STUDENT NURSES' PERCEPTIONS OF THE NURSE MANAGER AS A 'SERVANT LEADER'

K. Jooste, D Litt et Phil
University of Western Cape
School of Nursing
Correspondending author: kjooste@uwc.ac.za

E. Jordaan, MCur
University of Johannesburg
Department of Nursing

ABSTRACT

South Africa focuses on service delivery at primary health care (PHC) clinics. A 'servant leader' could guide student nurses towards service delivery at PHC clinics. The purpose of this study was to describe the role of nurse managers acting as servant leaders of student nurses at some PHC clinics in the Johannesburg, South Africa, area. A quantitative, exploratory and descriptive design was followed. The accessible population comprised 302 third- and fourth-year diploma and degree student nurses enrolled at a university in Johannesburg and its affiliated nursing college who were allocated to PHC clinics for learning experience. A survey was conducted by means of a structured questionnaire which was returned by 288 (95%) respondents. The findings indicated that student nurses perceived shortcomings in the nurse managers as 'servant leaders' regarding empowerment, compassion and role modelling. Nurse managers should be briefed with regard to empowering student nurses, showing compassion and role modelling during interaction with them as well as building relationships of trust between them and the student nurses.

KEYWORDS: healthcare manager, primary health care, servant leader, student nurse

INTRODUCTION AND BACKGROUND INFORMATION

In the repertoire of leadership styles, the concept of 'servant leadership' is growing in popularity (Walumbwa, Hartnell & Oke, 2010:517). Greenleaf (1904–1990) is the scholar who reintroduced this leadership concept (Greenleaf, 1991:7–8). He stated that a 'great leader first serves, that begins with the natural feeling that one wants to serve, where a conscious choice brings one to aspire to lead' (Greenleaf, 1977:21–28). Servant leaders lead through their visible attitudes and actions, seeking to involve others in

decision making (Gersh, 2006:3). Certain aspects, such as empowerment, compassion, role modelling and the building of a reciprocal relationship based on trust, are all functional characteristics of a servant leader (Russell & Stone, 2002:2).

Servant leaders are required to focus on the development of other people and to consider identifying their followers' strengths and meeting clients' needs as being more important than their own interests (Washington, Sutton & Field, 2006:1). Servant leadership is also relevant in the primary health care (PHC) clinical area where student nurses are placed for their clinical training. The PHC nurse manager in charge of the clinic has the ultimate educational accountability to ensure student teaching and learning in practice. The nurse manager within this context is thus in the position to act as a servant leader.

In organisational settings, such as a PHC clinic, nurse managers could act as servant leaders by doing the following: devoting themselves to serving the needs of their followers (students); focusing on meeting the learning needs of those they lead; developing followers to bring out the best in them; coaching students and encouraging their self expression; facilitating personal growth in followers; and listening to what followers have to say in an effort to build a sense of community. By doing these things, nurse managers as servant leaders are effective by encouraging and facilitating their followers (students) to reach their full potential during their training, allowing them to perform at their best, which ultimately is better for the organisation as a whole (Washington et al., 2006:1).

At a PHC clinic, the educational focus is on the development of the student nurse as a servant leader to deliver health care services to the community. The primary motivation of servant leadership in nursing is to improve service delivery (Walumbwa et al., 2010:517). The PHC nurse manager in charge of the clinic should act thus as a servant leader to guide students towards effective PHC service delivery.

LITERATURE REVIEW

Servant leadership, as a recognised style of leadership, appears to be insufficiently supported by empirical research (Dennis & Borcanea, 2005:7). Research about servant leadership has focused mainly on servant leadership in relation to other leadership models and on the characteristics of a servant leader (Washington et al., 2006:1).

South Africa has a wide network of district health care service clinics staffed by health workers from various disciplines. Servant leadership should address the needs of all the team members, and should ensure that other people's highest priority needs are being served. It also refers to training students, enabling them to manage a clinic and to lead the activities at such a facility.

During an address by the late Minister of Health, Dr Manto Tshabalala-Msimang (2006), at an International nursing conference with the theme of 'We lead together', she expressed four salient concepts that could be directly linked to servant leadership. She appealed to senior nurses to embrace junior nurses and to guide them to develop into effective and responsible nursing practitioners. This statement indirectly indicates the importance of the characteristics of empowerment and compassion. She also emphasised that competent leaders are the most important resource to tackle challenges through role modelling and the facilitation of change. Thirdly, she mentioned the importance of leadership for improving nursing. She indicated that, if junior nurses were to be involved in the planning and implementation of programmes, their leadership attributes and clinical skills should be identified in order to develop these attributes and skills. Fourthly, she mentioned the importance of empowering followers.

