CHAPTER - II

REVIEW OF LITERATURE

Extensive search was done on the selected topic. Literature relevant to the present study has not been documented in a large scale. However an attempt is made in this chapter to present the available literature related to the study under the following headings:

- Quality care
- Pentagonal roles of nurses (PELCE)
- Performance appraisal
- Perception of nurses performance by health professionals

QUALITY CARE

India is one of the countries that can boast of having records of early nursing practices. In fact even in ancient times when diseases were shrouded in myths, it has been found that nursing did exist in a primitive form. From 1500 BC to the current day, a tortuous path of progress, regress, change and progress has been indelibly etched into the history of our notable profession.\textsuperscript{11}

\textbf{Watson R} et al., (2003) has described that the type of nurse required today is one who possesses an all round personality, the requisite general education, professional education and a degree of maturity to work in the community.\textsuperscript{24}
Quality management, quality assurance, total quality management and continuous quality management are all terms related to the same, improving upon what you do everyday. Quality assurance refers to the mechanism used for determining, effecting and evaluating quality of care\textsuperscript{24}.

**Frame of reference for quality assurance**

One of the first steps in the development of quality assurance in nursing program is to *clarify the values and attitudes of professional health groups and the public about nursing*. Is the quality of nursing care to be viewed as minimal, optimal, moderate or acceptable? What level of nursing care is the public willing to accept and pay for? Does the professionals and public accept the role of nurses in accordance with the Nurses Act?\textsuperscript{25}

**Lang N** (1976) in his study on quality care stated that most professional nurses today recognize that the major sources of values are societal, professional and scientific. As society and its values change, the nature of quality changes. He also stated in quality assurance model that the philosophy, objectives and methodology of quality assurance for nursing care will be influenced by the values and attitudes of nurses toward their right and responsibility for the systematic quality appraisal of nursing practices and services. In the development of a model for quality assurance in nursing, the component of quality assurance must be understood and agreed on by the planners and users of the methodology\textsuperscript{25}.
Donabedian and Block (1989) have outlined and defined 3 major approaches or criteria for assuring the quality of care: a structure, process and outcome. Each of these criteria measures a different aspect of patient care. Donabedian associated the concept of quality with a process of evaluation, defining the quality of care as the conformity between actual care and preset criteria.  

In structure assessment, it would be checked whether the working systems and organization lead to qualitatively desirable results. This is called structure assessment or evaluation. In addition, a process assessment or process evaluation may be carried out focusing on performance and procedures. Therefore process standards and criteria will have to be developed. Finally, evaluation might be outcome oriented. This requires the use of outcome standards and criteria to indicate the result that should eventually be achieved.

Springer (1998) revealed that health care organizations are going through tremendous changes. The performance appraisal process is a vehicle that can effectively keep employers focused. In addition to keep the organizations expectations clear to employers, a strong appraisal process can be used to measure, track and improve overall performance and quality care.
Perkins (1997) in his study of peak performance identified that quality of care within an organization and efficiency of the organization are reflected by the performance of all employees. Providing employers with clear and measurable expectations is essential in obtaining high performance. A good performance appraisal process can unify the organization so that it can achieve its mission.28

Lehmann D (1995) who studied on measuring performance identified that people want to know how they are doing in their jobs. That is human nature. Nurses must know what is expected of them to meet the expectations of the organization.29

The essence of continuous quality development is that quality goals are set based on both patients and communities wishes and expectations. This should be a dynamic and progressive process that identifies and uses the best healthcare outcomes to achieve high quality healthcare.

