CHALLENGES OF THE HEALTH CARE UNIT MANAGER AS LEADER-MANAGER IN THE 21st CENTURY, THE QUANTUM AGE

by

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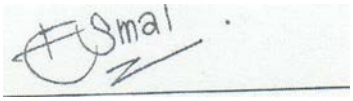
DECLARATION

I declare that **CHALLENGES OF THE HEALTH CARE UNIT MANAGER AS LEADER-MANAGER IN THE 21st CENTURY, THE QUANTUM AGE** is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete reference and that this work has not been submitted before for any degree at any other institution.



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ABSTRACT

A qualitative, exploratory, descriptive and contextual study was conducted to explore health care unit managers' view of their role as leader-managers, and to determine the challenges they experience and the skills they need to be effective leader-managers in the 21st century, the Quantum Age. Semi-structured interviews were conducted with eight health care unit managers from a selected public hospital in the Western Cape Province. The findings revealed that health care unit managers experience workforce challenges, with staff shortage being a serious concern; personal challenges, such as an increased workload and role diversity; and organisational challenges with regard to the management of equipment. Desired attributes and skills for leader-managers as indicated by unit managers concur with Shelton's (1999) Quantum Skills Model. Recommendations were made for nursing practice, education and research, including recommendations on the development of the seven quantum skills.

KEY CONCEPTS

Challenges; health care unit manager; leadership; management; leader; manager; leader-manager; Quantum Age; quantum skills.

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"For He will give His angels charge concerning you;
to guard you in all your ways." Psalm 91:11

This has been like my personal "9111", instead of "911", call number for so many years. Thank you, *Lord*, for giving me so much more than I deserve.

Sarel, my pillar of strength, my other half, for always supporting me, giving advice, constantly motivating me, to the very end.

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Thank you!

Dedication

This work is dedicated
to all the nurse managers
I have had the pleasure to work with.

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CHAPTER 1

ORIENTATION TO THE STUDY

"We cannot solve our problems with the same thinking
we used when we created them."
Albert Einstein

1.1 INTRODUCTION

The 21st century could be called the Quantum Age. Computers, the internet, barcode readers and laser surgery are only a few of the new and innovative outcomes of a theory of physics called quantum mechanics (Shelton & Darling, 2001b:264). The environment of health care organisations is changing rapidly as a result of these innovations, as well as other factors affecting health care services, such as political and economical changes, population growth, and poverty-stricken communities posing new challenges to health service leaders (Fairholm, 2004:370; Jooste, 2009:10).

Other issues impacting on health care organisations include globalisation, deregulation, e-business, telecommuting, virtual teams, outsourcing, economic uncertainty, ethical scandals and insecurity associated with war and terrorism (Daft, 2011:7). Additional challenges impacting on the health care profession as a part of the global community include internationalisation, capitalism within a consumer society, an ageing workforce, staff shortages, international migration and advanced technology (Bester, 2008:2).

The elements of the Quantum Age are altering leadership and management characteristics and roles. Roles and behaviours must model the context into which systems are moving; not those out of which organisations are leaving. Success will depend on the individual's ability to adapt and incorporate new skill and mindsets (Porter-O'Grady, 1997:16, 20; 1999:40).

Health care leaders are no longer primarily focused on task achievement and how work is done – the processes of care. Leaders today are increasingly responsible for excellence and outcomes. Quantum leaders identify old habits and learn new ways to

adapt to the chaos of change and create the context for transformation from Industrial Age work to Quantum Age change and growth, not only for him/herself, but for those he/she leads (O'Reilly [s.a.]:3).

According to Jooste (2009:22) and Porter-O'Grady (1999:37), for leaders and health care organisations to thrive in the 21st century, a whole new mind- and skill set must emerge in health care managers and leaders. Marquis and Huston (2009:44) affirm that rapid, dramatic changes will continue in nursing and health care. It is, therefore, important that nurses develop their skills in both leadership roles and management functions to become effective leader-managers.

Gardner (1990) in Marquis and Huston (2009:44, 45) asserts that integrated leader-managers possess six distinguishing traits: they think long-term, they look outward, towards the larger organisation, they influence others beyond their own group, they emphasise vision, values and motivation, they are politically astute and they think in terms of change and renewal.

1.2 BACKGROUND TO THE RESEARCH PROBLEM

Few environments have been more unpredictable in the 21st century than health care. It is difficult to plan for the future even when environments are relatively static; when they are dynamic, the challenges multiply exponentially (Huston, 2008:905, 910).

The traditional management skills of planning, organising, directing and controlling are inadequate in the fast-paced, constantly changing, highly complex environment of 21st century health care organisations; these skills were derived from classical, seventeenth-century Newtonian physics (Jooste, 2009:12; Shelton & Darling, 2001b:265). Traditionally organisations were defined as being characterised by control, prediction and measurement (Fairholm, 2004:370; Fris & Lazaridou, 2006:6). The 20th century has reflected the defining work of Newton and his colleagues on the classical physics (Porter-O'Grady, 1997:15; Shelton, 1999:4), however, the world has moved out of the industrial age into a new age characterised by a new set of realities.

The 21st century represents the Quantum Age where quantum theory is viewed as one of the most successful scientific theories – it explains, among others, the structure of

DNA and produced the microchip, compact disk, the computer and CD-Rom. Medical technology used quantum theory to develop the MRI (magnetic resonance imaging) scan (using quantum properties of protons) for diagnostic purposes (Hastings, 2002:206).

Quantum concepts offer new images of a world of constant change, a world where order emerges out of chaos and a world of subjectivity where the intentions of the observer affect that which is observed. According to Shelton *et al. (*2002b:53), the quantum realm is a much better metaphor for 21st century leadership and organisational life than is the machine metaphor of the Newtonian perspective. Table 1.1 depicts the differences between the two world views.

Table 1.1 Two world views

Two world views	
From a Newtonian perspective the world is	**From a quantum perspective the world is**
1. Material, visible, concrete	1. Intangible, invisible, abstract
2. Static, stable, passive, inert	2. Dynamic, vibrating, continuously changing
3. Predictable, controllable	3. Unpredictable, indeterminate
4. Unaffected by observation; reality is objective	4. Affected by the consciousness of the observer; reality is subjective
5. A machine; things are best understood by reducing them to their simplest parts; the parts determine the whole	5. A system; everything is part of an interrelated whole; the whole determines the parts
6. Controlled locally; cause and effect are clearly discerned	6. Affected by much more than meets the eye; things happen "from a distance"
7. Dependent upon extrinsic energy sources; without external force, things fall apart	7. Filled with energy; energy is intrinsic to life and its systems

(Shelton, 1999:5; Fris & Lazaridou, 2006:7)

According to Shelton *et al. (*2002a:4) and Fairholm (2004:370), Wheatley's (1992) groundbreaking work was the first to use quantum mechanical concepts as a metaphor for a new way of thinking about leadership.

In today's business and organisational operations, people want to be led, not managed. Successful managers must develop and nurture leadership skills that are congruent with

the perspective of organisations as human-based systems that are fundamentally unpredictable, interactive, living systems rather than stable, mechanistic-like operations. The basic principles of quantum mechanics provide significant insights into today's organisations that are objective and subjective, logical and irrational, linear and nonlinear, orderly and chaotic. These principles of quantum mechanics challenge managers to turn their view of reality upside down and inside out and to recognise that effective leadership entails much more than was considered in the past (Shelton & Darling, 2001b:264, 265).

Quantum skills are based on the principles of quantum theory that focus on leadership-related qualities necessary for success in today's health care environment. These skills are premised on the assumption that the quantum realm of energy is of primary importance and thereby causal to everything else in the universe. Consequently, the material aspects of the universe are of secondary importance (Jooste, 2009:13). The seven quantum skills include quantum seeing: the ability to see intentionally; quantum thinking: the ability to think paradoxically; quantum feeling: the ability to feel vitally alive; quantum knowing: the ability to know intuitively; quantum acting: the ability to act responsibly; quantum trusting: the ability to trust life, and quantum being: the ability to be in relationships.

The quantum skills model focuses on leader-manager skills that enhance our understanding of why a new metaphor for organisations would be useful. This new way of looking at organisations concentrates on relationship and culture more than on control and measurement techniques and cause leaders and managers to see nature in different ways; to see leadership in novel, more precise ways. These changes in thinking are perplexing and they threaten the foundation of organisational orthodoxy, but, as elements of the new sciences become clearer, our grasp of leadership and management – past, present and future – is deepened. Our ability to define and predict leader-manager behaviour will be enhanced (Fairholm, 2004:369-371).

Huston (2008:905, 910) highlights eight leadership competencies and concludes that nurses must now be prepared to be effective leader-managers in 2020. These essential nurse leader-manager competencies include: (1) a global perspective/mindset regarding health care and professional nursing issues; (2) technology skills, which facilitate mobility and portability of relationships, interactions and operational processes; (3)

expert decision-making skills rooted in empirical science; (4) the ability to create organisational cultures, which permeate quality health care and patient as well as health care worker safety; (5) understanding and appropriately intervening in political processes; (6) highly developed collaborative and team-building skills; (7) the ability to balance authenticity and performance expectations, and (8) the ability to envision and proactively adapt to a health care system characterised by rapid change and chaos.

Hastings (2002:205) critiques the literature proposing that the esoteric but fundamental brand of physics known as quantum theory contains insights that can be appropriately used by nurses to inform clinical nursing practice and health care management. Norden and David (2005:1) developed a conceptual model of the cognitive abilities that a criminal investigator uses during a criminal investigation. The authors suggested that these skills complement classical Newtonian management skills in helping an investigator make sense of a crime, as well as in deciding the approach of the criminal investigation. Wirrmann and Carlson (2005:205) analysed the concept of leadership in relation to the UK Government's current approach to modernising the NHS in England focusing on primary health care. The authors questioned the concept of leadership skills as a taught competence and provided Shelton and Darling's (2001b:265) quantum skills model of leadership to suggest new ways in which public health leadership in a primary care context might be approached. Snyman (2007:9) explored the comparison between what South African executive leaders view as required skill sets and quantum skills to establish whether leaders understand these skills and utilise them. She found that the participants understood the new roles of leadership, but have not mastered them yet due to the fact that the skills required are known, but not internalised. Recommendations to develop these skills were made. Hall (2009:6) conducted qualitative research on the development of a quantum leadership model and quantum leadership questionnaire in South Africa. A unique view of leadership is presented that integrates perspectives from the quantum physical, social and management as well as humanistic psychological sciences, into one holistic leadership model. This model has a predictive nature on organisational outcomes.

The nursing profession is directly affected by international changes. Nursing shortages, international staff migration and an ageing workforce can cause depleting and efflux of nursing leaders, while nurse leaders play an important role during times of change. According to Kerfoot (2006:115) in Bester (2008:3), today's health care leader-

managers need to recognise and anticipate current, as well as future trends and adapt to them.

1.3 STATEMENT OF THE RESEARCH PROBLEM

The transformation from an industrial to an information age has brought about a fast-changing world focus and a competitive economy. This transformation due to globalisation, internationalisation and capitalism within the consumer society, an ageing workforce, staff shortages, international migration and advanced technology is challenging the nursing profession.

In the light of the 21st century representing the quantum age it is not certain whether health care unit managers are adequately equipped to face the new challenges in the health care environment and whether they have the necessary skills to fulfil their roles as leader-managers.

1.4 RESEARCH PURPOSE

The purpose of this study was to

- explore how health care unit managers view their role as leader-managers
- determine the challenges they experience and the skills they perceive they need to be effective leader-managers

1.5 RESEARCH OBJECTIVES

The objectives of this study were to

- describe how health care unit managers view their role as leader-managers
- identify the challenges health care unit managers experience in executing their leader-manager roles
- determine what skills health care unit managers perceive they need to be effective leader-managers

1.6 SIGNIFICANCE OF THE STUDY

This research study may provide information regarding the way in which health care unit managers view their role as leader-managers, the current challenges they experience in the workplace and the skills they perceive they need to be effective leader-managers. Based on the research findings, ways in which health care unit managers can develop these skills may be recommended. Awareness of the current challenges they experience can lead towards improvement of future preparation and training of nurse leaders. Implementation of the recommendations of the study may lead to empowerment of health care unit managers to function more effectively as leader-managers in the health care services in the 21st century. As a result not only the public may benefit by receiving improved health care delivery but the students working in the health services may benefit from having good role models.

1.7 DEFINITION OF KEY CONCEPTS

Challenges

A challenge is defined as “a demanding task or situation” (*South African Pocket Oxford Dictionary,* 2002:140). A challenge in this study refers to a demanding task/situation health care unit managers currently experience in their work environment.

Health care unit

A health care unit is the smallest patient care structure within a health services organisation (Muller, 2000:46). In this study a health care unit refers to a hospital health care unit where patients receive health care.

Health care unit manager

A health care unit manager is a registered nurse who is accountable at an advanced practice level for the coordination of clinical practice and the provision of human and material resources in a specific patient/client area (Muller, 2000:45; Hewson, 2008).

Leadership

Leadership is “an influential relationship among people, involving the leaders and followers who intend real changes that reflect their shared goals” (Jooste, 2009:5).

Leader

A leader is an individual who influences and guides the direction of opinion and the course of action within a group or organisation (O’Donnell, 2002:79).

Management

Management is defined by Huber (2006:7) as the coordination and integration of resources through planning, organising, coordinating, directing and controlling to accomplish specific institutional goals and objectives.

Manager

A manager is an individual who has responsibility and accomplishes, conducts and make things happen (O’Donnell, 2002:79). In this study a nurse manager has 24-hour responsibility for the operation and strategic planning of a health care unit in a hospital.

Leader-manager

A health care leader-manager integrates leadership skills with the ability to carry out management functions (Marquis & Huston, 2009:46).

Quantum Age

The 21st century can technologically be called the Quantum Age. New and innovative outcomes represent the theory of physics called quantum mechanics, which is the study of subatomic particles in motion. The subatomic realm refers to everything in the physical world that is smaller than an atom (Shelton, 1999:1; Shelton & Darling, 2001b:264).

Quantum world view

The quantum world view characterises the universe as a dynamic, unpredictable, subjective, self-organising system rather than as a static, predictable, objective machine (Shelton, 1999:4).

Skills

A skill is defined as “the ability to do something well”, “a particular ability” (*South African Pocket Oxford Dictionary,* 2002:845).

1.8 RESEARCH DESIGN AND METHODOLOGY

A brief overview of the research design and methodology is provided.

1.8.1 Research design

The research design is a set of decisions regarding the topic to be studied, the population and the research methods followed for the purpose of the study. It focuses one’s perspective for the purposes of a particular study (De Vos, Strydom, Fouché & Delport, 2011:142, 143). In this study a qualitative research approach was used following an exploratory, descriptive and contextual research design.

Polit and Beck (2008:763) define qualitative research as the in-depth and holistic investigation of phenomena through the collection of rich narrative materials using a flexible research design. According to De Vos *et al*. (2011:65), the qualitative research paradigm refers to research that elicits the participant’s accounts of meaning, experience or perceptions. Data, produced in the participant’s own words, allows the researcher to identify the participant’s experiences, beliefs and values regarding a phenomenon. The qualitative paradigm was used in this study for the purpose of understanding and interpreting the meanings health care unit managers have about their role as leader-managers, the current challenges they experience and the skills they perceive they need to be effective leader-managers.

1.8.2 Research methodology

The research method is “the techniques used to structure a study and to gather and analyze information in a systematic fashion” (Polit & Beck, 2008:765).

1.8.2.1 Research population

The research population refers to individuals who possess specific characteristics that are of interest to the researcher (De Vos *et al.,* 2011:223, Polit & Beck, 2008:337). The research population for this study comprised health care unit managers. The target population was health care unit managers at a selected regional hospital in the Western Cape Province.

1.8.2.2 Sampling

Sampling refers to the process of selecting a portion of the population to represent the entire population (Polit & Beck, 2008:339; De Vos *et al.,* 2011:224). Purposive sampling, a non-probability sampling method, was the method of choice in this study. The sample size was not determined beforehand as qualitative research data collection ends when data saturation occurs.

1.8.2.3 Data collection

According to Burns and Grove (2005:733), data collection is the precise and systematic gathering of information relevant to the research purpose. Data was collected from health care unit managers who met the eligibility criteria by using semi-structured interviews as the data collection method. Data saturation was reached after eight interviews were conducted.

1.8.2.4 Data management and analysis

Data analysis is “the process of bringing order, structure and meaning to the mass of collected data” (De Vos *et al.,* 2011:397). According to Creswell (2007:150-155), in qualitative research the process of data analysis and interpretation is best represented by a spiral image. The researcher moves in analytic circles rather than using a fixed

linear approach. All interviews were transcribed verbatim and the researcher analysed the data manually through content analysis using open and axial coding.

1.9 TRUSTWORTHINESS

Trustworthiness is the degree of confidence qualitative researchers have in their data and is assessed by using the criteria of credibility, transferability, dependability, confirmability and authenticity (Polit & Beck, 2008:196, 540, 541, 768). Measures to ensure the credibility of the study included prolonged engagement, interview technique, structural coherence, referential adequacy, peer examination, member checking, reflexivity and authority of the researcher. To enhance the dependability in this study the researcher implemented a code-re-code procedure and left an audit trail. Confirmability was ensured through the audit trail and reflexivity and measures employed for transferability included purposive sampling and dense descriptions. The researcher gave recognition to all participants' voices to honour authenticity.

Trustworthiness is discussed in detail in chapter three of this dissertation.

Credibility

This means that participants recognise the meaning which they themselves give to a situation or condition and the truth of their feelings in their own context (Holloway & Wheeler, 2010:303).

Dependability

Dependability in qualitative research relates to the consistency of findings (Holloway & Wheeler, 2010:302, 303).

Confirmability

Confirmability means that the research findings and conclusions achieved their aim and that they are not the results of the researcher's prior assumptions and preconceptions (Holloway & Wheeler, 2010:303).

Transferability

Transferability means that the findings in one context can be transferred to similar situations or participants and that the knowledge acquired in one context will be relevant in another. Those who conduct the same research study in another context will be able to apply certain concepts originally developed by other researchers (Holloway & Wheeler, 2010:303).

Authenticity

Authenticity is the term used to demonstrate that the findings of a research study represent participants' perspectives, is fair and assists participants in understanding and improving their social world (Holloway & Wheeler, 2010:337). Authenticity consists of fairness, ontological authenticity, educative authenticity, catalytic authenticity and tactical authenticity.

1.10 ETHICAL CONSIDERATIONS

Ethics is a set of moral principles, which offers rules and expectations on the most correct conduct towards participants, employers, sponsors, other researchers, assistants and students. Ethical guidelines serve as standards and provide a basis for researchers to evaluate their own conduct (De Vos *et al.,* 2011:114).

The researcher obtained ethical clearance from the University of South Africa and permission to conduct the study was requested from the relevant authority where the study was conducted.

The ethical considerations are discussed in detail in chapter 3.

1.11 OUTLINE OF THE DISSERTATION

The chapters of this dissertation are divided as follows:

Chapter 1 Orientation to the study
Chapter 2 Literature review

Chapter 3 Research methodology

Chapter 4 Data presentation

Chapter 5 Conceptualisation, synthesis of findings, conclusion and recommendations

1.12 CONCLUSION

An overview of this study conducted on the view health care unit managers have of their leader-manager role, the challenges they currently experience and the skills they perceive they need to be effective leader-managers, was presented. The background to the study, problem statement, research purpose and objectives were described. Key concepts were defined and the research design and methodology concerning the population, sampling, data collection and data analysis were briefly described. A brief overview of trustworthiness and ethical considerations were explained and the outline of the dissertation given.

Chapter 2 focuses on the literature review.

CHAPTER 2

LITERATURE REVIEW

Go to the people. Learn from them. Live with them. Start with what they know. Build with what they have. The best of leaders, when the job is done, when the task is accomplished, they will say we have done it ourselves.

Lao Tzu

2.1 INTRODUCTION

The literature review is a "critical summary of research on a topic of interest, often prepared to put a research problem in context" (Polit & Beck, 2008:757).

Existing literature is reviewed to prevent duplication of a previous study; to discover the most recent and authoritative theory about a subject; to discover the most widely accepted empirical findings in a field of study and to ascertain the most widely accepted definitions of key concepts in a specific field (Mouton, 2001:87).

The researcher chose the topics and subjects of the literature review on the basis of the research questions and objectives.

This chapter provides a literature review of the challenges experienced by unit managers as leader-managers in the 21st century, the Quantum Age and seven quantum skills.

The literature review is composed from national and international literature. Databases used during this literature review include non-electronic sources, ie handbooks, articles in scientific journals, theses and dissertations. Electronic sources such as CINAHL, Pubmed and ScienceDirect provided the researcher with a broad spectrum of literature.

The keywords used for the search were: nursing, health care, leaders, managers, leadership, management, leader-managers, quantum leadership, quantum skills and

challenges. In the search the keywords were used singularly as well as in various combinations.

2.2 TWO WORLD VIEWS

The 20th century, called the Industrial Age, was dominated by the Newtonian, mechanistic or systems world view and aligns with the being view of nature (Curtin, 2011:36; Fris & Lazaridou, 2006:4). It is a world view based primarily on Isaac Newton's law of classical physics. These laws are premised on the assumption that reality is objective, effects are predictable and knowledge comes through analysis. A world view based on these assumptions requires logical, linear, left-brain thinking skills.

Wheatley (2006:31) contends that living in this machine universe has not been easy and that a mechanical world feels distinctly anti-human. She quotes Zohar's (1990:18) description: "Classical physics transmuted the living cosmos of Greek and medieval times, a cosmos filled with purpose and intelligence and driven by the love of God for the benefit of humans, into a dead, clockwork machine …Things moved because they were fixed and determined; cold silence pervaded the once-teeming heavens. Human beings and their struggles, the whole of consciousness, and life itself were irrelevant to the workings of the vast universal machine".

For more than 300 years the skills of the Industrial Age have served society well. The ability to plan, organise, direct and control are mechanistic skills and were formulated for life in a stable universe that functions in a logical, linear and predictable manner (Shelton, 1999:xxi). Leadership meant being a good manager guiding workers and directing their activities in the best interests of the organisation (Porter O'Grady & Malloch, 2011:3).

Leadership in the Industrial Age is referred to by Covey (2004) in Bester (2008:6) as a position rather than as a skill where people were regressed to "things" or "objects", managed by means of rules, control and efficiency.

These skills are not adequate for life and work in the 21st century, the Information or Quantum Age, with its fast-paced, constantly changing, intricately interconnected world, which is neither static nor predictable (McDaniel, 1997:24; Shelton, 1999:xxii).

Leadership and management cannot be the same. The old models of leadership and management are no longer adequate to meet the demands of today (Porter-O'Grady & Malloch, 2011:2). Leadership by means of rules, control and efficiency tends to lead to increased mistrust, misalignment and disempowerment. The importance of leadership and management should remain essential (Bester, 2008:7).

Capra (1982, 1983, 1996), Wheatley (1992, 2006), Zohar (1990, 1997) and Zukav (1979, 1989) in Shelton (1999:xxii) suggest that the so-called new sciences (quantum physics, chaos theory and complexity science) provide concepts and images for an updated world view, aligning with the becoming assumption and characterising the universe as a complex, unpredictable, interactive system rather than as a stable, objective machine.

The impact of technology has brought about a new construct for social structures and relationships. Newer technologies, using quantum theory, that effect life from the molecular to the global levels, were created. These changes, however, have also raised the level of conflict surrounding basic issues; claims that once seemed beyond question are now open to investigation and continuous challenge (Porter-O'Grady & Malloch, 2011:5).

According to Porter-O'Grady and Malloch (2011:7,8) changes in the Information Age include the following:

- The Web – this fastest-growing primary business tool is fundamentally altering the way in which business gets done.
- In today's world information is transmitted instantly via the use of fibre optics in conjunction with satellite technology.
- Information is highly portable with everyone having access to almost anything they want/need.
- Each person has control over any relationship (personal or business), can personalise any interaction within any context at any time and in any which desired way.
- People can be mobile and still remain connected to everything and anyone. This miniaturisation has made innovations in service, communication, information and health care faster, easier and cheaper to implement.

- Globalisation has created a world community without boundaries (political, social or physical).
- Biotherapeutics and chemotherapeutics are forever changing Western medicine.

The structures supporting the provision of Western medicine will also need to change.

In table 2.1 the difference between old and new medical therapies is outlined.

Table 2.1 Changing medical therapies

Old therapies	New therapies
Surgery	Lasers
Salves and creams	Microsurgery
Accommodation	Genomics
Nothing can be done	Pharmaceuticals
Treatments	Chemotherapy
Enemas	Radiotherapy
Blood-letting	Synthetic products
General supplements	Specified supplements

(Porter-O'Grady & Malloch, 2011:11)

The impact of micronisation, genomics and biotherapeutics is forever altering Western medicine, therefore, the structures that support the provision of Western medicine will also need to change. The infrastructure and current administrative and operational framework are no longer entirely relevant and adjustments will need to be made in response to financial, political and technological pressures (Porter-O'Grady & Malloch, 2011:10, 11).

Malloch and Porter-O'Grady (2009:21, 23) describe the characteristics of the Quantum Age as being mobile, portable, fast, fluid, flexible, systems-driven, digital and relational, while the infrastructure of the Quantum Age is holistic, relational, synthesised, multifocal, multidirectional and integrated.

In table 2.2 the differences between leadership in the Industrial Age and the Quantum Age are shown.

Table 2.2 Differences between Industrial and Quantum Age leadership

Difference between Industrial and Quantum Age leadership		
	Industrial Age leadership	**Quantum Age leadership**
Skills	Technical skills	People skills
Authority	Command and control	Invitation and interdependence
Strategy	Gaining advantage	Discerning purpose
Methodology	Competition	Cooperation
Focus	Gathering facts	Finding meaning
Value	What you have (wealth)	What you know (information)
Structure	Hierarchy (top-down)	Circular (egalitarian)
Meaning of leadership	Leadership: position	Leadership: trusteeship

(Marquis & Huston, 2009:63)

From the above discussion it is concluded that various authors suggest that leaders and managers, at their current level of understanding, cannot thrive in the new environment for health care services, where the milieu for service has been altered radically.

In the words of Porter-O'Grady and Malloch (2011:10): "Moving into a new age does not mean leaving everything behind. It does mean thinking about what needs to be left behind and reflecting on what does go with us as we move into an age with a different set of parameters."

2.3 LEADER-MANAGERS

The debate on whether managers are leaders or whether leaders are managers continues (Turk, 2007; Munene, 1997; Johnson, 2009; Kent, 2005; McCartney & Campbell, 2005). The terms "management" and "leadership" are still confusing to practitioners, as they are used interchangeably by some while others argue that the terms are substantially different, and distinct comparisons are drawn. These authors conclude that the term leader-manager seems to be a logical solution to the semantics problem concerning leadership and management.

In table 2.3 the main differences between managers and leaders are summarised.

