REGISTERED NURSES' PERCEPTION REGARDING THE BUREAUCRATIC VIEW OF POWER IN HEALTH CARE SERVICES IN THE TSHWANE METROPOLITAN REGION

By

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DECLARATION

I declare that **Registered nurses' perception regarding the bureaucratic view of power in health care services in the Tshwane metropolitan region** is my own work and that all sources that I have used or quoted have been acknowledged and indicated by means of complete references and that this work has not been submitted before for any other degree at any other institution.

…….. **……..**

VINDI SARAH MOJI **DATE**

The human mind, once stretched to a new idea, never goes back to its original dimensions.

Oliver Wendell Holmes

American physician, professor, and writer

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I am grateful to God for the noble nature of my calling and the presence of God and His Holy Spirit who encouraged, strengthened and provided finances for me to fulfill my mission for Him. I would have fainted had I not believed that I would see the goodness of the Lord in the land of the living (Psalm 27:13).

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ABSTRACT

REGISTERED NURSES' PERCEPTION REGARDING THE BUREAUCRATIC VIEW OF POWER IN HEALTH CARE SERVICES IN TSHWANE METROPOLITAN REGION

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This study investigated the registered nurses' perceptions of the bureaucratic view of power in health care services in the Tshwane metropolitan region. The study further sought to describe how power affects the role of registered nurses in an organisation that is perceived to be predominantly bureaucratic in its' approach to management.

A quantitative descriptive exploratory approach was adopted. Data was drawn from 121 respondents by random distribution of questionnaires to three selected health care services in the Tshwane metropolitan region. The findings revealed that registered nurses were largely divided in their perception of the bureaucratic view of power in health care services. Almost half of the respondents indicated that great strides had been taken by organisations in transforming health care services in accordance with the *White Paper* (1997) *on Transformation of the Health System in South Africa* and the recommendations of the 2001 Health Summit. The others indicated that registered nurses still needed to break out of the restraints of their dependant role towards taking ownership of health care services by equally bearing the burden of the organisation with management.

KEY CONCEPTS

Bureaucracy, health care services, perception, power, registered nurse.

TABLE OF CONTENTS

CHAPTER 1

CHAPTER 2

LITERATURE REVIEW **Page**

CHAPTER 3

RESEARCH DESIGN AND METHOD **Page**

CHAPTER 4

DATA ANALYSIS AND INTERPRETATION **Page**

CHAPTER 5

FINDINGS, LIMITATIONS AND RECOMMENDATIONS **Page**

LIST OF TABLES

LIST OF FIGURES

ACRONYMS

ANC	**African National Congress**
CRN	**Clinical Resource Nurse**
ER	**Emergency Room**
HCS	**Health Care Services**
ICU	**Intensive Care Unit**
LP	**Labour Party**
LRA	**Labour Relations Act**
NHP	**National Health Plan**
NHS	**National Health System**
NSMs	**Nursing Service Manager**
OT	**Operating Theatre**
RNs	**Registered Nurses**
RSA	**Republic of South Africa**
SA	**Saudi Arabia**
SANA	**South African Nursing Association**
SANC	**South African Nursing Council**
SAS	**Statistical Analysis Systems**
UK	**United Kingdom**
USA	**United States of America**

ANNEXURES

CHAPTER 1

ORIENTATION TO THE STUDY

1.1 INTRODUCTION

Since the inception of the new political dispensation in 1994, the Republic of South Africa (RSA) has experienced dynamic changes in the practice and implementation of new policies at national, provincial and local level. The health sector has been impacted by the

- African National Congress' (ANC) (1994) *National Health Plan for South Africa* as the basis for restructuring the national health care system in the RSA
- Department of Health's *(1997a) White Paper for the Transformation of the Health System in South Africa,* Department *of Health's* (1997b) *White Paper* (*Batho Pele* – "Putting people first" Principles) *on Transforming Public Service Delivery, and* National Patient's Rights Charter
- Resolutions of the 2001 Health Summit held in the Sandton Convention Centre, from 18 to 30 November 2001 (Schneider & Gibson 2001:17).

In the midst of the restructuring initiatives, the 2001 Health Summit emphasised the need to change the workplace culture from a top-down and authoritarian approach to a more democratic set-up. According to the 2001 Health Summit, the intention was not to indict top management per se, nor was it to set up a political ploy that would cause them to abdicate their position of authority and responsibility, but rather an amicable way of decentralising decision-making processes (Schneider & Gibson 2001:12). The Summit further acknowledged the mammoth task of having to deal with changing the mind-set stating that the "human element is perhaps the most complex one to address", because it involves emotions and attitudes. Individuals can effectively deal with these emotions themselves through willingness to change, in order to accelerate transformational efforts (Schneider & Gibson 2001:17).

Webster (2005:2) concurred, pointing out that while transformation of any type is difficult, drastic changes that involve image, whether personal or organisational image, are the most difficult to embark on. With regard to how individuals and organisations deal with their own perceptions and image of themselves in any given environment and the communication strategies in place, Webster (2005:2) found that people's mental software could not handle change easily. People's lives seemed to be highly influenced and programmed by their environmental experiences, hence there was a tendency to resent change.

Transformation of health care services (HCS) requires a change of mindset from traditional, administrative practices to participative management. This could maximize involvement of registered nurses (RNs) in decision-making processes that directly or indirectly affect their daily duties (Schneider & Gibson 2001:19). The ANC's National Health Plan (NHP) (1994:79) stated that transformation of the health system needs a re-orientation of the existing personnel and a proper utilization of their skills to enable them to play a more effective role in promoting health.

Regarding the problems in the bureaucratic system, Howkins and Thornton (2002:139) stressed that the National Health Service (NHS) in the United Kingdom (UK) is still attempting to move from a hierarchical structure to a flatter structure with the aim of building teams. Globerman, Davies and Walsh (1996:178) stated that institutions and hospitals in the United States of America (USA) are also experiencing ongoing restructuring. Abedian, Strachan and Ajam (1998:3) indicated that decision makers, senior managers, politicians and consumers of health care in the RSA agree that change or transformation within the country has not advanced as expected. There is no effective model yet that is congruent with the mandates of the 1997 White Paper to accelerate transformational initiatives at district and provincial level. Buys and Muller (2000: 50) found that very little has been done to democratise HCS within the country.

Given that transformation from a bureaucratic to a democratic model evolves gradually over years, there is tremendous pressure on outdated bureaucratic

practices from the new health legislation, policies and guidelines mandating acceleration of democratisation across the health care spectrum in the RSA (South Africa 1997b: 19).

According to the Health Summit (Schneider & Gibson 2001:11), nursing and other professions perpetuate attitudes, values and styles of management adopted as a legacy from the bureaucratic regime. The Department of Health (South Africa1997b: 19) stated that junior staff members could easily perpetuate bureaucratic practices by quickly picking up non-verbal information on the organisation's culture and values from the example set by senior managers in their daily interaction with them. Another obstacle noted was the transfer of bureaucratic culture, which took place while newly qualified nurses were mentored and socialised in the workplace through what Skinner (1904) called operant conditioning (Meyer, Moore & Viljoen 1989:187; Schneider & Gibson 2001: 11). In the context of this study, operant conditioning implies that RNs' behaviour is usually preceded and controlled by the modus operandi of hospital management. If RNs note that they get approval from top management and certain benefits for adhering to bureaucratic principles are given, they tend to give little or no support for democratisation of HCS. Years of negative programming, in terms of bureaucratic practices in HCS, are not easy to eradicate. It is normal practice in every sector where certain norms have been established for people to fear invasion from outside the circles of their conglomerates, thus slowing down the process of transformation (Schneider & Gibson 2001:11).

Nevertheless, Buys and Muller (2000:52) found that some nursing service managers (NSMs) expressed anger over HCS transformation because of a lack of consultation and involvement of RNs in planning for transformation within the health care system in the RSA. They saw transformation as top-down administration where many things were actually forced on RNs for implementation, making it no different from bureaucratic organisations. NSMs believed that transformation brought negative effects, such as the moratorium on filling of vacant posts for RNs and resignation of highly skilled RNs, which contributed to increased workload (Buys & Muller 2000:52-53).

Jones, Schedler and Mussari (2004:206), however, stated that hospital management's control was based on the assumption that most RNs took employment primarily for personal gain and not necessarily to realise the vision of the organisation, making decision control necessary within the organisation.
Buys and Muller (2000:53) highlighted the lack of professional development in HCS because of insufficient study opportunities to acquire new skills and knowledge to cope with transformational changes. This could cause RNs to prefer a bureaucratic structure since full-time study leaves were liberally given under the bureaucratic regime. However, some felt that transformation was better than the bureaucratic view of power because RNs were empowered by learning cultural diversity, better race relations and dealing with diverse problems that made them feel part of the organisation because of their extended role (Buys & Muller 2000:54). The Department of Health (South Africa1997b: 23) indicated that a number of dedicated public servants seem frustrated by bureaucratic systems and procedures, which appear to hinder efficient HCS delivery.

The foregoing motivated the researcher to explore the perceptions, ideas and sentiments of RNs regarding bureaucratic practices in HCS. The purpose was to contribute to the growth and improvement of the health sector in the changing socio-politico-economic climate, especially because transition is a long process.

1.2 BACKGROUND TO THE PROBLEM

The researcher had discussions with HCS managers who disclosed their dilemma of seeing transformational initiatives as mere rhetoric because of pressure from top management who maintain control over the dynamics of their HCS. Further discussion with RNs from different health care settings brought to light feelings of despair towards bureaucratic practices still being perpetuated in HCS. The literature review also revealed conflicting interests among NSMs whereby some were for the bureaucratic model they were accustomed to, while others believed in transformation because salaries were negotiable and it opened up a whole new dimension of cultural diversity and empowerment for RNs. Given these concerns, the researcher wished to determine the perception of the larger

population of RNs regarding the bureaucratic view of power in the Tshwane metropolitan region.

The twenty-first century has seen many changes directly or indirectly impacting different levels of care in the health sector, from a totalitarian autocracy to a liberal democracy. Many nations embarked on structural and institutional changes in their health care systems. According to Harrison (2004:1, 9), several European and Scandinavian countries dissolved their governmental bureaucracies viewed as instruments of “top-down” policy implementation and translated them to programmes that involve operational officials at the functional levels.

In the RSA, a previous health care dispensation formally determined policies and practices affecting employees in HCS (Bezuidenhout, Garbers & Potgieter 1998: 276). In the new dispensation, the restrictive job description of RNs, encapsulated within the bureaucratic model, was required to change in order to enable them to provide comprehensive, integrated and autonomous health care service to their patients (South Africa 1997a: 23).

Swanburg and Swanburg (1999:355-358) described bureaucracy as a dominant organisational form of administration and organising, comprising centralised and highly structured hierarchical authority where hospital management formulated policies and made decisions without involving the RNs at operational levels. It is believed that this administrative approach enforced subordination to authority, which led to frustration and resentment of control over the independent functions of RNs. In addition, the Public Service was also seen as “still operating within over-centralised, hierarchical and rule-bound systems inherited from the previous dispensation” (South Africa1997b: 12).

HCS managers have been given the right to make decisions in formal bureaucratic organisations to influence behaviour towards implementation of these decisions. One person gives instructions or commands another, in an attempt to bring about the desired behaviour or action through the efforts of the

other person or group of people within a bureaucratic system. The relationship between management and subordinates in this case is officially recognised. This means the person acting in authority is empowered and authorised by the particular organisation employing the two parties to act on behalf of the organisation. The person endowed with this power has the right to issue appropriate instructions and make decisions for subordinates (Smith 1999:79).

According to the Health Summit (Schneider & Gibson 2001:11), there are still rigid management structures and procedures that exacerbate tension between HCS managers and RNs in bureaucratic organisations. These authoritarian management systems do not reward good behaviours, are devoid of positive strokes and often ignore bad practices to avoid confrontation in other areas. In contrast to these practices, the Department of Health (South Africa1997b: 23) advocates rewards and recognition for good performance in the new dispensation of health care delivery. Bezuidenhout et al (1998:5) asserted that in the past, NSMs have been “accustomed to speaking to people as subordinates, making snap decisions, issuing instructions and maintaining absolute control”, without considering the views and desires of their subordinates. Buys and Muller (2000: 52-53), however, found that NSMs felt they were not empowered enough to exercise complete authority over situations in the new health care system.

Given these problems, in conjunction with Buys and Muller’s (2000:52-53) findings, it is deduced that HCS managers who have positions and principles of democratisation without power, cannot influence RNs to achieve organisational goals. In their quest to please top management, therefore, bureaucratic practices will seemingly be perpetuated in HCS. Concomitantly, HCS managers who have power, position and no principles of democratisation, may experience difficulty and not be effective in implementing transformational initiatives, thus, leaving the RNs entrapped within bureaucratic practices. Smith (1999:77) contended that if organisations did not give managers the authority to make decisions, managers would not be able to properly perform their management responsibilities. This could, in turn, cause the organisations to collapse due to constant arguments over the direction in which they should go.

The above background indicates a need to establish the strengths and weaknesses of the bureaucratic power in HCS, from the perception of RNs.

The Department of Health (South Africa1997b: 20) stated that the influence of the bureaucratic model in HCS has infringed on the rights of RNs to autonomy and independent decision-making in their daily execution of tasks (as required by their scope of practice, stipulated in the South African Nursing Council (SANC) Regulations chapter 2 of R2598, as amended). This was seen as most restraining to RNs creativity and innovation in the workplace (Regulation R2598, 1984, chapter 2(a-r)). According to Bezuidenhout et al (1998:5), policies and memos within the bureaucratic system, which were distributed in a top-down fashion, were also seen as undermining the skills, intelligence and potential of RNs. Furthermore, by virtue of their qualifications, RNs have the required information, knowledge and good judgment on situations, products and problems arising from their work environment, which put them in a better position to make good decisions than management (South Africa 1997b: 19).
Lorriman, Young and Kalinauckas (1995:12) found that a significant number of RNs joined organisations in the hope that the organisations would help develop and use their skills. However, Harrison (2004: 8-10) pointed out that in spite of endless reengineering programmes by huge organisations under the guidance of central governance, a health care service suitable for the twenty-first century has yet not been produced. In Harrison's (2004:9) view, the National Health System (NHS) organisations have been based on hierarchies of bureaucracy, which served the interest of health care leaders to the detriment of patients and employees at operational levels. RNs' perceptions regarding the bureaucratic view of power therefore do not seem to be adequately covered.

Bezuidenhout et al (1998: 279) indicated further that formerly, in the absence of formalised grievance procedures, suggestions emanating from RNs to top management were usually not welcome in HCS because of the structure of power in place, which in most instances was (and still is) a closed system. This was seen as a hindrance to various complaints and grievances RNs could have

(Bezuidenhout et al 1998:279). In conjunction with the introduction of the grievance procedure in the workplace, the Department of Health also issued a mandate that opportunities be made available for staff to make suggestions, as a way of contributing to better health care delivery and for senior managers to take these suggestions seriously and endeavour to respond to them in a timely manner (South Africa 1997b: 19).

Relative to this study, the impact made by trade unions on circumstances surrounding RNs, is given more perspective. According to Bezuidenhout et al (1998:278), trade unions took advantage of the RNs' ordeals by providing a mechanism through which their complaints, feelings, perceptions and desires could be communicated to hospital management.

The nursing profession in the past was largely represented by professional associations in areas where their professional obligations were breeched, to obviate severe sanctions on their members. Other grievances, such as conditions of service, salaries and other disparities, did not receive appropriate and radical attention until the rise of trade unions. Some RNs began to experience a paradigm shift of subscription to trade unions, to represent their views in decision-making meetings through the appointment of shop stewards according to the prescriptions of the Labour Relations Act (LRA) 66 of 1995 (Bezuidenhout et al 1998:276).

Bezuidenhout et al (1998:7) believed that the RNs' motivation to join trade unions could be summarised as an attempt to minimise favouritism and discrimination encapsulated within the bureaucratic system with regards to study opportunities, wage increases, promotions, transfers and vacations, which were independently decided by management. Moreover, these incentives were allocated in a highly subjective manner and accessed only by employees with close relationships to HCS managers. Unions therefore, ensured a fair and equitable distribution of these opportunities and incentives under the new health care system (Bezuidenhout et al 1998: 279).

The above exposition suggests that the dissatisfactions, inconsistencies and disparities deeply entrenched in the bureaucratic system, may also have been responsible for the widespread burnout and high turnover rate among RNs throughout the country. With regard to the international migration of nurses, the Health Summit (Schneider & Gibson 2001:55) asked whether money was the only factor in international migration or whether the rigid bureaucratic system also contributed. This study therefore wished to investigate the above conjectures by eliciting and consolidating RNs' perceptions regarding the bureaucratic view of power in HCS.

Mufti (2000:37-38) examined HCS in the kingdom of Saudi Arabia (SA) and found the country's complete dependence on foreign manpower, including RNs from all over the world within the kingdom, a weakness. The bureaucratic approach appears to be the only solution at their disposal at present, however, while efforts are directed towards Saudisation of manpower within the kingdom. In order to enforce a sense of financial responsibility and accountability upon all RNs, who happen to be expatriates, a portion of the public sector budget has been allocated to individual units as a control measure. The main aim was to achieve performance by uniform rules to ensure order in the workplace and maximise productivity (Mufti 2000:34; Swanburg & Swanburg 1999:357). This resolution was made by participants of a national symposium on health sector development and reform held in Riyadh (SA) from 5 to 8 December 1998, which paralleled the resolutions of the 2001 Health Summit in the RSA (Mufti 2000: 95). Subsequent to that, the operating budgeting system is now in operation because of its perceived ability to allow unit costs for various health activities to be determined from cost centres in a competitive manner for scarce resources, without the devolution of bureaucratic power (Finkler & Kovner 2000:262-264; Mufti 2000:99).

During the development of the financial information systems in Zimbabwe, Mills, Bennett and Russell (2001:86) found that financial accounting was highly centralised in their health sector, with RNs given no responsibility for expenditures. Financial inputs were not linked to activities in order to justify

financial resource allocation. After the decentralisation of decision-making processes in 1992, 57 cost centres were established. RNs now take complete responsibility for their expenditures, which gave them the benefit of also taking ownership in the delivery of health care (Mills et al 2001:86). According to Mills et al (2001: 86), the results of these restructuring and empowerment programmes for RNs in Zimbabwe are still phenomenal, even though implementation of changes from bureaucratic practices to democracy was slow to take off due to the fact that these changes were not supported by government reform of accounting and management systems.

Globerman et al (1996:178) and Kornai and Eggleston (2001:123) stated that institutions and hospitals in the USA were also still experiencing restructuring as an ongoing process of decentralising decision-making processes within the health sector.

In the light of the visible global shift from bureaucratic practices to more participative styles of management, it is clear that developments in the RSA are consistent with developments internationally, in terms of moving towards phasing out bureaucratic practices. It is therefore crucial to establish RNs' perceptions of the bureaucratic system in HCS, in view of solidifying interpersonal relationships between management, RNs and patients.

1.3 STATEMENT OF THE PROBLEM

The background to the problem suggests that the bureaucratic system presents obstacles to RNs views, personal growth and fulfilment, and empowerment.

In some health care settings, it is alleged that exclusion from crucial plenary sessions has raised complaints from RNs across the country, leaving them no option but to explore other avenues, including subscription to trade unions and international recruitment. Subscription to trade unions for RNs came as an attempt to access meaningful participation in decision-making processes that affect them, their patients and the HCS (Bezuidenhout et al 1998:279).

According to Buys and Muller (2000:52), some NSMs felt that the transformation of bureaucratic organisations still excluded consultation and involvement of RNs in the planning processes. Transformation was seen as top-down administration where many things were actually forced on RNs for implementation, making it no different from the bureaucratic view of power. In addition, transformation had negative effects such as the moratorium on filling of vacant posts for RNs and the resignation of highly skilled RNs, which contributed to increased workload. Nevertheless, some supported the transformational initiatives, stating that discrimination in terms of promotions and recruitment had been eliminated and the selection criteria were now based on seniority and performance. Moreover, some indicated that transformation exposed them to cultural diversity and race relations, and dealing with diverse problems, which was not previously the case (Buys & Muller 2000:52-53).

Buys and Muller (2000:5) investigated the experiences and perceptions of NSMs regarding the transformation of HCS. However, the researcher found no studies that investigated the perceptions, views and attitudes of RNs as operational officers, regarding the bureaucratic view of power in the HCS in the Tshwane metropolitan region. Accordingly, the following problem statement was formulated for this study:

> *What are the perceptions of registered nurses regarding the bureaucratic view of power in the health care services?*

1.4 RESEARCH QUESTIONS

In order to examine the problem, the study sought to answer the following research questions:

- What are the perceptions of registered nurses with regard to the bureaucratic view of power in health care services?