Quality Assessment

Standards and criteria are used to give an indication of desired quality against which the criteria can be used to measure actual quality. The measurement takes place by comparing what is desirable against what is actually taking place. However, evaluation is generally a more comprehensive study concerned with determining the extent to which a planned intervention achieves predetermined objectives in a systematic and scientific manner.30
Quality Assurance and Improvement

The results of the assessment can be used in two ways. Firstly, things which can be regarded as satisfactory may be accepted and maintained. This presupposes that it was quality which was defined in the first place. This is called quality assurance. For things which turn out to be unsatisfactory, an attempt to improve should be made. This is quality improvement. Quality assessment should never be carried out as an end in itself. It cannot be isolated from quality assurance. In addition, the assessment and subsequent corrective action need to be undertaken at regular intervals to ensure that systematic quality assurance is being carried out and maintained. As quality systems have developed within health care, the complex, dynamic nature of quality and its measurement, coupled with inability to guarantee a degree of excellence have led us to talk much more about quality improvement systems and less about quality assurance systems. Some would go so far as to say that assurance is impossible and improvement is a more realistic and accurate description of what actually takes place within health care. The American Health insurers, Blue Cross and Blue Shield of Chicago (1954) proposed that quality in relation to health care should possess five characteristics it should be available, acceptable, comprehensive, continuous and documented.
Donabedian (1970) associated the concept of quality with a process of evaluation, defining the quality of care as the conformity between actual care and preset criteria. Donabedian (1966) proposed the dimensions of QC in three components.  

Fig. 1.a: Dimensions of Quality Cycle (Donabedian’s)

- **Technical Performance**
  - Attributes
    - Effectiveness
    - Expertise
    - Capability
    - Safety
    - Carefulness
    - Indicators of care & cure

- **Interpersonal Care/Professional Attitudes**
  - Attributes
    - Respect for persons
    - Confidentiality
    - Providing adequate information
    - Establishing relationships
    - Personal interest
    - Client autonomy
    - Equality

- **Organization Aspects**
  - Attributes
    - Organizational aspects of the environment e.g.
      - Safety
      - Comfort
      - Equipment
      - Continuity
      - Efficiency
Quality Assurance in Health Care

Many activities assess or regulate the quality of care but unless they include effort to improve quality when necessary, they are not quality assurance activities. At its simplest, quality assurance is about describing, measuring and taking action (three distinct phases).

Williamsons (1982) defined quality assurance as the measurement of the actual level of the service provided plus the effort to modify when necessary.

Bendikter H (1975) stated that health care professionals have gained experience in the process of monitoring and evaluation. Several consistent premises can be identified as differentiating successful from unsuccessful approaches. Success in this instance, is determined by the yielding of useful result that lead to improvements in care and practice.
Quality assurance carries with it a commitment to respond positively to results obtained from an evaluation or assessment. When roles of nursing practice are specified, only then actual performance can be measured. Those aspects of nursing practice which do not meet the criteria need to be improved.

A structured and systematic method of quality improvement can only be achieved when assessment is carried out at regular intervals and is an integral part of professional practice.

The Role and Function of the Nurse in Quality Care

Wilson (1987) suggested that today’s view of quality incorporates knowledge, skills and behaviors of practitioners, as well as use of patient, physician and payer’s measures of quality. When defining quality nursing care, it is important to take account of the underlying values and beliefs of nurses and the way they organize nursing care.33

Historically, it has been extremely difficult to define the role and function of the professional nurse, with a certain amount of confusion and a lack of clarity surrounding the role. Furthermore, “good” nursing has often been invisible and only conspicuous by its absence.34

Describing this intangible nature of nursing, Benner (1984) stated that the knowledge embedded in actual nursing practice has gone “uncharted and unstudied”. The failure of systematically examining such practices closely has deprived nursing theory of the uniqueness and richness of the knowledge embedded in expert clinical practice.35
A study undertaken by the University of York (Car Hill et al., 1992) set out to examine the links between inputs into the process of nursing in particular the skill *mix of nursing staff* and the outputs of nursing in terms of the quality and outcome of care. The results indicated that in general, grade mix had an effect on the quality of care. Quality of care was better with higher grade (and skill) of the nurses who provided it, but the variation in the quality of care between the different grades of staff was reduced when higher graded staff worked in combination with lower grade staff. The implementation of quality assurance programmes can contribute significantly to professional development\(^3\).

American nurses Association stated that Nurses involved in quality assurance are required to

(a) Conduct *insightful assessment* of these areas of practice while researching and writing a scope of care.

(b) *Demonstrate accountability* as the determined aspects of patient care that are essential to their areas of expertise.

