UNIVERSITY OF KWAZULU-NATAL

ANALYZING THE RELATIONSHIP BETWEEN LEADERSHIP STYLE, ORGANISATIONAL FACTORS AND RETENTION OF PROFESSIONAL NURSES IN PUBLIC HEALTH CARE FACILITIES IN KWAZULU-NATAL

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BY

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DEDICATION

This study is dedicated to my parents Mrs Thandi (MaSikhakhane) Nkosi and my late father Mr John Nkosi.

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DECLARATION

I hereby declare that this dissertation is the researcher's original work and the work used or cited has been acknowledged in the text and in the references.

Signature..... **Date**..16 April 2010

Signature..... **Date**..16 April 2010

ABSTRACT

BACKGROUND : Many professional nurses have left the employment to work in developed countries. Quality patient care is declining because the few PNs that are rendering care have limited expertise. Literature review showed that nurse managers have a role to play in retention of staff.

PURPOSE : The study aims to analyze the leadership styles and organizational factors toward the retention of professional nurses working in public health facilities.

POPULATION : Professional nurses in four public hospitals, four union managers, twelve professional nurses working abroad and representative from SANC. A total of 188 participated in the study which formed part of the 70% of the sample.

DESIGN : A Case study design which included both quantitative and qualitative approaches. Observations in the wards and document analysis were done guided by a case protocol.

INSTRUMENTS : Revised Nursing Work Index and Revised Conditions of work effectiveness was administered among the professional nurse and chief professional nurses. Chief nursing service managers and union managers were interviewed using interview guides. Focus groups among professional nurses who had overseas experiences were conducted. Reliability was maintained by having a Cronbachs alpha of above 0.70 in all variables except leadership.

RESULTS : Cases presented differently in all aspects, except Case C who was consistent in all the variables. The professional nurses in Case C viewed their CNSM as being visible and accessible. Case A and B were similar in terms of the organizational factors. All CNSM verbalized that they were willing to send PNs for educational programmes but the DOH policy was allowing nurses to work anywhere in the province. PNs had little access to resources on time to do tasks and paperwork as compared to access to support and opportunity.

CONCLUSION : PNs are willing to stay in their organizations provided they will be given educational and promotional opportunities. There was a relationship between organizational factors and retention. Leadership factors showed a weak negative relationship with other variables.

TABLE OF CONTENTS

CHAPTER 5: DISCUSSION, CONCLUSIONS AND RECOMMENDATIONS

List of Figures

List of Tables

List of abbreviations

AACN	:	AMERICAN ASSOCIATION OF COLLEGES OF NURSING
AIDS	:	ACQUIRED IMMUNODEFICIENCY SYNDROME
ANA	:	AMERICAN NURSES ASSOCIATION
ANC	:	AFRICAN NATIONAL CONGRESS
ANC	:	ANTE-NATAL CLINIC
ANCC	:	AMERICAN NURSES CREDENTIALLING CENTRE
BEE	:	BLACK ECONOMIC EMPOWERMENT
CEO	:	CHIEF EXECUTIVE OFFICER
CFO	:	CHIEF FINANCIAL OFFICER
CNO	:	CHIEF NURSING OFFICER
CPN	:	CHIEF PROFESSIONAL NURSE
CNSM	:	CHIEF NURSING SERVICE MANAGER
COHSASA	:	COUNCIL FOR HEALTH SERVICE ACCREDITATION OF SA
DOH	:	DEPARTMENT OF HEALTH
DSH	:	DISTRICT HEALTH SYSTEM
DENOSA	:	DEMOCRATIC NURSING OF SOUTH AFRICA
EAP	:	EMPLOYEE ASSISTANCE PROGRAMME
EI	:	EMOTIONAL INTELLIGENCE
EN	:	ENROLLED NURSE
ENA	:	ENROLLED NURSING ASSISTANT
HASA	:	HOSPITAL ASSOCIATION OF SOUTH AFRICA
HIV	:	HUMAN IMMUNE VIRUS
HOSPERSA	:	HEALTH & OTHER SERVICE PERSONNEL TRADE UNION OF SOUTH AFRICA

HRD	:	HUMAN RESOURCE DEVELOPMENT
HST	:	HEALTH SYSTEMS TRUST
ICN	:	INTERNATIONAL COUNCIL OF NURSES
JCAHO	:	JOINT COMMISSION ON THE ACCREDITATION FOR HEALTHCARE ORGANIZATION
JCIA	:	JOINT COMMISSION INTERNATIONAL ACCREDITATION
KZN	:	KWAZULU NATAL PROVINCE
MOH	:	MINISTRY OF HEALTH
MRC	:	MEDICAL RESEARCH COUNCIL
NDOH	:	NATIONAL DEPARTMENT OF HEALTH
NEHAWU	:	NATIONAL HEALTH ALLIED WORKERS UNION
NSM	:	NURSING SERVICE MANAGER
OSD	:	OCCUPATIONAL SPECIFIC DISPENSATION
PHC	:	PRIMARY HEALTH CARE
PN	:	PROFESSIONAL NURSE
SADNU	:	SOUTH AFRICAN DEMOCRATIC NURSES UNION
SMT	:	SENIOR MANAGEMENT TEAM
SPN	:	SENIOR PROFESSIONAL NURSE
SPSS	:	STATISTICAL PACKAGE FOR SOCIAL SCIENCES
TOP	:	TERMINATION OF PREGNANCY
WHO	:	WORLD HEALTH ORGANIZATION
UK	:	UNITED KINGDOM
UKZN	:	UNIVERSITY OF KWAZULU-NATAL
UN	:	UNITED NATIONS

LIST OF APPENDICES

CHAPTER 1: INTRODUCTION

1.1. BACKGROUND

The nursing profession in South Africa is currently experiencing an ongoing shortage of nursing personnel caused, among other reasons by globalisation .The purpose of globalisation was originally brain circulation with the advantage of integration, but it has since become a process of brain drain to the detriment and marginalisation of poor countries. Globalisation is the internationalisation of societal issues, which has brought about interdependence among countries economically, politically and socially (van Rensburg, 2004).

The impact of globalisation on health care, including migration, is more and more linked to and determined by global developments, and less and less by local geographical events (WHO, 2004). Its implications range from the trade and investment flows which interest economists, to the changes that we see in our daily lives (WHO, 2004).

"Brain circulation" means that personnel are sent out of the country temporarily to gain skills for the benefit of their own country of origin. In the long term, globalisation has led to "brain drain", whereby African countries are faced with the growing problem of the mass exodus of health professionals to the more developed countries .Furthermore, developing countries are experiencing voluntary movement from public to private hospitals and therefore public hospitals are the worst hit by these movements (WHO, 2004).

Globalisation causes international trends to impact on policy formulation and decision- making. Yeates (1999) states that external global factors outweigh the local factors, leading to developed countries benefiting from push factors instead of pull factors among the health care workers in developing countries.

Push factors are financial, and include poor working conditions, lack of professional development opportunities, non-involvement in decision-making and a lack of support from supervisors. Pull factors offer a better life, good salaries, safety and involvement in decision making opportunities (Kingma, 2007, Awases, Nyoni, Gbary & Chatora 2004).

Globalisation has provided opportunities for nurses in developing countries to work in developed countries. The British register shows that the number of nurses in Britain who come from Botswana, Ghana, Nigeria, Kenya, South Africa, Zambia and Zimbabwe have soared since 1999 (Pang, Lansang & Haines, 2002).

There are no accurate and consistent statistics in South Africa for the number of nurses who migrate for the following reasons:

- Some nurses are registered with the South African Nursing Council (SANC) but are not practicing;
- Other nurses register in more than one country as *locums*, not permanent workers in their country;
- Records focus on registrations only and not related variables e.g. deaths, retirements, emigration, immigration etc. (Geyer, 2004).

For these reasons, there are discrepancies between the SANC register and those of other countries, because a nurse who has died will have the same registration code as a nurse who is still alive, but not working in South Africa. Furthermore, the SANC numbers inflate the apparent number of health workers who are working within and outside the country of origin. Moreover, the number of nurses leaving the country is in excess of the numbers of potential graduating students. SANC statistics indicate that the numbers of student nurses who will progress towards the professional nurse's category are declining as follows. See Table 1.1. below:

Table 1.1: Total number of students from 1997-2001(Geyer, 2004)

Year	Total students	Deficit
1997	11903	
1998	11290	613 (5%)
1999	10398	892 (8%)
2000	9639	759 (7%)
2001	9527	112 (1%)

According to the SANC (2008), there were 173703 nurses in the register in 1998 and the number dropped to 171645 in 2000, indicating a deficit of 1% in 2007. According to the Department of Health (2006), there are 203948 nurses who are registered with the SANC. This number does not indicate the total number of nurses

who are working in South Africa; it only confirms the nurses who are registered with the South African Nursing Council.

The lack of reliable data on the supply and demand for nurses is a big problem in South Africa. The SANC register is the most comprehensive source of data on nurses; however no data is available from the register on the number of professionals currently actively employed in nursing in South Africa (Hall, 2004). Unfortunately the exact numbers of nurses who are working in other countries is also not available because SANC does not collate or publish registration data of migrating nurses (Gerein, Green & Pearson, 2006 and Buchan, 2004).

Table 1.2. : Growth in the South African Nursing Council register of nurses for period 1998-2007 (SANC, 2008)

Categories of nurses	**1998**	**1999**	**2000**	**2001**	**2002**	**2003**	**2004**	**2005**	**2006**	**2007**
RN/RM	91011	92390	93303	94552	94948	96715	98490	99534	101295	103792
EN/EM	32744	32925	32399	32120	32495	33575	35266	37085	39305	40582
ENA	49948	47578	45943	45666	45426	47431	50703	54650	56314	59574
Total	**173703**	**172893**	**171645**	**172938**	**172869**	**177721**	**184459**	**191269**	**196914**	**203948**

It is also reported that SANC processes more than 300 applications per month for overseas registration. Fouché (2003) on the other hand asserts that more than 5000 South African nurses are working overseas. According to the South African Nursing Council (SANC) statistics, there is a shortage of professional nurses in the country. In the year 2000, out of the 16 000 available posts, only 10 000 posts were filled, leaving 6000 vacancies (Nkonzo-Mthembu, 2005). From the above figures it would

appear that nurses are apparently leaving the country on a monthly basis, and one wonders how many will be left by the year 2010.

The majority of nurses who leave the country are specialised nurses who were trained by the government to improve the health status of the country. The Department of Health (DOH) sponsors nurses to further their skills in clinical programmes. These nurses are specialists in Intensive Care Nursing, Operating-Room Theatre Technique, Nurse Educators and Nurse Managers (Zondagh, 2005). According to Mngomezulu (2004) there are more than three hundred specialised nurses who leave South Africa monthly. Not only are the nurses leaving the country, but the doctors too. The South African Medical Association Statistics (2004) reveal that there are more South African doctors in developed countries than there are left in South Africa. For example, in America there are 2000, Britain 3334, Canada 1953, New Zealand 831, totalling 8118. This is also echoed by Buchan (2004) who confirms that a number of South African-born workers are practicing in the medical profession in certain developed countries as indicated in Table 1.3. below.

Table 1.3: South African-born workers working in developed countries

Country	Practitioners[1]	Nurses & Midwives	Other Health Professionals[2]	
Australia	1114	1085	1297	3496
Canada	1345	330	685	2360
New Zealand	555	423	618	1596
United Kingdom	3625	2923	2451	8999
United States	2282	2083	2591	6956
Total	**8921**	**6844**	**7642**	**23407**

1. Doctors, dentists, veterinarians, pharmacists and other diagnostic practitioners
2. Including assistants

Source: Eurostat employment survey for the European countries (2008).

Nurses cite many reasons in varying degrees for leaving their countries of origin. For example, the developed countries pay high salaries, and provide safe environments, conducive to health care and improved quality of life (Dovlo, 2007, Buchan & Sochalski, 2004; Xaba & Philips, 2001). Security is also seen to be

another advantage of employment in developed countries (Xaba & Philips, 2001). Several authors cite reasons for leaving developing countries as poor working conditions, organisational environment (Gerein, 2006) poor management and lack of training or development opportunities, and not so frequently financial reasons (O'Brien-Pallas, Duffield & Hayes, 2006 , Mngomezulu, 2004 and Chan & Morrison, 2000). Salaries are very modest and vertical growth is totally absent (Trewick, 2008). Lack of infrastructure, as well as HIV and AIDS contribute to the flight of health care workers (Lehmann, Dieleman & Martineu, 2008).

Similar responses were cited by South African nurses working in London. They cited poor working conditions, low wages, lack of appreciation from management, a feeling of isolation from the rest of the health care system and disappointment, rooted in their lack of involvement in the planning process, as the main reasons for leaving South Africa (King & McInerney, 2006, Hall, 2004). The quality of nursing services, health care provision, nurses' lives, nurses' right to expect and want good education for their children, nurses' right to freedom of movement, effective and efficient health care and the right to want and expect good working conditions are the things the nurses value most (Gwele, 2003).

British nurses cite the same reasons as South African nurses, for example, dissatisfaction with promotion and training opportunities and less of monetary reasons and workload. The same factors have been quoted by Letlape (2004), Nduru (2003) and Aiken *et al.* (2001) as reasons for health care workers leaving South Africa.

The nursing profession in South Africa is also portrayed as no longer being enticing since the majority of cases treated in health care institutions are those suffering from AIDS-related diseases. The other factor which depletes the number of health professionals in sub-Saharan Africa is HIV/AIDS. Ill health due to HIV/AIDS among health workers is the worst in African countries, with the highest adult HIV prevalence rates (Gerein *et al.*, 2006). More than 40 % of health workers are living with HIV/AIDS in many sub-Saharan countries (Gerein *et al.*, 2006). Absenteeism resulting from burnout due to the excessive workload related to HIV/AIDS can be substantial (Dovlo, 2003). The younger generation is afraid of contracting the deadly virus, despite the universal precautions taken. This disincentive is aggravated by the

declining numbers of nurses who are still interested in taking up a nursing career as illustrated in Table 1.1.(Geyer, 2004).

The migration of skilled personnel has impacted negatively on the country in terms of economic, educational and psychosocial factors. For example, while compensation is not attractive in developing countries, the remaining health personnel are also overworked with many responsibilities because the country is left with too few nurses to undertake all the health care (van Rensburg, 2004 and Booyens, 1996). Staff shortages keep personnel at work to the detriment of development or training opportunities and this is consequently a reason cited for leaving the country. According to Zondagh (2005), staff shortages were a factor in one of every four unexpected hospital deaths or injuries. Increased workload further drains the health care personnel physically, psychologically and emotionally, leading to stress and burnout with related symptoms. The impact on their family relations and roles, caused by fatigue, for instance, prevents them from fulfilling their marital roles.

Nurse shortages in developed countries have accelerated international nurse recruitment and migration, sparking debate about the consequences for sending and receiving countries and for meeting global health needs (Aiken, Buchan, Sochalski, Nichols & Powell, 2004).

The scourge of HIV/AIDS has increased the shortage of nurses because most morbidity and the majority of fatalities from HIV/AIDS fall between the ages of 15-49 years, which is the economically active age group and most nurses fall into this category. Morbidity and mortality result in unproductiveness, ineffectiveness and shortage of nurses. Furthermore, HIV/AIDS is a large impediment to economic empowerment and the skills development issues that are among the reasons for the brain drain from the country (WHO, 2007).

The only solution to the shortage of nurses is to have good retention strategies and policies in place, which will encourage people to stay in their countries of origin. Retention depends not only on focusing on nurses, but also on other workers in the corporate world. Opara (2002) found that the profit associated with serving and retaining customers, is significantly higher than the profit associated with new customers. Copacino (1997) concluded that companies that do a better job of

keeping their customers generate better financial results than do companies with poor retention records. Opara (2002) concluded that it is vital that companies in the sector of external logistic management ensure client retention, thus minimising sales and set-up costs and simultaneously developing a strong and steadily growing economy.

In 2000, the South African National Department of Health (2000) drafted a white paper which was intended to transform health care service delivery. The focus on health was on the decentralisation of responsibility, accountability, power and authority to the local levels of health care delivery, greater involvement of the community, reduction of bureaucratic practices far removed from the community, and effective use of resources. Putting these principles into practice is the issue now facing the nurse leaders of the South African health care sector (Jooste, 2003).Access to good quality health services goes hand in hand with a fair distribution of health personnel. If health workers are not available, there will be imbalances in the delivery of good quality care (Dussault & Franceschini, 2006).

Nurses are willing to stay in their countries of origin provided that their needs are addressed (Msidi, 2008). This issue was demonstrated by nurses who belonged to DENOSA (Democratic Nursing Organisation of South Africa), when they marched in Bloemfontein in June 2005. Nurses emphasised that they would not go abroad, but they would stay and challenge the government to respond to their demands (Sunday Times, May 2005). The focus now is definitely on how managers retain their staff, because nurses have verbalised that they do not want to have to join thousands of nurses who have migrated to developed countries.