Table 2.3 Differences between managers and leaders

Differences between managers and leaders	
Managers	**Leaders**
1. Managers do things right (carry out the policy of the organisation)	1. Leaders do the right thing (formulate policy)
2. The main aim of managers is to maximise output through administrative implementation	2. The main aim of leaders is to ensure the attainment of organisational goals through the facilitation of healthy relationships among employees
3. Managers have employees	3. Leaders have followers
4. Managers command and control their employees	4. Leaders empower and inspire their followers
5. Managers seek stability	5. Leaders seek flexibility
6. Managers make decisions and solve problems	6. Leaders give direction, empower and enable the members of their teams to make their own decisions and creatively solve their problems
7. Managers accept the culture and structure of the organisation	7. Leaders use innovation to look for better ways
8. Managers do things by the book and follow policies	8. Leaders follow their intuition
9. Managers control	9. Leaders guide their actions and behaviour by vision, strategies, goals and values
10. Managers are respected for their position of authority	10. Leaders are naturally followed

(Jooste, 2009:27)

2.3.1 Leading and managing

According to Kent (2005:1012), one way to understand something is to identify how it differs from something else and, while it is recognised that the two processes, managing and leading, must work together and reside within the same individual, it is useful to comprehend them separately. Kent, Crotts and Azziz (2001:224) provide a framework for clarifying the differences between leading and managing, and, using the ideas of several authors, including Bass (1985, 1988); Bennis and Nanus (1985); Yukl, Wall and Lepsinger (1990), provide a definition of the two processes. The framework in table 2.4 defines both the leading function and the managing function with regard to purpose,

products and processes. Each term/perspective is distinctly different from the other two.

Table 2.4 Differentiating and defining leading and managing

	Leading	Managing
Purpose *Why does this function exist?*	To create direction and the unified will to pursue it through the development of people's thinking and valuing	To determine and compare alternative uses and allocations of resources and to select that alternative, which is most energy-effective towards accomplishing or producing a product, end or goal
Products *What does each function result in or create?*	The establishment of thrust toward a purpose or end The creation of social orderliness to carry out that thrust Higher state of behaviour and thinking in terms of principles, values, morality and ethics	Resources, organised effort and awareness of performance and progress toward goals The creation of a desired mode of working among people and other resources The creation of the most energy-effective way of dealing with the cause of events and situations in accomplishing a purpose tied to a particular situation
Processes *How is each function manifested?*	Creating vision, aligning people within a team, managing the "Self", recognising and rewarding, communicating meaning and importance of the vision	Planning Organising Controlling Coordinating

(Adapted from Kent, Crotts & Azziz, 2001:224; Kent, 2005:1013)

Leading and managing each has a distinct purpose, products and processes, and in the Quantum Age leader-managers, who successfully integrate the two concepts, are needed. Turk (2007:21) states: "… a good leader and good manager can, and should, be one and the same."

2.3.2 Similarities between leadership and management

Kent (2005:1013) argues that the two processes, leadership and management, while distinct, cannot effectively work without each other working in tandem. Health care practitioners use managerial and leadership skills to facilitate the delivery of quality nursing care (Huber, 2006:3). This view is supported by other sources. Calpin-Davies (2003:4) argues that the terms ‘management’ and ‘leadership’ are often confused and used synonymously although they may be considered complementary activities. Keller (2010:10) describes management as the efficient and productive use of things and leadership as the ability to get extraordinary results from teams of people and both are needed to achieve success in organisations. Marquis and Huston (2009:31) state that if a manager guides, directs and motivates, and a leader empowers others, then every manager should be a leader and leadership without management results in chaos and failure for the organisation and the individual executive. Mathena (2002:136, 137) mentions that health care managers make up the largest layer of hospital middle management and they are in the unique position to interact directly not only with the nursing staff, but with other health care workers. They can use their leadership skills to achieve successful transitions in their health care environments. McCartney and Campbell (2005:199) proposed a model, the model of individual success and failure, for explaining the relationship among leadership skills, management skills and individual success and failure. These authors believe an appropriate mix of leadership and management skills is essential for organisations to be successful.

Jennings, Scalzi, Rodgers and Keane (2007:174) state that the convergence of leadership and management competencies might reflect a different dynamic. The dramatic changes altering the social context of health care may have influenced this evolution. Leadership is a subsystem of the management system, included as an element of management science in management textbooks and other publications. In some, the term ‘directing’ has been replaced by the term ‘leading’. Managers are sometimes described in less glowing terms than leaders, but successful managers are usually successful leaders. Leadership is a desirable and prominent feature of the directing function of nursing management (Roussel & Swansburg, 2009:630; Swansburg & Swansburg, 2002:404, 405).

According to Gardner (1986:13) most managers exhibit some leadership skills and most leaders on occasion find themselves managing. It, therefore, makes sense to include managing in the list of tasks leaders perform. Gardner (1990), as quoted in Marquis and Huston (2009:44, 45), also states that first-class managers are usually also first-class leaders and that leaders and leader-managers distinguish themselves beyond general run-of-the-mill managers in six respects:

- They think longer term – beyond the day's crises, beyond the quarterly report, beyond the horizon.
- They look beyond the unit they are heading and grasp its relationship to larger realities – the larger organisation, of which they are a part, conditions external to the organisation and global trends.
- They reach and influence constituents beyond their jurisdiction, beyond boundaries. Florence Nightingale influenced nurses all over the world, Thomas Jefferson influenced people all over Europe and Mahatma Ghandi influenced people all over the world. In an organisation, leaders overflow bureaucratic boundaries – often a distinct advantage in a world too complex and tumultuous to be handled "through channels". Their capacity to rise above jurisdictions may enable them to bind together the fragmented constituencies that must work together to solve a problem.
- They put heavy emphasis on the intangibles of vision, values and motivation and understand intuitively the non-rational and unconscious elements in the leader-constituent interaction.
- They have the political skill to cope with the conflicting requirements of multiple constituencies.
- They think in terms of renewal. The routine manager tends to accept the structure and processes as they exist: the leader-manager seeks the revisions of process and structure required by ever-changing reality.

Mitchell (1968) in Roussel and Swansburg (2009:630) and Swansburg and Swansburg (2002:405) describe five major requirements effective health care leader-managers will work to achieve: adjustment to a complex social environment of several or many units; the ability to influence and guide subordinates; emotional and intellectual maturity as a preparation for leadership; the ability to think through and make decisions and to

translate decisions into effective action and the capacity to see beyond the immediate or surface indications and, with experience, to acquire perspective.

That a relationship between leadership and management exists seems scarcely arguable. Nienaber (2010:670) concludes that both management and leadership roles have a common goal and both are concerned with the overall success of the business. Management and leadership are inextricably interwoven.

Management includes written plans, clear organisational charts, well-documented annual objectives, frequent reports, detailed and precise job descriptions, regular evaluations of performance against objectives and the administrative ordering of theory. Leader-managers use these tools of management, without making them a bureaucratic roadblock, to guide employees towards autonomy, participatory management, maximum performance and productivity (Roussel & Swansburg, 2009:630; Swansburg & Swansburg, 2002:405).

2.4 CHALLENGES IN THE QUANTUM AGE

The current health care environment is seen as a period of transition characterised by competition, conflict, consumer orientation, rapid communication and chaos (Huber, 2006:4).

Daly, Speedy and Jackson (2004:9-11) discuss the challenges and issues health care leader-managers experience as economic and political, social and demographic and professional issues. In this review the researcher will use this framework.

2.4.1 Economic and political challenges and issues

Contemporary leader-managers have become familiar with the phrase ‘doing more with less’. They are challenged to deliver quality patient care in an environment of rising consumer expectations, increasingly constrained human and financial resources, continued downsizing of health care facilities and/or services and increased acuity and decreasing lengths of stay. There is also a shift in the location of care from a hospital setting to a primary health care facility and transfer of patients between acute and chronic settings and then back to their homes (Daly *et al*., 2004:9; Jooste, 2009:7).

Leader-managers have to achieve better expenditure control, greater productivity and efficiency. This challenges the moral imperatives in health care services, which are to maintain access to the necessary health care services and to ensure an equitable distribution of resources. The public demands equitable, universally accessible services, which are funded by the government (Jooste, 2009:7).

The South African Health Summit of 2001 focused on better health for all citizens and the National Patients' Rights Charter outlines patients' rights. All patients have the right to participate in decision-making on matters affecting their health. Health care providers have to display and demonstrate courtesy and tolerance and provide adequate health information and continuity of care. White Papers for the transformation of health care services focus on the decentralisation of responsibility, accountability, power and authority to the lower levels of care delivery, greater involvement of the community, reduction of bureaucratic practices and effective use of resources. Putting these principles into practice is the challenge health care leader-managers now face. The role of health care leader-managers is dramatically changing towards information management (Jooste, 2009:7, 8).

2.4.2 Social and demographic challenges and issues

There are social changes both inside and outside the health care profession. Worldwide demographic changes lead to increased cultural diversity. According to Daly *et al*. (2004:9) two distinct social classes, based on literacy, have developed: the educated and the uneducated. In South Africa the "two-class" character of the health system remains, characterised by a weak and overburdened public sector offering "second-class services" and a much stronger private sector offering "first-class services" (Van Rensburg & Pelser, 2004:163).

There is a rising phenomenon of violence and crime in society. These include sexual violence and rape, corruption, burglaries, assaults and xenophobia (Bester, 2008:129; Daly *et al*., 2004:10). This leads to an even higher workload in hospitals, especially in trauma units. Health workers also suffer workplace violence and patients and visitors misbehaving.

Due to advancing medical technology and research, what was once considered extraordinary, has now become ordinary. This makes patients' needs more complex (Ulrich, Taylor, Soeken, O'Donnell, Farrar, Danis & Grady, 2010:2516). Our increasing capabilities to "create", extend and/or "end life" through artificial insemination, cloning, genetic engineering, legal abortions, assisted suicide and euthanasia is a huge ethical challenge to today's health care leader-managers (Daly *et al*., 2004:10; Jooste, 2004:219; Jooste, 2009:7). Health care leader-managers need to address ethical issues encountered in their units to ensure that quality care is delivered to patients and to enhance the retention of staff (Ulrich *et al*., 2010:2517).

Jooste (2009:7) points out that worldwide the population is ageing. People live longer and healthier lives and there is an increasing population of very old people requiring nursing care. Due to the HIV/Aids pandemic thousands of orphans are left without parents or homes. Risks to health and wellbeing are increasing. There is an apparent reluctance of many to embrace preventative measures and lifestyles and strong views, while not wanting to pay more for health care. Population growth is also causing challenges to health care leader-managers (Bodenheimer & Pham, 2010:801; Almalki, Fitzgerald & Clark, 2011:309).

The tendency toward litigation to resolve conflict is increasing (Daly *et al*., 2004:10).

2.4.3 Professional issues

The changing demographics of the nursing workforce are a well-known challenge to current leader-managers (Daly *et al.,* 2004:11). The shortage of nursing staff is a worldwide issue, coupled with the shift toward part-time work and a trend to work shorter hours per week. Enrolment in nursing courses is fluctuating. It is a huge challenge to retain nursing staff, and career opportunities for women are expanding (Daly *et al.,* 2004:11, Gould *et al.,* 2001:16). Finding competent staff and generational issues in the workforce are also challenges that health care leader-managers experience (Sherman, Bishop, Eggenberger & Karden, 2007:89).

Two major factors contributing to the high turnover rate of professional nurses in South Africa are internal migration within the South African health care sector and emigration to other countries – the so-called "brain drain" phenomenon. These nurses are lured by

more affluent countries offering more in terms of competitive incentives, better working conditions, resources, safety and a lower prevalence of HIV/Aids (Bester, 2008:129; Breier, Wildschut & Mgqolozana, 2009:4-5; Daly *et al*., 2004: 11; Mokoka, Oosthuizen & Ehlers, 2010:1).

It is increasingly demanded of leader-managers to deal with resource issues and they are expected to be conversant with information technology (Booysen, 2009:2; Gould, Kelly, Goldstone & Maidwell, 2001:16).

It is expected of leader-managers to enhance good professional relationships and communication between nurses and physicians, nurses and nurses, and nurses and patients (Breier *et al*., 2009:97; Sherman, Bishop, Eggenberger & Karden, 2007:89). Breier *et al*., 2009:97 state that often poor interpersonal relationships exist between the various role players in health care delivery systems. In the Quantum Age relationships are very important.

Jones and Cheek (2003:127) conclude that managers of nurses need to know how to be innovative and proactive and enable the ongoing professional development of both themselves and their staff.

2.5 QUANTUM SKILLS

The quantum world view provides the conceptual foundation for seven quantum skills (Shelton 1999:4). The skills are referred to as quantum skills because they are premised on the assumption that the quantum realm of energy is of primary importance and thereby causal to everything else in the universe. The material aspects of this universe are consequently of secondary importance. The quantum skills are quantum seeing, quantum thinking, quantum feeling, quantum knowing, quantum acting, quantum trusting and quantum being.

These seven skills do not function independently; they represent an integrated skill set (Shelton & Darling, 2001a:2).

Figure 2.1 displays Shelton's (1999:6) quantum skills model.

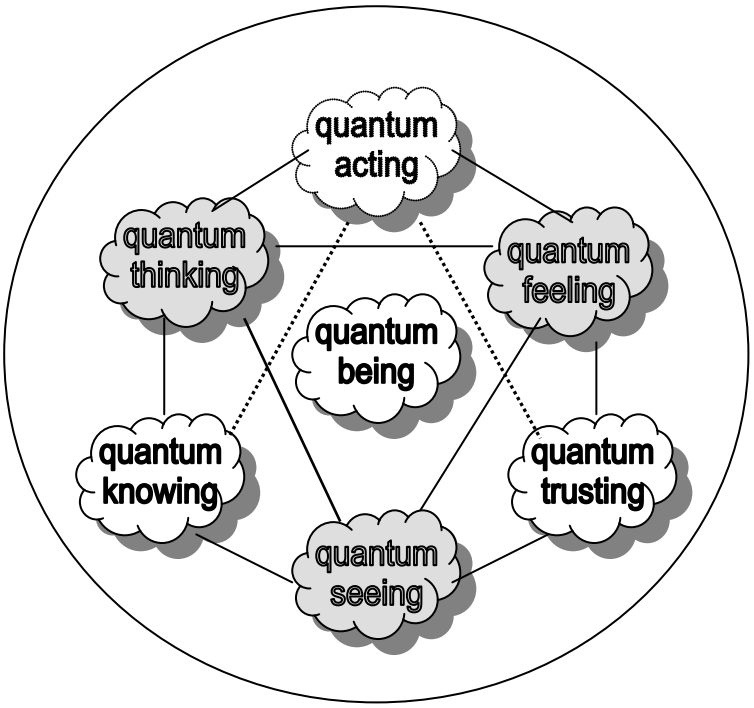

Figure 2.1 Shelton's quantum skills model

These quantum skills are based on various quantum physics models (see table 2.5).

2.5.1 Psychological quantum skills

The model's inverted triangle displays three **psychological skills**: quantum seeing, quantum thinking and quantum feeling. These skills are new key paradigm concepts, but they alone are not sufficient – they are essentially egocentric. The focus is on self – my intentions, creative potential, and feelings. They enable us to actualise more of our human potential, but additional skills are needed; skills that shift the focus from narrow self-interest to concern for the good of the whole. These skills are premised on three well-known principles:

1. Perception is highly subjective. Past experiences, assumptions and beliefs shape what we see in the material world (quantum seeing).
2. Non-rational thinking enhances creative problem-solving. The rational, linear, left brain has limited creative ability (quantum thinking).
3. Feelings are not caused by external stimuli. They are the by-product of our perceptual choices (quantum feeling) (Shelton, 1999:6, 7).

2.5.1.1 Quantum seeing

Definition

Quantum seeing is the ability to see intentionally and is based on the premise that reality is inherently subjective – it shows up according to the expectations and beliefs (intentions) of the observer. Research supports the premise that the majority of what is seen in the external world is a function of internal assumptions and beliefs (Shelton & Darling, 2004:28).

Health care leader-managers function and make decisions within the context of a subjective organisational environment. According to Zukav (1979) in Shelton and Darling (2001b:266), reality is what individuals take to be true and what they believe; their beliefs are based on their perceptions and what they see in the external world is a function of their own internal beliefs.

Shelton, Darling and Walker (2002a:54) state: “Clear intention serves as a magnifying glass, a new lens through which leaders can make new perceptual choices – choices that otherwise would have been missed.” Intention is the psychological mechanism we use to create reality. The skill of quantum seeing is a reminder of the power of human intention (Shelton, 2010:165).

Practice

It is often difficult for people to change their perceptions and they tend to see the environment as they have always seen it. Leader-managers can learn to become more aware of their intentions and as they change these, their perceptions shift accordingly and leadership is enhanced. Quantum seeing enables leader-managers to consciously select their intentions and thus expanding their vision of what is possible for themselves and all stakeholders, aligning their perceptions with their desires. This skill furthermore acts as a reminder to leader-managers that all stakeholders should be involved in visioning and planning processes, riding above organisational and professional boundaries. (Dolamo, 2009:5; Jooste, 2003:14, 2009:14; Shelton *et al*., 2002a:54).

2.5.1.2 Quantum thinking

Definition

Quantum thinking is the ability to think paradoxically and is derived from quantum physics research, which suggests that the physical universe functions in illogical, paradoxical ways and that the visible three-dimensional world is composed solely of invisible energy. While many professionals rely on logical, rational, linear, black-and-white thinking skills, many health care issues are paradoxical and pose questions that cannot be answered by rational thinking (Jooste, 2003:15; Shelton *et al*., 2002a:10).

Zohar (1997), in Curtin (2011:37) asserts: "Quantum thinking is called into play when the unexpected happens, in situations of crisis or opportunity when our rule-bound [serial] and habit-bound [associative] thinking can't cope. In the brain, serial, parallel, and quantum … thinking structures are integrated and work in tandem to generate our uniquely human thinking processes."

Practice

The application of quantum thinking requires leader-managers to awaken to the capacities of the right hemisphere of their brains, allowing images, innovation and creativity to assist in quick, creative, often illogical exercises of problem solving (Jooste, 2003:15, 2009:14,15; Shelton *et al*., 2002a:10). The right brain can gather up seemingly unrelated ideas and arrange them into highly creative idea constellations and thus bypass the left brain's propensity for binary thinking. Another advantage of the right brain hemisphere is that it can process millions of visual images in microseconds and solve problems exponentially faster than the clock-bound left hemisphere. The process of imagistic thinking may assist health care leader-managers in escaping the tyranny of time and enter a realm where seemingly opposite options can effortlessly superimpose themselves into highly creative solutions (Shelton, 2010:166).

According to Curtin (2011:37), leader-managers who work with uncertainty and ambiguity strive to see day-to-day events in terms of the big picture, support creativity and support the view that change is centred in people, not the organisation.

2.5.1.3 Quantum feeling

Definition

Quantum feeling is the ability to feel vitally alive, and is based on the premise that humans are made up of the same energy as the rest of the universe and are, therefore, subject to universal laws of energy excitation.

Positive emotions (love, caring, compassion and appreciation) increase the energy of the mind, body and spirit due to increased coherence in the heart's electromagnetic waves, energising the individual. Negative emotions in the form of stress are evident in health care settings, resulting in a loss of energy, a fast-paced working tempo, interpersonal conflict and differences that exhaust individuals (Dolamo, 2009:5; Jooste, 2003:14, 2009:14; Shelton, 2010:166, 167).

Practice

Knowing that negative emotions exhaust and positive emotions energise still does not solve the pervasive epidemic of stress and conflict. The skill of quantum feeling enables leader-managers to feel good internally, regardless of what happens externally. As health care leader-managers use this skill, they become masters in the art of reframing; they choose to see all events through a positive lens and generate high levels of vitality (Jooste, 2003:15, 2009:15; Shelton *et al*., 2002a:56).

They become increasingly aware of the perceptual choice point between an external stimulus and a subsequent internal response and begin to recognise that their energy is never depleted by other people or events, but rather by their own perceptual choices (Shelton, 2010:167). The coherence achieved internally is always reflected externally and according to Shelton (1999:73) that is how energy works.

2.5.2 Spiritual quantum skills

The skills of quantum knowing, quantum acting, quantum trusting – shown on the model's lower, upright triangle and quantum being, displayed in the hexagonal area in the centre of the two overlapping triangles, indicating that they are intricately connected

to each of the other skills, are **spiritual skills.** These skills enable us to shift our focus from "what is good for me" to "what is good for all of us". These skills are grounded in four universal spiritual principles:

1. Humans live in an intelligent universe (quantum knowing).
2. Everything in the universe is interconnected (quantum acting).
3. Chaos is used to create order (quantum trusting),
4. Life transforms itself through relationships (quantum being) (Shelton, 1999: 5-7).

2.5.2.1 Quantum knowing

Definition

Quantum knowing is the ability to know intuitively and to learn from the inside out. It is the ability to connect with information in non-sensory ways with information in the quantum field of potentiality. A belief in certainty leads to mindlessness because when a person is certain about something, the tendency is not to pay attention any longer; they are thus less mindful. Uncertainty keeps individuals attentive to both their internal intuition and their external conditions. Mindfulness keeps people connected to the quantum field of infinite information (Jooste, 2003:16; Shelton, 1999:81; Shelton *et al*., 2002a 56, 57).

Practice

When leader-managers incorporate the space for mindfulness into their daily work lives, they will nurture whole-brain organisations and value intuitive knowing as much as rational analysis. Andrews (2006), in Marquis and Huston (2009:8), suggests that "one of the critical skills separating good leaders from great leaders is the conscious use of intuition in daily decision-making. Great leaders actively call on their intuition to enhance decision- making, whereas less effective leaders tend to rely too heavily on traditional approaches".

Klein (2004), a leader in the field of intuitive decision-making research, suggests that, instead of using classical rational or systematic decision-making processes, many individuals act on an impulse if the "imagined future" looks acceptable. He reveals that,

in fact, 90% of the critical decisions we make are based on our intuition (Marquis and Huston, 2009:8).

Aloi (2006) contends that intuition should be used in problem-solving and decision-making. She warns that the dark side of intuition is misjudgement and that intuition should serve only as an adjunct to decision-making founded on nursing's scientific knowledge base (Marquis & Huston, 2009:8).

2.5.2.2 Quantum acting

Definition

Quantum acting is premised on the quantum concept of non-separability and its by-product, non-local causation. Once two systems are connected, they remain inseparable; any measurement of one of these systems affects the second system instantaneously. Quantum acting is the ability to act with concern for the whole: the whole self, the whole organisation, the whole community and the whole planet (Jooste, 2003:16, 17; Shelton, 2010:168; Shelton, Darling & Walker, 2002b:16, 17; Shelton, 2010:168, 169).

Practice

Health care leader-managers can use this skill to design lives of impeccable action. The focus of this skill is on intentions that are good for both the self and the larger system and leads to responsible decision-making – a leader-manager's choices will affect the nature of his/her future choices as well as the choices of others. Incorporating principles of caring and integrity will enhance the quality of best decisions for all. Living conscious lives means to live with conscious awareness of our values and a clear intention to act in ways that are congruent with them (Jooste, 2003:16, 17; Shelton, Darling & Walker, 2002b:16, 17; Shelton, 2010:168, 169).

Curtin (2011:37) suggests that leader-managers should emphasise the importance of values and help to clarify them, support belief in the plurality of values, listen and watch for indicators of values, articulate visions and model values.

2.5.2.3 Quantum trusting

Definition

Quantum trusting derives from chaos theory, which views change and the turbulence that accompanies it. Quantum trusting is the ability to trust the natural process, to fully participate and appreciate the change process without having to control or manipulate its course (Jooste, 2003:17; Shelton, 1999:123-125).

Practice

When health care leader-managers use the skill of quantum trusting, traditional organisations, where value is placed on prediction and control are replaced with open space technology which demonstrates in quantifiable ways the ability of a group of people to organise themselves in meaningful and productive ways (Jooste, 2003:17; Shelton, 1999:123-125). They begin to focus on the mystery of existence, rather than on their mastery over it; less intent on manipulating life and more intent on appreciating it (Shelton, 2010:169).

According to Curtin (2011:37), health care leader-managers can utilise the following strategies for self-organisation: facilitate the free flow of information and the development of feedback loops, focus on nourishing and sustaining relationship, encourage trust and support fractal organisation where individual members act independently, with their behaviour bounded by shared vision and values.

2.5.2.4 Quantum being

Definition

Quantum being recognises the relational nature of organisations and their environment. Quantum relationships are prerequisites for human transformation, because it is through relationships that one's potential is released. It is the ability to be in relationships, based on unconditional positive regard and acceptance (Jooste, 2003:18; Shelton, 1999:147-149; Shelton, 2010:170).

Practice

This skill enables leader-managers to own their feelings rather than to project them onto others. They discover that all relationships are extraordinary learning opportunities and the individuals that do the teaching, regardless of position, are valuable contributors to the psychological and spiritual well-being and organisational effectiveness (Jooste, 2003:18; Shelton, 1999:147-149; Shelton & Darling, 2001:271, 272).

Leader-managers need to create the time and space for dialogue – improved relationships will translate into improved results; progress is a by-product of partnership (Shelton & Darling, 2001:272).

In table 2.5 different aspects of the seven quantum skills are summarised.

Table 2.5 Summary of different aspects of Shelton's seven quantum skills

Quantum skill	Definition of quantum skill	Quantum physics models	Key behaviour	Psychological aspect	Spiritual practice	Workplace issue	Practice
Quantum seeing	The ability to see intentionally	Double Slit Experiments Probability Waves Superimposition	Focused	Perception	Affirmations	Quality	Shared visioning
Quantum thinking	The ability to think paradoxically	Complimentarity Principle Uncertainty Principle, Quantum Tunnelling	Creative	Creativity	Visual Imagery	Innovation	360º thinking
Quantum feeling	The ability to feel vitally alive	Planck's Constant, Bose-Einstein Condensates Electromagnetic Theory	Energetic	Attribution	Detachment	Motivation	Response-ability
Quantum knowing	The ability to know intuitively	Field Theory Delayed Choice Phenomenon Quantum Potential	Confident	Intuition	Meditation	Empowerment	Intuitive decision making
Quantum acting	The ability to act responsibly	Holograms Principle of Nonseparability E-P-R Effect / Bell's Theorem	Ethical	Synchronicity	Mindfulness	Social responsibility	Values Audits
Quantum trusting	The ability to trust life	Chaos Theory Self-organising Principle Strange Attractors	Flexible	Resilience	Faith	Change / Chaos	Self-organisation
Quantum being	The ability to be in relationship	Exclusion Principle Theory of Everything Scattering Matrix Theory	Compassionate	Forgiveness	Compassion	Teamwork / Diversity	Dialogue

(Adapted from Shelton 1999)

2.6 CONCLUSION

In this chapter two world views, namely the Newtonian and quantum world views, were discussed. The concept of health care leader-managers, as well as the challenges, economic and political, social and demographic and professional that health care leader-managers face, was explored. Seven quantum skills that leader-managers can utilise in the Quantum Age were described.

In chapter 3 the research methodology for this study will be discussed.

CHAPTER 3

RESEARCH METHODOLOGY

"We do not believe in ourselves until someone reveals that what is deep inside us is valuable, worth listening to, worthy of our trust, sacred to our touch. Once we believe in ourselves we can risk curiosity, wonder, spontaneous delight or any experience that reveals the human spirit."

EE Cummings

3.1 INTRODUCTION

This chapter provides a detailed description of the research design and methods. Aspects that will be covered include the research population, sampling, data collection method and instrument and data analysis. The methods used to ensure trustworthiness and ethical considerations are discussed in detail.

A qualitative methodological approach was used to establish how health care unit managers view their role as leader-managers and to explore the challenges they experience and the skills they perceive they need to be effective leader-managers.

3.2 RESEARCH DESIGN

The research design is a blueprint for conducting a study. It guides the researcher in planning and implementing the study to achieve the intended goal and includes specifications for enhancing the integrity of the study (Burns & Grove, 2005:211; Polit & Beck, 2008:765). In this study the design was qualitative, exploratory, descriptive and contextual.