Beukes (2005:347) states that nurse managers should recognise student nurses as human beings by including them in nursing actions and by not ignoring them. One of the most important duties of a role model, in this case the nurse manager at a PHC clinic, is to provide leadership to her followers, including student nurses. Shaw (2007:91) believes that leaders have an instrumental role to play as trainers in an attempt to change and shape their followers' motives, values and aspirations.

PROBLEM STATEMENT

During clinical supervision of student nurses at various PHC clinics, the researchers observed different kinds of leadership styles being practised by nurse managers. However, all these styles appeared to focus on self-interest instead of contributing towards the development of students into future leaders. This observation was substantiated by the students who expressed similar perceptions. It was unclear to what extent nurse managers were guiding the students in their capacity as servant managers.

Study purpose

The purpose of the study was to explore and describe student nurses' perceptions of nurse managers as servant leaders at PHC clinics in Johannesburg with the aim of making recommendations in this regard to nurse managers.

Definitions of keywords

A **student nurse** is a registered student with the South African Nursing Council (SANC) and enrolled for the third or fourth year of a four-year comprehensive nursing training programme.

A **professional nurse** is a person registered in terms of article 31 of the Nursing Act, Act No. 33 of 2005.

A **servant leader** focuses primarily on his/her followers (students) while the interests of the organisation are of secondary importance (Dennis & Bocarnea, 2005:2). For the purposes of this study, servant leadership focused on the aspects of empowerment, trust, compassion and role modelling in the interest of student nurses. All the nurse managers involved in the study were female.

Primary health care nursing refers to promoting preventative and rehabilitative health care offered at district level at a PHC clinic (Vlok, 2008:8–9). It is based on the primary health care approach.

RESEARCH METHODOLOGY

Design

A quantitative, exploratory and descriptive design was followed to explore and describe student nurses' perceptions of the nurse manager as a servant leader at a PHC clinic (Terre Blanche, Durrheim & Painter, 2006:167). Quantitative research involves a formal, objective and systematic process which employs numerical data to gather information about the phenomena of a study (Burns & Grove, 2005:23).

Population

The accessible population of the study comprised third- and fourth-year diploma and degree student nurses (N = 302) enrolled at a university in Johannesburg and its affiliated college who were allocated to PHC clinics in Johannesburg for learning experience. The accessible population comprised that portion of the target population to which the researcher had reasonable access (Polit & Beck, 2008:19).

No sampling was done as the entire accessible population of third and fourth year students (N = 302) assigned to PHC clinics, was invited to participate; 288 questionnaires (95.0%) were returned and used for data analysis purposes. Only diploma students completed questionnaires as no degree students happened to be assigned to the PHC sites during the data collection phase of the study.

Method

A survey was conducted in August 2009 to gather data from the identified student population (Burns & Grove, 2005:398; 06:569; Polit & Beck, 2008:511). A comprehensive literature review focused specifically on the functional characteristics of a servant leader. No previously developed instrument could be found during the literature review. A questionnaire was thus purposefully developed (Burns & Grove, 2005:400). Respondents took about 30 minutes to complete the questionnaire covering the following aspects: empowerment (15 items), compassion (10 items), trust (22 items) and role modelling (16 items). The closed-ended questions were based on a four-point Likert scale (1 = never, 2 = sometimes, 3 = often, 4 = always).

Data analysis

Descriptive and inferential data analysing procedures were conducted to process the collected data (Burns & Grové, 2005:461). A statistician assisted with the analysis of the data by using the Statistical Package for Social Sciences (SPSS version 10.0). Descriptive statistics addressed frequencies, mean values and standard deviations. The number of responses on items varied. Inferential statistics included a factor analysis that drew observed comparisons between the variables by identifying a smaller number of common factors, which gave an account of the observed comparisons between variables (Norusis, 2003:396–396). An oblique rotation method was used because variables were grouped around one associated factor (Polit & Beck, 2008:449). The subsequent varimax rotation established nine factors (see table 1).