- How does power in a bureaucratic organisation influence the role of registered nurses in health care services?

1.5 AIM OF THE STUDY

This study aimed to determine and describe the perceptions of RNs regarding the bureaucratic view of power in HCS in the Tshwane metropolitan region, for the purpose of enhancing interpersonal relationships in their daily interaction with management, patients and other RNs.

1.6 RESEARCH OBJECTIVES

The specific objectives of the study were to

- determine registered nurses perception regarding the bureaucratic view of power in health care services
- describe how power in a bureaucratic organisation affects the role of registered nurses in health care services.

1.7 SIGNIFICANCE OF THE STUDY

Conducting an empirical study to determine RNs' perception of the bureaucratic view of power has several implications for both RNs and HCS management. It could provide a new direction for nursing management, education and research in the context of the radical transformational initiatives encapsulated within the 1997 White Paper on the Transformation of the Public Health Services and the recommendations of the 2001 Health Summit. The perceptions of RNs on the phenomenon under study could provide the basis for recommendations on the involvement of RNs in decision-making processes, the degree of their participation in management processes of the HCS and the recognition of their input for improvement of health care delivery.

1.8 DEFINITION OF KEY CONCEPTS

For the purpose of this study, the following concepts/terms are used as defined below.

- **Bureaucracy**

Swanburg and Swanburg (1999:355-358) defined bureaucracy as "a dominant organisational form of administration and organising, comprising centralised and highly structured hierarchical authority where top management formulates policies and makes decisions without involving the employees at operational levels". This structure is commonly found, for example, between the Departments of National Health and health institutions as well as between HCS managers and their subordinates in health care settings. In this study, bureaucracy is "a system of administration, which is based on organisation, division of labour and a hierarchy of authority designed to delegate duties in a routine manner" between RNs and HCS managers (Hanks 1979:2000).

- **Health care services (HCS)**

This concept refers to either "a public or private health care service centre, which provides health services to individual patients, their families and communities" (Buys & Muller 2000:51). It includes any community project where patients and the public receive preventive, promotive, curative and rehabilitative services.
In this study, HCS refers to the health care environment in which RNs carry out their functions under the auspices of a regime perceived to be bureaucratic in nature.

- **Perception**

Collins English Dictionary (1991:1156) defines perception as "the act or the effect of perceiving; insight or intuition gained by perceiving; way of perceiving; awareness or consciousness". King (1981:20) described perception as "sensory

experiences, percept and images, which translate themselves to human ideas, cognition and memory. These sensory experiences help formulate ideas, which provide knowledge and meaning." Perceptions are a representation of what individuals consider as reality, which is what makes perceptions differ from person to person (King 1981:20; Ungerer 2001:116). This study consequently aimed to elicit each RN's perception of the bureaucratic view of power in HCS.

- **Power**

King (1981:127) described power as the "authority and position one has to influence others within an organisation. This means ability to control and direct events and behaviours through decision-making, by virtue of the power vested in them." According to Smith (1999:80), authorities use power to influence the actions and behaviour of those under their jurisdiction. King (1981:127) went on to explain power as "a situation where people accept what is being done while not necessarily agreeing with it. The person who has more power in an organisation is the one who has delegated authority and control to mobilise resources in order to achieve organisational goals."

In this study, power refers to the ability given to HCS managers to control the allocation of human, material and financial resources the way they see fit, in bureaucratic organisations. HCS managers also have power to choose between alternatives and to enforce such choices without involving RNs in their decisions in a bureaucratic environment.

- **Registered nurses (RNs)**

Blackwell's Dictionary of Nursing (1997:459) describes a registered nurse as "an individual who is specially educated and registered by an accredited Nursing Council to provide care to the sick, wounded and other health problems". For the purpose of this study, registered nurses refer to those individuals who are registered as nurses under section 16 of the Nursing Act, 50 of 1978, as amended, to independently execute acts and procedures stipulated in their scope

of practice. RNs are an indispensable commodity in HCS and proportionately form a major part of the total health manpower.

1.9 THEORETICAL FOUNDATION OF THE STUDY

Support for the theoretical significance of this research stemmed from King's (1981) open systems' framework. King (1981:10) postulated that human beings are an open system, usually involved in multiple interactions with one another through verbal and non-verbal communication, as well as through how they perceived their environment. In the context of nursing, there is continuous interaction between RNs and HCS managers, as well as between RNs and patients within the health care milieu.

According to King, these interactions lead to transactions. Transactions are "purposeful interactions that lead to goal attainment" (King 1981:1).

King's (1981:11) conceptual framework was used in this study to portray the dynamics of human interaction within HCS through a schematic diagram, which depicts personal, interpersonal and social systems, to describe the bureaucratic view of power within the changing socio-politico-economic climate in HCS (see figure 1.1).

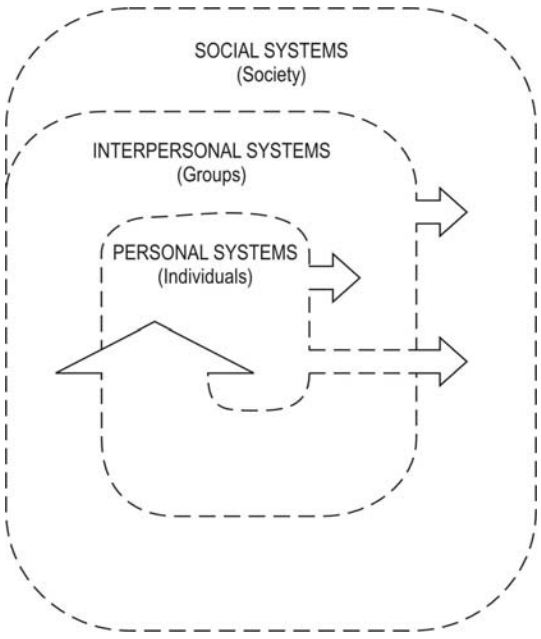

Figure 1.1 Dynamic interacting systems

Adapted from King's (1981:11) open systems framework

- **Personal systems**

Personal systems refer to individuals. King (1981:19) used the following concepts to explain RNs' interaction and the dynamics of their work environment in HCS: *perception, self, body image, space, learning, time, growth and development.* These concepts enable RNs to relate past experiences to current events in their quest to find meaning to their world (see chapter 2).

- **Interpersonal systems**

Interpersonal systems deal with groups of people. They comprise interaction between human beings and objects. In the context of this study, there is continuous interaction between RNs and patients, RNs and hospital management, as well as between RNs and other categories of staff. While individuals have their own subjective interpretation of their environment, they also differ in their reaction to objects, other human beings or phenomena in their environment. Accordingly, this study aimed to unpack the perceptions RNs have of the bureaucratic view of power in the HCS.

- **Social systems**

Social systems are organisations formed by groups of people with common interests and needs. Changes in disease patterns within social systems alter social environments, impact the delivery of health care and influence perceptions and the health of societies. HCS are an example of social systems in pursuit of specific goals. Since *power, authority, status* and *decision-making* are characteristic of social systems, RNs have a commitment to patients to make correct judgments and right decisions in a bureaucratic system. They are also accountable to hospital management as an *authority*, with *status* and *power* vested in them, for the delivery of quality health care. In reengineering HCS,

certain procedures, policies and practices would require a revamp, which necessitates inputs and active participation from RNs.

1.10 RESEARCH METHOD

Research methods are steps, procedures and strategies used by the researcher in order to gather and analyse data for the study.
The Research Method includes the target population from which the sample was drawn and the specific selection criteria. The nature and the development of the instrument, validity and reliability, ethical considerations and data analysis procedures are also explained in chapter 3.

The researcher chose a quantitative, descriptive, exploratory approach. Talbot (1995:87) described a quantitative study as “a rigorous, objective and systematic process of obtaining numerical data and using control measures and statistical analysis to eliminate contaminating factors”. Babbie and Mouton (2001:49) stated that quantitative researchers believe that “phenomena such as attitudes of people could best, if not only, be measured through quantitative measurement, using numerical data to quantify perceptions or qualities under study”.
A quantitative, descriptive, exploratory study was therefore conducted to describe the perceptions of RNs of the bureaucratic view of power in the HCS, with the aim of achieving the objectives.

1.11 SCOPE AND LIMITATIONS

The researcher selected three hospitals in the Tshwane metropolitan region, one public and two private hospitals. According to Polit and Hungler (1995:233), the findings of a study can only be safely generalised in cases where the study sample has been randomly selected from a population of subjects with the same characteristics. Brink and Woods (1998:283) stated that a variable identified in one population does not guarantee the existence of the same variable in another population. Since hospitals differ in size and management styles, generalisation

was jeopardised. It cannot be concluded with absolute certainty, therefore, that all hospitals will benefit from the findings of this study for the following reasons:

- The study was conducted in a metropolitan area; therefore, RNs' perceptions will differ significantly with perceptions of RNs from rural areas.
- Some RNs were not willing to participate in this study for fear of victimisation by management for divulging information about management practices in their health care system.
- Several RNs were sceptical about whether identified problems would be addressed in a more truthful manner or whether this would be just more research.
- All the authorities that gave permission were expecting a comparative study for the three selected hospitals so as to assess significant differences and similarities between private and provincial hospitals. However, this was not a comparative study. They nevertheless unanimously requested to be provided with the findings of this study.
- This study only elicited RNs' perceptions of the bureaucratic view of power from three hospitals with the total population of 121, therefore the study cannot be generalised.

1.12 OUTLINE OF THE STUDY

Chapter 1 introduces the problem, formulates the research questions and objectives, describes the significance of the study, defines key terms and delineates the theoretical foundation of the study.

Chapter 2 discusses the literature review.

Chapter 3 describes the research design and method.

Chapter 4 presents the data analysis and interpretation

Chapter 5 concludes the study, briefly discusses its limitations, and makes recommendations for practice and further research.

1.13 CONCLUSION

This chapter discussed the background to the problem, the rationale for and purpose, objectives and theoretical framework of the study, and defined key terms. The researcher adopted a quantitative, descriptive, exploratory approach to determine RNs' perceptions of the bureaucratic view of power in HCS.

Chapter 2 discusses the literature review undertaken for the study.

CHAPTER 2

LITERATURE REVIEW

2.1 INTRODUCTION

The researcher conducted a literature review pertaining to the bureaucratic view of power in HCS. King's (1981) theoretical framework of open systems was used to solicit and consolidate different perceptions of RNs on the subject of bureaucratic practices in HCS. The literature review covered *perception*; the concept of *self*; *growth and development*; *organisation*, *authority* and *power* within the bureaucratic structure in HCS.

2.2 PERSONAL SYSTEMS

According to King (1981:19), personal systems refer to individuals. The registered nurse as a person is a total system and the patient as a unit is also a total system. RNs, therefore, derive and process information from their personal world and begin to organise, categorise and process certain inputs through their senses. This information influences future decisions and how they respond to people and events in the bureaucratic system (King 1981:19). In order to fully understand RNs as persons, King applied the following specific relative concepts: *perception, self, time, space, growth* and *development* and *body image.*

The RNs' *perception* of *self*, how they view and feel about themselves as recipients of orders and memos from top-down bureaucratic structures, the *time* they have been exposed to this system, the *space* they desire for innovation and creative thinking, *growth* and *development* opportunities at their disposal in bureaucratic organisations as well as their *body image,* which is determined by their age and lifestyle, were given individual attention in this study (King 1981:20-22).

2.2.1 Perception

King (1981:20) described *perception* as sensory experiences, percept and images, which translate themselves into human ideas, cognition and memory. These sensory experiences are the source of particular impressions and help formulate ideas, which provide knowledge and meaning. *Perceptions* are a representation of what individuals consider as reality, which is what make *perceptions* differ from person to person (King 1981:20; Ungerer 2001:116). Luthans (1998:101) argues that *perceptions* may present a picture that is different from reality. RNs in the same environment may observe the situation but respond to it differently.

King (1981:20) believes that RNs' *perceptions* have an impact on both personal and organisational goals. King (1981) further stated that RNs' *perceptions* are influenced by past experiences within bureaucratic organisations, their concept of "self", biological inheritances, educational background and socio economic class. This also means that RNs who qualified from the old curriculum could have different perceptions about bureaucratic practices from those who qualified from the 4-year integrated course, by virtue of their age differences and the new way they have been prepared for their role in HCS. Kupperschmidt (1998:36) describes this latter category of RNs as a group that is compatible with the Generation "X" that emerged during the time of unprecedented change and social turbulence, [such as changes in public policy and economic climate in the RSA].

2.2.1.1 Characteristics of perception

- ***Perception is universal***

RNs may all be subject to bureaucratic practices under the same hospital management, but come out with entirely different *perceptions*. According to Robbins (1996:141), people will always try to validate their *perceptions* in some way.

- ***Perception is subjective, personal and selective for each person***

Perception is a mindset or what individuals choose to believe. RNs' experiences differ depending on their nervous system make-up, level of intelligence, degree of development and experience, and the context or situation in which *perceptions* are experienced. For example, difference in age influences *perceptions* of young and old to give different versions or perspectives of the same situation, as commonly seen in health care settings (Lancaster 1999:256; Luthans 1998:113; King 1981:22). In addition, Kupperschmidt (1998:40) cited previous researchers' perception of the Generation 'X'ers as rebellious and audacious in their workplace.

RNs' *perceptions* of HCS managers' attitudes can also differ according to what RNs perceive as control, rather than determining HCS managers' approval or disdain of the bureaucratic model (Brown 2002:16; King 1981:24). King (1981) calls this behaviour "stereotyping," because it is biased information.

- ***Perception is action-oriented in the present***

According to King (1981:24) *perception* may also be influenced by high emotional states such as anger, fear and love in the workplace, which invoke certain behaviours. Current interests, needs, role and status in their field of work also influence their *perception* and the way they respond. Education plays an important role in influencing people's *perceptions*; in other words, the information RNs have in their area of specialty influences their *perception* as to how things ought to be done. Stifling of innovation and creativity in bureaucratic organisations could cause stress, anger, fatigue, personal conflict, alcohol and drug use, leading to perceptual distortions and/or retaliation (Lancaster 1999:256; Luthans 1998:112; King 1981:23; Robbins 1996:134.).

- ***Perception in transactions***

Whenever two or more people come together there is interaction, which results in transactions. People's *perceptions* are in line with their individual positions, personal behaviour, experiences and needs in any given situation. Every person's *perception* remains unique during transactions. Past events, values, beliefs, motives, interests, future goals and needs determine one's *perceptions* about situations and people (King 1981:22-23).
Hospital management's *perception* of RNs' needs and RNs needs, are therefore, dichotomous. Hospital management may perceive them as personal gain, with not much vested interest in patient care. Professional behaviour requires that both RNs and hospital managers should clarify their *perceptions* as they plan together to achieve the organisational goals (Brown 2002:20; King 1981:25; Mufti 2000:34).

2.2.2 The concept of 'self' in RNs

According to King's (1981:27) personal systems, *self* is the subjective person who perceives, thinks, aspires, imagines and decides, based on past experiences, genetic make-up and their perception of the external environment. The knowledge of *self* is key to understanding the RNs' reactions and responses in any given situation.

2.2.2.1 Characteristics of self

- ***Self is a dynamic individual***

Balance in the lives of RNs is maintained by consistency in their values and beliefs. Any ideas or events that threaten these beliefs and values destabilise the *self,* which in defence will seek to demystify new information by aggressively trying to protect the status quo, avoid the challenge or embrace the change (King 1981:27). This means that RNs can engage professional associations or unions to advance their demands for change, or choose to leave bureaucratic

organisations in search of better opportunities elsewhere, including outside the country (Bezuidenhout et al 1998:278; King 1981:27; Kotlolo 2004:8).

- ***Self is an open system***

King (1981:27) stated that each person has an innate nature to protect their *self* in any environment where there is interaction with people or objects. How RNs perceive themselves highly influences their attitude towards bureaucratic organisations. In the presence of positive experiences, the *self* is enhanced; however, where negative experiences exist, such as the use of control within bureaucratic organisations, the *self* needs help from the external environment, or simply put, a way of escape.

Jooste (2003:16) advocated the use of a psychological quantum skill by RNs known as “quantum feeling,” which secures a sense of peace in the midst of chaos and adversity. Jooste (2003:16-17) referred to an example of how RNs could choose to remain calm in the middle of an organised strike action. This means that RNs should display determination not to let other people or situations decide their feelings even under bureaucratic power. Haas (1999:1) indicated that making their way through a professional life could be daunting because RNs could be fortified or destroyed by the very organisations they serve, depending on whether RNs experience “control” or “autonomy” within the organisation.

- ***Self is goal orien*ted**

King (1981:27) holds that focused individuals are not easily swayed by the opinions of others, but through determination continually direct activities towards the desired goal, regardless of the structure of power and control in place.

Mason, Levitt and Chaffee (2001:2) believe that if RNs could take cognisance of the power they possess over political and policy-making processes, they could bring about dramatic changes in HCS, as opposed to abandoning their patients and their countries, or worse still, retaining their jobs with a passive, unenthusiastic attitude.

2.2.3 Time

King (1981:44) regarded *time* as the difference between the duration of an occurrence of an event and the occurrence of yet another event. *Time* speaks of the order of events and the duration experienced by each person. There is also physical *time*, which speeds up with age (King 1981:41). Perception of people in relation to *time* differs. One may perceive the same period of *time* as longer in duration than another. In the context of this study, the perception of the duration of *time* RNs had been employed under the bureaucratic system may have seemed longer to those who worked where there was more control than those in lighter departments and were perhaps on much friendlier terms with hospital management. Years of experience also affect perceptions (King 1981:40-41).
In a bureaucratic setting, activities are organised in a particular way to fit in with the rigid *time* schedules such as meal *times*, on and off-duty *times* and leave schedules (King 1981:42).

Lorriman et al (1995:9) expressed concern about a great deal of *time* being expended in meetings, lengthy telephone calls, internet conversations and attending to problems resulting from the incompetence of workers. Sometimes problems are caused by HCS managers themselves, due to poor judgment and lack of updates to keep abreast of new developments and technology. Lorriman et al (1995:18) also believe that HCS managers do not have *time* to address important issues with their staff and, worse still, to coach and develop them.

2.2.4 Space

King (1981:37) explained *space* as the territory occupied by human beings and their behaviour in that particular space. Sometimes RNs can use non-verbal communication to protect or defend their individual *space*, especially where excessive control is exercised.

According to King (1981:38), a change in distance between people in their interaction is an indication of their relationship. Buys and Muller (2000:53) found

that some participants indicated that they felt separated from hospital management and only received orders for implementation at the operational level.

Hospital *space* in bureaucratic organisations is structured to suit medical specialties, such as intensive care units (ICU), emergency rooms (ER) and operating rooms (OR), which are designed in such a way that they do not cater for patients' and nurses' personal *space*. King (1981) goes on to suggest that nurses are very seldom involved in important decisions and committees that plan hospital expansions and extensions.

Turshen (1999:57) saw *space* as a given opportunity to make decisions, and exercise responsibility and accountability. To illustrate this point, Turshen (1999:57) cited a report on francophone West Africa where St Louis Hospital in Senegal was rewarded with responsibility to retain their revenues and the possibility of further devolution of power within their health care service, to encourage responsibility and accountability. This came as an incentive when they proved themselves capable of managing their health care service independently of the Central Ministry of Health. Turshen (1999:57) also cited the hospital of Kati in Mali, which has been progressing rapidly towards autonomy, a shift from central control. However, Cotê d'Ivoire was reported as still over centralised while district hospitals and two rural health centres in Zambia moved aggressively towards decentralisation of HCS, in appreciation of *space* for autonomy and expansion they were given. Leatt and Mapa (2003:184) concurred, referring to an example where merging of the "grass-roots" and "grass-tops" initiated by operational officers in other countries successfully bridged the gap.

2.2.5 Growth and development

Lorriman et al (1995:9) stated that in order to continue to grow, hospital managers needed to relinquish certain decisions to RNs to facilitate growth and development. This would assist them to complete their tasks efficiently, doing them the right way first time and every time. Hospital and unit managers would

then become facilitators as opposed to dictators, which is typical of a bureaucratic organisation. The more fulfilled the workers are, the more satisfied the patients, and the more organised and successful the organisation (Lorriman et al 1995:10).

Howkins and Thornton (2002:230) regard personal growth and development as one of Maslow's requirements for personal fulfilment, and maintain that workers thrive well where there is challenge and involvement in problem-solving and decision-making. This could contribute to job satisfaction, especially where employees have the support of hospital management.

Howkins and Thornton (2002:231) further said that most employees seize available moments for training and development and then return to their organisations to give the best of their services to their employers. Lorriman et al (1995:10) concurred and suggested that hospital managers take cognisance of the talent and skill still untapped in RNs who are also willing to contribute to achieving organisational goals from the knowledge and skill they have acquired.