(c) *Apply basic research techniques* as data gathering strategies are designed and conducted.

(d) *Communicate* with peers and colleagues in her disciplines, as the results of an assurance activity are analyzed and reported throughout the organization.
Accountability in nursing practice must be able to depend on accountability in management, thus that the importance of maintaining and improving standard on making the best use of ward resources.  

Donabedian has stated in his Encyclopedia of Nursing Care Quality, that it is now a well established fact that nursing is by far the largest item in a hospital budget and that this one item alone accounts for over one third of health boards/authorities revenue expenditure, and consumes 3% of all public expenditure. In the light of this, it is imperative that there is effective and efficient use of such resources.

Brooks (1990) suggests that quality is a moving target-a process of continuous improvement, and continues to suggest, pessimistically, that quality is a prize to be coveted if only ever to be imperfectly achieved.

WHO (1993) defined quality assurance as making sure that the service provided by the hospital are the best possible, with given existing resources and current medical knowledge.

Sanazora (1980) said quality assurance is a systematic effort to maintain satisfactory performance or improve nursing care and its results.

Quality assurance in health care is often taken to be an innovation of the late twentieth century but its gestation has a much longer history. In the nineteenth century, the concept of quality nursing was first introduced by Florence Nightingale.
Fooks et al. (1990) describes the standards of nursing care as standards implicit or explicit. Explicit standards are defined as specific criteria for care. It gives a list of activities. Implicit standards are defined as “usual and customary practice”. Assessors recognize good care when it concurs with their own clinical knowledge. Implicit standards can also be understood as general checklist of items. Ideally, standards should be written and explicit. This allows both the data collection process and the assessment of care to be based on clearly delineated, agreed upon benchmarks rather than relying on the discretion of assessors. In such instances there is less room for disagreement over whether a practitioner or a professional as a whole has met the criteria established.  

Quality Assurance in India

The concept of quality in nursing practice is not new in India. However the amount of stress in this area is negligible. Though standardization in nursing education is note-worthy, there is no significant initiation or progress in provision of standards in nursing care process. Various committees and commissions were set up to look into health care delivery system. Though these committees have dealt with the issues of training, shortage of man-power, creation of more posts, filling up of vacancies, improvement of service conditions, none have listed or highlighted the importance of improving the standards of nursing care. The licensing bodies, the Indian Nursing Council and the State Registration
Councils are registering the educational institutions and practitioners and this helps to some extent the standardization of nursing education, examination and qualification.\textsuperscript{11}

The senior professionals in India have identified that nursing standards are not good and nurses’ roles are not clearly defined and identified. Many of the consumers opine that nurses’ role is mainly restricted to administration of drugs, treatment, bed making, recording and assisting the physician etc. This is perhaps because consumers rarely come in contact with professionals in nursing.\textsuperscript{11}

\textbf{Nandraj Sunil} et al., (1994) explored in their studies that health care utilization in general showed that around 60\%-70\% of health care contacts are made in the private sector. In India except for a few well equipped city based hospitals, almost all the private nursing homes are manned by unqualified persons who are designated as nurses. Non availability of qualified nurses and financial constraints in private hospitals are responsible for recruitment of unqualified and under qualified staff.\textsuperscript{41}

\textbf{PENTAGONAL ROLES OF NURSES}

Nurses’ roles and administrative responsibilities have multiplied over the past 20 years. Although nurses started doing numerous clinical researches, little empirical data exist related to specific roles of nurses. To be an ideal and effective nurse the following qualities are required.
Clinical skills.
Teaching skills
Leadership qualities
Communication abilities
Evaluation skills

Based on these skills, the following roles are very essential to strengthen the professional practice: Practitioner, Educator, Leader, Communicator and Evaluator. These pentagonal roles complement one another and strengthen the registered nurse as a professional. A nurse who possesses all these five qualities in the right proportions and use them in her job, is an asset to the profession and to society. The absence of any one of these five qualities will weaken the nurse as a key figure in hospital administration.

