrently. Research instruments also contain both qualitative and quantitative components. The researcher recruited two research assistants (RAs) to assist in data collection. The research assistants were trained on how to administer and handle the questionnaires, as well as on how to administer and handle the consent.

3.10.1. Training of the Research Assistants

The two RAs were recruited and trained on the procedures to be followed when administering and handling the questionnaires and consents, data collection techniques, and ethical issues. The research assistants were recruited from the MLNM at Tenwek Hospital. This is because their qualifications render them well-suited to conduct the interviews, as they possess substantial experience and a comprehensive understanding of leadership roles. This expertise enables them to effectively address any clarifications needed in the questionnaires and interviews with the respondents. Research assistants'

briefing was done, which encompassed the requirement for the research assistants to clarify to the respondents that:

- The study intended to help explain the current perceptions and understanding of leadership role preparedness before administering the questionnaire.
- The study would provide feedback on the preparedness of MLN managers to be able to discharge their mandate.
- Knowledge generated will assist the hospitals' leadership on how to strategize for capacity building for the MLNMs and also for training institutions in what to consider when reviewing the nursing training curriculum.

Research assistants are also required to clarify to the respondents that the purpose of the questions is to capture individuals' perspectives regarding leadership role preparedness in relation to professional training in order to create dialogue to further develop effective role preparation for those who are charged with leadership responsibilities. Training for the research assistants will be done in order to secure accurate data collection and to improve the reliability of the research study by counteracting researcher effects like inaccurate coding of responses, coding errors, and classification errors (Hutchinson and Moran, 2005)

3.10.2. Administration of the Instruments

The collection of data was done within a period of two months in the nine selected study sites. The researcher organized the data collection procedures in three phases in each of the study sites, such that the first phase was the administration of questionnaires and key informant interviews, the second phase was for FGDs, and the third phase was for curriculum review in the nurse-training institutions.

3.10.2.1 Data Collection through Questionnaires

The questionnaires were self-administered, accompanied by letters of introduction explaining the purpose of the study and the written informed consent. The filled questionnaires were collected after the agreed period had elapsed. The researcher and the research assistants followed up to ensure that the questionnaires were administered to as many nurse managers as possible.

The data collection by use of questionnaires was done through the following sequence:

The researcher first obtained permission from the key 'gatekeepers' or administrative leadership for the nine selected hospitals to facilitate entry to the institutions for the purpose of conducting the research study. Once the permission was granted, the researcher together with the research assistants, paid a courtesy visit to each of the Nursing directors because each of them represented the leadership of the nursing departments for the particular hospitals under the study. The NDs facilitated linkage between the researchers and the MLNM who participated in the study.

With the guidance of the NDs, the researcher and the RAs met each participant at a prior agreed time and did a self-introduction and explanation on the purpose of the survey. The participants were then taken through the informed consent and given the opportunity to make an informed decision on whether to participate in the study. Those who chose to participate were offered the opportunity to sign the consent form.

The researcher and the RAs distributed the questionnaires through hand delivery to respondents to fill out and agreed on the time of collection. Every study instrument was accompanied by a letter of introduction explaining the purpose of the study and written

informed consent. The researcher and RAs collected the duly filled questionnaires after the agreed duration while checking them for completeness and legibility.

The researcher and the RAs facilitated closure by appreciating the respondents for participating in the research survey and communicating with the NDs on the closure of the process for each day.

3.10.2.2 Data Collection through Key Informant Interviews (KII)

Interviews refer to face-to-face or telephone encounters involving oral administration of questionnaires or interview schedules, which consist of structured and open-ended questions. Interviews are used in order to provide in-depth data that is not possible to get using a questionnaire (Davis, 2019). Additionally, individual interviews can result in rich data that is essential to credible research findings and judgments about the transferability of findings to other individuals or contexts (Hall and Roussel, 2014).

The interviews for this study involved the Nursing Directors (NDs) for each of the nine selected hospitals as the Key Informants. This was a purposive selection of the appropriate participants because NDs are directly involved with the appointment, capacity building, and supervision of the MLNM heading service delivery units; therefore, they are well-versed with information regarding the practice and experience of the MLNM in each of the hospitals. The steps that were involved in the data collection process were guided by the work of Davis (2019).

The researcher organized interviews with the nursing directors on dates that were convenient to each one of them, and contacts were taken for easy scheduling of the appointments. Once the appointments were secured, the researcher booked the time and

venue for the interview ahead of time. The researcher provided the key informants with the option of face-to-face or recorded telephone interviews.

On the material day of the interview, the researcher, the RAs, and the particular participant met at the agreed venue. The process of establishing rapport was done through the researcher, beginning with greetings, followed by self-introduction and introduction of the RAs with their respective roles during the interview process. The researcher then introduced the purpose of the interview and presented the informed consent for the participants.

The researcher carried out the interviews through face-to-face encounters with the respondents. The researcher interviewed each of the Nursing Directors of the nine selected hospitals for the study, while the RAs took notes and recorded the proceedings of the interview for transcription later, in line with the study objectives. The interviewer was guided by the interview schedule throughout the data collection process. The researcher ensured that all the questions in the interview schedule were exhausted before bringing the interview session to a close.

At the end of the interview, the researcher inquired from each of the key informants if they had any questions or final comments. The researcher then summarized the interview session by explaining what would happen with the information that was collected and concluded by appreciating the participants for their time. After the completion of each interview, the researcher proceeded to the time of compiling and organize the data on the same day while the information could still be recalled easily. Responses from the interview will be used for the triangulation of responses from the other instruments that will be applied in the proposed study.

3.10.2.3 Data Collection through Focus Group Discussion (FGD)

Focus Group Discussion refers to a data collection procedure where a researcher interviews several people at one time (Hall and Roussel, 2014). FGD may comprise six to twelve homogenous people representing a section of the population, brought together to engage in a guided discussion on a particular research topic using semi-structured questions and themes (Gray & Grove, 2024). For this study, the researcher with the RAs organized and conducted a single FGD in each of the eight study sites through either face-to-face as the first choice or online Zoom as the second option (Nyumba et al., 2018). The FGDs were composed of MLNMs ranging from seven to nine, selected through purposive sampling while considering the pre-determined selection criteria.

3.10.2.3.1 Selecting FGD Participants

According to Crossman (2019), the participants of a focus group are selected based on their relevance and relationship to the topic under study. This, therefore, formed the basis for the purposive selection of Mid-Level Nurse managers as the participants for this study.

The process of selecting FGD participants was done in collaboration with the Nursing director from each of the study sites. The researcher set the criteria for selecting the participants, which encompassed: being a Mid-Level Nurse Manager or a Front-Line Nurse Manager, having served in the current position for at least two years or more, being of either male or female gender, being able to express oneself without difficulty, and being willing to participate in the discussion. This criterion formed the basis of the homogeneity of each FGD, which comprised: Professional qualification [being a nurse], Hierarchy [being a MLNM or FLNM], and Experience [at least two years and above in the current position]. Age and gender did not determine inclusion or exclusion in participating in FGD. The researcher shared the criteria with each of the NDs from the study sites, who then used

it to facilitate the selection of the participants who best suited the specified criteria. This is because the NDs know and are well conversant with the attributes of the MLNM they supervise.

3.10.2.3.2 Preparation for FGD

This involved the researcher confirming with the participants in advance that they were ready and planning to attend and participate in the FGD. The researcher then ensured that the location and time were clear and agreeable for all the participants. Additionally, it included making sure that the FGD venue is in a convenient place where participants can access public transport and that the kind of setting does not introduce bias in the information being collected. The researcher also organized refreshments during the FGD and took financial responsibility for the same, including payment for the participants' participation, because they might have abandoned productive work to participate in the FGD.

3.10.2.3.3 Conducting the FGD

The researcher held and led the FGDs in each of the eight selected hospitals on the date that had been agreed upon ahead of time (Daniels et al., 2019). The researcher booked the venue for FGD ahead of time and ensured a conducive environment that let participants feel at ease; and allowed them to be heard by the facilitator, the recorder, and by each other (Eaton, 2017). On the material day for FGD, the researcher, together with the RAs, arrived at the venue before the start time and before the participants arrived and ensured that everything was set as planned. The researcher made arrangements, and the snacks were set and ready before the commencement of the session, so that as the participants arrived, they were served, which made them feel at ease. The researcher provided them with an

attendance list where participants registered before commencing the FGD session. The participants filled in the spaces provided for the demographic data in the attendance list.

Once the participants were settled, the researcher then began by declaring the FGD session officially opened and proceeded with self-introduction, and also introduced the RAs by name and provided a brief explanation of the purpose of the meeting and the approximate expected time that the discussion would take, ideally 60 to 90 minutes. As a way of setting the climax, the researcher provided the opportunity for the participants to do self-introductions by name as well as provide other information about themselves at their discretion, while making sure that discussions were confined to the introductory formalities only for the sake of time. The researcher also ensured that the participants were comfortable and provided informed consent. The researcher then involved the participants in setting the ground rules for conducting the FGD. This helped in establishing rapport and making the team relaxed and free to discuss issues concerning the research topic.

The researcher proceeded to the discussion phase and began by introducing the topic of leadership-role preparedness among the mid-level and front-line nurse managers, and encouraged participants to be open and candid in making their contributions, and assured them of the confidentiality of the information that was being shared. The researcher and the RAs facilitated the discussion by using the FGD guide and the researcher took the moderator's role while the RAs took the role of documentation and audio recording of the proceedings of the FGD. The researcher used moderators' techniques such as remaining neutral so as to encourage freedom in sharing opinions by participants, dealing with dominant participants by acknowledging their opinions, as well as soliciting other opinions, especially from the shy participants. Throughout the FGD, the researcher and the

RAs reulated their pace to ensure that it did not last less than 60 minutes, for the purpose of ensuring full exploration of the topic under inquiry; and that it did not go beyond 90 minutes in order to avoid the participants getting weary or discussion starting to impose on the participants (Prasad and Gracia, 2017 and WHO Archives, N.D). However, the researcher, being the moderator of the FGD, diligently assessed the input from the participants and allowed for more time when the participants deemed not exhausted their information by the end of the stipulated time. Once the contributions from participants achieved the "saturation level" where no new insights or themes emerged, the researcher proceeded to carefully evaluate the list of questions outlined in the Focus Group discussion guide. This evaluation involved a thorough discussion of potation probing questions designed to elicit deeper responses. After the comprehensive deliberation, the researcher then took the necessary steps to formally conclude the FGD session, ensuring that all the participants got the opportunity to share their thoughts and that the objectives of the session were met.

Toward the end of the discussion, the researcher used approximately the last ten minutes to summarize and recap the information gathered during the discussion. The researcher informed the participants that the session was closing and gave them the opportunity to ask questions, make corrections, or make clarifications, if any. The researcher then appreciated the participants for their time and contributions.

The researcher has participated in conducting an FGD in a previous study done by an experienced researcher, which provided her with the experience. However, for this study, the researcher engaged an expert who worked together with the researcher and the RAs to

transcribe the audio recordings and notes taken during the FGD as soon as the discussions were completed.

3.10.2.4 Data Collection through Document Review

Document review involves a systematic gathering, documentation, analysis, organization, and interpretation of data as a data collection method in research (Bretschneider et al., 2017). The researcher obtained permission through the Principals of the respective nursing training institutions in the selected hospital to enter the institutions and for the nursing training curriculum to be availed for scrutiny by the researcher. Once the permission had been secured, the researcher then introduced the purpose of the study and provided the informed consent form to the respective Principals. With the signing of the consent for the study, the researcher requested to be provided with a room or space for use when examining the 'Leadership and Management' section of the curriculum and extracting information relevant to the study, while filling the document review checklist.

The researcher also requested that the principal clarify any concerns that arose and give his or her opinion regarding the adequacy of the leadership and management section of the curriculum in preparing MLNM for their roles. Once the exercise was completed, the researcher thanked the principals for their time, permission, and contribution to the study. The researcher then summarized the information collected in preparation for data analysis.

3. 11: Methods of Data Management and Analysis

This stage pertains to a crucial process through which the researcher systematically transitions raw, bulk, unprocessed data into acoherent and meaningful understanding. Through careful organization and analysis, the researcher applies various methods to interpret the data, uncover patterns, and extract insights. This process encompasses data cleaning, categorization, and analysis, ensuring that the findings are relevant, valid, and

reliable. The goal of this process is to distill complex information into a comprehensive narrative that enhances understanding of the subject matter (Bhatia, 2018).

Since this study is of a 'concurrent Mixed-Methods design – [QUAN + QUAN]', both qualitative and quantitative data processing and analysis were done concurrently, and the results were merged and interpreted together as illustrated in **Fig 4** below.

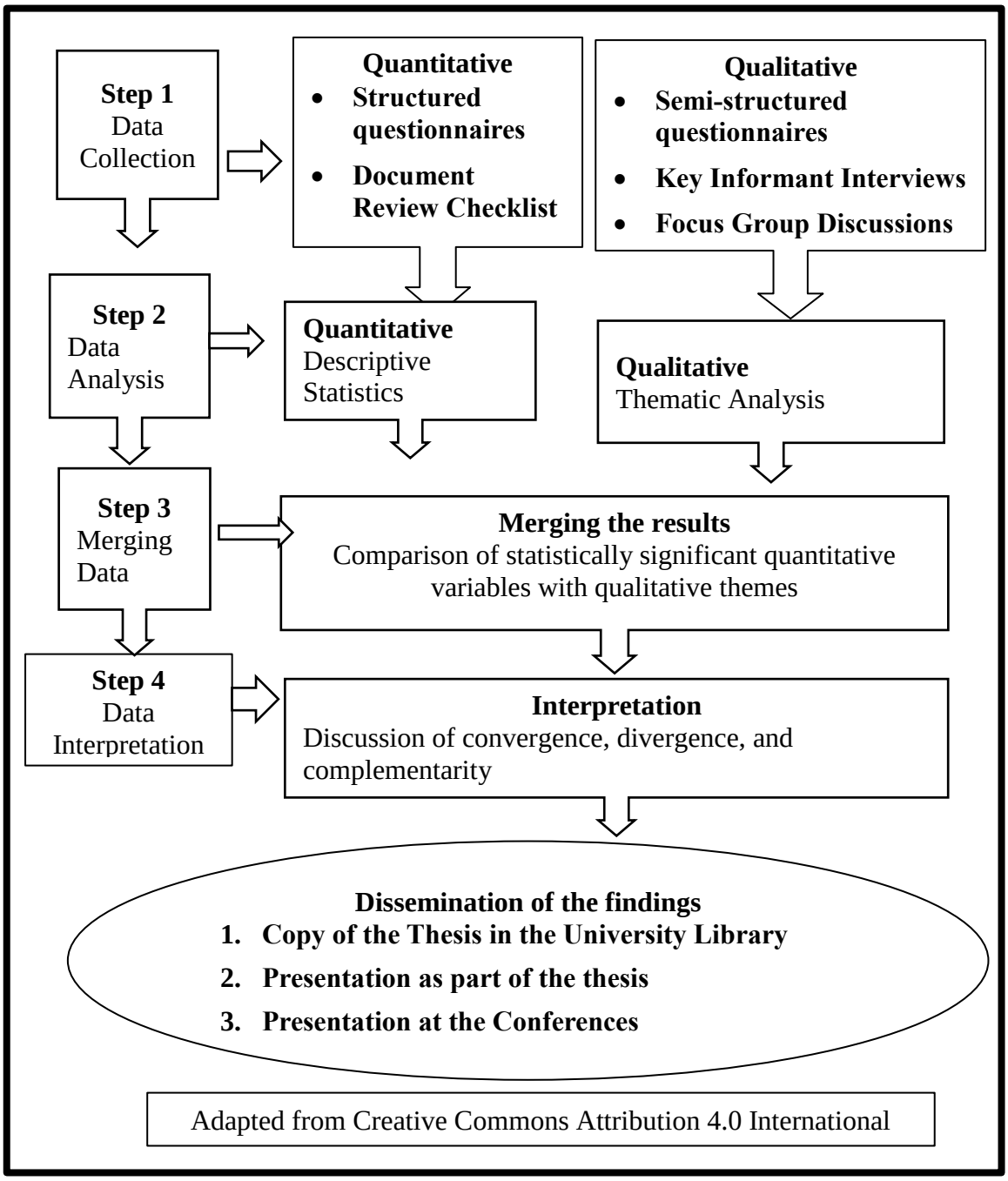

Figure 5: Flow chart of convergent mixed methods research design.

3.11.1: Quantitative Data Preparation and Processing

Following the collection of data by use of structured questionnaires, a systematic data preparation process consisting of four stages was implemented to ensure the integrity of the quantitative dataset, as guided by the framework of Lutabingwa and Auriacombe (2018). The first stage was data editing, whereby the researcher conducted a thorough, question-by-question assessment of each data collection instrument. This thorough review aimed at ensuring that all responses were complete, clearly legible, and internally consistent. By examining each entry with a critical eye, this stage functions as a vital quality control measure, allowing the researcher to identify any missing values, inconsistencies, or errors made by respondents. This careful inspection not only enhances the overall integrity of the data but also lays a strong foundation for credible analysis and findings.

The second stage is data coding, whereby the researcher systematically converts the responses collected during the study into numerical identifiers to streamline analysis. For non-numerical data acquired from Likert scales and rating systems, each response category was assigned specific numerical codes. This process was essential for enabling efficient computational analysis and ensuring the accuracy of the data interpretation. Such coding not only facilitated statistical evaluation but also supported the aggregation and comparison of responses across different variables and groups within the dataset.

Thirdly, the researcher proceeded to do the data entry. During this stage, coded data was systematically entered into both Microsoft Excel and the Statistical Package for Social Sciences (SPSS) version 20. Microsoft Excel served as the primary tool for the preliminary

organization and tabular formatting of the data. In contrast, SPSS was employed for its advanced analytical capabilities and its user-friendly interface, facilitating a comprehensive analysis of the dataset (Rahman & Muktadir, 2021).

The final stage was data cleaning wherebyesearcher the researcher was engaged in a comprehensive verification process to identify and rectify inaccuracies that may have arisen during the coding or transmission phases. This procedure was essential to ensure the integrity of the dataset, thus rendering it "clean" and suitable for subsequent analysis (Rahman & Muktadir, 2021).

3.11.1.1. Quantitative Data Analysis Strategy

The study adopted a multi-tiered analytical approach based on the series of processes postulated by Davidson (2019). Analysis was categorized into descriptive and inferential statistics to address the research variables.

The researcher employed descriptive statistics to effectively define the profiles of mid-level nurse managers, an approach that facilitated the condensation of raw data into coherent and interpretable patterns. The measures of central tendency, particularly the mean and mode, were utilized to ascertain the average performance levels of the mid-level nurse managers and to identify the most frequently reported responses, respectively. The measures of dispersion used included standard deviations, which were computed to evaluate the variability of the data in relation to the mean, providing insights into the distribution and consistency of responses. Additionally, the distribution in terms of frequencies and percentages was applied to illustrate the demographic variables and to assess the occurrence of particular managerial competencies within the sample population.

This methodological framework emphasizes the importance of quantitative analysis in understanding the characteristics and competencies of mid-level nurse managers.

To move beyond simple descriptive analysis and to establish potential relationships, the researcher conducted a One-way Analysis of Variance (ANOVA). This statistical method was specifically employed to assess whether demographic characteristics, for example, years of experience and the type of leadership training received (basic professional nursing versus formal leadership courses), had a statistically significant influence on the preparedness levels of nurse managers in their leadership roles (Bevans, 2020).

3.11.1.2 Quantitative Data Presentation and Interpretation

Data was systematically organized into structured Excel spreadsheets and subsequently presented through tables and charts to facilitate visualization of the relationship between descriptive statistics and the research variables. The researcher ensured that each descriptive statistic was aligned with the corresponding level of measurement, namely, nominal, ordinal, or interval, thereby maintaining the scientificintegrity and validity of the conclusions drawn.

3.11.2 Qualitative Data Preparation and Processing

In this study, qualitative data preparation and analysis were conducted concomitantly, reflecting a cyclical process where early data collection informed subsequent analysis (Peel Region Evaluates Platform, 2018). Data were gathered through Key Informant Interviews (KIIs) and Focus Group Discussions (FGDs).

3.11.2.1 Qualitative Data Preparation and Immersion

The process began with data immersion, involving the following steps: First was the transcription, whereby audio recordings were reviewed multiple times and transcribed into textual format by a transcription expert to ensure accuracy. This was followed by the familiarization step, whereby the researcher repeatedly read the transcripts to gain a holistic understanding of the participants' experiences and to identify recurring ideas and basic observations (Bhatia, 2018). Next was the data reduction, whereby raw data were skimmed and refined to extract essential information, transforming complex narratives into accessible segments aligned with the research objectives.

3.11.2.2 Qualitative Data Organization and Categorization

Following immersion, data were organized according to the specific study objectives. A specialized data extraction form was developed to visualize responses individually and identify emerging topics. The organization was guided by four thematic pillars, including the overall level of leadership role-preparedness, the extent to which basic nursing training prepared nurses for leadership preparation, the existing role-induction modalities, and their contribution to leadership preparedness, as well as determining leadership and management training needs among the mid-level nurse managers in the selected study sites.

3.11.2.3 Qualitative Software and Coding Framework

The study utilized NVivo software to manage and organize data during the coding and theme development phases. NVivo was selected for its efficiency in handling unstructured data and its compatibility with the study’s mixed-methods design (Kent State University, 2020). The researcher employed a thematic content analysis approach, integrating three

distinct methods to ensure depth. Content analysis was done through classification and tabulation of recurring words, phrases, and behavioral data to identify patterns. During this step of the study process, the researcher was looking for words, statements, language, or phrases that the respondents had used, as well as noting those that had been used recurrently. The researcher also looked for ideas and concepts while coding and categorizing them into patterns and themes, and also interpreting their meanings. Secondly, the researcher utilized narrative analysis by reformulating respondents' stories and experiences to preserve the "voice" of the mid-level nurse managers. Thirdly, thematic analysis was performed through assembling of coded data into overarching themes that directly address the research questions regarding views, opinions, and beliefs on preparedness. For this study, qualitative data comprising of views, opinions, and beliefs regarding leadership role preparedness for MLNM, which were generated from open-ended questions, Key Informant Interviews, and FGDs, were summarized in written words to generate themes. The researcher also used the information from the general statements, themes, and patterns, which were categorized into coherent categories for narration.