There is a significant relationship between leadership style and staff retention. For example, a study by Larabee, Janney, Ostrow, Withrow, Hobbs & Burrant (2003) showed that leadership style was a major predictor of job dissatisfaction which made nurses leave their organisations. Boyle, Bott, Hansen, Woods & Taunton (1999) identified that a manager's leadership characteristics were a determinant factor in the critical care nurse's intention to stay. Cummings (2004) also maintains that nurse managers are responsible for the achievement of the organisation. If the leadership style is good the followers will be productive and therefore will not leave their

organisation. This was further asserted by Huber (2000) when she revealed that the effectiveness of the organisation is related to the leadership style of the manager.

Different leadership styles have varying influences on employees working in different settings. The authoritarian leader tells her employees what she wants done and how she wants it done whereas the democratic style involves a leader including one or more employees in a decision-making process. In Singapore, Chiok Foong Loke (2001) explored the relationship between leadership styles and employee outcomes. With the authoritarian leadership styles, organisational objectives were achieved quickly whereas the employees' levels of satisfaction and morale were neglected. The impact of the leadership behaviour on the employees' job satisfaction, productivity and commitment was not established.

The other classification of leadership styles which is used is transformational and transactional. The transformational leader differs from the transactional leader because the former has a vision which is shared among the subordinates, whereas the latter deals with punishment and rewards. The transactional leader works through creating clear structures for subordinates and the rewards they will get if they follow these orders. Punishments are not always mentioned, but they are also well understood by followers (Cameron, 2004).

Transformational leadership style is viewed as the type of leadership of choice for job satisfaction. Several studies researching transformational leadership as a strategy for job satisfaction and staff retention have been conducted internationally in the following countries: Canada, Sweden, Taiwan, the United Kingdom and the United States of America. Transformational leaders are visionary leaders who involve staff in decision- making (Trofino, 2003; Thyer, 2003 and Laschinger *et al.*, 1999). Staff satisfaction is increased in institutions where transformational leadership is practiced (Kleinman, 2003; Trofino, 2003; Thyer, 2003; Shieh, Mills & Waltz, 2001, Scott, Sochalski & Aiken, 1999; Kangas, Kee & Mc Kee Waddle, 1999).

Few studies have been done in South Africa about leaders and nurses, and the only relevant study asserts that nurses resigned from their jobs because nurse managers were uncaring, had poor attitudes and had not involved staff in decision-making (King & McInernery 2007).

One can conclude that leadership style has a great impact on staff satisfaction. The most commonly applied leadership style which produces a positive result is the transformational leadership style. Since the late 1990s, there has been a trend of focusing on transformational leadership rather than other types of leadership styles. Transformational leadership ensured that nurse managers had a vision and worked positively towards the attainment of organisational goals and encouraged staff to participate actively in the activities of the institution. The transformational managers were also willing to share knowledge and to encourage participative management with their staff. Since staff members were involved in decision-making, they felt that they were part of the team and did not feel the need to leave their organisations.

There are various retention models which are utilised in different institutions. These models include shared governance models and magnet hospital models. Shared governance is a model of nursing practice designed to integrate core values and beliefs that professional practice embraces, as a means of achieving quality care. Shared governance models were introduced to improve nurses' work environments, satisfaction and retention (Anthony, 2004).

The Magnet hospital model will now be discussed as it has been researched to produce effective results. The concept of Magnet hospitals was started in 1981 in the United States of America by the American Academy of Nursing (AAN) in order to recruit and retain nurses in the profession, and is now managed by the American Nurses Credentialing Centre (ANCC). All hospitals requesting magnet hospital status need to apply to the ANCC for accreditation. The ANCC focuses on institutions that ensure a culture of excellence, support for education, self-governance and opportunities for specialised practice. Magnet status is an award given by the American Nurses Credentialing Centre to hospitals which satisfy a demanding set of criteria measuring the strength and quality of nursing. A Magnet hospital is one where nursing delivers excellent patient outcomes, where nurses have a high level of job satisfaction, low staff turnover and an appropriate grievance procedure (ANCC, 2005). Magnet nurse leaders involve their staff in decision-making processes (Upenieks, 2002, Buchan, 1999).

One has to look at other countries' retention strategies because the shortage of staff has been a worldwide problem. Rich countries also suffered an exodus of nurses in

the early 80s resulting in the development of the concept of the Magnet Hospital for the United States of America to build a programme of excellence for the delivery of nursing care, and also to promote the quality that supports professional practice. The Magnet program has a good reputation for the recruitment and retention of registered nurses.

The key characteristics of Magnet hospitals were grouped in three categories which are administration, professional practice and professional development (Buchan, 1999). Administration characteristics include a supportive management style, career opportunities, decentralised structures and flexible working schedules. Professional practice includes autonomy and responsibility, availability of specialist advice, and emphasis on the teaching responsibilities of staff. Professional development includes planned orientation of staff, emphasis on continuing education and management development (Buchan, 1999).

According to Buchan (1999) the variables that distinguish a Magnet hospital from a non-Magnet hospital include a supportive management and adequate staffing. This view was echoed by Upenieks (2003), in that a supportive organisational climate, an autonomous climate, continuing education, adequate compensation and flexible scheduling are the elements of a successful organisation.

The Magnet institutions shared several characteristics which include the following:

- Giving nurses the status necessary to influence people and to obtain the resources needed for good patient care;
- Good collaboration and communication between nurses and physicians;
- Primary nursing benefits patients because they get continuity of care
- Nurse participation in policy decisions (Trossman, 2002; Mason, 2000).

In the 1990s, nurse researchers found that Magnet hospitals had better outcomes than hospitals without Magnet status. Magnet hospitals have higher patient satisfaction rates and lower mortality, lower nurse burnouts and needle-sticks to nurses (Mason, 2000). The study by Aiken & Patrician (2000) showed that Magnet hospitals are cost-effective because patients/clients have shorter lengths of stay in hospitals and in intensive care units. Nurses have fewer patients in their workloads,

better support services, greater control over their practices, greater participation in policy decisions and more powerful chief nurse executives.

According to Upenieks (2002), nurses who work in Magnet hospitals show greater job satisfaction than nurses from non-magnet hospitals. Magnet hospitals are led by nurse executives in a decentralised structure which emphasises participatory management. In a flat organisational structure in Magnet hospitals, there are minimal levels between clinical nurses and nurse executives. Staffing and scheduling is conducted at unit level, which enables nurses on each shift to be empowered and accountable for making staff decisions for the next shift.

In South Africa, hospitals voluntarily apply for accreditation from the Council for Health Service Accreditation of Southern Africa (COHSASA). Accreditation is a self-assessment and external review process used by health care organisations to assess accurately their level of performance in relation to established standards and to implement ways to improve continually (Booyens, 1998).

Staff shortages lead to nursing staff being unable to provide quality nursing care. In South Africa, there are high levels of absenteeism which leads to inadequate time being available to teach other nurses because of the workload, thus newly qualified nurses are expected to work on their own from their first day of employment which further contributes to the declining standard of care (Geyer, 2004).

Many nurses who are employed in South African institutions are not orientated to the new surroundings because there is a staff shortage. This shortage leads to staff working without fully conceptualising what is expected from them. There are many nurses who are in charge of departments, or are working alone in remote areas because there is no supporting staff member. This lack leads to more health hazards and risks (Zondagh, 2005).

Retention strategies have been introduced by the South African government to curb the professional exodus. According to Scott, Wheelan, Dewdney & Zwi (2004) developing countries need to review their salary scales to be on a par with developed countries. The recruiting agencies from developed countries need to pay compensation to the countries from which they are recruiting. According to the Department of Health (2003), retired nurses were invited back to the hospitals to

work as nurses in order to bridge the shortage of nurses. Hospitals are surviving because these nurses contribute significantly to the dispensation of health care in this country.

The education of nurses in South Africa is sponsored by the government. Nurses who train at colleges are heavily subsidised, whereas nurses who study at university pay for their tuition fees and the university only gets a subsidy. Students are granted bursaries by the Department of Health, and on completion of training, they are expected to pay back the bursary by working in needy areas for a time equivalent to the number of years for which they received a bursary. All health care graduates have to serve one year's community service before being registered by the relevant Council (DOH, 2004). The government is trying to ensure that no one leaves the country immediately after training. Graduates are posted in areas where they are needed the most.

The government has introduced a rural allowance to health care workers in rural settings with the hope of retaining the staff. The former Minister of Health, Dr Tshabalala- Msimang held ongoing negotiations with the British government to curb British hospitals from soliciting staff from developing countries. Recently, the Minister of Health had a meeting with South African nurses in London, in the hope of encouraging them to come back home (IOL, September, 2005).

Another strategy to curb the exodus of health personnel is to enter them in a contract with the Kings College Hospital Trust in the United Kingdom, to work there for two years, then return to South Africa and work here for three years, in the hope that they will have gained skills and knowledge by experiencing developed countries' earnings and exposure (Thom, 2003). In this way, private hospitals are also contributing to the retention of staff. Netcare and Life Care Hospitals have signed a contract with United Kingdom (UK) hospitals for a three months' staff exchange programme. This programme includes nurses, doctors, physiotherapists and laboratory technicians. Staff members working in the UK are paid double their salaries according to the UK system. This strategy is done with the aim of exposing them to high salaries without losing staff to the United Kingdom (Thom, 2003).

Not all strategies planned by the Minister of Health are accepted by other health professionals. One has to look carefully at retention strategies which may have a

negative impact on the already declining number of health professionals. The Minister of Health has launched a medical assistant programme which is a four year programme based on the medical curriculum. On completion of training, the graduate will be registered with the Health Professions Council of South Africa. The introduction of this category has caused more harm than good to the country because of the overlapping of duties between the scope of practice of a registered nurse and a medical assistant. At present, it seems as if the medical assistant will earn more than the registered nurse and this will cause further role conflict and ambiguity among registered nurses (Geyer, 2004).

In summary, one can conclude that nurses are leaving South Africa in numbers for different reasons. Many people are suffering from HIV/AIDS, including the nurses. The health sector is under strain because the human and financial resources are inadequate to meet the demands of the country. The government has developed recruitment policies around health workers being solicited by developed countries. Newly qualified health personnel are expected to serve their country for a year and those who received government funding are expected to serve the country for a couple of years. The government is busy with transformation in the hope that leadership will have a positive effect on retaining health workers. Unfortunately, there are very few studies conducted in Africa about the impact of leadership style on staff retention in the health sector.

1.2. PROBLEM STATEMENT

From the above discussion it is apparent that the impact of globalisation has led to the freedom of movement of health personnel to other countries .Nurses are now migrating from South Africa in large numbers. The reasons given are poor salaries, poor working conditions and a lack of opportunities for training and development (Buchan & Sochalski, 2004).The current shortage of nurses in the country has impacted negatively on the quality of nursing care rendered to patients. Because there are fewer nurses, those remaining are burdened with extra work because of staff shortages and many very ill patients (Kingma, 2006).

Despite the work done by the government in putting retention strategies in place to deal with the migration of health workers to other countries, there is little improvement. Nurse Managers work directly and indirectly with professional

nurses, and the managers have a great influence on nurses' decisions to stay in organisations. Several studies have revealed or identified a relationship between leadership styles and nursing staff retention (Aiken *et al.*, 2001; Laschinger *et al.*, 2001). Studies done internationally have revealed that nurse leaders have a great impact on the retention of staff. Such studies have not been done in South Africa. It would therefore be interesting to conduct such a study in the context of South Africa to ascertain whether leadership styles of nurse managers and other organisational factors have an influence on staff retention.

1.3. PURPOSE OF THE STUDY

To analyse the relationship between leadership styles, organisational factors and retention of professional nurses in public health care facilities in KwaZulu-Natal.

1.4. RESEARCH OBJECTIVES

1.4.1. To distinguish and describe the different leadership styles within the public health care facilities in terms of vision, accessibility, visibility, power and authority.

1.4.2. To identify organisational factors in terms of access to support, resources, opportunity and information that prevails in these public health facilities.

1.4.3. To examine retention trends in these public health care facilities.

1.4.4. To analyse the relationship between organisational factors, leadership styles and nursing staff retention.

1.5. SIGNIFICANCE OF THE STUDY

The study aims to analyse the relationship between leadership styles, organisational factors and staff retention. The results could influence the Department of Health in designing policies that will address the problems of staff attrition. Retention strategies will be implemented according to the needs identified. These retention strategies will be specific to the problems identified, and will be tailor-made for each institution.

The study will also be beneficial to the profession, because the findings will inform the delivery of nursing education in the country including empowerment of nurse

leaders in terms of appropriate leadership and organisational factors that promote retention. Findings from this study will inform the National Department of Health on the role leadership and organisational factors can play in influencing retention. This study can lead to the development and implementation of evidence-based retention strategies. Future intervention studies can be informed by the findings of this study. The findings will inform the development of the retention hospital model which can assist policy-makers to design policies which influence retention in much the same way in which the Magnet hospital model has been implemented with success in the United States of America

1.6. OPERATIONAL DEFINITIONS

For the purpose of the study, the following key concepts are defined and applied within the context in which they have been explained.

1.6.1.**Leadership** is a process of leading people, getting people to do what you want them to do by imparting knowledge, attitude and behaviours to influence people towards the achievement of the goals of the organisation. In this study leadership will be measured by visibility, accessibility, power and authority of the nursing service manager.

1.6.2. **Leadership style**

Leadership style is the manner and approach of providing direction, implementing plans and communicating a vision to subordinates and followers in terms of the support given to them in the achievement of organisational and individual goals.

1.6.3. **Staff retention**

For the purpose of this study, the term will be applicable to professional nurses who stayed in the country and did not leave their health institutions to go and work in other non-health industries, or abroad. Loss will be measured by the turnover rate within a period of twelve months.

1.6.4. **Nurse Managers**

These are registered nurses who are in charge of their units/wards, and carry out leadership duties having been in these positions for more than six months. In this study they are termed Chief Professional Nurses (CPN). A Chief Nursing Service Manager (CNSM) is a professional nurse who is in charge of all the nurses in a hospital.

1.6.5. **Professional Nurse**

This is a registered nurse who trained for a degree or diploma in general nursing under SANC regulation R425 including those that did the Bridging course leading to professional nurse (R284).

1.6.6. **Organisational factors**

This term means a combination of factors which influence the individual in an organisation in terms of access to information, support, resources and available opportunities for advancement in her/his health care facility.

1.6.7. **Public health care facility**

This refers to a health care centre/ hospital which has a variety of patients and departments and also renders comprehensive health care, managed by the government.

1.7. THE CONCEPTUAL MODEL

The theory which will guide this study is based mainly on Kanter's theory with some reference to Theory Z, Maslow's and Herzberg's theories which are further supported by collegial, formal and political models of an organisation. Formal models deal with the hierarchical structure of the organisation, collegial models deal with participative management and political models focus on the distribution of power and alliances within the organisation (Bush, 1995).

The Kanter model provides an integrating framework for a wide range of literature relevant to a multilevel system-oriented leadership perspective and predicts interrelationship among other variables. The characteristics of Kanter's theory

encompass the major variables of the study within the research instrument, theoretical framework and the study itself. According to Kanter's theoretical framework (1977), systematic power factors such as formal and informal power, influence access to job-related empowerment structures which have a personal impact on employees. Components of this psychological empowerment of employees include increased autonomy, decreased job stress, lower burnout, increased satisfaction and increased commitment. This present research, based on Kanter's framework, assumes that increased psychological empowerment of nurses will be positively associated with retention and the intention to remain in nursing positions in South Africa. If this relationship is supported in this research, then further work can explore the relationship between these factors and work effectiveness.

Kanter's theory has been utilised by all researchers in testing the effectiveness of Magnet hospitals (Laschinger & Wong, 2006; Laschinger & Johnstone, 2006; Nedd, 2006; Laschinger *et al.*, 2003; Matthews, & Upenieks, 2002 and Laschinger, 1999). This theory was also utilised by Miller *et al.* (2001) in evaluating physical therapists' perceptions of empowerment. This study also has some relevance to other theories because of the common variables which are described such as support, opportunity, information and participative management. The variables which are highlighted by Kanter's theory are the organization, individual factors, alliances and organizational factors which are information, support, resources and opportunity.