3.2.1 Qualitative research

Polit and Beck (2008:763) define qualitative research as the in-depth and holistic investigation of phenomena through the collection of rich narrative materials using a flexible research design.

In table 3.1 the characteristics of qualitative and quantitative research are listed.

Table 3.1 Differential characteristics of qualitative and quantitative research

Characteristic	Qualitative research	Quantitative research
Philosophical origin	Naturalistic, interpretive, humanistic	Logical positivism
Epistemological roots	Phenomenology	Positivism
Focus	Broad, subjective, holistic; the whole is always more than the sum	Concise, objective, reductionism; elements form part of the whole
Reasoning	Dialectic, utilise inductive logic	Logistic, utilise deductive logic
Basis of knowing	Meaning, discovery, understanding	Cause-and-effect relationship
Theoretical focus	Develops theory	Tests theory
Research design	Flexible, unique and evolves throughout the research process; no fixed steps that should be followed and design cannot be exactly replicated	Standardised according to a fixed procedure and can be replicated
Researcher involvement	Shared interpretation; seeks to understand phenomena	Seeks to control phenomena
Methods of measurement	Unstructured interviews and observations	Structured interviews, questionnaires, observations, scales or physical instruments
Data	Words	Numbers
Data sources	Determined by information richness of settings; types of observation are modified to enrich understanding	Data are obtained systematically and in a standardised manner
Analysis	Individual interpretations	Statistical analysis
Findings	Uniqueness, dynamic, understanding of phenomena and new theory	Generalisation, accept or reject theoretical propositions

(Burns & Grove, 2006:24, De Vos *et al*., 2011:66; Speziale & Carpenter, 2007:20)

The qualitative paradigm stems from naturalism and involves an interpretive, naturalistic approach, which aims to understand social life and the meaning people attach to everyday life. It refers to research, which elicits participants' accounts of meaning, experience or perceptions. Descriptive data in the participants' own spoken word is

produced. It is, therefore, concerned with non-statistical methods and small samples. Qualitative research takes place in the natural setting where participants live and work. A qualitative researcher is concerned with describing and understanding rather than with explaining or predicting human behaviour; focuses on the emic (insider) view as opposed to the outsider view, and is the primary instrument for data collection and analysis (De Vos *et al*., 2011:64-66).

The qualitative paradigm was chosen for the purpose of understanding and interpreting how health care unit managers view and experience their role as leader-managers within the current dynamic and changing health care environment.

3.2.2 Exploratory research

Exploratory research is conducted to gain insight into a situation, phenomenon, community or individual. It generally has a basic research goal and researchers frequently use qualitative data (De Vos *et al*., 2011:95, 96).

The reason for choosing this approach was to gain insight into how health care unit managers view their role as leader-managers, the current challenges they experience, as well as the skills they perceive they need in order to be successful leader-managers.

3.2.3 Descriptive research

In descriptive research the researcher begins with a well-defined subject and conducts research to describe it accurately (De Vos *et al*., 2011:96). Polit and Beck (2008:19) state that qualitative researchers describe the dimensions, variations and importance of phenomena.

A descriptive design enabled the researcher to describe the current challenges health care unit managers experience, as well as the skills they perceive they need in order to be successful leader-managers. The researcher attempted to provide an accurate description of the health care unit managers' experiences.

3.2.4 Contextual research

Context is defined by Burns and Grove (2005:732) as “the body, the world, and the concerns unique to each person within which that person can be understood.” The context of this study was health care units in a selected regional hospital in the Eden/Central Karoo region of the Western Cape and the focus was on health care unit managers.

3.3 RESEARCH METHOD

The research method is “the techniques used to structure a study and to gather and analyze information in a systematic fashion” (Polit & Beck, 2008:765).

3.3.1 Research population

Research population refers to individuals who possess specific characteristics that are of interest to the researcher (De Vos *et al.,* 2011:223; Polit & Beck, 2008:337). The research population for this study comprised health care unit managers at a selected regional hospital in the Western Cape Province.

3.3.2 Sampling and sample

Sampling refers to the process of selecting a portion of the population to represent the entire population (Polit & Beck, 2008:339; De Vos *et al*., 2011:224).

Purposive sampling, a non-probability sampling method, was the method of choice in this study. In purposive sampling, also referred to as judgemental sampling, participants are selected because they are able to give the researcher access to a specific perspective, experience or condition that the researcher wishes to understand (De Vos *et al.,* 2011:232). The researcher was interested in how health care unit managers view their role as leader-managers, the current challenges they experience and the skills they perceive they need to function as effective leader-managers. Health care unit managers were selected because they are first-line managers having direct, every-day contact with the nursing and administrative staff, other members of the health care team, patients and the public.

In qualitative research there is no need to determine the sample size as the goal is not to generalise the findings. Instead, data gathering concludes when data is saturated. That is, data gathering continues until no new data emerges but previously collected data is repeatedly re-introduced into the study (Brink, 2006:134). In this study data collection was terminated after eight participants have been interviewed and no new data emerged.

The advantage of purposive sampling is that it allows the researcher to hand-pick the sample. The disadvantages include potential sampling bias, not representative of the population and generalisability difficulties and limitations (Brink, 2006:134).

Sampling criteria define who is included in the population of a study. Eligibility criteria specify population characteristics while exclusion criteria define characteristics that participants must not possess (Polit & Beck, 2008:338).

The eligibility criteria comprised inclusion and exclusion criteria. Participants had to meet the following inclusion criteria:

- They must be professional nurses.
- They must be in charge of a health care unit/ward.
- They must have two or more years' experience as health care unit managers.

The exclusion criteria were as follows:

- Categories of nurses, other than professional nurses.
- Professional nurses not in charge of a health care unit/ward.
- Unit managers with less than two years' experience.

3.3.3 Setting

The setting of a research study is defined by Polit and Beck (2008:766) as "the physical location and conditions in which data collection takes place". In this study the setting was one regional hospital in the Eden/Central Karoo region of the Western Cape. A

regional hospital renders services at a general specialist level, receives referrals from district hospitals and provides general specialist services to a number of district hospitals. It also serves as a platform for training of health workers and research (Government Gazette No. 35101:36). This site was conveniently sampled by the researcher, as it is situated where she lives.

3.4 DATA COLLECTION

According to Burns and Grove (2005:733), data collection is the precise and systematic gathering of information relevant to the research purpose.

3.4.1 Data collection approach and method

Data was collected from health care unit managers, who met the eligibility criteria. The exploratory nature of the study influenced the researcher's decision to use semi-structured interviews as the method of data collection. Eight out of eleven health care unit managers were interviewed individually between July and September 2012.

The researcher was the primary instrument for data collection. Qualitative research is an interactive process between the researcher and the participants. Data are mediated through this human instrument rather than with questionnaires. The relationship between the researcher and participant is close and based on a position of equality as human beings (Polit & Beck, 2008:429). The researcher adopted a non-judgemental stance towards the thoughts and words of the participants. She was honest and open about the research study. The researcher also strived to bracket out the world and any presuppositions in an effort to confront the data in pure form. Bracketing is defined by Polit and Beck (2008:228,748) as "the process of identifying and holding in abeyance preconceived beliefs and opinions about the phenomena under study".

3.4.2 Data collection instrument

In this study semi-structured interviews were conducted. This type of interview is used when researchers want to be sure that a specific set of topics is covered; they know what they want to ask, but cannot predict what the answers will be (Polit & Beck, 2008:394). The purpose of interviews is to find out what is on someone's mind and thus

find things one cannot elicit by direct observation. With semi-structured interviews the interviewer generally asks a number of specific questions with additional probing questions to clarify issues. Questions were neutral rather than value-laden or leading. Open-ended questions were asked allowing participants to express themselves freely. The questions were focused to ensure that participants gave specific information required for the purpose of this study. In this study the researcher probed into the view health care unit managers have on their role as leader-managers, the current challenges they experience and the skills they perceive they need to function as effective leader-managers. All participants were asked the same questions (see annexure C).

The following questions were posed to each of the participants:

- As a health care unit manager how do you see the role of a leader-manager?
- Do you experience any challenges in executing your leadership and management functions in your current health care environment?
- What skills do you perceive you need to be an effective leader-manager in your current work environment?

Probing questions were developed by the researcher in order to get more specific information on aspects pertaining to Shelton's seven quantum skills.

The workplace issue of quantum seeing is quality and it is practised by shared visioning. Participants were therefore asked: "How do you ensure quality in your unit?" To probe into the workplace issue of innovation and the practice of 360º thinking (quantum thinking) participants were asked how they view and manage crises that arise in their units. Quantum feeling is practised by response-ability and the workplace issue is motivation – participants were asked how they motivate themselves and others. Quantum knowing relates to empowerment and is practised by intuitive decision-making; the participants were asked how they make decisions. The workplace issue for quantum acting is responsibility and values. The participants were asked how they nurture win-win relationships in their units. As quantum trusting pertains to change and chaos in the workplace, and is practised by self-organisation, participants were asked how they experience transformation in nursing and the workplace. The final skill,

quantum being, refers to teamwork and diversity in the workplace and is practised by dialogue. The participants were asked how they ensure good teamwork in the unit.

3.4.3 Data collection process

When preparing for the interviews the researcher identified the research problem, ensured she understood which information from participants was needed and she identified information-rich participants. The researcher met with the participants before the actual interview session in order to prepare them. She made an appointment with the Director of Nursing to visit on a Monday when a meeting with the unit managers was conducted. The preparation included introducing the participants to the researcher, explaining the purpose of the research, handing out information letters (see annexure E), obtaining written, informed consent from the health care unit managers who were willing to participate in the research study (see annexure D), and negotiating an appropriate date, time and venue, suitable for both the participants and the researcher, for conducting the interviews. Participants were reminded that their participation was voluntary; they were entitled to withdraw from the study at any stage without any penalty and that the researcher would need to tape-record the interviews. It was also explained that the audio-tapes would be destroyed on completion of the study.

Interviews were conducted in the natural setting of the participants' workplace to ensure their views were not isolated from their context. A comfortable, quiet, vacant office in the training school of the hospital acted as venue for the interviews. Interviews lasted between thirty to forty-five minutes. There were no disturbances during the interviews. The researcher built rapport and established a trust relationship with participants by again informing them of the purpose of the study and their rights to anonymity and confidentiality. The researcher handed the interview schedule to the participants and they read it together. Participants were allowed to discuss the questions in a sequence preferential to them.

The researcher used the following communication techniques as discussed in De Vos *et al. (*2011:345-346):

- Responding verbally with interjections such as: "hmm", "okay" to show participants the researcher is listening actively.

- Paraphrasing to enhance meaning.
- Clarifying statements made by participants were unclear.
- Reflecting in order to get participants to expand on certain statements.
- Encouraging when pursuing a certain line of thought.
- Commenting to inject the researcher's own idea/feeling in order to stimulate participants to provide more information.
- Reflectively summarising participants' ideas, thoughts and feelings.
- Probing to deepen the response to a question, increase the richness of the data and to give cues to participants on the desired response.
- Showing understanding and allowing the participants time for elaboration.
- Acknowledging by repeating participants' answers to demonstrate attentiveness.
- Procuring details: asking further questions to find more information.

The researcher thanked each participant for her contribution and informed each participant that a follow-up interview might be necessary if the data lacked clarity and to discuss research findings before finalising the results for the sake of member-checking.

3.5 DATA ANALYSIS

Data analysis is "the process of bringing order, structure and meaning to the mass of collected data" (De Vos *et al*., 2011:397). According to Creswell (2007:150-155), the process of data analysis and interpretation is best represented by a spiral image. The researcher moves in analytic circles rather than using a fixed linear approach.

In figure 3.1 Creswell's spiral image is shown.

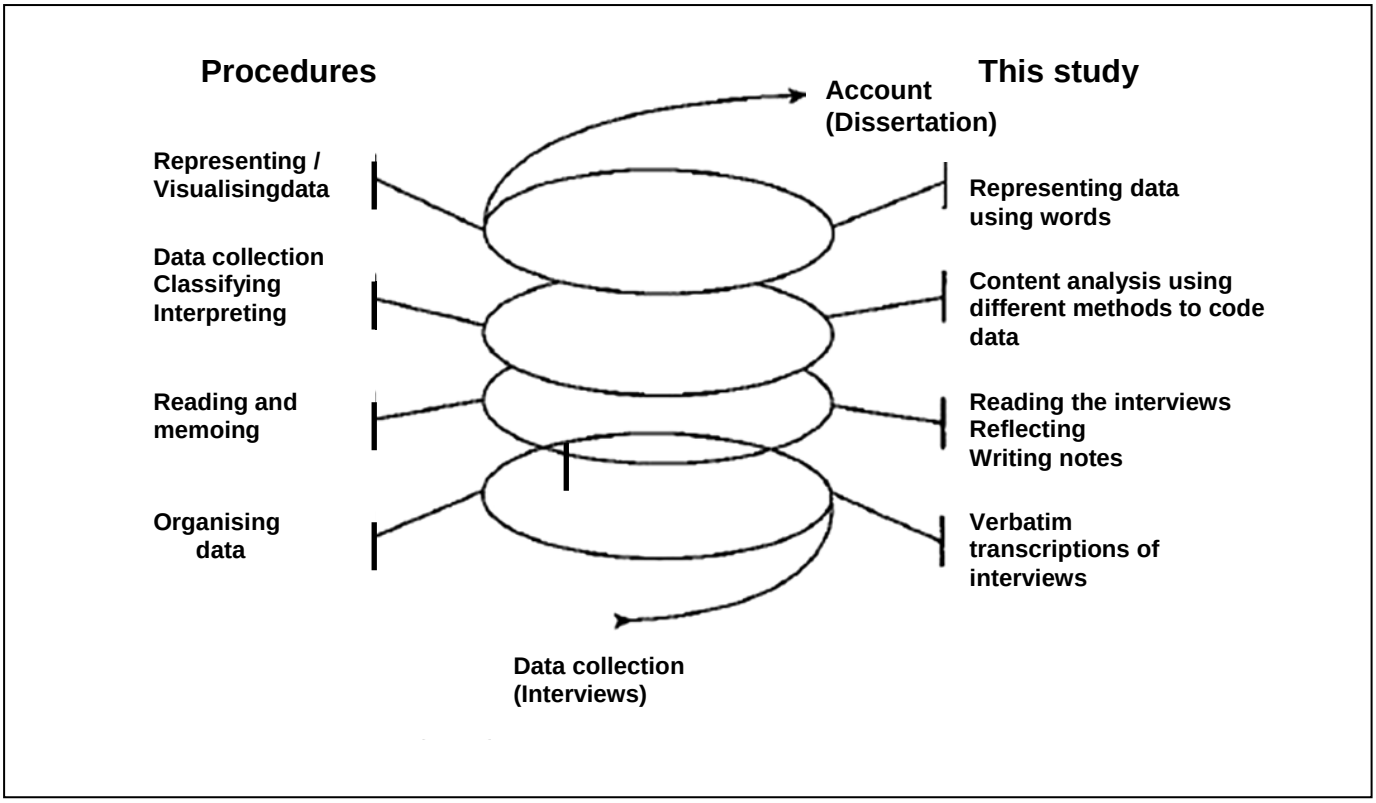

Figure 3.1 Creswell's spiral of data analysis (Creswell 2007:150-155)

The spiral image illustrates the researcher's repeating path through the data. Data collection serves as the entry point to the spiral. In this study the researcher conducted and recorded the interviews. The second loop of the spiral is data management when the researcher's focus is on organising the data to preserve it and to prepare it for analysis. In this study each interview was transcribed verbatim. The next loop Creswell describes is reading and memoing. The researcher first read through each of the transcribed interviews to get a holistic view. The fourth stage of the spiral is description, classifying and interpreting. Content analysis was done using different methods to code data. Open coding (level 1 coding) was conducted by giving descriptive codes to chunks of data (1-2 sentences), which summarises the primary topic of the data. During axial coding (level 2 coding) data was categorised and re-categorised by linking similar level 1 codes. The final loop of the spiral is that of representing the data. In this qualitative, descriptive and explorative study this in done using words. The account, in this instance, a dissertation, is the exit point of the spiral (Creswell, 2007:150-155; De Vos *et al*., 2011:403-419; Polit & Beck, 2008:748; Speziale & Carpenter, 2007:144, 146).

3.6 TRUSTWORTHINESS

According to Polit and Beck (2008:196, 540, 541, 768), trustworthiness is the degree of confidence qualitative researchers have in their data and is assessed by using the criteria of credibility, transferability, dependability, confirmability and authenticity.

3.6.1 Credibility

Credibility refers to confidence in the truth of the data (Polit & Beck, 2008:751). A qualitative study is credible when it presents such accurate descriptions or interpretation of human experience that people who share that experience would immediately recognise the descriptions. To enhance the credibility of this study the researcher applied the following strategies described by Krefting (1991:216-221).

Prolonged engagement

Prolonged engagement refers to the researcher spending enough time with participants to learn about their environment and to build rapport. The researcher built a trusting relationship with the participants by honouring anonymity, honesty and openness. The researcher had an information session with all participants before they signed consent. Before each interview a few minutes were spent with each participant to make them feel comfortable. Data collection continued until data saturation occurred. After the eighth interview no new data emerged.

Interview technique

The researcher applied different communication techniques when conducting the interviews such as verbal responses, paraphrasing, clarification, reflection, encouragement, comments, reflective summary, probing, showing understanding and allowing time for elaboration, acknowledging, direct questions and procuring details. The first interview was conducted as a means of a pilot interview.

Structural coherence

Structural coherence ensures that there are no unexplained inconsistencies between the data and the interpretation thereof. The researcher integrated the collected data into a logical flow of argumentation and presented a holistic picture of the phenomena that were studied.

Referential adequacy

The researcher used references that are current, relevant and accounted for in the list of sources.

Peer examination

The researcher discussed all aspects of the study with her supervisor and a debriefing interview was held between the researcher and the supervisor after the first interview with a participant was conducted. This enabled the researcher to voice her experience and feelings and to gain insight on changes to be made in the upcoming interviews.

Member checking

Informal member checking has been done during interviews through clarifying and summarising with the participants. The researcher went back to three of the participants to verify that she has interpreted their words correctly. A literature control has been conducted.

Reflexivity

Reflexivity involves self-awareness and critical self-reflection of the researcher on her potential biases and predispositions, which may affect the research process and conclusions drawn (Klenke, 2008:43). In this study the researcher made use of field notes and was debriefed by her supervisor after the first interview.

Authority of the researcher

The researcher is viewed as an instrument tool. The researcher is familiar with the phenomena under study as well as the setting in which the research was conducted, she undertook a course in research methodology and her supervisor has extensive experience in supervising qualitative research (Krefting, 1991:216-221; De Villiers & Van der Wal, 2009:128-130; Polit & Beck, 2008:539-540).

3.6.2 Dependability

Dependability relates to the consistency of findings (Polit & Beck, 2008:751). To enhance the dependability in this study the researcher applied the following strategies:

A code-recode procedure

All aspects of the research study are fully described, including the research methodology, the sample and process followed for sampling and data analysis. Data quality checks were conducted by the researcher and her supervisor.

Audit trail

An audit trail is the systematic documentation of data, which allows an independent auditor of the research study to draw conclusions on trustworthiness. The researcher in this study developed an audit trail that will allow external auditors to follow through the natural progress of events in study and to understand how and why decisions were made (Krefting, 1991:216-221; De Villiers & Van der Wal, 2009:128-130; Polit & Beck, 2008:539-540).

3.6.3 Confirmability

Confirmability refers to the objectivity or the neutrality of the research data and the interpretation thereof (Polit & Beck, 2008:750). Data neutrality, not investigator neutrality, is the criterion to be considered. Confirmability in this study was improved by utilising the following strategies.

Audit trail

An audit trail of the verbatim descriptions, categories, themes and subthemes has been kept and the supervisor acted as co-coder.

Reflexivity

In this study the researcher made use of field notes, which were written during interviews as well as afterwards. She was also debriefed by her supervisor after the first interview (Krefting, 1991:216-221; De Villiers & Van der Wal, 2009:128-130; Polit & Beck, 2008:539-540).

3.6.4 Transferabililty

Transferability refers to the extent to which qualitative research findings can be transferred to other settings or groups (Polit & Beck, 2008:768).

To enhance transferability of this study the researcher employed the following strategies:

Purposive sampling

Information-rich participants were selected through purposive sampling. This ensured that the results of the research are representative of the group. In this study the participants were health care unit managers. Sampling was criterion-based, with inclusion criteria set by the researcher.

Dense description

The results of the study are described in-depth with direct quotations from the participants. The results are also recontextualised in the literature. The researcher ensured that the research design and methodology were fully discussed in such a way that the study could be easily read by fellow researchers (Krefting, 1991:216-221; De Villiers & Van der Wal, 2009:128-130; Polit & Beck, 2008:539-540, 768).

3.6.5 Authenticity

Authenticity is the extent to which a researcher fairly and faithfully shows a range of different realities in the analysis and interpretation of the data that was collected. A study is authentic when the strategies that were used are appropriate for the true reporting of the participants' ideas. Authenticity consists of fairness, ontological authenticity, educative authenticity, catalytic authenticity and tactical authenticity (Holloway & Wheeler, 2010:304).

Fairness

The researcher must be fair to participants and gain their acceptance throughout the whole of the study. In this study the researcher gained informed consent from all participants. She also took into account the social context in which the participants work. She treated all participants' stories fairly and in a balanced manner.

Ontological authenticity

This means that all those involved, readers and participants, will have been helped to understand their social world and their human condition through the research. In this study participants provided statements that document their understanding of being health care unit managers. The researcher had a telephonic debriefing interview with her supervisor and an audit trail was developed (Holloway & Wheeler, 2010:304; Polit & Beck, 2008:540, 541, 544, 748; Powers & Knapp, 2011:7).

3.7 ETHICAL CONSIDERATIONS

Data collection commenced once the researcher obtained an ethical clearance certificate from the Department of Health Studies Higher Degrees Committee, College of Human Sciences, University of South Africa (see annexure A). Permission to conduct the study was granted by the Deputy Director: Nursing Services of the hospital were the data was collected (see annexure B).

De Vos *et al. (*2011:114) define ethics in research as "a set of moral principles which is suggested by an individual or group, is subsequently widely accepted, and which offers

rules and behavioural expectations about the most correct conduct towards experimental subjects and respondents, employers, sponsors, other researchers, assistants and students".

The three primary ethical principles on which standards of ethical conduct in research are based include beneficence, respect for human dignity and justice (Polit & Beck, 2008:170).

Because qualitative studies involve the participation of people it requires an awareness of the ethical issues that may derive from the interaction between the researcher and the participants. Ethics in health research includes appropriateness of the research design, the methodology and behaviours in reporting data (Orb *et al*., 2001:93).

According to Van der Wal (2005) in Pera and Van Tonder (2005:151), the researcher's first concern is the participant.

3.7.1 Beneficence

The first ethical principle pertains to participants' rights not to be harmed, but protected from exploitation.

The right to freedom from harm and discomfort

The researcher has protected participants from harm and discomfort and tried to bring about the greatest possible balance of benefits in comparison with harm be it physiological, emotional, social or economic in nature (Burns & Grove, 2005:190).

The right to protection from exploitation

Participants' involvement in this study has not placed them at a disadvantage or exposed them to situations they have not prepared for. Participants were assured that their participation and all information they provided would not be used against them in any way (Polit & Beck, 2008:171).

In this study participants did not show any signs of physical or emotional discomfort. The participants, as well as unit managers in other settings, may benefit from the findings of this research study. The researcher believes it was emancipating for the unit managers who participated in this study to reveal their feelings and concerns when asked how they experience their leader-manager role, the challenges they currently experience in executing their roles as leader-managers and the skills they perceive they need to be effective leader-managers.

3.7.2 Respect for human dignity

Respect for human dignity is the second ethical principle. Autonomy and the right to full disclosure are the two major principles on which informed consent is based (Orb *et al*., 2001:95).

The right to self-determination (autonomy)

Participants should be treated as autonomous agents who are capable of controlling their own activities; they have the right to decide voluntarily whether to participate in a study without risking any penalty or prejudicial treatment. They also have the right to ask questions, to refuse to disclose information and to withdraw from the study.

The right to full disclosure and informed consent

Full disclosure is necessary for participants to make informed, voluntary decisions about participation. In this study the researcher fully described the nature of the study to the participants, gained written consent, ensured participants of their right to refuse participation and described the researcher's responsibilities (Mulaudzi, Mokoena & Troskie, 2010:198,199; Polit & Beck, 2008:172).

The researcher gained permission to conduct the research at the selected institution as well as to meet with all the health care unit managers beforehand. The target group was handed information letters and consent forms, which the researcher collected a few days later. The purpose of the study, the type of data to be collected and data collection method were explained. Participants were ensured that they could terminate their participation at any stage during the research without penalty and no measures of

coercion were used; no monetary incentives were given (Burns & Grove, 2005:181; Mulaudzi *et al.,* 2010:198,199; Polit & Beck, 2008:171,172).

3.7.3 Justice

The third principle articulated in the Belmont Report concerns justice, which includes participants' right to fair treatment and their right to anonymity and confidentiality.

The right to fair treatment

According to Polit and Beck (2008:173, 174), this aspect of the justice principle is concerned with the equitable distribution of benefits and burdens of research.

In this study the researcher selected participants based on the research requirements, health care unit managers, not on the vulnerability or compromised position of certain people. Unit managers, who refused to participate by not giving written consent, were treated without prejudice. The researcher honoured all agreements with participants and she demonstrated sensitivity to and respect for the beliefs, habits and lifestyles of people from different backgrounds and cultures and afforded participants courteous and tactful treatment at all times. Justice was compromised as a result of the sampling method employed. Purposive sampling, a non-probability sampling method, was chosen. Health care unit managers were chosen to participate – not anybody could, therefore, participate.

The right to anonymity and confidentiality

Anonymity occurs when even the researcher cannot link participants to their data. A promise of confidentiality is a guarantee that any information participants provide will not be publicly reported in a manner that identifies them and will not be made available to others unless permission to do so has been given (Polit & Beck, 2008:180).

Anonymity in this study was adhered to by not attaching names to the interview data; a numerical number was given to each interview. To maintain confidentiality audio tapes, transcribed interviews and field notes were locked away in a safe place and destroyed on completion of the study. Only the researcher and her supervisor had access to the

information that was obtained. Participants were informed before they signed consent to participate in the study that the researcher was going to make the findings known in the research report.

3.7.4 Integrity of the researcher

The researcher is responsible for conducting the research study in an ethical manner. To do this the researcher had to ensure that the research was carried out competently and resources had to be managed honestly.

The researcher ensured she was competent to conduct the research by completing a course in research methodology as part of an Honours degree at the University of South Africa. She spent a considerable amount of time on reading books and articles on the research topic and research methodology.

Plagiarism was not committed as she acknowledged all sources and contributors.

Discussions were balanced in the literature review and data collected or results found were communicated accurately, and not fabricated and/or distorted (De Villiers & Van der Wal, 2009:25).

3.8 CONCLUSION

In this chapter a full description of the research design and methods used was provided. Steps taken to ensure trustworthiness, as well as measures taken to ensuring high ethical standards, have been provided.

In chapter 4 the research findings will be discussed.

CHAPTER 4

DATA PRESENTATION

A true leader has the confidence to stand alone, the courage to make tough decisions and the compassion to listen to the needs of others. He does not set out to be a leader, but becomes one by the quality of his actions and the integrity of his intent.

Douglas MacArthur

4.1 INTRODUCTION

This chapter presents the data and literature control. The data base comprised information gathered through semi-structured interviews conducted with health care unit managers at a regional hospital in the Eden district of the Western Cape Province. Field notes made during and immediately after each interview session acted as an aid to enrich data.