3.11.2.4 Qualitative Data Interpretation and Synthesis

The final stage involved an iterative review of organized data to assign meaning and significance. This culminated in the synthesis of general statements and patterns into coherent categories for narration. By interpreting the findings through the lens of the research questions, the researcher was able to draw sound conclusions and outline the practical implications of the results for nursing leadership.

3.11.3 Trustworthiness of the Qualitative Data

Trustworthiness refers to the level of rigor and the degree of confidence in the data, interpretation, and methodological processes employed to ensure study quality (Connelly, 2016; Stahl & King, 2020). Following the framework of Lemon and Hayes (2020), this study utilized specific strategies to ensure that the findings are credible, transferable, confirmable, and dependable.

3.11.3.1 Credibility

To ensure that the findings are credible, the researcher employed triangulation. This strategy allowed for the convergence of material from multiple sources, including Key Informant Interviews, Focus Group Discussions, and document reviews, to validate the topic of study. Triangulation not only identifies inconsistencies within emerging themes and patterns but also facilitates a more profound understanding of the phenomenon while significantly reducing systematic bias.

3.11.3.2 Transferability

The researcher addressed transferability by giving much attention to contextual details in observing and interpreting during the process of data collection and processing in order to illustrate that the research findings are transferable to other contexts. To justify that the study findings are transferable and to minimize researcher bias, the researcher ensured that the data collection and analysis process was done transparently and made certain that the study findings were centered on respondents' narratives.

3.11.3.3 Confirmability

To minimize researcher bias and ensure that the findings are strictly centered on the respondents' narratives rather than the researcher's preconceptions, a transparent audit trail was maintained. The data collection and analysis processes were documented step-by-step, ensuring that the interpretations can be traced directly back to the original qualitative transcripts, thereby maintaining objectivity.

3.11.3.4 Dependability

Regarding the reliability of the research findings over time, the researcher ensured dependability by identifying and reporting coherent themes consistently across various data transcripts. The use of NVivo for systematic coding and the assistance of a statistician for verification helped maintain a stable and repeatable analytical process (Statistics Solutions, 2016). Regarding the dependability of the research findings, the researcher made sure that coherent themes were identified and reported across the different data transcripts (Statistics Solutions, 2016)

3.12. Ethical Considerations

The research proposal was presented to the supervisors and to the Department of Medical Education (Moi University), and following the clearance, the researcher ensured the following:

3.12.1. Clearance by the Ethics Committee

After the clearance of the research proposal from the department, it was presented to the Moi Institutional Research and Ethics Committee (IREC) in Moi University and Moi Teaching and Referral Hospital for approval. The researcher was granted formal approval Number FAN:0003903 before the commencement of the study (Appendix VIII). This is a

requirement before conducting research studies, and it is a crucial consideration in social research studies.

3.11.2 Clearance by NACOSTI

Following ethical approval by IREC, the researcher sought permission from NACOSTI, and this was granted with License Number: NACOSTI/P/21/12899 (Appendix IX). This is also a requirement before data collection commences.

3.12.3 Permission to carry out the Study

After being issued the license from NACOSTI, the researcher sought permission from the County Chief Officers of Health and Education in the five counties, namely Kericho, Nyamira, Kisii, Bomet, and Narok. The researcher also sought permission from the institutional review boards for those that had accredited Research and Ethics committees, and also permission from key individuals who are "gatekeepers" within the organization of the selected hospitals. The study sites involved in this study were: Longisa County Referral, Kaplong Mission Hospital, Litein Mission Hospital, Kapkatet Hospital, Narok County Referral, Kericho County Referral, Kericho Nursing Home, Nyamira County Referral, and Narok County Referral Hospitals.

3.12.4 Respect for Autonomy

The participants who met the eligibility criteria were provided with detailed information regarding the purpose of the study. After deciding to participate, they were given a consent form containing the details of the study's nature to sign before providing information. They were also made aware that participating in the study was voluntary and that they were free to withdraw at will (Appendices 2, 3, 4).

3.12.5 Anonymity

The participants in the study were assured that the data collected would be anonymized as early as possible by removing all identifiers that could link them to participating institutions or individuals. The anonymized data subsequently could not be linked with persons or institutions, not even for the researcher involved in data analysis. The obtained data were kept in locked cabinets with restricted access to the researcher only.

3.12.6 Confidentiality

The confidentiality of the participants was assured by ensuring that only the investigators could identify the responses from individual participants. Information collected from the participants was not shared or discussed with anyone who was not involved in the research study. Computerized data were password-protected.

3.12.7 Principle of Beneficence

Beneficence refers to the researcher's obligation to maximize benefits and minimize potential harms (Varkey, 2021). For this study, risk mitigation was exemplified by the researcher ensuring that the study did not pose physical or psychological risk to the nurse managers. One way of ensuring this was to ensure that the interviews and questionnaires were scheduled at the convenience of the participants to avoid interfering with their clinical duties or causing professional stress. On the other hand, this study provided a potential opportunity for social benefit. This is because the primary benefit of this study is the potential for the findings to inform better capacity-building programs, ultimately improving the working environment and leadership preparedness for the nursing staff.

3.12.8 The Principle of Justice

Justice involves the fair and equitable distribution of the benefits and burdens of research. For this study, this was demonstrated by the fair selection of the participants. During the process, the participants were selected based on objective criteria rather than personal bias or convenience. Also, upheld during the study processes was the inclusion. No group was unfairly excluded or overburdened by the research process. All managers within the inclusion criteria were given an equal opportunity to voice their experiences regarding leadership preparedness, ensuring that the final findings represented a broad spectrum of the nursing leadership.

3.13 Dissemination of the Findings

Dissemination in research refers to the intentional process that comprises consideration of target audiences, the settings where research findings would be shared and received, as well as communicating and networking with wider policy or service audiences in a manner that will advance research uptake in decision-making processes and practice (DeCarlo, n.d; National Institute for Health Research, 2019). The findings of this study will be published in refereed journals in order to make it accessible to the public and academic audiences. It will also be presented in seminars and conferences attended by target audiences. Copies of the research findings will also be available for County Health Management Teams of the five Counties and Hospital Management Committees of each of the nine selected hospitals. A copy of the thesis will be made available in Moi University library and repository.

CHAPTER FOUR

RESULTS

4.0. Introduction

This chapter presents the research findings based on the collected, analyzed, and interpreted data from the nine selected hospitals in Bomet, Kericho, Narok, Kisii, and Nyamira Counties of the South Rift and Nyanza regions in Kenya. Additionally, the findings in this chapter describe the demographic characteristics of the respondents and the challenges they face, aligning with the study's objectives.

The total sample size of Mid-Level Nurse Managers (MLNMs) was 88. From these, 68 MLNMs responded, which gave a response rate of 77.2%. For the qualitative data, from the sample size of 9 Nursing Directors (ND), 7 participated in the KII for the study, therefore giving a response rate of 77.7%. Out of the 9 anticipated FGDs, 8 were conducted successfully, which represents a response rate of 88.8%. Additionally, the researcher reviewed 4 basic nursing training curricula, 2 from public KMTs and 2 from faith-based MTCs.

Both qualitative and quantitative data were collected, and the statistical methods were performed according to the research objectives. The descriptive statistics performed for the quantitative data are percentage, mean, and mode, while the thematic analysis was used for the qualitative data.

4.1 Demographic Characteristics

The respondents' demographic characteristics captured were age, gender, professional qualifications, college of graduation, level of responsibility, place of work, duration at the workplace, and duration in the leadership position. The descriptive statistics were as follows:

Regarding the age distribution, three participants declined to state their chronological age; therefore, age-related analysis was conducted on the valid responses of $N = 65$ mid-level nurse managers. The participants' ages ranged from 25 to 57 years, with a mean of 36.7 years (SD = 7.45). The largest age cluster was the 33–40 years group, representing 33.8% of the valid sample, which indicates a mid-career demographic. This was within the acceptable inclusion criteria.

On the gender of nurses, 77.9% of the MLNMs were female compared to 22.1% who were male. Looking at the professional qualifications, 48.5% were diploma holders in nursing, followed by 32.4% who had bachelor's degrees in nursing, and the least were 19.1% with a higher diploma in nursing. When asked where they studied, 40.3% studied at public KMTC, 35.8% at faith-based colleges, and 23.9% in other institutions, as presented in **Table 4.1.** This demographic information shows that the nurse managers' population in the selected sites has a higher number of females compared to males, the majority of the nurses are diploma holders, and they studied at a public KMTC.

Table 4.1: Demographic Characteristics

		Frequency	percent
Age group	25 – 32 Years	15	22.1
	33 – 40 Years	23	33.8
	41 – 48 Years	17	25
	49 – 57 Years	10	14.7
	Missing (not indicated)	3	4.4
	Total	68	100
Gender	Male	15	22.1
	Female	53	77.9
	Total	68	100
Professional qualifications	Diploma in Nursing	33	48.5
	Higher Diploma in Nursing	13	19.1
	Bachelor's degree in nursing	22	32.4
	Total	68	100
College of graduation	Public KMTC	27	40.3
	Faith-based college	24	35.8
	Other	16	23.9
	Total	67	100

When it comes to the work experience, all the nurses who participated in the study were managers; 83.3% were middle-level nurse managers, and 16.7% were front-line nurse managers. Similarly, more than two-thirds (73.1%) had been in leadership for 1-5 years, 23.9% for 6-10 years, and only 3% had been in leadership for 11-15 years. Lastly, when looking at the duration at the workplace, 41.2% had worked for 1-5 years, 32.4% for 6-10 years, 17.6% for 11-15 years, while less than 10% (<10%) had worked for between 16 and 31 years. This demographic information on the work experience shows the respondents were managers, which validates the response as the inclusion criteria were managers. The information also shows the managers were at the entry level since most (73.1%) had been in the position of leadership for 1-5 years. However, cumulatively, nearly three quarters (73.6%) of the nurses had work experience of 1-10 years, which shows they had enough experience to provide the correct information in this study.

Further, the mean number of years that one had worked before promotion to leadership was 5 years, with a median of 4 years as presented in **Table 4.2.**

Table 4.2: Demographic information on work experience

		Frequency	Percentage
Level of responsibility	Mid-level Nurse Manager	55	83.3
	Front-line nurse manager	11	16.7
	Total	66	100
Duration at the workplace	1-5yrs	28	41.2
	6-10yrs	22	32.4
	11-15yrs	12	17.6
	16-20yrs	1	1.5
	21-25yrs	3	4.4
	26-30yrs	1	1.5
	31 yrs and above	1	1.5
	Total	68	100
Duration in the leadership	1-5yrs	49	73.1
	6-10yrs	17	23.9
	11-15yrs	2	3
	Total	68	100

The data was collected in the selected hospitals in Bomet, Kericho, Narok, Kisii, and Nyamira Counties. Most respondents worked in Narok County Referral Hospital (16.2%) and Kisii Teaching and Referral Hospital (16.2%). Others were Kericho County Referral Hospital (11.8%), Litein Mission Hospital (11.8%), Kapkatet Hospital (10.3%), and Longisa County Referral Hospital (10.3%).

Hospitals with less than 10% were Kericho Nursing Home (8.8%), Kaplong Mission Hospital (7.4%), and Nyamira County Referral Hospital (7.4%). The specific hospitals varied as indicated in **Table 4.3.**

Table 4.3 displays the distribution, which shows the variance distribution of the hospitals within the area of study.
Table 4.3: Location of the study

	County	Hospital	frequency	Percentage
Place of work	Bomet	Longisa County Referral Hospital	7	10.3
	Bomet	Kaplong Mission Hospital	5	7.4
	Kericho	Kapkatet Hospital	7	10.3
	Kericho	Litein Mission Hospital	8	11.8
	Kericho	Kericho County Referral Hospital	8	11.8
	Narok	Narok County Referral Hospital	11	16.2
	Nyamira	Nyamira County Referral Hospital	5	7.4
	Kisii	Kisii Teaching and Referral Hospital	11	16.2
	Kericho	Kericho Nursing home	6	8.8
		Total	68	100

4.2 Findings based on the Research Objectives

The research had four objectives, which were as follows:

1. Assess the level of leadership preparedness for MLNMs' role among the nurse managers in selected hospitals in Bomet, Kericho, Narok, Kisii, and Nyamira counties, Kenya.
2. Determine the extent to which basic nursing training prepares nurses for MLNMs' leadership roles in selected hospitals in Bomet, Kericho, Narok, Kisii, and Nyamira counties, Kenya**.**

3. Assess the contribution of role-induction programs to MLNMs' leadership role preparedness among the Nurse Managers in selected hospitals in Bomet, Kericho, Narok, Kisii, and Nyamira counties, Kenya.
4. Determine MLNMs' training needs for leadership role preparation in selected hospitals in Bomet, Kericho, Narok, Kisii, and Nyamira counties, Kenya.

4.2.1 Nurse Managers' level of preparedness for MLNMs' leadership role

The respondents were asked to rate their level of agreement on key functions of management using a five-point Likert scale. The functions that were rated highly were based on the percentage of 'agree' and 'strongly agree'. The respondents' response arranged in descending order based on the cumulative percentage of the two were; 'I am adequately prepared to execute the organizing function of management' agree (60.6%) and strongly agree (33.3%) with cumulative percentage of 93.9%, 'I am adequately prepared to execute the planning function of management' agree (47.8%) and strongly agree (44.8%) with the cumulative percentage of 92.6%, 'I am adequately prepared to execute the coordinating function of management' Agree (50.7%) and strongly agree (41.8%) with a cumulative percentage of 92.5%, 'I am adequately prepared to execute the controlling function of management', Agree (58.2%) and Strongly agree (29.9%), with cumulative percentage of 88.1% and undecided (10.4%), and 'I am adequately prepared to execute the staffing function of management' agree (46.2%) and strongly agree (41.5%) with cumulative percentage of 87.7%.

The one function ranked low but with a higher percentage of unknown was 'I am adequately prepared to execute the budgeting function of management' Agree (47.7%) and strongly agree (21.5%) with a cumulative percentage of 69.2%, undecided (20%). As

presented in **Table 4.4,** the managers were well equipped to execute the organizing function of management, the planning function of management, the coordinating function of management, the controlling function of management, and the staffing function of management. However, the least ranked skill was the budgeting function of management.

Table 4.1 Percentage of role-preparedness to execute management functions

	Strongly disagree	Disagree	Undecided	Agree	Strongly Agree
I am adequately prepared to execute the planning function of management	1.5	3	3	47.8	44.8
I am adequately prepared to execute the organizing function of management	1.5	1.5	3	60.6	33.3
I am adequately prepared to execute the controlling function of management		1.5	10.4	58.2	29.9
I am adequately prepared to execute the coordinating function of management			7.5	50.7	41.8
I am adequately prepared to execute the staffing function of management	1.5	3.1	7.7	46.2	41.5
I am adequately prepared to execute the budgeting function of management	3.1	7.7	20	47.7	21.5

Further analysis on the same based on the mean (M), standard deviation (SD) and skewness (Skw) was performed to determine the highest role and responsibilities that managers perceived that they were prepared to execute. The highly ranked based on the highest mean was; 'I am adequately prepared to execute the coordinating function of management' (M=4.34, SD = .617, Skw -.370) followed by 'I am adequately prepared to execute the planning function of management' (M=4.31, SD = .802, Skw -1.726), 'I am adequately prepared to execute the organizing function of management' (M=4.23, SD = .719, Skw -1.652), 'I am adequately prepared to execute the staffing function of management' (M=4.23, SD = .844, Skw -1.432), 'I am adequately prepared to execute the controlling function of management' (M=4.16, SD = .665, Skw -.514) and the least was 'I am

adequately prepared to execute the budgeting function of management' (M=3.37, SD = .981, Skw -.848).

All the roles had a lower SD of <1, which shows a higher level of agreement on the leadership role's preparedness ranking. These results validate the percentage results where the managers were well equipped to execute the organizing function of management, the planning function of management, the coordinating function of management and the staffing function of management.

However, the least ranked skills were the controlling functions of management and the budgeting function of management s shown in **Table 4.5,**.

Table 4.2: Mean and Standard deviation on role-preparedness to execute management functions

	N		Mean	Std. Deviation	Skewness	Std. Error of Skewness
	Valid	Missing				
I am adequately prepared to execute the planning function of management	67	1	4.31	.802	-1.726	.293
I am adequately prepared to execute the organizing function of management	66	2	4.23	.719	-1.652	.295
I am adequately prepared to execute the controlling function of management	67	1	4.16	.665	-.514	.293
I am adequately prepared to execute the coordinating function of management	67	1	4.34	.617	-.370	.293
I am adequately prepared to execute the staffing function of management	65	3	4.23	.844	-1.432	.297
I am adequately prepared to execute the budgeting function of management	65	3	3.77	.981	-.848	.297

Overall, when asked to rate their preparedness on the current leadership role, slightly more than half (56.9%) indicated their preparedness was above average, and 24.6% indicated it was excellent.

However, 15.4% indicated as average and 3.1% as below average, as indicated in **Figure 5.**

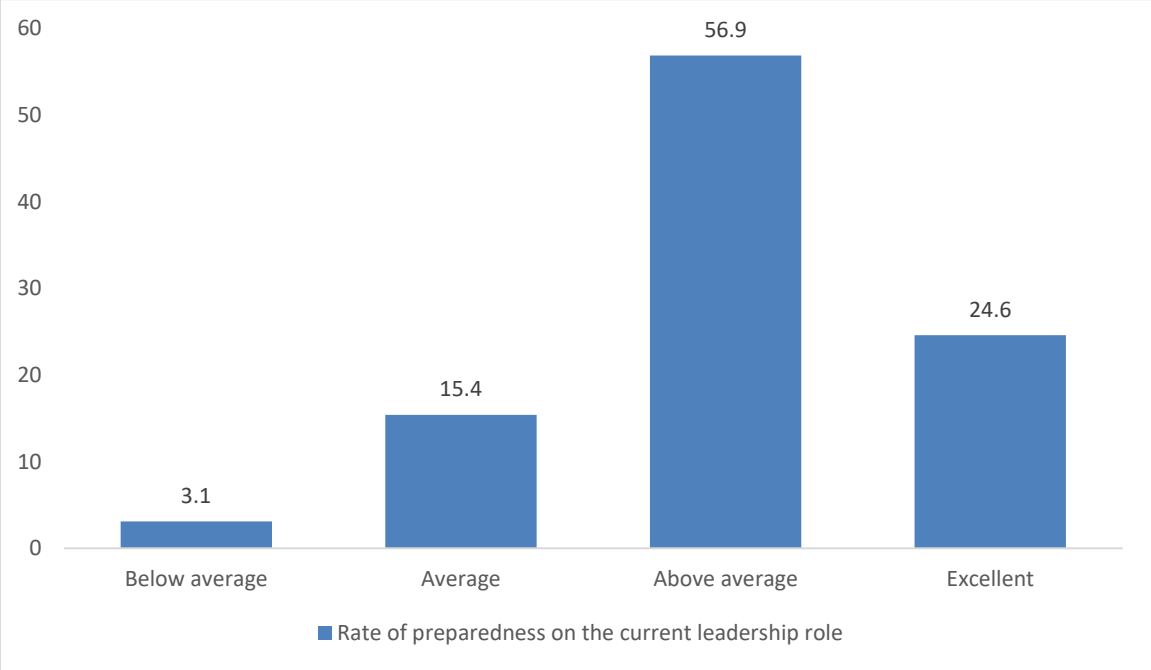

Figure 6: Rate of preparedness on the current leadership role

From the qualitative data from key informants, the respondents argued that MLNMs experienced challenges and exhibited deficiencies in the knowledge and skills required for the budgeting process for their units, and this necessitated constant guidance and support from the finance team. In addition, from the findings from FGDs, respondents emphasized that nurse managers were least prepared to execute the budgeting function of management. Below is an extract from FGD.

> ***Nurse manager 6:*** *Also, I like the issue of budgeting in terms of ah, when you are a staff nurse, you're not seriously exposed to different types of budget, we normally have a personnel budget, operational budget and also we have a capital budget. So we find the capital budget it's a problem because to most of us we were not being exposed to that issue of budgeting because when it comes to a serious situation like*

> *this, there is that capital budget whereby the institution has placed so much in terms of capital infrastructure and then the care of those equipment is compromised….. at some point you find that the people who were seriously responsible on the same may not even have obligations. So you find that budget is also a key thing when it comes to our 'nini' (whatever), but you find those ones are just being crushed when you are in school, as in, it doesn't teach as much.Yes….(FGD 4)*

On the qualitative data, the respondents were asked to describe how the appointment into leadership takes place. All the nurse managers responded that they had no prior preparation for leadership role and at the same time there was no preparation soon after the appointment to leadership position. They further alluded that the appointment criteria influence leadership role preparedness. The three forms of appointments that emerged were; direct appointment without a prior area of responsibility, appointment following a reputable clinical performance (merit), and lastly, the appointment on progressive promotion from one level to another. Each of these is analyzed thematically and presented as follows:

The direct appointment

The direct appointment without prior area of responsibilities came out during the FGDs with the managers. This is based on the manager's as well as the supervisors interest and are characterized by a lack of advertisement, no formal applications, no interviews or acceptance letter but there is an allocation of appointment letter to the specific person given a specific managerial position. The direct appointment is also characterized by verbal consent without written agreements. Below three extracts from different FGDS.

> ***Nurse Manager 1:*** *After they have sat down and asked themselves who is preferable, because they ask themselves. They write down at least three names and then they now look at the character, relationship with others, your flexibility, if you*

are hardworking, all those and then they now agree. After they agree, they call you if you are comfortable with that position. So if you are comfortable with the position you agree though there is no written application….there is no letter of acceptance. You just agree orally and then they just give you a letter to start on first or immediately. You then from there you take off (FGD 1).