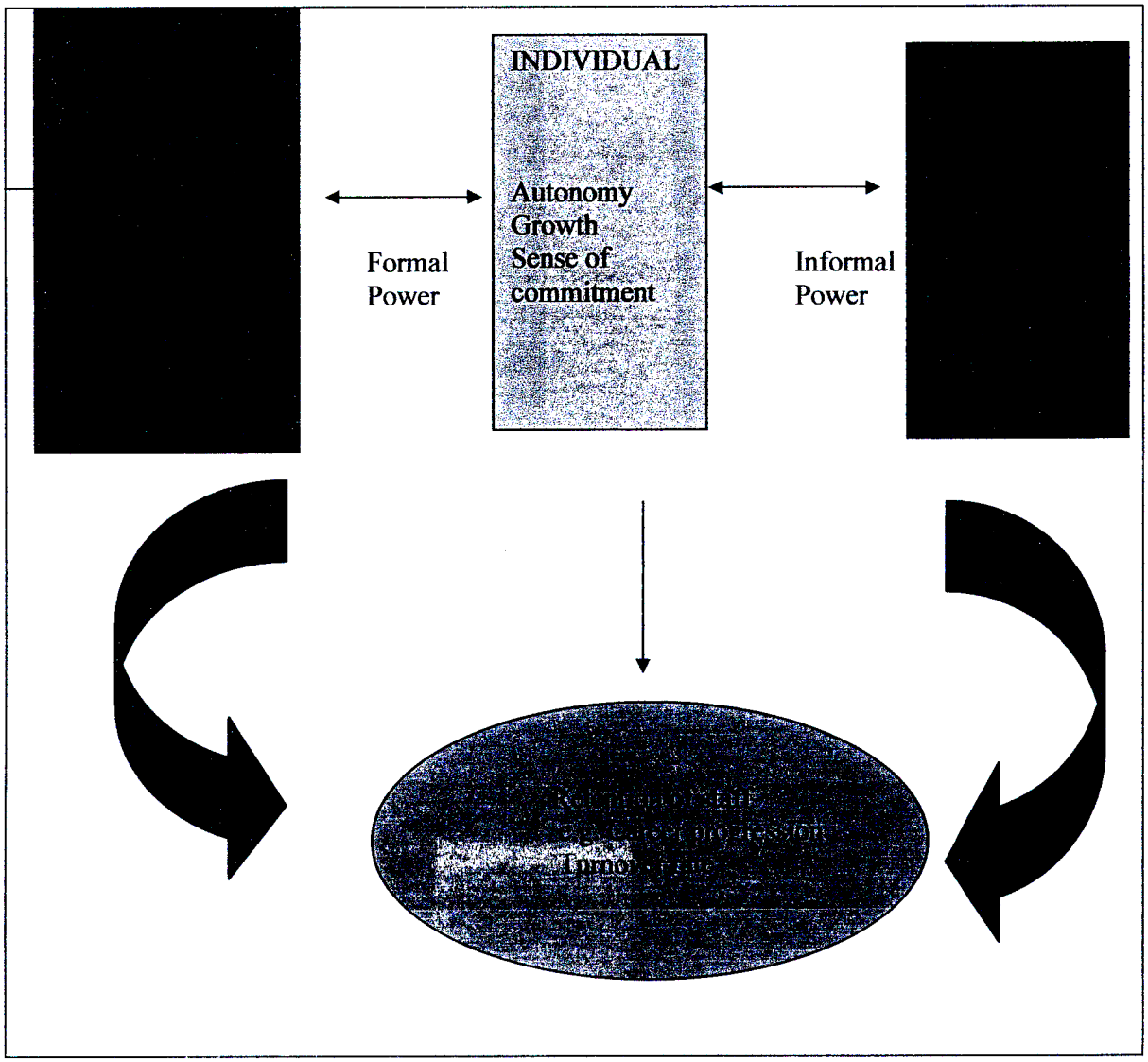

Fig 1.1: Kanter's conceptual framework as modified from Laschinger, Finnegan, Shamiam & Wilkis, 2001)

Organization

The organization looks at the leader behaviour and organizational factors. Leadership behaviour of the CNSM is measured by visibility, accessibility, power and authority of the CNSM and CPN to the professional nurses. The leadership style was informed by the leadership behaviour of the CNSM.

Organizational factors

Access to information is represented by the current state of the hospital, the values of top management and the goals of top management. It also relates to the data, technical knowledge, and expertise required to perform one's job. **Access to opportunity** includes challenging work, the chances to gain new skills and the tasks that use all of your own skills and knowledge. **Access to support** which looks at the specific info about things one does well. The specific comments about things one could improve and accessing helpful hints or problem solving advice. It also refers to guidance and feedback received from subordinates, peers, and supervisors to enhance effectiveness (Kanter, 1977; Laschinger, 1996).

Access to resources is represented in terms of time available to do necessary paperwork and accomplish job requirements. Acquiring temporal help when necessary is also part of access to resources. It also refers to the ability to acquire necessary materials, supplies, money, and personnel needed to meet organizational goals. Power refers to the ability to access and mobilize resources, information, and support from one's position in the organization to get the job done successfully. Power is the ability to do and means having opportunities, information, resources and support needed to get tasks done (Kanter, 1977).

Kanter (1977) believed that access to empowerment structures is associated with the degree of formal and informal power an individual has in the organization. Formal power is derived from jobs that allow flexibility, visibility, and creativity. Formal power is also derived from jobs that are considered relevant and central to the organization. Informal power is developed from relationships and networks with peers and subordinates outside of the organization. In this study the informal power is based on the alliance which is the labour union.

Individual factors include autonomy, growth and a sense of commitment. The individual in this study represent a professional nurse who has a sense of autonomy. Autonomy is defined as the ability to execute independent responsibilities without close supervision (Keys, 2009).

The professional nurses are expected to access the organizational factors which will allow them to grow in the nursing profession. The empowerment structures result in increased levels of commitment to the organisation and feelings of autonomy and self efficacy leading to job satisfaction (Buchan, 1999).

An alliance refers to the unions where nurses are affiliated. According to Kanter (1977), alliances give informal power to the professional nurses. Union managers represented the role of unions in ensuring that nurses have access to the organizational factors and that the CPN'S and CNSM support the professional nurses in attaining these factors.

Retention of professional nurses includes career progression and turnover rate. Retention refers to professional nurses who stayed in the country and did not leave their health institutions to go and work in other non-health industries, or abroad

1.8. CONCLUSION

This chapter highlighted the various reasons why professional nurses leave the nursing profession. All countries are affected by the movement of nurses from one country to another. The impact of globalisation in the developing countries is of great concern, considering the health challenges affecting the populations. Globalisation has encouraged a drift of skilled emigrants to developed countries. This drift has obviously had a serious effect on the quality of health care that can be provided in the developing countries, particularly those badly affected by HIV/AIDS. The literature also shows that there is a link between the leadership style of a manager and the organisational factors determining the future of a nurse in any organisation. The study will determine whether this relationship prevails in the South African context. A literature review will be presented in the next chapter.

CHAPTER 2: LITERATURE REVIEW

2.1. INTRODUCTION

This section is based on studies retrieved from the Cinahl, Medline, Pubmed, Ebsco Host and Google Scholar databases. The key words used were 'nurse retention', 'staff retention', 'leadership', 'leadership styles', 'organisational factors', 'professional nurses', 'Kanter's theory', and 'unions'. The search was restricted to papers published since 1995 with the exception of frequently cited research. The original authors date as far back as 1970, although there is one article dated 1959. A manual search at the university libraries was also conducted; however, because there has been little research in this country, and even within the continent as a whole, the literature search was not restricted to South Africa and Africa.

The literature review consists of studies which describe the impact of globalisation on the nursing profession. Different types of leadership styles and leadership theories are also explored, together with the theoretical models of management. The organisational factors that influence the management of nurses who either stay or leave their employment are also discussed. Different retention strategies, such as the Magnet hospital model, are also explored.

2.2. THE CONCEPT: GLOBALISATION

Globalisation is a term with multiple contested definitions and meanings (Labonte & Schrecker, 2007). Globalisation refers to the international exchange or sharing of labour force, production, ideas, knowledge and services across borders (World Bank, 2006). Van Rensburg (2004) views globalisation as multifaceted, with many dimensions such as economic, social, political, environmental, cultural and religious. Globalisation varies with the context of analysis, but generally refers to an increasing interaction, across national boundaries, that affect many aspects of life (United Nations, 2007). Globalisation is a key concept for the study of social determinants of health (SDH). Broadly stated, SDH are key conditions under which people live and work, that affect their opportunities to lead healthy lives (Labonte & Schrecker, 2007). Nurses in South Africa leave this country to work in developed countries so as to better their lives.

The World Health Organisation (2006) views globalisation as an increased interconnectedness and interdependence of people and countries since borders have opened to enable the fast flow of goods, services, finance, people and ideas across international borders. The ever-increasing ease and speed of travel means that people, as well as goods and services, are in constant movement around the globe. This study will adopt a definition of globalisation as a process of integration within the world economy through the movement of goods and services, capital, technology and labour, which lead increasingly to economic decisions being influenced by global conditions (Jenkins, 2004).

The nursing profession cannot ignore these developments (Seloilwe, 2005).The aim of globalisation is to bring improvements to the lives of people, by making sure that they have access to health facilities, education and economic opportunity. Modern globalisation is characterised by increasing connections among people across the planet (WHO, 2006).

The impact of globalisation on Africa is damaging to economic and political development. It poses a great threat to the economy of African countries as a result of dominance by richer countries which has led to the poaching of the majority of health care workers by developed countries, leaving Africa poorer (Aluko, 2000; Martineau, Decker & Bunderd, 2004).

Measures to resolve local and national nurse shortages are interfering with international nurse workforce goals. The demand for migrant nurses is exceeding the available supply, and threatening the public's health (Brush, 2008).

2.2.1 The positive aspect of globalisation

People are free to work in any country and this may boost the economy of the country of origin. Free trade on a large scale might lead to more bilateral agreements with other countries (www.kwymca.org). According to Seloilwe (2005), many of the nurses who migrate abroad will return to their home countries with additional experience, diverse perspectives, skills and money. Nurses also send money home to their families, and this income is often an incentive for source countries to initiate, maintain or increase the export of their nationals. Local families may live better lives afterwards.

Remittances sent through formal channels are more than twice the size of international aid flows (World Bank, 2006). The International Organisation of Migration (IOM) believes that remittances are at least as effective in targeting the poor in developing countries, as the aid currently is available (IOM, 2003). The World Bank asserts that remittances are associated with declines in the poverty headcount ratio in several low-income countries which supply nurses abroad. Remittances account for considerably more than foreign direct investment, and South African nurses remit 26 percent or more of their income (Buchan *et al.*, 2005).

2.2.2. The negative aspect of globalisation

Globalisation is not without negative aspects which have particularly affected developing countries, because the tendency is for the skilled people from developing countries to migrate to developed countries for better pay and more stability. Despite a growing supply of registered nurses in absolute numbers, the relatively inadequate supply of nurses in their home countries has had a dramatic impact on patients and health care systems, as well as economic and social development worldwide (Kingma, 2007).The heavy dependence of health systems on international recruitment and migration to fill their vacancies has exacerbated shortages in countries of origin (ICN, 2005). Mass recruitment campaigns have greatly enhanced the opportunities and incentives that encourage nurses to migrate (ICN, 2004).

Nurses migrating to industrialised countries often leave behind an already disadvantaged system, thus worsening the working conditions at home. The nurses who remain assume heavier workloads, experience reduced work satisfaction and low morale. This contributes to high levels of absenteeism and poor quality of care (Kingma, 2007; Dovlo, 2005). A country's health care system is weakened by the loss of its workforce, and the consequences in certain cases can even be measured in lives lost (WHO, 2006) .The insufficient presence of supervisors, mentors and educators threatens not only current health care delivery, but the preparation of future generations of nurses. Left with an inadequate nursing workforce, many developing countries lack the resources to implement programs to improve the health of the poor (Kingma, 2007).

Some of the points that highlighted the impact of globalisation were identified by Tompaine (2004) as follows:

- Globalisation has the tendency to destabilise a nation's public finances by prescribing a drastic reduction in the activities of the government such as the dismissal, retrenchment and premature retirement of employees in the public sector.
- The communities' growth is stunted by an increasing proportion of unemployment which reduces social welfare services, and also reduces the standards of living of the lower levels of the population (Tompaine, 2004).

Numerous codes of practice on ethical international recruitment have been introduced at national and international levels, e.g. the UK Code of Practice, the Commonwealth Code of Practice and an ICN position statement on ethical recruitment. Their effectiveness is yet to be demonstrated (WHO, 2006) and the support systems, incentives and the means for monitoring their implementation continue to be weak or non-existent (Buchan & Sochalski, 2004).

One can conclude that globalisation has brought more harm than good to African countries because the richer countries become richer, while the poorer countries become poorer. It is not Africa alone which is affected, Asia is also suffering. In a report by Hilotin (2004) in Dubai, statistics showed that more than seven million Filipinos work overseas. They send home $ 7 billion annually, and those who are at home are looking forward to joining their relatives at work overseas. Labour migration is set to grow with globalisation. Fifty percent of Filipino nurses remit more than 26 percent of their income. The nurse migration contributes to the welfare of the families left behind, as well as to the national economy of their country of origin (Kingma, 2007).

2.3 MIGRATION OF NURSES

Globalisation has opened gates for nurses in developing countries to work in developed countries because of high salaries, safe and conducive hospital environment and an improved quality of life. Traditionally, international nurse migration tended to be North-North or South-South, for example, Irish nurses working in the United Kingdom, Canadian nurses practising in the United States of America. Now, however, the rapid growth in international recruitment from

developing countries has gained most media and policy attention (Kingma, 2007; WHO, 2006). Many reasons cited by health workers for leaving their countries of origin, in no particular order, are poor remuneration, bad working conditions, an oppressive political climate and discrimination (Buchan, 1999; Andrews, 2003; Buchan & Sochalski, 2004; Geyer, 2004; Glaser & Pathman, 2007). Recent statistics revealed that many nurses from developing countries are moving to developed countries in pursuit of high salaries and security (Kingma, 2007; Xaba & Philips, 2001).

Governments need to recognise the dimension of globalisation and systematically assess the consequences of policy initiatives on the situation, and behaviour of the individuals who make up the workforce (van Lerberghe, Conceicao, van Damme & Ferrihno 2002). Policies on ethical recruitment in South Africa are available, but have not yet been implemented.

One of the impacts of globalisation in the developing countries is brain drain. Since opportunities were made to allow workers to have freedom of movement, (mainly) professional workers have chosen to leave their country of origin to explore the possibilities in developed countries. Some remain permanently in a developed country whereas other professional workers choose to come back to the country of origin. The brain drain of health professionals is a global problem which needs global solutions. This brain drain worsens the already depleted health care resources in poor countries and widens the gap in health inequities worldwide (Pang *et al.*, 2002).

A study in Australia by Scott *et al.* (2004) reported on the ethical recruitment of health personnel by wealthy countries from developing countries. This threatens the viability of crucial health programs in poor countries, especially in Sub-Saharan Africa. The number of foreign doctors and nurses on the Australian register has increased, and African countries are correspondingly disadvantaged by this brain drain.

According to Marchal & Kegels (2003) who researched health workforce imbalances in terms of globalisation, the opening up of international borders for goods and labour has resulted in adoption of different languages and cultures including professional mobility or brain circulation and brain drain.

2.4. THEORETICAL FRAMEWORK

The researcher has identified four theories that will form a supportive framework for this study, namely:

- Hertzberg's two factor theory of motivation
- Maslow's hierarchy of needs
- Theory Z by Ouchi
- Kanter's theory of organisational behaviour

These theories will be discussed in detail and integrated hereunder.

2.4.1. Herzberg's two-factor Theory of Motivation

Herzberg's theory, as described by Owens (1998), is a motivation theory which derives from a humanistic perspective holding that human beings have personal needs for growth and development, cultivation of self-esteem and engaging in interpersonal relationships. Herzberg's theory of motivation takes the concept of personnel motivation beyond a traditional hierarchy of needs (e.g. Maslow's hierarchy of needs). Herzberg has two aspects of motivation which are hygienic (maintenance) and motivating factors. Maintenance factors include the work environment, supervision, working conditions, organisational climate, physical conditions, job security, policies, salary and status. Motivating factors include possibilities for achievement, advancement, the work itself, responsibility, growth and recognition (Herzberg, 1959). According to Nimno & Holland (2000), employees cannot be motivated by the hygiene aspects of their work, but dissatisfaction with those aspects can interfere with motivating factors. Satisfied employees tend to be more creative and are committed to their jobs.

The motivating factors are evidenced through job satisfaction, which is attributed to innate human characteristics and intrinsic factors, while job dissatisfaction is linked to the characteristics of the organisation, and to the organisational climate (Owens, 1998). Thus, in respect of staff retention, it is important for nurse managers and hospital management to recognize that in terms of Herzberg's model, dissatisfied personnel are less likely to maintain long term employment with their employing body (King, 2005).

Motivation is a state of mind with which a person views any specific task or goal. Motivation also describes a process of activating human behaviour. The phenomenon of motivation encompasses a concern with what energises behaviour, directs or channels behaviour and maintains or sustains behaviour (Huber, 2000).There are different ways in which unit managers can motivate their staff either by promoting them to senior positions, or allowing them to further their studies by giving them study leave as an incentive for their indispensable commitment to the organisation.

Few studies showed a relationship of health workers being motivated by their leaders resulting in the intent to stay in their organisation. Ellenbecker (2004) suggested that employers should be encouraged to assure nurse satisfaction since job satisfaction is directly related to retention, and indirectly related to retention through intent to stay. Nurses will stay in their present employment if they are satisfied. Presently, nurses are encouraged to study further and they are supported by their employers. In a study in South Africa, nurses were supported by their leaders to further their studies and were exempted from their duties by obtaining study leave. These nurses stayed in their employment because they were supported to study further by the employers (Nkosi & Uys, 2005).

A study by Smeltzer, Tseng & Harty (1991) found that new graduates wanted extensive orientation, strong preceptor programmes, high starting salaries, safe and convenient locations, flexible duty schedules, weekend and holidays off. Ntsanganye (2004) also found that graduates need strong and knowledgeable preceptors who were willing to teach, support and guide the graduate. He intimated that if nurses were promoted to senior positions, they would have an inclination to stay in the profession. Corley, Farley, Geddes, Goodloe & Green (1994) agreed that retaining competent nurses required a work environment that supported nurse autonomy. Nurses left health care institutions because of a need for career mobility, job stress and dissatisfaction.