The linkages between the five qualities are:
A nurse who has all these five qualities and who can integrate and internalize them into her personality will make meaningful contribution not only to individual patient care but also to the nursing profession and to the improvement of quality care. The nurse is not just a leader, neither just a clinical nurse. She is a combination of the five.42

A nurse of a unit without practitioner skills will be ineffective. If she has good performance skills, she will be able to provide direct care in emergency or make the right decisions about patient care.42

A nurse with communicative and teaching abilities has more power. She will be able to co-ordinate, disseminate information with regard to preventive, promotive and curative aspects. A nurse with leadership qualities will be popular in the ward. She will be able to take the staff along with her. A nurse with communication skills will be relevant as an efficient nurse. She will be able to guide and supervise nursing care provided to patients. A nurse who evaluates properly and rightly is able to guide and supervise others in an effective manner. Thus the roles of nurse are broadly categorized into the following:42

* Those connected directly with patient care and treatment as *practitioners*.

* Those dealing with organizing, guiding, delegating work and supervising in the ward dealing directly or indirectly with patient care as *leaders*.
Those dealing with teaching, making patients to understand their illnesses and preventive, promotive, curative and rehabilitative aspects as educator.

Those dealing with and interpersonal relationship with patients, patients relatives and public as communicator.

Those dealing with appraisal of performance, evaluating patient care as evaluator.

The nurses who do not possess any one of these qualities will be exploited. When she is called on to provide direct nursing care, she will not be able to guide and lead her staff. When the nurse perceives and performs all these roles in right amount, she will have more power and autonomy.42

Brooks (1990) stated that continuous non judgmental observation of self can bring us to new levels of excellence and personal effectiveness. “Holding up a mirror” helps us to focus not only on our competence and strengths but also on how we can get approaches to improve performances.43

The American Organization of Nurse Executives (AONE) outlined changes in the evolving role of the registered nurse and the evolving nurse executive practice in statements designed to clarify the role changes occurring in nursing. These statements identified new competencies under four main categories; clinical processes, leadership, continuous improvement and critical thinking.44
The Institute of Medicine’s comprehensive report (1997) on nursing staff in hospitals and long term care stressed that skill; knowledge and educational background of nurses have to undergo considerable changes to meet the changing roles in nursing. The report indicated that several changes will influence the nurses’ role in the near future. The report outlined the following four changes: (1) increasing need for interdisciplinary teamwork (2) Greater intensity of management care with emphasis on outcome research. (3) Changing care delivery models, with nurses taking leadership roles in design and implementation. (4) Expanded and different roles for advanced practice\textsuperscript{45}.

Barter M et al. (1994) said in their report that increased use of unlicensed assistive personnel has also altered the role of the nurse in giving direct care\textsuperscript{46}.

Barnsteiner JH (1996) suggested that while there will be variation among hospitals, a critical skill set for professional nursing practice includes; the application of clinical knowledge and judgment; care coordination; competent communication; and both change management and leadership skills. A spirit of inquiry and critical thinking are important qualities for professional nursing practice as well. Contemporary professional practice also requires a focus on nursing sensitive outcomes\textsuperscript{47}.
Keene et al. (1987) used the care instrument to identify what behavior cancer nurses perceived as most important in making patients feel cared. Nurses ranked as the most important items “knows when to call the doctor” “gives good physical care” and “puts the patient first no matter what else happens”. According to the results of these studies, perceptions of caring appear to be influenced by the setting.48

Srilatha S (1998) explained that the importance of articulating professional responsibility and the professional expertise required in the planning and delivery of care of the highest quality have never been more evident. Nursing profession is badly in need of standards in various aspects of care especially in Indian context. The consumer protection act and other consumer organizations are demanding quality services. They need to be informed what to expect from a qualified nurse and who is a qualified nurse. The responsibility for maintaining professional standards should not be left to professional committees alone but every professional should feel it is her duty to lift her profession to heights by co-operation and valuable contributions.49

Krejci JW (1997) in his study identified which roles were present in their setting. Participants were asked to identify roles for which no changes were planned over the next 3 years. Categories of roles included assistive personnel, managers, administrators, coordinators and case managers.
Almost all the participants enquired whether they currently employed the roles identified. Many indicated that they did not know whether changes were planned or they simply did not answer the questions related to planned changes. On an average, approximately 25% of the sample consistently noted that no changes were planned in the roles listed in the survey.  