Table 1: Factors relating to the validity and reliability of the questionnaire

Section	Cronbach Alpha (α)	Factor	Description
Empowerment of students	0.847	1	Involvement and formulation of policy
		2	Participation in patient care
		3	Delegation of authority
Compassion towards students	0.890	4	Acknowledgement and support
Trusting relationship between manager and student	0.930	5	Trustworthiness and loyalty
		6	Usefulness of a vision in clinical practice
		7	Participation in vision formulation
Manager as role model	0.931	8	Setting an example
		9	Acknowledging the value of others

Validity and reliability

The study ensured internal validity by pre-testing the instrument in order to establish whether the respondents understood the questions and instructions. Five third-year and five fourth-year students, who met the sample criteria, participated in the pre-test (Burns & Grove, 2005:218–219). During pre-testing of the instrument, the respondents indicated that the Likert scales were appropriate and did not need an option: 'do not know' or 'not applicable'. External validity was enhanced by inviting the accessible population to participate in the study (Rossouw, 2003:182). Content validity and face validity were ensured by submitting the questionnaire to subject experts in order to establish instrument readability and clarity. Construct validity was supported by a factor analysis as indicated in table 1 and the same table exhibits proof of the reliability of the instrument with Cronbach's Alpha scores exceeding 0.80.

Ethical considerations

Written consent to gather data from third- and fourth-year student nurses at the particular institutions was obtained from the Higher Degree and Ethics committees of the educational institutions and the PHC authority in 2009. Written consent was also obtained from each student. The human rights of autonomy, privacy, confidentiality and anonymity, fair treatment and protection against discomfort and harm were respected during the study (Burns & Grove, 2005:181–190). No funding was provided for the study.

RESULTS AND DISCUSSION

All respondents (100.0%; n = 288) started their nursing career directly after school and were at least 23 years old during their third or fourth year of studies. Almost half of the respondents (46.8%; n = 135) were fourth-year diploma student nurses, while 34.0% (n = 98) were third-year diploma student nurses.

Empowerment of students

Factor 1 addressed the involvement of the nurse manager in policy issues. Most respondents, 84.8% (n = 244) indicated that the nurse manager 'never' or 'sometimes' allowed them to contribute to the budget (mean 1.27; sd 0.669) and 57.6% (n = 155) indicated that they 'never' or 'sometimes' contributed to information sessions (mean 1.64; sd 0.860). Corresponding mean values of students' perceptions were found as far as information about clinic procedures was concerned (mean 2.05; sd 1.086) and the mission of the clinic (mean 2.04; sd 1.089).

The mean value of responses with regard to the involvement of the student in the formulation of objectives (mean 1.84; sd 0.982) was higher than the mean response on the inputs of the student in the planning of community involvement (mean 1.61; sd 0.839). On the other hand, the standard deviations around the mean values of these items were similar.

Higher mean values ('sometimes' or a slightly higher response value) were reflected in items of Factor 2. Of 271 respondents, 74.9% (n = 203) shared the opinion that they were not given opportunities by the nurse manager to perform patient assessments on their own (mean 2.31; sd 0.848). Similarly, 65.6% (n = 177) of the respondents indicated that they 'sometimes' or 'regularly' performed certain diagnostic procedures as independent practitioners (mean 2.32; sd 0.946) and that their contribution to the delivery of nursing care, as part of a health care team, was regarded as being important (mean 2.33; sd 1.005).

Dennis and Bocarnea (2005:4) believe that empowerment is the servant leaders' ability to entrust their followers with authority. The mean responses on items about the allocation of tasks (Factor 3) indicated corresponding responses on the delegation of certain managerial tasks to accept responsibilities (mean 1.82; sd 0,894); the creation of learning opportunities by allowing the student to reorganise tasks (mean 1.80; sd 1.009); and the delegation of the necessary authority to the student in order to execute certain tasks (mean 1.81; sd 0.894). Negative perceptions were obtained, as 47.6% (n = 127) of the respondents were of the opinion that the nurse manager was 'never' or 'sometimes' available to answer questions by the student about the nursing care of patients with specific health care needs (mean 2.70; sd 0.978). Meyer and Van Niekerk (2008:171–172) are of the opinion that servant leaders should pose questions in order to establish whether the follower fully understood what was expected of him/her. Only 34.3% (n = 93) indicated responses of 'regularly' or 'always' in Factor 4, with regard to the students' independent decisions to schedule follow-up visits (mean 2.21; sd 1.042). This indicated more negative perceptions of students concerning their independent decision making during PHC clinical training. Risinga and Jooste (2010:225–227) believe that servant leadership embodies the proposition of choice and encouragement of followers to accept ownership of decision making and responsibility, which appeared to be lacking among this study's respondents.