2.2.5.1 Characteristics of growth and development

King (1981:30) postulated that growth and development include continuous behavioural changes in human beings and their environment. The presence of people and objects in an environment can influence growth and development either in a positive or negative way, depending on their subjective perception of the event. Health professionals are an example of how HCS can ruin their professional future, personal lives, welfare and happiness if there is no room for personal, financial, professional and emotional growth within the organisation. Many RNs end up nowhere in life after serving large bureaucratic organisations for years. This comes as a result of failure to use their talents, wisdom, creativity and innovation to make an impact and navigate their career path so as to realise both their personal and professional goals (Haas 1999:3).

In King's (1981:20) theory of personal systems, RNs' self-image can be enhanced through participative hospital management, seminars, in-service

education programmes and study opportunities, based on the identified needs of the organisation (Douglas 1996:288; Lancaster 1999:180; Luthans 1998:424).

2.2.6 Body image

King (1981:33) saw *body image* as a constant change of feelings and perceptions in one's body, which is significantly different from others. *Body image* is an integral part of growth and development. According to King's (1981:31) theory of personal systems, *body image* is one's own body, which constitutes the concept of the "I" in RNs. This view encapsulates the RN's growth and development that includes the cognitive aspect, which is influenced by personal goals and needs.

In this study the researcher considered it crucial to establish whether hospital management in bureaucratic organisations take cognisance of emotional factors that come into play when disturbances or alterations in *body image occur*, such as fear of losing their jobs, anger, anxiety and depression.
To encourage health, fitness and well being, some organisations have upgraded their medical aid schemes to include health and wellness clubs. RNs are rewarded with benefits such as travel vouchers, discounts on prepaid airtime and movie benefits to encourage participation (Discovery Holdings 2000:2).

2.3 INTERPERSONAL SYSTEMS

According to King (1981:59), interpersonal systems comprise interaction between human beings, objects and their environment. Two individuals in interaction are called dyads, three individuals are called triads while four or more individuals are referred to as a group. Groups may be small or large. Concepts central to understanding the concept of interaction mentioned above are *interaction, communication, transaction* and *role.* These also serve to delineate interpersonal systems (King 1981:60).

2.3.1 Interaction

According to King (1981:60-61) there is a continuous *interaction* between RNs and HCS managers. While RNs have their own subjective interpretation of their environment, they react differently to objects, other human beings or phenomena in the environment. Whenever *interactions* take place, RNs bring their personal knowledge, needs, goals, expectations, perceptions and past experiences that influence *interactions* (King 1981:60.) Malin (2000:33) stated that trust is a firm foundation for professional relationships where there is interaction. Good leaders listen to those around them and begin to solicit ideas, contributions, concerns, hopes and aspirations to realise organisational goals, based on the principle of trust. Howkins and Thornton (2002:84) emphasised that leadership is about helping the oppressed groups voice their concerns, irrespective of the nature of the organisation.

Figure 2.1 depicts King's (1981:61) schematic diagram to illustrate RNs and HCS managers' *interaction* in bureaucratic organisations, from perceptions and judgments of RNs and HCS managers, respectively, which are not visible to the naked eye. These perceptions and judgments result in actions, then reactions to *interactions* in an attempt to resolve issues through negotiation during transactions, leading to attainment of goals.

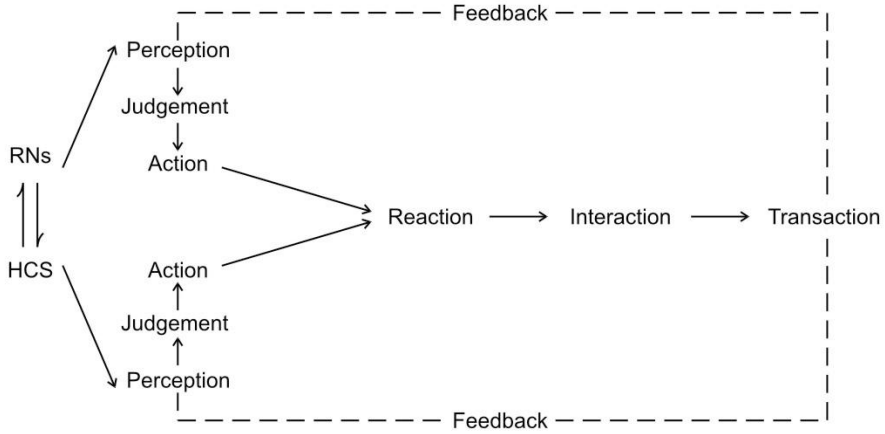

Figure 2.1 A process of human interaction

Adapted from King (1981:61)

2.3.2 Communication

Communication in HCS is used to provide information, reprimand, negotiate or exchange ideas. This can happen in a face-to-face meeting, telephonically or through memos, directives or policies and supervisors who represent units in meetings with hospital management in a bureaucratic organisation (King (1981:74).

To be effective, *communication* should be a two-way process that allows subordinates' active participation in decision-making processes that affect them. This requires an atmosphere of mutual respect, understanding and acknowledgement of people's individuality, talents, perceptions, sensitivity and the role they play within the bureaucratic organisation (King 1981:59-60). However, Buys and Muller (2000:53) found that *communication* in bureaucratic organisations was top-down while some believed that transformation allowed them to participate in problem-solving and decision-making processes. Mason et al (2001:12) contended that lack of *communication* in HCS is a major problem. By engaging their *communication* skills, RNs could learn how to work with others, irrespective of their differences. According to Denill, King and Swanepoel (1999:68), RNs are faced with the challenge of learning interdisciplinary negotiations. RNs could seize these opportunities to acquire collaborative and negotiation skills in the multidisciplinary team, which will facilitate and improve their *communication* with management, and perhaps reduce the existing gap between management and RNs.

2.3.3 Transactions in interactions

According to King's (1981:1) framework, *transaction*s are interactions with a specific purpose in mind that work towards attainment of goals. In the process, values between two or more people are transferred. Subsequently, some *transactions* produce job satisfaction, productivity and the realisation of short- and long-term goals in groups that share the same values and are cohesive. Reciprocity is an integral part of all *transactions* in a group and is key to

understanding interaction of RNs with hospital managers within bureaucratic organisations (King 1981:81).

According to King (1981:82), it is crucial to maintain balance and a state of harmony within the organisation during *transactions* involving conditions of service on the one hand and a good day's work for a good day's salary on the other. In other words, hospital authorities provide the job which has a financial incentive and RNs reciprocate with their services (Bezuidenhout et al 1998:8; King 1981:81-82).

2.3.4 Role

According to King (1981:93), *role* in interpersonal systems is a set of expected behaviour displayed by a person who occupies a given position in a particular organisation or any social system. Douglas (1996:71) and George (2002:249) saw *role* as a set of expected behaviours for individuals with particular positions in organisations.

RNs use their knowledge, skills and values to identify *roles* in each situation and to help hospital management to achieve goals in bureaucratic organisations. *Roles* are not a personal choice but are ascribed to positions held by RNs and HCS managers, respectively. Since RNs have a different *role* to play in their interaction with their environment, dyads, triads, small groups and large groups are formed. This means that RNs with the same mindset, perceptions, feelings and purpose can easily pool resources together to defy or overthrow any system posing as an impediment on their way, as evidenced by mass strike actions (Bezuidenhout et al 1998:403; King 1981:82). In addition, a scripture verse from Ecclesiastes (4:12) states that: "A person standing alone can be attacked and defeated, but two can stand back-to-back and conquer. Three are even better, for a triple-braided cord is not easily broken" (Graham, Hendricks, Kennedy & Palau, 1996:1030).

Gordon (1999:62) pointed out that hospital management and society, including individual patients, expect RNs to fulfil their *roles,* working together as a team. These expectations are necessary to regulate the RNs' behaviour within organisations (Badenhorst 2001:291; King 1981:94).

Howkins and Thornton (2002:225) maintain that RNs are not valued in bureaucratic organisations, as they are considered replaceable, meaning that hospital managers are more concerned about their *roles*, offices and getting the job done than RNs' concerns.

- **Role changes**

Lancaster (1999:176) indicated that any *role* that an individual assumes in an organisation continuously evolves over time. According to Hardy and Conway (1988:69), health professionals are faced with a continuing need to redefine and realign their *roles* because of the expansion of knowledge and demands made by consumers seeking ready access to care. *Role* change involves deliberately restructuring interactions. This means that the *role* of RNs is different from the one expected and hospital management modify their approach to enhance interaction. *Role* modification is a way of avoiding conflict. RNs are constantly faced with *role* changes as their patients, society and organisations' expectations change (Hardy & Conway 1988:69, 244).

According to Lancaster (1999:177), there must be ongoing dialogue between hospital management and RNs to negotiate changes regarding new *roles* and responsibilities consistent with new developments in HCS. It is imperative for authorities to listen to RNs' suggestions and be sensitive to the concerns of the nurses regarding changes in HCS since they have firsthand information as operational officers and can tell what works in a given situation (Flarey 1995:70; Luthans 1998:344; Schneider & Gibson 2001:16). Douglas (1996:288) maintains that it is incumbent on hospital management to provide RNs with professional preparation and to offer them opportunities to grow professionally as they climb the professional ladder to be future hospital managers.

- **Problems associated with changing roles**

According to Lancaster (1999:25), HCS are always influenced by social, scientific and technological changes. RNs are obliged to respond to these challenges, threats and opportunities in the nursing profession and HCS. These factors entail *role* change, which puts more pressure on RNs by introducing new responsibilities that RNs are not prepared for. For example, changes in disease patterns, technological changes, global mobility of health professionals, transcultural nursing, expansion of HCS and budget allocation to cost centres demand collaborative efforts between hospital management and RNs in decision-making processes (Douglas 1996:288; Schneider & Gibson 2001:6). True change creates a feeling of intimidation and vulnerability in any given situation and sometimes affects the *role* played by RNs in the organisation (Douglas 1996:74; William & Sibbad 1999:739). Lorriman et al (1995:20) stated that change is an ongoing process within organisations due to the introduction of new technologies, new competitors, new staff coming or old staff leaving, mandating adjustments in *roles* in bureaucratic organisations. Mason et al (1999:5) pointed out that most organisations "still do not have a policy statement on hospital management development nor a special budget," for emerging new roles. Jones et al (2004: 206) called new *roles* a "cultural shift" and regarded them as essential components of change if transformational initiatives have to be successful. Harrison (2004:4), however, referred to emerging *roles* as "modernity" and accepted the concept of modernity as one of the guiding principles of change in HCS around the globe.

Luthans (1998:102) emphasised that it is important to establish how a perceived *role* differs from a prescribed *role* in as far as it concerns RNs in bureaucratic organisations.

2.4 SOCIAL SYSTEMS

Social systems are organisations formed by groups with specific and common social roles, behaviours and norms meant to maintain values and develop mechanisms that will regulate practices and rules within the system. Examples of

social systems are families, religion, educational system and HCS (King 1981:113).

Changes in disease patterns and other dynamics of society directly impact the practice of nursing, therefore, precipitating change in health care delivery. It is expected that in restructuring HCS, certain procedures, policies and practices will undergo a revamp (Schneider & Gibson 2001:17; South Africa 1997b: 23). Since RNs are the middle man between the changing society and hospital management, it is crucial to understand how RNs view the bureaucratic rule in HCS, in their endeavour to bring about a balance between the society they serve and the authority they are accountable to, concerning the implementation of policies and procedures. King (1981:114) used the following concepts to describe social systems: *organisation, authority, power, status* and *decision-making.*

2.4.1 Organisation

King (1981:116) has it on record that formal *organisations* came into being during the Industrial Revolution because people became dependent on one another for survival. Communities relied on wages as a way of making a living. It became necessary to institute control measures on formal *organisations* by introducing an organised structure with authority, span of control and decision making from top-down in the *organisation,* typifying a bureaucratic structure. Prescribed rules became an integral part of communication (King 1981:117). Later the move towards informal *organisations* emerged in the workplace to meet individual and group needs not met by formal *organisations.* These are characterised by recognition in the work place, attending to basic needs, flexibility to change, the emergence of an informal leader and “who talks with whom” (King 1981:117).
Howkins and Thornton (2002:223) pointed out that the move from formal or bureaucratic structures to informal *organisations* faces tremendous challenges because people do not react the same way to specific change proposals within an *organisation.* Some may perceive change as threatening or damaging, depending on their positions and benefits within the *organisation*.

Figure 2.2 diagram illustrates the organisational structure, culture, and climate (organogram) schematically.

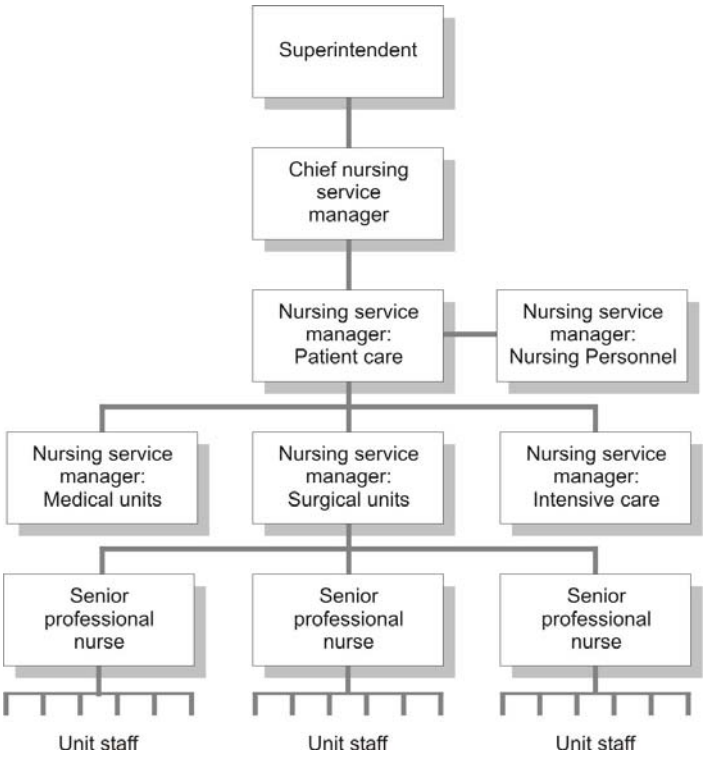

Figure 2.2 The chain of Command

Source: Booyens (1999:189)

- **Challenges to bureaucratic practices**

Harrison (2004:1-2) claimed that from the 1990s, a move from centralisation saw policies for HCS being enforced to make service providers more directly accountable for costs of services and quality care. It became critical to compare outputs to inputs in order to maximize efficiency by using a system that ensured payments commensurate to the services provided. The introduction of business and market concepts to health care reform became a new concept that would later impact the nursing personnel, not only at the operational level but would also influence the nursing curriculum (Harrison 2004:2).

This new approach was seemingly due to the failure of the bureaucratic approach to respond to public needs, which were lacking in accountability systems and had a stifling effect on the creativity and innovation of employees within the system. Organisations began looking at synthesising the top-down administration and the “bottom-up,” in order to regulate *organisational* change (Harrison 2004:5, 8).

According to Harrison (2004:5), in spite of all efforts to adopt the new system of hospital management, governments did not fully abandon the bureaucratic approach, but exercised control over HCS through central governance, perpetuating the same pattern of administration between hospital management and RNs. Powell and Wessen (1999:13) contended that hospitals and other health care institutions were still organised in a bureaucratic order. However, Turshen (1999:54) was in favour of central governance and argued that central governance should balance decentralisation with specific reference to allocation of resources.

Lorriman et al (1995:12) stated that experience and research have shown that a significant number of RNs have joined *organisations* in the hope that *organisations* would help develop and use their abilities. However, Harrison (2004:8-10) pointed out that in spite of endless reengineering programmes by bureaucratic *organisations,* under the guidance of central governance, a health care service that is suitable for the twenty-first century has not yet been produced. In Harrison’s (2004:9) opinion, NHS *organisations* have been based on hierarchies of bureaucracy, which serve the interest of health care leaders to the detriment of patients and employees at operational levels. Malin (2000:68) stated that bureaucratic practices tend to be detrimental to the survival of the nursing profession. However, Buys and Muller (2000:53) indicated that some NSMs embraced change and saw transformation bringing cultural diversity and empowering them to handle diverse problems.

- **Participative hospital management**

Participative hospital management is a modern tool with no boundaries between RNs and hospital management. There is communication and sharing of ideas in decision-making processes. In this way, staff feel empowered, valued and can develop their leadership skills (Howkins & Thornton 2002:133). In contrast to this view, Malin (2000:15) suggested that in spite of challenges to management, power, control and accountability; de-skilling and centralisation of work planning still continues in the workplace.

Harrison (2004:4) cited the British Prime Minister, Tony Blair's (2001:5) statement in a Labour Party (LP) conference in 2001 that "it is not the reform that is an enemy of the public service; it is the status quo". Blair (2001:5) in (Harrison 2004:5) added further that there is "too much bureaucracy; too many outdated practices; too great an adherence to the way we've always done it rather than the way public servants would like to do it if they got the time to think and freedom to participate in decisions". This speech portrayed the British government's resentment of the command and control approach in bureaucratic *organisations* (Harrison 2004:5).

Malin (2000:15) stressed that the former dominating professional culture, which separated hospital management from hospital professionals, was necessary for decision-making in bureaucratic *organisations* since the hierarchical structure ensured accountability through control. However, Harrison (2004:12) contended that the challenge of HCS today is to change the culture of the bureaucratic *organisation* in HCS to participative hospital management. Lorriman et al (1995:10) and Harrison (2004:12) hold that positions are not positions if they are acquired through delegated authority, as evident in bureaucratic organisations. They need to add value by empowering RNs to benefit as stakeholders.

2.4.2 Authority

King (1981:123) described *authority* as being endowed with power by holding a certain position and possessing certain expertise to make decisions and guide the actions of others in order to achieve the goals of the organisation. Howkins and Thornton's (2002:225) depiction of the bureaucratic order as a superior and subordinate relationship is similar to King's (1981) description of *authority* in that a superior person holds a certain position, which is acknowledged and accepted by subordinates. This pyramid has *authority* at the apex, followed by different levels of designated positions and supervision, with operations resting at the base of the pyramid.

According to King (1981:122) it is natural for RNs to depend on *authority* in certain areas of their work. Jones et al (2004:206) concurred that the element of central *authority* was beneficial since it maintains control for increased efficiency, effectiveness and productivity. Control was also seen as instrumental in minimising agency costs by sourcing nursing services from within the organisation.

Jooste (2003:19) claimed that the changing environment in the health sector requires that health service managers also, as authentic *authority* in HCS, be empowered with specific managerial skills that set a trend for future hospital managers.

It is likewise desirable that RNs also be given certain authority in their daily operations as a way of empowering them.

In bureaucratic organisations that attempt to embark on transformation, it is frequently found that RNs are reluctant to exercise their authority because of opposition from supervisors who feel intimidated by the RNs' new independent role (Smith 1999:77).

2.4.3 Power

King (1981:127) described *power* as the authority and position one has to influence others in an organisation. This means the ability to control and direct

events and behaviours through decision-making by virtue of the *power* vested in them. Furthermore, *power* is a situation where people accept what is being done while not necessarily agreeing with it. The person who has more *power* in an organisation is the one who has delegated authority and more control within an organisation to use and mobilise resources in order to achieve goals (King 1981:127; Sullivan & Decker 2001:257).

Lorriman et al (1995:30) maintain that the Western concept of hospital management represents the bureaucratic view of *power* in that it is highly prescriptive about what is required. However, Jones et al (2004:206) hold that central *authority* is still essential to direct and control activities to keep the story going in the right direction. Lorriman et al (1995:30) regarded this prescriptive rule based on the power one has as counterproductive and ironically still widely practised in Western countries. The division of power may result in conflicting strategies being used and may cause departments to compete with one another for scarce resources (Smith 1999:79). Therefore, authority is only one of the sources of power.

2.4.3.1 Types of power

Power is instrumental in the internal politics of a bureaucratic organisation in order to enforce law and order (Smith 1999:77).

- ***Rational or legitimate power***

This power emanates from the position that the person holds in the hierarchy over subordinates in a bureaucratic organisation (Sullivan & Decker 2001:43).

- ***Power to grant or refuse benefits***

This power is used to control the rewards and other benefits due to RNs either by granting or denying them. This element of power has the potential to influence the response of RNs who are the recipients of these benefits. RNs may perform

unnecessary favours for supervisors in order to be considered for these rewards and benefits, leading to corruption. On other occasions, supervisors may promote RNs that are in informal relationships with them to certain positions, in order to protect their positions from the challenges of more radical ones. In this situation a fair deal would be to give rewards according to the process of performance appraisal (Smith 1999:84).

- ***Information power***

HCS managers have this power on account of the information they possess from meetings with administrators that affect employees' work situation and the organisation. Followers are attracted by information that will meet their personal and sometimes their organisational needs (Booysens 1999:447; Sullivan & Decker 2001:44).