Erlen (1997) explored the changing roles and recommendation for graduate preparation for nurses in health care. It is a crucial time for nurse administrators to increase their clarity of focus on the essence of nurses unique contribution to health care across the different roles.  

Donnelly GF (2003) said that leadership role is crucial to the nursing profession because of the unprecedented changes in the health care and the demand on nurses to improve care delivery.  

Perception and cognition undoubtedly shape our views of roles. What follows is an exploration of familiar myths, early models, modern theories and research findings on how leadership works and how such information may be practically applied in the leadership role.

May (1990) asserted that although nurse-patient relationship are viewed as important by nurses, the evidence showed that verbal interaction is often poor, with nurses creating tactics that give the conversational control, responding negatively to patient cues, spending little time with
patients. The unsatisfactory nature of nurse-patient interaction is possibly due to the perception that being “incharge” of the ward has more status than interacting with the patient.\textsuperscript{53}

\textbf{Stevens} (1981) revealed that it is vital for the nurse executives to critically examine her role conception and her role performance. She should take activities in regard to her role making, it should be rather than merely filling the role as others expect or anticipate.\textsuperscript{54}

\textbf{Morrison et al.} (1997) in the explorative study on the relation between leadership style and empowerment on job satisfaction of nurses concluded that both transformational and transactional leadership were positively related to job satisfaction as an empowerment.\textsuperscript{55}

\textbf{Bryans} (1985) points out in her study that nurse managers should be satisfied that everything needed is available and well maintained for professional care by non nursing personnel. They should be responsible for delivery and provision of goods, materials and equipment including bedding, linen, clothing, stationery, furniture, and the equipment needed for patient care and treatment of patients.\textsuperscript{56}

\textbf{Doron DJ et al.} (2002) investigated the propositions depicted in the nursing role effectiveness model in which nurse and patient structural variable were expected to influence nurses role performance, which, in turn was expected to affect patient outcome achievement. A model was
developed that describing nursing practice in relation to the roles nurses assume in health care. The independent and interdependent outcomes were assessed. The three role performance variably was associated with patients’ self-care ability at hospital discharge. Nurses’ independent role performance associated with better function status. The nursing role effectiveness model provides a well defined conceptual frame- work to guide the evaluation of outcomes of nursing care.57

Hall (1998) explained that managing patients care directly and managing a group of care providers require two different skill sets. Managing a group of care providers involves delegating patient care activities to be performed by an individual consistent within his or her license or scope of practice and the provision of guidance, evaluation, and follow up.58

The American organization of nurse executives (AONE) (1996) described the role of the nurse as evolving and professional practice as containing a unique constellation of value-based processes that assist patients in their response to illness.59

Kanter (1977) suggested that giving staff members’ opportunities to assume new roles encourages feeling of achievement and increase motivation to further expand their skill mixes.60
Laschinger et al. (1994) did empirical testing of the Kanter’s model of organizational empowerment. The results of this study have provided beginning understanding of how nurses and managers perceive access to power and job opportunity in their jobs. The results also establish a link between perceived empowerment and increased work effectiveness in various roles.\textsuperscript{61}

The newly developed meridian system has described nursing philosophy as a foundation for identifying roles and responsibilities of the RN in system. The philosophy states that each nurse has the personnel responsibility to deliver high quality patient care which is founded upon established nursing standards and practice, emphasizing education, leadership practice skills and leadership qualities.\textsuperscript{6}

Ukande (1999) explained that nursing leadership role start at the student-nurse level itself but the graduate needs to develop and refine these skills through her career and constantly improve them.\textsuperscript{62}

Jones (1955) found that staff nurse in patient care units with high level of patient care satisfaction described that the nurse managers of these units having significantly higher transformational leadership behaviors than did employees working on units that had low patient care.\textsuperscript{63}
A study was conducted by Morrison and Fuller (1997) at Regional Medical centre, Alabama, to find out the relationship between leadership styles and its effects on job satisfaction among nursing staff concluded that transformational leadership appears to have a powerful influence of job satisfaction, both directly and indirectly through its influence on a person’s intrinsic task motivation and empowerment.\textsuperscript{64}