Compassion for students

In Factor 4, 66.0% (n = 175) of the respondents indicated that the nurse manager 'never' or 'sometimes' referred students for counselling after they had encountered an unpleasant experience (mean 1.55; sd 0.901) or used lunch time to explain unclear procedures (mean 1.16; sd 0.975). The respondents indicated that the nurse manager admitted student nurses' shortcomings to a lesser extent (mean 1.0; sd 0.9.5%). Managers should

at all times be aware of their own professional limitations with regard to specialist knowledge, interpersonal communication skills and other aspects of professional conduct (Muller, 2007:287).

The shortcomings in the nurse manager's compassion were pointed out where the respondents indicated that the nurse manager 'sometimes' or 'regularly' demonstrated her knowledge to encourage the professional development of the students (mean 2.27; sd 1.055); encouraged them to repeat procedures when their first attempts were unsuccessful (mean 2.31; sd 1.050); and encouraged those students who struggled with specific procedures (mean 2.37; sd 0.998). The servant leader should use encouragement to assist students to realise their potential and inspire them to try once more after they have made mistakes (Klopper & Bester, 2010:188).

Negative mean values were found about students' perceptions concerning the politeness of the nurse manager during service delivery (mean 2.48; sd 1.018) and the expression of appreciation for the students' contributions to patient care (mean 2.48; sd 1,076). Similar negative responses were found with regard to the low mean values on students' perceptions concerning recognition of each student's uniqueness (mean 2.13; sd 1.011) and in respect of reallocation of tasks while the student was experiencing a personal crisis (mean 2.06; sd 0.932). The standard deviation on these four items indicated a broad distribution of responses around the mean values.

Trusting relationship between manager and student

In Factor 5, the manager 'never' or 'sometimes' gave students opportunities to formulate their own visions for the clinic (mean 1.31; sd 0.654) and to discuss this vision during meetings (mean 1.30; sd 0.675). The nurse manager did not 'regularly' explain to the students how the vision of the clinic related to the larger organisation (mean 1.42; sd 0.749). The presence of continuous communication could have ensured that the vision was constantly communicated to the students in a creative and comprehensible manner in order to inspire them to realise the vision.

The highest mean values in Factor 6 concerned the manager's perceived honesty about facts in the practice situation (mean 2.43; sd 1.072) and adhering to decisions taken about day-to-day activities (mean 2.51; sd 0.996). According to Dennis and Bocarnea (2005:4), servant leaders should ensure that they keep their promises, thereby increasing the trust of their followers.

In Factor 7, students did not indicate that the nurse manager formulated achievable goals for them (mean 2.37; sd 1.051), nor that she explained exactly what had been expected of the students (mean 2.34; sd 1.071). A higher mean value was attributed to the manager's keeping her word (mean 2.25; sd 0.982) than informing students openly about problems

experienced in the clinic (mean 2.14; sd 1.063), but both issues addressed trust about the verbal interactions of the nurse manager with the students. Out of 258 respondents, only 40.7% (n = 105) indicated that accepting the students' contributions to the treatment team of a specific patient occurred 'sometimes' (mean 2.20; sd 0.934).

Certain items showed corresponding mean values in responses about trust. Students 'never' or 'sometimes' experienced that the nurse manager could be trusted to give positive and negative feedback about their actions (mean 2.10; sd 0.953); that the nurse manager was readily available at the clinics (mean 2.09; sd 0.971); and shared information about a patient with the students to develop a nursing care plan (mean 2.12; sd 0.967).

Respondents indicated that the nurse manager employed the vision of the clinic to a lesser extent than was needed to establish the role of the follower and to ensure that the follower is informed about his/her function in achieving this vision (mean 1.68; sd 0.889). Lower mean responses and a broad distribution of responses around these mean values, were obtained on items relating to the pursuit of a vision by the manager, reminding the student of the vision (mean 1.60; sd 0,962) and students' insight into the vision (mean 1.50; sd 0.869) than by her actions to realise the vision (mean 1.87; sd 0.934). The servant leader with a clear vision contributes towards the proper functioning of an organisation, the leadership of followers and self leadership (Dennis & Bocarnea, 2005:3–4).

Corresponding lower mean responses pertained to the nurse manager's discussion of administrative functions with the students (mean 1.74; sd 0.929) and explaining the vision of the clinic to them (mean 1.75; sd 0.906).