Nurse Manager 2: *As earlier said, we don't have specific procedure but we have trained an officer who have been identified to be given that mandate. He would just call you to the office, so he has plans on the one who take you from this point, then lead to this ward. All then we have seen you have potential leadership skills…you are appointed where there is a vacant position (FGD 2).*

Manager 5: *…Who do you know and how do you know them, sometimes that one is also used. So if you know someone at the top and maybe you have an interest in becoming an in charge or something so they can be used to appoint you especially this county government that is too rampant. It is just everywhere if you want something you have to know someone somewhere, so for those that don't want to be leaders are forced to. As I said if you look like you can be a leader so you are forced to be a leader. Those that may want to be leaders and maybe hawaonekani (not identified) or something so they use someone, for them to be a leader (FGD 6)*

Appointment by merit

The appointment by Merit or reputable clinical performance came out strongly and was characterized by past performance of the nurse during his or her practice. The past performance was based on responsibilities, experience, attitude, knowledge, and clinical skills. Similar to the direct appointment, the merit was also characterized by lack of advertisement, no formal applications, no interviews or acceptance letter but there is an allocation of appointment letter. In the appointment process, the human resource department was not mentioned but the process was managed by the department head. The below narrative shows this:

Nurse Manager 5: *The appointment from a certain department depending on how responsible you are and you can be given when you are just undertaking some minor activities and then when also a chance occurs. When there is a vacancy (FGD 4).*

> ***Nurse 2****: Yeah as Mwangi (pseudo name) has said it, they usually see the experience, how long you have stayed in hospital 'M' and as we mentioned earlier, willingness to work, it is now the management to decide. The managers are the ones who appoint (FGD 3).*

The nurses' knowledge and clinical skills were critical in the appointment, especially in supervisory roles in the hospital. This is seen as a risk mitigation strategy in the hospital by the managers. The two narratives below show this.

> ***Nurse 3****: Yes, when you are appointed, the way Mr. Yeye (name blinded) has explained, we normally observe the attitudes, the knowledge and the clinical skills the individual has pertaining the leadership position that is going to be appointed….(FGD 4)*
>
> ***Manager 3****: knowledge pertaining the department that is going to lead is important. Maybe an example is whereby, if I'm appointed to be a theatre nurse in charge I should have some prerequisite knowledge on some of the issues that are happening there (FGD 1)*

Progressive Promotion

The last form of appointment was progressive promotion. This promotion was step by step process where one grows through the ranks of employment. The appointment on progressive promotion from one level to another for example being the assistant nurse in-charge of a unit, to nurse in charge, nurse coverage, then to overall nurse manager or nursing officer in-charge of the hospital. The key determining factor is education level as the qualifications and previous position held. Other qualifications such as the skills, clinical experience and disciplinary matters are considered based on the human resource department. The main difference of the progressive promotion and merit is the education qualification, and the human resource involvement. The following extract shows the narrative on the progressive promotion:

> ***Nurse Manager 2:*** *The process is; they base on education; level of education: Being identified if you are active in day to day activities. You don't have any record of any disciplinary action. Even to some other cases when you know other leaders ahead of you somebody can pay so that you can be appointed (FGD 2)*

> ***Nurse Manager 4:*** *The officer who has been a deputy is appointed to serve as in charge if there is another department that is opened, so we have this deputy to take leadership roles in the new department. But they are given appointment letter (FGD 4)*
>
> ***Nurse Managers 3:*** *Once someone has the qualification, maybe has done course like senior management course… they stand a chance to be appointed (FGD 3)*

The narrative on the involvement of the human resource, and formal appointment letters based on the terms of engagement was clear on the progressive promotion. The following narrative shows this.

> ***Manager 2****: Yes so, once we have identified there is also types of documentation, the letter has to be written to show him that he has been identified and he has been appointed, also it has to be discussed with the HR (Human Resources) and also the management so that If there is any recommendation, the HR people are aware of someone has been appointed and, after receiving the letter (FGD 3)*
>
> ***Nurse Manager 2:*** *Usually what is usually done is assessing the skills of the staff and the level of service because the more the staff work in the department, they have more knowledge and skills. So, skills and education, and also clinical experience (FGD 4)*

From the three forms of appointments described above, the demographic information of the respondents determined the forms of appointment. Such information as age, education level, professional qualifications, duration that one has worked in an institution and duration in leadership position informed the responsibilities, experience, attitude, knowledge, and skills of a nurse which were the determining factors in the appointment to leadership.

To further understand the perspective of Mid-Level nurse managers regarding leadership role preparedness, the researcher checked if the demographic information of the respondents had a significant role on preparedness of nurses in the current leadership role. The demographic information was; age, gender, professional qualification, duration of working and duration in a leadership position.

As indicated in **Table 4.6,** one-way analysis of variance (ANOVA) was performed and the result showed all the demographic information had no significant influence on the rate of preparedness of the nurses on the current leadership role; Age (F(3,64) = .893, p = .450), Gender (F(3,64) = 1.773, p = .162), Qualifications (F(3,64) = .338, p = .798), Duration worked (F(3,64) = . 098, p = .961) and Duration in leadership role (F(3,63) = .376, p = .770). This shows the demographic characteristics of the nurses does not prepare them for any leadership position hence, they all require adequate preparation for the leadership role.

Table 4.3: ANOVA on the rate of preparedness on the current leadership role and demographic Characteristics of the nurses

		Sum of Squares	df	Mean Square	F	Sig.
Age of respondents	Between Groups	148.520	3	49.507	.893	.450
	Within Groups	3382.619	61	55.453		
	Total	3531.138	64			
Gender of respondents	Between Groups	.925	3	.308	1.773	.162
	Within Groups	10.613	61	.174		
	Total	11.538	64			
Highest professional qualification of the respondents	Between Groups	.847	3	.282	.338	.798
	Within Groups	50.907	61	.835		
	Total	51.754	64			
the duration the respondent has worked in the current institution	Between Groups	.490	3	.163	.098	.961
	Within Groups	101.510	61	1.664		
	Total	102.000	64			
The duration the respondent has been working in the current leadership role	Between Groups	.320	3	.107	.376	.770
	Within Groups	17.039	60	.284		
	Total	17.359	63			

The research objective was to determine the perception of Mid-Level nurse managers regarding leadership role preparedness. In summary, overall the MLNM indicated that they did not have any preparation prior to nor soon after the appointment to leadership position. However, they rated their preparedness on the current leadership position as; more than half (56.9%) indicated above average, 24.6% indicated it was excellent, 15.4% indicated as average and 3.1% as below average. The specific functions the nurses were prepared to

execute in leadership were; ‘coordinating function of management’ (M=4.34, SD = .617, Skw -.370), ‘planning function of management’ (M=4.31, SD = .802, Skw -1.726), ‘organizing function of management’ (M=4.23, SD = .719, Skw -1.652), ‘staffing function of management’ (M=4.23, SD = .844, Skw -1.432), ‘controlling function of management’ (M=4.16, SD = .665, Skw -.514) and the least was ‘budgeting function of management’ (M=3.37, SD = .981, Skw -.848). Three themes emerged from the qualitative data on the forms of appointments; direct appointment without a prior area of responsibility, appointment following a reputable performance (merit), and lastly, the appointment on progressive promotion from one level to another. Despite the variance forms of appointment, an ANOVA test showed all the demographic information had no significant influence on the rate of preparedness of the nurses on the current leadership role.

The findings on objective one conclude:

a. Nurse managers did not receive any form of preparation for leadership role prior to nor soon after the appointment to the current leadership positions.

b. More than half (56.9%) indicated their level of preparedness for the current leadership as above average, while a quarter (24.6%) of the nurses perceived their rate of preparedness on the current leadership position as excellent.

c. On the specific leadership functions, the nurses were well prepared to execute the coordination, planning, organizing, staffing, and controlling functions of management, but were least prepared to execute the budgeting function of management

d. The nurses were appointed into leadership directly without prior experience, by merit, or by progressive promotion

e. However, the demographic characteristics of the nurses do not prepare them for any leadership position; hence, they all require adequate preparation for the leadership role.

4.2.2 The extent to which basic nursing training prepares Nurse Managers for MLNMs' leadership roles

The respondents were asked to rate the extent of the adequacy of basic nursing training in preparing nurses for leadership roles using a point Likert scale. The high percentage was on the 'agree', 'strongly agree', and 'undecided'. The respondents' response arranged in descending order based on the high rating of the cumulative of 'agree' and 'strongly agree' were; 'For a nurse manager to function effectively in the leadership role, there is need for additional leadership training on top of the basic nursing training' agree (11.9%), strongly agree (79.1%) with cumulative of (91.0%). Followed by 'The course content for the bachelor's degree level nurse adequately prepare nurses for leadership role' agree (38.5%), strongly agree (46.2%) with cumulative of (84.7%), 'The course content for the Higher Diploma Registered level nurse adequately prepare nurses for leadership role' agree (47.7%), strongly agree (33.8%) with cumulative of (81.5%), 'The course content for the Diploma Registered level nurse adequately prepare nurses for leadership role' agree (41.5%), strongly agree (33.8%) with cumulative of (75.3%) and lastly, 'Overall, basic nursing training adequately prepare nurses for leadership roles' agree (31.7%), strongly agree (42.9%) with cumulative of (74.6%).

The items with the highest level of undecided were 'diploma registered' at 18.5%. The 'higher diploma' and 'bachelor's degree level' had the same level of undecided each at 10.8%. Overall, a quarter (25.4%) of the nurses rated the basic nursing training as inadequate in preparing nurses for leadership roles, with 'disagree at 12.7% and 'undecided

at 12.7% as presented in **Table 4.7**. This shows the need for nurses to receive further education on leadership, despite the formal professional certification.

Table 4.4: Percentage of extent of basic nursing training in preparing nurses for leadership roles

	Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree
The course content for the Diploma Registered level nurse adequately prepares nurses for leadership role		6.2	18.5	41.5	33.8
The course content for the Higher Diploma Registered level nurse adequately prepare nurses for leadership role	1.5	6.2	10.8	47.7	33.8
The course content for the bachelor's degree level nurse adequately prepares nurses for leadership role		4.6	10.8	38.5	46.2
Overall, basic nursing training adequately prepare nurses for leadership roles		12.7	12.7	31.7	42.9
For a nurse manager to function effectively in the leadership role, there is need for additional leadership course in addition to the basic nursing training	1.5	3	4.5	11.9	79.1

Further analysis on the adequacy of basic nursing training in preparing nurses for leadership roles same based on the mean (M), standard deviation (SD), and skewness (Skw), was performed to determine the adequacy of the managers' preparation based on their professional training. The highly ranked based on the highest mean was; 'The course content for the bachelor's degree level nurse adequately prepare nurses for leadership role' (M=4.26, SD = .834, Skw -1.030), 'The course content for the Higher Diploma Registered level nurse adequately prepare nurses for leadership role' (M=4.06, SD = .916, Skw -1.130), and 'The course content for the Diploma Registered level nurse adequately prepare nurses for leadership role' (M=4.03, SD = .883, Skw -.622). From these findings, it is clear

the bachelor's level nurse training prepared the nurses for leadership roles, followed by the higher diploma, and the least qualified was the basic diploma.

The findings also showed that 'For a nurse manager to function effectively in the leadership role, there is a need for an additional leadership course in addition to the basic nursing training' (M=4.64, SD=.829, Skw -2.686). Also, 'Overall, basic nursing training adequately prepares nurses for leadership roles' (M=4.05, SD = 1.038, Skw -.812). However, this had a higher SD of >1, which shows the respondents did not agree or they had varied views on whether 'basic nursing training adequately prepares nurses for leadership roles'.

This shows the need for nurses to undergo additional leadership courses in addition to their basic nursing training. These findings are presented in **Table 4.8.**

Table 4.5 Mean and standard deviation on the extent of basic nursing training in preparing nurses for leadership roles

	N		Mean	Std. Deviation	Skewness	Std. Error of Skewness
	Valid	Missing				
The course content for the Diploma Registered level nurse adequately prepare nurses for leadership role	65	3	4.03	.883	-.622	.297
The course content for the Higher Diploma Registered level nurse adequately prepare nurses for leadership role	65	3	4.06	.916	-1.130	.297
The course content for the bachelor's degree level nurse adequately prepare nurses for leadership role	65	3	4.26	.834	-1.030	.297
Overall, basic nursing training adequately prepare nurses for leadership roles	63	5	4.05	1.038	-.812	.302
For a nurse manager to function effectively in the leadership role, there is need for additional leadership course in addition to the basic nursing training	67	1	4.64	.829	-2.686	.293

Overall, when asked to rate the extent to which the basic nursing professional education prepared the respondent for his/her leadership role, 41% indicated they were adequately prepared, 57% as averagely prepared, and 2% as never prepared, as indicated in **Figure 6.**

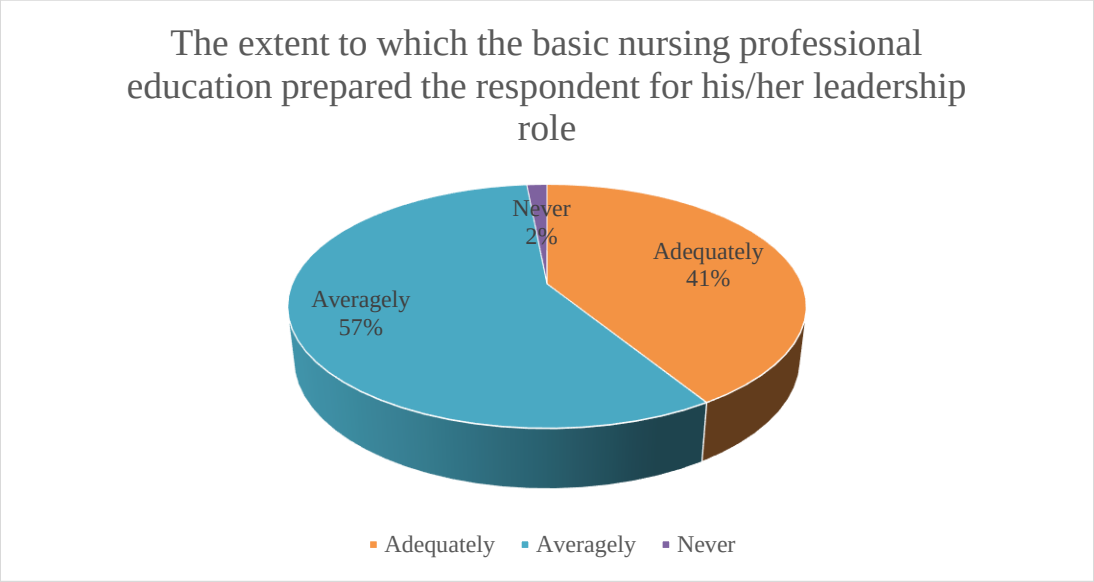

Figure *7*: The rate of adequacy preparation by basic nursing professional training in the leadership role

To further understand the rate of adequacy of preparation by basic nursing education, FGD and interviews were conducted to triangulate the information in **Figure 6.**

From the qualitative data, the respondents were asked to elaborate on how the basic nursing education prepares nurses for leadership roles. From the FGDs and the interviews, the respondents agreed that the training had average and inadequate preparation. The three minor themes that emerged to explain their perspective were: the curriculum content, the focus of the students on assessments, and the degree of students' supervision. The themes were minor, and each is presented as follows:

The curriculum:

Some of the reasons given are that the leadership section covered in training has so much theory content, and yet the time for the clinical rotation period for leadership is too short

to allow adequate interactions. The variance on the level of training based on the KMTC and University curriculum had no significant difference on the time allocated for practical as was both perceived to be inadequate. The university allocates nursing management rotation unit in the fourth year for one month, while the KMTC also allocates management rotation for one month in the final year of nursing training. However, the respondents agreed that the practical aspect had a higher contribution in preparing nurses for management roles, yet the time allocated in the program was not sufficient to allow for enough experience in the practical aspect of nursing leadership and management.

> ***Nurse 1:*** *Yeah the basic nursing prepares you, but not that much, at least you encounter, fourth year you will take nursing management for one month, you do the hospital coverage for one day, yes, and then you are done. It's not adequate…you find it in the field because where you tend to the responsibilities arising (FGD 1 – university graduate)*
>
> ***Nurse 3:*** *... yeah so the basic nurse training eh to the best of my knowledge eh in the preparation for leadership position, I think it contributes to around fifty percent in preparation for leadership position, otherwise the rest ah really lies on experience as time goes by, and also may be furthering your education as well as leadership training on the middle level managers, yes I think 50 percent comes from the others (FGD 5 – KMTC graduate)*

Nurse manager 2:…..okay you can say the prior training and leadership in school prepare us to some extent but not fully because there is challenges will come across,…… let's say rating from zero to ten, ten is the stem I can say five because there is other aspects which come along when you are leading people because we lead people with different

background and that has not prepared us in class, so those are the challenges you would really come across (FGD 4)

Nurse manager 4: Okay, basically we acquire the skills of leadership qualities from school that has enabled us to carry out the roles given on leadership. So I can say, 50% (FGD 4)

Nurse manager 3: *Okay, I think in terms of preparedness for the leadership role, when you see on point of it, what you see on the preparation , we do more practicals and we do theory as well you find very when it comes to leadership you are given a very short span of time. To do the leadership when you are still a student……. Yes, suppose the students were given more time, more space to exercise their leadership when they are still in school, I think that could help promoted much when it comes to the later on being in charge or the managers or the departments or a unit. Yes……..Okay, is like when it comes to management , we used to taste only for a month (FGD 6).*

Yeah I think they can move that unit to third year so that as they continue. So that if they are rotating, there also doing rotation for nurse manager, going all the way to fourth year, so it will be just congested. It is about the curriculum; review of the curriculm on the sequencing.Okay (FGD 2)

Students' focus on examinations and assessments:

Another factor that came out was that during the management training, students focus on passing the examinations done at the end of the theory unit and practical assessment done during the clinical rotation, but they do not internalize the learning for practice in the future. Apart from attaining certification for the nursing training, the opportunities in the basic nursing training for induction into leadership roles in the future are not given attention

by the students. This was attributed to the weight of the curriculum, hence, the students focus on passing the exams rather than the practical aspects such as management.

Nurse 1: *You know the assessment they focus on patients, they want to say the name and history and you have around 50 patients in a ward and cram all of them you realize the management used to shake a lot because they are asking you about patients, they need you to take this report and cram in your head and you know it is not about cramming ask me about 5 patients in which you have prepared me, 'si hiyo utashika vizuri' (will master well)? (FGD 2)*

Nurse 1: other than confusing and shake for that assessment. so unaeza kuwa unafanya vizuri (your may be doing well) at the end of the day you fail, unashake (you are shaking).Ukiwa kwa hiyo(when in that) process you just concentrate on patients. You want to take history before assessment, ukuwe na hizo records zote (when you have all the records) so you don't concentrate on the leadership part of it, you concentrate taking history, cut texts so hata hizo vitu zingine(that those other things) you tend to overlook you just want to finish assessment and that is it. So may be assessment walegeze (adjust) not only clinical, here is about management. Si wame kuasses (they already assessed you) midcycle, so I think its about the management bit and it should be at least….. purely management, and then at least few things about the patient also, yeah (FGD 2)

Nurse Manager 2: *I would also say integrity is intense; like there is a lot of content in the training that this student need to have. So by the time they are finishing they don't even have the content itself. So how about the management bit now? So like everything has been compressed in a sense that they are not able to come out as managers because even the*

other bit they don't already have it. And you can't manage if you don't know even how to supervise these other procedures and other nursing services. Yeah. Even their teachers from respective colleges (FGD 3)

***Nurse manager 3**: I was also saying that the training is not sufficient because our fathers are different, now when you come to the ground or maybe when you're in school your there to pass exams... What you wanted is to pass exams you have never taken it serious that maybe one day you will become a leader and when you come to the ground you are chosen as a leader and you don't know where to start. Yeah as Mercy said we have some orientation when you are chosen as a leader. Most of the time unless it is a very senior position but to this middle leadership most of the time there is no training taking place. no orientation (FGD 7)*

The students' supervision:

During the practical sessions, the supervisors focus on assessing the students based on the patient's assessment and not on the management aspects. This was attributed to the lack of a full-time instructor from KMTC or a university who could make a follow-up to see the student in the clinical. However, some hospitals have very elaborate training that instills management skills due to tight rules and regulations.

***Nurse Manger 1:** The training is adequate because you are assigned some duties every day so that you develop some accountability and responsibility, and also they train you on management and leadership…There is also a written assessment on the same; Daily allocation of nursing modalities (responsibilities) (FGD 1)*

***Nurse Manager 4:** Even there is no follow up. You see, when you do management you need to make duty roosta, you assign duties; this student should understand where did they put*

those duties, this one to head this one, this has a weekend, academic certificate, now who will get weekend roles? Why should they even be given an off? They don't even understand. They don't understand the night shifts, they don't understand. I think preparation of these students from class is inadequate… In other words…, there is no full-time instructor from KMTC who make a follow up to see the *student in the clinical (FGD 5).*

Nurse Manager 6: They don't do a follow up on their students; they feel they are doing their management. They will appear in the morning of their assessment.

Nurse Managers 1*: Even there is no follow up. You see, when you do management you need to make duty rota, you assign duties; this student should understand where did they put those duties, this one to head this one, this has a weekend, academic certificate, now who will get weekend roles? Why should they even be given an off? They don't even understand. They don't understand the night shifts, they don't understand. I think preparation of these students from class is inadequate… In other words ….., there is no full-time instructor from KMTC who make a follow up to see the student in the clinicals like we used to have for other institutions if you can remember very well.*

Nurse Manager 7*: It is left to the nurses, more likely the in-charges in the wards, and you know, as we have said earlier, we have a shortage in the wards. And because of this shortage and there is so much that you are supposed to do, until you don't have time for these students (FGD 7).*

To further determine the adequacy of preparation of nurses by basic nursing professional training in leadership roles, the researcher checked if the demographic information had a significant difference in the adequacy of preparedness of nurses in their leadership role. The demographic information was: age, gender, professional qualification, duration of

working, and duration in a leadership position. One-way ANOVA was performed and the result showed; Age ($F(3,64) = .893$, $p = .450$), Gender ($F(3,64) = 1.773$, $p = .162$), and Qualifications ($F(3,64) = .338$, $p = .798$), had no significant influence on the adequacy of preparedness of the nurses on the current leadership role.