- ***Expert power***

People with expert power are respected for their abilities regardless of their position in the hierarchy of the organisation. The followers simply admire these skills and find them necessary while they pursue their own objectives. Followers are willing to submit to the power of the expert. With this kind of power it is common to find supervisors at the mercy of RNs who are more specialised and possess scarce skills. In this case, the power of RNs at the lower levels in the hierarchy may clearly contradict the position that they hold in the hierarchy. Such RNs are normally irreplaceable or difficult to replace because of their skill, knowledge and expertise (Booysens 1999: 446; Gillies 1994:388;Tappen 2001:438).

- ***Punishment or cohesive power***

This element of power uses sanctions of varying degrees on individuals. Compliance is based on fear of punishment. Warnings, withdrawals of rewards

and sometimes dismissals are examples (Gillies 1999:127; Sullivan & Decker 2001:257).

- ***Positional power***

This power is ascribed to the position itself rather than the individual who holds that position. It is power delegated by the organisation. The organisation is willing to address requests made by the holders of this power (Sullivan & Decker 2001:257).

- **Power cohesive strategies**

Changes in a bureaucratic organisation are made through laws, policies and directives. The authorities in the bureaucratic organisation can control and force change by putting restrictions on budgets of the organisation. RNs at the functional level may not be aware of what hospital management are planning to do, which makes no difference because they have no power to oppose management's decision even if they did know. It is a question of "take it or leave it" to force submission to authority (Gillies 1994:462;Sullivan & Decker 2001:257).

2.4.4 Status

King (1981:129) defined *status* as a position held by an individual within an organisation in relation to a group or as perceived by others within the same group. Role and position accentuate the *status* of a person. There are certain privileges, duties and obligations that are attached to *status* within bureaucratic organisations (King 1981:130). According to King (1981:129), the *status* of RNs in HCS is determined by the position they hold in the organisation. For example, the hospital manager's role has more prestige than the RN's and is viewed as having a higher *status.*

2.4.5 Decision-making

Decisions are the judgments made that affect the course of action in a specific situation on a day-to-day basis. *Decision-making* deals with defining the problem, analysing the facts gathered, weighing risks against gains and selecting the best alternative course of action in relation to the set goals (Monareng & Jooste 2001:71).

Decision-making at all levels of care influences how nurses carry out their nursing duties. RNs need to understand the difference between formal bureaucratic organisations and informal participative hospital management to help them cope with conflicting interests between organisational and professional obligations. It would seem that when there is clarity on the role and function of RNs and HCS managers, there is minimal conflict within the organisation and the standards of nursing are raised (Badenhorst 2001:300; Lancaster 1999:177; King 1981:120). Flarey (1995:70) and Luthans (1998:344) emphasised that it is important for authorities to listen to the suggestions, concerns and desires of RNs pertaining to the organisation to enhance decision-making.

According to Douglas (1996:289), patients expect continuous quality care from RNs, which is core to nursing. However, it all depends on how much liberty and power RNs are given by hospital management to make independent decisions within the bureaucratic system. RNs have their own perceptions that determine their behaviour, particularly if they find themselves trapped between two conflicting opinions: patients and organisational expectations (Douglas 1996:71; King 1981:94).

Mistakes in *decision-making* can be the result of subjective perception. It is crucial that RNs take cognisance of their perceptual biases (Lancaster 1999:280; Luthans 1998:112; King 1981: 24, 130). Effective *decision-making* is key to organisational survival and productivity. Ströh (2001:21) stated that if HCS managers failed to implement the prescribed democratic principles or deliberately excluded providers in *decision-making* processes, their positions and motives

would be questionable, invoking confrontation on the basis of constitutional rights.

2.5 CONCLUSION

The literature review provided a better understanding of the bureaucratic view of power in HCS, the problems inherent in the system and the challenges faced by health institutions in the implementation of transformational initiatives. The authorities and RNs are both considered responsible for the success of change within bureaucratic organisations.

Chapter 3 deals with the research design and method.

CHAPTER 3

RESEARCH DESIGN AND METHOD

3.1 INTRODUCTION

This chapter describes the research design and method, including the population, data-collection instrument and procedures, used in this study.

3.2 RESEARCH OBJECTIVES

The objectives of the study were to

- determine registered nurses perception regarding the bureaucratic view of power in health care services
- describe how power in a bureaucratic organisation affects the role of registered nurses in health care services.

3.3 RESEARCH DESIGN

The researcher adopted a quantitative approach. Talbot (1995:87) described a quantitative study as “a rigorous, objective and systematic process of obtaining numerical data and using control measures and statistical analysis to eliminate contaminating factors”. Babbie and Mouton (2001:49) stated that quantitative researchers believe that phenomena such as people’s attitudes “can best, if not only, be measured through quantitative measurement, using numerical data to quantify the qualities under study”.

A quantitative study, using a descriptive, exploratory design, was therefore conducted to describe the participants’ perceptions of bureaucratic practices in HCS in the Tshwane metropolitan region, with the aim of achieving the objectives of the study.

Burns and Grove (1999: 39) defined a research design as “a blueprint that guides the planning and implementation of the study”. Polit and Hungler (1995:713) described it as “an overall plan designed to elicit answers to the research questions and address all other related specific aspects in order to ensure quality of the study”.

- **Descriptive**

This study was descriptive because the researcher found no literature on RNs’ perceptions of the bureaucratic view of power in HCS in the RSA. Descriptive designs entail “a full description of a single broad variable or concept, either unstudied or understudied, within a given population” (Brink & Wood 1998:289; Talbot 1995:229). According to Saunders, Lewis and Thornhill (1997:96), descriptive research provides “an accurate profile of events, persons or situations to clarify the problem before data can be collected”. Burns and Grove (2001:795) added that descriptive studies provide “an accurate account of the uniqueness of the participants, group or events in their original setting for the purpose of describing what exists, discover new meaning and categorise information”. A quantitative descriptive design was therefore selected since this study focused on a single variable, namely the perceptions of RNs of the bureaucratic view of power in HCS in the Tshwane Metropolitan region.

- **Exploratory**

Babbie and Mouton (2001:79-80) stated that research is exploratory when the researcher “examines a new interest or explores a topic, especially where a phenomenon is persistent”. Saunders et al (1997:97-98) emphasised that exploratory studies are useful if the researcher wishes “to assess and understand a phenomenon in a new light, ask questions and search for new insights”.
This view is consistent with the purpose of this study, which is to determine and describe the perceptions of RNs regarding the bureaucratic view of power in HCS within the Tshwane metropolitan region, with the purpose of enhancing

interpersonal relationships in their daily interaction with management, patients and other RNs.

3.4 RESEARCH METHOD

Research methods are steps, procedures and strategies used by the researcher in order to gather and analyse data for the study.
The research method included the target population from which the sample was drawn and the specific selection criteria. The nature and the development of the instrument, validity and reliability, ethical considerations and data analysis procedures are also explained.

3.4.1 Research population

According to Burns and Grove (1999:474), population, also called the target population, refers to the “individuals, objects, or substances that qualify by meeting the set criteria for inclusion in a study”. In this study, the target population comprised all RNs working in selected HCS in the Tshwane metropolitan region. Three hospitals were selected for the study, of which two were private and one was public, bringing the total number of RNs to 724. Out of this total, 228 participants were selected for the study.

3.4.2 Eligibility criteria

Burns and Grove (2001:229) stated that eligibility criteria are synonymous with sampling criteria and identify the characteristics essential for inclusion in the target population. Polit and Hungler (1995:278) pointed out that eligibility criteria are also known as inclusion criteria. These characteristics delimit the population of interest. In this study, the following inclusion criteria were used to select RNs to qualify for participation:

- Participants had to have at least three years’ working experience after registration with the SANC, to ensure familiarity with

bureaucratic view of power since transformation has been a gradual process in most HCS.

- RNs of all racial groups were selected.
- There was no age restriction.

3.4.3 Sample

A sample is a subset of the population selected to represent the entire population in order to obtain information on the construct being studied (Brink & Wood 1998:292; Polit & Hungler 1995:281). Out of a total of 724 RNs from the three hospitals, a sample of 228 participants was selected for the study.

3.4.4 Sampling

Burns and Grove (2001:369) believe that in order for each person in the target population or accessible population to have an opportunity to be selected for the sample, each person in the population must be identified.

RNs were randomly selected from the allocation lists available from the units, which constituted the sampling frame (Babbie & Mouton 2001:174). The researcher assigned consecutive identification numbers to 724 names of RNs on the unit lists. A simple random sampling technique was used. Every second number was chosen from each unit list to constitute a sample (Polit & Hungler 1995:285). In cases where RNs declined participation in the study, the next number was chosen, since participation was on a voluntary basis. The researcher distributed questionnaires to 228 participants whose numbers were selected. 131 questionnaires were returned, of which 121 were usable.

3.4.5 Data collection

Burns and Grove (1999:460) defined data collection as “a process of gathering information using questionnaires, interviews or observation”. According to Talbot (1995:293), if a researcher wants to obtain information about attitudes, feelings, beliefs and perceptions, which are not immediately observable, the value of

structured questionnaires cannot be overemphasised. Data was collected using self-administered structured questionnaires for the three selected HCS.

- **Research instrument**

The data-collection instrument is a device or tool used by the researcher to collect data and may comprise interviews, recording, observation or questionnaires (Polit & Hungler 1995:704). In this study self-administered structured questionnaires were utilised to collect data from the participants. A questionnaire is a formal instrument comprising pre-defined items and response options.

- **Development of the questionnaire**

The researcher developed a questionnaire to collect data on RNs' perceptions of the bureaucratic view of power in HCS (see annexure F). The questions included were derived from the literature reviewed and King's theoretical framework, as well as views of colleagues from discussions on the topic. The questionnaires, also known as self-report instruments, comprised pre-determined items and response options specifically designed for the participants to choose the most appropriate answers and/or furnish desired information in writing, where necessary (Talbot 1995:293; Polit & Hungler 1995:334).

The initial questionnaire was submitted to the statistician at the University of Pretoria for evaluation and to ensure congruence with statistical analysis.

- **Advantages of questionnaires**

Questionnaires have the following advantages:

- Questionnaires are less expensive to administer as opposed to conducting interviews, which require the use of trained and hired interviewers or field workers.

- The format is standardised for all participants to ensure uniformity of questions.
- Researcher bias is obviated by the absence of the researcher while the participants complete the questionnaires.
- Participants are free to provide honest answers when they realise that the information they provide cannot be linked with specific participants in an atmosphere of anonymity provided (Babbie & Mouton 2001:523).

- **Structure of the questionnaire**

A covering letter was attached to the questionnaires, explaining the purpose of the study and providing instructions on completion of the questionnaire. All the questions were coded prior to distribution to enable computation of data. The questionnaire was divided into eight (8) sections (see annexure F).

3.4.6 Pilot study

A pilot study is “a small-scale trial of the research design. It is conducted to identify possible weaknesses in the research instrument” (Polit & Hungler 1995:318-320). A pilot study was conducted on ten (10) RNs from a group that was not part of the major study. According to Polit and Hungler (1995:320), researchers who develop their own instruments should subject them to a small pre-test. The pilot study assisted in estimating the length of time the participants needed to complete the questionnaire. It also helped to identify questions that were either offensive or ambiguous to participants.

The pilot study revealed that the units in which participants worked were not all included in the questionnaire and therefore created a long list of “other items not included”. The researcher subsequently corrected this and 228 questionnaires were distributed to the three selected hospitals.

3.4.7 Administration of the questionnaire

The researcher personally distributed the questionnaires in the selected institutions to ensure an acceptable response rate. Seaman (1987:284) stated that hand delivered questionnaires are good in stimulating participants' timely response and cooperation. The participants were allowed to complete these questionnaires at their earliest convenience, but all questionnaires were expected back with unit managers within 48 hours of distribution from where the researcher collected them (De Vos 1998:155). The researcher also found it easier to collect them from specific points in the hospitals, at the appointed times arranged with NSMs and unit managers.

3.5 VALIDITY AND RELIABILITY

Validity and reliability are two important criteria by which a quantitative instrument is evaluated in terms of its adequacy and quality.

3.5.1 Validity

Validity refers to the ability of the instrument to measure the truthfulness or falsity of the data collected, given the context in which it is applied (Burns & Grove 2001:226; Polit & Hungler 1995:418). In this study validity means the extent to which the information provided by participants reflects the truthfulness or falsity of bureaucracy in terms of the perceived challenges reported by participants.

- **Face validity**

Face validity means that an instrument empirically appears to measure what is needed, given the construct that is supposed to be measured (Polit & Hungler (1995:418). Including only the items that reflected the concept "bureaucratic organisation" in the questionnaire in order to measure the RNs' perceptions regarding bureaucracy in HCS ensured face validity (see annexure F).

- **Content validity**

Content validity deals with the question of how representative or adequate the compiled questions are to comprehensively cover the construct being measured (Bowling 1997:133). Content validity relates well with the traits of the affective domain such as feelings, perceptions and emotions. To ensure content validity, the researcher conducted an extensive literature review on bureaucratic practices in HCS and the move towards transformation of HCS. Other questions were constructed from King's (1981:11) theoretical framework.

Polit and Hungler (1995:419) stated that it is common practice to seek experts who are familiar with the content area to judge the relevancy and congruency of the questions; that is, how well a questionnaire is designed. In this study, content validity was enhanced by presenting the questionnaire to the researcher's supervisors for review, in order to establish whether the individual items in the questionnaire adequately measured all the dimensions of the bureaucratic view of power within HCS, because of their many years of service and vast experience in this area. This helped with validation and authenticity of meanings and interpretations conveyed by the questions to avoid confusion and ambiguity. They also examined the clarity of item wording and the necessary adjustments were made, from rewording of items to rephrasing of questions (Brink & Wood 1998:259). In addition, the statistician went through the questionnaire prior to distribution. Some of the NSMs and the researcher's colleagues were also requested to go through the questionnaire, which contributed to the construction and proper phrasing of the questions (see annexure F).

- **External validity**

According to Burns and Grove (2001:798) external validity refers to generalisation of the study findings to other settings or samples, other than the one studied. The sensitiveness of the title of this study could have jeopardised generalisation because some participants who volunteered could have refrained from providing their genuine perceptions of bureaucracy in HCS just to please

the researcher or quickly get through the questionnaire. Participants, however, were not coerced to complete the questionnaires.

- **Internal validity**

Brink and Woods (1998:106) described internal validity as “the extent to which the outcome of the study can be attributed to the independent variable rather than other factors”.

Pertinent factors to the history of bureaucratic practices in HCS posed a threat to the internal validity in that the concept of bureaucracy in itself is a sensitive issue where people do not open up easily and those who volunteered might not have given their genuine opinion for fear of victimisation and various other reasons. This ordeal is supported by Burns and Grove’s (2001:229) statement that the type of participants selected for the study and the process of selection followed could influence the findings of the study, leading to validity being compromised. As indicated before, the selection of participants for this study was purely on a voluntary basis.

3.5.2 Reliability

According to Polit and Hungler (1999:255), reliability of the tool implies how consistent or stable the data-collection instrument is in measuring the construct it is intended to measure. According to Burns and Grove (1999:257), the characteristics of reliability are that the tool should be dependable, consistent, accurate and comparable. In other words, it has to be established whether the tool is capable of yielding the same results when repeatedly used under similar circumstances by different investigators (Brink & Woods 1998: 264). In this study, completed questionnaires were split into two equal groups and each group was scored separately. The findings were then correlated between related aspects in the questionnaire to ensure consistency.

3.6 ETHICAL CONSIDERATIONS

Polit and Hungler (1995:701) defined ethics as “principles or moral values which regulate or govern research processes to comply with professional, legal and social obligations” in an attempt to safeguard participants under study. According to Pera and Van Tonder (1996:5), ethics is about the act of rightness or wrongness, good or bad. Ethics, therefore, is concerned about the protection of subjects from harm. Many professions have developed a code of ethics and principles that safeguard their clients. Streubert and Carpenter (1999:33) emphasised that researchers must assume ultimate responsibility for ethical decision-making and protection of participants in any given study they undertake.

3.6.1 Principle of beneficence

Polit & Hungler (1995:134) considered the principle of beneficence as one of the most fundamental ethical principles in research. Beneficence is an ethical principle that deals with the act of doing well and no harm to the study participants. In this study, the participants were given the opportunity to make informed decisions about their participation.

- **Freedom from harm**

Protecting human beings from harm is not only physical, but refers to psychological consequences of participating in a study as well. Harmful effects can be very subtle and therefore require serious consideration by researchers. Questions should not probe into people’s personal views, weaknesses and fears, as participants might perceive them as intimidating. In this study, the researcher carefully considered the phrasing of the questions so that they did not sound offensive to participants. The pilot study was also instrumental in assessing the nature and weight of the questions. Voluntary participation was assured in the covering letter about the nature and expectations of the study, in view of the fact that some of the information required about the organisation could have been perceived as sensitive (Polit & Hungler 1995:134).

- **Freedom from exploitation**

The questions were phrased in a simple and short manner to avoid unnecessary stress to the participants, given the fact that some nursing activities are stressful. Moreover, the tool was subjected to a pilot test to ensure that the questions were not too long and ambiguous for participants, and that they were comprehensible and relevant. The participants were further reassured that they would not be victimised since they were not required to provide personal details. The participants were also allowed to keep the questionnaires for two days, if necessary, and to leave them at designated places in their units for collection by the researcher, so that no information could be linked to any particular person. De Vos (1998:155) suggested 48 hours for the return of questionnaires. According to Polit and Hungler (1995:120), participants of the research should not be placed at a disadvantage. No advantage was taken of the participants since they were not put under duress to complete the questionnaires (Polit & Hungler 1995:134).

3.6.2 Principle of respect for human dignity

This is an ethical principle, which includes the right to self-determination and to full disclosure.

- **Right to self-determination**

According to Polit and Hungler (1995:136), this ethical principle deals with autonomy of participants. Self-determination means that the participants have the right to choose a course of action. In other words, participants have the right to choose to participate in a study and to terminate their participation at any stage or process of the study. Coercion of participants is considered unethical. In this study, the researcher ensured that a letter clarifying the nature and purpose of the study accompanied all questionnaires. The researcher distributed the questionnaires and a good rapport was established with the participants. Participants did not receive any reward in this study.

- **Right to full disclosure**

Polit and Hungler (1995:122, 140) emphasised the principle of full disclosure. This means voluntary consent after full comprehension by participants to take part in the study, based on true and sufficient information provided with regard to the research, without any form of coercion. The researcher personally distributed the questionnaires and attached a covering explanatory letter to every questionnaire. The participants voluntarily gave consent to participate in this study.

3.6.3 Principle of justice

This ethical principle refers to the right to fair treatment and the right to privacy for all participants.

- **Right to fair treatment**

Polit and Hungler (1995:138) stated that all participants have the right to fair and equitable treatment before, during and after their participation in the study. Polit and Hungler (1995:138) further emphasised non-discriminatory selection of participants. In this study, a simple random sampling technique was used. RNs were randomly selected from the allocation lists available from units, which constituted the sampling frame (Babbie & Mouton 2001:174). The researcher assigned a consecutive identification number to each name from the unit lists. Every second number was chosen from each unit list to constitute the sample (Polit & Hungler 1995: 285). In the event that the selected participant declined to participate in the study, the next volunteer from those who were not selected was assigned a number. All participants were treated with courtesy and respect.

- **Right to privacy**

According to Polit and Hungler (1995:285), information derived from participants should be kept in the strictest confidence possible. In this study, all the returned

questionnaires were returned without any personal or organisational details on them, to ensure anonymity. Thereafter, all returned questionnaires were coded by allocating numbers to them, which would help identify a particular questionnaire in the event that any information was missed during data capturing. Confidentiality was also ensured in that it was impossible even for the researcher to link information to any participant (Burns & Grove 1999:163). The names of the selected HCS were also protected by labelling them A, B and C, respectively (see chapter 4, table 4.1).

3.6.4 External review and consent

The researcher requested permission to conduct the study, which was subsequently submitted to the research advisory panel for review of the research proposal. Permission to conduct the study was later given in writing by the authorities of selected HCS (see annexure B, C and D).

3.7 DATA ANALYSIS

Data cleaning, coding and analysis was done using the Statistical Analysis Systems (SAS) statistical software package from the University of Pretoria with the assistance of an experienced statistician. Descriptive and inferential statistics such as percentages, averages and variations of responses were utilised. It should be noted that frequencies and percentages would be presented as calculated by the SAS programme, which means that not all percentages totalled 100.0%. On other occasions a total of 100.1% or 99.9% was obtained, which should be expected in statistical terms.