The nurse manager as role model

In Factor 8, responses indicated high mean values that were negatively skewed. Responses indicated that the nurse manager 'regularly' or 'always' acted self-confidently as part of the health care team (mean 2.94; sd 0.46) and projected a positive image towards patients (mean 2.82; sd 0.41). A mean value of 2.78 was found for the professional interaction of the nurse manager during the execution of clinical procedures (sd 0.416) and for accepting responsibility for her actions (sd 0.439). A high mean value of 2.76, with a narrow distribution of responses around the mean value (sd 0.390), indicated that the nurse manager displayed the necessary leadership knowledge in order to guide the students to complete clinical procedures.

A reasonably normal distribution of responses was found when it came to the nurse manager following the legal and ethical standards of the profession (mean 2.51; sd

0.517) and setting an example by doing what she expected other people to do (mean 2.64; sd 0.344).

The lowest mean responses of items related to ethical principles. The nurse manager created a culture of high ethical standards (mean 2.43; sd 0.515) and applied her communication skills to facilitate the functioning of the nursing team at the clinic (mean 2.47; sd 0.509). Responses indicated that the nurse manager did not need accolades from other people for her daily actions (mean 2.49; sd 0.836). Jooste (2009) says that leaders' moral actions are necessary all the time and that the best training in ethical behaviour is achieved by setting an example for their followers.

The nurse manager as role model recognised the value of students to a lesser degree (Factor 9). It was indicated that the nurse manager did not always consider the needs of the students (mean 2.22; sd 0.539) and that she did not act as a shield to protect the students against negative external and internal work influences (mean 2.19; sd 0.605). Furthermore, it was indicated that the nurse manager did not implement the suggestions from the students, which would have improved the functioning of clinic activities (mean 1.90; sd 0.615). The responses were normally spread around the mean values with regard to the nurse manager's recognition of contributions to the operational success of the clinic (mean 2.54; sd 0.5) and her position of control (mean 2.44; sd 0.539). A role model, according to Jordaan (2009:175–176), prepares other people to invest in a service-orientated model by the example he/she portrays. Yeo (2006:63) argues that visible commitment and attitudes are important characteristics of a role model's example.

CONCLUSIONS

The mean values on the majority of items regarding empowerment of student nurses, indicated that students perceived that the nurse manager 'never' and 'sometimes' acted as a servant leader to students in PHC clinics. The items with the highest mean values indicated that the nurse manager 'never' or 'sometimes' allowed students the opportunity to contribute to the budget. Higher mean values were obtained in response to items regarding students' participation in patient care (Factor 2) than in administrative aspects at the PHC sites concerned.

The item with the lowest mean value on compassion towards student nurses was related to the nurse manager admitting her shortcomings to students to a limited extent (mean 1.0%; sd 0.9.5%). The items with the highest mean values were negative, indicating that the nurse manager's politeness during service delivery (mean 2.48; sd 1.018) and her recognition of students' contributions to patient care (mean 2.48; sd 1,076) could be improved according to the students' responses.

The student nurses' perceptions of the trusting relationship between managers and students indicated that the highest mean value was related to the students' participation in formulating a vision for the PHC site (mean 2.34; sd 1.071). The manager 'never' or 'sometimes' gave the students opportunities to discuss this vision during meetings (mean 1.30; sd 0.675).

As a role model, the lowest mean responses were related to ethical principles (mean values of 0.5 and lower). Negative perceptions were obtained about the nurse manager's implementation of students' suggestions (mean 1.90; sd 0.615).

RECOMMENDATIONS

Student nurses could be empowered by policy guidelines, available at all times, indicating the correct clinic procedures to be followed during an orientation programme of the PHC site's operations. The nurse manager should be aware that making mistakes is part of students' learning processes. Acknowledging tasks successfully performed during adequate supervision, could enhance students' PHC clinical learning experiences.

Compassion should be shown to students through encouraging them to verbalise their opinions, know their developmental level, and envisage hope. The manager's non-verbal behaviour should be of such a nature that caring is experienced by students.

A trusting relationship could be established by the nurse manager through being honest about organisational problems; setting attainable goals for students; keeping her word; discussing negative behaviours or incidents in the PHC clinic; and discussing a clear vision for and the functions of the clinic.

As a role model, the nurse manager should portray a professional image by emphasising the importance of a healthy learning environment for the students; integrating theory and practice for the students; and listening to their ideas.

LIMITATIONS OF THE STUDY

Only third- and fourth-year students, assigned to PHC sites during the data collection phase, participated in the study. The results of the study might thus not be generalisable outside this context, unless further studies have been conducted at other PHC sites.