However, the duration worked ($F(2,67) = 6.228$, $p = .003$) and duration in leadership role ($F(2,66) = 6.253$, $p = .003$) had a significant difference on the adequacy of preparedness of the nurses on the current leadership role. However, the turkey post result could not be performed due to lower number of cases in a group hence the results could not identify the exact duration with the significant role on adequacy of preparation. This shows the duration that a nurse has worked in an institution and the duration that a nurse has worked as a leader in an institution has a role on the adequacy of the preparedness of nurses on leadership roles. This should be a factor in appointing nurses to leadership positions. As indicated in **Table 4.9,** the influence of demographic characteristics on leadership preparedness

Table 4.6: ANOVA on the level of preparedness on the current leadership role and demographic characteristics of the nurses

		Sum of Squares	df	Mean Square	F	Sig.
Age of respondents	Between Groups	321.435	2	160.718	2.853	.065
	Within Groups	3661.447	65	56.330		
	Total	3982.882	67			
Gender of respondents	Between Groups	.082	2	.041	.230	.795
	Within Groups	11.609	65	.179		
	Total	11.691	67			
Highest professional qualification of the respondents	Between Groups	.440	2	.220	.271	.763
	Within Groups	52.780	65	.812		
	Total	53.221	67			
The duration the respondent has worked in the current institution	Between Groups	17.973	2	8.987	6.228	.003
	Within Groups	93.791	65	1.443		
	Total	111.765	67			
The duration the respondent has been working in the current leadership role	Between Groups	2.947	2	1.474	6.253	.003
	Within Groups	15.083	64	.236		
	Total	18.030	66			

The researcher also reviewed the curriculum pedagogy used and the content of the curriculum of four institutions to determine the relevance of the content in preparing nurses for the leadership role. The key pedagogy used was lecture, practical demonstration, assignments, self-directed learning and group work. As indicated in **Figure 4.3,** the average percentage of each of the curriculum content showed the lecture has the highest accumulation of the curriculum at 65% and was followed closely by practical demonstration at 52.5%. Other content was distributed as follows; assignments at an

average of 37.5%, group work at 20.0% and self-directed learning at 20.0%. These findings were in line with qualitative findings that showed the training has so much theory content and yet the time for clinical rotation period for leadership is too short to allow adequate interactions.

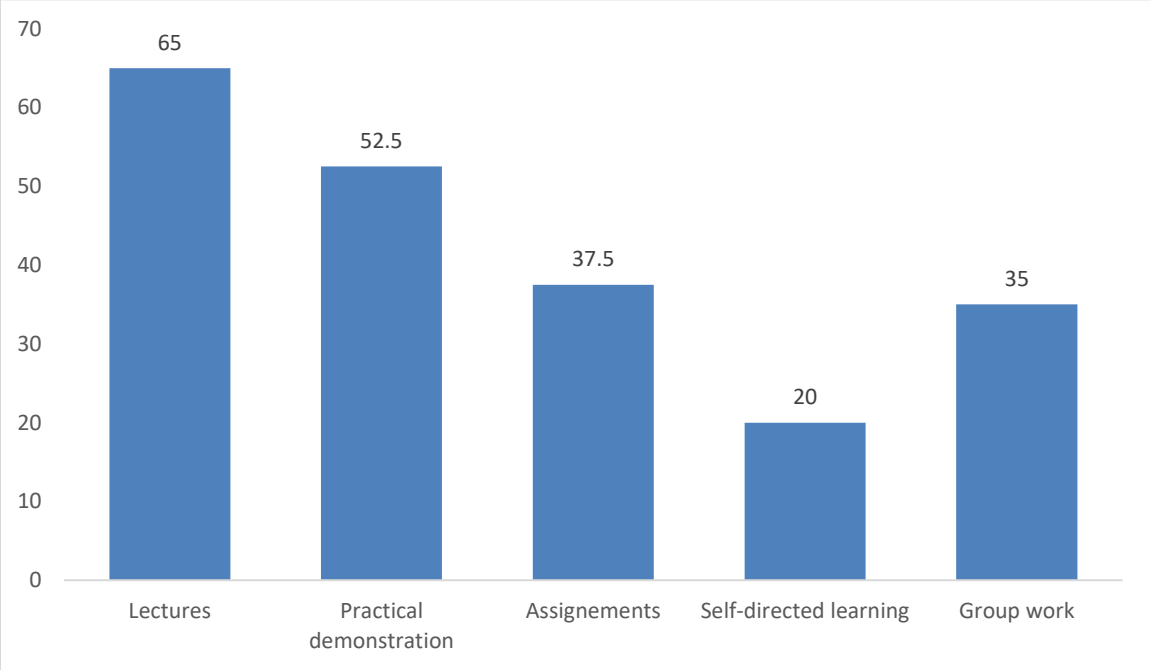

Figure *8*: Pedagogy of the curriculum used in training nursing professionals in leadership roles

On the leadership course content in the curriculum in percentages, the content tested were; knowledge in leadership, skills in leadership, attitude in leadership and values in leadership. The knowledge in leadership had a 24% average score, followed by skills in leadership at 23.75% average, attitude in leadership at 15.25% average and the least was the value in leadership at 12.0%. These findings are also in line with qualitative findings that showed the basic professional nursing education had average and inadequate preparation of nurses for leadership role.

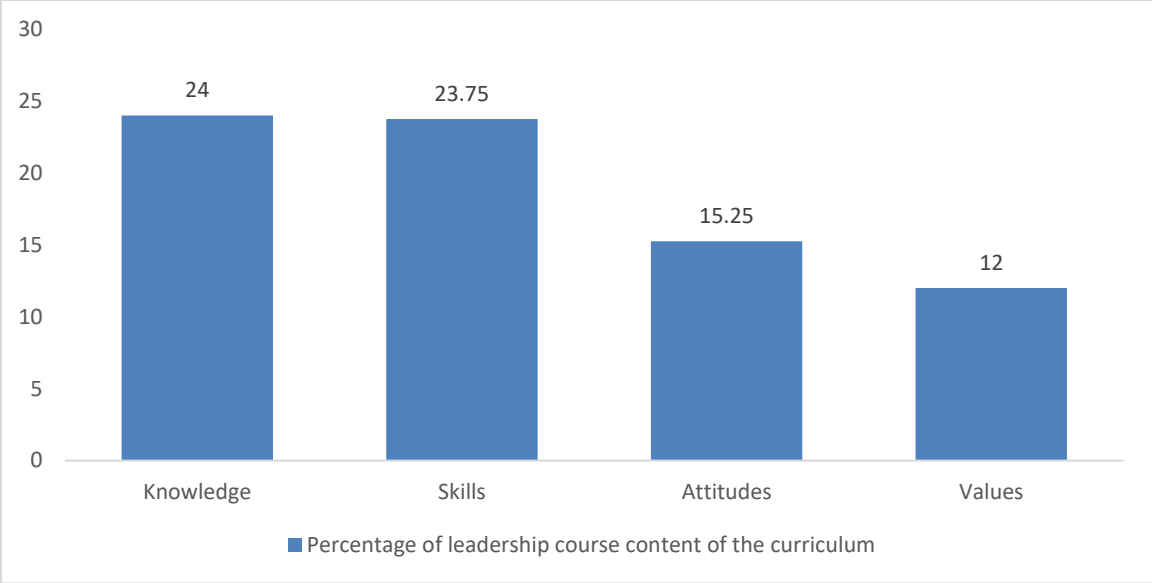

Figure 3: The percentage of leadership course content in the curriculum for nurses' training

The objective two sort to determine adequacy of basic nursing training in preparing nurses for leadership roles. The nursing managers rated the basic nursing training as; 41% indicated they were adequately prepared, 57% as averagely prepared and 2% as never prepared. On the mean functions, the managers agreed the basic nursing training adequately prepare nurses for leadership roles' (M=4.05, SD = 1.038, Skw -.812). On the contrary, the nurses also agreed for effective functioning of the nurse manager in the leadership role, there is need for additional leadership course in addition to the basic nursing training' (M=4.64, SD = .829, Skw -2.686). On the specific training, it is clear the bachelors level nurse training prepared the nurses for leadership role better (M=4.26, SD = .834, Skw -1.030), followed by the higher diploma (M=4.06, SD = .916, Skw -1.130) and the least was the basic diploma (M=4.03, SD = .883, Skw -.622). From the qualitative data, the respondents agreed the training had average and inadequate preparation. The three minor themes that explained these perceptions were; the curriculum content, the focus of

the students and the supervision. AVOVA was performed to determine if the demographic information had significant different on the adequacy of preparedness of nurses in their leadership role; the duration worked ($F(2,67) = 6.228$, $p = .003$) and duration in leadership role ($F(2,66) = 6.253$, $p = .003$) had significant difference on the adequacy of preparedness of the nurses on the current leadership role. On the curriculum used in training, the lecture method was the common at 65%, practical demonstration at 52.5%, assignments at 37.5%, group work at 20.0% and self-directed learning at 20.0%. On the percentage of leadership content, the knowledge in leadership had a 24% average score, skills in leadership at 23.75%, attitude in leadership at 15.25% and the least was the value in leadership at 12.0%. The results conclude:

a. Less than half (41%) of nurses were adequately prepared to management at the basic nursing training. The bachelor's level nurse training prepared the nurses for leadership role better, followed by the higher diploma and the least was the basic diploma.

b. However, for effective functioning of the nurse manager in the leadership role, there is need for formal leadership course in addition to the basic nursing training.

c. The factors explained the variance in the basic nursing training are the curriculum content, the focus of the students and the supervision. The curriculum review showed the common pedagogy used was lecture and practical which were in line with qualitative findings that showed the training has so much theory content and yet the time for clinical rotation period for leadership is too short to allow adequate interactions to enhance development of leadership skills.

d. Similarly, on the leadership content in the curriculum; knowledge, skills, attitude, and value had <25% average score which is in line with qualitative findings that showed

the basic professional nursing education had average and inadequate preparation of nurses for leadership role.

e. On the demographic information, the duration that a nurse has worked in an institution and the duration that a nurse has worked as a leader in an institution has a role on the adequacy of the preparedness of nurses for leadership role. This should be a factor in appointing nurses to leadership positions.

4.2.3 Perceptions about the association between role-induction programs and MLNMs' leadership role preparedness

The respondents were asked to rate the role-induction program available for mid-level managers using the Likert scale. The high percentage was on the 'agree', 'strongly agree', and 'undecided'. Only one aspect was rated as 'disagree' while none was rated as 'strongly disagree'. The respondents' responses arranged in descending order based on the high rating of the cumulative of 'agree' and 'strongly agree' were; 'Additional formal leadership training contributes significantly to leadership role development' agree (13.4%), strongly agree (85.1%) with cumulative of (98.5%), and 'Mentorship contribute significantly to leadership role development' agree (28.4%), strongly agree (70.1%) with cumulative of (98.5%). These were followed by; 'On-job training contributes significantly to leadership role development' agree (34.3%), strongly agree (62.7%) with cumulative of (97.0%), 'Supportive supervision contributes significantly to leadership role development' agree (25.4%), strongly agree (70.1%) with cumulative of (95.5%) and 'Preceptorship contribute significantly to leadership role development' agree (39.4%), strongly agree (48.5%) with cumulative of (87.9%).

As further presented in **Table 4.10,** the role-induction program rated as undecided was 'Preceptorship contributes significantly to leadership role development', with 10.6% undecided and 1.5% disagree. This finding shows the importance of additional leadership training in leadership roles of the nurses.

Table 4.7 Percentage of role-induction programs for mid-level nurse managers

	disagree	Undecided	Agree	Strongly agree
Additional formal leadership training contributes significantly to leadership role development		1.5	13.4	85.1
On-job training contribute significantly to leadership role development		3	34.3	62.7
Mentorship contribute significantly to leadership role development		1.5	28.4	70.1
Preceptorship contribute significantly to leadership role development	1.5	10.6	39.4	48.5
Supportive supervision contributes significantly to leadership role development		4.5	25.4	70.1

Further analysis on the role-induction programs for mid-level nurse managers based on the mean (M), standard deviation (SD), and skewness (Skw) was performed to determine the adequacy of the role-induction program for the mid-level nurse managers. The highly ranked based on the highest mean was; 'Additional formal leadership training contributes significantly to leadership role development' (M=4.84, SD = .412, Skw -2.502), followed by 'Mentorship contribute significantly to leadership role development' (M=4.69, SD = .499, Skw -1.196), 'Supportive supervision contributes significantly to leadership role development' (M=4.66, SD = .565, Skw -1.430), 'On-the-job training contribute significantly to leadership role development' (M=4.60, SD = .552, Skw -.955), and lastly, 'Preceptorship contribute significantly to leadership role development' (M=4.35, SD = .734, Skw -.899).

As outlined in **Table 4.11**, the SD for all the aspects was <1 (less than one), which shows the respondents highly agreed on the rating of the response. From these findings, it is clear that additional formal leadership training, mentorship, supportive supervision, on-the-job training, and preceptorship contribute significantly to leadership role development.

Table 4.8 Mean and Standard deviation of role-induction programs for mid-level nurse managers.

	N		Mean	Std. Deviation	Skewness	Std. Error of Skewness
	Valid	Missing				
Additional formal leadership training contributes significantly to leadership role development	67	1	4.84	.412	-2.502	.293
On-job training contribute significantly to leadership role development	67	1	4.60	.552	-.955	.293
Mentorship contribute significantly to leadership role development	67	1	4.69	.499	-1.196	.293
Preceptorship contribute significantly to leadership role development	66	2	4.35	.734	-.899	.295
Supportive supervision contributes significantly to leadership role development	67	1	4.66	.565	-1.430	.293

Similarly, from the qualitative data, the formal leadership training, on-job training, mentorship, preceptorship, and supportive supervision were mentioned to significantly contribute to the development of leadership roles. From these, the respondents were further asked to outline the factors that enhance leadership role preparedness under the role induction modalities. From the qualitative data, two factors emerged: more time for practical experience and individual initiatives to learn.

More time for practical experience

The opportunity to practice more by the nurses was identified as a key factor to enhance leadership role preparedness. The more one practices, the better they enhance their leadership skills in supervision, record keeping, and accounting, among other roles. The practice was also suggested to be subject specific, such as rotational opportunities for acting in different managerial positions in shifts, which provides opportunities for nurses to enhance their leadership skills.

Nurse Manager 1: *Given a chance to practice (daily). We also have handing over programs which enables one to prepare since they know they have a continuous supervision, keeping records- responsibility of an accounting for equipment (FGD 1)*

Nurse manager 1: *I think we go back to even the basic nursing. We can increase the rotation, and then in the hospital, we you are almost becoming a manager at least you sit in an acting position, and then now, as much you are in are in acting position you are allowed to go to trainings (FGD 2)*

Nurse manager 2. *And then in the hospital, where you are almost becoming a manager, at least you sit in an acting position, and then now as much you are in are in acting position you are allowed to go to trainings (FGD 8).*

Nurse manager 2**:** *But remember, we try to tell the officer you have been in this state of leadership for maybe five years, and this office has seen you have potential to be a leader. At the end of it, the officer accepts the offer. But I argue with a protocol of having to give someone a leadership role you have not acted yet. Yeah (FGD 5)*

Individual initiatives to learn

The individual initiative to learn was also outlined as a factor to enhance leadership role preparedness. Such learning includes at work or outside work trainings, seminars, and further studies. The nurse, as an individual, should have a personal drive to achieve this. The respondents agreed there was a need for the nurses to improve their level of learning since the class prepared them to a certain level of leadership while the rest was based on individual effort, including practice at the hospital. Some of the narrative extracts from the respondents on these are:

> ***Nurse managers 3:*** *Must be a performer, somebody who can think (critical thinking); can handle situations by himself/herself, then may seek for further clarification after he/she has tried, yeah… management accountability, resource management; someone who is recording patients to be their leader; yes. Anyone with disciplinary issues; some people are known… somebody with good communication skills (FGD 3)*

Nurse Manager 2*: I think one of them is on job training; they will be able to have and figure out this staff is having skills- how they handle issues. And that will be rewarding them/appreciating them for what they have done (FGD 3)*

Manager 2: *You find that the class could prepare you around 70% and then the rest you can easily get it from the workplace. From the day you begin working in your environment, now you can easily learn, there are few different things that you need to do that pertain the workplace than what you learn from school. So, there are some few areas where you need to really adjust, not exactly what you learn from school, but you need to adjust to adapt to that environment... like meeting with people, instructions on how you do some meetings. It may not directly come from school, but with the environment that you are living in and where you are working, you can easily learn some of the basics there (FGD 4)*

To further identify the significance of the role-induction programs in leadership role preparation for mid-level nurse managers from the selected hospitals, the researcher checked if the demographic information of the respondents had any significant role. The demographic information was age, gender, professional qualification, duration of working, and duration in a leadership position. As indicated in **table 4.12**, one-way ANOVA was performed and the result showed all the demographic information had no significant influence on the role-induction programs for mid-level nurse managers from the selected hospitals; Age ($F(6,66) = .727$, $p = .630$), Gender ($F(6,66) = .775$, $p = .593$), Qualifications ($F(6,66) = .519$, $p = .791$), Duration worked ($F(6,66) = .515$, $p = .795$) and Duration in leadership role ($F(3,65) = 1.227$, $p = .306$). This shows the demographic characteristics of the nurses does not prepare them for any role-induction programs for mid-level nurse managers.

Table 4.9: ANOVA on the rate of role-induction programs for mid-level nurse managers and demographic

		Sum of Squares	df	Mean Square	F	Sig.
Age of respondents	Between Groups	269.739	6	44.957	.727	.630
	Within Groups	3711.365	60	61.856		
	Total	3981.104	66			
Gender of respondents	Between Groups	.838	6	.140	.775	.593
	Within Groups	10.804	60	.180		
	Total	11.642	66			
Highest professional qualification of the respondents	Between Groups	2.592	6	.432	.519	.791
	Within Groups	49.915	60	.832		
	Total	52.507	66			
the duration the respondent has worked in the current institution	Between Groups	5.475	6	.913	.515	.795
	Within Groups	106.286	60	1.771		
	Total	111.761	66			
The duration the respondent has been working in the current leadership role	Between Groups	1.990	6	.332	1.227	.306
	Within Groups	15.949	59	.270		
	Total	17.939	65			

The third objective was to ascertain the role-induction programs for mid-level nurse managers from the selected hospitals. The key factors identified were; Additional formal leadership training contributes significantly to leadership role development' (M=4.84, SD = .412, Skw -2.502), followed by 'Mentorship contribute significantly to leadership role development' (M=4.69, SD = .499, Skw -1.196), 'Supportive supervision contributes significantly to leadership role development' (M=4.66, SD = .565, Skw -1.430), 'On-job training contribute significantly to leadership role development' (M=4.60, SD = .552, Skw -.955), and lastly, 'Preceptorship contribute significantly to leadership role development' (M=4.35, SD = .734, Skw -.899). Similarly, the qualitative data identified that formal leadership training, on-the-job training, mentorship, preceptorship, and supportive supervision to significantly contribute to the leadership roles. On the factors that enhance leadership role preparedness under the role induction modalities, two factors emerged: more time for practical and individual initiatives to learn. A one-way ANOVA was performed, and the result showed all the demographic information had no significant influence on the role-induction programs for mid-level nurse managers from the selected hospitals: age, gender, professional qualification, duration of working, and duration in a leadership position.

The study concludes;

a. Additional formal leadership training, Mentorship, Supportive supervision, On-job training, and preceptorship contribute significantly to leadership role development
b. Similarly, the qualitative data identified the formal leadership training, on-job training, mentorship, preceptorship, and supportive supervision to significantly contribute to the leadership roles

c. On the factors that enhance leadership role preparedness under the role induction modalities, two factors emerged; more time for practical and individual initiatives to learn.

d. All the demographic information had no significant influence on the role-induction programs for mid-level nurse managers from the selected hospitals: age, gender, professional qualification, duration of working, and duration in a leadership position

4.2.4 MLNMs' perceived training needs for leadership role preparation

The last objective was to establish the middle-level managers' perceived training needs. In order to identify these areas, the researcher picked the responses from the way objectives were answered, the functions or responsibilities of the nurses as discussed on the FGD and interviews, and the areas of challenges experienced by the MLNM in their day-to-day work.

Special leadership training from the objectives

From the first objective on the perspective of MLNM regarding leadership role preparedness;

a. A quarter (24.6%) of the nurses perceived their rate of preparedness for the current leadership position as excellent. To increase this percentage, formal leadership training is needed for the nurses.

b. The specific functions the nurses prepared to execute in leadership were; 'coordinating function of management' (M=4.34, SD = .617, Skw -.370), 'planning function of management' (M=4.31, SD = .802, Skw -1.726), 'organizing function of management' (M=4.23, SD = .719, Skw -1.652), 'staffing function of

management' (M=4.23, SD = .844, Skw -1.432), 'controlling function of management' (M=4.16, SD = .665, Skw -.514) and the least was 'budgeting function of management' (M=3.37, SD = .981, Skw -.848). There is a need to train managers in the least ranked functions, precisely budgeting. Also, a refresher course on the other leadership functions is needed, especially with the changes in technology.

c. From the qualitative study, the forms of appointments used in hospitals were; direct appointment without a prior area of responsibility, appointment following a reputable performance (merit), and lastly, the appointment on progressive promotion from one level to another. The MLNM requires training on the Human Resource policy regarding appointments in various positions.