3.8 CONCLUSION

This chapter focused on the research design and method used to determine the participants' perception of the bureaucratic view of power in selected hospitals in the Tshwane metropolitan region. The discussion covered the development of the questionnaire and the ethical considerations observed.

Chapter 4 presents the data analysis and interpretation.

CHAPTER 4

DATA ANALYSIS AND INTERPRETATION

4.1 INTRODUCTION

A quantitative, descriptive, exploratory study was conducted to determine RNs' perceptions of the bureaucratic view of power in selected HCS in the Tshwane metropolitan region. This chapter discusses the analysis and interpretation of the data collected.

4.2 DATA MANAGEMENT AND ANALYSIS

Data was collected using self-administered, structured questionnaires. A total of 228 questionnaires were distributed, 131 were returned. Ten of them did not comply to the criterion of three years' experience after registration with SANC and were therefore unusable. The sample comprised of 121 RNs. The number of questionnaires not returned was reasonable in the context of the study, in view of the nature of the topic for this study, which might have been intimidating to some RNs, in terms of providing such sensitive information about their organisations.

Table 4.1 represents the distribution and response return of questionnaires.

Table 4.1 Response return

Hospital	Questionnaires Distributed	Returned	Not Returned	Usable	Unusable
A	90	62	28	60	2
B	49	31	18	26	5
C	89	38	51	35	3
Total	**228**	**131**	**97**	**121**	**10**

Section A elicited the participants' biographic data while sections B to H covered items related to the bureaucratic view of power (see table 4.2).

Table 4.2 Sections of the Questionnaire

Section	Topics	No. of items in Questionnaire
B	Management	13
C	Organisation	23
D	Communication	7
E	Decision-making	6
F	Management of patient care	10
G	Growth and development	12
H	Research	9

The Statistical Analysis Systems (SAS) software package was used for data management and analysis with the assistance of a statistician. The researcher used descriptive and inferential statistical tests, which included frequencies, percentages, the mean, standard deviations and measures of variance. Pearson's correlation coefficient test was also calculated to correlate RNs' responses to some of the selected items in sections B to H of the questionnaire.

4.3 RESEARCH RESULTS

The research results are discussed by referring to the sample characteristics and the participants' perceptions of the bureaucratic view of power in HCS.

4.3.1 Sample characteristics

Section A of the questionnaire comprised five items on the participants' biographical data.

4.3.1.1 Age

Of all the participants, 31 (25.6%) were 45-61 years of age, and were valued for their considerable employment longevity with their current organisations to make intelligent assessment of bureaucracy. 48 (39.6%) of the participants fell in the age category of 35-44. The researcher assumed that this was the more stable group in the organisations, which could be trusted to provide their genuine

opinion, since they were conversant with both bureaucracy and democratisation of HCS. They were considered less critical than the younger generation and could face challenging questions better than the older generation. 35 (28.9%) were 25 - 34 years of age and were considered adventurous while 7 (5.8%) did not indicate their ages (see table 4.3).

Table 4.3 Participants' age distribution (n=121)

Age	Frequency	Percentage
25-34	35	28.9
35-44	48	39.6
45-61	31	25.7
Missing	7	5.8
TOTAL	**121**	**100**

4.3.1.2 Academic qualifications (n=121)

Of the participants, 51 (42.15%) held a basic nursing diploma; 30 (24.79%) had a basic nursing degree; 35 (28.93%) held a post-basic nursing diploma; 4 (3.31%) held honours degrees, and 1 (0.83%) a master's degree. No participants held a doctoral degree. The latter two statistics could indicate that a very small proportion of RNs were involved in continuing education in nursing, or else held positions of supervisors in their units (see figure 4.1).

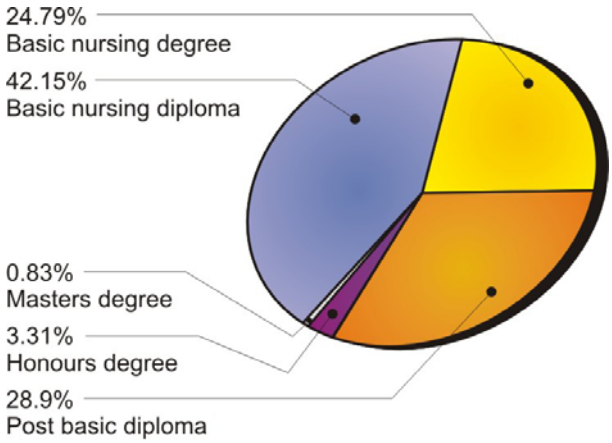

Figure 4.1 Academic qualifications

4.3.1.3 Professional registrations (n=121)

Of the participants (n=121), all were registered general nurses; 16 (13.22%) were in possession of the diploma in nursing only; 39 (32.23%) had the four-year integrated course; 24 (19.83%) had a diploma in General and Midwifery, and 9 (7.44%) had registrations in General, Midwifery, Psychiatry, Community and Nursing Education in the clinical area (see table 4.4). The value of these extra qualifications in terms of the required registration as a general nurse could inspire further studies.

Table 4.4 Professional registrations (n=121)

Professional registration	Frequency	Percentage
General	16	13.22
General + Midwifery	24	19.83
General + Midwifery + Paediatrics	1	0.83
General + Midwifery + Nurse Educator	2	1.65
General + Community	4	3.31
General + Midwifery + Community	13	10.74
General + Midwifery + Community + Paediatrics	1	0.83
General + Midwifery + Community + Nurse Educator	4	3.31
General + Psychiatry	1	0.83
General + Midwifery + Psychiatry	4	3.31
General + Psychiatry + Community	2	1.65
General + Midwifery + Psychiatry + Community (4-year course)	39	32.23
General + Midwifery + Psychiatry + Community + Paediatrics	1	0.83
General + Midwifery + Psychiatry + Community + Nurse Educator	9	7.44
General + Midwifery + Psychiatry + Community + Nurse Manager	0	0
TOTAL	**121**	**100%**

4.3.1.4 Years of professional experience (n=121)

The mean for the years of professional experience was (m=14.4) and the standard deviation (7.6). The participants' years of experience varied between 3 and 42 years. These years of experience were divided into 3-7, 8-12 and 13+ years. Of the participants, 64 (52.89%) had 13+ years of experience, which was a good indication because of the valuable information about the bureaucratic view of power that could be derived from their input. A further 31 (25.62%) participants had 8-12 years' experience, which was also valued because they entered the nursing profession at the dawn of the new political dispensation, of democratisation of HCS in the RSA. Finally, 26 (21.49%) participants had 3-7 years' experience, which was encouraging, since this is reasonable service to be able to distinguish between bureaucratic practices and transformation in HCS (see figure 4.2).

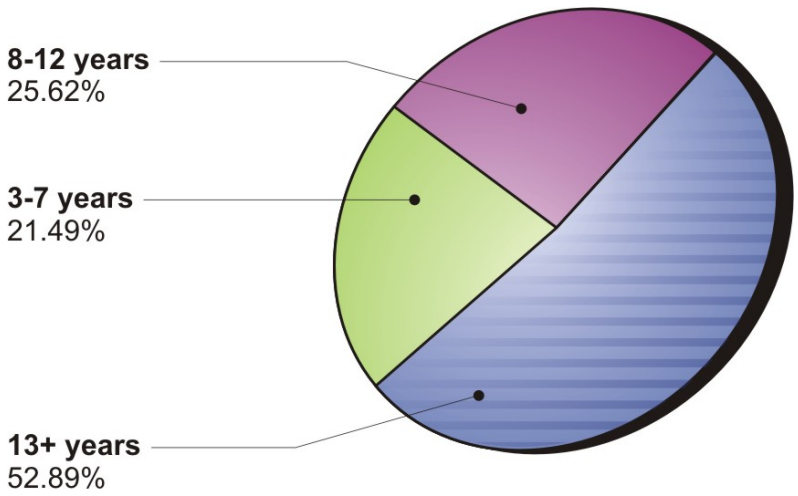

Figure 4.2 Years of professional experience

4.3.1.5 Units in which participants work (n=121)

Of the participants, 29 (23.97%) worked in medical wards; 22 (18.18%) in surgical wards; 7 (5.79%) in Paediatric wards; 6 (4.96%) in Maternity; 2 (1.65%) in Psychiatric wards; 6 (4.96%) in Emergency Room; 7 (5.79%) in OT; 1 (0.83%)

in Orthopaedics; 8 (6.61%) in Gynaecology; 6 (4.96%) in Oncology wards; 20 (16.53%) in ICU; 5 (4.13%) in NICU; 1 (0.83%) in OPD and 1 (0.83%) in Personnel Development (see figure 4.3). There was no indication under “other” categories not listed. There were few participants from Maternity, Casualty and OT because they are emergency units. They did not get time to complete questionnaires as they were often busy and could not complete them at home since they were always tired after a long day’s work.

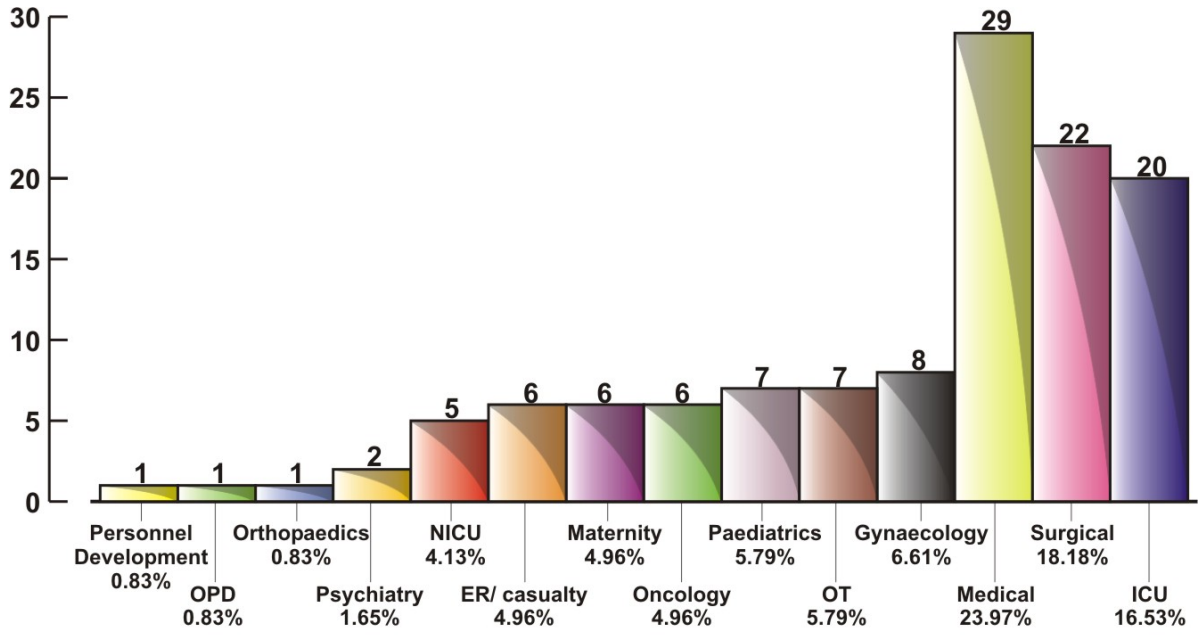

Figure 4.3 Units in which respondents work

4.3.2 Management

Section B of the questionnaire comprised 13 items pertaining to management aspects in a bureaucratic organisation. Table 4.5 depicts the participants’ perceptions of the bureaucratic organisation according to items on the questionnaire. The items are discussed after table 4.5.

Table 4.5 Management (n=121)

Items	Disagreed		Agreed		Total		Missing values	N
	Number	Percentage	Number	Percentage	Number	Percentage		Total
B1, B6, B9-B10, B13	40	33.56	79	66.43	119	100	2	121
B2-B5, B8	45	39.46	70	60.53	115	100	6	121
B7	21	17.36	100	82.65	121	100	-	121
B11	33	27.73	86	72.27	119	100	2	121
B12	59	50.43	58	49.57	117	100	4	121

Item B1 RNs are interviewed after employment to find out how they are settling in

Of the participants, 44 (36.36%) strongly disagreed; 42 (34.71%) disagreed; 21 (17.36%) agreed, and 14 (11.57%) strongly agreed with this statement. A total of (86; 71.07%) disagreed with this item. This gives an indication that follow-up interviews to reassure new employees are not conducted.

Item B2 RNs develop operational plans for delivery of care

Of the participants, 6 (5.08%) strongly disagreed; 17 (14.41%) disagreed; 79 (66.95%) agreed, and 16 (13.56%) strongly agreed. A total of (95; 80.51%) is a good response, which negates dictatorship deeply entrenched in bureaucracy where for example, patients' records are revamped without consultation with RNs. The above response signifies involvement of RNs in decisions pertaining to the delivery of care. There were 3 missing frequencies out of the sample of 121.

Item B3 RNs compile budgets

Of the participants, 39 (36.11%) strongly disagreed; 35 (32.41%) disagreed; 29 (26.85%) agreed, and 5 (4.63%) strongly agreed with this item. Therefore, the majority of the participants (74; 71.52%) disagreed, indicating that RNs were not included in financial planning. This could be due to the traditional bureaucratic approach adopted by the nursing profession of embracing the medical model to the exclusion of pecuniary skills, which are also crucial in the practice of nursing. Thirteen participants did not respond to this item.

Item B4 RNs are empowered with management skills to effectively run the units

Of the participants, 10 (8.47%) strongly disagreed; 48 (23.73%) disagreed; 40 (50.85%) agreed; 20 (16.95%) strongly agreed, and only 3 did not respond to this item. Almost half of the participants (60; 50.84%) therefore, agreed that there is an effort to empower RNs with managerial skills in a bureaucratic organisation, while the other (58; 52.25%) felt that much still needed to be done to empower RNs. It could be an indication of efforts directed towards transformational initiatives.

Item B5 RNs are still restrained by their dependent role

Of the participants, 9 (8.11%) strongly disagreed; 32 (28.83%) disagreed; 54 (48.65%) agreed, and 16 (14.41%) strongly agreed. Of the participants, (70; 63.06%) therefore, admitted that RNs were still labouring under the constraints of their dependent role in a bureaucratic organisation. The 10 missing frequencies were significant in that the results could have been different had they all answered this question.

Item B6 RNs choose areas of work according to their specialty

Of the participants, 7 (5.83%) strongly disagreed; 25 (20.83%) disagreed; 60 (50%) agreed, and 28 (23.33%) strongly agreed. Thus, (88; 73.33%) of the

participants agreed that RNs in a bureaucratic organisation were given the liberty to choose the units they want to work in, which is encouraging as opposed to the previous autocratic and subjective manner in which hospital allocations were done. There was only 1 missing frequency.

Item B7 RNs perform activities that are above the content of their job description

Of the participants, 3 (2.48%) strongly disagreed; 18 (14.88%) disagreed; 51 (42.15%) agreed, and 49 (40.50%) strongly agreed. This overwhelming response (100; 82.65%) of those who agreed with the above item is an indication that RNs were still inundated with activities beyond their job description. This situation is exacerbated by international recruitments of RNs and other factors that took advantage of the ordeal of RNs in terms of poor salaries and working conditions among other things, within the country.

Item B8 RNs practise sound conflict management skills

Of the participants, 10 (8.55%) strongly disagreed; 37 (31.62%) disagreed; 54 (46.15%) agreed, and 16 (13.68%) strongly agreed. Most of the participants (70; 60.83%) agreed that they practice conflict management. By virtue of their leadership and supervisory role over nursing students, enrolled nurses, enrolled nursing assistants and patient care activities; RNs take charge to resolve conflicts between doctors and nurses, patients and nurses and patients' relatives and other members of the multidisciplinary team in their units. There were 4 missing frequencies on this item.

Item B9 RNs plan their own vacations

Of the participants, 12 (10.34%) strongly disagreed; 20 (17.24%) disagreed; 67 (57.76%) agreed, and 17 (14.66%) strongly agreed. Therefore, of the participants, (84, 72.42%) agreed with this item, showing contentment with the opportunity to plan their own vacations within bureaucratic organisations. This shows that great strides have been taken to transform HCS in that the

bureaucratic model was devoid of this component of flexibility. Previously, it was not uncommon to find RNs either resigning or engaged in serious conflicts with nursing management over ‘trivial’ issues such as RNs desiring to be with their children during Christmas holidays or for other personal reasons. There were 5 missing frequencies.

Item B10 RNs decide their own indemnity cover

Of the participants, 7 (5.83%) strongly disagreed; 4 (3.33%) disagreed; 65 (54.17%) agreed, and 44 (36.67%) strongly agreed, thus indicating that most of them (109; 90.84%) had the liberty to choose their own indemnity cover. This fact had to be established in this study because in the previous apartheid regime RNs were forced to subscribe to the South African Nursing Association (SANA), which according to Jansen (1991:169) was “an extremely pro-government organisation”. With the stipulations of the new LRA 66 of 1995, some RNs began to experience a paradigm shift of subscription to trade unions, according to their personal choices (Bezuidenhout et al 1998:276). There was only 1 missing frequency.

Item B11 RNs follow the grievance procedure to lodge their complaints

Of the participants, 10 (8.40%) strongly disagreed; 23 (19.33%) disagreed; 86 (56.30%) agreed, and 19 (15.97%) strongly agreed. Thus, (86; 72.27%) of the participants indicated that the grievance procedure was utilised in bureaucratic organisations. Bezuidenhout et al (1998:152) explicates a grievance procedure as a process that facilitates upward-movement of communicating complaints, which is a fair practice to both the employee and management. There were 2 missing frequencies.

Item B12 RNs are afraid to complain

Of the participants, 15 (12.82%) participants strongly disagreed; 44 (37.61%) disagreed; 36 (30.77%) agreed, and 22 (18.80%) strongly agreed, indicating that almost half of the participants (58; 49.57%) felt that RNs were afraid to complain,

while (59; 50.43%) was not afraid to complain. These figures indicate that the participants were divided, probably because of the variance in the participants' perceptions with specific reference to age, years of experience, academic qualifications and professional registrations in relation to this item. Further details on these variances will be addressed in chapter 5. There were 4 missing frequencies.

Item B13 RNs have an exit interview after submission of resignation

Of the participants, 18 (15.00%) strongly disagreed; 22 (18.33%) disagreed; 59 (49.17%) agreed, and 21 (17.50%) strongly agreed. Therefore, most of the participants (80; 66.67%) agreed that there were exit interviews in bureaucratic organisations. Exit interviews assist with identification and analysis of reasons for resignation so that similar incidences can be avoided in the future to retain skilled personnel. New recruits have proven to be expensive to acquire in many ways. There was 1 missing frequency.

4.3.3 Organisation

Section C of the questionnaire comprised 23 items pertaining to a bureaucratic organisation. Table 4.6 depicts the participants' perceptions of the bureaucratic organisation in response to the items. The responses to the items are discussed after the table.

Table 4.6 Organisation (n=121)

Items	Disagreed		Agreed		Total		Missing values	N
	Number	Percentage	Number	Percentage	Number	Percentage		Total
C1-C7	66	55.54	52	44.44	118	100	3	121
C8-C10	51	45.17	62	54.83	113	100	8	121
C11-C18, C23	79	68.25	37	31.75	116	100	5	121
C19-C21	27	22.99	87	77.20	114	100	7	121
C22	83	72.18	32	27.83	115	100	6	121

Items C1-C7 RNs participate in issues pertaining to the organisation

Of the participants, 56 (55.54%) disagreed and 52 (44.44%) agreed with the above statements. These figures indicate that the participants were also divided on this item, probably because of the variance in the participants' perceptions with specific reference to age, years of experience, academic qualifications and professional registrations in relation to this item. This is covered in further detail in chapter 5. There were 13 missing frequencies, which probably could have influenced the results towards a different direction had all participants responded to this item.

Items C8-C10 A central budget system is used

Of the participants, 51 (45.17%) disagreed while 62 (54.83%) agreed with the above items. There were 8 missing frequencies. From these figures, it would appear that hospital budgets are controlled from a central point, as opposed to the new concept of allocation of financial resources to cost centres.

Items C11-C18, C23 Promotions and awards are fairly distributed

Of the participants, 79 (68.25%) disagreed with these statements while 37 (31.75%) agreed. This is an indication that there was still dissatisfaction among RNs regarding promotions. Possibly, only a few senior positions were available in organisations. There were 5 missing frequencies.

Items C19-C21 Quality and cost-effectiveness are emphasised in units

Of the participants, 27 (22.99%) disagreed with the above items while 87 (77.02%) agreed. It would thus appear that quality and cost-effectiveness are emphasised in HCS, in spite of challenges faced by RNs. There were 7 missing frequencies.

Item C22 RNs negotiate own salary to sell their skills

Of the participants, 83 (72.18%) disagreed while 32 (27.83%) agreed with the above statement. Negotiation of salaries is commonly found in private hospitals, since salaries in public hospitals are pre-determined. Further details on this item are provided in chapter 5. There were 6 missing frequencies.