The student nurses completed questionnaires only. More in-depth information might have been obtained if focus group and/or in-depth individual interviews could have been conducted.

Only the viewpoints of the student nurses were obtained in the study. The nurse managers might have had similar and/or different views.

Acknowledgement

The authors wish to thank all institutions and persons who granted permission for the study to be conducted and every student nurse who participated. Without these student nurses' completed questionnaires, the study would not have been possible.

REFERENCES

Beukes, S. 2005. *Standaarde vir waardesensitiewe kliniese begeleiding in gemeenskapsverpleegkunde.* D. Cur. verhandeling. Johannesburg: Rand Afrikaans University.

Burns, N. & Grove, S.K. 2005. *The practice of nursing research: conduct, critique and utilization*. 5th Edition. New York: W.B. Saunders.

Dennis, R.S. & Bocarnea, M. 2005. Development of the servant leadership assessment instrument. *Leadership & Organizational Development Journal,* 26(8):2–4.

Greenleaf, R.K. 1977. *A journey into the nature of legitimate and greatness: servant leadership.* New York: Paulist Press.

Greenleaf, R.K. 1991. *The servant as leader.* Indianapolis: The Robert K. Greenleaf Center. Available at: http://www.greanleaf.org (accessed 5 January 2012).

Gersh, M.R. 2006. Servant leadership: a philosophical foundation for professionalism in physical therapy. *Journal of Physical Therapy Education,* 20(2):1.

Jordaan, E. 2009. Leadership in teams and networking. In *Leadership in health services management.* Edited by Jooste, K. 2nd Edition. Kenwyn: Juta.

Jooste, K. (ed.) 2009. *Leadership in health services management*. Kenwyn: Juta.

Jooste, K. (ed.) 2010. *The principles and practice of nursing and health care: ethos and professional practice, management, staff development, and research*. Pretoria: Van Schaik.

Klopper, H.C. & Bester, P. 2010. Leadership and guidance in a health care unit. In *The principles and practice of nursing and health care: ethos and professional practice, management, staff development, and research.* Edited by Jooste, K. Pretoria: Van Schaik.

Meyer, S. & Van Niekerk, S. 2008. *Nurse educator in practice*. Kenwyn: Juta.

Muller, M.E.M. 2007. *Nursing dynamics*. 3rd Edition. Sandton: Heinemann.

Norusis, M. 2003. SPSS 12.0 *Statistical procedures companion*. New Jersey: Prentice Hall.

Polit, D.F. & Beck, C.T. 2008. *Nursing research: generating and assessing evidence for nursing practice*. 8th Edition. Philadelphia: J.B. Lippincott.

Risinga, R. & Jooste, K. 2010. Clinical leadership and supervision. In *The principles and practice of nursing and health care: ethos and professional practice, management, staff development and research*. Edited by Jooste, K. Pretoria: Van Schaik.

Rossouw, D. 2003. *Intellectual tools – skills for human sciences*. Pretoria: Van Schaik.

Russell, R.F. & Stone, A.G. 2002. A review of servant leadership attributes: developing a practical model*. Leadership & Organization Development Journal,* 23(3):145–157.

Shaw, S. 2007. *International Council of Healthcare Professionals. Healthcare leadership*. Oxford: Blackwell.

South Africa. 2005. *South African Nursing Act, No. 33 of 2005*. Pretoria: Government Printer.

Terre Blanche, M., Durrheim, K. & Painter, D. 2006. *Research in practice: applied methods for the social sciences*. 2nd Edition. Cape Town: University of Cape Town Press.

Tshabalala-Msimang, M. 2006. Closing address by the Minister of Health at the International Nursing Conference. Available at: http://www.doh.gov.za/docs/sp/2006/sp0511.html (accessed 3 March 2011).

Vlok, M.E. 2008. *Manual of community nursing*. Landsdown: Juta.

Washington, R.R., Sutton, C.D. & Felid, H.S. 2006. Individual differences in servant leadership: The roles of values and personality. *Leadership & Organizational Development,* 27(8):3–4.

Walumbwa, F.O., Hartnell, C.A. & Oke, A. 2010. Servant leadership, procedural justice climate, service climate, employee attitudes, and organizational citizenship behavior: a cross-level investigation. *Journal of Applied Psychology*, 95(3):517–529.

Yeo, R.K. 2006. Developing tomorrow's leaders: why their world views of today matter? *Industrial and Commercial Training,* 38(2):63–69.