Benner’s (1997) model evaluated the practitioner on 5 different levels as Novice, advanced beginner, competent practitioner, proficient practitioner and expert practitioner. She demonstrated a new ability to identify the changes in the situation and implement skilled responses to the situation.\textsuperscript{35}

Gupta and Walia (2000) conducted a study on nurses’ perceptions and attitudes towards the professional activity and accountability. The information from the study revealed that more than 50% nurses viewed that their job is neither defined nor rationalized. Yet majority of them (77%) expressed that they are satisfied with their job. About their activities, more than 75% bedside nurses perceived that their role is to administer medication injection, gastric gavages etc. These activities carried out by nurses have been categorized as ‘medical-care’ activities in a study conducted in 1982, whereas activities related to general and comfort of patients are described as ‘basic patient care’ activities in a study conducted
by Darsyshire in 1970. These activities were grouped under nursing care activities by Jeyalakshmi in 1980. But these patient care or nursing care activities are perceived as their activities only by 10% - 49% of nurses. From these findings, one could perhaps conclude that nurses are more concerned about medical care activities than basic care activities.²⁰

Leddy et al. (1989) defined role ambiguity as a situation in which the role is not clearly defined. This frequently occurs because of the lack of good job descriptions and clear communication.⁶⁵

PERFORMANCE EVALUATION

Studies Related to Performance Appraisal

Joint Commission on Accreditation of Health Care Organization (1980) developed a scale to rate each criterion. But in the transition from the subjective process, the performance appraisal became narrow, frequently not addressing issues such as interpersonal relations, teaching skills which are essential to quality care.⁶⁶

Payne K et al. (1998) identified the performance appraisal process in nursing has evolved over the years from a very loose subjective process to one that focuses on competency. Many of the annual performance appraisals were vague and relied on the nurses relationship with the manager or writing ability of the manager.⁶⁷
Benner et al (1984) developed professional performance systems for appraising competency. Benner defined competency as the ability to perform a task with desirable results under the varied circumstances of the real world.35

According to Booth (1985) competence in the nursing profession is reached after varied experiences, allows the nurse to conceptualize a norm and then formulate judgments about deviations from that norms.68

Cohen (1981) in his guidelines regarding expectations of the professional nurse stated that the end-product of professional socialization must be a person who has both technical competencies and the internalized values and attitudes demanded by the professions and expected by the public at large. Nursing competence has also been linked with the development of evaluation system.69

Lunde and Lafferty (1986) explained that performance evaluations are management tools that provide bases for recognizing achievement, rewarding superior performance. Correcting deficient one and setting future goals to be achieved within specified time periods.70

Behrand, et al. (1986) contended that performance evaluation tools have been under-used as a mechanism to convey the value of professionalism to clinical nurses.71
Levit et al. (1985) emphasized the importance of evaluation tool by stating the accuracy of the appraisal is dependent not only upon the evaluator but also the appropriateness of the tool being used for the task.\textsuperscript{72}

Bray (1982) asked “How the nurses’ performance will meet standards, if the nurse doesn’t know what current standards are?” When you set a standard, a measurement is needed to ascertain whether the standard is met or not met.\textsuperscript{73}

Stalker et al. (1986) stated that do not assume that all performance categories are equal. They believed that some type of nursing performance is of greater importance than others and so weigh the scoring of different categories.\textsuperscript{74}

Megal (1983) stated that criterion-based performance appraisals are superior to other forms of ratings, because they are more objective. The terminology used to describe behaviors, not traits the tools are developed by both management and staff. The validity and reliability of the criteria can be determined and criteria not only evaluates staff performance but also indicate what behavior would lead to improved performance.\textsuperscript{75}