In summary, the theory showed that there is a relationship between job satisfaction, a conducive work environment and retention of nurses.

2.4.2. Maslow's Hierarchy of needs

Abraham Maslow's motivation theory states that man's behaviour is controlled by both internal and external factors, although the behaviourists believe that human behaviour is controlled only by external factors, and psychoanalyst psychology is based on the idea that human behaviour is controlled only by internal unconscious forces. Human beings have the unique ability to make choices and exercise free will. Maslow described needs as being hierarchical in nature, meaning that some needs are more basic or more powerful than others, and as these needs are satisfied, other needs emerge (Maslow, 1943).

Abraham Maslow belongs to the group of need theorists who assume that individuals possess internal needs that motivate them to exert effort. Different people have different needs at different times, so they require motivators. Abraham Maslow classified needs into a hierarchy with basic needs at the bottom and motivators of behaviours at the top. This classification indicates that employees will be the happiest when they are working toward self-actualisation which can only happen when their basic needs are met first.

Need hierarchy theory suggests that an individual must satisfy the lowest level of needs before moving to the next level, but Aldefer (1972) proposed that individuals can also move down the hierarchy under certain conditions. He further reworked Maslow's five needs into three, namely existence, relatedness and growth (Aldefer, 1972).

According to the American Society of Health-System Pharmacists, (2003), there is a relationship between Maslow's hierarchy of needs and staff retention as illustrated below:

- Physiological: physical environment (shelter, food, warmth)
- Safety: stability, job security, vision for the future, acquisition and mergers
- Belonging, love, affection: sense of community, training, team involvement, pay equity
- Self esteem: learning recognition, opportunities, bonuses and
- Self-actualization: challenges, personal growth.

According to this study, registered nurses stay in their jobs to provide for themselves and their families, which bring love and belonging, a conducive environment which is a basic human right. Once security is guaranteed, they can improve themselves by further educational opportunities which lead to personal growth. Although it takes time to reach self-actualisation, if registered nurses are given enough support and opportunities there are greater chances to reach self-actualisation.

2.4.3. Theory Z- Ouchi

Theory Z was developed by William Ouchi based on the Japanese model which states that employment is viewed as a lifetime term with mutual commitment, in which the organisation takes responsibility for the social, as well as the economic wellbeing of its employees, while employees are given an active role in decision-making and self- governance. William Ouchi combined both Japanese and American cultures to form Theory Z (Booyens, 1996). The Japanese believed in collective decision-making and responsibility, whereas the American believed in short-term employment, individual decision making and individual responsibility. William Ouchi (1981) explored the management concepts Japan used to succeed that could be applied successfully in America (Ouchi, 1981). Leaders who utilise the Theory Z strategy apply decentralised control on performance quality, and are also concerned for both the employee's and the organisation's welfare (Booyens, 1996).

Theory Z examines how workers contribute, and proposes that workers naturally wish to co-operate and are loyal to the organisation. This interaction denotes participative management. According to Ouchi (1981) participative management is essential because he believes that if workers are involved in the organisation's decision, tasks will be done efficiently. The idea behind Theory Z is that employees who develop a sense of ownership in, and commitment to the organisation in which they work will be more dedicated to the goals of the organisation and will thus become more productive contributors (Barnhardt, 1987).

Critics of Theory Z assert that this theory did not appeal to managers because of its emphasis on holistic concern, collective decision-making responsibility and long term employment (Safranski, Kwon, Walker & Unger, 1986).

2.4.4. Kanter's theory of organisational behaviour

Kanter's theory postulates that worker empowerment evolves from formal and informal power. Formal power is found in jobs that are visible and central to the purpose of the organisation and that allow for discretion in decision-making. In addition to formal high - profile job activities, individuals derive informal power from the alliances they form within the organisation with superiors and peers, as well as subordinates. These alliances provide informal sources of power that enable individuals to get the cooperation they need to get things done (Kanter, 1977).

According to Kanter's theoretical framework (1977), systematic power factors such as formal and informal power, influence access to job-related empowerment structures which have a personal impact on employees. Components of this psychological empowerment of employees include increased autonomy, decreased job stress, lower burnout, increased satisfaction and increased commitment. This present research, based on Kanter's framework, assumes that increased psychological empowerment of nurses will be positively associated with retention and the intention to remain in nursing positions in South Africa. If this relationship is supported in this research, then further work can explore the relationship between these factors and work effectiveness.

Kanter (1993) argues that people react rationally to the situation in which they find themselves. When situations are structured in such a way that employees feel empowered, they are more likely to be satisfied with their work. Kanter states that power in organisations is derived from structural conditions in the work environment, not from an individual's personal characteristics or socialisation effects. Power is the ability of individuals to get things done, and is derived from the position that a person occupies in the organisation (Kanter, 1993).

According to her Theory of Structural Power in Organisations, Kanter (1977, 1993) argues that work behaviours and attitudes are shaped in response to an individual's position and the situations which arise in an organisation, as opposed to individual/personal characteristics and socialization experiences. Kanter (1993), as cited by Laschinger (2004), considers power as a structural determinant affecting organisational behaviour and attitudes. Power is obtained from the ability to access and mobilise support, information, resources and opportunities from one's position

in the organisation. Access to support, information, resources and opportunities is influenced by formal and informal power. Those with sufficient power are able to accomplish the tasks required to achieve organisational goals. These individuals have the ability to empower those around them, and thus to create an effective work unit within the organisation. The individuals who are unable to access resources, support, information and opportunities are powerless (Kanter, 1993).

Formal power thus includes a job description relevant to organisational goals and recognition, while informal power involves interpersonal relationships e.g. alliances (Laschinger, Finegan, Shamiah & Wilkis, 2001). According to Kanter (1977), individuals with power and opportunity feel empowered, and are happy and productive at work. These individuals are able to contribute to activities that address organisational goals.

According to Kluska, Laschinger & Kerr (2004), and Anthony (2004), formal and informal power in turn enable the workers to access empowerment structures such as having access to information, receiving support, job autonomy and positive feedback, having access to resources necessary to do the job, and having the opportunity to learn from challenges and grow professionally. The empowerment structures result in increased levels of commitment to the organisation and feelings of autonomy and self efficacy leading to job satisfaction. The latter will finally result in participative management, cooperation, respect, success, achievement and, more importantly, retention of staff (Anthony, 2004; Laschinger *et al.*, 2003; Manojlovich & Laschinger, 2002; Upenieks, 2002; Miller, Goddard & Laschinger 2001; Hatcher & Laschinger, 1996 and Laschinger, 1996).

Employees who believe their work environment provides access to opportunity, information, resources and support are empowered by Kanter's thinking. Support has been found for Kanter's proposition that the ability of an individual to access and mobilise the organisational empowerment structures of power and opportunity is influenced by the location of that individual's position within the organisational hierarchy (Laschinger & Wong, 2006; Anthony, 2004 and Laschinger *et al.*, 2003).

The key consideration in applying any theory is that only those aspects which best serve the study should be adopted (Safrani *et al.*, 1986). All these theories will be utilised, but the main framework will be based on Kanter's theory. There are

common and differing aspects among these four theories as set out in the table below:

Table 2.1. Common aspects of theories of organisational behaviour

Theory	Kanter	Herzberg	Maslow	William Ouchi
Participative Management	Information to achieve • Autonomy • Commitment • Recognition • Job Satisfaction	Motivation • Achievement • Advancement • Growth • Recognition	Self actualization • Challenges • Personal growth • Advancement • Achievement	Decision making • Influences on policies, • Self governance • Sense of ownership • Commitment to the organisation
Empowerment	Empowerment thro'Opportunity • Growth • Development • Training • Responsibility	Motivation • Responsibility • Work itself	Self esteem • Learning recognition • Opportunities	Participative management • Responsibility
Support	Alliances • Subordinates • Peers • Funders		Belonging • love • affection	Loyalty to the organisation
	Support • through alliances • job description	Maintenance • policies • salaries • job security	Safety • job security • bonuses	Long term employment
Resources	Resources • Salaries • Staffing adequacy • Equipment • Supplies	Maintenance • Physical condition • Organisational climate	Physical environment • Shelter • Food • Warmth	

The above four theories have similar characteristics in terms of support, opportunity, access to resources, although William Ouchi does not discuss physiological factors. In Herzberg's theory, there is no sense of belonging, as is included in the other theories.In a study by Ma, Samuels & Alexander (2003), Maslow's and Herzberg's theories were integrated to determine which factors affected job satisfaction among nurses in South Carolina.

2.5. LEADERSHIP

2.5.1. Definition of leadership

Leadership is an art that is difficult to define and learn (Swearingen, 2004)).One of the problematic issues regarding leadership is the lack of consensus regarding definition (Coomber & Barriball, 2007). Several authors define it according to their own situations and views. Madden (2008) and Bass (1995) state that leadership is the ability to influence a group of people towards the achievement of the chosen organisational goals. Muller, Bezuidenhout & Jooste (2006) maintain that leadership is the influential relationship among people, involving the leaders and followers who intend real changes that reflect shared goals, whereas Hersey & Blanchard (1988) view leadership as the act of guiding or influencing people to achieve desired outcomes.

Leadership is related to influence, and the quality of the leader directly impacts on the retention of nursing staff (Swearingen, 2004). Leadership occurs any time a person attempts to influence the beliefs, opinions or behaviour of an individual or group. Leadership refers to the influencing and directing of the behaviour of followers in such a way that followers willingly strive to accomplish the goals and objectives of the organisation. "Leaders do the right things, whereas managers do things right" (Hanson, 1979, 164). Leaders display different leadership attributes such as clear vision, strategic thinking abilities, a change in management skills, giving strength and courage, engaging in negotiation and displaying confidence. Nursing leadership has been demonstrated to have a direct effect on professional practice behaviour (Kramer & Schmalenberg, 1993).

Successful leadership is dependent on one's ability to inspire confidence, show personal interest, productivity, foster teamwork, gather and use people's ideas (Madden, 2008). Leaders utilise different leadership styles in dealing with their subordinates. The leader's behaviour has a great impact on organisational effectiveness. According to Cummings (2004), nursing leaders at all levels hold responsibility in the healthcare workplace for contributing to the achievement of the organisational, nursing and patient outcome.

Leaders need a clear vision of the direction of change, and skill in identifying and responding to change (Porter-O'Grady, 2003). The focus of change in this study is the moving away from leadership styles which do not allow shared governance, and engaging in transformational leadership style. Similar results were cited by Kangas, Kee & Mc Kee-Waddle (1999) in a study of organisational factors. They found less nurse job satisfaction and patient satisfaction with patient care where the leader who followed traditional leadership styles did not allow shared governance with her/his subordinates.

Leadership plays a major role in retaining staff and effectiveness is the key outcome of leadership efforts in health care. Nursing leadership plays an important role in the future of health care policy and management in this country. Because of the numerical strength of the nursing profession in our health care system, nurses are needed to render health care services which are potentially limitless, especially when competing for stretched resources (van Rensburg, 2004; Jooste, 2001).

In discussing leadership, it is important to make a distinction between the terms management and leadership. The difference may be summarised as activities of communication and coordination among people, which facilitate the effectiveness as a leader, versus activities of controlling resource and mastering procedures and routines which facilitate efficiency as a manager (Muller *et al.*, 2006). The main differences between management and leadership are as follows:

- Managers have employees, leaders have followers
- Managers command and control, leaders empower and inspire
- Management can be taught, leadership must be experienced to be learned
- Managers seek stability , leaders seek flexibility
- Managers make decisions and solve problems, whereas leaders set directions and then empower their team to make their own decisions and solve their own problems (Jooste, 2003).

2.5.2. Theories of leadership

The researcher will conceptualise only the few theories which are relevant to this research study. The theories of relevance are trait theory, situational theory, path-goal theory, Blake and Mouton's theory, transformational theory and transactional

generally had more productive work groups, and consequently received higher performance evaluations from superiors. Structured activity can increase motivation by reducing role ambiguity and allowing for externally imposed controls.

Critiques of Path Goal Theory

Few researchers have criticised path goal theory, pointing out that organisational culture plays an important part in encouraging productivity among workers. Dorfman *et al.* (1997), asserted that the theory should have variables which have potentially wide applications across cultures, whereas Huber (2000) reported that the government cannot be compared to private companies in terms of incentives, promotions and job security.

2.5.2.3. Situational Leadership theory

This theory was developed by Hersey and Blanchard (1977), whereby the leader utilises an appropriate leadership style based on the degree of maturity of the followers at that particular time. According to Hersey and Blanchard (1988), leadership style changes based on the situation and the maturity of the follower, suggesting that different leadership styles may be appropriate in different situations (Womack, 1996). A situational theory explores the context in which leadership occurs. A person may be a leader in one situation and a follower in another (Muller *et al.*, 2006). Situational leaders thus change their leadership style depending on the person they are working with and the situation (Madden, 2008).

Hersey and Blanchard (1977, 1988) illustrate the situational leadership theory in a four-quadrant model (see Fig 2.1). The horizontal continuum registers low emphasis on the accomplishment of tasks on the left side, to a high emphasis on the task behaviour on the right side. The vertical continuum depicts low emphasis on interpersonal relationships at the bottom of the model to high emphasis on relationships at the top. The lower left quadrant therefore represents a *laissez faire* type of leadership with little concern for production. The lower right quadrant represents an autocratic leadership with considerable concern for production but little concern for people. The upper right quadrant designates a high concern for both tasks and relationships. The left upper quadrant represent a leadership style that stresses relationship, but shows little concern for tasks (Marriner-Tomey, 1993). The

nurse manager will have to assess the maturity levels of subordinates with regard to the task at hand in order to decide which leadership style would be appropriate (Hersey, Blanchard & Johnson, 2001).

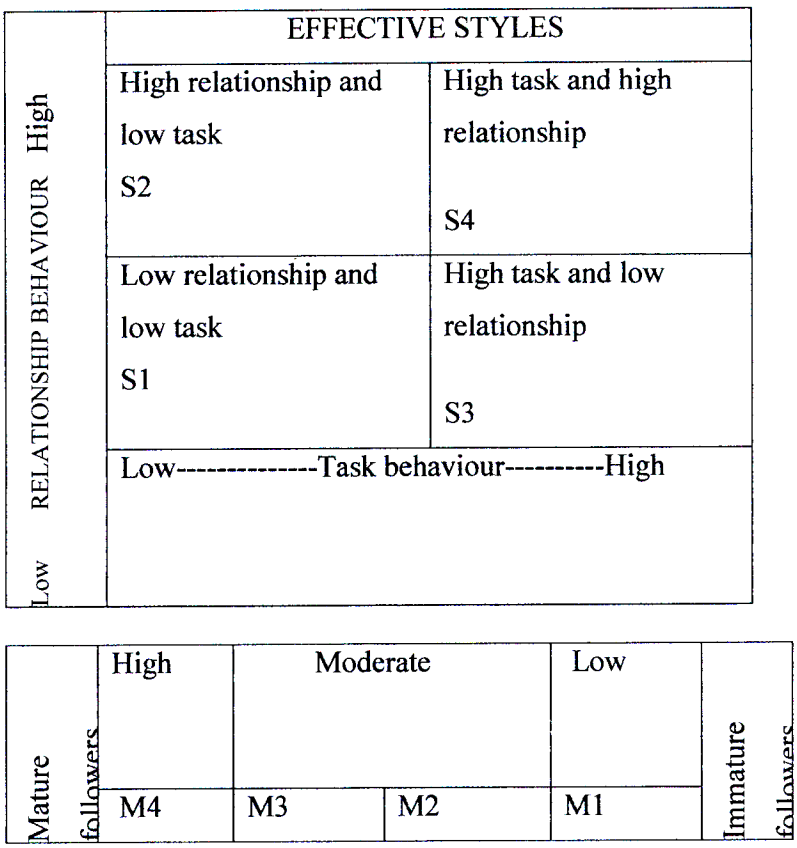

Fig 2:1. Situational leadership theory by Hersey & Blanchard (1977)

Key:

Maturity level

M1: Low maturity

M2: Low to moderate maturity

M3: Moderate to high maturity

M4: High maturity

Leadership style

S1: Telling style (Directing)

S2: Selling style (Coaching)

S3: Participating (Supporting)

S4: Delegating

According to Madden (2008) there are four basic leadership methods, namely directing, coaching, supporting and delegating. Directing method: The leader provides specific direction and closely monitors task accomplishment which allows the doer to solve problems and make decisions. Coaching method: The leader changes to a more two-way communication because a staff member understands the

expectations and moves through the novice phase in the development of skills and abilities. Supporting method: The leader shares decision-making and problem-solving functions because staff members take more ownership for accepting responsibility. Professional nurses become more proficient in their roles. Delegating method: The leader turns over responsibility for decision-making and problem-solving. This method offers more latitude for authority and autonomy.

Critique of Situational Leadership theory

According to Scheiner (1974), it is for the leader to judge the behaviour of the individual using only the maturity of the follower; there are always operational principles which are applied in all situations to detect the behaviour of the follower. Likewise, Babb & Kopp (1978) asserted that in line with the maturity of the followers, one can look at the performance of work without determining the exact cause of behaviour.