Training on Roles and responsibilities of a manager

The main responsibilities and functions of the nurses in management positions discussed and outlined in the FGDs and interviews were categorized into five: administrative role, management of personnel, management of resources, service provider to other nurses and lastly, educator. From the findings in objective two, the respondents indicated that Less than half (41%) of nurses were adequately prepared to execute the leadership and management role by the end of the basic nursing training and for effective functioning of the nurse manager in the leadership role, there is need for formal leadership course in addition to the basic nursing training' (M=4.64, SD = .829, Skw -2.686). The proposed training are:

i. Administrative role: planning, organizing, coordination, supervising and evaluation of activities and processes in the department/unit

ii. Managing personnel: planning, scheduling, supervision, appraisal, disciplining, training/capacity building,

3. Managing resources: Planning, budgeting, procurement, responsible for storage, care and use of resources, inventory/maintenance

4. Nurse manager 1: Yes, a span of one month, you can use some of it in terms of leadership, say the leadership style, there is aspect of budget which in terms of budget should be expound in terms of budget because by the end of the day as nurse managers there is element of doing the budget but budget you can see there is a short introduction of budget but does not in terms of accounts, some of it has to be also to be improved on that area…(FGD 8)

iii. Service provider role: handling staff shortage issues, balancing staffing level vs departmental workload, taking up service provision role due to staff shortage therefore time for leadership role is taken up, supervising the work of other multidisciplinary team other than nursing

iv. Educator role: Induction of new staff, assessing staff training needs, organizing for staff training, and overseeing the learning of students during clinical placements in the units that they lead.

4.3 Challenges faced by the MLNMs

The challenges experienced by MLNM on the current leadership role varied. There is need for frequent assessment of the challenges of the MLNM and training the managers on how to overcome the challenges. The major challenge lies in the:

a. Dynamics surrounding the preparation and activities of the MLNM.

Nurse 2: Work burden like you see as a manager in the ward one has to take care of the equipments, you have to take care of your staffs and even patients he burden is a lot….. (FGD 2)

Nurse 1: Sometime you are required by this day you have worked to strategic planning, attend to inventories so you realize you are alone today, tomorrow and at times it can be hard you strain ,some reports are needed ,you are in the ward, you are taking care of the patients, so….(FGD 2)

Nurse Manager 2: So as managers of nursing we are not only managing nurses, we find ourselves cutting across so we keep on crashing with everybody in the hospital (FGD 3)

Nursing Manager 1: Here as a nurse I have to push her and call for help for this particular patient. Then there you are: the seniors want to think… you are labelled with so many names "unajifanya wewe ndio unataka vitu ifanywe." You see these funny labels you get all of them; "hospitali ni yako, sijui what!"(FGD 3)

Nurse Manager 5: Yeah. So there is communication issue and in any case nursing office is labelled as a bully. Why a bully? Because you want things to be done: you are with patients at the moment; I am calling a doctor who is far away from the patient but he is trying to take the story long, to pass me through other corridors, and me I want the service to be given to the patient immediately. So our office (the nursing office) we hold 24hrs. When you call a doctor he has to think twice before he receives. Yeah (FGD 8)

Nurse Manager 8: So it is upon you to look for a language to calm down the relatives before you get the facts of what happened. Yeah (FGD 5)

b. Other challenges include: Motivation, training, support from administration, and compensation in terms of allowances. These challenges, according to the respondents, were perceived as not being commensurate with the demands inherent in their leadership role, considering the dynamics outlined above

c. The management systems around government provision of resources and procurement procedure, *so you may order what you want to implement as a leader, and you may be given after a very long time, so you get demoralized.* This will help with planning and involvement in follow-up for the delivery of required resources on time.

d. Long working hours and lack of life-work balance that comes with fatigue, burnout, anxiety, and stress. This implies that training in personal management and emotional intelligence will help the nurses navigate these complexities.

Nurse 2; also our challenge is time. You see you cannot balance the work and the sometime they keep alot of time to work but they forget that at home….. So you lose in touch with social life…(FGD 4)

Nurse 6; Sometimes you can encounter maybe in your ward shortage of staffs…… so you have to take responsibilities instead of you resting, then you work and then you have to sacrifice your off, because you cannot call someone today, tomorrow and maybe …(FGD 1)

Nurse Manager 5: As nurse managers we end up doing overtime cause we are the first people to report the hospital in the morning hours and we are the last group to leave the hospital cause there is no way you can leave the hospital if the hospital is not stable……. In short we carry all the burdens of the hospital (FGD 3).

Nurse Manager 4: The nurse manager office is opened throughout the day. So most of the blames of the hospital wherever the patient is mismanaged in whichever department; whether it is nursing or not, we are the "kangaroo" court of it; it is where all the OP is registered. They ventilate on us seriously and yet maybe we are not informed of that particular incident….(FGD3)

The training needs of the MLNM can be categorized into two: the structured ones based on their roles and responsibilities and the unstructured ones based on the various challenges that they face. The structured training identified for leadership roles and responsibilities are: those that relate to the dynamics of nurse managers' roles to include administrative role/formal leadership, budgeting, managing resources-staffing/personnel and educator/mentor role functions of management. The unstructured will be informed by an assessment of the respective challenges as experienced by the MLNM, which vary depending on specific hospitals and positions of leadership. To address the lack of preparedness, nurses would benefit from structured preparatory training and seminars while responding to challenges with work-life balance, Nurses may be offered training on personal management and emotional intelligence.

CHAPTER FIVE

DISCUSSION

5.0. Introduction

This chapter presents the discussion of the research findings according to the literature review, with the objectives of the study. The research objectives were to: assess the level of leadership preparedness for MLNMs' role, determine the extent to which basic nursing training prepares nurses for MLNMs' leadership roles, assess the contribution of role-induction programs to MLNMs' leadership role preparedness, and determine MLNMs' training needs for leadership role preparation among the nurse managers in selected hospitals in Bomet, Kericho, Narok, Kisii, and Nyamira counties, Kenya.

5.1. Nurse Managers' level of preparedness for MLNMs' leadership role

The first objective of this study was to determine the perceived level of preparedness among Mid-Level Nurse Managers (MLNMs) for their leadership roles. The findings revealed a contradiction because while a majority of respondents (56.9%) perceived their overall preparedness as "above average," a discrete functional analysis revealed significant competency gaps, particularly in financial management.

Regarding proficiency in operational management functions, the quantitative results indicated that nurse managers felt highly prepared in the operational domains of organizing (93.9%), planning (92.6%), and coordinating (92.5%). These high percentages suggest that MLNMs are confident in the clinical-administrative aspects of their roles, such as aligning multidisciplinary activities and managing service delivery units. This confidence aligns with the assertions of Zendrato, Hariyati, and Afriani (2019), who noted that nurse managers must harmonize various teams to ensure quality care. However, while Zendrato

et al. (2019) highlight the necessity of these skills, the current study provides empirical evidence that Kenyan MLNMs believe they have mastered these specific coordination functions.

Conversely, the function ranked lowest was executing the budgeting function, with only 69.2% reporting preparedness and 20% remaining undecided. This implies a budgeting deficit and a deficiency in overall financial management. Qualitative findings from Focus Group Discussions (FGDs) corroborated this, with managers citing "lack of and inadequate preparation in the finance management aspect." These findings are consistent with Goktepe et al. (2018) and Naranjee et al. (2019), who identified that while nurse managers play a critical role in unit financial health, they consistently lack the requisite skills for financial monitoring and evaluation.

The implications of this deficit in a Kenyan context are profound. Unlike high-resource settings described by Warshawsky et al. (2020), where administrative support may mitigate a manager's lack of financial knowledge, MLNMs in Kenyan referral hospitals often operate without such safety nets. As argued in the literature, this leads to inappropriate resource allocation, such as overspending or understaffing, directly impacting patient outcomes and undermining the manager's professional credibility.

A significant finding in this study was the influence of appointment criteria on preparedness. Qualitative data revealed three themes: direct appointment, merit-based clinical performance, and progressive promotion. None of these pathways provided a standardized induction for leadership preparation. This random approach to leadership

selection is similar to the findings of Alomairi, et al. (2018) and Nyikuri et al. (2015), confirming that clinical excellence is frequently mistaken for managerial competence.

The study findings challenge the assumption by Warshawsky et al. (2020) that managers will eventually acquire knowledge through "on-the-job" experience. Instead, this research supports the view of Bryant and Stone (2022) that entering a role without prior preparation leads to a cycle of role stress and suboptimal performance. The qualitative narratives in this study described a sense of being pushed or forced into leadership roles, similar to the "reluctant" managers identified by Nzinga et al. (2018) in their study of Kenyan hospitals.

Regarding the influence of demographic characteristics on leadership preparedness, as presented in the study, the One-way Analysis of Variance (ANOVA) performed in this study showed that age ($p = .450$), gender ($p = .162$), professional qualifications ($p = .798$), and duration of work ($p = .961$) had no significant influence on the level of preparedness. This is a critical finding as it suggests that neither seniority nor clinical experience automatically translates to leadership readiness. These results are in alignment with Gunawan et al. (2020), who found that the length of time working in an institution did not contribute to leadership competence. This reinforces the argument that leadership preparedness is a distinct variable requiring specific, formal intervention rather than being a byproduct of chronological age or professional longevity.

In summary, while MLNMs in this study expressed a general willingness to lead, which is consistent with the 53% willingness rate reported by Al Sabeiet al. (2024), their functional competence remains uneven. They are prepared for organization and coordination functions, but remain ill-equipped for budgeting or staffing functions. This transition from

clinical practice to leadership remains an anxious path due to a lack of formal prerequisite criteria and structured induction, leading to what Pilat and Merriam (2019) describe as performance compromise and frustration.

5.2 The extent to which basic nursing training prepares Nurse Managers for MLNMs' leadership roles.

This study examined the extent to which basic nursing training prepares mid-level nurse managers (MLNMs) for leadership roles. The findings of the study depicted triangulated insights into the adequacy of current nurse preparation for leadership. This argument analyzes the extent of nurse preparation for leadership roles, focusing on three key themes: the adequacy of course content for bachelor's, higher diploma, and diploma programs, including the design of the curriculum and teaching methods; the duration and supervision of leadership clinical experiences, along with the structure and process of clinical practicum assessments.

Regarding perceived preparedness for leadership roles, given the basic nursing training, findings revealed that slightly more than half (56.9%) of MLNMs rated their preparedness for leadership roles as above average, and 24.6% rated it excellent. However, nearly one-fifth reported only average or below-average readiness, reflecting persistent gaps between training and leadership demands. This pattern echoes findings by Kukkonen et al. (2023), who noted that nurse managers across various contexts identify a disconnection between educational preparation and leadership expectations in practice. Similarly, Södersved Källestedt et al. (2020) and Tetui et al. (2016) found that new nurses often lack confidence in leadership and decision-making, requiring ongoing guidance from senior managers. Study findings also corroborate a study in Kampala that found that nurses in leadership

roles exhibited inconsistent practices influenced by their training backgrounds, affecting their performance (Nanyonga et al., 2020). Findings also align with evidence from Kenya that depicts systemic challenges in healthcare leadership where nurse managers at Kenyatta National Hospital reported insufficient induction, limited mentorship support, and a lack of clear policy guidance, all of which hinder their preparedness and effectiveness in leadership roles (Mwasi et al., 2024). Qualitative findings supported these findings, with respondents indicating average to inadequate preparation for leadership. These results align with other studies showing that nurses often feel unprepared in leadership and management competencies despite their basic nursing training (Ocho et al., 2021; Frasier, 2019; Marcellus et al., 2018)

The current study's results suggest that basic nursing training programs establish foundational knowledge, but many graduates still depend on post-training mentorship and in-service programs to attain effective leadership performance. The findings imply that basic nursing programs are insufficient for developing leadership competence, necessitating a systemic shift towards strong, structured mentorship and ongoing professional development to bridge the theory-practice gap. The persistent self-reported gaps in leadership preparedness among new nurses, corroborated by prior research, lead to a critical implication: current basic nursing education must be critically evaluated and augmented. Simply providing foundational knowledge is not enough to meet the complex leadership demands of clinical practice. Therefore, healthcare organizations and educational institutions share a joint responsibility. They must collaboratively design and implement mandatory, structured post-graduate mentorship programs and in-service

leadership training to translate foundational knowledge into confident leadership performance and decision-making at the point of care.

The adequacy of the course content for entry-level nurse training emerged as a crucial factor in leadership preparation. Most respondents (91%) agreed that additional formal leadership training beyond entry-level basic nursing education is essential for effective performance. While the bachelor's degree program produced the highest sense of preparedness (84.7%), followed by higher diploma (81.5%) and diploma (75.3%) levels, the overall adequacy of leadership training was rated lowest at 74.6%. This indicates that even with increasing academic qualifications, nurses perceive basic nursing education preparation as only a partial foundation. Similar evidence by Hughes (2018) confirms that many mid-level managers pursue supplementary education to bridge the gap between theoretical understanding and leadership practice. Moreover, international studies demonstrate that leadership competence at the practice level often surpasses what entry-level programs deliver (Cummings et al., 2021). According to the study by Ocho, et al. (2020**),** they further found that while nurses acknowledge the inclusion of leadership topics in curricula, the content lacks sufficient depth to meet the demands of real-world leadership challenges. Thus, the present findings reinforce the global concern that basic nursing training curricula inadequately prepare nurses for managerial responsibilities despite growing leadership expectations in health systems.

The course content alone cannot inform the body of knowledge without considering the curriculum design and pedagogical methods for its delivery. The review of curricula revealed that leadership content is typically taught late in training (third year for diploma programs and fourth year for degree programs), limiting opportunities for practical

application before graduation. These findings are similar to a scoping review on undergraduate nurse education regarding ‘learning to lead’, which found that newly registered nurses are often poorly prepared for leadership roles owing to leadership instruction late in the program. It recommends earlier and repeated leadership theory and clinical role modeling in curricula to enhance course content and address the inadequacies in leadership training (Scammell et al., 2020).

Participants also noted that leadership courses are densely theoretical, covered over short instructional periods (one block in colleges or one semester in universities). However, previous studies suggest that leadership development should be embedded throughout nurse training rather than confined to a course unit (AACN Essentials, 2021; Cummings et al., 2021; Mohammadpourhodki et al, 2025**)**. This supports sustained and structured leadership development as key to producing effective nurse leaders. Addressing these gaps requires curriculum reform to emphasize experiential learning, competency-based assessment, and structured mentorship.

Pedagogical review showed that lectures dominate (65%), followed by practical demonstrations (52.5%), assignments (37.5%), group work (20%), and self-directed learning (20%). This heavy reliance on structured teacher-centered instruction corresponds with Nzinga et al. (2018) and Jones (2018), who observed that overly theoretical pedagogy and insufficient experiential learning hinder skill acquisition in health leadership education.

The findings also indicated that nurses often prioritize passing examinations rather than developing leadership understanding, echoing Frasier (2019), who emphasized that exam-oriented systems restrict reflective learning and leadership growth. Similarly, Cummings

et al. (2021) and Hsieh et al. (2021) advocate for competency-based and experiential pedagogies that integrate leadership into practical and interdisciplinary settings rather than treating it as a standalone theoretical subject.

Regarding clinical experience duration and supervision, respondents expressed concern that the one-month clinical leadership rotation is insufficient for cultivating leadership competencies. Many described limited interaction with mentors and inconsistent supervision, restricting experiential leadership learning. They further stressed that it would help if the leadership clinical experience duration were increased, and also enhanced the instructors' mentorship contact periods. Alilyyani et al. (2024) corroborate that the duration and quality of clinical experience strongly influence leadership development, as longer placements enhance decision-making confidence and team coordination. The current study's findings, therefore, emphasize that leadership learning should be embedded longitudinally throughout clinical practice rather than condensed into a brief clinical placement.

Moreover, the inconsistency in supervision reported by participants aligns with Ocho et al. (2020), who found that structured mentorship and role modeling are critical in translating classroom leadership theory into practice. Effective leadership learning requires that clinical instructors explicitly model leadership behaviors, delegate responsibilities, and provide structured feedback, yet these are elements that were largely absent in this study's context.

In the clinical practicum assessment, qualitative findings indicated that students tend to prioritize cramming leadership content mainly for exam preparation, largely due to the

strong emphasis on theory. Additionally, over time, the focus of assessments has shifted from leadership skills to clinical skills, necessitating that the students plan care for a specific number of patients instead of demonstrating their managerial abilities. As a result, supervisors often mentor students with a heavy focus on patient care rather than on management competencies. This trend has led learners to concentrate more on clinical practice and passing their assessments, rather than developing their leadership skills. These observations mirror findings from Miles and Scott (2019), who identified a lack of standardized leadership assessment frameworks in basic nursing education. This limits students' ability to link leadership theory to clinical practice. In the present study, only a small proportion of respondents believed that current practicum assessments adequately evaluate leadership competence, further highlighting the disconnect between leadership learning objectives and evaluation criteria.

In summary, this study found that basic nursing training provides only moderate preparation for leadership roles, with less than half of respondents feeling fully ready for managerial responsibilities. While bachelor-level programs yielded better outcomes than diploma programs, both levels demonstrated gaps in leadership readiness. These shortcomings are attributed to overly theoretical curricula, brief and inadequately supervised clinical leadership experiences, and limited integration of leadership competencies across the learning continuum.

Integrating formal leadership content into early training years, extending clinical leadership rotations, restructuring, and standardizing assessment tools will enhance preparedness for the increasingly complex leadership demands in modern healthcare. As

health systems evolve, nurse training institutions must reorient curricula from theory-heavy instruction toward practice-based, reflective, and competency-driven leadership education.

5.3. The contribution of roleinduction programs to MLNMs' leadership role preparedness among the Nurse Managers.

The third objective of this study was to assess the contribution of various role induction programs to the leadership preparedness of Mid-Level Nurse Managers (MLNMs). The findings demonstrated a high degree of perceived value across multiple induction modalities, yet highlighted a systemic failure in their implementation and availability within healthcare settings.

Quantitative findings identified additional formal leadership training as the highest-ranked induction program (M = 4.84, SD = .412). This strong preference suggests that MLNMs recognize that basic nursing education alone is insufficient for the complexities of mid-level management. This aligns with Balluck (2023), who argues that insufficient training is a primary factor in the low confidence levels and reluctance of nurses to embrace leadership opportunities. Furthermore, the results resonate with the World Health Organization (2020a) "State of the World's Nursing" report, which emphasizes that as experienced nurses migrate, younger, less-experienced nurses are thrust into leadership roles without prerequisite competencies. The high mean score for formal training in this study supports the WHO (2020) assertion that technical competence earned through clinical experience does not automatically translate into managerial skill. While Josefina (2018) observed that NUMs often struggle to put short-course knowledge into practice, the

current study findings suggest that MLNMs view structured, formal training, rather than just isolated workshops, as the most credible pathway to bridging the competency gap.

In this study, mentorship was the second-highest-ranked modality for role induction (M = 4.69, SD = .499). Qualitative data from FGDs and key informants reinforced this, viewing mentorship as an essential collaborative opportunity where mentors provide modeling and assistance. These findings are consistent with Vitale (2018) and Charlotte (2015), who describe mentorship as both an art and a science that allows mentees to understand organizational culture and navigate complex tasks like the budgeting process through shadowing.

The high value placed on mentorship by Kenyan MLNMs echoes the work of Rosser et al. (2023) and Rees et al. (2022), who recognize mentorship as a strategic tool for developing future leaders at an organizational level. As noted by Channing (2020), the mentor acts as a more capable professional who fosters problem-solving skills in the prospective manager. This is particularly vital in resource-constrained environments where formal training may be scarce, and peer-to-peer knowledge transfer becomes the primary mechanism for survival and growth.

The study findings indicate that both supportive supervision (M = 4.66) and On-the-job Training (OJT) (M = 4.60**)** were highly rated, highlighting the importance of real-time, hands-on experience. The findings correspond with Agufana (2022) and Timsal et al. (2016), who posit that OJT allows managers to acquire job-related skills under direct supervision within the context of their everyday environment. This is crucial for MLNMs

who, as the qualitative data showed, often transition into roles without prior area responsibility and must learn to navigate personnel and machinery pertinent to the job.

From this study, preceptorship (M = 4.35), while ranked slightly lower, was still recognized as a valid approach for developing both clinical and managerial competencies (Araújo et al., 2023). Remarkably, while preceptorship is often associated with the student-to-clinician transition, these findings support the Baylor University (2022) perspective that the role of a preceptor inherently develops leadership styles by requiring the nurse to be accountable for healthcare delivery outcomes and supervision.

This study revealed that a critical disconnect emerged between the perceived value of these programs and their existence in practice. Although respondents acknowledged that role induction programs significantly influence leadership preparedness, they reported that these programs did not exist in most healthcare settings or were never implemented consistently. This gap highlights a major policy gap. As Bakir et al. (2022) noted in their study of newly graduated nurses, exposure to clinical leadership experiences is superior to immediate immersion without induction. The lack of standardized, mandatory induction processes in the South Rift and South Nyanza regions contributes to what Pilat and Merriam (2019) describe as role stress and performance compromise. Without a formal baseline of support, as Kim and Lim (2022) argue, the "learning by doing" approach does not foster true competency, but rather a cycle of trial-and-error that can jeopardize patient care quality and organizational performance.

In conclusion, the findings for objective three demonstrate that MLNMs are highly receptive to structured induction, with a specific preference for formal leadership training

and mentorship. However, the current random approach to role transition, marked by a lack of formal prerequisite criteria and inconsistent induction, leaves managers ill-equipped for their responsibilities. There is an urgent need for institutional policy to mandate standardized role induction programs to ensure a seamless and competent transition for newly appointed nurse managers.

5.4. Mid-Level Nurse Managers' training needs for leadership role preparation

The fourth objective of this study was to determine the specific training needs required to enhance the leadership preparedness of Mid-Level Nurse Managers (MLNMs). The findings revealed a clear mandate for a shift from predominant clinical training to a multi-dimensional leadership curriculum that encompasses formal management training, financial literacy, and emotional intelligence.

A critical finding of this study was the perceived inadequacy of basic nursing education in preparing nurses for managerial transitions. While participants generally agreed that basic training provides a foundational introduction to leadership (M = 4.05, SD = 1.038), there was an overwhelming consensus (M = 4.64, SD = .829) on the necessity of formal leadership courses as a prerequisite for effective role execution. This demand for specialized training echoes the General and Industrial Management Theory of Henri Fayol (1949), who posited that professional graduates often lack the management component and require comprehensive instruction in planning, organizing, coordinating, and controlling. Qualitative data from the Focus Group Discussions (FGDs) reinforced this by identifying formal leadership training as the most recurring theme. This is consistent with Al Sabei, et al. (2024) and Frasier (2019), whose research demonstrated that leadership preparedness

scores significantly improve, often from an average of 58% to 83%, following structured development programs. These results validate the assertion by Channing (2020) that leadership can indeed be taught, with 86% of leaders attributing their skills to formal academic or professional programs.