The purpose of this study was to establish how health care unit managers view their role as leader-managers and to explore the challenges they experience and the skills they perceive they need to be effective leader-managers.

Semi-structured individual interviews were conducted with eight health care unit managers.

The first interview was conducted as means of a pilot study. As this presented no challenges and the researcher was debriefed by her supervisor, the pilot study was included in the sample. The researcher conducted a further seven interviews until data saturation was accomplished.

The field notes and verbatim transcriptions formed the database that was analysed. The researcher used the following guide:

Interviews were recorded on tape after which each interview was transcribed verbatim. The researcher first read through each of the transcribed interviews to get a holistic view. Content analysis was done using different methods to code data. Open coding (level 1 coding) was conducted by giving descriptive codes to chunks of data (1 – 2 sentences), which summarises the primary topic of the data. During axial coding (level 2 coding), data was categorised and re-categorised by linking similar level 1 codes (Creswell, 2007:150-155; De Vos *et al.,* 2011:397; Polit & Beck, 2008:748; Speziale & Carpenter, 2007:144, 146). Data collection and analysis were done simultaneously. Themes, categories and subcategories emerged. The supervisor acted as independent co-coder.

4.2 IDENTIFIED THEMES, CATEGORIES AND SUBCATEGORIES

Three themes, twenty-two categories and eleven subcategories emerged during the data analysis process.

Figure 4.1 shows a diagrammatical representation of the three themes.

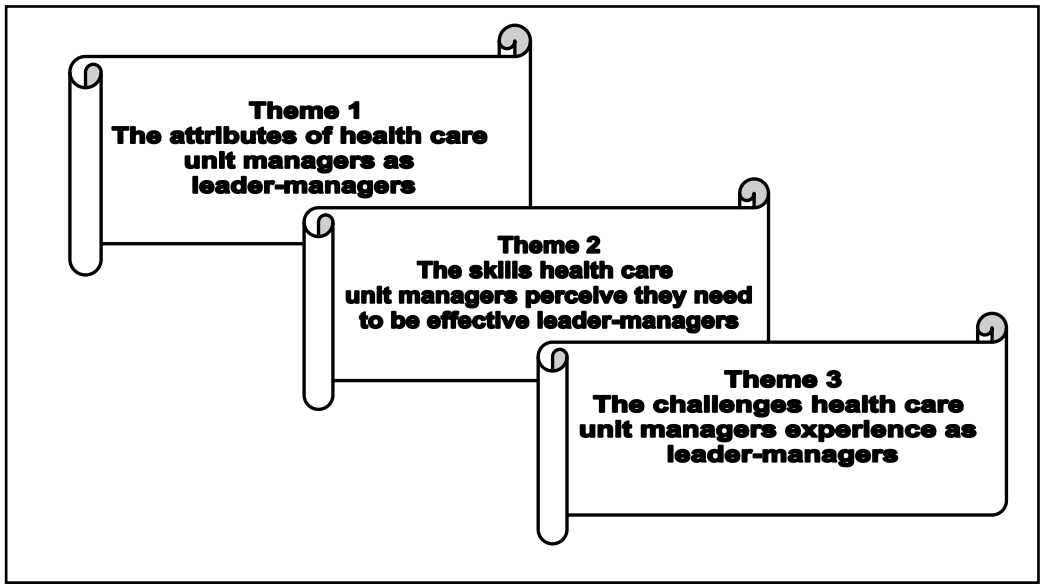

Figure 4.1 Diagrammatic representation of themes

All three themes, with their categories and subcategories, are summarised in table 4.1.

Table 4.1 Themes, categories and subcategories

Themes	Categories	Subcategories
4.2.1 Theme 1 The attributes of health care unit managers as leader-managers	4.2.1.1 A leader-manager lives six core values **Acronym: C_2AIR_2**	4.2.1.1.1 Caring
		4.2.1.1.2 Competence
		4.2.1.1.3 Accountability
		4.2.1.1.4 Integrity
		4.2.1.1.5 Responsiveness
		4.2.1.1.6 Respect
	4.2.1.2 A leader-manager is flexible	
	4.2.1.3 A leader-manager is a role model	
	4.2.1.4 A leader-manager is fair	
	4.2.1.5 A leader-manager is assertive	
	4.2.1.6 A leader-manager is courageous	
	4.2.1.7 A leader-manager is creative	
	4.2.1.8 A leader-manager has a vision and a mission	
4.2.2 Theme 2 The skills health care unit managers perceive they need to be effective leader-managers	4.2.2.1 Planning skills	
	4.2.2.2 Organising skills	
	4.2.2.3 Change management skills	
	4.2.2.4 Conflict management skills	
	4.2.2.5 Staff development skills	
	4.2.2.6 Communication skills	
	4.2.2.7 Budgeting skills	
	4.2.2.8 Interpersonal relationship skills	
	4.2.2.9 Participative leadership skills	
	4.2.2.10 Computer literacy skills	
	4.2.2.11 Motivation skills	
4.2.3 Theme 3 The challenges health care unit managers experience as leader-managers	4.2.3.1 Workforce challenges	4.2.3.1.1 Staff shortages *Causes* *Consequences*
		4.2.3.1.2 Staff performance appraisal
		4.2.3.1.3 Multigenerational workforce
		4.2.3.1.4 Staff empowerment
	4.2.3.2 Personal challenges	4.2.3.2.1 Increased workload
		4.2.3.2.2 Role diversity
	4.2.3.3 Organisational challenges	4.2.3.3.1 Management of equipment

Each theme with its categories and subcategories will be discussed with relevant quotations from participants. Verbatim transcripts are presented without any attempt by the researcher to correct the grammatical errors, and relevant literature is cited as a means of control to the findings of the research.

4.2.1 Theme 1: The attributes of health care unit managers as leader-managers

Table 4.2 presents the first theme, namely the attributes of health care unit managers as leader-managers. An 'attribute' is defined by the *South African Pocket Dictionary* (2002:49), as "a characteristic quality". Apart from specific values, which participants thought a leader-manager should adopt and display, they also indicated flexibility, fairness, courage, creativity, being a good role model and having a clear vision and mission as desirable attributes for leader-managers.

Table 4.2 Theme 1, categories and subcategories

Theme 1	Categories	Subcategories
4.2.1 The attributes of health care unit managers as leader-managers	4.2.1.1 A leader-manager lives six core values	4.2.1.1.1 Caring
		4.2.1.1.2 Competence
		4.2.1.1.3 Accountability
		4.2.1.1.4 Integrity
		4.2.1.1.5 Responsiveness
		4.2.1.1.6 Respect
	4.2.1.2 A leader-manager is flexible	
	4.2.1.3 A leader-manager is a role model	
	4.2.1.4 A leader-manager is fair	
	4.2.1.5 A leader-manager is assertive	
	4.2.1.6 A leader-manager is courageous	
	4.2.1.7 A leader-manager is creative	
	4.2.1.8 A leader-manager has a vision and a mission	

4.2.1.1 A leader-manager lives six core values

The Western Cape Department of Health has adopted a values-driven approach. In 2010 a Barrett Survey was conducted to assess the personal and organisational values of departments.

The Barrett Values Centre provides metrics to enable leaders to measure and manage their organisations' cultures and the leadership development needs of their managers and leaders. The core product, Cultural Transformation Tools, enables one to identify and map the values of an individual, organisation, community or a nation. It was created by Richard Barrett, an author, speaker and social commentator on the evolution of human values in business and society. Employees in the Western Cape Department of Health were requested to identify the values they would desire and experience in the department. Top management participated in a 360º evaluation process, Barrett Survey Values workshops with middle management were held in order to create an awareness of values and the impact thereof on service delivery and a second Barrett Survey was undertaken in July 2011 across a broader sample of staff. The findings of the second study were similar to the initial survey, which confirmed the need for sustained effort to deepen the process of emphasising the six core values effectively.

Core values are guiding principles, which are important to people in an organisation (Jooste, 2009:38). In this research study the participants focused on the following six core values. The overarching values identified by the Provincial Government of the Western Cape are caring, competence, accountability, integrity, responsiveness and respect (this last value was included as a core value by the Department of Health, after an internal reflection during 2011/2012). From these six core values the acronym C_2AIR_2 has developed. These values are now used by all staff members and this emerged repeatedly from the data.

4.2.1.1.1 Caring

Caring is the "core value of the nursing profession" (Jooste, 2010:24). The *Free Online Dictionary, Thesaurus*, defines caring as "feeling and exhibiting concern and empathy for others". It means to value and respect an individual's emotional and spiritual needs (Jooste, 2009:19). According to Smith, Turkel and Robinson Wolf (2013:166), the six

Cs of Compassion, Competence, Confidence, Conscience, Commitment and Comportment have evolved in response to the question: 'What is a nurse doing when he/she is caring?" These are referred to as the attributes of caring and serve as a helpful basis for the identification of specific caring behaviours.

Participants in this study understand caring as being human, showing compassion towards staff and patients, creating a positive work environment and giving recognition to staff.

> *"And you must be able to be a human. It is not only about tasks, your people. She must be a person's people, person. She must deal with her people, she must see that her staff is capable, is healthy, is problem free to do the work. It's not about the works needs to be done. She must look after her people." (Data # 45)*
>
> *"And she must give recognition to her people." (Data # 50)*
>
> *"And the other thing is that you must compliment them, you must compliment them so that they can feel worth it or valued for work. So, this is also a motivation for them." (Data # 160)*
>
> *"Ja, you have to be compassionate to them and try to help them to solve whatever the problem is." (Data # 276)*
>
> *"Be compassionate to staff, towards patients and staff and team building skills to work together and not against each other." (Data # 345)*
>
> *"… I could see that she feels proud of her work in the ward. And I also feel proud, that is another thing I want to like the people, they must feel proud to work there …" (Data # 240)*

Although the health care unit managers stressed the importance of caring towards others (patients and staff), no one mentioned care to one's self. While most nurses are familiar with Orem's theory of self-care describing the need to institute activities and practices to promote and maintain health and an overall sense of well-being, they seem to find it difficult to instil self-care practices into their personal lives. Much research has

been conducted on self-care practices for nurses and nurse leaders in the 21st century. This includes O'Connor (2002:69-79), Andrews, Burr and Bushy (2011:69-77), Shiparski, Richards and Nelson (2011:26-30), Kravits, McAllister-Black, Grant and Kirk (2010:130-138) and Nahm, Warren, Zhu, An and Brown (2012:e23-e31). If leader-managers take care of themselves they can reduce the feelings of stress and burnout and set an example to their staff to pursue. Pillay (2009:501) in his comparative analysis of the perceived competencies of nurse managers found that the participants assessed their ability to manage self relatively high and this is not surprising, given that the nursing profession is by nature a very structured and disciplined one that requires nurses to balance domestic and work responsibilities.

4.2.1.1.2 Competence

Competence is: "(a) the state or quality of being adequately or well qualified" and "(b) a specific range of skill, knowledge or ability" (*The Free Online Dictionary, Thesaurus*).

Nurses are accountable to their patients and community for the quality and character of their service for safe and competent practice through licensing laws. No longer is it enough to just follow procedures or processes correctly; nurses should uncover and utilise research-based knowledge as the foundation for evidence-based practice. They should be competent to make practice-related decisions quickly to affect positive outcomes for patients. The outcome of nursing care delivery is the "what" of a nurse's performance, while competencies are the "how". Competencies translate vision into behaviour, the strategic direction and values of the organisation into the behaviour expected from staff. Competencies may be behavioural, for example, to show initiative in a way such as to promote particular goals or technical, for example, the ability to use a computer program in a particular context (Jooste, 2010:51, 55).

The title 'clinical nurse specialist' refers to a registered nurse who has a degree in nursing and expertise in a clinical nursing specialty. The primary responsibilities of a clinical nurse specialist depend on the particular needs of the setting and include clinical practice, consultation, education, research and leadership activities. They mentor nurses, contribute to the development of nursing knowledge and evidence-based practice and address complex heath care issues for patients, families, other disciplines,

administrators and policy makers (Donald, Bryant-Lukosius, Martin-Misener, Kaasalainen, Kilpatrick, Carter, Harbman, Bourgeault & DiCenso, 2010:189-210).

Statements made by the participants in this study indicate that they view clinical competence and nurse specialists in their fields as very important.

> *"As a manager I must stand on ground floor if a admission comes in … I must go into the admission room. I must deliver as a nurse deliver. I must undress the patient; I must do all the observations of that patient …" (Data # 10)*
>
> *"I need to be a clinical specialist …" (Data # 14)*
>
> *"And you must have all the skills in all the programmes that they're using … A manager needs to know how to give a BCG …" (Data # 34)*
>
> *"… the core values … you must have the competence also, so the ability and the capacity to do the job appropriately and what you want to do next …" (Data # 155)*

Spitzer (2008:6) states that for health care leader-managers to be successful it is no longer enough to be knowledgeable about nursing practice and the organisation of nursing services. They also have to build skills in a variety of other disciplines, for example, financial skills. Rhodes, Morris and Lazenby (2011:8) conclude that: "The image of nurses as 'competent and intelligent caregivers' must become as well-known as the image of nurses as 'angels in white' …". Stanley (2012:1-11) purports that being clinically competent is a characteristic associated with clinical leadership.

The skills health care unit managers in this research perceive that they need as leader-managers will be discussed in theme 2 of this analysis.

4.2.1.1.3 Accountability

Accountability means taking responsibility for one's actions and having the ability to explain them (*South African Pocket Oxford Dictionary,* 2002:6). According to Jooste (2010:57, 58), accountability is: "taking responsibility for one's conduct or being willing to be answerable for one's actions". It is more than responsibility. A nurse should have

the knowledge, skills and values (abilities) required to do the work effectively, be given or take responsibility for taking an action, have formal backing or the legal right to carry out responsibility and be accountable for the action taken. Accountability means being answerable; nurses are answerable for their decisions and the outcomes of those decisions.

The participants in this research commented on the importance of accountability and responsibility:

> *"… they need to take responsibility. Whatever action they're doing. But then afterwards they need to be responsible." (Data # 61)*

> *"… the core values … And then you also must be accountability, so you must take responsibility of what you are doing." (Data # 155)*

> *"… I must have the ability to evaluate whether, if I appoint a specific task to a specific person, whether he was capable to do it or did he struggle to do it." (Data # 284)*

Lewis, Yarker, Donalson-Feilder, Flaxman and Munir (2009:310) conducted an exploratory study examining specific management behaviours associated with stress in nursing. Taking responsibility was one of the behaviours elicited by content analysis. Examples of positive manager behaviour were taking steps to help out when needed, and dealing with difficult customers on behalf of employees.

4.2.1.1.4 Integrity

Integrity is defined as "the quality of being honest and morally upright" in *The South African Pocket Oxford Dictionary* (2002:468) while the *Online Dictionary Thesaurus* defines it as "steadfast adherence to a strict moral or ethical code". According to Robbins, Odendaal and Roodt (2003:75) in Jooste (2009:141), integrity (honesty and truthfulness) is one of the key dimensions of trust together with competence, loyalty and openness. De Laine (2000) in McIntosh and Sheppy (2013:35) defines integrity as "a consistent, habitual honesty and a coherent integration of reasonably stable, justifiable

moral values, with consistent judgment and action over time", while Johnson (2012:85) states that integrity is wholeness or completeness.

Leaders with integrity are true to themselves, they reflect constantly on what they say publicly and how they act and think privately, and they are honest in their dealings with other people. Followers watch leader-managers' behaviour closely and one untrustworthy act can undermine a pattern of credible behaviour. Common "trust-busters" include inconsistent messages, behaviour, rules and procedures; blaming; dishonesty; secrecy and unjust rewards (Johnson, 2012:85).

Participants pointed out their understanding of integrity as establishing trust through honesty and practising what you preach.

> *"So that they can trust you as a leader and know that you will bring everything back to them and not hear it from one of the other wards …" (Data # 202)*
>
> *"I must practise what I preach." (Data # 265)*
>
> *"… the core values … And the other one is integrity. So, it is that you must be honest and do the right thing." (Data # 155)*
>
> *"…I must practise what I preach so I must be a good leader to expect good quality from the person that follows me." (Data # 280)*

A review of the nurse unit manager's role conducted in Australia states that trustworthiness and honesty are important attributes nurse managers possess, which make them suited to the position (Hewson, 2008:19). McIntosh and Sheppy (2013:35-39) discuss the effects of stress, caused for example, by staff shortages, turnover and absenteeism, on nursing integrity. These authors conclude that nursing integrity can be maintained and promoted through learning to manage and reduce stress by developing insight and coping strategies.

4.2.1.1.5 Responsiveness

To be responsive means to respond readily and with enthusiasm (*The South African Pocket Oxford Dictionary,* 2002:765). Health care unit managers in their role of leader-

managers need to respond to different issues regarding patients and their families, the community as well as staff issues. As one participant put it:

> *"… the core values … And then the other one is responsiveness, to serve the needs of our citizens and employees." (Data # 155)*

In a study conducted in Australia on the role of nurse unit managers the findings indicated they need to be energetic, motivated, have a sense of humour and act as advocates for patients and staff (Hewson, 2008:19).

4.2.1.1.6 Respect

Respect is "a common term used to denote the honouring of individual, family, or community rights and responsibilities. It is also a term used for describing a virtue in professional relationships". When nurses describe the quality of their work environments and the quality care they provide to patients, families and communities, feeling respected or not, plays a major role. The recipients of care also voice concerns over wanting to feel respected (Milton, 2005:20, 22).

The following comments were made by participants in this study on the value of respect:

> *"But I stress it with my staff, respect. You must respect your patient to get the best out of it.*
> *And you must give your patient a choice to make a decision and to plan." (Data # 62)*

> *"… core values … it's mos now a new thing for us and we have to implement it and take the person from core value to core value every time explain to them and why you have to do it …" (Data # 272)*

Leader-managers need to treat their patients, as well as their staff members, with dignity and respect. Bressler and Fischer (2012:11) state that mutual respects starts with nurse managers and formal and informal leaders in a nursing unit. This creates a self-motivated environment for patients and staff.

4.2.1.2 A leader-manager is flexible

Flexibility as an element of emotional intelligence is defined operationally by Codier, Muneno, Franey and Matsuura (2010:943) as "adjustment to a changing situation". Marquis and Huston (2009:3) state that flexibility is also a characteristic of a critical thinker. A leader-manager uses creative and flexible scheduling based on patients' needs for care to increase productivity and retention and any leader-manager who wishes to acquire power should develop a reputation as someone who can compromise (Marquis & Huston, 2009:305, 337). An uncompromising leader-manager can be viewed as insensitive to the needs of others.

According to Lekalakala-Mokgele (2009:325), flexibility and adaptability are task-related personality traits closely associated with task accomplishment. A leader-manager as a change agent needs to be flexible to cope with changes and must influence followers to change. In the Quantum Age, with its technological advances and constantly changing workforce, flexible leader-managers are required.

Participants indicated the need for the leader-manager to be flexible because he/she is working with people.

> *"And you as a manager must also be flexible." (Data # 173)*
>
> *"You must be flexible; otherwise if you're not flexible, the staff won't change." (Data # 344)*
>
> *"But flexible, ja you know, one can be flexible. Because you're working with people, people*
> *and even emotions." (Data # 132)*
>
> *"… you need to be flexible … the nurses also need to be flexible hmm…because sometimes you need, you must ask them to go on night duty if there's shortages of night duty…" (Data # 244)*

In a study on emotional intelligence conducted by Codier *et al* (2010), flexibility as an attribute of emotional intelligence was found illustrated in the nursing stories that were analysed. Stanley (2012:1-11) reports on the characteristics most commonly

associated with leadership in clinical practice; flexibility is considered to be one of the important characteristics health care leader-managers need in their clinical environment.

4.2.1.3 A leader-manager is a role model

A role model is defined as "someone who sets a positive example and is worthy of imitation" and role models "serve as a catalyst to transform as they instruct, counsel, guide, and facilitate the development of others". People attempt to imitate a role model's behaviour and learn the role model's attitudes and values. Role models attend to the little things, make connections, model and affirm others (Perry, 2009:37-40).

A role model is described as someone who holds a respected position, has rights, responsibilities, privileges and obligations, experiences role stress, continues to develop professional competence, function as a member of the multidisciplinary team, is confident and competent, treats people with respect and dignity and is able to control his/her emotions in stressful situations. Strategies to ensure that leader-managers become positive role models include being conscious of body language, facial expression and eye contact; showing enthusiasm for the nursing profession and discussing nursing in a positive light; providing quality care to patients and encouraging followers to do the same; delivering constructive criticism to staff members in a way that does not humiliate them, and providing solutions to problems (Du Plessis, Jordaan & Jali, 2010:218).

Participants commented on the importance of being a role model and indicated some of the attributes of a good role model.

> *"As a role model I need to be a role model. To … I can't panic; walk around anxiously and panic. I must grab it as it comes. I can't leave my staff in the ward because they must look at myself as a manager." (Data # 9)*

> *"… No, she must be a humble. She must lead by example, by experience I would say a leader must be." (Data # 47)*

> *"You as a leader must be positive…" (Data # 157)*

"You must also be pro-active." (Data # 171)

"I'm sending them to courses and I name them, if I find that a person has a problem with, for nurse specific things, then I there's a course, then I nominate them for that course as I try to get her there so that she can acts better when she comes back." (Data # 275)

Weng, Huang, Tsai, Chang, Lin and Lee (2010:240) examined the influence of role modelling on the job satisfaction and organisational commitment of staff members and conclude that the role modelling function appeared to be significant in the mentoring process of staff. Studies conducted to examine the qualities of exemplary nurse leaders (Anonson, Walker, Arries, Maposa, Telford & Berry, 2013:1-10) and exemplary role models (Perry, 2009:36-44) identified the importance for health care leader-managers to be positive role models. Sandström, Borglin, Nilsson and Willman (2011:212-223) describe the importance that health care leader-managers as role models have in promoting the implementation of evidence-based care, while Gifford, Davies, Edwards, Griffin and Lybanon (2007:126) state that health care leader-managers facilitate the use of research in their units by role modelling and valuing research.

4.2.1.4 A leader-manager is fair

To be fair is defined in the *South African Pocket Oxford Dictionary* (2002:318) as "treating people equally, just or appropriate in the circumstances". Kreitner and Kinicki (2007:352) in Jooste (2009:141) present fairness as one of Bartoleme's (1989) six guidelines for building and maintaining trust, the other five being communication, support, respect, predictability and competence. The leader-manager is fair when acting objectively, impartially and by giving recognition where and when deserved. In the Josephson Institute's *Character Counts!* approach fairness is described as one of the six pillars of character, the others being trustworthiness, respect, responsibility, caring and citizenship. Fairness is accomplished by playing by the rules, taking turns and sharing, being open-minded, listening to others, not taking advantage of others, not blaming others and by treating all people fairly.

The participants in this study indicated fairness as a required attribute of the health care leader-manager.

> *"And you must be fair." (Data # 179)*

> *"I must be hmm …"nie bevooroordeeld nie". Fair, fair at all circumstances." (Data # 254)*

Being fair and balanced was found to be an important attribute in the Australian review of the nurse unit manager role (Hewson, 2008:19).

4.2.1.5 A leader-manager is assertive

Assertiveness is operationally defined by Codier *et al. (*2010:943) as "expression and defence of feelings, beliefs and thoughts and rights in a non-destructive way". According to Kelly (2010:135), it is "the willingness to actively participate, state and maintain a position until convinced by the facts that other options are better". Assertiveness differs from passive and aggressive behaviour. Lampert (2012:1) states three ways to improve assertiveness: be confident, not pushy; listen, do not pretend to hear; and be clear, not confused.

Participants considered assertiveness as important and emphasised confidence as a required attribute of the health care leader-manager.

> *"And you must be assertive also." (Data # 178)*

> *"Must be assertive at all times." (Data # 252)*

> *"A leader must be confident, because otherwise the people that work in your unit won't confide in you." (Data # 311)*

> *"… she must be confident." (Data # 106)*

In the study conducted by Codier *et al. (*2010:940-948) the research question on which attributes of emotional intelligence were found in the nursing stories, assertiveness was identified by participants as an important attribute of emotional intelligence. In a

qualitative study on the relationship between assertiveness and burnout among nurse managers, Suzuki, Saito, Tagaya, Mihara, Maruyama, Azuma and Sato (2009:71-81) found that increasing assertiveness and satisfaction with own care provision contributes to preventing burnout. According to Mahmoudirad, Ahmadi, Vanaki and Hajizareh (2009:120-127), nurse leaders require support from top managers to enhance their assertiveness.

4.2.1.6 A leader-manager is courageous

According to Clancy (2003:128), courage is one of the four virtues considered cardinal by Aristotle (prudence, justice, courage and temperance), while Hackett and Wang (2012:868) add two virtues (humanity and truthfulness) considered cardinal by Confucius.

Virtue is defined by Coloma (2009:16) in Hackett and Wang (2012:874) as "the norms of conduct or the habits of action". Crigger and Godfrey (2011:E14) state that a virtue is "a quality of character that when used properly leads to good ends and is a demonstration of moral excellence in the individual who uses it".

Aristotle defined courage as "the ability to face danger gladly or being courageous for its own sake" (Clancy, 2003:129), while Crigger and Godfrey (2011:E14) add that a courageous person is one who demonstrates the virtue of courage as a life pattern. Courage gives the leader-manager power to speak and act (Crigger & Godfrey, 2011:E15). Florence Nightingale demonstrated the virtue of courage by standing up for what she believed, regardless of consequences (Hegge, 2011:24).

Being able to take risks and not shy away from handling problems when they occur was mentioned by participants in this study as attribute health care leader-managers must possess.

> *"She must be able to take risks. She must be able to manage if there's nothing, which means if there is a risk she must be able to manage the risk. I there's a tragedy she must know how to stand in. She mustn't run away. She must jump in." (Data # 48)*

"… If staff or patients have complaints with what you are doing, you have to leave everything with what you were busy doing, it's time to handle problems in the department and sometimes it is difficult to resolve the problem." (Data # 330)

Research supporting the power of courage as a "driving force behind courageous acts" is a five-year study by Walston (2003:5). Research on advocacy and courage by Spence and Smythe (2007) and Hanks (2008) suggest that nurses learn to act as advocates or to be courageous in practice by modelling, on the job situations and through experience not associated with educational experiences (Crigger & Godfrey, 2011:E20). Leader-managers need to teach their followers to have courage by setting an example and well- considered risk-taking. Courage and risk-taking were mentioned as leadership skills by participants in an inquiry to explore ward managers' leadership and decision-making skills (Harding & Sque, (2010:42). Hackett and Wang (2012) systematically and comprehensively reviewed Aristotelian and Confucian literature on virtue ethics and literature on seven leadership styles. They propose that the more leaders practise the six cardinal virtues, the more they are likely to be effective.

4.2.1.7 A leader-manager is creative

Creativity is an integral part of leadership requiring lateral thinking: looking at issues from different perspectives, thinking in broad categories and finding different solution options. Creativity is "a process of making new associations that relies on the right hemisphere of the brain, which controls intuition, visualisation and spatial relationships" (Jooste, 2009:218).

According to Marquis and Huston (2009:3), creativity is a characteristic of critical thinking and is also needed in decision-making and problem-solving.