2.5.2.4. Blake and Mouton Theory

Blake and Mouton proposed a managerial grid which depicts two critical dimensions, a concern for people and also a concern for production. The two dimensions are independent. A manager may be high on one and low on the other, or high or low on both. The grid consists of two axes. The vertical axis represents the manager's concern for people and the horizontal axis represents the manager's concern for production. There are five basic styles, one in each corner of the grid and one in the middle (Booyens, 1998).

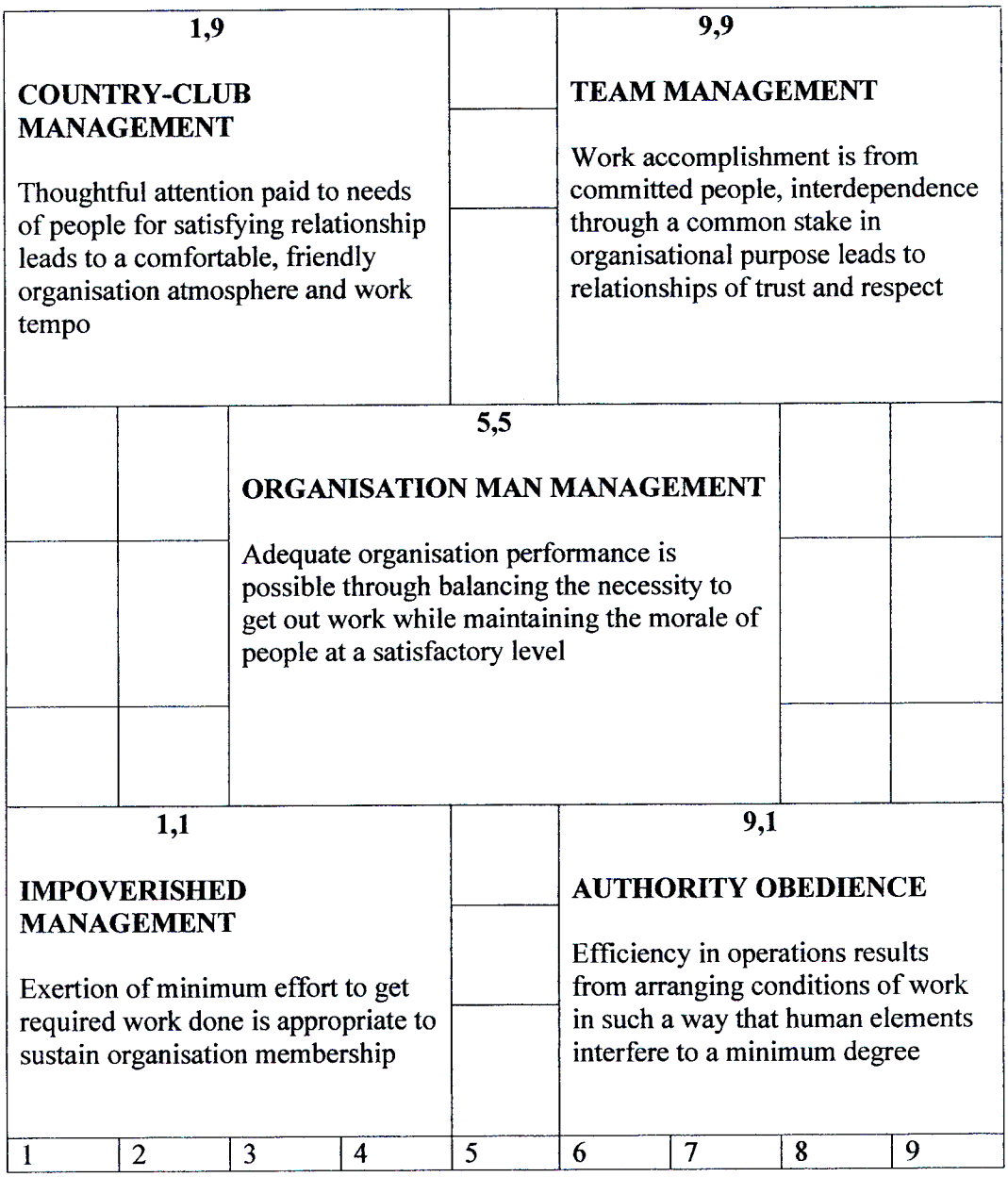

Fig 2. 2: Managerial grid by Blake and Mouton (1978)

The task manager at 9.1 has the highest regard for production and the lowest concern for people. The style of management is called authority obedience management. The people manager at 1.9 is thoughtful and friendly but production is not considered. This style of management is called country club management. The 'organisation man' manager at 5.5. displays a moderate concern for both people and production, but not necessarily at the same time. The emphasis shifts from time to time. This type of management is called middle-of-the road management. While the

work gets done, the morale of the employees is kept at satisfactory level. The team manager at 9.9 is the best manager. This type of manager integrates his or her concern for people and production. The work is accomplished by committed people who are working together independently by having a common stake in the purpose of the organisation. The manager at 1.1. is low on concern for people as well as on production. This style is called impoverished management. This manager exerts the minimum effort to get work done and to sustain organisational membership (Booyens, 1998).

2.5.3. Leadership styles

A leadership style is the approach that the leader follows to provide direction, implement plans and to motivate people (Jooste, 2003). Job satisfaction, productivity and organisational commitment are affected by leadership behaviours. A leader is expected to build effective teams, create a conducive environment, manage relationships, build consensus and develop interpersonal relationships. All of these competences combined have the power to align and inspire the contributions of the workers (O'Neil, 2005). According to Huber (2000), leadership is a unique role. Autonomy and commitment are associated with leadership. Effectiveness is the key outcome of leadership efforts in health care. Managers who shared the vision of the organisation were rated highly by their members in ensuring achievement of organisational goals compared to managers who did not share the vision of the organisation (Chiok Foong Loke, 2001).

Different leadership styles have different influences on the employees. In Singapore, Chiok Foong Loke (2001) explored the relationship between leadership styles and employee outcomes. With authoritarian leadership styles, organisational objectives were achieved quickly, whereas the employees' levels of satisfaction and morale were neglected. Unfortunately, the impact of each leadership style on the employees' job satisfaction, productivity and commitment were not established. Leaders must be trained to incorporate their leadership behaviours in their management skills.

According to Boyle et.al (1999), managers' leadership characteristics were a determinant factor in the critical care nurses' intent to stay in their jobs. A nurse manager's position of power and influence over work coordination had a direct link

to staff intent to stay. Communication, autonomy and group cohesion decreased job stress and thus increased job satisfaction which was directly linked to intent to stay.

In a study by Lymbery (2002), staff members who were involved in decision-making had a high level of job satisfaction. These findings also showed that where staff members are involved they feel valued and make a better contribution to service delivery, so reducing staff turnover. Employees were empowered with appropriate leadership skills and given more responsibility and accountability. A study conducted in Ireland by Carney (2004) found that nurse managers who involved their staff in the decision-making promoted greater satisfaction among their nurses and therefore these nurses remained with one institution longer. In a study in Canada by Laschinger & Wong (2006), leaders who developed organisational structures that empowered nurses to deliver optimal care promoted greater work engagement and less burnout.

Examples of leadership styles cited in literature are categorised into two groups, namely traditional and innovative. The traditional leadership styles are autocratic, democratic and *laissez-faire,* whereas the innovative leadership styles are transformational and transactional. Emotional intelligence is discussed as an attribute to innovative leadership style.

2.5.3.1 Autocratic leadership style (restrictive)

The autocratic leadership style is characterised by the giving of orders. The leader usually makes decisions alone, and frequently exercises power with coercion. This style of leadership is necessary and useful in crisis situations, but in normal day-to-day activities leads to a dependent and aggressive group of employees who have lost the power to think innovatively and are unproductive in the leader's absence (Booyens, 1998).

2.5.3.2. Democratic leadership style (teamwork)

The democratic leadership style is concerned with human relations and teamwork. It is particularly appropriate for groups of people who will work together for extended periods of time, when interpersonal relationships can affect the productivity of the group. Group members usually exhibit high morale, are not entirely dependent on

the leader, and are thus not afraid to take risks and to think creatively. Their work output is not dependent on the leader's presence or absence. Studies show that democratic leadership is not as efficient quantitatively as authoritarian leadership (Booyens, 1998).

2.5.3.3. *Laissez-faire* leadership style (without direction)

This type of leadership style is also known as "free reign". The leader sets no limits, is permissive, has no established goals or policies, and offers very little to a group because few commands, suggestions and criticism are given. These leaders tend to behave inconsistently and will occasionally become directive and issue commands. *Laissez-faire* is often practiced by a person who has a great need for approval and is afraid to offend subordinates (Tappen, 1995).

2.5.3.4. Innovative leadership

The leadership style of a manager has a great impact on the nurses because the leader can either build or break an individual. Leaders have the essential authority, power and influence to lead followers in their goals. Nurse leaders are expected to implement effective leadership styles in a complex health environment. According to the study in South Africa by Jooste (2004), a different kind of leader should emerge to lead in a new way, differing from those leadership styles that we have known in the past. Leadership skills are needed by all nurses. Nurse leaders must move from the traditional to the innovative styles and plan for the future (Mahoney, 2001). In this study, innovative leadership will mean transformational and transactional leadership.

2.5.3.4.1 Transformational leadership style

A transformational leader is defined as a leader who motivates followers to perform to their full potential at work. Transformational leaders use charisma, individualised consideration and intellectual stimulation to produce greater effort, effectiveness and satisfaction of followers (Bass & Avolio, 1990). Transformational leaders are believed to be at the final stage of the leadership development process. These leaders organise the world based on personal values and they motivate followers (Bass, 1985).

Transformational leaders build relationships and trust by creating an empowering work environment, and a culture that supports knowledge development which leads and sustains change. This change balances competing values and priorities (Madden, 2008).

Studies show that the best leaders for successful organisations are transformational leaders. Leadership is critical to establishing a culture of excellence and transformational leadership is reported in all successful nurse executives. Transformational leadership is argued to be more congruent for professionals and for work requiring high levels of decision-making and independence (Mc Daniel &Wolf, 1992).Transformational leadership is heralded as a new criterion for nurse managers and can be achieved through training, education and professional development in key leadership competencies (Murphy, 2005).

A few studies have linked transformational leadership with job satisfaction. In a study by Kleinman (2003), the findings showed that transformational leaders generate greater commitment in their followers than those who use other leadership styles. Nurses also verbalised that they were happy to work with transformational leaders because they involved them in decision-making and offered more responsibility, which contributed positively to staff retention, as described by Laschinger (2001).

In a study by Larrabee *et al.* (2003), transformational leadership, nurse patient relationships and group cohesion were the major predictors of job satisfaction. Nurses rated their nurse managers who utilised the transformational leadership style as having the best and greatest influence on their job satisfaction. Scott, Sochalski & Aiken (1999) show that leadership and retention findings among Magnet status hospitals provided support for the significant relationship among effective leadership characteristics, staff nurse satisfaction and retention.

Effective leadership is crucial to the establishment of a cohesive efficient work team and ultimately, to the success of the service. Leadership has a direct influence on staff nurses' participation in hospital affairs, staffing and adequate resources (Manojlovich & Laschinger, 2007). Kleinman (2004) pointed out that nurse leaders are challenged to recruit and retain nurses in the midst of increasing job vacancies and turnover rates averaging 21%.

In the study by Scott *et al.* (1999), visionary leaders were those who exercised autonomy, were enthusiastic, supportive and knowledgeable. These qualities were also present in a transformational leader as stated within the Magnet hospital research. Dunham-Taylor (2000) differentiated between transformational and transactional leadership in that the transformational leaders identify and communicate a vision or direction for the work group and also lead by values such as respect and trust. The transformational leader uses his or her influence to lead followers to higher levels of thinking. Transformational leadership is characterised by idealised influence, inspiration, intellectual stimulation and individualised consideration (Bass, 1985). Transformational leaders build on the strengths of transactional leaders by attempting to create and shape their work environment (Levy, Cober & Miller, 2002).

Transformational leaders raise their follower's levels of intellectual stimulation towards valued outcomes, tend to individualised needs and promote the sacrifice of the self for the benefit of organisational-level performance (Levy *et al.*, 2002). The characteristics of transformational leadership are explained by Bass (1985) as follows:

- Idealised influence is a process whereby the leader provides followers with a vision and mission and gains respect, trust and confidence from followers.
- Inspirational leaders engage in confidence building of their subordinates thereby influencing them to perform tasks successfully.
- Intellectual stimulation is a process whereby the leader increases follower awareness of problems, and influences followers to view problems from a new perspective.
- Individual consideration is a process of providing support, encouragement and developmental experiences for followers. The leader shapes and creates an empowered working environment by addressing behavioural differences among individuals and developing people with those differences in mind.

2.5.3.4.2 Transactional leadership

On the other hand, a transactional leader operates within an existing system, prefers risk avoidance and focuses on efficiency. When performance does not meet expectations, transactional leaders clarify follower task requirements (Levy *et al.*, 2002). According to Madden (2008), transactional leadership is typical of the leader who functions in a caretaker role, focuses on day-to-day operations, surveys the followers' needs and sets goals for them, based on what can be expected from them. Bass (1985) offers a leadership framework within which a transactional leader functions, for example, three components which are contingent rewards, active management by exception, or passive management by exception (Dunham-Taylor, 2000). Contingent reward is a process by which the leader contracts with the follower by providing rewards for an agreed upon effort. Followers are given a clear understanding of what is expected from them (Morrison, Jones & Fuller, 1997). Bass (1985) described transactional leaders as providing stable, but risky leadership within the boundaries of an organisational culture in exchange for subordinate effort toward performance of goals. Management by exception is the leader's reaction when a problem occurs (Booyens, 1998); the leader intervenes only if standards are not met, or if something goes wrong. If the leader uses active management by exception, s/he watches and searches for deviations from rules in order to take corrective action. The leader utilises passive management by exception, by intervening only if standards are not met (Morrison *et al.*, 1997).

A study by Dunham-Taylor (2000) showed that transformational leaders were very effective and that staff members were happy to have them as their leaders, when compared to transactional leaders. The staff verbalised that transformational leaders motivated staff to do more and these leader types set more challenging expectations which motivated the nursing staff to achieve higher expectations. A study in America by Medley & Laroche (1995) showed that head nurses who exhibited a transformational leadership style had a positive influence on job satisfaction compared to those nurses who exhibited a transactional leadership style.

A similar comparison was done in Taiwan by Shieh, Mills & Waltz (2001) in ascertaining academic leadership style predictors for nursing faculty job satisfaction. Transformational leaders had a positive predictor for job satisfaction, whereas active

management-by-exception was a significant and negative predictor for job satisfaction.

Emotional intelligence is a new concept which was brought about by the paradigm shift in organisational behaviour and social changes (Mc Queen, 2003). Emotional intelligence (EI) offers new potential for nurse leadership in terms of reciprocal interdependent interaction that is embedded in a social context. Emotional intelligence represents a set of core competencies for identifying, processing and managing emotions that enables nurse leaders to cope with daily demands in a knowledgeable, approachable and supportive manner (Akerjordet & Severinsson, 2008). Emotional intelligence is one of the particular variables which are of importance to health care organisations (Guleryuz, Guney, Aydin & Asan, 2008).

Emotional intelligence (EI) refers to self-awareness, mood management, self-starter, empathy and is based on people skills (Madden, 2008). Emotional intelligence is the ability to know and manage oneself, along with the awareness of, and ability to manage one's relationship with others (Bucher, 2003). Emotional intelligence supports nurse leadership which fosters a healthy environment, further inspiring relationships based on mutual trust. Nurse leaders who exhibit characteristics of emotional intelligence enhance organisational and staff outcomes (Akerjordet & Severinsson, 2008).

While there are many studies about different leadership styles, there are only few which have dealt with a relationship between leadership style and staff retention. For example, a study by Larabee *et al.* (2003) showed that leadership style was a major predictor of job dissatisfaction which made nurses likely to leave their organisation, while Boyle *et al.* (1999) identified that managers' leadership characteristics were a determinant factor in the critical care nurses' intent to stay in their jobs.

Transformational leadership is regarded as the best strategy to retain staff. Trofino (2003) researched different leadership styles which influence staff retention and the findings were that staff satisfaction increased, in institutions where transformational leadership was practised. In Australia, Thyer (2003) argued that transformational leadership may hold the key to reducing nurse shortages where nurses were visionary, creative and also involved in decision-making.

There are a few studies which have been done in South Africa about leaders and nurses, but none have been conducted about leadership and staff retention. Leaders are seen as the backbone of the nursing profession but, according to a study in South Africa by King (2005), nurse managers are the major cause of staff resignation. Nursing staff resigned from their jobs because managers were uncaring, had poor attitudes, did not involve staff in decision-making and also denied staff training and development opportunities. Mabaso (1998) asserted that nurse managers did not motivate professional nurses even when nurses did well. Leaders play a great role in motivating staff, because nurses are prepared to work hard in their organisations if they are acknowledged by their leaders.

The original Magnet hospital research commented on the importance of visible, supportive leadership to the professional nursing practice (Mc Clure, Poulin, Sovie & Wandelt, 1983). Follow-up Magnet hospital research demonstrated that, without leadership support throughout all levels of the organisation, an environment conducive to professional nursing practice could not unfold (Manojlovich, 2006).