The study identified financial management, specifically budgeting, as the most challenging and complex function for MLNMs. Ranked lowest in perceived preparedness (69.2%), budgeting emerged as the second most urgent training need in qualitative reports. Participants attributed this deficit to limited content coverage during basic nursing training. This finding is strongly supported by Naranjee et al. (2019), who noted that while nurse managers are expected to oversee unit finances, they are often deficient in the requisite skills. As Marquis and Huston (2021) argue, nurse managers are responsible for the entirety of the budgeting process, including monitoring and evaluation. The necessity for this competency is further underscored by Jones (2018), who emphasized that because nursing represents the largest portion of healthcare personnel expenditures, a manager's fiscal illiteracy can lead to systemic organizational failure. The high ranking of financial management as a training need in this study is similar to the scoping review by González-García et al. (2021), which placed financial competence second only to communication as a critical manager competency.

An emergent and highly significant finding from the qualitative data was the multifaceted, complex, and challenging nature of the MLNM role, which frequently leads to burnout, fatigue, and a lack of work-life balance. Consequently, Emotional Intelligence (EI) was identified as a critical training need to help managers maneuver through these stressors.

The study aligns with Kelly, Lefton, and Fischer (2019), who found that as burnout increases, emotional intelligence often decreases, creating a cycle of leadership inefficiency. These findings support the propositions of Tyczkowski et al. (2015) and Frias et al. (2021), who define EI as a teachable capacity to recognize and address emotions in oneself and others. By incorporating EI into professional development, as suggested by participants, institutions can equip managers with the soft skills necessary to navigate the tough encounters described by Bryant and Stone (2022).

The study findings suggest that the current learning by doing model is insufficient. As Gunawan et al. (2020) demonstrated, managers who do not participate in designed leadership preparation fail to achieve optimal managerial competencies compared to those who do. This has implications for the nursing curriculum and policy. The call for a curriculum review, to enhance budgeting components and introduce emotional intelligence, aligns with Fayol's (1949) historical recommendation that management concepts must be integrated into university education and then complemented by specialized training during professional practice.

The findings for objective four indicate that MLNMs identify a three-pronged training need: formal leadership training, financial Management/budgeting, and Emotional Intelligence. Addressing these needs is essential to move the quarter of "excellent" performers (24.6%) toward a majority, ensuring that clinical expertise is matched by managerial proficiency. As suggested by Nghe et al. (2020), these tailored training interventions are particularly vital for new managers to prevent the role stress and performance compromise identified in this study.

5.5. Implications of the Research Findings

This study contributes to the body of knowledge by shifting the discourse from a generalized view of nurse leadership unpreparedness to a functional analysis of competency deficits. It uniquely identifies that in the Kenyan devolved context, clinical seniority does not mitigate managerial illiteracy, and it establishes a three-pronged training mandate, of the theory, finance, and emotion, as the essential requirement for modern nursing leadership

CHAPTER SIX

CONCLUSION AND RECOMMENDATIONS

6.0. Introduction

This chapter presents the conclusions and recommendations of the research findings as per the study objectives.

6.1. Conclusions

The First objective of the study was to assess the level of leadership preparedness for MLNMs' role among the nurse managers in selected hospitals in Bomet, Kericho, Narok, Kisii, and Nyamira counties, Kenya.

The study concludes that leadership role preparedness among MLNMs is suboptimal and uneven. While managers exhibit high confidence in operational functions like planning and coordinating, they are critically underprepared for the financial and strategic demands of their roles. This preparedness gap is attributed to the current random transition from being a clinical expert to becoming a manager, contributed to by the prevailing appointment procedures, which lack adequate preparatory opportunities, as well as the emphasis on demographic characteristics during the selection process for leadership positions. While 56.9% perceive themselves as above average, the significant deficit in budgeting skills (69.2% preparedness and the qualitative narratives of role shock indicate that clinical seniority is being incorrectly used as a substitution for managerial competence.

Furthermore, the study also demonstrated that the MLNMs' demographic characteristics, particularly professional qualification, duration of working in the institution, and duration in a leadership position, did not prepare them for the leadership position.

The second objective of the study was to determine the extent to which basic nursing training prepares nurses for MLNMs' leadership roles in selected hospitals in Bomet, Kericho, Narok, Kisii, and Nyamira counties, Kenya**.**

The study findings conclude that while basic nursing training provides a foundational introduction to leadership, it is insufficient in depth and structure to prepare nurses for the complexities of mid-level management.

There is a critical gap in the course content because the current curriculum is heavily weighted toward clinical proficiency, leaving the management component underrated. While students are taught the theory of POSDCoRB, the content lacks the practical application required for financial management and human resource strategy.

Additionally, the duration of leadership-focused clinical rotations was found to be too brief to allow for the internalization of managerial roles. Most rotations focus on patient care, with leadership being a secondary, often observational, experience rather than an active one.

Also, the structure of clinical practicum assessments is not commensurate with the leadership expectations in the clinical practice settings. Assessments during training are predominantly clinical and task-oriented. The lack of rigorous, management-focused assessment criteria during practicums means that nurses graduate with a "clinical mindset," making the eventual transition to a Mid-Level Nurse Manager (MLNM) role a "role-shock" rather than a natural progression.

Overall, it can be concluded that the basic nursing training had average and inadequate preparation for leadership owing to the much emphasis on theory, shift in assessment focus, and short duration for leadership and management clinical rotations.

The third objective of the study was to assess the contribution of role-induction programs to MLNMs' leadership role preparedness among the Nurse Managers in selected hospitals in Bomet, Kericho, Narok, Kisii, and Nyamira counties, Kenya.

The study concludes that although formal training and mentorship are highly valued by MLNMs (M=4.84 and M=4.69, respectively), there is an institutional lack of standardized and consistent induction programs within healthcare settings. This institutional failure in induction forces a "learning by doing" approach by nurse managers, which increases role stress and operational inefficiency. Additionally, Statistical analysis confirmed that age, gender, and duration of experience do not significantly influence preparedness. This suggests that the competency deficit is a universal issue across the managerial group, necessitating a standardized training intervention rather than relying on natural career progression.

Findings indicate that formal leadership training, on-the-job training, mentorship, preceptorship, and supportive supervision significantly contribute to nurse managers' leadership role preparedness. Therefore, these programs must be integrated within the healthcare settings, particularly for newly appointed nurse managers, to strengthen the development of their leadership and management competencies.

The fourth objective for the study was to determine MLNMs' training needs for leadership role preparation in selected hospitals in Bomet, Kericho, Narok, Kisii, and Nyamira counties, Kenya.

From the findings, it is clear that there is a clear mandate for a revised training framework. MLNMs require a three-pronged training competency consisting of formal leadership and

management training, financial and budgetary proficiency, and Emotional Intelligence. Study revealed that for effective functioning of the nurse managers in their leadership role, there is a need for formal leadership courses in addition to the basic nursing training. Findings also determined that financial management, particularly the budgeting function, emerged second after the formal leadership training, with nurse managers stressing that it is the most complex and challenging function of management and that nurse managers were least prepared to execute this function. The challenge of executing the budgeting function of management was attributed to limited coverage on the topic during basic nursing training and a lack of induction into the leadership role. Finally, findings of the study revealed that the complexity and the challenges of nurse managers' roles contributed to difficulties in achieving work-life balance. This underscores the need for training in emotional intelligence to be integrated into the basic nursing training and professional development courses within health care systems. Such courses would enhance the effectiveness and success of nurse managers in their leadership roles.

6.2 Recommendations

Based on the findings, this study makes the following recommendations:

6.2.1 Recommendation for Nursing Practice and Management

The study recommends that healthcare institutions should move away from random appointments to establishing mandatory standardized inductions. Every newly appointed MLNM should undergo a mandatory, structured induction program before assuming full leadership responsibilities.

Secondly, healthcare institutions should design and implement structured mentorship and shadowing programs where prospective managers work alongside experienced financial officers or senior managers to demystify the budgeting process.

Thirdly, hospital managements should embrace supportive supervision to provide a safe environment for new managers to apply theoretical knowledge without the immediate fear of professional repercussions for minor errors during the learning curve.

6.2.2 Recommendation for Nursing Education and Curriculum Policy

The study recommends that regulatory bodies and educational institutions should review the basic nursing curriculum to increase the weight of the Management and Leadership component, with a specific focus on financial management.

Secondly, training in Emotional Intelligence (EI) should be integrated into both undergraduate education and professional development to equip nurses with the "soft skills" required to manage high-stress leadership environments.

Also, the study proposes that there should be a policy requirement for MLNMs to hold or be pursuing a post-graduate certificate in leadership and management to ensure they possess the requisite leadership skills.

6.2.3 Recommendation for Policy and Governance

The study recommends that the Ministry of Health and hospital management teams should establish formal prerequisite criteria for leadership appointments. Clinical merit must be balanced with evidence of leadership training or potential.

Additionally, policymakers should proactively make provision for resource allocation for training. Policymakers should allocate specific budgets for leadership development within the health sector to prevent the migration of leadership capital and foster a resilient internal succession plan.

6.2.4 Recommendations for Further Research

The study recommends a longitudinal study to measure the impact of formal leadership training on actual patient outcomes and unit cost-efficiency.

Also, there is a need to conduct a comparative study between public and private healthcare settings regarding the efficacy of their informal mentorship networks.

REFERENCES AND BIBLIOGRAPHIES

Abdul-Rahim, H. Z., Sharbini, S.H. & Ali, M. (2025). Leadership and management skills for student nurses: a scoping review. *BMC Nurs* 24, 111 https://doi.org/10.1186/s12912-024-02603-7

Abo Jalghef, M., Eshah, N., Al-Oweidant, I., & Nashwan, A. J. (2023) Self-Perceived performance-based training needs among middle-levelnursing managers in Jordan. International Journal of Healthcare Management, 1-13 Retrieved from https://www.tandfonline.com/doi/full/10.1080/20479700.2023.2231205

Acob, J. R. U., Nugroho, H. S. W., & Martiningsih, W. (2018). Nurse managers' utilization of Fayol's theory in nursing. *Journal of Health Science and Prevention, 2*(2), 64–65. https:// doi: 10.5958/0976-5506.2018.01490.0

Adom, D. Joe, A. A & Hussein, E. K (2018) Theoretical and Conceptual Framework: Mandatory Ingredients of a Quality Research. Retrieved from https://www.researchgate.net/publication/

Agufana, P. B. (2022). Effect of on-the-Job Training Technique on Job Performance at Murang'a University of Technology in Kenya. http://repository.mut.ac.ke:8080/xmlui/bitstream/handle/

Ahmad, N., Alias, F. A & Razak, N. A.A (2023) Understanding Population and Sample in Research: Concepts for Valid Conclusions. https://appspenang.uitm.edu.my/sigcs/2023-2/Articles/20234_UnderstandingPopulationAndSampleInResearch.pdf.

Ahmari T. H., Gaeeni, M., Rezaei, M., Khoramirad, A., & Parizad, A. (2021). The challenges of clinical education in nursing: A qualitative analysis of nursing students and clinical instructors' perspectives. *Journal of Nursing and Midwifery Sciences*, *8*(4), 260–267. https://doi.org/10.4103/jnms.jnms_151_20

Alakwe, K. O (2017). Positivism and Knowledge Inquiry: From Scientific Method to Media and Communication Research. https://www.researchgate.net/publication/319186037_Positivism_and_Knowledge_Inquiry_From_Scientific_Method_to_Media_and_Communication_Research

Allen, M (2017) Survey: Open Ended Questions. Retrieved from https://methods.sagepub.com/reference/the-sage-encyclopedia-of-communication-research-methods/i14345.xm.

Alilyyani, B., Althobaiti, E., Al-Talhi, M., Almalki, T., Alharthy, T., Alnefaie, M., Talbi, H., & Abuzaid, A. (2024). Nursing experience and leadership skills among staff nurses and intern nursing students in Saudi Arabia: A mixed methods study. *BMC Nursing, 23,* Article 87. https://doi.org/10.1186/s12912-024-02387-9

Almeida, F (2018) Strategies to perform a mixed methods study. European Journal of Education Studies.

Alomairi, S. B., Seesy, N. E & Rajab, A. A (2018) Managerial and Leadership Competencies of First-Line Nurse Managers in Makkah City: Mixed-Method Approach. https://d1wqtxts1xzle7.cloudfront.net/

Al Sabei, S., Ross, A. M., Al Yahyaei, A., Labrague, L., Al-Rwajfah, O., & Deterding, K. (2024). Motivation to Lead: A Study of the Supportive Nursing Leadership Environment. *Journal of nursing management, 2024*, 2652746. https://doi.org/10.1155/2024/2652746

Al-Yami, M. S., Al-Mansour, S. A., Al-Fayyad, I., Al-Khathami, A. M., & Al-Balawi, M. M. (2024). The relationship of perceived nurse manager competence with job satisfaction and turnover intention among clinical nurses: An analytical cross-sectional study. *BMC Nursing, 23*(1), 35. https://doi.org/10.1186/s12912-024-02203-5.

American Association of Colleges of Nursing, AACN (2021). *The essentials: Core competencies for professional nursing education*. https://www.aacnnursing.org/Portals/0/PDFs/Publications/Essentials 2021.pdf

American Organization for Nursing Leadership. (2024). *Nurse manager succession planning: An essential workforce strategy to retain and attract current and future leaders* (Workforce Committee White Paper) https://www.aonl.org/system/files/media/file/2024/02/AONL_WF_WhitePaper3_Succession_Planning.pdf

Araújo, M. C., Peduzzi, M., Mazzi, N. R., Souza, C. M. S & Leonello, V. M. (2023) Preceptorship contributions to the development of clinical and managerial skills in nursing residency. Rev Bras Enferm. 2023;76(2):e20220510. https://doi.org/10.1590/0034-7167-2022-0510

Areia, N. P., Tavares, A. O & Costa, P. J. M (2023) Public perception and preferences for coastal risk management: Evidence from a convergent parallel mixed-methods study.https://www.sciencedirect.com/science/article/pii/S0048969723020594

Averesch, L (2017) Competences of First-Line Management enhancing Effectiveness of Self-Managing Teams in the Health-Care Sector. Retrieved from https://essay.utwente.nl/72846/1/Averesch_BA_BMS.pdf

Bae, S.-H. (2022). Noneconomic and economic impacts of nurse turnover in hospitals: A systematic review. *International Nursing Review, 69*(3), 392–404. https://doi.org/10.1111/inr.12769

Baharum, H., Ismail, A., McKenna, L., Mohamed, Z., Ibrahim, R., & Hassan, N. H. (2023). Success factors in adaptation of newly graduated nurses: A scoping review. *BMC Nursing, 22*, Article 125. https://doi.org/10.1186/s12912-023-01300-1

Bai, Y., Gu, C., Chen, Q., Xiao , J., Liu, D & Tang, S (2017) The challenges that head nurses confront on financial management today: A qualitative study. https://pubmed.ncbi.nlm.nih.gov/31406731/

Bakir, A., Rahman, H. A., Haji-Ali, H. S & Abdul-Mumin, K. H. (2022) Leadership and Management Preparedness after Completing Induction Programme for Newly Graduate Nurses: A CrossSectional Study.

Baylor University (2022) Why We Need Preceptors and the Benefits of Preceptorship https://onlinenursing.baylor.edu/news/why-we-need-preceptors-and-benefits-preceptorship.

Bhandari, P. (2023). Population vs. Sample | Definitions, Differences & Examples. Scribbr. Retrieved May 7, 2025, from https://www.scribbr.com/methodology/population-vs-sample/

Bhatia, M (2018). Your Guide to Qualitative and Quantitative Data Analysis Methods Retrieved from https://humansofdata.atlan.com

Biddix, J. P (N.D) Research Rundowns: Instrument, Validity, Reliability. Retrieved from https://researchrundowns.com/quantitative-methods/instrument-validity-reliability

Bretschneider, P.J, Cirilli, S., Jones, T., Lynch, S & Wilson, N.A (2017) Document Review as a Qualitative Research Data Collection Method for Teacher Research. Retrieved from https://methods.sagepub.com/case/

Bryant, N & Stone, R. (2022) Enhancing Frontline Nurse Management in Long-Term Services and Supports: Research Brief.

Balluck, J. (2023). Increasing nurse leaders competence and confidence by implementing a novice nurse leader development program. *Nurse Leader*, *21*(3), e22–e27.

Cabral, A., Oram, C., & Allum, S. (2019). Developing nursing leadership talent-Views from the NHS nursing leadership for south-east England. *Journal of nursing management*, *27*(1), 75–83. https://doi.org/10.1111/jonm.12650

Connelly, L. M (2016) Trustworthiness in Qualitative Research. Retrieved from https://go.gale.com/ps/.

Channing, J (2020) How Can Leadership Be Taught? Implications for Leadership Educators. https://files.eric.ed.gov/fulltext/EJ1254573.pdf

Charlotte, D (2015) Mentoring our future nurse leaders Charlotte (2015) https://journals.lww.com/nursingmadeincrediblyeasy/fulltext/2015/07000/mentoring_our_future_nurse_leaders.1.aspx

Christiansen, B., Averlid, G., Baluyot, C., Blomberg, K., Eikeland, A., Strand Finstad, I. R., Holm Larsen, M., & Lindeflaten, K. (2021). Challenges in the assessment of nursing students in clinical placements: Exploring perceptions among nurse mentors. *Nursing open*, *8*(3), 1069–1076. https://doi.org/10.1002/nop2.717

Creswell, J. W., & Creswell, J. D. (2018). *Research design: Qualitative, quantitative, and mixed methods approaches.* 5th Edition, SAGE Publications, Inc. Los Angeles

Crossman, A. (2019) How to Use Focus Groups in Marketing Research. Retrieved from https://www. thoughtco.com/use-focus-groups-in-research

Cummings, G., Lee, S., Tate, K., Penconek, T., Micaroni, S.P.M., Paananen, T & Chatterjee, G. E (2021) The essentials of nursing leadership: A systematic review of factors and educational interventions influencing nursing leadership. International Journal of Nursing Studies Volume 115, March 2021, 103842 https://www.sciencedirect.com/science/article/abs/pii/S0020748920303333

Daly J., Jackson, D., Anders, R. & Davidson, P. M (2020). Who speaks for nursing? COVID-19 highlighting gaps in leadership. J Clin Nurs. Aug;29(15-16):2751-2752. doi: 10.1111/jocn.15305. Epub 2020 May 27. PMID: 32311793; PMCID: PMC7264653.

Daniels, N., Gillen, P., Wilson, I., & Casson, K. (2019). STEER: Factors to consider when designing online focus groups using audio-visual technology in health research. International Journal of Qualitative Methods, 18, 1. https://doi.org/10.1177/1609406919885786

Davidson, L (2019) Quantitative Data: A Comprehensive Overview. Retrieved from https://www.springboard.com/blog/quantitative-data/

Davis, B. (2019) Six Tips for Planning Successful Key Informant Interviews. Retrieved from https://upstream.consulting/grant-readiness/.

Davis, K. D. (2024) Levels of Management:Top, Middle and Lower in Organization. https://www.knowledgehut.com/blog/project-management/levels-of-management

Dawadi, S., Shrestha, S., & Giri, R. A. (2021). Mixed-Methods Research: A Discussion on its Types, Challenges, and Criticisms. Journal of Practical Studies in Education, 2(2), 25-36 DOI: https://doi.org/10.46809/jpse.v2i2.20

DeCarlo, M (N.D) Scientific Inquiry in Social Work: Disseminating your findings. Retrieved from https://scientificinquiryinsocialwork.pressbooks.com/chapter/16-2-

Demir, S. B., & Pismek, N. (2018). A convergent parallel mixed-methods study of controversial issues in social studies classes: A clash of ideologies. Educational Sciences: Theory & Practice, 18, 119–149. http://dx.doi.org/10.12738/estp.2018.1.0298

Eaton, S. E (2017) Research Assistant Training Manual: Focus Groups. Retrieved from https://drsaraheaton.wordpress.com

Edmonds, W., & Kennedy, T. (2017). Convergent-parallel approach. In *An applied guide to research designs* (pp. 181–188). SAGE Publications. https://doi.org/10.4135/9781071802779.n15

Eeuwijk, P. V & Angehrn, Z (2017). How to Conduct a Focus Group Discussion (FGD) Methodological Manual. *Swiss TPH - Fact Sheet Society, Culture and Health* https://www.swisstph.ch/fileadmin/user_upload/SwissTPH/Topics/Society_and_Health

Fernandes, R., Araújo, B, & Pereira, F (2018) Nursing management and leadership approaches from the perspective of registered nurses in Portugal. Journal of Hospital Administration 7(3):1DOI:10.5430/jha.v7n3p1. https://www.researchgate.net/publication/324312924_

Foster, A. A., Makukula, M. K., Moore, C., Chizuni, N. L., Goma, F., Myles, A., & Nelson, D. (2018). Strengthening and Institutionalizing the Leadership and Management Role of Frontline Nurses to Advance Universal Health Coverage in Zambia. *Global health, science and practice*, *6*(4), 736–746. https://doi.org/10.9745/GHSP-D-18-00067

Frasier, N (2019) Preparing Nurse Managers for Authentic Leadership: A Pilot Leadership Development Program. JONA: The Journal of Nursing Administration 49(2):p 79-85, | DOI: 10.1097/NNA.0000000000000714

Frias, A., Hampton, D., Tharp-Barrie, K., & Thomas, J. (2021). The impact of an emotional intelligence training program on transformational leadership. *Nursing management*, *52*(2), 18–25. https://doi.org/10.1097/01.NUMA.0000731924.03153.df

George, T. (2021). Mixed Methods Research | Definition, Guide & Examples. Scribbr. Retrieved from https://www.scribbr.com/methodology/mixed-methods-research/

Gilson, L., Barasa, E., Nxumalo, N., Cleary, S., Goudge, J., Molyneux, S, Tsofa, B. & Lehmann, U (2017) Everyday resilience in district health systems: emerging insights from the front lines in Kenya and South Africa. Retrieved from https://gh.bmj.com/content/2/2/e000224

Goktepe, N., Turkmen, E., Badir, A., Hayta, O., Yakar, H. K. &Buyukgonenc, L. A (2018)Development of Managerial Competencies for First-level Nurse Managers in Turkey *International Journal of Caring Sciences May-August 2018 Volume 11 | Issue 2| Page 1097* https://www.internationaljournalofcaringsciences.org/

González-García, A., Pinto-Carral, A., Pérez-González, S., Marqués-Sánchez, P. (2021) Nurse managers' competencies: A scoping review . J Nurs Manag . 2021 ; 29 : 1410 – 1419 . https://doi.org/10.1111/jonm.13380

Gray, J. R., & Grove, S. K. (2024). *Burns & Grove's the practice of nursing research: Appraisal, synthesis, and generation of evidence* (9th ed.). Elsevier

Gunawan, J., Aungsuroch, Y. Fisher, M. L., McDaniel, A. M & Marzilli, C (2020) Managerial Competence of First-Line Nurse Managers in Public Hospitals in Indonesia. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7524169

Hahn, C.A. & Lapetra, M.G. (2019), "*Development and use of the leadership competencies for healthcare services managers assessment*", Frontiers in Public Health, Vol. 7 No. FEB, pp. 1-7, doi: 10.3389/fpubh.