Ganong and Ganong (1983) developed objective performance evaluation system and they studied the effects of feedback and other process on employee development.\textsuperscript{76}
Invancevich et al. (1989) explained that there are two general purposes for the performance evaluation; judgmental purposes and developmental purposes. When performance appraisal is accomplished for the purposes of determining standards and merit, it is being termed as judgment. Developmental purposes are predominantly educative and involve coaching the employ to gain professionally through working within organizational goals. They also identified that a performance evaluation should be able to discriminate between excellent, good and poor performance. Any purpose for which an evaluation is done should involve identification of area requiring further development and areas that just need to continue possibly by some enrichment.77

Rowland H et al. (1985) described that development evaluation is done to establish standards of performance and gaining acceptance of those standards and giving feedback to the employee on his/her performance.78

Smith et al. (1982) explained that evaluator writes a summary of discussion, documenting the group members’ strengths and weakness, goals and plans for accomplishing the goals and gives an overall rating of the group member. It is helpful for both parties if a working document is developed. Both can keep a copy of the document and can chart the progress of the individual.79
Subhadra (2005) explored advisable measures for assessment of activity of nurses at various roles. She had explained the multitudinal roles in nursing as nurse educator, nurse communicator, nurse researcher and nurse practitioner. For each role, she has identified activity of nursing in different setting like nursing service, nursing education, community health service, and nursing research.\textsuperscript{80}

Weeks et al. (1988) described PACE, (Practice Alternative for Career Expansion) a successful career development program designed to achieve the goals. The inception of PACE required new job description and performance appraisal system. The PACE committee developed series of job description that defined the expected behavior for each track at each level. The expectations are clear as PACE was implemented in a group of head nurses, directors and staff nurses. Data was obtained using a four part questionnaire that surveyed data on demographic variables, opinions on PACE itself, job satisfaction, perception of leadership and self image. The questionnaire was distributed to all nursing staff. The study concluded that staff nurses have perception about performance program, remain somewhat unclear about all of its option, and worry about the fairness of grading nurses according to level that can be used as evidence for the next performance appraisal.\textsuperscript{81}
Hader et al. (1999) developed a registered nurse performance appraisal tool based on various role and responsibilities of the RN in the system. Indicator statements were developed to measure the performance in each of the role areas.  

**PERCEPTION OF PROFESSIONALS ON NURSES PERFORMANCE**

**Studies Related to Perception of Health Care Professionals on Nurses Performance**

Watson et al. (2003) conducted a study on perception of nursing: a study involving nurses, nursing students, patients and non-nursing students. Survey method was used with a longitudinal panel element incorporating a 35-Item version of nursing dimensions. The results of the study suggested that the perception of nursing across all participating group is largely the same. Some change in the perceptions of nursing takes place in nursing students. Diabetic outpatient perceived nursing differently from the other participant group. A narrow and unbalanced view of nursing may prevent the patient getting the best out of the nurse and may provide a clue to the nurse to expand certain parts of the nursing role in order to provide the best possible care to the patient.  

Patistea and Siemanta (1999) compared with nurses’ perception of caring with patients’. They revealed that nurses consider the important traits are those as the psychological end of the spectrum effect, attitude and comforting whereas patients are more concerned with what nurses can do for them in a practical sense.
Cairo (1996) conducted a qualitative study to examine the attitudes of emergency room physicians toward collaborative practice with emergency room nurse practitioner. The results indicated ambivalence towards the N.P. role. Although the physicians recognized the benefits of the role, they wanted to maintain a hierarchical relationship. It was speculated that this desire was because of a lack of understanding of the role. The research also found a relation between physician having little exposure to NPs and a negative attitude towards the role.84

Ford and Kish (1998) used a semi structured interview format to examine the perception of faculty physicians and family medicine residents towards NPs and a physician assistant in a family practice residency site. The study revealed that an overall acceptance of NPs, but there was role misinformation on a number of issues. The physicians’ lack of knowledge about role had negative attitude. The researcher also found that the more experience a physician had with an NP, the more positive the attitude towards the role.85