In summary, one can conclude that leadership behaviour has a great impact on job satisfaction. The most commonly applied leadership style that produces positive result is the transformational leadership style. Since the late 1990s there has been a trend of focusing on transformational leadership, compared to other types of leadership styles. Transformational leadership ensures that nurse managers have a vision and can work positively towards the attainment of organisational goals. It would encourage staff to participate actively in the activities of the institution. Transformational managers are also willing to share knowledge and encourage participative management in their staff. Since staff members become involved in decision-making they feel that they are part of the team and would not see the need to leave their organisations.

2.6. ORGANISATIONAL FACTORS

Organisational factors involve a combination of factors which affect an individual in an organisation in terms of access to information, support, resources and available opportunities. Research has indicated that staff members who have access to information, support, resources and available opportunities in their organisations tend to stay longer at institutions (Kanter, 1977).

Organisational factors are multifaceted, ranging from the environment, structure, culture and organisational climate. These factors have a great impact on staff retention because organisational culture deals with the structure, norms and values of the organisation whereas the organisational climate reflects the employee's perception of organisational culture. Both these factors dictate the quality of work life and quality of health care in health care organisations (Gershon, Stone, Barken & Larson, 2004). According to Sleutel (2000), the most common descriptors for an organisational environment are organisational climate and organisational culture.

There is a close relationship between organisational culture and climate which has often been overlooked in the literature (Huber, 2000). Moran & Volkwein (1992) argue that while culture and climate are distinctively identifiable elements within the organisation, there is some overlap between the two terms. This overlap was also indicated in the study by Wallace, Hunt & Richards (1999), where organisational cultures and climate had a strong link to managerial values. On the other hand, Mok & Au-Yeung (2002) assert that organisational climate is not synonymous with organisational culture as it focuses on measuring the perceptions of individuals about their organisations, rather than the beliefs and values shared by a group of people. In order to understand the context of this study, organisational factors will be discussed under organisational climate, culture and structure.

2.6.1. Organisational culture

Organisational culture is different from ethnic culture in that it focuses on organisational life. Organisational culture comprises the shared beliefs and values which occur in a particular organisation. It is the combination of the symbols, language and behaviours that are openly manifested in the values and norms of the organisation (Booyens, 1998). Organisational culture is a determining factor in nurse

job satisfaction, productivity, job attraction and retention (Kangas *et al.*, 1999).This study focused on the effect of organisational culture on staff retention.

A supportive organisational culture contributes to the development and enhancement of self-esteem, achievement and nurse autonomy (Strachota *et al.*, 2003). The findings revealed that the organisational culture of each institution is driven by its vision and mission statement. The critical factor in preventing nurses' turnover is a positive workplace culture that facilitates teamwork, encourages continuous learning, accountability and flexible scheduling (Chan *et al.*, 2004). Magnet hospitals believe in building a culture that fosters and promotes nursing excellence (Trossman, 2002). Geographical areas also determine how nurses behave and portray the image of the institution, for example, rural areas are reportedly isolated with no exposure to advancement.

There are five critical cultural elements in any organisation, as discussed by Huber (1996:106) and these are as follows:

- The vision statement, which outlines the organisation's philosophy
- The formal organisational structure, which outlines the hierarchical responsibilities of departments and individuals
- The political structure, which shows the distribution of power within the organisation
- The informal structure which includes networks or relationships
- The financial structure, which includes the fiscal resources to support the organisation's activities (Huber, 1996: 106).

The cultural values and norms of the organisation are reflected in the policies and practices related to dress, personal appearance, social behaviour, the physical environment, communication and status symbols (Booyens, 1998; Huber, 2000). Nurse Managers in health care organisations need to have an understanding of the organisational culture which exists in their organisations. The culture of the organisation is viewed as a critical driver of norms and the way things are done in an organisation (Carney, 2006).

When recruiting nurses, it is wise to bring in people who have comparable characteristics to a hospital culture. It is easier for a hospital employer to retain

outstanding employees who form an organisational culture that promotes a high quality of nursing services (Tzeng, 2002).

2.6.2. Organisational structure

The different ways of structuring health care institutions include the bureaucratic structure, the decentralised structure and the matrix structure. Kangas *et al.* (1999) defined organisational culture in a structural context as an organisation governed by bureaucratic, innovative or supportive cultures. Bureaucratic cultures are hierarchical with structural lines of responsibility and authority. Control and power are clearly evident (Kangas *et al.*, 1999).The decentralised structure is characterised by a flat structure and allows for quick dissemination of information from top management to the lower level (Huber, 2000). The matrix structure refers to the use of *ad hoc* committees to carry out special projects e.g. accreditation teams. Once the project is completed, the team is dissolved (Booyens, 1998). The organisational structure of any organisation falls into one or more of these theoretical models. The leadership style in any organisation is determined by the structure and power which is discussed under the theoretical models below.

2.6.2.1. Theoretical models of Organisational management

Theoretical models tend to be normative, in that they reflect beliefs about the nature of institutions and the behaviour of individuals within them. A theorist expresses views about how organisations should be managed, rather than simply describing aspects of management. Theories are classified into six major models which are formal, collegial, political, subjective, ambiguous and cultural (Bush, 1995:30). Only the first three models i.e. formal, collegial and political will be discussed here because they are particularly relevant to this study. The theoretical framework of the study has three major variables, which are the organisation, individuals and alliances. The organisation is linked to the formal and collegial model, whereas the individual is described under the collegial model. Alliances are the interest groups which form part of political models (Bush, 1995: 76).

2.6.2.1.1. Formal Models

Formal models assume that organisations are hierarchical systems in which managers use rational means to pursue agreed goals. Heads of hospitals possess authority legitimised by their formal positions within their organisations and are accountable to sponsoring bodies for the activities of their institutions (Bush, 1995:39). In this study, the CNSM are responsible to the DOH. Public health institutions are organised in formal models although others have assumed a decentralised model.

The various formal models have several common features:

- They treat organisations as systems
- They give prominence to the official structure of the organisation
- The official structure is hierarchical
- All formal approaches are goal seeking organisations
- Managerial decisions are made through a rational process
- Authority of leaders is a product of official positions within the organisation
- Accountability is emphasised (Bush, 1995).

Formal models include structural, systems, bureaucratic, rational and hierarchical models. Leadership is ascribed to the person at the apex of the hierarchy. This individual sets the tone of the organisation and establishes the major official objectives (Bush, 1995).

2.6.2.1.2. Collegial Models

These models include all those theories which emphasise that power and decision making should be shared among some or all members of the organisation. Collegial models assume that organisations determine policy and make decisions through a process of discussion leading to a consensus. Power is shared among some or all members of the organisation who are taught to have a mutual understanding about the objectives of the institution. The style of leadership both influences, and is

influenced by the nature of the decision-making process. Because policy is determined within a participative framework, the head of the institution is expected to adopt strategies which acknowledge that issues may emerge from different parts of the organisations (Bush, 1995:53). Professional nurses work in teams, not in isolation, and decisions which affect the patient need to be taken collectively.

Collegial models have the following features:

- They are strongly normative in orientation.
- They are appropriate for organisations with a significant number of professional staff .e.g. health.
- Collegial models assume a common set of values held by members of the organisation.
- The size of decision-making groups should be small enough to enable everyone to be heard.
- Collegial models assume that decisions are reached by consensus rather than division or conflict (Bush, 1995:53).

2.6.2.1.3. Political Models

Political models assume that in organisations, policy and decisions emerge through a process of negotiation and bargaining. Interest groups develop and form alliances in pursuit of particular policy objectives. Conflict is viewed as a natural phenomenon and power accrues to dominant coalitions rather than being the preserve of formal leaders. The head of the institution is the key respondent in the process of bargaining and negotiation.

Leaders can have a significant impact on the nature of the internal decision-making process and can exercise a controlling influence on the proceedings of committees (Baldbridge, 1971). Power is the capacity to act, the strength and the potential to accomplish something. Kanter (1993) considers power as a structural determinant affecting organisational behaviours and attitudes. Power is obtained from the ability to access and mobilise support, information, resources and opportunity from one's position in the organisation. Access to these empowerment structures is influenced by the degree of formal and informal power an individual has in the organisation (Kanter, 1993).

Power is the vital energy to make choices and decisions (Covey, 2004). Nurse Managers utilise different powers in their organisations as do union managers who instil power in their members.

Political models have the following features:

- They tend to focus on group activity rather than the institute as a whole.
- Political models are concerned with interests and interest groups.
- Political models stress the prevalence of conflict in organisations.
- Political models assume that the goals of the organisation are unstable, ambiguous and contested.
- Decisions emerge after a complex process of bargaining and negotiations.
- The concept of power is central to all political theories (Bush, 1995:80).

Political leadership does not adapt to change but initiates change, focusing either on accomplishing the will of the leader, which is power over people, or the will of the followers (power with the people). The "power with" style of political leadership empowers subordinates to accomplish important institutional and professional goals (Mothiba, 2006). Formal and informal powers have been found to be significant predictors of access to work empowerment structures (Laschinger, Wong, McMahon & Kaufmann, 1999). Sources of power will be briefly described to highlight the political model.

Power can be defined as the capability of acting, or producing effect, usually associated with the ability to influence allocation of resources. Several definitions of power have been used in nursing. Power has been defined as having control, influence, or domination over something or someone. Another definition views power as "the ability to get things done, to mobilise resources, to get and use whatever it is that a person needs for the goals he or she is attempting to meet"

(Manojlovich, 2007). Power can also mean the potential capacity to exert influence (Huber, 2000). In this study, power is significant because it determines whether a nurse manager is able to impart formal power to influence the professional nurse's

decision to stay in the organisation or not (Laschinger et.al, 2001). There are six significant forms of power:

- Positional power is a major source of power in any organisation, and is accrued to individuals who hold an official position in an institution. Formal positions confer authority on their holders, who have a recognised right to make decisions or to play a key role in the policy-making process.
- Expert power relates to the use of knowledge and expertise as a means of legitimising what one wishes to do, such as advancement.
- Personal power refers to individuals who are charismatic, or possess verbal skills to exercise personal power. It depends mainly on influence rather than authority.
- Reward power is used when the manager or leader has the power to reward employees for their work in the form of promotions, salary raises, desired assignments or formal acknowledgement of accomplishment.
- Coercive power is the opposite of reward power. The leader punishes employees who do not conform to the norms of the organisation (Balbridge, 1971).

2.6.3. Organisational climate

Organisational climate describes the practice and procedures of the entire organisation or subunits, and influences the attitudes and behaviour of respondents (Sleutel, 2000).The organisational climate needs to be improved positively so as to act as a retention strategy. Resources must be utilised appropriately in order to avoid the 'revolving door syndrome'. Cutcliffe & Wieck (2008) state that where there was a high degree of staff loss, work environment, organisation and the system needed to be changed, so that nurses could be retained because they were not satisfied with their jobs.

According to Booyens (1996), Frederick Herzberg (1959) found that the factors which make a job satisfying are different from those factors that make it dissatisfying. Offering nurses more pay does not replace the nurses' needs for undertaking fulfilling work. More money is a hygiene factor and fulfilling work is a motivator. Hygiene factors relate to such aspects as satisfactory pay, adequate

supervision, job promotions, special perks, good working conditions and job security. These factors tally with the expected rights of nurses in South Africa (Gwele, 2003).

According to Muss, Stratton, Dunkin & Jubl (1993) the following causes of dissatisfaction were fairly universal: salary scale, gap between administration and staff problems, insufficient amount of respect doctors show towards knowledge/skill of nursing staff, and insufficiency of received benefits. Five factors were found to be highly prevalent among short-term registered nurses only: poor earning potential, lack of consultation between administration and staff on day-to-day problems, few advancement opportunities, little control over number of hours worked, and little control in scheduling work shifts. These factors tended to contribute to a greater likelihood of intention to leave.

In South Africa, Ally (1997) cited the importance of emphasising retention strategies rather than recruitment strategies to avoid the revolving door syndrome. Likewise, the theoretical model of job retention by Ellenbecker (2004) proved that intrinsic and extrinsic factors are directly and indirectly related to retention through increasing intent to stay. Intrinsic factors are recognition and praise, autonomy in one's work, enjoyment of the work itself, challenges and opportunities for promotion, and a sense of achievement. Extrinsic factors are satisfactory pay, adequate supervision, job promotions, good working conditions and job security (Booyens, 1998).

According to Wells, Roberts & Medlin (2002), retention and turnover of staff, particularly highly skilled nurses, are important issues for administrators in the current health care environment. Robbins & Davidhizar (2007) assert that a healthy environment has a positive influence on staff retention.

Senge (2006) states that many leaders think that significant change will not occur unless it is driven from the top. From fear of stepping out of line with the hierarchy, people tend to cling to the view that significant change can only be initiated from the top. In order for people to be productive in their organisations, they need to work in a conducive organisation. In nursing, hierarchical authority is a norm, and this authority is not conducive to the production of quality of work life (Swearingen, 2004).

Organisational climate in hospitals has been an undervalued determinant of poor patient outcomes and failure in nurse recruitment and retention. Poorly organised practice environments can negate the benefits of excellent staffing (Aiken, Clarke & Sloane, 2002).

2.7. RETENTION

The recruitment and retention of staff is of national and political concern worldwide (Andrews, 2003). This concept means that the employer is capable of keeping an employee in his/her employment for as long as possible. Companies use different formulas for calculating retention rates. The public hospitals calculate the number of available nurses in a year, compared to the previous year's statistics. Managers are expected to make targets over a period of time. The accepted percentage of staff resignations is 5 % per month (Personal interview with CNSM, May 2006).

Staff retention is the responsibility of top management in adhering to sound retention policies which include some of the following:

- Retaining good staff begins with good recruitment
- New staff must be clearly oriented and trained
- Rewards and recognition can be powerful tools
- Promotions for diligent and deserving staff
- Job satisfaction (McIntosh, 2001).

2.7.1 Retention strategies

All over the world governments are trying to recruit and retain staff in their organisations, but, despite measures put in place, people are still leaving organisations for better salaries (Geyer, 2004), better working conditions (Chan & Morrison, 2000) and greater involvement in decision-making (Laschinger, 2001; Upenieks, 2002; O' Brien-Pallas *et al.*, 2006). Many developing and developed countries are affected by the declining numbers of nurses in the profession (Buchan, 1999). Several retention strategies that were put in place by different organisations had different impacts. Budge, Carryer & Wood (2003) identify three aspects of the nursing working environment, autonomy, control and nurse-physician relations, as linked to staff retention and levels of staff burnout. If people are given power to

govern, they contribute significantly to the decision-making actions in their units (Kanter, 1993).

Studies in Canada show that management needs to empower nurses in the work environment as a strategy to retain them (Kluksa, Laschinger & Kerr, 2004). A key determinant to successful nurse retention is the creation of a supportive work environment and the presence of empowering managers (Gill, Jackson & Beiswanger, 2003). Even big companies are of the similar idea that the three top strategies for attracting and retaining key staff are a good corporate reputation, ensuring an understanding of core values, mission and goals; and coaching, training and mentoring top performers for leadership positions (Vaida, 2005), which is also relevant to the nursing profession.

Education and training, flexible working hours, scheduling of staff, a top-down approach and reviewing pay and working conditions were the factors that were ascertained by the Department of Health in the United Kingdom in the study by Clarke (2004) on recruitment and retention of staff.

In South Africa, the government has introduced a rural allowance for all health workers who work in rural areas. A scarce skills allowance is also given to those health workers who are classified as contributing significantly to high risk cases which need expert care like Intensive Care, Advanced Midwifery and Operating Theatre Technique (Geyer, 2004).

Staff retention is not a problem which only the nursing profession experiences. Other organisations, like technology, have similar problems as described below. A study of Information Technology by Le Fave (2004) shows that technical leadership skills are the source of power that gives people the ability to bridge age and gender gaps, the need for technically competent leaders provides a level playing field.

Various studies were conducted internationally considering factors that persuade staff to stay in their jobs for longer periods. Unfortunately, these studies were not undertaken in South Africa. Several authors echo that, if employees take care of their staff and assist them positively, this will impact on job satisfaction (Laschinger, 2001; Buchan, 2004). The focus is generalised not looking at health care workers alone, but including all sectors such as technology, education etc.

According to Rush (1999) the following factors contribute to workers joining and staying longer in a company:

- Competitive pay rates
- A demonstrable commitment to training and professional development
- Professional challenges and advancement opportunities
- Skills management process
- Imaginative benefits programmes that satisfy diverse needs
- Clear vision and strong leadership
- A well defined recruitment process (Rush, 1999:)

The research findings indicated that 45 % of companies wanted to adopt retention programmes that would keep the turnover of employees lower. A study by McIntosh (2001) stated that staff retention is supported by hiring people, interviewing them to determine their areas of expertise, and lastly, training them around their area of expertise. The findings showed that such staff were more productive and happy, and tended to stay with the program longer.

Buchan (2004) reported that staff retention would increase by 10% if the quality of the relationship between managers and the employees was improved. Employees' relationships with their supervisors or managers and work and life balance are the most important determinants for staying with the organisation.

All countries are affected one way or the other. Source countries need to improve staff attraction and retention strategies, and recipient countries need to ensure that they do not permanently depend on health professionals from developing countries (Martineu *et al.*, 2004). The South African Government has instituted arrangements with the United Kingdom to be financially compensated, by paying for training of nurses recruited by the UK. Policy interventions that help governments reach mutually beneficial managed models of international recruitment have the best potential for success (Buchan, 2004).