Hall, H. R. and Roussel, L. A (2014) *Evidence-Based Practice: An Integrative Approach to Research, Administration and Pracice.* Burlington, JONES & BARTLETT LEARNING.

Hamer, A, & Bradford, A (2022). What is a Scientific Theory?. https://www.livescience.com/2149

Hedenstrom, L.M., Spiva, L., Thurman, S., Hale, R.L., Toney, S., Case-Wirth, J., Kairu, M. & Sneha, S (2022). Developing and Evaluating the Effectiveness of a Nursing Leadership Mentoring Pilot Program. https://pubmed.ncbi.nlm.nih.gov/36730703/

Holm A. L, Berland A. K, Birkeland A. K, Severinsson E. (2018) First-line nurse managers' perceptions of the challenges involved in decision-making when older patients' wish to die. Retrieved from https://onlinelibrary.wiley.com/doi/epdf/10.1002/nop2.131.

Hossan, D., Mansor, Z. D & Jaharuddin, N. S (2023) Research Population and Sampling in Quantitative Study. https://scispace.com/pdf/research-population-and-sampling-in-quantitative-study-30bj4ruol4.pdf

Hsieh, L.-W., Chang, Y.-C., & Yen, M. (2021). Improving leadership competence among undergraduate nursing students: Innovative objectives development, implementation, and evaluation. *Nursing Education Perspectives*. https://doi.org/10.1097/01.NEP.0000000000000866

Hughes, V. (2018) What are the Barriers to Effective Nurse Leadership? A Review. Athens Journal of Health - Volume 5, Issue 1 – Pages 7-20 https://doi.org/10.30958/ajh.5-1-1 doi=10.30958/ajh.5-1-1

Iheduru-Anderson, K. C., & Shingles, R. R. (2023). Mentoring Experience for Career Advancement: The perspectives of Black Women Academic Nurse Leaders. *Global qualitative nursing research*, *10*, 23333936231155051. https://doi.org/10.1177/23333936231155051

IntraHealth International, (2019) Investing in the Power of Nurse Leadership: What will it take? Retrieved from https://www.intrahealth.org/sites/ihweb/files/attachment-files/investing-nurse-leadershipreport.pdf

Iwendi, O. F, (2021) The Scientific Management Approach And The Nigerian Public Service: A Critical Appraisal. https://www.researchgate.net/

Johnson, O., Begg, K., Kelly, A. H & Sevdalis, N (2021) Interventions to strengthen the leadership capabilities of health professionals in Sub-Saharan Africa: a scoping review. Health Policy and Planning, Volume 36, Issue 1, February 2021, Pages 117–133, https://academic.oup.com/heapol/article/36/1/117/6032363

Josefina, T (2018) The Preparation of Nurse Unit Managers for Their Role. https://vuir.vu.edu.au/39477/

Kabir, S. M. S (2016) Preparing Questionnaire. Retrieved from. https://www.researchgate.net

Kent State University (2020) Statistical & Qualitative Data Analysis Software: About Nvivo. Retrieved from https://libguides.library.kent.edu/statconsulting/NVivo.

Kibuacha, F (2024) Key Informant Interviews: An In-Depth Guide for Researchers. https://www.geopoll.com/blog/key-informant-interviews/

Kim, M., Choi, S & Choi A. L (2016) Span of Control for Front-Line Nurse Managers: A Concept Analysis. Retrieved from. https://www.dx.doi.org/10:14257/astl.2016.128.01.

Kim, S. & Lim, Y (2022). Development and Evaluation of the “High-Up” Program for Enhancing the Nursing-Management Competency of Mid-Career Hospital Nurses: A Quasi-Experimental Study.Int. J. Environ. Res. Public Health 2022, 19, 4392. https://doi.org/10.3390/ ijerph19074392

Kirui, J. E & Too, J. K (2016) *A Step by Step Research Guide for Students: A Practical Handbook.* Kericho Kenya. REMAELI PUBLISHERS

Klaes, K (2018). "The Challenges of Frontline Nurse Managers A Quantitative Descriptive Study". Nursing Master's Theses. 45. https://digitalcommons.daemen.edu/theses/45

Kubai, E (2019). Reliability and Validity of Research Instruments. Retrieved from https://.www.researchgate,net

Kukkonen, P. Koskinen, S. Fatkulina, N. Fuster, P. Lehwaldt, D. Löyttyniemi, E. Salminen, L. Stubner, J. Sveinsdóttir, H. & Leino-Kilpi, H. (2023). Nurse managers' assessments about nursing education and work life's competence demands: A European multi-country cross-sectional survey. Nordic Journal of Nursing Research 2023, Vol. 43(1) 1–10 DOI: 10.1177/20571585221135304 journals.sagepub.com/home/njn

Kumah, E., Ankomah, S & Antwi, F (2016). The Role of First-Line Managers in Healthcare Change Management: A Ghanaian Context. Retrieved from https://www.researchgate.net/publication/310160596_

Lesly, K. A., Teri, W. L. & Richard G. D (2014) The Relationship of Training and Education to Leadership Practices in Frontline Nurse Leaders. *JONA: The Journal of Nursing Administration* 44(3):p 158-163, March. | https://journals.lww.com/jonajournal/abstract/2014/03000/the_relationship_of_training_and_education_to.9.aspx

Litza, J., Bourquin, B., Fayz, A., Carmichael, C., Hong, A., Hewlett, K., Araneta, L., Lin, A., Ajani, L., Munoz, P., Faulkner, G & Chao, J (2019) How to Develop a Research Questionnaire. Retrieved from https://www.wikihow.com/

Lutabingwa, J., and Auriacombe, C.J (2018) Data Analysis in Quantitative Research. Retrieved from https://www.researchgate.net/publication/

Maia, M. A, Paiva, A. C. O, Moretão, D. I. C, Batista, R. C. R & Alves, M (2019) The daily work in nursing: a reflection on professional practices. Cienc Cuid Saude 2019 Oct-Dec 18(4) e43349https://www.researchgate.net/

Manion, A., Griffin, P.E., & Van Dam, P.J. (2021). Nurses' perceptions of preparedness for acting as Nurse Unit Managers: A cross-sectional study. Collegian. https://www.semanticscholar.org/paper.

Marcellus, L., Duncan, S., MacKinnon, K., Jantzen, D., Siemens, J., Brennan, J., & Kassam, S. (2018). The role of education in developing leadership in nurses. *Nursing Leadership*, *31*(4), 26–35. https://doi:10.12927/cjnl.2019.25758

Mari, A. (2024). Making conventional data collection more child-friendly: Questionnaires with young students. *African Evaluation Journal*, *12*(1). https://doi.org/10.4102/aej.v12i1.690

Marquis, B. L., & Huston, C. J. (2021). *Leadership roles and management functions in nursing: Theory and application* (10th ed.). Wolters Kluwer.

Martine, J (2014) Documentation Review Checklist Template. Retrieved from https://techwhirl.com/documentation-review-checklist-template/

McGilton, K. S., Backman, A., Boscart, V., Chu, C., Gea Sánchez, M., Irwin, C., ... & Zúñiga, F. (2020). Exploring a common data element for international research in long-term care homes: A measure for evaluating nursing supervisor effectiveness. Gerontology and Geriatric Medicine, 6, 2333721420979812.

Megan, N., Jennifer, H., Susan, F., Larissa, H., & Ruth, L (2020) Developing Leadership Competencies in Midlevel Nurse Leaders An Innovative Approach https://journals.lww.com/jonajournal/

Miles, J. M., & Scott, E. S. (2019). A new leadership development model for nursing education. *Journal of Professional Nursing*, *35*(1), 5–11. https://doi.org/10.1016/j.profnurs.2018.09.009

Mohammadpourhodki, R., Hajizadeh, S., & Shams, S. (2025). A systematic review of interventions aiming to promote leadership skills among nursing students: From in-class strategies to curriculum revisions. *Journal of Advances in Medical Education & Professionalism*, *13*(2), 85–94. https://doi: 10.30476/jamp.2024.103763.2022

Mouza, M (2018) What is a Theory. https://doi.org/10.13140/RG.2.2.28009.34406

Mugenda O.M & Mugenda A.G (1999). *Research Methods: Quantitative and qualitative Approaches.* Nairobi. ACTS PRESS.

Mwasi, J. T., Njuguna, S., & Mulu, M. (2024). Policy Factors Associated with Nurse Managers' Preparedness in Mentorship Role at Kenyatta National Hospital, Kenya. Journal of Medicine, Nursing and Public Health, 4(3), 1-22. http://41.89.31.5:8080/xmlui/bitstream/handle/123456789/1985/Julita.pdf

Nanyonga, R. C., Bosire, E. N., Heller, D. J., Bradley, E., & Reynolds, N. R. (2020). Predictors of nursing leadership in Uganda: a cross-sectional study. *Health policy and planning*, *35*(Supplement_1), i51–i64. https://doi.org/10.1093/heapol/czaa100

Naranjee, N., Ngxongo, T. S. P., Sibiya, M. N (2019) Financial management roles of nurse managers in selected public hospitals in KwaZulu-Natal province, South Africa. Afr J Prim Health Care Fam Med. doi: 10.4102/phcfm.v11i1.1981. PMID: 31588771; PMCID: PMC6779971.

National Institute for Health Research (2019). How to Disseminate Your Research. Retrieved from https://www.nihr.ac.uk/documents/how-to-disseminate-your-research/19951.

NCK (2020) Scope of practice for entry level nurses and midwifes in Kenya. http://nckenya.com/wp-content/uploads/2020/08/Scope_of-Practice_For_Entry_Level_Programmes_17.08.2020.pdf

Shen, Q., & Tucker, S. (2024). Fostering leadership development and growth of nurse leaders: Experiences from Midwest Nursing Research Society Leadership Academy. *Nursing Outlook*, *72*(6), 102293

Nurmeksela, A., Mikkonen, S., Kinnunen, & Kvist, T. (2021) Relationships between nurse managers' work activities, nurses' job satisfaction, patient satisfaction, and medication errors at the unit level: a correlational study. https://pmc.ncbi.nlm.nih.gov/articles/PMC8017674/

Nyikuri, M., Tsofa, B., Barasa, E., Okoth, P & Molyneux, S (2015) Crises and Resilience at the Frontline—Public Health Facility Managers under Devolution in a Sub-County on the Kenyan Coast. Retrieved from https://journals.plos.org/plosone/article

Nyumba, T. O., Wilson, K., Derrick, C. J & Mukherjee, N (2018) Focus Group Methodology: Insights from Two Decades of Application in Conservation. Retrieved from https://besjournals.onlinelibrary.wiley.com/

Nzinga, J., McGivern, G. & English. M. (2018) Examining clinical leadership in Kenyan public Hospitals through the Distributed Leadership lens. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6037084/.

Ocho, O. N., Wheeler, E., Rigby, J & Murphy, G.T (2021) Core competencies andchallenges amongnursestransitioning into positions of leadership– a Caribbean perspective. lable on Emerald Insight at: https://www.emerald.com/insight/1751-1879.htm

Ocho, O. N., Wheeler, E., Sheppard, C., Caesar-Greasley, L., Rigby, J & Murphy, G.T (2020) Nurses' preparation for transitioning into positions of leadership—A Caribbean perspective https://onlinelibrary.wiley.com/doi/full/10.1111/jonm.13089?c

Ortega, J., Hooshmand, M., Foronda, C., Padron, M., Simon, D., Waters, M., … Peragallo, M. N. (2018). Developing nurse leaders across the Americas: Evaluation of an online nursing leadership course. *Revista Panamericana Salud Publica*, 42, https://doi.org/10.26633/RPSP.2018.152

Oxford University Press. (2021). Theory noun. In Oxford Learner's Dictionaries. Retrieved October 15, 2021, from https://www.oxfordlearnersdictionaries.com/definition/english/theory

Paarima, Y., Kwashie, A.A., Asamani, J.A. and Ofei, A.M.A. (2021), "Leadership competencies of first-line nurse managers: a quantitative study", *Leadership in Health Services*, Vol. 35 No. 3, pp. 338-354.

Peel Region Evaluates Platform (2018) How do you analyze qualitative data? Retrieved from https://peelevaluates.ca/wp-content/

Petersen, K. Sweden, K & Gencel, C. (2013) Worldviews, Research Methods, and their Relationship to Validity in Empirical Software Engineering Research, Joint Conference of the 23rd International Workshop on Software Measurement and the 8th International Conference on Software Process and Product Measurement, Ankara, 2013, pp. 81-89. Retrieved from https://ieeexplore.ieee.org/document/6693226.

Pilat, M & Merriam, D H (2019) Exploring the Lived Experiences of Staff Nurses Transitioning to the Nurse Manager Role.The Journal of Nursing Administration, October 2019, Vol. 49, No. 10 pp. 509-513 Published by: Lippincott Williams & Wilkins URL: https://www.jstor.org/stable/10.2307/26832859

Prasad, M & Gracia, C (2017) How to Conduct a Successful Focus Group Discussion. Retrieved from https://humansofdata.atlan.com

Price, P.C., Chiang, R & Chiang, I, A (N.D) Research Methods in Psychology. Retrieved from https://opentextbc.ca/researchmethods/chapter/reliability-and-validity-of-measurement/.

Prentice, D., Boscart, V., McGilton, K. S., & Escrig, A. (2017). Factors influencing new RNs' supervisory performance in long-term care facilities. Canadian Journal on Aging/ La Revue Canadienne du Vieillissement, 36(4), 463-471.

Purabdollah, M., Zamanzadeh, V., Ghahramanian, A., & Lotfi, M. (2024). Competency gap among graduating nursing students: What they have achieved and what is expected of them. *BMC Medical Education*, *24*(1), 546. https://doi.org/10.1186/s12909-024-05532-w

Quek, G. J. H & Shorey, S. (2018). Perceptions, Experiences, and Needs of Nursing Preceptors and Their Preceptees on Preceptorship: An Integrative Review. J Prof Nurs. https://pubmed.ncbi.nlm.nih.gov/30243699/

Rahman, A. & Mabrouk, R. (2017). The Impact of First-line Nurse Managers Leadership Development Training. Retrieved from https://sigma.nursingrepository.org/handle/10755/622506.

Rahman, S (2017) The Advantages and Disadvantages of Using Qualitative and Quantitative Approaches and Methods in Language "Testing and Assessment" Research: A Literature Review. https://files.eric.ed.gov/fulltext/EJ1120221.pdf

Rahman, A & Muktadir, G (2021) SPSS: An Imperative Quantitative Data Analysis Tool for Social Science Research. International Journal of Research and Innovation in Social Science (IJRISS) |Volume V, Issue X, October 2021|ISSN 2454-6186 www.rsisinternational.org Page 300

Rees, C. E., Lee, S. L., Huang, E., Denniston, C., Edouard, V., Pope, K., ... & Palermo, C. (2020). Supervision training in healthcare: a realist synthesis. Advances in Health Sciences Education, 25(3), 523-561.

Richey, K. & Waite, S (2019) Leadership Development for Frontline Nurse Managers Promotes Innovation and Engagement. https://www.sciencedirect.com/science/article/abs/pii/S154146121830377

RoGGKenya (2019) Kenya's Health Structure and the Six Levels of Hospitals - RoGGKenya. Retrieved from https://www.actionfortransparency.org

Rohwer, A.., Schoonees, A & Young T (2014) Methods used and lessons learnt in conducting document reviews of medical and allied health curricula – a key step in curriculum evaluation. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4289170/

Rosser, E., Buckner, E., Avedissian, T., Cheung, D. S. K., Eviza, K., Hafsteinsdóttir, T. B., Hsu, M. Y., Kirshbaum, M. N., Lai, C., Ng, Y. C., Ramsbotham, J & Waweru, S (2020) The Global Leadership Mentoring Community: building capacity across seven global regions https://pubmed.ncbi.nlm.nih.gov/32869285/

Rosser, E. A., Edwards, S., Kwan, R. Y. C., Ito, M., Potter, D. R., Hodges, K. T & Buckner, E (2023) The Global Leadership Mentoring Community: An evaluation of its impact on nursing leadership. https://pubmed.ncbi.nlm.nih.gov/37401926/

Sacred Heart University Library, (No Date) *Organizing Academic Research Papers: The Research Problem/Question*. Retrieved from https://library.sacredheart.edu/c.php?g=29803&p=185918

Salvage, J. R.G.N., Hon, L. L. D., Hon. D.S. White, J. A.M (2019). Nursing and Health Policy Perspectives: everybody's business. *Nursing leadership and health policy*. https://doi.org/10.1111/inr.12523

Scammell, J. M. E., Apostolo, J. L. A., Bianchi, M., Costa, R. D. P., Jack, K., Luiking, M.-L., & Nilsson, S. (2020). Learning to lead: A scoping review of undergraduate nurse education. *Journal of Nursing Management, 28*(3), 756–765. https://doi.org/10.1111/jonm.12951

Seims, L.R.K., Alegre, J.C., Murei, L., Bragar, J., Thette, N., Kibunga, P & Cheburet, S (2012). Strengthening Management Practices to Increase Health Service Delivery in Kenya: An Evidence- Based Approach. Human Resources for Health 10:25.http://www.human.resources.health.com/content/10/1/25

Shorten, A & Smith, J (2017) Mixed methods research: expanding the evidence base. Evid Based Nurs July 2017 | volume 20 | number 3 | 10.1136/eb-2017-102699

Shukla, S (2020) Concept of Population and Sample. https://www.researchgate.net/publication/346426707_

Sigma Theta Tau International (2017). *The Global Advisory Panel on the Future of Nursing & Midwifery (GAPFON®) report*. Retrieved from http://www.nursinglibrary.org/vhl/handle/10755/621599

Södersved Källestedt, M.-L., Asp, M., Letterstål, A., & Widarsson, M. (2020). Perceptions of managers regarding prerequisites for the development of professional competence of newly graduated nurses: A qualitative study. *Journal of Clinical Nursing, 29*(23–24), 4784–4794. https://doi: 10.1111/jocn.15522

Stahl, N. A & King, J. R (2020) Expanding Approaches for Research: Understanding and Using Trustworthiness in Qualitative Research. *Journal of Developmental Education Volume 44, Issue 1 • FALL 2020* https://files.eric.ed.gov/fulltext/EJ1320570.pdf

Stewart, D., Catton, H., Acorn, M., Burton, E., Fokeladeh, H. S., Parish, C. & Williamson, L (2022) ICN–International Council of Nurses, 3, place Jean–Marteau, 1201 Geneva, Switzerland. ISBN: 978-92-95124-01-1 https://www.icn.ch/sites/default/files/inline-

Stretton, A. (2015) Management Staffing Function and Activities. Retrieved from https://pmworldlibrary.net/wp-content/uploads/.

Suza, S. D. E & Siregar, F. L.S (2020). Managerial Competencies among Nurse Managers at Universitas Sumatera Utara Hospital in Medan, Indonesia. DOI: 10.5220/0010101909290932

Thomas, R (2023). Unraveling Research Population and Sample: Understanding their Role in Statistical Inference. https://www.enago.com/academy/population-vs-sample/

Timsal, A., Awais, M. and Shoaib, O (2016) On job Training and Its Effectiveness: An Employee Perspective. https://www.researchgate.net/publication/305699923_On_job_Training_and_Its_Effectiveness_An_Employee_Perspective

Tombs, M., & Strange, H. (2024). Using qualitative questionnaires in medical education research. *Perspectives on Medical Education*, *13*(1), 280–287. https://doi.org/10.5334/pme.1102

Turan, H (2015) Taylor's "Scientific Management Principles": Contemporary Issues in Personnel Selection Period. Journal of Economics Business and Management 3(11) DOI:10.7763/JOEBM.2015.V3.342

Turner, P. (2019). Assessing Health Professionals for Succession and Leadership Roles. In: Leadership in Healthcare. Organizational Behaviour in Health Care. Palgrave Macmillan, Cham Retrieved from. https://link.springer.com/chapter/10.1007/978-3-030-04387-2_10#citeas

Tyrańska, M (2016) Managerial Competencies for Various Management Levels. Retrieved from https://www.researchgate.net/publication/316311940_Managerial_Competencies_for_Various_Management_Levels

UCLA Center for Health Policy Research (n.d) Key Informant Interviews. Retrieved from https://healthpolicy.ucla.edu/programs/health-data/trainings/Documents/tw_cba23.

Ullrich, D., Cope, V & Murray, M (2020) Common components of nurse manager development programmes: A literature review. https://onlinelibrary.wiley.com/doi/pdf/10.1111/jonm.13183

Uniproject Materials (2016) How to Calculate a Reliable Sample Size Using Taro Yamane Method. Retrieved from. https://uniprojectmaterials.com/view

Varkey, B. (2021). Principles of clinical ethics and their application to practice. *Medical Principles and Practice*, *30*(1), 17–28.