4.3.4 Communication

Section D of the questionnaire consisted of 7 items on communication aspects in the bureaucratic organisation. Table 4.7 depicts the participants' perceptions of this section.

Table 4.7 Communication (n=121)

Items	Disagreed		Agreed		Total		Missing values	N
	Number	Percentage	Number	Percentage	Number	Percentage		Total
D1	39	32.77	80	67.22	119	100	2	121
D2, D3, D4, D7	27	22.92	91	77.07	118	100	3	121
D6	73	62.93	43	37.07	116	100	5	121

Item D1 Supervisors always follow channels of communication

Of the participants, 12 (10.08%) strongly disagreed; 27 (22.69%) disagreed; 67 (56.30%) agreed and 13 (10.92%) strongly agreed, thus, (80; 67.22%) indicated that supervisors followed the channels of communication in addressing pertinent issues within the organisation. The upgrading of channels of communication is attributed to the LRA 66 of 1995.

Items D2, D3, D4, D7 Communication with management

Of the participants, 27 (22.92%) disagreed with the above items while 91 (77.07%) agreed. There were 3 missing frequencies. These figures clearly indicate that much has been done in transforming HCS and bridging the gap between management and RNs in terms of exchange of information.

Item D6 A Suggestion box is used

Of the participants, 32 (27.59%) strongly disagreed, 41 (35.34%) disagreed; 34 (29.31%) agreed and 9 (7.76%) strongly agreed. Therefore, (73; 62.93%) of the participants indicated that a suggestion box was not used. A suggestion box is instrumental in soliciting ideas from the floor, whereby valuable information can be used to improve HCS and enhance job satisfaction among RNs. There were 5 missing frequencies.

4.3.5 Decision-making

Section E of the questionnaire consisted of 6 items on decision-making aspects in the bureaucratic organisation. Table 4.8 indicates the participants' perceptions of this section. The individual items are discussed after the tables.

Table 4.8 Decision-making (n=121)

Items	Disagreed		Agreed		Total		Missing values	N
	Number	Percentage	Number	Percentage	Number	Percentage		Total
E1-E2, E4-E5	28	23.52	91	76.47	119	100	2	121
E3	54	46.55	62	53.45	116	100	5	121
E6	34	28.57	85	71.43	119	100	2	121

Items E1, E2, E4 and E5 RNs participate in decisions regarding change of documents, shifts and equipment

Of the participants, 28 (23.52%) disagreed while 91 (76.47) agreed. There were 2 missing frequencies. This overwhelming response could mean that RNs have the freedom to decide their shifts and are informed about the purchase of new equipment and new records, since they know what is essential for their units.

Item E3 RNs are represented in policy-making sessions

Of the participants, 21 (18.10%) strongly disagreed; 33 (28.45%) disagreed; 48 (41.38%) agreed, and 14 (12.07%) strongly agreed. There were 5 missing frequencies. Therefore, (62; 53.45%) of the participants were satisfied that they were represented in policy-making sessions, while (54; 46.55%) disagreed with this item. This division could possibly be due to the fact that even though there are observable changes in the dynamics of hospital administration, more still

needed to be done to advance the mandates of the 1997 White paper on transformation of the public service delivery.

Item E6 RNs are empowered to design individualised care

Of the participants, 10 (8.40%) strongly disagreed; 24 (20.17%) disagreed, making a total of (34; 28.57%) participants who disagreed. Sixty-three (52.94%) agreed, and 22 (18.49%) strongly agreed. (85; 71.43%) agreed with the above item. Of this, 39 (32.23%) qualified from the 4-year course. This congruence in RNs perceptions regarding this item could mean that developments in the RSA are consistent with developments internationally. There were 2 missing frequencies.

4.3.6 Management of patient care

Section F of the questionnaire consisted of 10 items on management of patient care in the bureaucratic organisation. The participants' perceptions of this item are illustrated in table 4.9 and the discussion follows.

Table 4.9 Management of patient care (n=121)

Items	Disagreed		Agreed		Total		Missing values	N
	Number	Percentage	Number	Percentage	Number	Percentage		Total
F1-F3	46	39.26	72	60.40	118	100	3	121
F4-F5	17	14.62	99	85.37	116	100	5	121
F6	38	33.05	77	66.95	115	100	6	121
F7-F9	47	40.28	73	59.71	120	100	1	121
F10	13	11.01	105	88.98	118	100	3	121

Item F1 RNs decide which medications need protocols

Of the participants, 17 (14.41%) strongly disagreed; 49 (41.53%) disagreed; 43 (36.44%) agreed, and 9 (7.63%) strongly agreed. Over half of the participants (66; 55.94%) disagreed with this item. This could be an indication of the perpetual dominance of medicine in nursing, which has deep historical roots. There were 3 missing frequencies.

Item F2 RNs participate in decisions on the discharge of patients

Of the participants, 16 (13.56%) strongly disagreed; 38 (32.20%) disagreed; 54 (45.76%) agreed, and 10 (8.47%) strongly agreed. There were 3 missing frequencies. Most of the participants (64; 54.23%) agreed with this statement, which could indicate a good working relationship with doctors.

Item F3 RNs see themselves as multidisciplinary team

Of the participants, 5 (4.24%) strongly disagreed; 14 (11.86%) disagreed; 78 (66.10%) strongly agreed, and 21 (17.80%) agreed. An overwhelming majority of (99; 83.90%) participants who agreed was congruent with involvement of RNs in the discharge of patients (see item F2). There were 3 missing frequencies.

Item F4 RNs inform patients of their rights

Of the participants, 8 (6.90%) strongly disagreed; 19 (16.38%) disagreed; 72 (62.07%) agreed, and 17 (14.66%) strongly agreed. Most of the participants (89; 76.73%) agreed that RNs do keep their patients informed about their rights and the contents of the new legislation. However, there were 5 missing frequencies.

Item F5 RNs ensure that available services are relevant to patients' needs

Of the participants, 1 (0.83%) strongly disagreed; 6 (5.13%) disagreed; 89 (76.07%) agreed, and 21(17.95%) strongly agreed. An overwhelming majority of the participants (110; 94.02%) thus agreed with this item. These findings were

congruent with the item on informing patients of their rights and could indicate that RNs practise patient advocacy (see item F4). There were 4 missing frequencies.

Item F6 RNs' autonomy in patient care is acknowledged

Of the participants, 8 (6.96%) strongly disagreed; 30 (26.09%) disagreed; 63 (54.78%) strongly agreed, and 14 (12.17%) agreed. Thus, a majority of (77; 66.95%) agreed with this item. These findings were consistent with responses given in items F2 to F4. The significance of this data is found where RNs seem to have moved from a subservient role to acknowledging their rightful position as expects in their own discipline, within the multidisciplinary team. There were 6 missing frequencies.

Item F7 Patient care routines are inflexible, e.g. meal times

Of the participants, 7 (6.03%) strongly disagreed; 40 (34.48%) disagreed; 57 (49.14%) agreed, and 12 (10.34%) strongly agreed. However, there were 5 missing frequencies. Most participants (69; 59.48%) agreed with this item. This data could be referring to rigid patient care routines, which disregard the individuality of patients. A good example would be waking up a patient to serve them a meal.

Item F8 Workload is assessed according to the number of patients

Of the participants, 19 (16.24%) strongly disagreed; 31 (26.50%) disagreed; 45 (38.46%) agreed, and 22 (18.80%) strongly agreed. There were 4 missing frequencies. Most of the participants (67; 57.26%) agreed with this item. This perception disregards the amount of time RNs spend with one critically ill patient.

Item F9 Workload is assessed according to patient acuity levels

Of the participants, 20 (17.09%) strongly disagreed; 24 (20.51%) disagreed; 54 (46.15%) agreed, and 19 (16.24%) strongly agreed. Most participants, (73;

62.39%) agreed that patient acuity levels are taken into consideration as well when allocations and delegations are done, to ensure a fair distribution of workload among RNs. There were 4 missing frequencies.

Item F10 Upon discharge, patients complete an evaluation form for services rendered

Of the participants, 2 (1.69%) strongly disagreed; 11 (9.32%) disagreed; 74 (62.71%) agreed, and 31(26.27%) strongly agreed. Most of the participants (105; 88.98%) agreed. From this data it may be concluded that HCS were transparent on issues pertaining to their organisations. There were 3 missing frequencies.

4.3.7 Growth and development

Section G of the questionnaire consisted of 12 items on growth and development in the bureaucratic organisation. Table 4.10 represents the participants' perceptions. Discussion of the individual items follows.

Table 4.10 Growth and development (n=121)

Items	Disagreed		Agreed		Total		Missing values	N
	Number	Percentage	Number	Percentage	Number	Percentage		Total
G1-G2	56	47.86	61	52.14	117	100	4	121
G3-G8, G11	50	43.44	66	56.55	116	100	5	121
G9-G10, G12	40	34.27	77	65.72	117	100	4	121

Item G1 RNs experience psychological job satisfaction, which, to a large extent, determines the quality and quantity of their outputs

Of the participants, 31 (26.50%) strongly disagreed; 45 (38.46%) disagreed; 33 (28.21%) agreed, and 8 (6.84%) strongly agreed. Thus, most of the participants (76; 64.96%) disagreed that RNs experience psychological job satisfaction in their daily tasks. This could be attributed to the exasperated state of RNs in their process of adjustment to shortage of staff, whereby others have to stretch beyond resilience to make up for this deficiency. Intrinsic motivation plays a major role in determining the quality and quantity of any outputs in any company or organisation, more than pressure applied from the external environment. There were 4 missing frequencies.

Item G2 RNs tend to perform well if they see growth within the organisation and thus experience a sense of fulfilment

Of the participants, 12 (10.26%) strongly disagreed; 24 (20.51%) disagreed; 66 (56.41%) agreed, and 15 (12.82%) strongly agreed. Therefore, of the participants, (71; 69.23%) agreed with the above item. Satiated individuals tend to perform well especially if there is a balance between their personal and organisational goals. Successful organisations grow together with their staff by providing ample opportunities for growth. There were 4 missing frequencies.

Item G3 RNs have study days for part-time study

Of the participants, 13 (11.11%) strongly disagreed; 30 (25.64%) disagreed; 59 (50.43%) agreed, and 15 (12.82%) strongly agreed, thereby indicating a majority of (74; 63.25%) who agreed with the above item. This data portrays the state of dynamic and progressive organisations that increasingly extend their horizons by empowering their employees to meet the challenges of the twenty-first century. There were 4 missing frequencies.

Item G4 RNs have opportunities for full-time study

Of the participants, 24 (21.05%) strongly disagreed; 30 (26.32%) disagreed; 47 (41.23%) agreed, and 13 (11.40%) strongly agreed. Thus, most of the participants (60; 52.63%) agreed with the above item. No discrepancy can be drawn here because full-time studies have always been available for RNs both during and post-apartheid era. There were 7 missing frequencies.

Item G5 RNs have induction programmes

Of the participants, 7 (6.09%) strongly disagreed; 17 (14.78%) disagreed; 71 (61.74%) agreed, and 20 (17.39%) strongly agreed, thereby giving a majority of (91; 79.13%) who agreed with the above item. This data makes it clear that there is ongoing effort to empower RNs through induction programmes. There were 6 missing frequencies.

Item G6 RNs attend nursing seminars, symposia and conferences

Of the participants, 10 (8.55%) strongly disagreed; 25 (21.37%) disagreed; 63 (53.85%) agreed, and 19 (16.24%) strongly agreed. Most of the participants (83; 70.09%) agreed, meaning that their organisations could be sponsoring RNs to attend the above events to keep abreast of new developments. There were 4 missing frequencies.

Item G7 RNs are encouraged to search the Internet for new developments in the nursing field

Of the participants, 23 (19.83%) strongly disagreed; 48 (41.38%) disagreed; 38 (32.76%) agreed, and 7 (6.03%) strongly agreed. Hence the majority (71; 61.21%) disagreed with the above item. It would appear from the above data that RNs are expected to take initiative to search the Internet for new developments in the nursing field. This all boils down to the passion RNs have for nursing which drives them to desire to make a difference in their profession. There were 5 missing frequencies.

Item G8 Centralised facilitator to oversee educational programmes over the entire organisation (personnel development)

Of the participants, 18 (15.65%) strongly disagreed; 37 (32.17%) disagreed; 50 (43.48%) agreed, and 10 (8.70%) strongly agreed. Thus, of the participants, (60; 52.18%) agreed with the above item. It would appear from this data that having a centralised facilitator is a common practice in the RSA whereas other countries have since moved to creating posts for Clinical Resource Nurses (CRN) to take care of educational aspects in their organisations. There were 6 missing frequencies.

Item G9 RNs rotate as preceptors/mentors to orientate newly employed RNs in units

Of the participants, 23 (19.49%) strongly disagreed; 32 (27.12%) disagreed; 54 (45.76%) agreed, and 9 (7.63%) strongly agreed. Thus (63, 53.39%) of the participants agreed that preceptors rotated. This practice is commended for its ability to afford all RNs an opportunity to mentor protégées. There were 3 missing frequencies.

Item G10 RNs take personal responsibility to upgrade their professional skills to keep abreast of new developments

Of the participants, 3 (2.54%) strongly disagreed; 10 (8.47%) disagreed; 81 (68.64%) agreed, and 24 (20.34%) strongly agreed, thereby giving a majority of (105; 88.98%) who agreed with the above item. It can be construed from the above data that most RNs are engaged in independent studies apart from full-time study opportunities made available by their organisations. This is the group that has access to study days for their part-time studies (see item G3). There were 3 missing frequencies.

Item G11 RNs have a special budget for in-service education programmes

Of the participants, 25 (21.19%) strongly disagreed; 46 (38.98%) disagreed; 43 (36.44%) agreed, and 4 (3.39%) strongly agreed. The majority of the participants (71; 60.17%) disagreed that a special budget was provided for in-service education programmes. It is not clear from the above data how induction programmes, seminars, symposia and conferences attended by RNs are financed if a special budget has not been provided (see G5 & G6). There were 3 missing frequencies.

Item G12 RNs evaluate in-service education programmes

Of the participants, 14 (12.17%) strongly disagreed; 38 (33.04%) disagreed; 57 (49.57%) agreed, and 6 (5.22%) strongly agreed. Therefore, (52; 45.21%) disagreed while (63; 54.79%) agreed with the above item. It would appear from the above data that RNs evaluate in-service education programmes to make sure they address the organisational needs. There were 6 missing frequencies.

4.3.8 Research

Section H of the questionnaire comprised 9 items on research in a bureaucratic organisation. Table 4.11 depicts the participants' responses to this section. The individual items are discussed after the table.

Table 4.11 Research (n=121)

Items	Disagreed		Agreed		Total		Missing values	N
	Number	Percentage	Number	Percentage	Number	Percentage		Total
H1-H3	73	63.23	43	36.76	116	100	5	121
H4	59	50.00	59	50.00	118	100	3	121
H5-H9	83	72.14	32	28.46	115	100	6	121

Items H1-H3 RNs initiate, conduct, collect and analyse data

Of the participants, 73 (63.23%) disagreed, 43 (36.76%) agreed and there were 5 missing frequencies. From this data it can be construed that research aspects are not popular in bureaucratic organisations, either due to financial constraints or staff shortages.

Item H4 RNs compile reports and statistics needed for planning purposes

Of the participants, 16 (13.56%) strongly disagreed; 43 (36.44%) disagreed; 50 (42.37%) agreed, and 9 (7.63%) strongly agreed. The participants were equally divided on this item with (59; 50.00%) agreeing and (59; 50.00%) disagreeing. The division above could be ascribed to variance in the participants' perceptions with specific reference to age, years of experience, academic qualifications and professional registrations of RNs, in relation to this item, which will be dissected in chapter 5. There were 3 missing frequencies.

Items H5-H9 RNs apply research results, attend research seminars, have easy access to research reports and read research reports

Of the participants, 83 (72.14%) disagreed while 32 (28.46%) agreed with these statements. From this data, it is clear that RNs need to get more involved in research aspects with the involvement of institutions that support and finance research. There were 5 missing frequencies.

4.4 CONCLUSION

This chapter gave a broad outline of the data analysis and interpretation. The results revealed areas where RNs perceptions were equally divided on certain issues, where there was congruency and where they differed significantly on various aspects.

Chapter 5 concludes the study, discusses the findings and makes recommendations for practice and further research.

CHAPTER 5

FINDINGS, LIMITATIONS AND RECOMMENDATIONS

5.1 INTRODUCTION

This chapter concludes the study, discusses the limitations, summary and interpretation of the research findings related to the perceptions of the RNs regarding the bureaucratic view of power in HCS and makes recommendations for further research.

5.2 DATA SUMMARY AND INTERPRETATION

This section provides an integrated summary and interpretation of the findings obtained from the data. Where necessary, reference is made to the Pearson correlation coefficient results to assist in the interpretation of the data. The ANOVA scale was also used to analyse the variance in the participants' perceptions with specific reference to age, years of experience, academic qualifications and professional registrations of RNs in relation to items included in the questionnaire.

5.2.1 Management

Figure 5.1 illustrates the participants' perceptions of management aspects of a bureaucratic organisation (see annexure F).

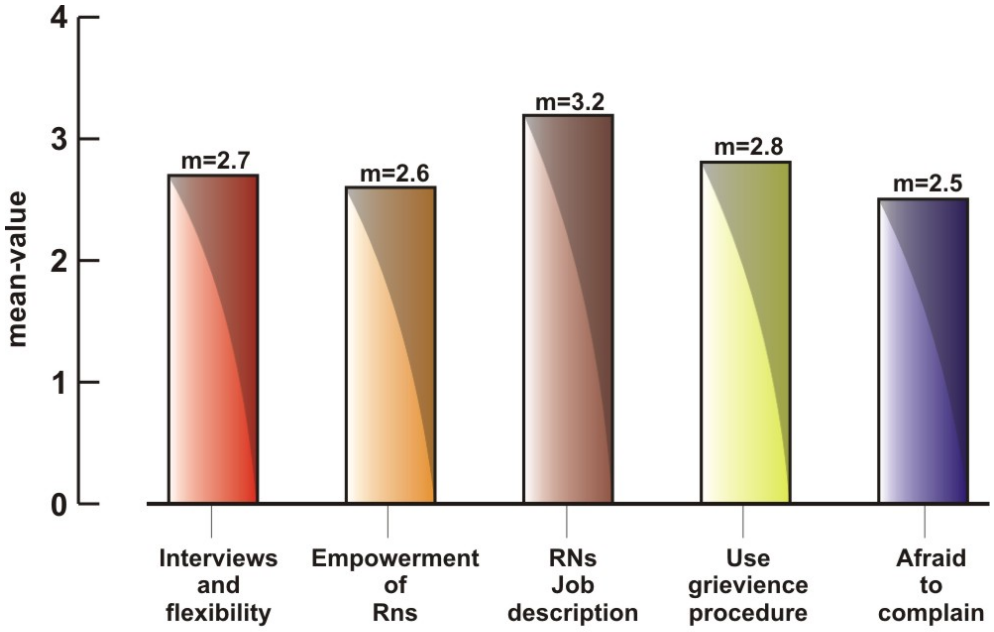

Figure 5.1 Management aspects **(n=121)**

Items B1- B5, B10 Interviews and flexibility of the organisation

Of the participants, only 40 (33.56%) disagreed while 79 (66.43%) agreed that exit interviews were conducted. Furthermore, of these 119 participants, (86; 71.02%) disagreed with post-employment interviews being in place (see item B1; chapter 4). It is crucial to note that interviews after employment are equally as important as exit interviews, since problems and dissatisfaction could be identified in the early months of employment and be addressed. In addition, it would appear that exit interviews would be too late to avert a situation already out of control. These results could depict the nature of a bureaucratic organisation. Of the participants, (109; 90.84%) agreed on flexibility to choose areas of work, desired vacation times and RNs' indemnity cover. This indicated that bureaucratic organisations have been highly influenced by the new

government policies. The new LRA No. 66 of 1995 also contributed by providing a framework within which trade unions, employers and their employees could collectively decide wages, conditions and terms of employment, and other matters of mutual interest (Bezuidenhout 1998: 9).

Items B2-B5, B8 Empowerment and job description

Of the participants, 60 (50.84%) agreed that RNs were empowered in organisations, giving the impression that much effort had been taken by bureaucratic organisations to empower RNs in some way, signifying ongoing transformation of HCS, in line with the Department of Health's 1997 mandates and the resolutions of the 2001 Health summit (see chapter 1, section 1.1).
Pearson's correlation coefficient test was (p=0.3399) between RNs with basic diploma and basic degree, and (p=0.3725) between basic diploma and post basic, with no significant value on a 0.0500 significant level. However, participants with Honours and Masters degree were significantly more negative than the others with regards to empowerment and differed with other qualifications with (p=0.0215) on a 0.0500 significant level. This data tends to indicate agreement statistically, when disagreement was to be expected because (70; 63.06%) RNs gave an indication that RNs were still restrained by their dependant role (see item B5; chapter 4). This indication could denote that while half the participants acknowledged progress with transformation, much still needed to be done to afford RNs their status of autonomy and power at unit level to do what they passionately feel needs to be done to create a positive and financially strong health milieu according to the stipulations of the SANC Regulations chapter 2 of 1984, R2598 as amended.