Once the retention programs are in place there are major benefits which are evident to the institution. The Heart Math Staff Retention and Development program showed the following major benefits:

- Immediate cost savings
- Decreased turnover
- Improved morale
- Cultural shifts measured
- Increased patient satisfaction
- More referrals and more business (Massy, 2003).

The findings in a study by Benedict (2004) show that improved staff recruitment and retention reduced staff attrition after nurse training was introduced. The reasons for nurses leaving Wales were inadequate support and resources which made nurses suffer because they were unable to support themselves and their families (Castledine, 2004).

Similar dissatisfactions were pinpointed by Cummings (2004), in that social care professionals understood that their independent judgment must somehow coexist alongside the impact of resource constraints on services and of performance management in the organisation. They appreciated that managing this co-existence is no easy task and then decided to leave. The impact of structural change and uncertainty is another significant factor which adds an intolerable burden to already stressful jobs.

There were some differences between levels of nurses and the way they perceived staff retention policies. Low tenure nurses preferred learning opportunities and advancement potential, while high tenure nurses favoured work flexibility (Proncea & Shewchuk, 1997).

2.8 HEALTH CARE FACILITY MODELS OF RETENTION PRACTICE

Since staff shortages are a worldwide problem, the retention strategies of other countries may be examined constructively. Rich countries also suffered an exodus of nurses in the early 80s resulting in the development of the concept of Magnet Hospitals in the United States of America. This developed a programme of excellence for the delivery of nursing care and also promoted the quality healthcare that supports professional practice (Buchan, 1999).

Various retention models are utilised in different institutions. These models range from shared governance models, Magnet hospital models, group practice models and others. Shared governance is a model of nursing practice designed to integrate core values and beliefs that professional practice embraces, as a means of achieving quality care. Shared governance models were introduced to improve nurses' work environments, satisfaction, and thus retention (Anthony, 2004). The following retention guidelines were introduced by McCarthy (2005) to retain staff in his specialty units: Promise small and deliver large, create a 90-day plan, keep resisters close, pick popular battles, and find the right people.

The researcher will deal with the Magnet hospital model as research has shown it to produce effective results.

2.8.1. Magnet Hospital Model

The concept of Magnet hospitals was started in 1981 in the United States of America by the American Academy of Nursing (AAN) in order to recruit and retain nurses in the profession, and is now managed by the American Nurses Credentialing Centre (ANCC). All hospitals requesting Magnet hospital status need to apply to the ANCC for accreditation. The ANCC focuses on institutions that ensure a culture of excellence, support for education, self governance and opportunities for specialised practice. Magnet status is an award given by the ANCC to hospitals that satisfy a demanding set of criteria measuring the strength and quality of nursing. A Magnet hospital is one where nursing delivers excellent patient outcomes, where nurses have a high level of job satisfaction, low staff turnover and an appropriate grievance procedure. Magnet nurse leaders involve their staff in the decision-making processes (Upenieks, 2002; Armstrong, 2005).

The key characteristics of Magnet hospitals include efficient administration, professional practice and professional development (Buchan, 1999). Administration characteristics include a supportive management style, career opportunities, decentralised structures and flexible working schedules. Professional practice includes autonomy and responsibility, the availability of specialist advice, and an emphasis on the teaching responsibilities of staff. Professional development includes planned orientation of staff, an emphasis on continuing education and management development (Buchan, 1999).

The Magnet programs are guided by several forces discussed hereunder (ANCC, 2007).

2.8.1.1. Forces of Magnetism (ANCC, 2007)

The original Magnet research study from 1983 identified 14 characteristics that differentiated organisations that were best able to recruit and retain nurses during the nursing shortages of the 1970s and 1980s. These characteristics became the ANCC Forces of Magnetism which provide the conceptual framework for the Magnet appraisal process. Described as the heart of the Magnet Recognition Program, the Forces of Magnetism may be thought of as attributes or outcomes that exemplify excellence in nursing. The full expression of the current fourteen Forces of Magnetism is the requirement for designation as a Magnet facility, and embodies a professional environment, guided by a strong and visionary nursing leader who advocates and supports excellence in nursing practice.

Force 1: Quality of nursing leadership

Knowledgeable, strong, risk-taking nurse leaders follow a well-articulated, strategic, and visionary philosophy in the day-to-day operations of the nursing services. Nursing leaders, at all levels of the organisation, convey a strong sense of advocacy and support for the staff and for the patient.

Force 2: Organisational structure

Organisational structures are generally flat, rather than tall, and decentralised decision-making prevails. The organisational structure is dynamic and responsive to change. Strong nursing representation is evident in the organisational committee structure. Executive-level nursing leaders serve at the executive level of the organisation. The Chief Nursing Officer typically reports directly to the Chief Executive Officer. The organisation has a functioning and productive system of shared decision-making.

Force 3: Management style

Health care organisation and nursing leaders create an environment supporting participation. Feedback is encouraged and valued, and is incorporated from the staff

at all levels of the organisation. Nurses serving in leadership positions are visible, accessible, and committed to communicating effectively with staff.

Force 4: Personnel policies and programs

Salaries and benefits are competitive. Creative and flexible staffing models that support a safe and healthy work environment are used. Personnel policies are created with direct care nurse involvement. Significant opportunities for professional growth exist in both administrative and clinical tracks. Personnel policies and programs support a professional nursing practice, work/life balance, and the delivery of quality care.

Force 5: Professional models of care

There are models of care that give nurses the responsibility and authority for the provision of direct patient care. The models of care (i.e. primary nursing, case management, family-centred, district, and holistic) provide for the continuity of care across the continuum. The models take into consideration patients' unique needs, and provide skilled nurses and adequate resources to accomplish desired outcomes. Nurses are accountable for their own practice, as well as for the coordination of care.

Force 6: Quality of care

Quality is the systematic driving force for nursing and the organisation. Nurses serving in leadership positions are responsible for providing an environment which positively influences patient outcomes. There is a widespread perception among nurses that they provide high-quality care to patients.

Force 7: Quality improvement

The organisation has structures and processes for the measurement of quality, and programs for improving the quality of care and services within the organisation.

Force 8: Consultation and resources

The health care organisation provides adequate resources, support, and opportunities for the utilisation of experts, particularly advanced practice nurses. In addition, the

organisation promotes the involvement of nurses in professional organisations and among peers in the community.

Force 9: Autonomy

Autonomous nursing care is the ability of a nurse to assess and provide nursing actions appropriate for patient care, based on competence, professional expertise, and knowledge. The nurse is expected to practice autonomously, consistent with professional standards. Independent judgment is expected to be exercised within the context of interdisciplinary and multidisciplinary approaches to patient/client care.

Force 10: Community and the health care organisation

Relationships are established within and among all types of health care organisations and other community organisations, to develop strong partnerships that support improved client outcomes and the health of the communities they serve.

Force 11: Nurses as teachers

Professional nurses are involved in educational activities within the organisation and the community. Students from a variety of academic programs are welcomed and supported in the organisation; contractual arrangements are mutually beneficial. There is a development and mentoring program for staff preceptors to enable them to help all levels of students (including new graduates, experienced nurses, etc). Staff members in all positions serve as faculty and preceptors for students from a variety of academic programs. There is a patient education program that meets the diverse needs of patients in all the care settings of the organisation.

Force 12: Image of nursing

The services provided by nurses are characterised as essential by other members of the healthcare team. Nurses are viewed as integral to the healthcare organisation's ability to provide patient care. Nursing effectively influences system-wide processes.

Force 13: Interdisciplinary relationships

Collaborative working relationships within and among the disciplines are valued. Mutual respect is based on the premise that all members of the healthcare team make essential and meaningful contributions to the achievement of clinical outcomes. Conflict management strategies are in place and are used effectively, when indicated.

Force 14: Professional development

The health care organisation values and supports the personal and professional growth and development of staff. In addition to quality orientation and in-service education addressed earlier in Force 11, (Nurses as Teachers), emphasis is placed on career development services. Programs that promote formal education, professional certification, and career development are evident. Competency-based clinical and leadership/management development is promoted and adequate human and fiscal resources are provided for all professional development programs.

According to Buchan (1999), the variables that distinguish a Magnet hospital from the non- Magnet hospital include supportive management and adequate staffing. This view was echoed by Upenieks (2003) who found that a supportive organisational climate, autonomous climate, continuing education, adequate compensation and flexible scheduling were the elements of a successful organisation.

Many studies which examined the efficiency and effectiveness of the Magnet status have been conducted in the United States of America and Canada. There is a noticeable difference in hospitals that have the Magnet status as compared to those without Magnet status. The majority of studies showed that if nurses are satisfied at work they will stay longer (Shaver & Lacey, 2003; Upenieks, 2002; Upenieks, 2003; Laschinger, 2003).When nurses enjoy what they are doing they will not suffer from burnout. A study by Kaliath & Morris (2002) shows that job satisfaction or dissatisfaction is a reliable predictor of burnout among nurses. Nurses who were satisfied at work did not suffer from burnout.

In Taiwan, a study by Tzeng (2002) shows that factors such as salary, promotion, good leadership style, self growth, challenging work and interaction with the patient ensured that nurses were satisfied with their work. In Australia, professional status, autonomy and remuneration are career issues of great concern for nurses and are particularly relevant to the retention of a newly qualified nurse (Acorn, Ranter & Crawford, 1997 & Cowin, 2002). In rural areas, nurses cited their dissatisfaction as being caused by the lack of educational opportunities, an unsupportive environment and poor working relationships which led them to leave the profession (Hegney & McCarthy, 2000).

There are organisational characteristics of Magnet hospitals which enhance nurse leader effectiveness and support clinical nurses, as researched by Havens (2001) and Upenieks (2002). These characteristics are as follows:

- At these organisations, the nurse executive is visible, influential, credible and responsive. He or she values nursing as a profession and values the professional nurse.
- The administrative team listens and responds to the needs of its employees. They also recognise the worth nursing brings to the organisation.
- The nurse leader not only articulates the importance of nursing to the administrative team, but also to the medical staff and community members.
- Interactions among nurses, physicians and the administrative team are respectful and mutual. All team members work collaboratively in attaining the mutual goal of optimal patient care.
- Nurses are encouraged to do for patients what they know best how to do in accordance with professional standards of care.
- In Magnet organisations there are opportunities for growth and upward movement. Nurses are encouraged to move and grow, to reach their potential.

The environment is viewed as one of the factors that influence the nurse's decision to stay in or leave her job. If the environment is conducive, there will be high job retention. In the 1990s, nurse researchers found that Magnet hospitals had better outcomes than hospitals without Magnet status. Magnet hospitals had higher patient satisfaction rates and lower mortality, fewer nurse burnouts and needle sticks to nurses (Mason, 2000).The study by Aiken & Patrician (2000) showed that Magnet

hospitals are cost-effective because patients/clients have shorter lengths of stay in hospitals and in intensive care units. Nurses have fewer patients making up their workloads, better support services, greater control over their practices, greater participation in policy decisions and more powerful chief nurse executives.

Magnet hospitals are led by nurse executives in a decentralised structure which emphasises participatory management. In a flat organisational structure, there are minimal levels between clinical nurses and nurse executives. Staffing and scheduling was conducted at unit level, which enabled nurses on each shift to be empowered and accountable for making staff decisions for the next shift. Transformational leadership is also regarded as a strategy that may retain staff (Thyer, 2003).

2.9 ACCREDITATION

Accreditation is a formal process by which a recognised body, usually a non-governmental organisation, assesses and recognises that a health care organisation meets applicable predetermined and published standards (Rooney & van Ostenberg, 2004). Accreditation is a self-assessment and external review process used by health care organisations to assess their level of performance accurately, in relation to established standards and to implement ways to improve (Rooney & Van Onstenberg, 2004).

The purpose of accreditation includes the following:

- To improve the quality of health care service delivery at all levels, by establishing optimal achievement of goals in meeting standards for health care organisations
- To stimulate and improve the integration and management of health care services
- To facilitate teamwork in the health care organisation
- To empower all health care workers to attain excellence
- To reduce risks in health care delivery (Shaw, 2003).

2.9.1 Origins of COHSASA

One of the tragic legacies of apartheid was the fragmented health system which yielded an unequal distribution of resources to the citizens of South Africa. The poor majority communities had compromised health care service delivery, whereas the rich minority had better serviced health care systems (Rooney & Van Onstenberg, 2004).

Because of the declining standards of care in the country, there was a great need for the implementation and monitoring of service provision in the country. COHSASA came about in 1981 and is based on the Joint Commission on the Accreditation for Healthcare Organisation (JCAHO)'s framework, which encourages accreditation of hospitals so that they are efficient. COHSASA has official national and international links and is also affiliated to major health professional societies which have helped COHSASA to develop standards. Examples of links include the Medical Research Council (MRC), Hospital Association of South Africa (HASA), Joint Commission International Accreditation (JCIA), World Health Organisation (WHO) and the Democratic Nursing Organisation of South Africa (DENOSA), to mention a few. This is a non-profit organisation which deals with ensuring quality for health care (Whitaker, Green-Thompson, McCusker & Nyembezi, 2000).

In South Africa, pilot accreditation started in 1994. The aims were to promote the quality of service rendering by hospitals and primary health care services through developing a comprehensive framework of standards for these services (Whittaker *et al.*, 2000). In South Africa, hospitals voluntarily apply for accreditation from the Council for Health Service Accreditation of Southern Africa (COHSASA). In 1998, COHSASA signed an agreement with the KwaZulu-Natal Department of Health for the first province-wide public hospital accreditation activity in the country (Salmon, Heavens, Lombard & Tavrow, 2003). COHSASA provides data on the quality of health service provision to governing authorities so that it can be used for strategic decisions. In the past 13 years over 489 facilities in South Africa have entered the COHSASA programme .To date, eighty-four public hospitals have signed an agreement with COHSASA in the province of KwaZulu-Natal, (COHSASA, 2004) unfortunately; the program was discontinued because of financial constraints in the province.

Table 2.2: Comparison of COHSASA and MAGNET Model

Concept	COHSASA	MAGNET MODEL
Origin	JACHO	JACHO
Duration	3 years	3 years
Service Elements	37 (too detailed)	3
Phases of inspection	Three	Four
Funding for a small hospital	R240 000.00	$ 18 000.00 = R126 000.00
Support	Training & visitation	Mentoring
Outcome	Awarded a certificate	Awarded a certificate

Telephone interview with Mr. Johan Brink (COHSASA manager, 10 May 2006)

2.9.2. Conclusion

In summary, one can conclude that globalisation brought both good and harm to the country. Globalisation opened the gates for economic development; however, it also facilitated skilled health care workers being lured to developed countries, leaving the developing country's health care system in disarray.

The literature studied also indicates that nurse managers are regarded as leaders who are influential in maintaining efficient health services by holding responsibility for the health care workforce. Transformational leadership is regarded as the best leadership style to retain staff, because leaders have a vision and the followers are guided in fulfilling the organisational goals.

There are several theories which deal with retention, but Kanter's theory seems the most relevant to this study. The same applies to the different retention models that were researched. The Magnet Hospital model, for instance, appears to have delivered a positive response to the health care system's problems.

CHAPTER 3: RESEARCH METHODOLOGY

3.1 INTRODUCTION

This chapter provides a detailed account of the research approach, the research design that was undertaken, the population under study, sampling techniques, data collection processes and the data analysis procedure. The rationale for using both the quantitative and the qualitative approach is highlighted. Academic rigor and aspects of reliability, validity and trustworthiness are clearly explained. Ethical considerations in the nursing research are presented. The terms 'respondents' and 'informants' were used according to the research approaches adopted in the study.

3.2. RESEARCH APPROACH

There are two major approaches to research: quantitative and qualitative. These approaches are based on different paradigms of viewing the world and knowledge. These paradigms are positivism (also called empiricism) and naturalism which refers to interpretive, constructivist or interactionist views (Holloway & Wheeler, 1996). Quantitative research is based on the positivist and early natural science paradigm which has influenced the social sciences. Quantitative research looks for relationships between variables in an attempt to explain causality and to give accurate predictions. These relationships are deduced from previous knowledge or research (Merriam, 1988). The quantitative approach underpinned the traditional scientific approach based on orderly, disciplined procedures which acquire information that can be quantified and generalised (Brink, 2006).

Positivism emerged to address the inability of speculative philosophy, which was idealism. Positivism was founded by Auguste Comte who believed that a philosopher needs an objective way of obtaining knowledge. Positivism depends on objective knowledge because it is verifiable. The most characteristic claim of logical positivism asserts that statements are meaningful only in so far as they are verifiable, and that statements can be verified in two exclusive ways: empirical statements, including scientific theories, which are verified by experiment and evidence, and analytic truth statements which are true or false by definition are also meaningful (Gower, 1987). Critics of positivism state that its fundamental principles cannot be formulated in a way that is clearly consistent. Another critique by constructivists is

that positivism ignores subjective experience (Terreblanche, Durrheim & Painter, 2006) which qualitative research addresses.

Qualitative research is based on constructing knowledge from the naturalistic paradigm. This research is also concerned with the in-depth study of human phenomena in order to understand the nature and meanings they have for the individuals involved, and tends to be more subjective than quantitative research (Merriam, 1988). A qualitative research approach is a rich way to conduct research when a researcher wants to gain insights through discovering meanings, and exploring the richness or complexity of the phenomenon (Burns & Groove, 1997).