In today's health care environment innovation and creativity are critically important for leader-managers because each health care provider shapes and lives in tomorrow's health care world. Creativity is stepping out of the usual box when attempting to develop a pathway for reaching a goal or solving a problem by putting aside old formulas, traditions, routines and current practices. "To think outside 'the box', it is best to 'be' outside 'the box'. Creativity is to do something different from the usual. It does

not occur in an oppressive, directive or evaluative environment. Health care leader-managers foster innovative opportunities by brainstorming (Rigolosi, 2013:390-392).

Jooste (2009:219) proposes that leader-managers require the following strategies to become creative problem-solvers: putting more effort into preparation; withholding judgement and criticism; building in periods of isolation; rewarding oneself and others and practising creative thinking through exercises.

Participants in this study mentioned creativity as a desirable attribute because a health care leader-manager needs to improvise continuously in order to deliver quality patient care.

> *"I think a nurse is born with creativity 'cause there's such a lot of things that you know if something is not at hand that you must use now you must improvise. That's a big thing now, I think that's why we need creativity. And I think we as nurses, especially the unit managers we have to improvise to supply a lot of things to the multi disciplinary team."(Data # 108)*
>
> *"… look for things to work smarter, we have to explore the avenues to work smarter because we can't change on and on." (Data # 125)*
>
> *"… you need to be creative to get the people motivated because boredom, once boredom sets in then you've lost them, because they don't do their work properly and they want the next one to do it." (Data # 133)*
>
> *"… you must always be creative and look how you can do things better and smarter things." (Data # 237)*
>
> *"The people expect from the management to know everything." (Data # 226)*

A study by Cook and Leathard (2004:436-444) focused on clinical leadership and identified creativity as an attribute of effective clinical leaders. Cummings, Olson, Hayduk, Bakker, Fitch, Green, Butler and Conlon (2008:508-518), as well as Cummings (2012:3325-3327), report that support for innovative ideas of others significantly increases nurses' job satisfaction. Hendricks, Cope and Harris (2010:717-725) conclude that participants in their study viewed magnanimity, openness and creativity whereby a

good leader recognises all people as equal, is able to defer personal judgement and listens to other staff members' ideas without shutting them down are important attributes of the health care leader-manager. Shiparski and Authier (2013:28-36) purport that health care leader-managers increase the impact of their leadership exponentially if they maximise innovative thinking and action.

4.2.1.8 A leader-manager has a vision and a mission

An organisational vision is defined by Flanagan and Finger (1998) in Jooste (2009:37) as "a mental image of a possible and desirable state of the organisation … a view of a realistic, credible, attractive future for the organisation, a condition that is better in some important ways than that which is currently in existence".

According to Roussel and Swansburg (2009:628), a vision is "the image of a realistic, attainable, credible, and attractive future state for an organization". Vision statements are written to describe where the organisation is going and how it will serve the community. Leader-managers who are visionary influence staff and others through the use of expectations, they set positive and negative expectations and motivate both themselves and others to accomplish great things (Jooste, 2009:119, 120).

An organisation's mission is not the same thing as its vision, but they work together. The mission is defined by Daft (2011:359, 360) as "the organization's core broad purpose and reason for existence". It states the organisation's core values, its reason for being and forms the basis on which the vision is created. Daft further states that the mission defines "the enduring character – the spiritual DNA" of an organisation. An organisation's mission acts as an inspiration to all staff and challenges the energy of staff in the same direction (Jooste, 2009:39).

In this study, from the following statements made by participants, it is evident that they are aware of the organisation's vision and mission, but not one of the participants mentioned having a personal vision and mission.

"… we have our vision and mission on the hmm "kennisgewingsbord" (notice boards), *the ward's and the hospital's, the vision and the mission is there displayed. Then we want to be the best surgical ward in this region or South Africa." (Data # 242)*

"You need to have a vision and a mission in the unit to guide staff towards rendering quality care to patients. (Data # 343)

"… you must know what you hospital's vision and mission is. Because if you know your vision you know your service that you need to deliver … we provide professional nursing care to every patient every day. And our mission is to strengthen our human resources and financial management, improve our performance with pride." (Data # 295)

"…a vision and a mission… It must be there…otherwise the nurses would be, everyone would just do their own thing and no one speaks to what they're supposed to do there." (Data # 271)

"… we must have a strategy, we must have a mission and a vision. You must know where are we going …" (Data # 52)

"… to have a vision and a mission … I've got one in the ward and it's very important that the operational manager just don't go and sit and do her own vision and mission of the ward. She must sit with the nurses and the sisters and they must plan it all together otherwise you won't get you outcomes that you planned for the ward. That's very, very important." (Data # 109)

The importance of health care leader-managers having a vision and a mission was found to be important for participants in the study by Hewson (2008:19), as well as in the study conducted by Harding and Sque (2010:43), on the impact that leadership skills have on clinical decisions made by ward managers.

4.2.2 Theme 2: The skills health care unit managers perceive they need to be effective leader-managers

Table 4.3 presents the second theme, namely the skills health care unit managers perceive they need as leader-managers. A skill is defined by the *South African Pocket Dictionary* (2002:845) as "the ability to do something well", "a particular ability". Participants mentioned a variety of skills they perceive as necessary to function optimally as health care leader-managers. Some of these skills such as planning, organising, budgeting, computer and change management skills relate to the organisation whereas the other skills indicated relate to human resources. These include conflict management, staff development, interpersonal relationships, participative leadership and motivation skills.

Table 4.3 Theme 2, categories and subcategories

Theme 2	Categories	Subcategories
4.2.2 The skills health care unit managers perceive they need to be effective leader-managers	4.2.2.1 Planning skills	-
	4.2.2.2 Organising skills	
	4.2.2.3 Change management skills	
	4.2.2.4 Conflict management skills	
	4.2.2.5 Staff development skills	
	4.2.2.6 Communication skills	
	4.2.2.7 Budgeting skills	
	4.2.2.8 Interpersonal relationship skills	
	4.2.2.9 Participative leadership skills	
	4.2.2.10 Computer literacy skills	
	4.2.2.11 Motivation skills	

4.2.2.1 Planning skills

Planning is described as "deciding in advance what to do; who is to do it; and how, when, and where it is to be done." Planning involves choosing among alternatives, it is a proactive and deliberate process to reduce risk and uncertainty, which enhances the unity of goals, directs attention to the objectives of the unit, provides the leader-manager with some means of control and encourages the most appropriate use of resources. When planning, the leader-manager identifies short- and long-term goals, as

well as the necessary changes needed to ensure the unit will continue to meet its goals. In today's rapidly changing health care environment, due to, for example, advanced technology, changing population demographics and workforce shortages, health care leader-managers are finding it increasingly difficult to appropriately identify long-term needs and to plan accordingly (Marquis & Huston, 2009:140).

Participants indicated planning as an essential skill to prevent chaos, prioritise work and ensure good patient care.

> *"… if you don't organise yourself hmm … or … like for the day, like plan, if you don't planning for the day, then it would be chaos. Then you don't get anything done. Or you don't prioritise your work." (Data # 305)*

> *"We want to reduce the unbooked cases and therefore we have to educate the clerks who's doing the bookings." (Data # 292)*

> *"I must have good planning skills." (Data # 279)*

> *"… planning skills for every day, but you also needs to plan for the future." (Data # 335)*

> "*Your delegating and allocating skills, when staff is absent, is to know what to do, your duty." (Data # 338)*

> *"Planning is very important because you have to plan how much staff do you need in the unit. Planning of time. You know, using your time …" (Data # 100)*

In Pillay's comparative analysis on the perceived competencies of nurse managers, the participants assessed themselves as being good in planning (Pillay, 2009:501). Lewis *et al. (*2010:310) describe the leader-manager's positive behaviour in planning. This involves reviewing work processes regularly to decide how work can be improved, prioritising future workloads and being proactive rather than reactive.

4.2.2.2 Organising skills

According to Leach and Gyurko in Kelly (2012*:*14*),* organising is defined as: "the process of ensuring that the necessary human and physical resources are available to achieve the planning goals."

Minnaar (2010:80) states that when the day-to-day organisation of the unit is discussed, relationships are defined, procedures outlined and supervision and delegation of tasks and client care assignment methods proposed.

Organising skills enable health care leader-managers to ensure their units function optimally. It includes organisation of human as well as physical resources.

> *"Organisation skills is to organise all the work to be done in the unit." (Data # 336)*

> *"… one is to organise your unit and if I say organise I mean now it's the staff, it's the stock; it's the "toerusting." (Data # 95)*

According to Pillay (2009:500), participants, both in public and private settings, regard organising as an important skill health care unit managers need. Lewis *et al. (*2010:310) indicate that health care unit managers can reduce stress by proactive rather than reactive organisation.

4.2.2.3 Change management skills

Change management is described by Khoza (2010:121) as: "a process that entails thoughtful planning, consultation with, and involvement of, the people affected by the changes." When all staff is involved in planning and implementing change empowerment occurs (Marquis & Huston, 2009:301).

Change is complex, chaotic and convoluted and change management is one of the health care leader-manager's most important roles. The leader-manager guide staff and others through the process of disruption in their current practice patterns, encourage them to let go of current realities, introduce new patterns, encourage staff to

adopt new standards and stabilise the equilibrium as soon and painlessly as possible (Stichler, 2011:166, 167).

According to Potter (2001:56), staff can resist change, going through a complete 7-stage psychological adaptation sequence, namely: discovery, denial, passive resistance, active resistance, exploration, commitment and broadcast. Effective change leader-managers are aware of this sequence and use it to their advantage.

It was evident in this study that leader-managers are working in a changing environment and that they realise it needs to be managed.

> *"… you must know the new things that is happening in your work environment, new equipment, new…like this core values. Things don't stay the same, there's always changing." (Data # 218)*

> *"Change management – more senior nurses rejects changes. Due to the age difference among the staff members conflict also arise." (Data # 334)*

> *"… you need to do is to motivate for change." (Data # 124)*

Chase (2010:82, 84), in her research on nurse manager competencies, found that the change process is a leadership function of the nurse manager. Potter (2001:54-58) presents a set of seven core leadership competencies, which were used to create a semi-structured change strategy elicitation questionnaire. From Potter's research five consistent factors emerged: create understanding, communicate effectively, release the potential in your people, set a good personal example and pace yourself. The author concludes that, by paying attention to these five factors, it is possible to create an organisation which truly "thrives on change".

Participants also indicated the challenge they experience from staff members being resistant to change.

> *"… improving the employees' performance. A lot of employees are stagnated and they do not want to change." (Data # 71)*

"… if you sort of put the in service training programme in the ward they don't always adhere to what you tell them to do." (Data # 73)

"… it's difficult sometimes because they don't want to change …" (Data # 113)

"The people are not really changing … Resistant, they're resistant to change." (Data # 285)

4.2.2.4 Conflict management skills

Conflict is defined by Folger, Poole and Stutman, in Brinkert (2010:146) as "the interaction of interdependent people who perceive incompatibility and possibility of interference from others as a result of this incompatibility".

The following conflict management techniques are discussed by Kelly (2012:312-315): avoiding – ignoring the conflict; accommodating – one side gives in to the other; competing – the sides are forced to compete for the objective; compromising – each side gives something up in gain of something else; negotiating – high-level discussion that seeks conformity but not necessarily consensus; collaborating – both sides work together to develop the ultimate end result; and confronting – immediate and obvious movement to bring to an end conflict at the very start.

The participants indicated the need to manage conflict and find solutions for emerging conflict situations.

"… but we manage to … try to get solutions to the problems. So, we try to manage any conflict that is in the department." (Data # 318)

"Then you also must have, I must have good conflict management skills." (Data # 277)

Brinkert (2010:152), in a literature review of conflict communication causes, costs, benefits and interventions in nursing, conclude that nurse managers can positively deal with conflict by normalising conflict, implementing proven proactive/reactive interventions and by helping to build integrated conflict management systems. In Pillay's (2009:501) comparative analysis managing conflict was examined as a leader

competency and participants assessed themselves as being good at managing conflict. Chase's study on nurse manager competencies (2010:82, 84) and Hewson's (2008:19, 32) review of the nurse unit manager role found conflict resolution to be seen as an acquired skill by unit managers. However, in the study conducted by Lewis *et al. (*2010:309) managing conflict was mentioned by less than 1% of the participants.

4.2.2.5 Staff development skills

Staff development is "the systematic process of teaching, training and growth through which an individual acquires skills and knowledge and develop attitudes and perceptions". It consists of identifying the needs/problems of staff members; planning opportunities for development; creating and implementing opportunities for learning in order to solve staff concerns/problems and evaluating the effectiveness of the opportunities. Development programmes need to be innovative and include the induction and orientation of staff, clinical teaching, in-service training and continuous education (Jooste, 2009:254).

The importance of the health care leader-manager's teaching and mentoring function in the unit was repeatedly mentioned by participants in this study.

> *"… so you must also teach them." (Data # 185)*

> *"… or if they do not know you must know at first what you must doing and tell them what to do." (Data # 207)*

> *"you need to have some education skills, so, there's … sometimes you need to do this on-the-job training. in-service training and you are suppose to know what you are talking about and you must also have the skills to, to like education skills so that people can actually understand what you are dealing with and talk on their level and you also you must look at so everybody in the work environment." (Data # 219)*

> *"… the household staff, also to see that they are doing what they're supposed to do. So…and you must also tell them the correct way to do certain things, especially we got now new, we have the cleaning staff, so you must teach them how to do the stuff, how to do everything …" (Data # 220)*

"… you need education skills as a unit manager … I think so, I mean, I'm not trained as an educator, but I think I need some …" (Data # 304)

"And like the students we have, you must, you got that all the categories in your ward so you can also put one on the other one on that same level so they can also be a mentor for that one." (Data # 186)

"… she must do on the spot teaching. I love it, on the spot teaching." (Data # 54)

"… another skill is teaching. Teaching is a very important skill and there's a lot of methods and I'm really in for all the methods 'cause on the spot teaching it's so important." (Data # 110)

Chase (2010:82, 84), in her study on nurse manager competencies, found staff education to be a leadership skill nurse manager participants perceived as important, while staff development strategies were perceived to be an important human resource skill. In the framework developed by Lewis *et al. (*2010:310) staff development is a competency leader-managers possess. Examples of positive manager behaviour include encouraging staff to attend training courses, to be a mentor and coach, to regularly review staff development and to assist staff to develop within their roles.

It is important for leader-managers to identify their own development needs, plan to develop these needs, create opportunities to further develop themselves and evaluate themselves. In this study only one participant mentioned the importance of continuous self-development by making the following comment:

"A manager, man, it's about a lifelong learning. She must always be ready to answer. She must be a person who gets herself more and more qualified. She must be a, it must be programmed in herself to learn, lifelong learning". (Data # 32)

The participants in this study mentioned the challenge arising when having to allocate staff to attending in-service and other development programmes. They commented as follows:

"In-service training is normally held on Tuesdays and Thursdays. It's difficult for staff to attend these in-service trainings, because there's only one sister and one nurse on duty." (Data # 333)

"... to empower the people in our ward, especially the sisters, it can actually be a challenge because of the shortage of the personnel." (Data # 247)

4.2.2.6 Communication skills

Communication is "an interactive process that occurs when a person (the sender) sends a verbal or nonverbal message to another person (the receiver) and receives feedback". This process is influenced by emotions, needs, perceptions, values, education, culture, goals, literacy, cognitive ability and the communication mode. The three levels of communication are intra-, interpersonal and public (Kelly, 2012:199, 200, 218).

When a leader-manager listens carefully and is sensitive to others, communication is enhanced (Jooste, 2009:206). The art of listening is the key to understanding not only what a person is saying, but also what that person is trying to communicate. People add to a conversation with facial expressions, body language and hand gestures that can speak as loudly as words. To listen more, be silent more and attend to what others are saying more is the result of many long, practised habits that will continue to manifest themselves as the leader-manager goes through her day (Vestal, 2012:8-9).

Participants in this study emphasised the need to have good listening skills, giving feedback to staff and open communication channels on all levels of the organisation.

"Circulars. Your people must be up to date with that …" (Data # 201)

"… that's why every Monday or Tuesday I start my day and I said okay, they can come so that I can hand over to them what we get yesterday." (Data # 203)

"… because you must have open communication with these people, you must know what you are doing in the wards and you must get their input as well in everything that you do." (Data # 231)

"Be equipped to communicate …" (Data # 228)

"Listening skills … Active listening skills, yes. Because people need to know that you're actually listening to them and that you actually not just listening but that you are going to act on what they say to you." (Data # 246)

"I must also be a good listener." (Data # 253)

"… sometimes management can be a challenge too… they're not always willing to hear what I say what will work for my department at that stage." (Data # 261)

"How do you make decisions … I always consult with … staff … especially when it concerns the lower categories, the nurses and I was unfair then I go to them to hear what the story is." (Data # 267)

"… you need to keep up to trend of new circulars, policies - to keep yourself up date. So, and then you must also give feedback to your staff in your unit." (Data # 291)

"… communication skills … it can be many times a challenge because you must know how to, if a doctor explain to a patient of the operation, you as the nurse must ask the patients whether the patient understands what the doctor said, but you must also speak on the level of the patient. See, you can't use medical terms for the patient … who doesn't speak a word English." (Data # 308)

"Communication with other departments can also be problematic, for example supply chain management: if you've got a problem to ask them, they just say they'll come back, which never happens." (Data # 332)

"Communication skills especially with your staff, your patients, your public and the members of the multidisciplinary team." (Data # 341)

Pillay (2009:498, 500, 501) examined the competency of communicating organisational goals as a leadership function with nurse manager participants who assessed themselves as being good at communicating. It is also a competency elicited by content analysis in the study by Lewis *et al. (*2010:310) with positive examples of manager behaviour being to keep the team informed on what is happening in the organisation, goals and objectives must be clear and staff members should know

exactly what is required of them. According to Stanley (2012:1, 9), leaders have effective communication skills. In a study conducted by Chase (2010:38, 75) managers ranked effective communication, a component of human resource skills, as the highest in perceived importance.

4.2.2.7 Budgeting skills

A budget is "a financial plan that estimates expenditures and revenues by an agent for a stated future period … it includes estimated expenses as well as income for a period of time. Accuracy dictates the worth of a budget; the more accurate the budget blueprint, the better the institution can plan the most efficient use of its resources". Because a budget is a prediction or plan, not a rule, flexibility, ongoing evaluation and revision are required when doing fiscal planning (Marquis & Huston, 2009:211). Financial management or business astuteness can be learned, developed and mentored. For requesting and obtaining the necessary resources such as staff and supplies or equipment nurse managers need to understand the business or financial aspects of their units (Kallas, 2011:18).

Budgeting is one of the functions of the leader-manager in a health care unit, and participants in this study indicated the need for budgeting skills.

> *"… we are going to be now a functional financial business unit and that is skills that we need to develop or enhance or become to manage our hmm…our units and as a business unit we will get our own budget and personnel and we must use them and we must decide …" (Data # 230)*

> *"She must be skilful in working out the budget." (Data # 41)*

> *"We've got a budget that we work on in the hospital and normally in the beginning of the financial year we get instructions from management that we must see what equipment we need in the wards. To modify everything that's in your unit and get all the old stock out of your unit. So we do give them a list of what we need in the unit and then they see if the budget is okay, if we can order the stuff that we need." (Data # 97)*

In Chase's study (2010:83, 85) on nurse manager competencies financial management, including cost containment, productivity measures, budget forecasting, cost benefit analysis, unit budget control measures, financial resource procurement and financial resource monitoring are skills health care leader-managers need. Hewson (2008:19, 32) affirms that health care unit managers need business and financial management skills. Pillay (2009:498, 500, 501) examined the competencies of budgeting and the control and allocation of financial resources goals as part of a nurse manager's organising skills. Sherman *et al*. (2007:91) found that most nursing leaders in their study cited financial management as their weakest area although they recognised that they will not survive in their roles if they do not possess financial management skills.

4.2.2.8 Interpersonal relationship skills

Interpersonal relationships are "the way humans interact with one another and this includes communicating, cooperating, changing, problem solving and motivation". Interpersonal factors, which may influence interpersonal relationships, are self-regard, assertiveness, independence, self-actualisation and empathy. The characteristics of positive interpersonal relationships are loyalty, a positive and supportive attitude, understanding, mutual trust, open communication and caring. Possible obstacles in interpersonal relationships may be differences in perception and semantics, organisational structure, cultural and generational differences (Jooste, 2010:214-215).

Participants were aware that they have to be skilful in maintaining good interpersonal relationships with all members of the health care team as well as with the public. They mentioned the occurrence of communication breaks between doctors and nursing staff, conflicts between different departments, having to cope with different personalities to get all staff's cooperation, and accommodating visitors' rudeness and social comments on the evolution of human values in business and society.

> *"… good relationships … it's very important, because you do get sometimes where the nursing staff, you know, hmm … between them they got quarrels and then, I mean you can't work like that. Hmm … the doctors you will always find things that's not, or sometimes the doctors will do things on their own without consulting the nursing staff, but hmm … we had many conflict between nurses, staff and doctors and other departments and our department, but we manage to*

… try to get solutions to the problems. So, we try to manage any conflict that is in the department." (Data # 317)

"And the public is also a challenge because some of them are really rude sometimes but we must also practice Batho Pele and we have the Patients' Rights Charter in the ward so that the nurses can see and we also …" (Data # 168)

"… you must have good relationship with your personnel so that they feel that they will do it for you." (Data # 245)

"Then there's the public … Visitors more than the patients … the visitors are the problem because we handle all kind of visitors and all kind of emotions. Some are cross, some are just rude and we have to handle them." (Data # 259)

"The number of the staff. They're there to do the work in the ward and then sometimes personalities, because when three people can't work together; then it become my business to see that they work in a proper way to ensure quality patient care at the end of the day." *(Data # 256)*

Hewson (2008:19, 32) found people management- and interpersonal skills to be desirable skills for health care unit managers. In the Chase study (2010:75) team-building strategies, as a human resource skill, was perceived to be a skill necessary for leader-managers to be effective, while Pillay (2009:498, 500, 501) examined team management as a component of managers' leading skills, and participants assessed themselves to be good in leading their staff. In their study on the influence of interpersonal relationships on nurse managers' work engagement and proactive work behaviour, Warshawsky, Havens and Knaft (2012:418) found that organisational cultures, which foster quality interpersonal relationships, will support the job performance of nurse managers.

4.2.2.9 Participative leadership skills

According to Feldman (2012:291), the basic component of participative leadership style is taking into consideration the thoughts and opinions of employees prior to decision-making. A participative leader becomes part of the team, usually as the facilitator, in

order to implement new projects or to solve problems. Team members have the authority to make decisions, but also the responsibility to execute parts of the plan. Through a participative process shared visions and values emerge and thus a fair, transparent and trusting work environment is developed. Participative leaders are accessible, approachable, caring, motivating, creative, innovative and empowering. They give constructive feedback, act as mentors and coaches, promote teamwork and collaboration and resolve problems through effective negotiation.

Participants realised the value of participative decision-making, teamwork, empowerment, being approachable and caring.

> *"… decisions … I make my conclusion, but I will also ask the group to come in and ask if they are suitable or comfortable with that. So that they can also give their feedback or there ... input ... input so that we can just do the best out of the decision that we make." (Data # 156)*

> *"I … normally when we have to make big decisions or … I always include the staff, because I want their opinions. Hmm … then we decide as a team." (Data # 310)*

> *"Be compassionate to staff, towards patients and staff and team building skills to work together and not against each other." (Data # 345)*

> *"I can't be an effective manager without the help of everybody else around me. I can't manage my ward on my own. Definitely not. I need, I need the trauma girls, I need the education department, I need the stores, I need the pharmacy." (Data # 135)*

> *"… it's participation. My management is participation. I don't ever make a decision on my own. I go to the ground floor, to the nurse, to the seccie, to the cleaner and we sit around the table and I ask them which way is the best way. They must interact. I love to hear their opinions …" (Data # 59)*

> *"It's very important to remember to sit with your staff and have meetings and ask them what they think we need for the unit. You need to get their cooperation 'cause they have to, they have to work with all these equipment and it's very*

important for them to feel part of the team if you ask them all these questions." *(Data # 98)*

Participative leadership by health care leader-managers reduce tensions within the nurse working team (Bortoluzzi, Caporale & Palese, 2013:1). Current health care literature attributes participative leadership as essential to achieving organisational outcomes, including effectiveness, increased job satisfaction among staff, the retention of staff, productivity, organisational commitment and productive nurse-leader relationships (Chiok Foong Loke, 2001:191, Kleinman, 2004:2,8, Cummings, Hayduk & Estabrooks, 2005:2, Germain & Cummings, 2010:425 & Kramer, Schmalenberg & Maguire, 2010:10) in Feldman (2012:191,192). Participative leadership also leads to improved patient outcomes such as patient satisfaction and decreased mortality rates and adverse events (Squires, Tourangeau, Laschinger-Spence & Doran, 2010:914; Wong & Cummings, 2007:508).

4.2.2.10 Computer literacy skills

Computer literacy is the ability to use microcomputers confidently to obtain information, solve specific problems and perform data-processing tasks. It includes a fundamental understanding of the operation of microcomputers, as well as the use of several types of application software packages. A narrower definition suggests that computer literacy means to focus only on imparting immediately useful skills (Easton, Easton & Addo, 2006:2).

Sorensen (2013:188) uses the definition of nursing informatics as given by The American Nurses Association (2008) as "a speciality that integrates nursing science, computer science and information science to manage and communicate data, information, knowledge and wisdom in nursing practice. Nursing informatics facilitates the integration of data, information and knowledge to support patients, nurses and other providers in their decision-making in all roles and settings. This support is accomplished through the use of information technology and information structures which organise data, information and knowledge for processing by computers." According to Sorensen (2013:192), in today's health care environment, the 21st century being called the Information or Quantum Age, health care leader-managers, as knowledge workers, need new knowledge and skills to be able to use new technologies

(Barton, 2005:323-328; Garde, Harrison & Havenga, 2005:899-907; Gassert, 2008:507-521).

Participants in this study repeatedly indicated the need for computer skills. They have to enter patient data, do bookings and order supplies and equipment on computer.

> *"… computer skills … it is very important. Because everything comes through with e-mails and you must be on, you must be, you must have that knowledge, because statistics and everything is now on computer. And it is that you can also send e-mails. That is the faster thing nowadays, so you must equip yourself if I can say that." (Data # 183)*
>
> *"And then, nowadays, with this computer device, you must have your computer skills and always improving it and another thing, to go for the courses." (Data # 225)*
>
> *"Computer takes up a lot of time, it's time consuming, especially with CLINICOM which is extra work, this…the ward secretary can't do CLINICOM because they can't do the coding which doctors' only suppose to be doing, the CLINICOM can't be completed; the patient's entry on the CLINICOM." (Data # 327)*
>
> *"I think everybody should be computer literate, because we do our booking system. You'll have to be computer literate to do a booking. The ordering of any consumables or any buy-outs, you must order it on the computer. So, that is one challenge – everybody must be computer literate and that's why we send people and, to get trained and make them computer literate." (Data # 298)*
>
> *"Computer skills ... I have enough skills for the work I have to do on the computer. You must at least be able to know where to start and how to go on and do the things that I am suppose to do on the computer here with my working place." (Data # 270)*
> *"It does take up a lot of my time to do the computer work, 'cause I can't ask my secretary to do that 'cause he's got his own work to do. It would be very nice if you could have somebody to do the computer work for you." (Data # 82)*
>
> *"… computer skills in today's health care environment … it's very important and it's very important to go to extra courses and not get stagnated because you will*

have to learn to do e-mails and Excel and Word and you can't just do the beginner's part, you have to go on and on and on to do advance courses as well ja." (Data # 101)

"Computer skills – example sending, receiving e-mails, ordering as well as CLINICOM. " (Data # 342)

When reviewing the recent literature on health information technology to determine its effect on outcomes, including quality, efficiency and provider satisfaction, Buntin, Burke, Hoaglin and Blumenthal (2011:464) found that 92% of these articles reached conclusions that were positive overall, but highlight the need for studies that document the challenging aspects of implementing health information technology more specifically. Huryk (2010:606-612) concludes that the attitudes of nurses towards information technology are overall positive and that increased computer experience is the main demographic indicator for positive attitudes.