Vos, R. A (2017). "An Assessment and Analysis of the Complexity of the Frontline Nurse Leaders' Role" Doctoral Projects. 63. DOI: https://doi.org/10.31979/etd.mka5-fvq3 Retrieved from https://scholarworks.sjsu.edu/etd_doctoral/63

Walekhwa, N. M., & Suge, V. (2023). *Research methods: Essential tools and techniques* (pp. 91-104). Utafiti Foundation.

Wajdi. B.N & Nganjuk, M. U (2017) The differences between management and leadership Sinergi, Volume 7, Nomor 2 MARET 2017 https://www.researchgate.net/publication/318597967

Wanza, L & Mwakesi, F.M (2014) Factors Hindering Health Professionals from Achieving Hospital Goals at Moi Teaching and Referral Hospital, Kenya. Retrieved from https://pdfs.semanticscholar.org/c41f/e26064dc0d91b5c60832ac44fade2ceb80ba.pdf

Warshawsky, N. E., Caramanica, L & Cramer, E (2020) Organizational Support for Nurse Manager Role Transition and Onboarding: Strategies for Success *JONA: The Journal of Nursing Administration* 50(5):p 254-260, https://journals.lww.com/jonajournal

Whitby, P. (2018). Role of front-line nurse leadership in improving care. Retrieved from https://www.ncbi.nlm.nih.gov/pubmed/29856167.

Willie, M. M (2023). Distinguishing Between Population and Target Population: A Mini Review. Sur Res J. 2023;3 (2):1-2

Willie, M. M. (2022). Differentiating Between Population and Target Population in Research Studies. International Journal of Medical Science and Clinical Research Studies, 2(6), Article 14. https://doi.org/10.47191/ijmscrs/v2-i6-14 .

World Health Organization (2017) Primary Health Care Systems (PRIMASYS): Case Study From Kenya, a bridged version, Geneva. Retrieved from https://www.who.int.

World Health Organization. (2020a). *State of the world's nursing 2020: Investing in education, jobs and leadership*. https://www.who.int/publications/i/item/9789240003279

Wright S, O'Brien BC, Nimmon L, Law M, Mylopoulos M. Research Design Considerations. J Grad Med Educ. 2016 Feb;8(1):97-8. doi: 10.4300/JGME-D-15-00566.1. PMID: 26913111; PMCID: PMC4763399.https://pmc.ncbi.nlm.nih.gov/articles/PMC4763399/

Wu, X. V., Enskär, K., Pua, L, H., HengD. G.N & Wang (2017) Clinical nurse leaders' and academics' perspectives in clinical assessment of final-year nursing students: A qualitative study. *Nursing and Health Sciences (2017) 19, 287–293* https://doi.org/10.1111/nhs.12342

Younes, B. M., Adam, S. M & Abdrabu, H. M (2019) The Effect of Leadership Program on Leadership Practice among Nurse Managers, *International Journal of Novel Research in Healthcare and Nursing* Vol. 6, Issue 3, pp: (470-477), Month: September - December 2019, Available at: www.noveltyjournals.com

Zendrato, M. V., Hariyati, T. S & Afriani, T. (2019). Description of an effective manager in nursing: A systematic review. The Second International Nursing Scholar Congress. https://www.elsevier.es/es-revista-enfermeria-clinica-35-articulo-description-an-effective-manager-in-S1130862119301809.

Zeng, W., Musiega, A., Oyasi, J., Giorgio, L. D., Chuma, J., Lu, R & Ahn, H (2021) Understanding the performance of county health service delivery in Kenya: a mixed-method analysis. Health Policy and Planning, 37, 2022, 189–199 DOI: https://doi.org/10.1093/heapol/czab129

Zimano, F.R. and Chilunjika, A. (2019) 'Mixed methods in multi-level sampling: a research paradigms teaching and learning case to spur downstream innovation', Int. J. Innovation in Education, Vol. 5, No. 4, pp.323–339.

APPENDICES

APPENDIX I: INFORMED CONSENT FOR QUESTIONNAIRE FOR THE MID-LEVEL NURSE MANAGERS

Moi University, School of Medicine
Department of Medical Education
P.O. Box 4606 – 30100, Eldoret, Kenya

Dear Participant,
My name is Annah C. Towett. I am a student at Moi University, Eldoret, Kenya, pursuing a Doctor of Philosophy (PhD) in Medical Education. I am conducting a study on: **Training Adequacy and Leadership Preparedness of Nurse Managers in South Rift and South Nyanza, Kenya,** as a partial fulfillment of the requirements for the award of the degree.

This is a descriptive cross-sectional study involving the collection of data using questionnaires. The respondents will be **Mid-Level Nurse managers and Nursing Directors.** Considering your role as a Mid-Level nurse manager, you have been selected to participate in the study. This letter aims to request that you participate by responding to the questions in the questionnaire.

The purpose of this questionnaire is to assess your perceptions regarding leadership role preparedness for Mid-Level Nurse Managers. Kindly be assured that your views will be kept confidential, and upon completion of the study, the findings will be used for academic purposes and will also be made available to you. There are no identifiers in this questionnaire that can link you to your views, and the information will be coded, recorded in the computer protected with a password, and stored under lock and key that is known to the researcher only. Data obtained will be analyzed solely by the researcher. There are no direct or indirect benefits or risks involved in participating in this study. Although healthcare training experts may use findings from this study to inform the design of training programs, information from you will be treated with ultimate anonymity. Your participation in this study is entirely voluntary, and you are free to opt out or even withdraw your participation at any time.
If you agree to participate in this study, kindly sign this consent on the space provided.

Participant's Consent: The purpose of this study has been explained to me and I have understood. I voluntarily agree to participate in this study.

Participant's signature: …… Date: ……

Thank you for agreeing to participate in the study.
Sincerely

Annah C. Towett
PhD/ME/4248/20 Tel: +254769268882
E-mail: mrstowett@gmail.com; towettannah@yahoo.com

APPENDIX II: QUESTIONNAIRES FOR THE MID-LEVEL NURSE MANAGERS

Serial No._____

The purpose of this questionnaire is to seek information on perceptions on Mid-Level managers regarding leadership role preparedness in relation to professional education. The questionnaire consists of five sections and will take you approximately 20 to 30 minutes to complete:

- Section A- Demographic Data
- Section B- The Perception of Mid-Level Nurse Managers Regarding Leadership Role-Preparedness
- Section C- Determine adequacy of basic nursing training for preparing nurses for leadership roles
- Section D- The association between role-induction programs and leadership role preparation for mid-level nurse managers from the selected hospitals.
- Section E- Establish leadership training needs for mid-level nurse managers from the selected hospitals.

SECTION A- Demographic Data

Please respond to all items in this form by circling the correct answer or filling in the space provided

1. Age in years _____
2. Gender
    a) Male [ ] Female [ ]
3. Highest Professional Qualification
    a) Diploma in Nursing

b) Higher Diploma in Nursing

c) Bachelor's Degree in Nursing

4. The college you graduated from

a) Public KMTC [ ] b) Faith Based College [ ] c) Other [ ]

5. Current position held

a) Mid-Level Nurse Manager

b) Front-Line Nurse Manager

6. Please indicate your current place of work from the list below.

a) Longisa County Referral Hospital
b) Kaplong Mission Hospital
c) Kapkatet Hospital
d) Litein Mission Hospital
e) Kerciho County Referral Hospital,
f) Narok County Referral Hospital,
g) Nyamira County Referral Hospital
h) Kisii Teaching & Referral Hospital

7. For how long have you been working in the current institution?

a) 1-5 yrs
b) 6 -10
c) 11 -15
d) 16 – 20
e) 21 – 25
f) 26 – 30
g) 31 and above

8. List the institution you have worked in before moving to your current institution

_____

_____

_____

9. For how long have you been working in the current leadership role?

a) 1-5 yrs
b) 6 -10
c) 11 -15
d) 16 and above

10. Please describe your understanding of what is involved in your role._____

SECTION B- Structured questionnaire to evaluate the perception of Mid-Level nurse managers regarding leadership role-preparedness

11. List other leadership roles you have been involved in before your current position and indicate the duration for each.

_____
_____
_____

12. Please describe your entry or appointment process into your leadership role.

_____
_____
_____

13. Indicate the level of agreement for each of the following statements (tick in the appropriate boxes) regarding role-preparedness to execute management functions

Key: Scale

SA – Strongly Agree 5

A- Agree 4

UD – Undecided 3

D- Disagree 2

SD- Strongly Disagree 1

	Attribute	**SA**	**A**	**UD**	**D**	**SD**
		5	4	3	2	1
a	I am adequately prepared to execute the Planning function of management					
b	I am adequately prepared to execute the Organizing function of management					
c	I am adequately prepared to execute the Staffing function of management					

d	I am adequately prepared to execute the Controlling function of management
e	I am adequately prepared to execute the Coordinating function of management
f	I am adequately prepared to execute the Budgeting function of management

14. On a scale of 1 -5, how would you rate your preparedness for the current leadership role?

a) 1
b) 2
c) 3
d) 4
e) 5

15. What are the challenges you face in your current leadership role?

_____
_____

- **SECTION: Determine adequacy of basic nursing training for preparing nurses for leadership roles**

16. Indicate the level of agreement for each of the following statements (tick in the appropriate boxes) regarding leadership role preparedness in relation to basic nursing training.

Key: Scale

SA – Strongly Agree 5

B- Agree 4

UD – Undecided 3

D- Disagree 2

SD- Strongly Disagree 1

	Attribute	SA	A	UD	D	SD
		5	4	3	2	1
A	The course content for the Diploma Registered level nurse adequately prepare nurses for leadership role					
B	The course content for the Higher Diploma Registered level nurse adequately prepare nurses for leadership role					
C	The course content for the Bachelors' Degree level nurse adequately prepare nurses for leadership role					
D	Overall, basic nursing training adequately prepares nurses for leadership roles					
E	For a nurse manager to function effectively in the leadership role, there is a need for an additional leadership course in addition to the basic nursing training					

17. To what extent do you think your basic nursing professional education prepared you for your leadership role? Please select the best response as: **Satisfied, Somewhat satisfied, and Dissatisfied**.

    a) Satisfied

    b) Somewhat satisfied

    c) Dissatisfied

18. Based on your answer for No 8 above, please give your reasons in the space provided below

_____
_____
_____

SECTION D. Ascertain nurse managers' perceptions of the association between role-induction programs and mid-level nurse managers' leadership role preparedness**.**

19. Please list other role preparation programs for role preparation that you have and indicate which ones you have benefited from.

_____
_____
_____
___

20. Indicate the level of agreement for each of the following statements (tick in the appropriate boxes) regarding role-induction programs.

Key: Scale
SA – Strongly Agree 5
C- Agree 4
UD – Undecided 3
D- Disagree 2
SD- Strongly Disagree 1

	Attribute	SA	A	UD	D	SD
		5	4	3	2	1
A	Formal leadership training contributes significantly to leadership role development					
B	On-job training contributes significantly to leadership role development					
C	Mentorship contributes significantly to leadership role development					
D	Preceptorship contributes significantly to leadership role development					
E	Supportive supervision contributes significantly to leadership role development					

SECTION E- Establish training needs for mid-level nurse managers from the selected hospitals.

21. Please provide your suggestions on the training needs areas for Mid-Level nurse managers in the space provided below:

_____
_____
_____

Thank you for your time and participation in completing this questionnaire
Annah C. Towett - Researcher

APPENDIX III: INFORMED CONSENT FOR KEY INFORMANT INTERVIEW (KII) FOR THE NURSING DIRECTORS

Moi University, School of Medicine
Department of Medical Education
P.O. Box 4606 – 30100, Eldoret, Kenya

Dear Participant,
My name is Annah C. Towett. I am a student at Moi University, Eldoret, Kenya, pursuing a Doctor of Philosophy (PhD) in Medical Education. I am conducting a study on: **Training Adequacy and Leadership Preparedness of Nurse Managers in South Rift and South Nyanza, Kenya,** as a partial fulfillment of the requirements for the award of the degree.

This is a descriptive cross-sectional study involving the collection of data using questionnaires. The respondents will be **Mid-Level Nurse managers and Nursing Directors.** Considering your role as a Nursing Director, you have been selected to participate in the study. This letter aims to request that you participate by responding to the questions presented to you by the interviewer.

The purpose of this KII is to assess your perceptions regarding the leadership role preparedness of Mid-Level Nurse Managers who are under your supervision. Kindly be assured that your views will be kept confidential, and upon completion of the study, the findings will be used for academic purposes and will also be made available to you. There are no identifiers in this questionnaire that can link you to your views, and the information will be coded, recorded in the computer protected with a password, and stored under lock and key that is known to the researcher only. Data obtained will be analyzed solely by the researcher. There are no direct or indirect benefits or risks involved in participating in this study. Although healthcare training experts may use findings from this study to inform the design of training programs, information from you will be treated with ultimate anonymity. Your participation in this study is entirely voluntary, and you are free to opt out or even withdraw your participation at any time.
If you agree to participate in this study, kindly sign this consent on the space provided.

Participant's Consent: The purpose of this study has been explained to me and I have understood. I voluntarily agree to participate in this study.

Participant's signature: …… Date: ……

Thank you for agreeing to participate in the study.
Sincerely

Annah C. Towett
PhD/ME/4248/20 Tel: +254769268882
E-mail: mrstowett@gmail.com; towettannah@yahoo.com

APPENDIX IV: KEY INFORMANT INTERVIEW SCHEDULE FOR NURSING DIRECTORS

Serial No._____

Interview Guide: Questions for Nursing Directors

1. Institution
    a) Longisa County Referral Hospital[ ]
    b) Kaplong Mission Hospital [ ]
    c) Kapkatet Hospital [ ]
    d) Litein Mission Hospital [ ]
2. For how long have you been working in the current institution?
    a) 1-5 yrs
    b) 6 -10
    c) 11 -15
    d) 16 and above
3. List the institution you have worked in before moving to your current institution

    _____
    _____

4. Please describe your understanding of what is involved in the role of MLNM under your leadership.

    _____
    _____

5. Describe the appointment processes for the leadership role for MLNM under your leadership.

    _____
    _____

6. Please describe the modalities used at your organization to prepare MLNM for their leadership roles?

_____
_____

7. From your perspective, to what extent do you think nursing professional education prepares MLNM for their leadership role? **Satisfied, Somewhat satisfied, and Dissatisfied**.
    a) Satisfied,
    b) Somewhat satisfied
    c) Dissatisfied
8. Based on your answer for No 8 above, please give your reasons in the space provided below

    _____
    _____
9. Please explain your involvement in preparing Mid-Level Nurse managers for their roles

    _____
    _____

10. On a scale of 1 -5, how would you rate the level of leadership role preparedness among the Mid-Level managers in your institution for their current leadership role?
    a) 1
    b) 2
    c) 3
    d) 4
    e) 5

11. What are the challenges encountered by the MLNMs in your institution regarding their current leadership role?

    _____
    _____

12. Given the opportunity, what would be your suggestions for improving leadership role preparedness among the MLNM?

    _____
    _____

Thank you for your time during this interview

Annah C. Towett - Researcher

APPENDIX V: INFORMED CONSENT FOR FOCUS GROUP DISCUSSION (FGD)

Moi University, School of Medicine
Department of Medical Education
P.O. Box 4606 – 30100, Eldoret, Kenya

Dear Participant,
My name is Annah C. Towett. I am a student at Moi University, Eldoret, Kenya, pursuing a Doctor of Philosophy (PhD) in Medical Education. I am conducting a study on: **Training Adequacy and Leadership Preparedness of Nurse Managers in South Rift and South Nyanza, Kenya,** as a partial fulfillment of the requirements for the award of the degree.

This is a descriptive cross-sectional study involving the collection of data using FGDs. The respondents will be **Mid-Level Nurse managers and Nursing Directors.** Considering your role as Mid-Level nurse managers, you have been selected to participate in the FGD. This letter aims to request that you participate by contributing to the discussions to provide in-depth information that may not have been captured in the questionnaires.

The purpose of this FGD is to assess your perceptions regarding leadership role preparedness for Mid-Level Nurse Managers. Kindly be assured that your views will be kept confidential, and upon completion of the study, the findings will be used for academic purposes and will also be made available to you. There are no identifiers in this questionnaire that can link you to your views, and the information will be coded, recorded in the computer protected with a password, and stored under lock and key that is known to the researcher only. Data obtained will be analyzed solely by the researcher. There are no direct or indirect benefits or risks involved in participating in this study. Although healthcare training experts may use findings from this study to inform the design of training programs, information from you will be treated with ultimate anonymity. Your participation in this study is entirely voluntary, and you are free to opt out or even withdraw your participation at any time.

If you agree to participate in this study, kindly sign this consent on the space provided.

Participant's Consent: The purpose of this study has been explained to me and I have understood. I voluntarily agree to participate in this study.

Participant's signature: …… Date: ……

Thank you for agreeing to participate in the study.
Sincerely

Annah C. Towett
PhD/ME/4248/20 Tel: +254769268882
E-mail: mrstowett@gmail.com; towettannah@yahoo.com

APPENDIX VI: FOCUS GROUP DISCUSSION (FGD) GUIDE

Serial No._____

Interview guide: Guiding questions for Mid-Level Nurse Managers

1. **Institution**

	Hospital	√
1.	Longisa County Referral	
2.	Kaplong Mission Hospital	
3.	Kapkatet Hospital	
4	Litein Mission Hospital	
5	Kericho County Referral Hospital	
6	Narok County Referral Hospital	
7	Nyamira County Referral Hospital	
8	Kisii Teaching and Referral Hospital	

2. From your understanding, what constitutes leadership role preparedness for MLNMs

3. Are there formal leadership role preparedness programs in place in your institution? Yes / No

   Please explain your answer above.

4. Describe the process of appointment into a leadership role in your institution.

5. What are your views regarding the extent to which your basic nursing training prepared you for the MLNM's leadership role?

6. Which other forms of leadership role preparation are in place at your institution?

7. In your opinion, what do you consider as factors that enhance leadership role preparedness for MLNM?

8. What challenges are encountered by the MLNMs in their leadership role?

9. Please provide your suggestions on how leadership role preparation can be better managed in individual institutions and in Kenya.

APPENDIX VII: DOCUMENT REVIEW CHECKLIST FOR CURRICULUM REVIEW

Serial No._____

This checklist will be used to review the course content of the basic diploma nursing training curriculum, with a focus on the leadership and management section

1. College category [a] Public KMTC [b] Faith-Based college

2. Is it a common curriculum for all the nursing training programs in all public KMTs? Yes [ ] No [ ]
3. Is it a common curriculum for all the nursing training programs in all faith-based colleges? Yes [ ] No [ ]
4. Is there a Leadership and Management Course in the curriculum? Yes [ ] No [ ]
5. Course Objectives are based on essential competencies, attitudes, and knowledge for each Yes [ ] No [ ]
6. Written instructional strategy Yes [ ] No [ ]

7. Leadership course content of the curriculum

	Attribute	Percentage
1	Knowledge	
2	Skills	
3	Attitudes	
4	Values	
	Total	

8. Learning process (List all the opportunities provided)

Attribute	Types	Percentage
Learning experiences	Classroom	
	Educational visits	
	Library	
	Clinical rotations	
Pedagogy (How learning is delivered)	Lectures	
	Practical demonstration	
	Assignments	
	Self-directed learning	
	Group work	
	others	

9. Assessment of Learning

	Attribute	Percentage
1	Knowledge	
2	Skills	
3	Attitude	
4	Practical	

5 Oral
6 Others

10. a) Which year was the last review of the curriculum done?_____
b) What changes were incorporated----------
--------- ----------

---
c) What process was followed in the review----------

---
d) Evidence of the process

APPENDIX VIII: APPROVAL FROM THE INSTITUTIONAL RESEARCH AND ETHICS COMMITTEE

INSTITUTIONAL RESEARCH AND ETHICS COMMITTEE (IREC)

MOI TEACHING AND REFERRAL HOSPITAL
P.O. BOX 3
ELDORET
Tel: 33471//2/3

MOI UNIVERSITY
COLLEGE OF HEALTH SCIENCES
P.O. BOX 4606
ELDORET
Tel: 33471/2/3

Reference: IREC/2020/104
Approval Number: 0003903
10th June, 2021

Annah Chebet Towett,
Moi University,
School of Medicine,
P.O. Box 4606-30100,
ELDORET- KENYA.

Dear Ms. Towett,

PERSPECTIVES OF MID-LEVEL NURSE MANAGERS' LEADERSHIP ROLE-PREPAREDNESS IN RELATION TO PROFESSIONAL EDUCATION IN SELECTED HOSPITALS IN BOMET, KERICHO, NAROK, KISII AND NYAMIRA COUNTIES, KENYA

This is to inform you that ***MTRH/MU-IREC*** has reviewed and approved your above research proposal. Your application approval number is ***FAN: 0003903.*** The approval period is **10th June, *2021- 9th June, 2022.***
This approval is subject to compliance with the following requirements;

i. Only approved documents including (informed consents, study instruments, Material Transfer Agreements (MTA) will be used.
ii. All changes including (amendments, deviations, and violations) are submitted for review and approval by ***MTRH/MU-IREC***.
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 ***MTRH/MU-IREC*** 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 ***MTRH/MU-IREC*** within 72 hours.
v. Clearance for export of biological specimens must be obtained from ***MOH at the recommendation of NACOSTI*** for each batch of shipment.
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 ***MTRH/ MU-IREC.***

Prior to commencing your study; you will be required to obtain a research license from the National Commission for Science, Technology and Innovation (NACOSTI) https://oris.nacosti.go.ke and other relevant clearances from study sites including a written approval from the CEO-MTRH which is mandatory for studies to be undertaken within the jurisdiction of Moi Teaching & Referral Hospital (MTRH) and its satellites sites.

INSTITUTIONAL RESEARCH & ETHICS COMMITTEE
10 JUN 2021
APPROVED
P. O. Box 4606 - 30100 ELDORET

Sincerely,

PROF. E. WERE
CHAIRMAN
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Prof. Anne Syomwene Kisilu
CERM-ESA Project Leader Date: 04/06/2025