Item B7 Job description

The above figures show that the majority of the participants (m=3.2) correspond with the 100 (82.65%) who agreed that RNs performed activities beyond the content of their job description. The problem of shortage of staff experienced in most HCS may have been responsible for this outcome, since available staff had

to stretch beyond resilience to make up for the shortage and ensure that all tasks were completed at the end of the day. These views are consistent with Buys and Muller's (2000:52) findings where NSMs indicated that transformation came with negative effects, such as the moratorium on filling of vacant posts for RNs, coupled with the resignation of highly skilled RNs, which contributed to increased workload. There was no difference in responses in terms of age, years of experience, qualifications and the 4 years integrated course.

Items B11-12 Grievance procedure and RNs afraid to complain

According to figure 5.1, the participants (m=2.8) who used the grievance procedure indicated that the majority, (86; 72.27%) complied with the requirements of the LRA, 66 of 1995 to avoid conflicts between management and RNs in HCS (see chapter 1, section 1.2). In contrast, responses to item (B12) on RNs being afraid to complain revealed a division among participants. 58 (49.57%) participants consented to the presence of fear while 59 (50.43%) disagreed. The participants who agreed had 6 - 42 years experience while those who disagreed had 3-5 years experience. The latter group is compatible with the Generation X that emerged during the time of unprecedented change and social turbulence, such as changes in public policy and economic climate in the RSA. They are known for grasping a situation quickly and dealing with it decisively and fearlessly, leaving no room for complaints, as opposed to the older generation (Kupperschmidt 1998:36).

5.2.2 Organisation

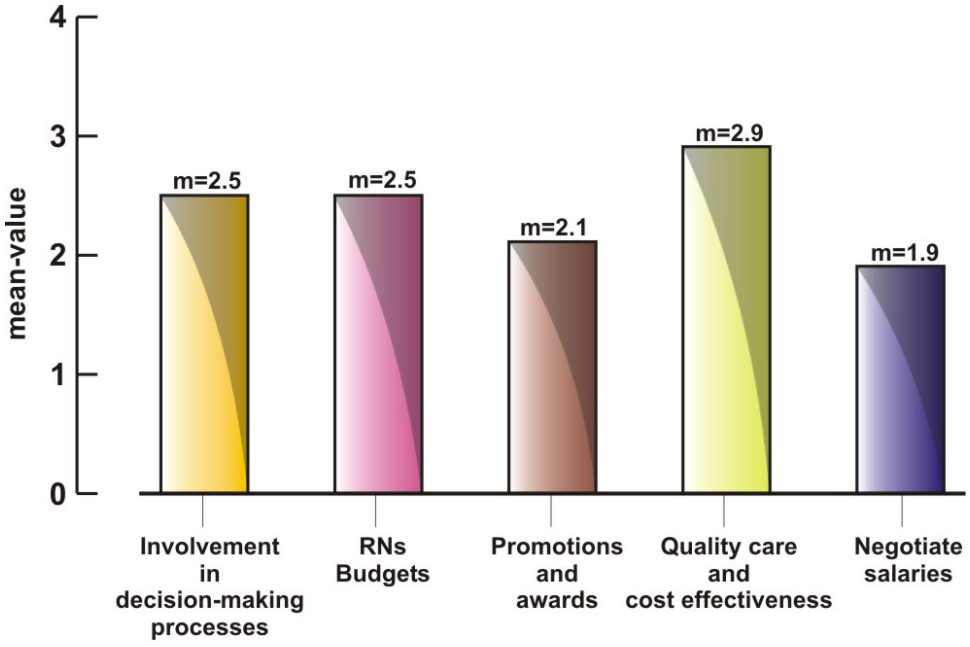

Figure 5.2 Organisational aspects **(n=121)**

Items C1-C7 RNs participate in issues pertaining to the organisation

Sixty-six (55.54%) participants disagreed with this statement while 52 (44.44%) agreed. Those with basic diploma, basic degree and post-basic RNs were among those who were fairly positive about this item. However, those with Honours and Masters degree statistically appeared to differ significantly than the others with a (p=0090) on a 0.0500 significant level. This could indicate that RNs with higher qualifications felt that RNs were not involved in issues pertaining to the organisation, therefore, they could have felt that this was an infringement of their right to practice what they had learned, which explains the division above. Although there were 13 missing frequencies, this would probably not influence the above results towards any specific direction. Haas (1999: 1) supports the above findings by stating that RNs can be fortified or destroyed by the very organisations they serve.

Items C8-C10 Registered nurses and budgets

According to figure 5.2, the mean (m=2.5) is congruent with 62 (54.83%) participants who agreed that a central budget system was still practised in HCS. The Pearson's correlation coefficient (p=0.0212) revealed that RNs with basic diploma were not as comfortable with handling unit budgets as those who had basic degrees. This could indicate a need for empowerment with pecuniary management skills. Upenieks (2003:147) also cited lack of business astuteness as a shortcoming of the department of nursing, purporting that it takes a strong fiscal background for effective leadership in current financial times.

During the development of the financial information systems in Zimbabwe, Mills, Bennett and Russell (2001:86) also found that financial accounting was highly centralised in their health sector, with RNs given no responsibility for expenditures. Financial inputs were not linked to activities in order to justify financial resource allocation. After the decentralisation of decision-making processes in 1992, 57 cost centres were established. RNs now take complete responsibility for their expenditures in Zimbabwean HCS, which gave them the benefit of also taking ownership in the delivery of health care. The results of these restructuring and empowerment programmes for RNs are reported to be still phenomenal in Zimbabwe.

Items C11-C18, C23 Promotion and awards

Seventy-nine (68.25%) participants expressed their dissatisfaction statistically on how promotions and awards were handled, against 37 (31.75%) of their counterparts. This picture is portrayed in Bezuidenhout et al (1998:7) where RNs' motivation to join trade unions is summarised as an attempt to minimise favouritism and discrimination encapsulated within the bureaucratic system with regards to study opportunities, wage increases, promotions, transfers and vacations, which were independently decided by management. Unions therefore, ensured a fair and equitable distribution of these opportunities and incentives in the new health care system (Bezuidenhout et al 1998: 279).

Items C19-C21 Quality and effectiveness

Of the participants, (87; 77.20%) agreed that emphasis in the clinical area was on quality care, cost effectiveness and that there is an incident investigating policy in place. This is significant in terms of visible transformational efforts in HCS in as far as measuring the progress of the Department of Health's 1997 mandates (see chapter 1, section 1.1). The three HCS were unanimously positive about quality care and differed only in degrees of agreement, since the mean values were all above (m=2.5). This was a clear indication that there were induction programmes and workshops in place to empower RNs to cope with the changing socio-politico-economic climate in bureaucratic organisations to the benefit of the patients.

Item C22 RNs negotiate own salaries

The statistical figures indicate that all the participants generally disagreed because their mean values were below (m=2.5), but only differed in degrees of disagreement. The participants' age factor appeared to influence this variable in that the younger and the older generation, namely age 25-34 and 45-61 respectively, both had (m=2.1). The 35-44 years of age scored (m=1.6), meaning that they were more dissatisfied with this item than the other two groups. This could be due to the fact that the 25-34 years of age had no serious financial commitments yet and were very adventurous, preferring contract versus permanent employment. The 45-61 years of age might have accepted the rigid predetermined salaries that are commensurate with the posts occupied by incumbents, particularly in the public sector, while the 34-44 years of age desperately wanted to negotiate salaries, which is common practice in private sector.

5.2.3 Communication

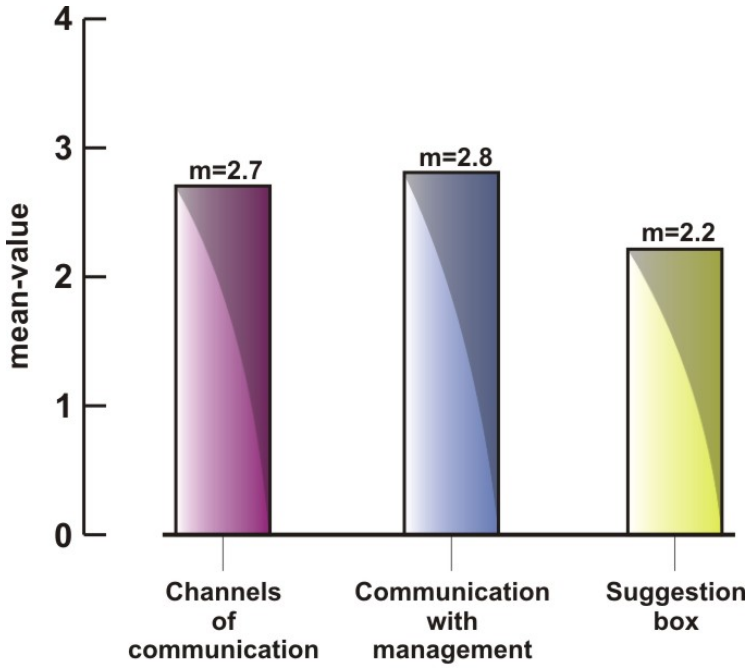

***Figure 5.3 Communication aspects* (n=121)**

Item D1 Supervisors always follow Channels of communication

Of the participants, 80 (67.22%) agreed with this item. The Pearson's correlation coefficient test showed a highly significant relationship of (p=0.5417) on a 0.0500 significant level between supervisors following channels of communication and the importance of the chain of command (see annexure F; item D2). Both supervisors and RNs appeared to place more value on the importance of the chain of command in bureaucratic organisations.

Items D2-D4 Communication with management

There seemed to be a significant relationship between the findings on communication channels and the bureaucratic organisation. The majority of participants, 91 (77.07%) agreed while 27 (22.92%) disagreed that there was

exchange of information between management and RNs. This is a significant contrast with the responses given under the organisational aspect (see items C1-C7) where 66 (55.54%), against 52 (44.44%) participants disagreed that there was transparency pertaining to most issues within the organisation. The participants appeared to be divided in this regard, probably because of the LRA, 66 of 1995, which stipulated issues and decisions that are subject to joint determination in the workplace (Bezuidenhout et al 1998:276).

Item D5 Promotions are advertised in a timely manner

The post basic RNs were more negative towards timely advertisement of promotions than the basic degree participants with a (p=0.0185), on 0.0500 significant level. This could have been due to the participants' desire to apply for positions, which they were academically and professionally equipped for. This situation is exacerbated by few senior positions available, in the face of increasing qualifications with fiscal restraints mandated by the new legislation.
Participants who qualified from the 4-year course (m=2.0) were also statistically more negative (p=0.0463) towards advertisement of promotions in a timely manner, compared to (m=2.1) of those from the older curriculum, though the mean values revealed a very small difference. This is also the Generation 'X,' which is presumed to be slow to commit to long-term relationships (Kupperschmidt 1998:39). Lack of experience required for promotions could have contributed to this factor, or they could just be expressing a concern for justice to be done for those who qualify.

Item D6 Suggestion box

According to figure 5.3, the mean value (m=2.2) is consistent with 73 (62.93%) who disagreed that a suggestion box was used while 43 (37.07%) agreed. A suggestion box is instrumental in soliciting ideas from the floor, providing valuable information that can be used to improve HCS and enhance job satisfaction among RNs. This component of communication did not bear much weight on the findings because the exchange of information between RNs and

management indicated a positive relationship without much use of the suggestion box (see items D2-D4). There were no distinctions in opinions in terms of age, years of experience, qualifications and the 4-year integrated course.

5.2.4 Decision-making

Figure 5.4 depicts the results on decision-making aspects.

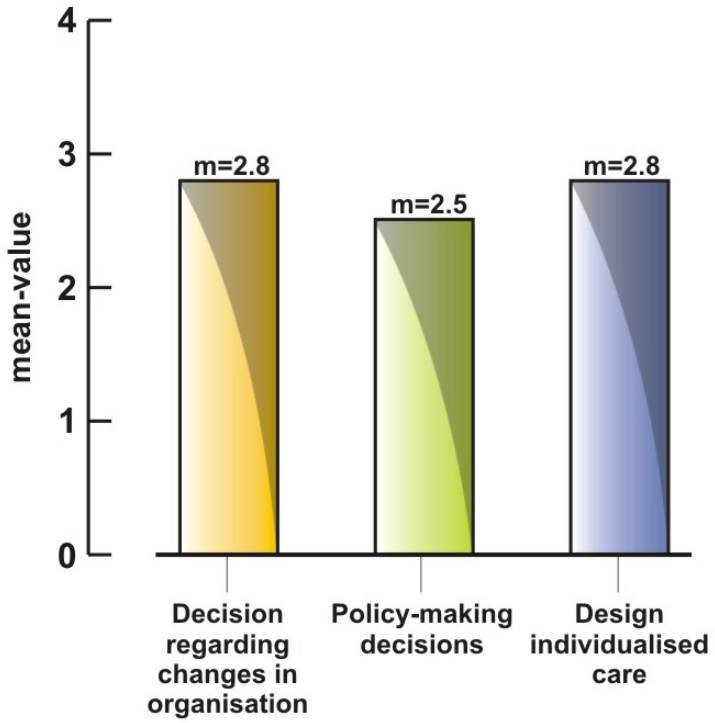

Figure 5.4 Decision-making aspects **(n=121)**

Items E1-E2, E4-E5 Decisions regarding changes in the organisation

From figure 5.4, there appears to be a general trend in aspects related to decision-making processes regarding changes within the organisation and management at unit level, which includes individualised care. Not all of the 121 participants answered all the questions in this item. Out of 110 usable questionnaires, 91 (76.47%) agreed that RNs were represented in policy-making decisions, which agrees with a slight increase in the mean value (m=2.8) for

participants who put more weight on decisions made at unit level. This positive correlation was very significant in that RNs' contribution to decisions regarding the organisation can highly influence policy-makers to address pertinent issues arising from departments within the organisation (Mason 2001:2).

These findings are also congruent with Denill et al's (1999: 68) assertion that RNs should acquire collaborative and negotiation skills in multidisciplinary teams which create a platform to meet with management.

Item E3 RNs are represented in policy-making decisions

The participants appeared to be divided on this item as 62 (53.45%) agreed while 54 (46.55%) disagreed. It should be noted that such a response was to be expected because of the positive scores on aspects of channels of communication with management and involvement in decision-making processes (see figure 5.2 and 5.3).

Item E6 RNs Design individualised care

Most of the participants, namely 85 (71.43%), of which 39 (40.50%) qualified from the 4-year integrated course, agreed with the above item, which was to be expected because all participants who qualified under the 4-year course were well equipped with contemporary nursing skills (see table 4.4). Statistically all participants showed a positive trend towards designing individualised care because the mean values for both was above (m=2.5), meaning that they were generally quite comfortable with designing individualised care. This could be attributed to empowerment programs in place.

5.2.5 Management of patient care

Figure 5.5 illustrates the responses to aspects of patient care management.

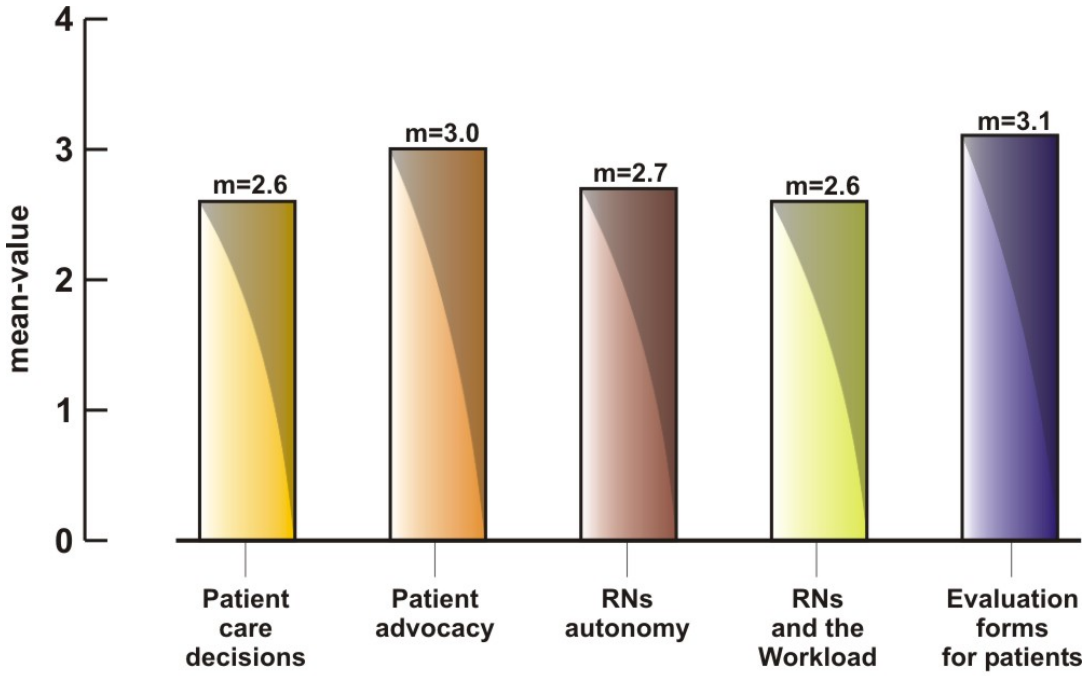

Figure 5.5 Management of patient care aspects **(n=121)**

Items F1-F3 Patient care decisions

Of the participants, 72 (60.40%) agreed that they were at liberty to make patient care decisions, which was a positive indication that RNs take pride in their work and have the freedom to exercise their delegated authority over patient care issues.

Items F4-F5 RNs practice patient advocacy

Of the participants, the majority, namely 99 (85.37%), agreed with the item on patient advocacy in a bureaucratic organisation. There was a strong correlation between information given to patients (see item F4, chapter 4) and the relevance of services provided to patients' needs (see item F5, chapter 4). It was significant

to note that RNs still put their patients first in spite of their dissatisfaction with the increased workload. There were no distinctions in opinions in terms of age, years of experience, qualifications and the 4-year integrated course.

Item F6 RNs autonomy

Autonomy for RNs to take ownership in their sphere of influence also rated high with 77 (66.95%) of the participants agreeing with the above statement. Only 38 (33.05%) disagreed that RNs were autonomous in their function. The 6 missing frequencies would not influence or alter the results in any case. Participants who graduated from the 4-year integrated course among those who agreed scored the same as their counterparts with the mean value of (m=2.7) on this item. The mean value for participants who also agreed and had 8-12 years experience was (m=2.9) while those with 3-7 years and 13+ years was (m=2.6) and (m=2.7) respectively, showing a division on this view. It could be that those with 3-7 years did not give their honest opinion for many reasons and the 13+ still needed more flexibility in the workplace while the 8-12 years with the highest mean value could be feeling comfortable and autonomous.

Items F7-F9 RNs experience increased workload

Of the participants, 73 (59.71%) agreed with the above statement. This response was expected because of the high attrition rate among RNs in HCS through international recruitments, case management, laboratory services and other operational systems that recruit RNs. These findings are supported by Buys and Muller's (2000: 53) findings on how NSMs also complained about increased workload due to shortage of staff, coupled with the moratorium imposed on staff employment. Thom (2004: 8) published a report on medical exodus shock and cited the 2003/4 South African Health Review, which revealed that the number of public sector posts was reduced drastically between the year 2003 and 2004. Thom (2004: 8) further stated that the UK Nursing and Midwifery Council also confirmed registration of 2 114 nurses and midwives from the RSA.

Item F10 Evaluation form for patients

Of the participants, 105 (88.98%) agreed with this statement, which was a general trend and a good indication of involvement of patients in their care. There were no differences in the opinions of participants in terms of age, years of experience, qualifications and the 4 years integrated course.

5.2.6 Growth and development

Figure 5.6 depicts the findings on growth and development aspects.