4.2.2.11 Motivation skills

Motivation is defined by Campbell, McAllister and Eley (2012:2) as: "the reasons, beyond personal traits, that drive an individual towards a goal." Their analysis is underpinned by Hertzberg's seminal framework of motivation at work classifying worker motivation incentives as intrinsic and extrinsic types. Extrinsic motivation incentives are provided by the workplace and include salary, work status, security, leave allowances and professional development. These incentives are also called hygiene factors as they prevent job dissatisfaction. Limitation of these factors has been linked to reduced job satisfaction. Intrinsic motivation incentives are inherent in the work, the pleasure which is derived from the work itself. They make a person feel good about their work performance. Examples include autonomy and perceived significance of the work performed.

Participants in this study indicated that they had to motivate staff to prevent boredom and stagnation.

"… you need to be creative to get the people motivated because boredom, once boredom sets in then you've lost them, because they don't do their work properly and they want the next one to do it." (Data # 133)

"You can sort of say they've stagnated and you have to motivate them a lot a lot." *(Data # 67)*

Sellgren, Kajermo, Ekvall and Tomson (2009:3181) found intrinsic values of motivation to be a major factor identified by participants as having a possible influence on staff turnover. Five categories of factors affecting nurses' work motivation were identified by Toode, Routasalo and Suominen (2011:246) as workplace characteristics, working conditions, personal characteristics, individual priorities and internal psychological states. According to Germain and Cummings (2010:425), nursing managers and leaders may enhance their nurses' performance by understanding and addressing the factors that affect their ability and motivation to perform.

4.2.3 Theme 3: The challenges health care unit managers experience as leader-managers

In table 4.4 the third theme, namely the challenges health care leader-managers currently experience in their work environments, is presented. Data analysis revealed three categories. The first category, workforce challenges, comprises four subcategories, which are staff shortages – these include the causes as well as consequences thereof – staff performance appraisal management, leading and managing a multigenerational workforce, and staff empowerment. Personal challenges that participants experience include an increase in their workload and role diversity. An organisational challenge is the maintenance and provision of equipment.

Table 4.4 Theme 3, categories and subcategories

Theme 3	Categories	Subcategories
4.2.3 The challenges health care unit managers experience as leader-managers	4.2.3.1 Workforce challenges	4.2.3.1.1 Staff shortages *Causes* *Consequences*
		4.2.3.1.2 Staff performance appraisal
		4.2.3.1.3 Multigenerational workforce
		4.2.3.1.4 Staff empowerment
	4.2.3.2 Personal challenges	4.2.3.2.1 Increased workload
		4.2.3.2.2 Role diversity
	4.2.3.3 Organisational challenges	4.2.3.3.1 Management of equipment

4.2.3.1 Workforce challenges

This category revealed the challenges the current workforce poses to health care leader-managers. The causes and consequences of staff shortages, the staff performance appraisal process, a multigenerational workforce and staff empowerment were indicated by participants as challenges.

4.2.3.1.1 Staff shortages

Coetzee, Klopper, Ellis and Aiken (2013:163, 164) state that South Africa has the fewest nurses per 10 000 population and by far the worst patient outcome when benchmarking with other developing countries such as Chili, Costa Rica, Colombia, Thailand and Argentina. There is an estimated personnel shortage of more than 30 000 professional nurses in the public health care sector alone (Solidarity Helping Hand, 2010).

Demand is defined by Huston (2013:70) as: "the quantity of a commodity or service wanted at a specific price and time". In nursing, demand would be the number of nurses an employer would be willing to employ at a given price. A shortage develops when an employer wants more employees at the current market wages than it can get. The demand continues to grow while the supply decreases.

Jooste and Jasper (2012:59-60) describe initiatives of the Department of Health indicating its commitment towards health and nursing. One initiative relates to the occupation-specific dispensation, which was expected to financially benefit more than 100 000 government nurse employees. Today nurse managers still have to deal with nurses' complaints on incorrectly calculated salary increases. Another initiative relates to a human resource strategic framework for the health sector to develop human resource planning documents with the main aim of approaching human resource planning systematically and innovatively.

Causes of staff shortages

In this study participants named the causes for staff shortages as a growing population, an aging workforce and migration of nurses.

Growing population

The population growth rate is the average annual percent change in the population, resulting from a surplus (or deficit) of births over deaths and the balance of migrants entering and leaving a country. The rate may be positive or negative. The growth rate is a factor in determining how great a burden would be imposed on a country by the changing needs of its people for infrastructure (e.g. schools, hospitals, housing, roads), resources (e.g. food, water, electricity) and jobs (*CIA World Factbook*).

Participants indicated the population growth as impacting negatively on the existing staff shortage.

> *"… there was an explosion of the population …" (Data # 1)*

> *"… there's a cry out for more hands there's a cry out really there is because the patients they got more." (Data # 22)*

> *"… because we're more sisters as nurses, but I think in future with the total of number of patients that's growing … So in future we are definitely going to need more staff." (Data # 297)*

Growing populations worldwide are increasing the demand for nurses (Huston, 2013:70; Sutcliffe, Caird, Kavanagh, Rees, Oliver, Dickson, Woodman, Barnett-Paige & Thomas, 2012:2376; Almalki *et al*., 2011:309; Bodenheimer & Pham 2010:801; Barnett, Namasivayam & Narudin, 2010:33). Not only are populations growing, they are also ageing (Nichols, Davis & Richardson, 2010:113; Juraschek, Zhang, Ranganathan & Lin, 2012:244; Neff, Cimiotti, Heusinger & Aiken, 2011:4).

Ageing workforce

Ageing of the nursing workforce is another factor contributing to current and future shortages (Neff *et al.,* 2011:5; Nichols *et al*., 2010:122; Juraschek *et al*., 2012:246). According to Buchan (2012:3), the ageing nursing workforce in many countries is focusing policy attention on how to retain older workers. Letvak (2008:22) in Huston (2013:76) states that nursing cannot afford to lose the experience of so many older nurses. He also points out that older workers have higher job satisfaction and lower turnover, are more dedicated to their jobs, take pride in their jobs, possess good listening skills, are not intimidated by difficult personalities and demonstrate maturity.

Participants commented about the ageing nursing workforce and mentioned the absence of a middle-aged group of nurses to fulfil the staff requirements within the next 10 years when many nurses will reach retirement age.

> *"… most of the staff, you must have a look at their ages, its 45/58. If they leave, we haven't got that middle group there to step into their places. There's a gap now, because nobody was trained say within that 15 years and we sit there with a gap." (Data # 19)*

> *"… all the old sisters that working there for 25 years, 20 years. Whenever you call on them, somebody is sick, if you need somebody that people they close their doors. They are so faithful, they just, they just deliver. They just put their whole souls and their private things apart and they come on duty. And that has got an effect …" (Data # 20)*

> *"Especially for the next visiting when these people the experts when they go out from labour ward, when they go out of labour ward. You can have a look at labour*

ward at the ages, we've got it there, the statistics there, the people older than 45. Most of the staff there is above age 45." *(Data # 28)*

Jooste and Jasper (2012:59) state that 45 646 nurses will be retiring within the next 10 years in South Africa, which escalates the risk of a great loss in experience and expertise. Zarea, Negarandeh, Dehgan-Nayeri and Rezaei-Adaryani (2009:329) conclude that, although the nursing ageing issue is an important factor as far as the nursing shortage is concerned in Western countries, it is not true for Iran where a huge number of young graduated nurses exist but a nursing staff shortage in the clinical setting is apparent at the same time.

Migration of nurses

Migration is defined by Habermann and Stagge (2010:45) as: "movement of a person or a group of persons from one geographical unit to another across an administrative or political border, wishing to settle definitely or temporarily in a place other than their place of origin". The recruitment of foreign nurses has been a common means to alleviate the nursing shortage (Huston, 2013:87). Hiring nurses from other countries in a global service market is generally accepted as a rational choice by recruiting institutions as it typically produces a financial outcome within a defined period of time. The reasons why nurses migrate include: economic – higher salaries, working "for back home", social: better quality of life, safer environment; professional/educational – career opportunity and professional development, good working environment, job security and less workload; personal – to travel and see the world, divorce and change of lifestyle, political: political instability, violence and crime (Habermann & Stagge, 2010:45, 47, Dywili, Bonner & O'Brien, 2013:515). In May 2010 the World Health Organization presented a code of practice on international recruitment of health personnel providing ethical principles for countries to apply to their international recruitment processes (Dywili *et al.,* 2013:512).

A participant in this study made the following comment:

"Then all the other colleges, they closed it. And they only left one open where they trained only 100 nurses per year. And you know what happened to the nurses? Half of that nurses went out to the private sector. Some of that nurses

weren't so successful, say about a quarter of them failed. And the rest of them went overseas; they were looking for greener grass on the other side." (Data # 18)

According to Crush and Pendleton (2010:3), the emigration potential of health professionals from South Africa is very high, retention strategies have been largely unsuccessful and remedial efforts in South Africa will not slow the brain drain. Clemens and Pettersson (2008:1) found that approximately 70 000 African-born professional nurses were working abroad in a developed country in 2000 representing about one tenth of all African-born nurse professionals. Littlejohn, Campbell and Collins-McNeil (2012:1) conclude that the global nursing shortage is relevant and needs more investigation and appropriate interventions to ease this shortage and prevent an international public health crisis.

Consequences of staff shortages

The consequences of staff shortages mentioned by participants are burnout, high absenteeism and challenges when delegating and allocating staff.

Burnout

Freudenberger (1974) in Hughes (2008:1) uses the term burnout to describe workers' reactions to the chronic stress common in occupations involving numerous direct interactions with people. It is conceptualised as a syndrome that is characterised by emotional exhaustion, depersonalisation and reduced personal achievement. The domains of work and family life may be in conflict with stress resulting from the combined responsibilities of work, marriage and children. Four sources of stress in the nursing profession are described by Sorgaard, Ryan and Dawson (2010:3): educational, clinical, personal/social and organisational sources.

Participants in this study emphasised the challenge staff burnout is causing them.

"There were two that went off sick this morning because you can only do what you can although they tried so very hard …" (Data # 21)

"And we, you know, we who started those years we are so trained man, so drained in giving the best of yourself, giving the best." (Data #24)

"That's why I'm telling you the staff, they're drained man." (Data # 27)

"… they become burned out." *(Data # 329)*

"… staff burnout … especially in wards where there is really that it is really very busy. But all the wards is very busy. But you see it is that, there's a lot of other things that is also a factor with that. It is illness or the people go ... so it is that absenteeism, it is that long sick book from the doctor." (Data # 192)

"Ja, the staff, the staff is important. Hey, the staff. I can see what's going on with the staff because of this thing. How the staff, they're getting sick, sick, sick." (Data # 55)

"… the staff do get burnt out and it also cost a lot of money to the hospital 'cause they have to get somebody to work overtime as well." (Data # 80)

In a study by Coetzee *et al. (*2013:162) 45.8% of respondents reported high levels of burnout. Nurses in the study by Neff *et al.* (2011:8) also reported high levels of burnout and job dissatisfaction. More favourable practice environments and lower patient to nurse ratios have been shown to decrease burnout (Aiken, Sermeus, Van den Heede, Sloane, Busse, McKee, Bruyneel, Rafferty, Griffiths, Moreno-Casbas, Tishelman,Scott, Brzostek, Kinnunen, Schwendimann, Heinen, Zikos, Sjetne, Smith & Kutney-Lee, 2012:e1717; Nantsupawat, Srisuphan, Kunaviktikul, Wichaikhum, Aungsuroch & Aiken, 2011:426). In their study to investigate interrelationships between emotional intelligence, work stress and burnout in a group of nurses in the Western Cape Province, South Africa, Görgens-Ekermans and Brand (2012:2275) conclude that higher emotional intelligence is significantly related to lower stress and burnout, which suggests that enhanced emotional intelligence may help diminish burnout development when chronic stress is experienced.

Absenteeism

Absenteeism is defined by Davey, Cummings, Newburn-Cook and Lo (2009:313) as: "not coming to work when scheduled, and is measured by frequency or duration of work days missed". Two types of absenteeism are discussed: "non-culpable", i.e. involuntary or approved absence and "culpable", i.e. voluntary or unapproved absence. A practical way to distinguish non-culpable from culpable absence is to assess the frequency and duration of absence/sick days. Research has revealed consistently that frequency measures provide a reasonable index of culpable absenteeism. Absence frequency is measured by counting each incident/episode of absence regardless of the duration of the absence. For the assessment of absence duration the total number of days lost are tallied regardless of the number of incidents.

Participants in this study commented repeatedly on the challenges posed by absenteeism in the workplace.

> *"And you must also teach them about you know the absenteeism. It is also a thing that if you not see that it forms a precedent so that you can acknowledge it very early and pick it up and have a conversation with that person …" (Data # 191)*

> *"… there's also this absenteeism … and the absenteeism profile from nurses in the whole hospital is so poor …" (Data # 211)*

> *"So there can be some absenteeism, so you must think you need and you must cover that or you know that shift is not so strong than the other shift. No … everybody is not the same." (Data # 236)*

> *"… there is absenteeism of staff. That's a big problem. We have to focus on the interdependence of the staff, looking for patterns. You have to support them …you have to refer them …and that's really a problem." (Data # 76)*

> *"… afterwards you have to meet formally with them and act on the absenteeism and follow the disciplinary process and that takes a lot of time of yours*." *(Data # 78)*

Davey *et al. (*2009:328) in their systematic review of predictors of nurse absenteeism in hospitals conclude that their findings show trends toward individual nurses' prior attendance records, work attitudes, such as job satisfaction, organisational commitment and work/job involvement and also retention factors to reduce nurse absenteeism, while burnout and job stress increase absenteeism. Iwu, Allen-Ile and Ukpere (2012:10505) state that when employees are satisfied, organisations experience high productivity, low absenteeism and turnover, less job stress and burnout, better safety performance and a stronger tendency to achieve client loyalty, while the reverse is the case when employees are dissatisfied. According to Singh (2012:1), the annual loss to the South African economy due to absenteeism is between R12 billion and R 19.144 billion per year. Schreuder, Roelen, Van Zweeden, Jongsma, Van Der Klink and Groothoff (2011:585) conclude that effective nurse managers have less short-term sickness absence in their nursing teams.

Delegation

Delegation is "the transfer of responsibility for the performance of a task from one person to another. It means transferring responsibility to a competent individual by granting the authority to perform a selected health care task, in a selected health care situation, while retaining accountability for delegation" (Jooste 2010:136). According to Plawecki and Amrhein (2010:20), there are five rights of delegation: right task, right circumstances, right person, right directions and communication and right supervision and evaluation. Nursing governing bodies provide policies on scope of practice, but nurses still need to continually reflect on their practice and ensure it is aligned with associated legislation (Schluter, Seaton & Chaboyer, 2011:1211, 1212).

Participants in this study found delegation a difficult task as a result of staff shortages.

> *"Delegation and allocation are difficult with staff shortage, the need to allocate staff according to scope of practice: if you haven't got the staff, for example staff nurses in the department, then it's the sister's duty to do dressings …" (Data # 331)*

> *"And then when the professional nurse delegate or allocate the nursing staff some, certain tasks to do they haven't always got the time to check if the nursing*

staff did that task and that causes a problem cause the next morning when you do the allocation again and you as a unit manager go back and have to check did they do it and it's not always done and you get problems from the dietician, the chemist, the stores; from all the areas in the hospital." (Data # 75)

Schluter *et al.* (2011:1218) found that, when the process of delegation or the way to manage other levels of staff, were unclear to staff, they were less likely to see delegation as a solution to increased workload pressures. Bystedt, Eriksson and Wilde-Larsson (2011:540) conclude that heavy workload sometimes causes registered nurses to delegate more than they would like to and it also makes it difficult to follow up a delegated task as much as they would like. This study has also revealed insecurity among registered nurses regarding when to delegate and how delegation affects the quality of patient care. This insecurity is compounded by an increased demand for delegation. In the current study health care leader-managers experience difficulty when delegating tasks to staff due to the nursing shortage.

Quality care

Quality of care is the "degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge" (Leggat, Bartram, Casimir & Stanton, 2010:356).

According to Kelly (2012:35), health care systems have three simple components including structure, process and outcomes. The structure component includes resources/structures needed to deliver quality care such as human and physical resources (nurses, doctors, hospital buildings, medical records, pharmaceuticals). The process component includes the quality activities, procedures, tasks and processes performed within the structures such as hospital admissions, surgical operations, and nursing/medical care delivery following standards and guidelines to achieve quality outcomes. The outcomes component refers to the results of good care delivery, which is achieved by using quality structures and quality processes and includes the achievement of outcomes such as patient satisfaction, good health and functional ability and the absence of health care acquired infections and morbidity.

In this study it was evident that health care leader-managers are well aware of the need for rendering quality care but that it posed as a challenge as a result of staff shortages followed by increasing workloads for those who are on duty.

> *"… what we really experience is shortage of staff. That's a big problem and it is not because of anything excepting that the workload is getting more …" (Data # 117)*

> *"And good quality nursing care. So the staff must be enough and it is all over that you find that staff is really a problem." (Data # 193)*

> *"To render quality care … if it is the staff that is not on duty then we can't render proper." (Data # 262)*

Needleman, Buerhaus, Mattke, Stewart and Zelevinsky (2002:1715) measured the effects of staffing levels and adverse patient outcomes and found an association between the staffing level (nursing hours/patient/day) and complications. When there is a decrease in staffing, there is an increase in the incidence of pneumonia, urinary tract infections, gastrointestinal bleeding and length of stay. The authors reported that with an increase in registered nurses in the staff mix, there was a decrease in the incidence of shock, cardiac arrest and failure to rescue. Djukic, Kovner, Brewer, Fatehi and Cline (2013:105) examined work environment factors other than staffing associated with nurses' ratings of patient care quality, which leader-managers can use to strategically allocate resources that have the potential to improve quality care. The factors include workgroup cohesion, nurse-physician relations, procedural justice, organisational constraints and physical work environment. Yun, Jie and Anli (2010:122) and Coetzee *et al.* (2013:171) reported on the negative effect of inadequate nurse staffing on the quality of patient care while Poghosyan, Clarke, Finlayson and Aiken (2010:296) found the provision of safe and high quality care in a context of nurse burnout and nursing shortage to be very challenging. Zhao, Akkadechanunt and Xue (2008:1722) explored and compared nurses' and patients' perceptions of quality nursing care. Patients have increasingly voiced their concerns regarding health care quality. Gormley (2011:33) found significant differences between nurses and managers on their perceptions of the work environment and quality care. Wong, Spence Laschinger and Cummings (2010:889) conclude that health care leader-managers can improve quality care and

workplace conditions by paying attention to facilitating genuine and positive relationships with their staff.

In South Africa the Department of Health has established the National Core Standards programme for public health establishments in 2008, aiming to improve the quality of care in public health institutions by establishing a benchmark against which these institutions can be assessed and provide a national certification programme for institutions that comply with these quality standards. The quality standards include patient rights, patient safety, clinical governance and care, clinical support services, public health, leadership and corporate governance, operational management and facilities and infrastructure (South African Department of Health, 2011).

The *Best Care … Always!* campaign was launched in August 2009. It advocates a non-punitive approach and emphasises measurement, shared learning and continued, interactive improvement through implementation of a small number of solidly evidence-based tasks aggregated in "bundles" that should be performed in every instance on every eligible patient. There are four infection prevention interventions that collectively represent the majority of health care-associated infections: prevention of catheter-associated urinary tract infections, prevention of central line-associated infections, prevention of surgical site infection and prevention of ventilator-associated infections. It also aims to introduce antibiotic stewardship programmes. An "antibiotic use bundle" could reduce inappropriate use and promote appropriate choice, dosage and duration of antibiotic therapy to optimise clinical outcome while also minimising the development of antibiotic resistance (Kantor, Van den Bergh & Brink, 2011:3).

4.2.3.1.2 Staff performance management

The Staff Performance Management System was introduced and implemented in the public service at the start of the 2003/2004 financial year. It is aligned with the Constitution and other relevant acts and it signalled a change in approach and philosophy to measure performance. The aims are to assist in communicating and reinforcing the organisational strategies, values and norms; to integrate individual and corporate objectives; to ensure that employees are evaluated in terms of a system that is fair, objective, transparent and provides equitable rewards and recognition (Oliver, 2008:1).

According to Minnaar in Jooste (2010:87), employees' performance revolves around three major factors: commitment, knowledge and consequences of behaviour. To manage performance on a one-on-one basis leader-managers need to go through a cycle: clarify expectations about the work that must be done; ask followers what help they need to perform; monitor performance; offer coaching, counselling and support when needed; provide honest feedback and recognise good performance.

In this study participants found staff performance appraisal a challenge because of the unhappiness it can cause among staff as a result of the method used. Furthermore, some staff members are not able to express themselves in writing, thus making staff performance appraisal an unfair process according to them.

> *"… you must have the skills also to do the Staff Performance Management System and to manage the performance actually of the people you have under your supervision so that they are working on standard and not off standards." (Data # 221)*

> *"SPMS I think is also a challenge, hmm … I think it's a, I don't know if I can say it, it's a, like for me it's a very unfair hmm … hmm … method, hmm … that they use in the department, because it makes the people very unhappy." (Data # 301)*

> *"… the SPMS – staff sometimes is very unhappy, it's … they don't always know how to write or give evidence, proper evidence. They … it's sometimes unfair, especially to those that do work hard and don't know how to explain themselves on paper." (Data # 325)*

Lee and Ko (2010:839) in their study conducted to examine the influence of self-efficacy, affectivity and collective efficacy on nursing performance of hospital nurses conclude that individual-level variables such as job position, years of experience, employment status, self-efficacy and positive affectivity were positively related to nursing performance. Collective efficacy and the number of in-service meetings within units were statistically significant group-level variables. When leader-managers understand the effects of these variables, performance management in hospitals will be improved. Germain and Cummings (2010:425) conclude that leader-managers may enhance their nurses' performance by understanding and addressing the factors that

affect their ability and motivation to perform such as addressing nurse autonomy, relationships among nurses, their colleagues and leaders and resource availability.

Leggat, Bartram and Stanton (2008:32) explored human resource management practices in Australian hospitals and found little evidence of implementation of those aspects of human resource management that have been linked to better performance in organisational and patient outcomes. Health care leader-managers need to display transformational leadership with skills in information-sharing, the ability to encourage teams and decentralised decision-making to enhance the empowerment and performance of their staff (Leggat *et al.,* 2010:362).

4.2.3.1.3 Multigenerational workforce

We live in a time when many different generational groups are engaged in the workforce. The workplace is now made up of individuals from three of the four distinct generational groups: the Veterans (now retired), Baby Boomers, Generation X and Generation Y. The term 'generation' signifies the grouping of people within similar age groups. The Veterans (Traditionalists) were born in or before 1945 and they make up few if any of the current nursing workforce. Baby Boomers (live to work) were born between 1946 and 1964 and their core values are optimism, personal growth, health and wellness and involvement. Generation X (work to live) were born between 1965 and 1980; their core values focus on thinking globally, balance, technological literacy, having fun, travel, independence diversity and informality. Generation Y ("nexters", "internet Gen", "Millennials") were born between 1981 and 1999; their core values are optimism, civic duty, confidence, teamwork, modesty, achievement, morality, "street smart" and diversity. When health care leader-managers understand each generational group, it grants them the opportunity to grasp what it is that motivate them to successfully deal with the nursing shortage (Stanley, 2010:846; Sherman, 2006:1-8).

Participants found it difficult to manage the different generations:

> *"… generation X and generation Y nurses … there's a big difference between that. The old ones is the committed ones and the youngsters are really not so responsive and not committed …" (Data # 195)*

> *"… you know the older generation are not really like the younger generation*." *(Data # 140)*

> *"And then of course you get the older girls who are so rigid, they don't want change*." *(Data # 141)*

> *"… there's a difference between the older nurses and the younger generation… luckily for us, everybody is working there for years – there's about two, three sisters, but they previously did the bridging course, so, they're old staff nurses, I don't think there's any…maybe there's one or two staff that's in their thirties – all the others are forty at the moment … Old school." (Data # 316)*

> *"… the older generation staff and now we have the younger generation … Ja. And they always said: "Oohh, waar kom die kinders vandaan? In onse dae was dit nie so gewees nie!" … we must now bring them together and said: "Onthou, dis nou so en ons moet nou so maak". But they are very valuable those old nurses… Or you change their shift – they're suppose to work 'till one o'clock; then you ask can I change it to work 'till seven o'clock? Then they're willing to do it and they take there time back at another time. They are the people who are the most willing to do it." (Data # 286)*

Keepnews, Brewer, Kovner and Shin (2010:161) suggest interventions to reduce generational conflict in nursing and to promote a positive environment. These suggestions include assessing each unit's generational mix, understanding differing expectations and building on the strengths of different cohorts. Lavoie-Tremblay, Paquet, Cuchesne, Santo, Gavrancic, Courcy and Gagnon (2010:414) conclude that retention strategies that focus on improving the work climate are beneficial to all generations of hospital workers and nurses. However, Hendricks and Cope (2012:717) are of the opinion that acknowledgement of generational characteristics provides the health care leader-manager with strategies that focus on mentoring and motivation;

communication; the increased use of technology and the ethics of nursing. This can bridge the gap between generations of nurses and increase workforce cohesion.

4.2.3.1.4 Empowerment of staff

Empowerment refers to "the use of a person's potential and competencies, the discovery of new expertise, and the creation of new opportunities to apply such competencies" (Jooste 2009:222).

Huston (2013:38) describes Kouzes and Pozner's (2007) *Encourage the Heart* principle, which can serve health care leader-managers in developing the attributes of staff by motivating, growing and empowering them. Health care leader-managers need to make sure that staff feels what they do really matters in their hearts. The practice of encouraging the heart is aligned with two commitments: recognising contributions by showing appreciation for individual excellence and celebrating the values and victories by creating a spirit of community.

In this study the participants realised the importance of empowering staff:

> *"And she must develop her people. She must send out her people on training. She must spend money on her people to equip them with whatever they need to be competent to do the work." (Data # 46)*

> *"… you must make your people efficient, efficient." (Data # 57)*

> *"... to empower the people in our ward, especially the sisters, it can actually be a challenge because of the shortage of the personnel." (Data # 247)*

> *"And she must allow her people to do, to go into her office and to relieve her. She must trust them to do her work." (Data # 51)*

Cicolini, Comparcini and Simonetti (2013:1) found a significant positive relation between empowerment and nurses' job satisfaction, while Spence Lachinger, Finegan and Wilk (2011:124) found that high unit-level empowerment was associated with lower emotional exhaustion. According to DeVivo, Quinn Griffin, Donahue and Fitzpatrick (2010:1), health care leader-managers can initiate programmes focused on enhancing

staff perceptions on empowerment. The effects of positive supervisor relationships and their influence on empowering working conditions at the unit level will heighten nurses' organisational commitment (Spence Laschinger, Finegan & Wilk, 2009:228).

4.2.3.2 Personal challenges

The personal challenges experienced by health care leader-managers include the increase in their workloads and role diversity.