Aquilino and Colleagues (1999) conducted a survey of primary care physicians to evaluate attitudes toward and experience with NPs providing primary care. Overall, the physicians were supportive with a more positive attitudes expressed by those physicians who had worked with NPs.86
Suryamani E. (1989) conducted a study in King George Hospital, Visakhapatnam about the physicians’ perception on the ‘ideal’ and ‘real’ role of a nurse. The findings of the study revealed that as an important role set member the physicians’ perception of nurses’ role is very much relevant and essential for the efficient role performance of the nurse. \(^{87}\)

A study was conducted by Buckenham MA (1988) on student’s perception of the staff nurses’ role. A survey was undertaken to identify the developing perception of the staff. A sample of 190 was selected from the student nurses, staff nurses and sisters, working within those areas used for general nurse teaching at the two districts. The results indicated first year student nurses hold a perception of the staff nurse role which does not differ significantly from that held by staff nurses except for the clinical function. Questions relating to performance within these functions were less easily interpreted. \(^{88}\)

Green GJ (1988) revealed in the study on relationships between role model and role perception of new graduate nurses. The sample consisted of the 25 senior nursing students in a nursing program, the questionnaire was administered one month prior to graduation and 3 months after beginning employment. Results indicated that a majority of faculty role models of new graduate nurses are replaced by work related role models in the first 3 months of employment. Role perception orientations of new graduate nurses are overwhelmingly professional prior to graduation, but become more bureaucratic after exposure to work-related models. \(^{89}\)
Pelleties D et al. (1999) investigated the effects of graduate nurse education on clinical practice and career paths. Forty registered nurses undertaking graduate studies were surveyed as a pilot for an extensive longitudinal study of their perception of the effects of study on work performance and career opportunities. Overall, positive effects were noted by respondents on job satisfaction, self esteem, professional thinking and career moves.⁹⁰

Cronin SN et al. (1999) reported the results of a multisided survey which was conducted to compare staff and manager perceptions. Recognition for job performance was central to staff nurse moral. However little research has been done to identify recognition methods, valued by nurses themselves. They provided data for developing management intervention that may help to improve morale and increase retention.⁹¹

A study was conducted by Furegato AR et al. (1999) to learn about people’s opinions on nurses’ performance and on what do they expect from them. The results showed that the nurse is recognized as the one who is responsible for the care but there is still a representation of nurses as the doctor’s helps. They refer nurse as someone courageous, important and on whom they depend on. They look for human care, dedication, respect, responsibility understanding, affection and efficiency.⁹²
**Kim JH et al.** (2004) conducted a study on the difference in quality perception, expectations, evaluation and satisfaction for nursing service between patients and nurses. This study was performed to give direction to quality improvement strategies of nursing services by comparing the differences in quality perceptions and satisfaction for nursing services. There were difference between patients and nurses expectations and perception of nursing service and satisfaction. There were positive correlation among the expectations and perceptions on nursing service and satisfaction.\(^9^3\)

**Young WB et al.** (1996) made a comparison of patient and nurse perceptions of important aspects of patient care. Results indicated that a gap continues between patient’s actual values and what health professionals perceive as patient’s values.\(^9^4\)

**Essen CR et al.** (1991) explored the importance of nurse caring behaviors as perceived by Swedish hospital patients and nursing staff. It was found that patient perception of important nurse caring behavior differ from staff perception. The staff’s results are in accordance with studies of professional nurses’ perception of caring.\(^9^5\)

**Gardner and Wheeler** (1979) used a questionnaire and a structured interview to determine which supportive nursing behaviors nurses perceived as being most important. The results show that nurses ranked
the following behaviors as being most supportive. (i) Show interest in patients (ii) Create an environment where patients feel free to express feelings and (iii) Take time to listen to patients. According to the results of the studies, perceptions of caring appear to be influenced by the setting in which the nurse patient interaction occur and whether one is an enactor.96

It is fortunate that, well educated nurses are holding strategic positions in current healthcare settings. Nurse administrators and educators have formidable challenges ahead. Monitoring and evaluating role changes while creating a healthcare system that is caring, ethical, health promoting, and cost effective is the future task. Continued research is needed, not only to track these changes, but also to further evaluate the impact of these role changes on healthcare outcomes and the profession as a whole.