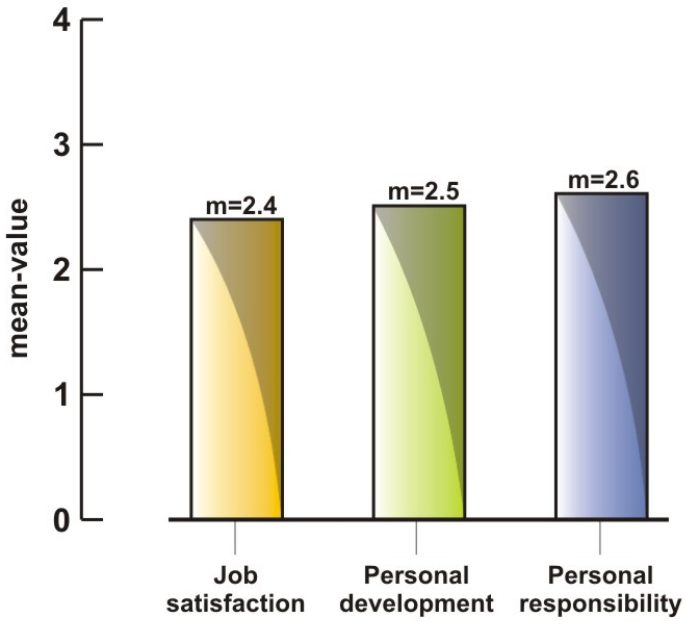

Figure 5.6 Growth and development aspects **(n=121)**

Items G1-G2 Job satisfaction

Of the participants, 61 (52.14%) agreed with this item, which did not reflect much difference with the 56 (47.86%) who disagreed. In general terms, the mean values in figure 5.6 indicate that most participants had similar perceptions on the variables included under aspects of growth and development in a bureaucratic

organisation. This means that there is a strong relationship between job satisfaction and personnel development.

Items G3-G8, G11 Personnel development

Of the participants, 66 (56.55%) agreed that RNs were empowered with management skills to effectively run the units; only 50 (43.44%) disagreed. It should be noted that the majority (74; 63.25%) indicated that study opportunities were available; with (91; 79.13%) showing that local induction programmes were in place to reinforce study opportunities, so that more RNs could be available for patient care as a tentative resolution for shortage of staff. This data is significant as it indicates that bureaucratic organisations have taken great strides in transforming their HCS.

Items G10 RNs take personal responsibility to upgrade their professional skills

Of the participants, (13; 11.01%) disagreed with this item while an overwhelming majority (105; 88.98%) agreed that RNs take personal responsibility to upgrade their professional skills to keep abreast with new developments. The correlation coefficient test was not significant with (p=0.5789) on a 0.500 significant level on items in this category, meaning that there was no difference in opinions in terms of age, years of experience, qualifications and the 4-year integrated course.

5.2.7 Research

Figure 5.7 reflects the responses to research aspects.

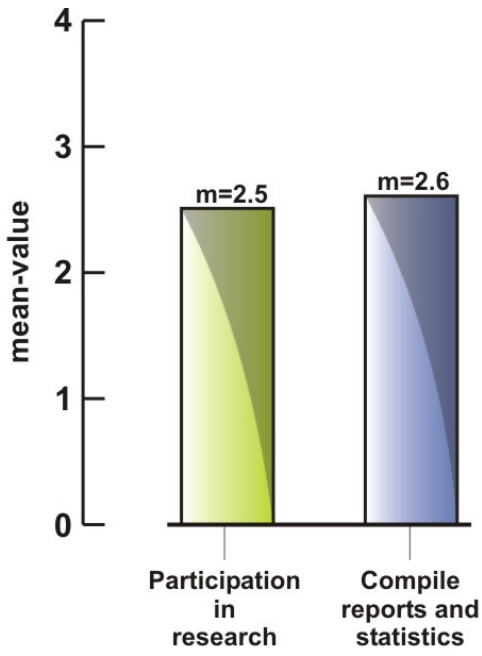

Figure 5.7 Research aspects **(n=121)**

Items H1-H9 Participation in research

There was a general negative trend towards research among all the participants. However, participants with high academic qualifications were more negative than the others with a (p=0.0213) on a 0.0500 significant level. This response could mean that they are still constrained in the application of acquired knowledge. It could also be deduced from the data that the aspect of research in bureaucratic organisations has not received much attention as yet. It is common practice for nurses to compile reports and statistics from their units at the end of each shift for the organisations, which could form the basis for research, depending on the trend of statistical information at hand.

5.3 OVERVIEW OF THE FINDINGS

The ANOVA scale was used to analyse the variance in the participants' perceptions with specific reference to age, years of experience, academic qualifications and professional registrations of RNs in relation to items included in the questionnaire.

Items B2-B3, B4-B5, B8 Empowerment of RNs

Even though almost half of the participants, namely 60 (50.84%), agreed that RNs were empowered with management skills to effectively manage the units, RNs with high academic qualifications were among 58 (49.15%) who disagreed. Their academic achievements was a personal effort with no financial support from their organisations, implying that had they not taken the initiative to empower themselves, more participants could have agreed with this statement. RNs should therefore be given power at unit level to do what they passionately feel needs to be done to create a positive and financially thriving health milieu. Lorriman (1995:9) concurs by stating that hospital managers need to relinquish certain decisions to RNs to facilitate growth and development, as an act of empowerment.

Item B12 RNs are afraid to complain

The participants were divided on this item, with 58 (49.57%) agreeing, and 59 (50.43%) disagreeing. The participants who agreed had 6 - 42 years experience while those who disagreed had 3-5 years experience. The latter group is compatible with the Generation 'X' that emerged during the time of unprecedented change and social turbulence, such as changes in public policy and economic climate in the RSA. They are known for grasping a situation quickly and dealing with it decisively and fearlessly, leaving no room for complaints, as opposed to the older generation (Kupperschmidt 1998:36).

The findings of this study supported the premise of King's Open System's Theory of human behaviour. The registered nurse as a person is a total system. RNs,

therefore, derive and process information from their personal world and begin to organise, categorise and process certain inputs through their senses. They would therefore be divided in their opinions and approach to this item and many others covered in previous chapters. This information influences their decisions and how they respond to people and events (King 1981:19).

Items C1-C7 RNs autonomy and Involvement in issues pertaining to the organisation

Sixty-six (55.54%) participants disagreed with this statement while 52 (44.44%) agreed. Those with basic diploma, degree and post-basic RNs were among those who were fairly positive about this item. However, those with Honours and Masters degree statistically appeared to differ significantly than the others with a (p=0090) on a 0.0500 significant level. This could indicate that most RNs with higher qualifications were not involved in issues pertaining to the organisation, therefore, they could have felt that this was an infringement of their right to practice what they had learned, which explains the division above. Howkins and Thornton (2002:231) stated that most employees seize available moments for training and development and then return to their organisations to give the best of their services. Lorriman et al (1995:10) also concurred and suggested that hospital managers take cognisance of the talent and skill still untapped in RNs who are willing to contribute to achieving organisational goals. This will be reciprocated with a sense of fulfilment amongst RNs.

The Department of Health (South Africa1997b: 23) also advocates rewards and recognition for good performance in the new dispensation of health care delivery.

Items C11-18, 23 Promotions and awards

Seventy-nine (68.25%) participants gave an indication of their dissatisfaction as to how promotions and awards were handled. Apart from Bezuidenhout et al's (1998:7) statement about RNs' motivation to join trade unions in order to address such discrepancies, this could also have been due to the participants' intense desire to occupy positions for which they were academically and professionally

equipped. This situation is exacerbated by few senior positions available in organisations, in the face of increasing qualifications with fiscal restraints mandated by the new legislation. The post basic RNs were more negative towards this statement than the basic degree participants with (p=0.0463) just below 0.0500 significant level. Participants who qualified from the 4-year course (m=2.0) were statistically less concerned about promotions than those from the older curriculum (m=2.1), though data revealed a very small difference. This is also the Generation 'X,' whereby younger RNs are presumed to be slow to commit to long-term relationships (Kupperschmidt 1998:39). Lack of experience required for promotions could also have contributed to this factor.

Item C22 RNs negotiate own salaries

The statistical figures indicate that all the participants generally disagreed with the above statement because their mean values were all below (m=2.5), but only differed in degrees of disagreement. The participants' age factor appeared to influence this variable in that the younger and the older generation, namely age 25-34 and 45-61 both had (m=2.1). The 35-44 years of age scored (m=1.6), meaning that they were more dissatisfied with this item than the other two groups. This could be due to the fact that the 25-34 years of age had no serious financial commitments yet and were very adventurous, preferring contract versus permanent employment. It could also be that the 45-61 years of age have accepted the rigid predetermined salaries commensurate with the posts occupied by incumbents, while the 34-44 years of age were sceptical about the status quo and desperately wanted to negotiate salaries. Howkins and Thornton (2002:84) believe that leadership is about helping the dissatisfied group voice their concerns, irrespective of the nature of the organisation. However, the LRA, 66 of 1995 provided a framework within which trade unions, employers and their employees could collectively negotiate salaries (Bezuidenhout et al 1998: 9).

Item E6 Design individualised care

Most of the participants (85; 71.43`%) of which 39 (32.23%) qualified from the 4-year course, agreed with the above item, which was to be expected because the majority qualified under the 4-year course and were well equipped with skills to render individualized care to patients. Statistically, all participants showed a positive trend towards designing individualised care because both mean values were above (m=2.5), meaning that both groups were quite comfortable with this item. These findings concur with Lancaster's (1999: 177) suggestion for ongoing dialogue between hospital managers and RNs to negotiate changes regarding new roles and responsibilities consistent with new developments in HCS. Douglas (1996: 288) also maintains that it is incumbent on hospital managers to provide RNs with professional preparation to meet the challenges of the new health system. Only 34 (28.57%) disagreed with this statement.

Items H1-H9 Research

There was congruence between these items and participants with high academic qualifications. This should be noted as it indicated the participants' desire to function at the level of their qualifications by conducting research projects for which they had been academically prepared. Age differences, years of experience, academic qualifications and professional registrations did not have much impact on the differences in the participants' perceptions on other items of the questionnaire.

5.4 LIMITATIONS OF THE STUDY

Certain limitations were identified in the course of this study (see chapter 1). Some of these limitations offer scope for further research related to the topic of this study, particularly qualitative studies in order to attain opinions from independent interviews.

Some RNs were not willing to participate in this study for fear of victimization for divulging information about management practices in their health care system. Those who participated might also not have given their genuine opinion.

5.5 RECOMMENDATIONS

In view of the above, it is also recommended that future studies investigate perceptions of RNs in a comparative study between private and provincial hospitals in as far as it concerns decentralisation of HCS.

The results of this study are potentially useful in determining the extent to which HCS have been transformed in view of the implementation of the Department of Health's 1997 mandates on transformation of HCS. It is incumbent on authorities to keep motivating and enlightening RNs on the value of acquiring new skills in order to offer nursing care that is relevant to this dispensation.
The question of salaries also needed to be addressed with specific reference to RNs' years of experience. This could help avert the high turnover and attrition rate among RNs. What Kotlolo (2004: 8) referred to as the "brain drain" (see chapter 2, section 2.2.2.1) could be reduced to a point where overseas recruitments will predominantly be for reasons other than pursuit for better opportunities with lucrative salaries.

The high tension in HCS could be relieved by the introduction of rewards for best nurse performer, units that excelled in standards of care or cost control and academic achievements. This exercise adds more value to the organisation while creating fun and a positive climate in the workplace as well.

RNs need to be empowered with the following skills:

- Financial management to be able to effectively handle allocated finances for cost centres.

- Strategic management to acquire business skills, mastery of management of change and work ethic.
- Project management to be able to spearhead new projects, risk management and team building.

It is also recommended that promotion be advertised in a timely manner and that sufficient time be given for responses, in order to accommodate RNs who are on vacation.

It would be encouraging and exciting for RNs who obtain professional and academic qualifications to be recognised and acknowledged by the organisation. Positive incentives could be given or their placement in units such that they have the liberty to implement the acquired knowledge and skills in their daily tasks. They could also be considered for assisting with induction programmes and mentorship with an additional stipend as a positive stroke. New variables, such as individualised care, could be addressed to bridge the gap between the old and the new curriculum.

The above measure could be instrumental in encouraging RNs to break out of the restraints of their dependent role towards taking ownership of HCS. Taking ownership eliminates the “blame” factor within organisations as RNs bear an equal burden for the organisation with management.

This study elicited RNs perceptions of the bureaucratic view of power. Future research should contrast these perceptions with those of hospital managers.

Lastly, RNs should be encouraged to initiate and conduct research. There are several problems arising from the workplace ranging from patient care problems to issues of management that need investigation through research.

5.6 CONCLUSION

This quantitative, descriptive exploratory study sought to describe the perceptions of RNs of the bureaucracy in HCS. The findings revealed positive and negative aspects in the process of transformation within organisations. Efforts made by organisations to comply with the government policy were noted.

Some felt that RNs still needed to break out of the restraints of their dependant role towards taking ownership of HCS by equally bearing the burden of the organisation with management.

The most significant component of any health system is its' personnel, since HCS cannot function efficiently without skilled human resources, necessitating the need for capacity building as discussed in previous chapters. One of the reasons for the division between RNs' opinions in terms of the implementation of transformational initiatives could be the lack of capacity of human resources at all levels. When manpower is depleted in an organisation, the health care service cease to function effectively (Thom 2004: 8).

The findings of this study could contribute in giving direction for necessary changes in the practice of nursing.

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TO BE COMPLETED BY REGISTERED NURSES

1 Do not write your name on this questionnaire
2 Your institution's name must not be written on this questionnaire

SECTION A

BIOGRAPHIC DATA

Please mark the appropriate number/ box with an "X" or complete in writing where necessary.

		For office use
1. Age in years at your last birthday ……	**A1**	

Indicate your academic qualifications

2. Basic nursing diploma		**A2**	
3. Basic nursing degree		**A3**	
4. Post basic nursing diploma		**A4**	
5. Honours degree		**A5**	
6. Master's degree		**A6**	
7. Doctorate degree		**A7**	
8. Other, specify …… . ……...		**A8**	

Indicate your professional registrations

9. General nurse		**A9**	
10. Psychiatric nurse		**A10**	
11. Community nurse		**A11**	
12. Midwife		**A12**	
13. Nurse educator		**A13**	
14. Nurse manager		**A14**	
15. Paediatric nurse		**A15**	
16. Neonatal nurse		**A16**	
17. Opthalmology nurse		**A17**	
18. Operating theatre nurse		**A18**	
19. ICU nurse		**A19**	
20. Other, specify …… ……		**A20**	

21. How many years of experience do you have as a registered nurse? ……	**A21**	

For office use

22. In which unit do you work?

23. Medical	
24. Surgical	
25. Paediatric	
26. Maternity	
27. Psychiatric	
28. Casualty /Emergency Room	
29. Out patients / Ambulatory services	
30. Operating Room	
31. Orthopaedics	
32. Gynaecology	
33. Oncology	
34. ICU	
35. Personnel development	
36. NICU	
37. OPD	
38. Other, specify …… ……	

A22

SECTION B

Please indicate the extent to which you agree or disagree with each of the following statements by marking the appropriate box with an 'X' on a four point scale

MANAGEMENT

		Strongly agree 4	Agree 3	Disagree 2	Strongly disagree 1	FOR OFFICE USE	
	From your experience in the bureaucratic organization, registered nurses						
1	are interviewed after employment to find out how they are settling in					**B1**	
2	develop operational plans for delivery of care eg procedure manuals					**B2**	
3	compile budgets					**B3**	
4	are empowered with management skills to effectively run the units					**B4**	
5	are still restrained by their dependant role					**B5**	
6	choose areas of work according to their specialty					**B6**	
7	perform activities that are over and above the content of their job description					**B7**	
8	practice sound conflict management skills					**B8**	
9	plan their own vacations					**B9**	
10	decide their own indemnity cover eg , Denosa					**B10**	
11	follow the grievance procedure to lodge their complaints					**B11**	
12	are afraid to complain					**B12**	
13	have exit interview after submission of resignation to establish the reason					**B13**	

SECTION C

ORGANISATION

		Strongly agree 4	Agree 3	Disagree 2	Strongly disagree 1	FOR OFFICE USE	
	From your experience in the bureaucratic organization,						
1	RNs receive information about the organization upon employment (induction)					**C1**	
2	RNs attend workshops for new projects					**C2**	
3	RNs are involved in different interdepartmental meetings and committees					**C3**	
4	there is transparency pertaining to most issues within the organization					**C4**	
5	RNs contribute ideas towards expansions and extensions of their hospital					**C5**	
6	an open-door system is utilized					**C6**	
7	an employee assistant program is in place (EAP)					**C7**	
8	a central budget system is used					**C8**	
9	Cost centers take responsibility for their own budgets					**C9**	
10	there is special allowance to retain staff					**C10**	
11	there are awards for best nurse performer of the year					**C11**	
12	promotions and opportunities are equally applied to all personnel who qualify					**C12**	
13	promotions are based more on seniority than on performance					**C13**	
14	RNs who excel in the area of their specialty are usually promoted to supervisory positions					**C14**	

15	achievements such as completing projects on time is celebrated in units					C15	
16	rewards and recognition are given for successful cost control					C16	
17	rewards and recognition are given for professional achievements					C17	
18	supervisors send a “Thank You” message after completion of a team task					C18	
19	emphasis in the clinical area is on quality care					C19	
20	emphasis in the clinical area is on cost effectiveness					C20	
21	there is an incident investigating policy					C21	
22	RNs negotiate their own salary, ie to sell their skills					C22	
23	RNs attend organized social functions with management, doctors and other hospital personnel					C23	

SECTION D

COMMUNICATION

		Strongly agree 4	Agree 3	Disagree 2	Strongly disagree 1	FOR OFFICE USE	
	From your experience in the bureaucratic organization,						
1	supervisors always follow channels of communication					D1	
2	the chain of command facilitates communication					D2	
3	there are general meetings with management to exchange information					D3	
4	RNs get regular updates on work-related decisions					D4	
5	promotions are advertised in a timely manner					D5	
6	a suggestion box is used to solicit ideas from the floor					D6	
7	RNs who are off duty on the day of the meeting have a means of receiving feedback					D7	

SECTION E

DECISION-MAKING

		Strongly agree 4	Agree 3	Disagree 2	Strongly disagree 1	FOR OFFICE USE	
	From your experience in the bureaucratic organization, registered nurses						
1	participate in decision making processes pertaining to patient care eg documentation					**E1**	
2	participate in decision making process pertaining to themselves eg change of shifts					**E2**	
3	are represented in policy-making sessions					**E3**	
4	share in decisions regarding equipment needed					**E4**	
5	RNs practice decision-making and problem-solving skills					**E5**	
6	are empowered to design individualized patient care					**E6**	

SECTION F

MANAGEMENT OF PATIENT CARE

		Strongly agree 4	Agree 3	Disagree 2	Strongly disagree 1	FOR OFFICE USE	
	From your experience in the bureaucratic organization,						
1	RNs decide which medications need protocols					**F1**	
2	RNs participate in decisions regarding the discharge of patients					**F2**	
3	RNs see themselves as a multidisciplinary team					**F3**	
4	RNs inform patients about their rights					**F4**	
5	Ensure that available services are relevant to patients' needs					**F5**	
6	your autonomy in patient care as a RN is acknowledged by eg doctors, patients					**F6**	
7	patient care routines are inflexible eg meal times					**F7**	
8	workload is assessed according to the number of patients					**F8**	
9	workload is assessed according to patient acuity levels					**F9**	
10	patients complete an evaluation form for services rendered upon discharge					**F10**	

SECTION G

GROWTH AND DEVELOPMENT

		Strongly agree 4	Agree 3	Disagree 2	Strongly disagree 1	FOR OFFICE USE	
	From your experience in the bureaucratic organization, registered nurses						
1	experience psychological job satisfaction, which determines to a large extent the quality and quantity of their outputs					**G1**	
2	tend to perform well if they see growth within the organization and thus experience a sense of fulfillment					**G2**	
3	have study days for part-time studies					**G3**	
4	have full time study opportunities					**G4**	
5	have induction programmes					**G5**	
6	attend seminars, symposia & conferences for nursing					**G6**	
7	Are encouraged to search the net for new developments in the nursing field					**G7**	
8	have centralized facilitator to oversee educational programmes over the entire organization					**G8**	
9	rotate as preceptors /mentors to orientate newly employed RNs in units					**G9**	
10	take personal responsibility to upgrade their professional skills to keep abreast of new developments					**G10**	
11	have special budget for in service education programmes					**G11**	
12	evaluate in service education programmes					**G12**	

SECTION H

RESEARCH

		Strongly agree 4	Agree 3	Disagree 2	Strongly disagree 1		FOR OFFICE USE	
	From your experience in the bureaucratic organization, registered nurses							
1	initiate research projects in their units after identifying problems						**H1**	
2	conduct surveys to identify the perceptions of service providers regarding any changes and developments in health care services.						**H2**	
3	are involved in the collection and analysis of data						**H3**	
4	compile reports and statistics needed for planning purposes						**H4**	
5	apply research results in the delivery of care						**H5**	
6	have easy access to research reports conducted in their organizations						**H6**	
7	attend research seminars for nursing research						**H7**	
8	attend medical research seminars						**H8**	
9	read research reports						**H9**	

Thank you for your participation