4.2.3.2.1 Increased workload

"Job demands refer to aspects of the job that constitute workload. Job demands are defined as an employee's perception of the pace of work and/or the excessive quantity of work to do" (Albrecht, 2010:130). Sources of role overload include demands from staff, colleagues, patients, families and the wider organisation (McCallin & Frankson, 2010:323).

Participants in this study experience an increase in workload due to staff shortages. It is difficult to teach staff, to follow up on delegated tasks and registered nurses doing tasks other categories of nurses could perform.

> *"… what we really experience is shortage of staff. That's a big problem and it is not because of anything excepting that the workload is getting more …" (Data # 117)*

> *"… so you got to keep picking up the loose ends and tying them together and doing them and what about this and what about that. So often the unit manager would do it herself. So your workload gets more and more …" (Data # 122)*

> *"We have to make use of new technology and encourage the use of new technology." (Data # 126)*

> *"… then is also difficult to get the sisters to do their administrative tasks or their supervisory skills, because they must now do all this stuff that the nurses must do." (Data # 213)*

"So I need to pull myself together and deliver a high work load within a short period of time …" (Data # 13)

"… there's a lot of administration for the unit managers, the staff, the doctors, everybody in the hospital. You sit, you do administration and administration and it feels that you get nowhere; you've got a lot of administration." (Data # 81)

Udod and Care (2011:57) found that managers face considerable job stress and conflicting demands, often caught between focusing on staff relations and organisational productivity. Equipping managers with appropriate preparation and support may make the role of health care leader-managers more attractive and facilitate succession planning. McCallin and Frankson (2010:324) conclude that the role of health care leader-managers is complex, ambitious and demanding. Their study has shown that role issues increase because expert nurses are commonly appointed to a role without business management competence. New approaches to the role development of leader-managers are needed. Role preparation for future health care leader-managers begins with succession planning and postgraduate management education before they take up these positions. Udod and Care (2012:76-79) investigated nurse managers' work stressors and coping experiences and found that a major stressor identified by all participants related to their struggle with prioritising work responsibilities. They expressed a continual vetting of paperwork and emails, responding to unit and organisational goals and priorities and responding to staff needs while attempting to maintain a clinical presence in the unit. Inability to meet the needs of the leader-manager workload may lead to burnout (Zwink, Dzialo, Fink, Oman, Shiskowsky, Waite, DeVine, Sanders & Le-Lazar, 2013:137).

4.2.3.2.2 Role diversity

A role is defined as "a person's function in a particular situation" and diversity is defined as "a range of different things" (*South African Pocket Oxford Dictionary*, 2002:778, 257). According to Cziraki, Mckay, Peachey, Baxter and Flaherty (2013:1), the first-line nurse manager's role is pivotal in linking management and employees and has a direct impact on organisational performance, including quality of care, financial stability and patient satisfaction.

Health care leader-managers in this study mentioned the challenge they experience with their roles. They have to fulfil multiple roles when staff is absent or insufficient.

"… on a weekend there's no social worker. We see ourselves as nurses. We have to do the work of a porter … We've got the role of the reverend and the role of a social worker to play." (Data # 8)

"Many of the roles to fulfill, for example a social worker – if there's no social worker on duty, especially when she's on leave, there's no, they don't always tell us who is on duty and then you have to phone from one place to another and that's also time consuming. When the ward secretary is absent, you must fulfill that work as well." (Data # 326)

"… we have only one general assistant in the department for the whole day. So, if you as a nurse sometimes needs to mops. You can't wait for her to come and clean up and to prevent any injuries or sometimes you have to take forms to be signed by the medical sup, walk self or fetch something … Ja, you get many other roles – it really is a challenge." (Data # 307)

"All the examinations that they go for, sonar and x-rays or anything. Any procedures also that was done on the patient, you must also write it in anything. Did you explain the medication, was the patient follow up. All that stuff that you must fill in there and you must put your handwriting there so that they can see who discharged or complete the forms." (Data # 199)

"… "Gevorderde operasies soos heupvervangings en dit." 'Cause they mos say it belongs to another "vlak", to our hospital, but we handle it here and we try to do our utmost best, but I think we, all our staff in our ward must go for an orthopedic course on their own. But we, luckily we're sending one sister mos now next year." (Data # 266)

"My role is multi, multi, multi task." (Data # 260)

"I must undress that patient; I must do all the observations ... If the seccie isn't there … I function as a seccie …" (Data # 11)

Gould, Kelly and Maidwell (2001:37) conclude that the findings of their exploratory investigation have established the diversity of the clinical nurse manager role, while Cziraki *et al.* (2013:1) conclude that the first-line nurse manager role has not been researched comprehensively enough. Further research is warranted to understand which strategies are most effective in supporting them. McCallin and Frankson (2010:321) found that the participants, charge nurse managers, had difficulty performing their jobs because their roles were unclear. The practical reality of this was that their roles were diverse when compared with the job description.

4.2.3.3 Organisational challenges

The management and provision of equipment is a huge challenge health care leader-managers face.

4.2.3.3.1 Management of equipment

According to Sokhela, Nonkelela, Sikuza and Sitole in Jooste (2010:99, 100), it is a health care leader-manager's responsibility to manage the clinical use of supplies/equipment in his/her unit, but it is the responsibility of all health care staff to obtain the necessary training to use equipment safely and effectively, to ensure that single-use devices are used only once and equipment and devices are not modified, and to report faults accurately. To control the risks associated with supplies/equipment the whole life cycle of the equipment needs to be controlled. This includes identification of needs; evaluating and selecting equipment; tendering and purchasing; training of all users; provision of appropriate infrastructure and services; proper storage and disposition; appropriate prescribing to clients; repair and maintenance and safe and legal disposal.

The supply chain management policy was adopted by the South African Cabinet in 2003. It replaced outdated procurement and provisioning practices. The aim was to implement a supply chain management function across all spheres of government that would be a part of financial management and would conform to international best practices. Supply chain management is built upon ensuring value for money, open and effective competition, ethics and fair dealing, accountability and reporting and equity (Ambe & Badenhorst-Weiss, 2012:11003)

Participants voiced the difficulties they experience with getting the stock and equipment they require in their units. This is caused by broken equipment which doctors need to use. All staff members do not treat equipment with the necessary care and staff is also reluctant to take responsibility for equipment and stock.

> *"The equipment … Sometimes it's old or not working and then the doctors are on my case, because they want to use it now and lots of problems to get it fixed again." (Data # 257)*

> *"Rather not waste and break equipment, so you need to be caring as well. You know, caring …" (Data # 137)*

> *"… the supply chain and the stock. There's not always enough stock in the supply chain, therefore we don't get all the stock we need. Then we have to e-mail to management, that is also time consuming – which never takes place all the time. They never come back to you …" (Data # 324)*

> *"… you wait sometimes for four to six weeks for goods to be delivered, but in the mean time you must render a service. So, and that is very, a big, big challenge." (Data # 299)*

> *"… is our stores. Our stores is a huge challenge because you've always got to be making plans and implementing and borrowing equipment and hiding equipment away so that nobody else can use it which is not fair. Because it is not for myself, it's for all the patients, but I want my own unit to be covered first because we have the critical ill patient." (Data # 119)*

> *"… supply chain management. We've got a problem with getting stock. We do order the stock on the necessity documents and then we don't get the stock back from …" (Data # 84)*

Ambe and Badenhorst-Weiss (2012:11013) conclude that there are enormous challenges with regard to the implementation of supply chain management in the South African public sector. These challenges include non-compliance with supply chain management policy and regulations, lack of appropriate bid committees, lack of strategic planning, skills and the capacity and knowledge of the workforce to implement

supply chain management successfully. Germain and Cummings (2010:438) purport that resource accessibility is one factor participants perceive as motivating to perform well. This is affirmed by Neff *et al.* (2011:9) who emphasise that it is also necessary for providing quality patient care

4.3 CONCLUSION

In this chapter the themes, categories and subcategories that emerged from the analysis of the data was discussed. The researcher also presented relevant literature as a control measure to the research findings.

CHAPTER 5

CONCEPTUALISATION: SYNTHESIS OF FINDINGS, CONCLUSION AND RECOMMENDATIONS

There are those who look at things the way they are, and ask why…?
I dream of things that never were and ask why not…?
Robert Kennedy

5.1 INTRODUCTION

In the centuries since Newton and Descartes people have prided themselves on the triumphs of reason and the absence of magic, planning, predicting and analysing the world, hooked on manipulation and holding onto a belief in cause and effect (Wheatley, 2006:28, 29). Patients were viewed as having broken mechanisms/parts, which can be repaired, processes were understood and analysed as linear and predictable (Kramer, Brewer, Halfer, Maguire, Beausoleil, Claman, Macphee & Duchscher, 2013:696).

With quantum physics and complexity science it was discovered that the universe is not stable, closed, predictable or controllable in ways scientists had thought. New models of thinking assert interconnectedness over fragmentation, networks over hierarchy, influence over control and direction over destination (Kramer *et al*., 2013:696). In the quantum world the relationship created between two or more elements is critical. While systems influence individuals, individuals call forth systems and this relationship evokes the present reality. Prediction and replication become impossible. People stopped being predictable and became surprising. Each person is different in different places – making us not inauthentic, but quantum (Wheatley, 2006:36).

According to Porter-O'Grady and Malloch (2011:20, 21, 37), leader-managers need to replace traditional leadership models with models reflecting the new framework. Leadership in the Quantum Age is not about managing function or work, but about coordinating the elements, for example workers, and facilitating their relationships at every organisational level. Leader-managers must be able to understand the

complexities of human interactions and human relationships. The relationship between work, the worker and the purpose of work must be considered as a dynamic continuously driving value. Leader-managers need new skills and insights about leadership. These skills and insights can be learned, adapted to current conditions and applied in a variety of ways. In the application of these skills a leader-manager may come to discover him/herself, feel the excitement of leadership and catalyse others in the journey of discovery and advancement.

Wheatley (2006:46) states: “I don’t personally spend time anymore on elaborate plans or time lines. I want to use the time formerly spent on detailed planning and analysis to create the organisational conditions for people to set a clear intent, to agree on how they are going to work together, and then practise to become better observers, learners, and colleagues as they co-create with their environment. And I have learned that great things are possible when we increase participation. I always want more people, from more diverse functions and places, to be there. I am always surprised by what people can create as they explore the webs of relation and caring that connect them. Finally, I no longer argue about what is real. We each construct reality, and when I become curious about this, I learn a great deal from other people. I expect them to see things differently from me, to surprise me.”

This study was undertaken in view of the many challenges brought along by a rapidly changing health care environment in the 21st century, which requires different sets of skills from leader-managers as expressed by Shelton (1999), Porter-O’Grady and Malloch (2011), Wheatley (2006), and others.

This chapter presents a synthesis of the findings, conclusion, and recommendations.

5.2 SYNTHESIS OF FINDINGS

A summary and interpretation of the research findings will be given according to the three themes that emerged from the data. The themes address the objectives of the study.

5.2.1 Attributes of a health care leader-manager

Health care unit managers clearly expressed their views on the role of a leader-manager in the current health care environment. They indicated eight attributes that leader-managers should have to fulfil their roles.

- According to the participants part of the role of a leader-manager is to live six core values. At the time the researcher conducted the interviews with the health care unit managers the six core values of the Western Cape Department of Health were being promoted by all staff members of the hospital where data was collected. These values are: caring, competence, accountability, integrity, responsiveness and respect. The acronym C_2AIR_2 developed out of these six values (see 4.2.1.1).
- Being a role model was regarded as important by the health care unit managers. According to them health care leader-managers must set positive examples to their staff by being competent, confident and treating all people with dignity. It embraces the attributes of flexibility, assertiveness, courage, fairness, creativity and having a vision and a mission (see 4.2.1.3).
- The participants realised that a leader-manager should treat all staff members fair and without discrimination. In their view being fair in all circumstances is essential for building and developing trustworthy relationships in the unit (see 4.2.1.4).

Living the six core values and being fair and a role model can be linked to the skills of quantum acting and quantum being. When health care leader-managers use the skill of quantum acting, they act responsibly, they create synchronised work environments in their units, they stay mindful, they take their values to work and serve as moral examples by modelling their values and encouraging their staff to live theirs as well. The skill of quantum being enables health care leader-managers to be in relationships, to be compassionate and forgiving, to engage in dialogue and to function well in a team, all of which imply respect and responsiveness and adopting a value system beneficial not only to self but also to others (Shelton, 1999:111).

- Health care unit managers indicated that they need the ability to be flexible in the 21st century when change and technological advances are at the order of the day

(see 4.2.1.2), and that they have to demonstrate the virtue of courage as a life pattern (see 4.2.1.6). It is courage that gives the health care leader-manager the power to speak and act and to take calculated risks, when it is required. By modelling courageousness the leader-manager set an example for staff members to become more courageous themselves, as well as becoming better advocates for their patients (Crigger & Godfrey, 2011:E14; E15; E20) .

The skill of quantum trusting facilitates flexibility and faith to trust life's process by focusing on the mystery of life rather than mastery over it. Resilience is practised and self is organised within a context of constant change and chaos (Shelton, 1999:123).

- Being assertive in the expression and defence of one's feelings, beliefs, thoughts and rights in a non-destructive way was regarded as an important attribute of a leader-manager. One has to be confident in one's beliefs, competencies and abilities and thus have a positive influence on relationships with staff, other members of the multidisciplinary team, patients and their families (see 4.2.1.5).

The skill of quantum knowing (Shelton, 1999:75-94) enables an individual to know intuitively and to be confident. When intuitive decision-making is practised, it leads to empowerment of self and others.

- Unit managers regarded being creative (see 4.2.1.7) and having a vision and a mission (see 4.2.1.8) as essential attributes of a leader-manager.

The skill of quantum thinking may provide health care leader-managers with an on-going stream of innovative and creative ideas, which may guide the implementation of the vision in the unit. They will realise that trying harder is not always the answer, but thinking differently is (Shelton, 1999:33-53). Health care leader-managers who involve their staff members in the development of a vision and a mission for their units utilise the skill of quantum seeing. It is a process of shared visioning, which changes staff's perceptions, enabling them to become more focused and to see new possibilities, resulting in better quality care for patients (Shelton, 1999:25).

5.2.2 The skills health care unit managers perceive they need in order to be effective leader-managers

The health care unit managers highlighted specific skills pertaining to the organisation and to human resources as requirements in order to perform as effective leader-managers in their current health care environment.

- Skills referring to the organisation include planning, organising, budgeting, computer and change management skills.
- Planning skills are required by health care leader-managers to ensure quality care is given to patients, the objectives of the unit are achieved, short and long-term goals are identified, and resources are appropriately used. With the staff shortages that are currently experienced leader-managers have to change work schedules on short notice and effectively plan staff members' leave (see 4.2.2.1).
- The unit managers indicated that organising skills are required to ensure the availability of human and physical resources for rendering quality patient care. They need to review the current processes of work, prioritise needs and look for better ways of functioning in their units (see 4.2.2.2).
- An increased need for budgeting skills in the current health care environment where the unit manager is expected to always 'do more with less' was expressed. Financial management skills are required for ordering and obtaining the necessary human and physical resources for their units (see 4.2.2.7).
- Unit managers indicated urgency for the development of computer literacy skills. However, some unit managers mentioned that they find computer work time-consuming and would like somebody else to do the computer work for them (see 4.2.2.10). In the 21st century – the Quantum Age – with its technological advances, health care leader-managers need to stay abreast of new technology and have to positively motivate staff to develop their technical abilities.
- Change management was indicated as one of the health care unit manager's most important roles in the 21st century with rapid changes in health care a constant. According to participants this role includes motivating staff to accept change, letting go of current practices and adopting new standards of practice. It involves guiding staff through the disruption change may cause in their practice environments, as well as restoring the equilibrium as soon as possible. Change

management was described as challenging due to staff's resistance to change and the reality of some members of staff having stagnated and stuck in old habits and ways of getting the work done (see 4.2.2.3).

The skill of quantum thinking enables one to use innovative and creative ways when planning and organising (Shelton, 1999:33-53). Computer skills and budgeting skills reveal the changes the Quantum Age has brought about. For health care leader-managers to be successful in their current dynamic environments, it is essential to achieve new skills and competencies and to use technology to their advantage.

Skills required with regard to human resources and that were indicated by the unit managers include conflict management, communication, interpersonal, motivation, participative leadership and staff development skills.

- Unit managers need conflict management skills to manage conflict situations arising with and between staff, with patients, and visitors. They need to normalise conflict by implementing proven proactive measures and by building integrated conflict management systems (see 4.2.2.4).
- The importance of having good communication skills were highlighted by unit managers. There need to be open communication channels between the unit manager, senior management, unit staff, other members of the multidisciplinary team, patients, family members and the public/community the organisation serves. The unit manager provides feedback from management to staff members and acts as advocate for staff by communicating staff needs and complaints to management (see 4.2.2.6).
- Unit managers realise that they need good interpersonal skills as leaders of the unit team, comprising of nursing staff and other members of the multidisciplinary team. They have to relate to patients, visitors, senior management and members of the community (see 4.2.2.8). They viewed participative leadership skills as a requirement for consulting with staff and others on matters where decisions have to be made concerning the functioning of the unit. Regular meetings with unit staff aid in the process of participative leadership (see 4.2.2.9).

- In the current health care environment, due to staff shortages, absenteeism and resistance to change, unit managers experience staff development as

challenging (see 4.2.2.5). They are responsible for the teaching, training and growth of the staff allocated to their units and have to identify staff's needs, plan opportunities for training and development, create skills development sessions and evaluate the effectiveness of such programmes.

- Unit managers regard staff motivation as extremely important and believe that they need to be creative and compassionate. When staff members feel the work they do is appreciated, and when they are allowed to function autonomously, they develop positive attitudes towards their work in the unit (see 4.2.2.11).

In managing human resources unit managers can utilise all seven quantum skills. Leader-managers who are competent in the skill of quantum seeing, model the ability to identify and test assumptions and beliefs. They give all staff involved in the functioning of the health care unit the right to have different perceptions. To reach win-win solutions for conflict and resistance to change, leader-managers require paradoxical thinking skills (quantum thinking), in order to find a fully acceptable solution to divergent points of view. The skill of quantum feeling, the ability to feel vitally alive and fully energised, regardless of external circumstances, will enable health care leader-managers to instil positive emotions in their staff, which are believed to increase coherence and staff motivation (Shelton, Darling & Walker, 2002:56). When leader-managers utilise the skill of quantum knowing, they treat people respectfully with deep intuitive insight, creating a climate of mindfulness, which leads to the discovery of more creative solutions to difficult challenges. The skill of quantum acting can enable health care leader-managers to model new ways of viewing and responding to conflict. They realise that, as they change their thinking and acting, the surrounding energy field is transformed. Quantum trusting enables leader-managers to guard against intercepting or resolving problems and challenges for others. They rather support and encourage others to use their inner wisdom to discover innovative win-win solutions. The skill of quantum being enables leader-managers to develop their emotional competencies. They learn to own their feelings rather than projecting them on others. In doing this they discover that all relationships are learning opportunities and difficulties begin to generate fewer negative emotions (Shelton & Darling, 2004:22-41).

5.2.3 Current challenges health care unit managers experience in their work environment

Challenges indicated by the health care unit managers appear to be workforce challenges, personal challenges and organisational challenges.

Workforce challenges

The challenge most frequently mentioned by participants was the staff shortage due to a growing population, an ageing workforce and the migration of nurses. The consequences of staff shortage are burnout, absenteeism, difficulty when delegating duties and responsibility and difficulty in rendering quality care to patients. Despite the measures (discussed in chapter 4), which were implemented by the South African Government and Departments of Health, staff shortage remains a serious challenge in health care and extensive measures are needed to attract people to the nursing profession (see 4.2.3.1.1).

Staff performance appraisals pose a challenge to unit managers because staff experiences it as an unfair process and not all staff members have the ability to write good appraisals. While this was implemented to be a fair, objective and transparent system providing equitable rewards and recognition, it is challenging to health care leader-managers to manage the performance of their staff members (see 4.2.3.1.2).

To manage a multigenerational workforce proves challenging to unit managers because each generational group has its own motivational factors and views of change. It is important that health care leader-managers are aware of the differences between the age cohorts in order to create a work environment conducive to growth and good relationships for all staff members (see 4.2.3.1.3).

Although the participants viewed the empowerment of staff members as very important, staff shortages, high absenteeism rates and high workloads pose challenges to unit managers' desire and ability to empower their staff members (see 4.2.3.1.4).

Personal challenges

The workload of health care unit managers has increased due to demands from staff, colleagues, patients, families and the wider organisation. Their roles are complex, ambiguous and demanding and they need to prioritise their work responsibilities and play an important role in the relationship building in their units (see 4.2.3.2.1 and 4.2.3.2.2).

Organisational challenges

Managing the equipment and stock the unit needs to provide quality care to patients poses a huge challenge to unit managers. Stock is not always available in the necessary quantities, waiting time for stock to arrive can be up to six weeks and communication channels are not always open (see 4.2.3.3.1).

5.3 CONCLUSION

Although Shelton's (1999) quantum skills model is not well-known in nursing science, it was possible to connect the skills health care unit managers need, and the role they have to fulfil as health care leader-managers, to the quantum skills.

It is evident that unit managers, as leader-managers, need both human resource skills and organisational management skills. Apart from the generic management skills, it was evident that they need leadership skills to perform their task.

The challenges health care unit managers currently are experiencing are workforce-related, with the shortage of staff being a serious challenge while striving to render quality patient care; personally they experience an increased workload and role diversity, and the management of equipment poses a challenge to them.

5.4 RECOMMENDATIONS

Recommendations are made with regard to nursing practice, nursing education and nursing research.

5.4.1 Recommendations for nursing practice

Recruitment of new nurses must be increased and retention should be improved. Wildschut and Mqolozana (2008:61-64) recommend that strategies and initiatives aimed at rectifying the impact of nursing shortages should concentrate on: (1) the retention of the nurses South Africa is producing; (2) the recruitment of nurses now working in other professions, and (3) identifying specific provinces and areas with shortages, as well as whether the shortages in provinces are in the public or private sectors.

Health care unit managers need to become politically astute and influence policy decisions regarding nursing service design, delivery and education (Jooste & Jasper, 2012:56). It is important that all stakeholders know the actual nurse–patient ratio and what a realistic ratio should be to appoint nurses in different categories.

In-service training for health care unit managers, as well as all staff on the Staff Performance Management System, can educate all involved on the who, what, why, how and when of the process. Staff should be treated fairly, without bias, and time should be spent with each staff member in order to evaluate them, as well as to identify strengths and weaknesses. The process should be utilised as a measure to motivate staff, not to negatively influence them.

Health care unit managers should be aware of the different age cohorts of workers and what they experience as important in their work environment. Staff in-service training can be given on the characteristics of the different age cohorts, the Baby Boomers, Generation X and Generation Y, so that unit managers are well-informed. This may lead to a better understanding of the different age cohorts. It should be recognised that every staff member, irrespective of the age cohort he/she represents, brings unique features and skills to the organisation – these need to be positively reinforced. Health care leader-managers should reframe perceptions about generational differences and view them as potential strengths (Sherman, 2006:1). Staff should be encouraged to tolerate their co-workers in other age cohorts.

Staff empowerment can be enhanced when unit managers provide an empowered work environment. This may be developed by providing staff in the unit with mentoring (both by peers and senior staff members); access to online internal and external sources,

which can make information more readily available for clinical care decision-making. In the Quantum Age, with its technological advances, computers need to be available to all staff members; educators and clinical nurse specialists need to play a key role in ensuring that innovative practices are implemented, staff is supported and knowledge needs are met and adequate resources – both human and physical – are critical workforce factors.

Health care unit managers should be supported by senior management on administrative matters, as well as human and physical resources. Senior nurse leaders should formulate directives for appropriate structures and processes to advance a multidimensional approach to support unit managers, as well as to create reasonable and realistic work expectations.

Communication between the health care unit and internal stock providers need to improve. This can be achieved by organising regular meetings between senior management, health care unit managers and stock providers to discuss challenges and build rapport.

5.4.2 Recommendations for nursing education

It is recommended that personnel development sessions be organised in the form of information sessions on quantum skills. For unit managers to develop quantum skills group discussions and seminars may be organised where unit managers conduct literature searches and actively participate by pair sharing and working in pairs, discussing and exploring the quantum skills.

Quantum skills are inner-personal by nature. For unit managers to understand their inner person they need to embark on a journey of self-awareness and self-understanding (Snyman, 2007:87). At the heart of self-awareness, according to Goleman (1998:54) are intuition and feelings, which are messages from a person's emotional memory, which in turn is his/her reservoir of wisdom and judgement. Self-awareness allows leader-managers to realise their strengths and weaknesses and where improvement is needed. It allows them to learn from experience, have self-confidence and know how their feelings affect their performance. Self-awareness also

refers to knowing and understanding oneself as a thinking and feeling individual who interacts within an ever-changing health care environment (Jooste, 2009:143, 245).

Shelton (1999) introduces specific techniques for learning and using the quantum skills.

- To develop the skill of quantum seeing health care leader-managers can learn the technique of thought-reframing, which is a process for monitoring, intercepting and changing non-productive thinking patterns. Affirmations, which are simple, short, positive statements of intentions, can assist in this process. Affirmations work best when written down and read often. A useful tool is a mind map. Displaying the mind map will provide a constant reminder of what it is that one desires to create. Using this visual aid results in increased consciousness of one's intentions. It is also a useful tool enabling unit managers to better organise, prioritise and integrate their daily activities (Shelton, 1999:24; Zipp, Maher & D'Antoni, 2009:59-69).
- Individuals think differently. Analytical, linear left-brain thinkers process information differently from creative, intuitive right-brain thinkers. For health care leader-managers to develop the skill of quantum thinking they need to awaken the capacities of the right brain. The right hemisphere of the brain "thinks" in images, not words. The practice of 360º imaging is a useful exercise to improve imagistic thinking. As health care leader-managers practise 360º thinking they learn to see multiple possibilities and creative options for their daily challenges. Whole-brain thinking is thus encouraged. Flexibility and fluency in thinking are required. This can be stimulated by brain-storming challenging issues. While organisations have valued left-brain thinkers more in the past, intuitive thinking is now being recognised as a valuable managerial asset (Marquis & Huston, 2009:16; Shelton, 1999:42-44).
- In order to use the skill of quantum feeling health care leader-managers need to open the floodgates of their hearts and allow unfelt, unresolved feelings to surface. The goal of quantum feeling is not to deny negative feelings, but rather to transform them. Regular physical exercise, deep breathing and music aid in improving positive energy flow through the mind-body system. Spontaneous and uncensored writing, through reflective journaling, aids in dissipating strong negative emotions, clearing them from one's system and thus enabling one to have greater emotional choice. Critical thinking is then increased as well. When

health care leader-managers use the skill of quantum thinking they develop response-ability - exercising their ability to consciously choose their emotional responses. Response-ability requires detachment, which is an important concept in nursing, to let things by and giving up one's need to fix and control, while viewing challenges and frustrations from a detached observer's viewpoint (Garrity, 2013:118-130; Zori, Nosek & Musil, 2010:305-313; Shelton, 1999:63-65).

The skill of quantum knowing can be enhanced by setting time aside for meditation. While meditating, one's intuitive knowing flourishes. Meditation has been shown to have major physical as well as psychological benefits and was also found to reduce stress and burnout (Birx, 2013:1895-1904). It has four simple requirements: a quiet environment, a focal word or image, a passive attitude and a comfortable position. When the rational mind is silenced, the intuitive mind produces extraordinary awareness enabling one to see things as they really are without the filtering lens of sensory perception; it assists one in creatively solving problems and transforming relationships (Shelton, 1999:86-89).

- The skill of quantum acting can be developed by becoming mindful. Mindfulness is the ability to bridge diverse disciplines and divergent thinking and implies that an individual is living in a state of conscious awareness of self, others and the environment and getting to know the unknown through other people's experience, thinking and ideas. Mindfulness allows a health care leader-manager to take a step back, and remove him/herself from an anxiety-laden situation to provide feedback to staff in a more conscientious manner, which is appropriate and defined for specified situations (VanVactor, 2012:556). Quantum acting acknowledges that there may be more than one right solution to any problem (Shelton, 1999:107).
- Quantum trusting can be developed by reflecting on challenges and problems, by turning within and connecting to a higher Intelligence to gain perspective and to release one's need to control all processes. Catastrophising may enhance quantum trusting, as the process of catastrophising is believed to assist one with realising that there are no catastrophes. A metaphor explicating this concept can be taken from nature, for example, for what the caterpillar calls the end of the world, the butterfly calls a beginning. When a person's ability to trust life

increases, his/her intentions begin to shift. He/She becomes much less concerned about designing his/her individual life, but much more concerned about bringing this life into alignment with the larger world. Catastrophising acts as a burnout and coping strategy (Shelton, 1999:127, 128; Subramanian & Kumar, 2012:1).

- The skill of quantum being may help health care leader-managers to create quantum relationships. To create this one needs to first have a clear sense of self. Quantum relationships emerge through dialogues with others. In times of change staff members expect leaders to focus on dialogue with them, which, in turn, aids in the prevention of resistance to change (Fagerström & Salmela, 2010:613-617). The word 'dialogue' comes from two Greek roots, *dia* and *logos*. Literally interpreted this means "meaning flowing through". Dialogue occurs when two or more people are willing to suspend their assumptions, beliefs and judgements and listen deeply. New meaning flows through such an encounter. The basic principles of dialogue are the ability to listen intently, the commitment to suspend judgement and the willingness to have one's beliefs and assumptions transformed (Shelton, 1999:150, 151).

Shelton (1999:7-9) further describes how the seven quantum skills relate to workplace concepts of vision, values, strategy and structure. The skill of quantum seeing is pre-requisite to vision implementation, the skills of quantum knowing and quantum thinking are required for strategy innovation, quantum feeling and quantum trusting are skills necessary for participative organisational structures, while quantum acting enables all employees to translate shared values into individual behaviours.

5.4.3 Recommendations for future research

- This study can be repeated in other public hospitals, primary health care clinics and community health care centres with health care unit managers/operational managers participating.
- This study may also be repeated to include health care unit managers from the private sector in order to make comparisons and identify differences.
- Managers other than unit managers, such as assistant directors of nursing services, nurse educators, registered nurses and students, may participate in a study similar to the current study.

5.5 CONTRIBUTIONS OF THIS STUDY

Knowledge of the quantum skills may assist health care unit managers in developing new skills necessary to function as health care leader-managers in the 21st age, the Quantum Age. All other categories of health care workers may find the information on the quantum skills as motivation. Students can be introduced to the skills.

5.6 LIMITATIONS OF THIS STUDY

Qualitative studies are contextual; they, therefore, make generalisations to other settings problematic. This study was conducted with health care unit managers of one public hospital in one province only and did not include health care unit managers from the private sector.

5.7 REFLECTION

I would like to call this study *'Elmarie's journey of five mountains'*.

Each chapter felt like a mountain I had to climb, moving up and down, back and forth. And, although I am familiar with Lao-Tzu's saying "a journey of a thousand miles begins with a single step", I often wondered why I took that first step on this journey. Now I know …

I learned an amazing lot! From quantum and chaos theory and complexity science I learned that I must have a vision and mission, think creatively, be energetic and motivated (vitally alive!), be confident in my intuitive decision-making, act responsibly, trust life and that I am very definitely not alone in this world – I am always in relationships: with God and with the most wonderful people.

I learned that courage does not always roar; sometimes it is the silent voice at the end of the day saying: "I will try again tomorrow" (Mary Ann Radmacher). I learned to persevere – I realised each mountaineering expedition leads to an oasis somewhere in the distance.

Conducting this study was challenging, very much so, but, in the end, the joy of being able to complete what I have started truly and completely overshadows the sorrows and challenges.

I do realise, though, that I am not yet an expert in mountaineering or in research and I look forward to whatever may follow …

5.8 SUMMARY

This study has assisted the researcher in understanding the views of health care unit managers with regard to their role as health care leader-managers, the skills they perceive they need, as well as the current challenges they experience in their work environment. The use of a qualitative, exploratory, descriptive and contextual design using semi-structured interviews for data collection has enabled the researcher to obtain rich descriptions of the health care unit managers' experiences. Their experiences form the basis on which the researcher synthesised the findings, came to a conclusion and proposed recommendations.

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UNISA university of south africa

UNIVERSITY OF SOUTH AFRICA
Health Studies Higher Degrees Committee
College of Human Sciences
ETHICAL CLEARANCE CERTIFICATE

HSHDC /3/2012

Date of meeting: 26 January 2012 Student No: 0873-135-7

Project Title: Challenges of the health care unit manager as leader-manager in the 21st century, the quantum age.

Researcher: Elmarie Smal

Degree: MA Health Studies Code: MPCHS94

Supervisor: Prof E Potgieter
Qualification: D Litt et Phil
Joint Supervisor: -

DECISION OF COMMITTEE

Approved [√] **Conditionally Approved** [ ]

Prof E Potgieter
CHAIRPERSON: HEALTH STUDIES HIGHER DEGREES COMMITTEE

Dr MM Moleki
ACTING ACADEMIC CHAIRPERSON: DEPARTMENT OF HEALTH STUDIES

PLEASE QUOTE THE PROJECT NUMBER IN ALL ENQUIRES

Annexure B

Request to conduct research

PO Box 127
George
6530

The Deputy Director Nursing Services: George Hospital
Postal Address: Private Bag X6534
George
6530

Physical Address: Davidson Road
Heatherlands
George
6529

Dear Ms Venter

Re: Research project for MA (Health Studies)

I am conducting a research project on the challenges of the health care unit manager as leader-manager in the 21st century, the Quantum Age. The purpose of this study will be to explore the challenges health care unit managers experience in executing their leadership and management roles and the skills health care unit managers perceive they need as leader-managers. This study will be conducted under the supervision of Prof E. Potgieter of the Department of Health Sciences, University of South Africa (contact number: 012 - 429 6545).

I hereby wish to request permission to conduct interviews with unit managers at the George Hospital.

Confidentiality will be adhered to and the results of the research will be disseminated. The researcher will ensure adherence to the highest standards of research planning, implementation and reporting.

Should you have any questions with regard to this research, I will be pleased to answer them (contact number: 083 304 3569).

Yours faithfully

Elmarie Smal
(MA researcher)

Western Cape Government
Health

George Hospital
Nursing Services
Enquiries: Ms. CE Venter

Ref.: Smal, E (Permission - Research)

Ms. E Smal
P.O. Box 127
GEORGE
6530

RESEARCH PROJECT FOR MA (HEALTH STUDIES)

Your request for conducting a research project on the challenges of the health care unit manager – "The Quantum Age", and your request to conduct interviews with the unit managers is hereby granted.

Best wishes with your research project.

Regards,

Ms. CE Venter
Deputy-Director: Nursing Services

Date: 10 July 2012

Annexure D

Information letter to participants

Dear Unit manager

I am conducting a research project to establish the challenges of the health care unit manager as leader-manager in the 21st century, the Quantum Age. The purpose of this study will be to explore the challenges health care unit managers experience in executing their leadership and management roles and the skills health care unit managers perceive they need as leader-managers. This study will be conducted under the supervision of Prof E. Potgieter of the Department of Health Sciences, University of South Africa (contact number: 012 - 429 6545).

It will be requested from you to conduct an interview with the researcher. The interview will be no longer than 30-45 minutes and the time will be negotiated with you. Your participation is of the utmost importance to me.

The researcher will adhere to your right to privacy and confidentiality.

Your identity will be protected. Your answers are confidential and your name will not appear in the research report. You have the right to withdraw from the study at any time during the study without any consequences to you. The research results will be made available to you on request.

The researcher will ensure adherence to the highest standards of research planning, implementation and reporting.

Should you have any questions with regard to this research, I will be pleased to answer them (contact number: 083 304 3569).

.

Yours faithfully

Elmarie Smal
(MA researcher)

Annexure E

Consent form participants

CONSENT FORM

I …… (Name) hereby give Elmarie Smal (contact number: 083 304 3569) consent to use the information obtained from the interview in her research as part of her MA Degree in Nursing Science.

The researcher is conducting a study to establish the challenges of the health care unit manager as leader-manager in the 21st century, the Quantum Age. The purpose of this study will be to explore the challenges health care unit managers experience in executing their leadership and management roles and the skills health care unit managers perceive they need as leader-managers. This study will be conducted under the supervision of Prof E. Potgieter of the Department of Health Sciences, University of South Africa (contact number: 012 - 429 6545).

I understand that:

- I have the right to withdraw at any time without any consequences to me.
- My answers are confidential and my name will not be used at any time.
- Information obtained will only be used for the purposes of this study and not for any other purpose whatsoever.

Participant's signature ……

Date ……..

Annexure F

Interview schedule

Interview questions

1. As a health care unit manager, how do you see the role of a leader-manager?

2. Do you experience any problems in executing your leadership and management functions in your current health care environment?

3. What skills do you perceive you need to be an effective leader-manager in your current work environment?

Probing questions:

- How do you ensure quality in your unit?
- How do you view and manage crises that arise in your unit?
- How do you motivate yourself and others?
- How do you make decisions?
- How do you nurture win-win relationships in your unit?
- How do you experience transformation in nursing and the workplace?
- How do you ensure good teamwork in your unit?

Annexure G

Transcribed interviews

Interview 5

15 August 2012

12:45

Researcher: Good day ....

Interviewee: Good day.

Researcher: Thank you for allowing me to have this interview with you. In front of you your consent form. Thank you for completing that. Then I've given you an information letter. I just want to go through that with you again. You know that I'm doing interviews, that I'm tape-recording it; then I'm transcribing and I'm using it for my research. Your identity will be protected. Your answers are confidential and your name will not appear in the research report. You have the right to withdraw from this study at any time during the study without any consequences to you. The research results will be made available to you on request. I will ensure adherence to the highest standard of research planning, implementation and reporting. And any questions you have about this research; I will be pleased to answer them.

Interviewee: Okay.

Researcher: And I've made a list of the interview questions, not really questions, the information we'll go through. The first one: as a health care unit manager how do you see the role of a leader-manager? Second one: Do you experience any challenges in executing your leadership and management function in your current health care environment? And then: what skills do you perceive you need to be an effective leader-manager in your current work environment? You can start with whatever you like.

Interviewee: My role as a health, as a leader-manager is, how do I say it, it is a quite challenging one, because I'm currently working in this very busy surgical ward and hmm sometimes I have to be really as a sister in the ward as well as the manager because of personnel shortages and hmm I see my role as you must lead from the

front, you must be an example and all times, to be on time in and absenteeism profile must be very good and hmm, you must not be, you must be consistent in your managing area with everybody, not preferences for the people must not see you are nicer with some people. You must be consistent. And hmm, you must be honest, all this quality standards and hmm and I say you must lead from the front, you must adhere to the deadlines and everything, 'cause you expect the people to do the same. And if you get some responsibilities or extra things to do from your manager, then you need to do it. And I see my role, you must also sometimes drive stuff. If there's new stuff, like this core values, you are the one to drive this now and let everybody be on par, or if they do not know you must know at first what you must doing and tell them what to do. So, yes, is there anything more or quite a lot.

Researcher: Fine, I think.

Interviewee: And showing this in the executing of my leadership is ultimately we are struggling with personnel shortages, we've got a few nurses in that ward, the surgical, 28-bedded ward. There's only now, to be exactly, only 2, 4, 5 nurses and I think we need 3 or 4 more, just for the nursing care part, because that is left behind sometimes because there's no nurses or health care workers to help with that function or that responsibility of looking after the patients' hmm, needs, like their hair, combing their hair, look at the nails and pressure parts and stuff like that, mouth and pressure care, mouth care and hmm the other thing the sisters, the senior, they also need to work as staff nurses because of the personnel shortages, or the imbalance now, because we've got now more sisters than nurses or staff nurses and there is quite a huge imbalance now with all this upgrading of the nurses, I mean the nurses that were nurses, now they become staff nurses and the staff nurses do the bridging course and they're now sisters. So that is quite challenging, especially when you must do your "wissellys"

Researcher: "Jy mag Afrikaans praat, hoor."

Interviewee: Okay. When you do. ja, that monthly "wissellys".

Researcher: Oh, when you decide who's working in the ward.

Interviewee: Ja. Because then you must ask for extra nurses from other units or from the education department as well, because the teaching department must help us out with nurses on night duty or on day duty. Then there's also this absenteeism, like for today especially we are only 4 on duty and I need to ask now for more nurses from other and the absenteeism profile from nurses in the whole hospital is so poor…….

So… You must ma then look where you can fit in and what you can do so that they, the nurses in the ward, can see that you are also there for them and there's also care that they are working so hard. Ja, and then is also difficult to get the sisters to do their administrative tasks or their supervisory skills, because they must now do all this stuff that the nurses must do. So they are not into to look after the equipment or after, hmm, certain supervisory duties that they must look, hmm, after the, hmm look after the, what do I say now, and writing of reports and the medication… and we now get this community service nurses too and we do not know on what level they were educated. So now we must now think how are we going to help them and how we are going to assist them, you know, how are we going to use them in the wards, hmm…And then you get this that patients don't get their medication right as they are prescribed sometimes, because "hulle is so haastig om hulle werk te doen dat hulle, partykeer kry pasiënte 3 x per dag, sê maar 4 keer 'n dag se medisyne 2 x want dan het hulle nie reg gelees nie, want partykeer word die voorskrif geskryf nie soos jy altyd verwag dit voorgeskryf word nie. Daar is 'n verskil in wat die dokter wil hê. Want nou met die gewoonte dit word 2 x 'n dag voorgeskryf, nou's dit skielik 4 keer, nou let hulle nie op nie , nou kry 'n mens dat vir 2 dae kry hy sy medisyne net 2 x waar hy dit 4 x moes gekry het of die dosis, ons is gewoond aan 'n dosis van 20mg, nou gee jy vir hom 20 mg, maar dokter het 40 mg voorgeskryf. So dis, dit veroorsaak ook, die personeeltekorte dat daar medies-geregtelike risiko's kan plaasvind en dit is 'n uitdaging vir ons. En dan hmm,……..I just show the people this morning a pressure sore report that somebody wrote, a sister, a newly trained sister, but it was so poorly wrote, but I see it is also because of, I don't know, lack of knowledge or I don't know, but, or maybe under pressure they write the report so half-half. "Ja, en dis ook uitdagings om jou bestuursfunksies heeltemal uit te voer want dit kom daarop neer dat jy soms als moet doen. Jy moet soms als doen wat, evaluerings van

verpleegdokumentasie, die evaluering om te kyk na die volledigheid van die dokumentasie, was die inventaris gedoen, kyk na die netheid van die saal, kyk dat bevele uitgevoer word en al daai. So dit is, kyk dat mense medikasies reg toedien en dat daar nie medies-geregtelike risiko's plaasvind nie, veral die toerusting, kyk dat dit in werkende orde is en almal verwag van jou om als te weet en waar is alles as dit nie daar is nie. So, jou oog moet elke dag wees op jou toerusting, weet waar dit is en wat is daar, want waar is dit nou heen. Soms moet jy dit sommer self gaan soek ook. So dit is 'n uitdaging en als. En dan moet jy op hoogte bly van al die dinge, van al die nuwe dinge en vir… "Change to the English? You need to be on hmm, you must always be ..

Researcher: Continuous education?

Interviewee: Yeah, you must know the new things that is happening in your work environment, new equipment, new…like this core values. Things don't stay the same, there's always changing. So, you must be, you must be on, sometimes I think you must a leader of it also. What skills do I need as an effective leader-manager. I think you need to have some education skills, so, there's…sometimes you need to do this on-the-job training. in-service training and you are suppose to know what you are talking about and you must also have the skills to, to like education skills so that people can actually understand what you are dealing with and talk on their level and you also you must look at so everybody in the work environment, especially the household staff, also to see that they are doing what they're supposed to do. So…and you must also tell them the correct way to do certain things, especially we got now new, we have the cleaning staff, so you must teach them how to do the stuff, how to do everything and you must have the skills also to do the Staff Performance Management System and to manage the performance actually of the people you have under your supervision so that they are working on standard and not off standards. Quality control, that is also for me a skill that you need to have especially we are now busy with this Best Care Always project that's coming from National level and we are busy with preventing of this catheter associated urinary tract infection. So you must implement it in the ward, you must drive it and you must prepare everybody, hold your finger on it. I was for 2 weeks on leave and there was 2 days that it was not done properly. So…And the other thing that you need actually

somebody that can look after the staff in the ward as you do. Hmm…one of your seniors, nurses or 2 and you must actually have the skills to bring out their leadership skills as well – to enhance or to develop these leadership skills. And then, nowadays, with this computer device, you must have your computer skills and always improving it and another thing, to go for the courses.

Researcher: Is it a challenge as well?

Interviewee: It is a challenge as well, yes. So, but to do your job you must have it. The people expect from the management to know everything. They ask you how, what number do you call. Then also this, you must have the skills how to order stock and equipment also, this supply chain management, hmm…their orders and their hmm…their policies, you must be able, you must know that. Be equipped to communicate with them. Well, is there anything that I can add? The other is also this research is also there is, I think a big gap in the unit. It is also a challenge to get people involved to hmm…because there is, there is really a need in the ward to do this research, because we do get certain cases that you are wondering how did it happen, is things happening, who is involved and all that, but seeing that the people are so busy and you can't do everything and you are so busy; at the end of the day you're tired, so you don't get to everything and to involve people in it actually. And the other challenge…we are going to be now a functional financial business unit and that is skills that we need to develop or enhance or become to manage our hmm…our units and as a business unit we will get our own budget and personnel and we must use them and we must decide with the, this head of the department which is a surgeon to, so you must have open communication with him as well and with the doctors so that you can work within your budget. So there is no over-expenditure or anything of the equipment or stuff like that as well as our supply chain stock.

Researcher: That's very interesting.

Interviewee: About this functional business unit?

Researcher: Ja

Interviewee: We're going to have a discussion tomorrow with dr Emmink, he's now the head of the department, he and… I did ask him, because you must have open communication with these people, you must know what you are doing in the wards and you must get their input as well in everything that you do. So..

Researcher: That is, so do I understand correctly, when you make decisions you also consult with your staff?

Interviewee: Yeah and especially sometimes they do the off-duties and when I see that it's not right, I do corrections; then I told them why I did it. I have a challenge now, a sister challenged me this morning about there's 6 people on the one shift and only 5 people on the other shift and now they tell me this and this and now it's just not for the conflict to go talk to that personnel and to tell them why they are this and the other small so that they can understand why you're deciding, why did you decide to do it like that.

Researcher: You also need conflict management skills?

Interviewee: You do, you do need conflict management skills. You can't really, as a manager you must always think, think, you're always thinking, you must always take all the people's feelings in consideration when you do certain, because they are not only here to work; they're families, they have family members.

Researcher: You must be compassionate.

Interviewee: Yes

Researcher: Tell me, intuition. You ever have this gut feeling that you must do something?

Interviewee: Ja, sometimes you do have and sometimes you don't listen but sometimes you so and then your gut feeling is actually the right thing in that position. So especially when you know, you foreseen, this people now okay they're sick from

their shift, but you know on their shift there's still people who've got back problems. So there can be some absenteeism, so you must think you need and you must cover that or you know that shift is not so strong than the other shift. No… everybody is not the same. Everybody is not the same. You've got your strengths and weaknesses, everybody.

Researcher: Ja.

Interviewee: All of us do have that.

Researcher: Okay. Any other skills you can think of?

Interviewee: Yes, creative, you must hmm…I hmm…when they say, when there's a new ward opening they get all new stuff, the old get thrown away. Then you can look at the equipment and see whether you can use it. So now I see that we don't have this runners that you can put the trolleys, the buckets in with what they use for the patients. So I go and see and it was not painted and what and they're old and need oil, the wheels need oil. So I went there and also the "linne" trolley and then…where you're going with all this old stock? I filled in a requisition for it to be painted and now we're looking well. We have these buckets and you don't see all this stuff on the linen trolley and it happens that we put it in or on the linen trolley, dirty linen trolley, then it goes down to the linen bank and then we get this report why do you put this. So now that's, they can't say now that you don't have an excuse for the buckets in the linen trolley.

Researcher: That's very nice.

Interviewee: Yes, so I speak to them and you also get this things you can put stuff in and I also got some of that in my office and everything looks new. So you must always be creative and look how you can do things better and smarter things and see how can you make this unit always nice for people to come in ad have the feeling of belonging or somebody wrote in a letter once when he came there is the people are strict, but you see they are always, they do it for the patients' concern and for their wellbeing and they also feel that there's some sort of homely feeling and that is what

I would like the people to say when they go out there and the personnel treat them efficient, they feel they are special when they were there.

Researcher: Caring.

Interviewee: They could feel the caring of the personnel, talk to them, wash them, everything that you do with patients. And if people come in there that they see it's a clean ward. They are now busy, one of the cleaners is now busy with cleaning the floor. She don't need to buff the floor, but I could see that she feels proud of her work in the ward. And I also feel proud, that is another thing that I want to like the people, they must feel proud to work there and everything must have their own place in the ward; you must know the trolley is standing there, these you'll find there.

Researcher: Organised.

Interviewee: Organised. They're not "deurmekaar". 'Cause I always say anybody can walk in here, it could be the minister, it could be anyone and then we must not have, not run around to get everything organized. They must come and see anything is clean and we are busy with scientific nursing and we must look like we are rendering effective nursing care for the patient. Then our documentation must also be complete and neat. We must always try to rise our degree if quality care or standards of care that we are render in the ward, because of the things I've, my expectations of the staff that my standards are too high. I think that I always feel if you do something, you must do it to the best of your ability so that nobody else can come and, back and come and do your work that you do half-half, complete it for you.

Researcher: Vision? Mission?

Interviewee: Yeah, we have our vision and mission on the hmm …"kennisgewingbord", the ward's and the hospital's, the vision and the mission is there displayed. Then we want to be the best surgical ward
in this region or South Africa.

Researcher: Good.

Interviewee: Because people, the come and tell us, they say that this hospital is one of the best hospitals in South Africa. So we feel that we must be one of the best wards in South Africa or people must compare us with, even with the private sector. We received such a letter two months ago that somebody wrote that we can be proud to be, to have such a service that we are rendering, this hospital.

Researcher: Oh, that's nice.

Interviewee: Very nice and we don't have to feel ashamed for the private sector.

Researcher: Not at all.

Interviewee: So, that's also what I would like, we must keep our standards high, always.

Researcher: You've describe for me that you must look for nurses elsewhere and so would you say you need to be flexible?

Interviewee: You need to and the nurses also need to be flexible hmm…because sometimes you need, you must ask them to go on night duty if there's shortages of night duty; then you got more on duty that day and, or ask them if they want to change their shift maybe for the weekend to work all weekend night duty. That's why you must have good relationship with your personnel so that they feel that they will do it for you. That's also a skill that you need, that is relationship skills, good relationship skills, because…it is something that she says to one of the sisters and she said thank you, you didn't chase me away.

Researcher: Listening skills, hey?

Interviewee: Listening skills and that is a thing that I need to work on because sometimes I can listen and not hear. Active listening skills, yes. Because people need to know that you're actually listening to them and that you actually not just listening but that you are going to act on what they say to you. If they are

complaining, they want to see that something's been done to their complains, as well as the patients. When they are complaining then you must look into the matter.

Researcher: Okay. Anything else?

Interviewee: Ja, I think nowadays, to empower the people in our ward, especially the sisters, it can actually be a challenge because of the shortage of the personnel. The persons, the personnel on our ward that we must have so sometimes you start with something and then suddenly you must stop because you can't go further because she must now be doing something; you can't say I'm now going to take you now for two weeks and to empower you, but you must try.

Researcher: Patients as well?

Interviewee: Ja, ja patients should look after themselves, but now also this, the health education, the giving of health education, it's also a big, it's actually not a challenge, but hmm.. .we must see that the people must know, you now, you're working with patients and you must tell them how they must look after themselves. How they must look after themselves, how they must care for themselves when they go home or in the hospital, how they must also hmm, hmm…

Researcher: Best care to themselves.

Interviewee: Ja, also "hulle moet hulle, wat wou ek nou sê? Hulle moet hulled eel doen." Their part, they must do their part to improve their health and and hmm…and really to, if they go out of the hospital they must say now I know I must do it this way and I must take medication this way. They must have a better insight into their health position than when they came into the hospital. Then we know we actually did something for that patient. That is why health education, I've made a file now for people to give to the patients on certain conditions, what they can hand out if the patient have an injury, they can give them the pamphlet: if this happens, then you need to seek help or this is what you must do for you, when you come for a colonoscopy or when you had a colostomy, it's like a booklet that we give them. But they must just, the person, the staff must become more aware to actually give the

patients this health information. I always tell them when you write a “raming”, assessment of patients, don’t just write, tell the patient at the action part when you must say; it’s your data, your interpretation, DIA, and your action. So you must actually write and talk to the patient, told them that you must sit up and you must move to prevent certain things like emboli or to prevent pneumonia post-operatively, especially when you draw up a careplan we also talk to them, the patient and tell them pre-operatively why they need to be nil per mouth, why we need to do an ECG, why the doctor must draw the blood, why certain things are happening to him, before the op, he will have a drip in, or they going to put in, you must tell the patient, the patients must know, and they will come and thank you it was better.

Researcher: Okay. Tell me the policies in your ward… Do you do audits?

Interviewee: Yes, we do monthly audits, 2-monthly audits especially on the nursing documentation and we do this monthly audits of the safety environment, health and safety environment of staff in the ward. You look at the risks and health risks in the ward and now we are also busy with this core values so we need to look at everything, our patients, how they perceive how we give the medications to them, how we do blood transfusion after they, everything actually that we do. How neat is the kitchen, how we give the patients their food ant that’s quite a lot of stuff that we need to evaluate actually to see because thing is that we must see that the patient..

Researcher: Sorry. Is that… are we talking about the Core National Standards?

Interviewee: Ja, the Core National Standards.

Researcher: Ja. Okay.

Interviewee: Ja, it is the core values and the Core National Standards. We have the core values and the core standards that we are now busy with. They have this 9 months for the core values and they want to see how we make it happen in the wards. We have this champions that we must chose and then we must decide how we’re going to act, make it happen. We chose one, a core value, then we chose

care, how will we make it happen to improve that in the wards. And we have 2 monthly to improve that and then we move on to another.

Researcher: Okay.

Interviewee: I think it's quality that we do need to have it, a person, but sometimes we just need to enhance it. We don't know how to be a caring person or how to be responsive and…

Researcher: That's very good. You've given me such a lot of information. Thank you very much. One last thing please; I am now going home and I am going to transcribe this, verbatim, exactly like you said, then can I please come back to you afterwards to member checking – to ask maybe is this what you meant?

Interviewee: That's fine.

Researcher: Thank you.

Interviewee: Okay.

Researcher: Thank you very much.