This study involves a systematic collection of numeric information, usually under conditions of considerable control followed by the analysis of that information using statistical procedures. The qualitative approach was utilised to complement the quantitative findings and also to strengthen the study.

3.3 RESEARCH DESIGN

The main purpose of a research design is to avoid a situation in which the evidence does not address the initial research questions. A research design deals with a logical problem and not a logistical problem (Yin, 2003). The researcher used multiple case studies to collect data from four public hospitals in KwaZulu-Natal. A case study can be described as a unit of analysis, for example, a case study of a particular organisation. A case study combines a number of qualitative and quantitative research techniques; it allows the context and the needs of the case to determine the methods used (Yin, 2003). Burns and Groove (1997) state that a case study is likely to possess both quantitative and qualitative elements. A blend of quantitative and qualitative approaches through the use of the mixed method is suggested by the literature (Gerrish & Lacey, 2006) as adding value and being complementary in offsetting the weakness of one or the other (Polit & Beck, 2006).

A case study research methodology relies on multiple sources of evidence to add breadth and depth to data collection, to assist in bringing the richness of data together in an apex of understanding through triangulation, and to contribute to the validity of the research (Yin, 2003). The cases are bounded by time and activity and researchers collect detailed information using a variety of data collection procedures

over a sustained period of time (Stake, 1995). Additional reasons for mixing different types of data emerged from the concept of triangulation. The results from one method can help inform the other method (Yin, 2003). A mixed method approach is one in which researchers tend to base knowledge claims on pragmatic grounds (Cresswell, 2003; Polit & Beck, 2006).

Case study research excels in revealing an understanding of a complex issue and can also emphasise detailed contextual analysis of a limited number of events or conditions and their relationships (Yin, 2003).The case study strategy also allows particular issues to be brought to the fore that would otherwise have remained hidden. Case studies allow investigations to take place in a natural setting (Polit & Beck, 2008) as well as allowing for in-depth exploration and examination of concepts and context under investigation (Brink, 2001; Yin, 2003). Case studies have become the mainstay of educational research. Case studies are used to analyse and understand the variables that are important to the development of a subject (Patton, 1990).

There are three types of case studies i.e. descriptive, interpretive and evaluative. Descriptive case studies present a detailed account of a phenomenon under study. They are not guided by any hypotheses. Descriptive case studies are useful in presenting basic information where little research has been conducted (Merriam, 1988). Interpretive case studies contain rich, thick descriptions which are used to develop conceptual categories which challenge theoretical assumptions held prior to data gathering. Evaluative case studies contain descriptions, explanations and judgements about the phenomenon under study (Merriam, 1988). This study adopted the descriptive case study, because the aim was to provide detailed information about the leadership styles, organisational factors and retention of professional nurses working in public hospitals in KwaZulu-Natal with the aim of exploring relationships among these phenomena.

According to Yin (1984), multiple case studies are better to use than single case studies because they produce a stronger effect. Multiple cases are extraordinarily helpful both in generating explanations, and in testing cases systematically. Multiple cases are the best resources for advancing our theories about the way the world works (Miles & Huberman, 1994). Multiple case studies were conducted so as to

obtain an in-depth investigation. Four hospitals represented cases leading to multiple cases. The respondents represent sub-units of the cases (chief nursing service managers, unit managers and professional nurses working in the selected hospitals, professional nurses with overseas experience and alliances). The alliances were the representatives from the union managers.

3.4. SETTING

The study was conducted in KwaZulu-Natal, one of the nine provinces in South Africa (Figure 3.1) which makes up 22% of the country's total population of 45 million. Seventy percent (70 %) of the population resides in the rural areas (Department of Health, KwaZulu- Natal, 2006). KwaZulu-Natal Province is divided into eleven districts. The province is the third smallest in the Republic, covering 7.7% of South Africa's land area, but it has the largest population of 10 million people. The size of the province is 94361 square kilometers. There are 72 public hospitals in the province.

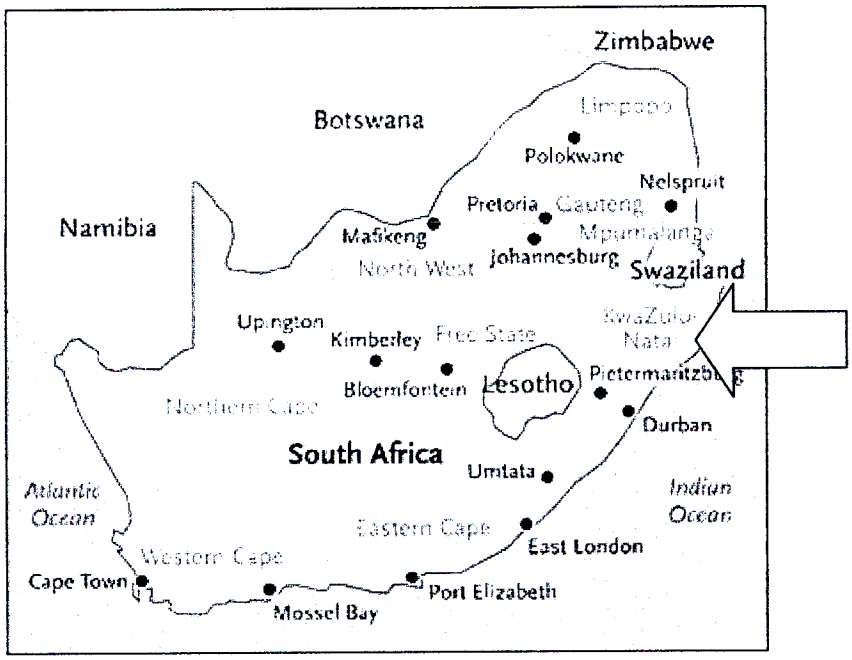

Fig 3.1: Map of South Africa http://home.global.co.za/~mercon/map.htm

3.4.1 Population and sample

Data were collected from four public hospitals situated in four districts, namely eThekwini, Ugu, Umkhanyakude, and uThukela. For confidentiality and anonymity, the names of hospitals will not be revealed. The hospitals were coded as Cases A, B, C and D. Locations of the organisations are indicated in Figure 3.2. The population of the study included big and small hospitals. The selected hospitals were the cases of analysis. The sub-population included the chief nursing service managers in charge of institutions, unit managers (CPN) in charge of wards, professional nurses working on day and night duty in the selected wards, and professional nurses with overseas experience. The regional managers of the unions where nurses were affiliated and reports by CNSMs about SANC & DOH were also included in the study.

3.4.2 Sampling

Probability sampling was conducted to ensure representativeness of the sample. According to Polit & Hungler (1999), probability sampling uses some form of random sampling in choosing the units. Greater confidence can then be placed in the representativeness of the sample. Stratified random sampling was conducted in choosing the districts, which involved grouping the hospitals according to size. Hospitals were grouped according to the number in each district. Those districts with fewer than five hospitals were in stratum A, and those districts with five hospitals or more were in stratum B. Twenty percent (20 %) of the hospitals were selected from each stratum. Hospitals in each district were listed and selected randomly. The names of hospitals were written on pieces of paper and mixed in a hat. Only twelve hospitals were selected from the hat. According to the KZN Department of Health (2005) there are twenty one hospitals in stratum A, and forty-one hospitals in stratum B, therefore the total number of hospitals from both clusters was twelve (see Table 3.1). Two hospitals declined to participate in the study, and six hospitals did not reply despite several reminders sent to them.

There are two types of sampling in a case study research, namely within-case sampling and multiple-case sampling. This study followed a multiple-case sampling which adds confidence to findings because it strengthens the precision, the validity and the stability of the findings (Crabtree & Miller, 1999).

Table 3.1: Provincial hospitals listed by district

DISTRICT	CODE	No Of Public Hospitals	Stratum
Ugu	DC 21	6	A
Umgungundlovu	DC 22	10	A
UThukela	DC23	3	B
Umzinyathi	DC24	4	B
Amajuba	DC 25	3	B
Zululand	DC 26	7	A
Umkhanyakude	DC 27	5	A
Uthungulu	DC 28	9	A
Ilembe	DC 29	3	B
Sisonke	DC 43	7	A
EThekwini	Durban	15	A
Total (11 districts)		**72**	

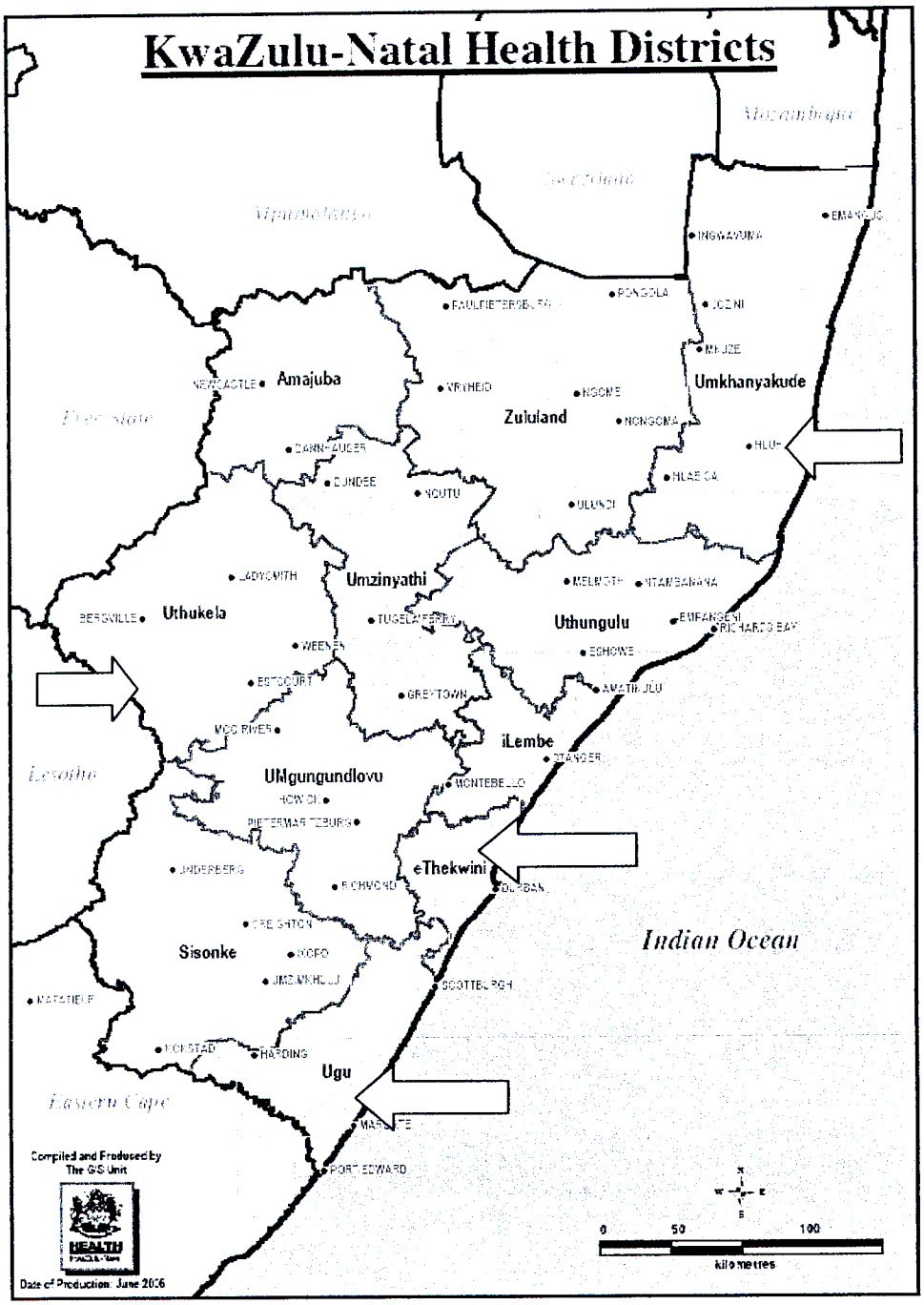

Figure 3.2: Map of KwaZulu Natal District Health System

3.4.3 Selected hospitals

Initially, twelve hospitals were sampled, but the study was done in four hospitals which agreed to be included in the sample. Two hospitals did not participate due to internal issues in their organisations. Six hospitals did not respond despite several reminders by letter and phone. A brief description of each case is discussed below.

3.4.3.1. *Case A*

Case A is a regional hospital situated in the eThekwini District. The district has a tertiary institution, regional hospitals and district hospitals totalling fifteen hospitals in all. The population served in this district is more than five million. Case A has downsized from 1200 to 800 beds and offers a tertiary service in the entire province of KwaZulu-Natal, part of Mpumalanga and the Eastern Cape provinces. Case A is the main teaching hospital for the local medical school and nursing colleges, and caters for both urban and rural communities. Patients from rural areas are referred to this urban hospital (www.kznhealth.gov.za). The total number of respondents was fifty-two (52) including the chief nursing service manager.

3.4.3.2. *Case B*

Case B is a regional hospital also serving as a district hospital situated in the Ugu district which has a population of 704023. The Ugu district has three district hospitals, one regional hospital, and one specialised hospital. The population is 76% rural, 16% urban and 8% dwellers in informal settlements. Case B has 337 beds with a regular bed occupancy ranging from 95 % to 100%. The services that are rendered by this organisation include an Out Patient Department (OPD), with various clinical departments and allied health departments. The total number of respondents was forty-three (43) including the chief nursing service manager who agreed to be interviewed (www.kznhealth.gov.za).

3.4.3.3 *Case C*

This hospital is a five hundred and eight (508) bed regional and district hospital situated in the uThukela health district. The district has one regional hospital and three district hospitals to serve an estimated population of 553671. The hospital serves 92% of the population, which comprises 25.6% urban and 74.4% rural from

10 950 square kilometers. Case C has an Outpatient Department with a variety of specialised clinics (www.kznhealth.gov.za). The total number of respondents was forty (40) including the chief nursing service manager who agreed to be interviewed.

3.4.3.4 *Case D*

The hospital is a district hospital with 184 beds situated in the remote part of Northern KwaZulu-Natal. This hospital falls under Umkhanyakude district which has a population of 503760. There are five district hospitals in this district. Case D serves more than 95 000 rural population members. The hospital has 6 wards: maternity, female surgical, male surgical, paediatrics, male medical and step-down, female medical and isolation wards. The step-down is an extension of a male ward. The hospital serves eight clinics within a catchment area of 100 x 30 km. The following services are provided in this hospital, namely: Outpatient Department, therapy, radiography, pharmacy, operating theatre, laboratory, dietician, dental department, social work department, PMTCT, ophthalmology and maternity department (www.kznhealth.gov.za). The total number of respondents was thirty-two (32), including the chief nursing service manager who agreed to be interviewed.

3.4.4 Selection of hospital units

According to the studies by Zondagh (2005) and Geyer (2004), brain drain has predominantly affected peri-operative areas which include the operating theatre and the ICU. Therefore, purposive sampling was conducted in these areas. In addition, medical, surgical and Outpatient Departments were selected. The Outpatient Departments were included to bring in different data from professional nurses who are working in these departments, because there is an assumption that working conditions are better in Outpatient Departments than those in In-patients owing to straight shift working hours.

3.4.5. Selection of professional nurses

The professional nurses were randomly selected from the off-duty list because random sampling ensures equal and fair representation (Polit & Hungler, 2001). Convenience sampling was done in those institutions with fewer than six

professional nurses per unit. All professional nurses who agreed to be part of the sample were included. Managers at all levels in the selected units were included.

According to the Health Systems Trust (2005), there are 9 531 professional nurses working in the public sector in KwaZulu-Natal out of a total of 43 660 professional nurses working in the public sector in the whole of South Africa.

The formula for calculating the sample for professional nurses is explained by Katzenellenbogen, Joubert & Karim (2007).

$$N = \frac{Z^2 \times P \times (1-P)}{d^2}$$

Where N= required sample size

Z= 1.96 corresponding to 95 % confidence level

P = Percentage of professional nurses in KZN (22 %, 9531 out of 43660 in public sector)

D= Margin error (5 %)

$$N = \frac{(1.96)^2 \times 0.22 \times (1-0.22)}{(0.5)^2}$$

N= 260

In the research project, the estimated number of professional nurses was 260. The number that was realised at the end was 183 which constitute 70 % of the estimated sample. This number included the unit managers and chief nursing service managers. Professional nurses who had left the country were also interviewed during their vacation leave in South Africa about the reasons which made them to leave the country. A snowballing technique was followed to trace professional nurses who were on leave.

Table 3.2: Number of respondents in the study

	Case A	Case B	Case C	Case D	Total
Prof Nurses	35	30	33	24	122
CPN	16	13	9	7	45
CNSM	1	1	1	1	4
Nurses with overseas experience					12
Total	52	44	43	32	**183**
Alliances					
Unions					4
Total					**187**

3.4.6. Selection of unions

Four unions were purposively selected based on the responses from the professional nurse's questionnaire. The researcher included the four unions which are also known as professional associations with the most respondents.

3.4.6.1. Democratic Nursing Organisation of South Africa (DENOSA)

This is the most popular nurses' organisation in South Africa. It has more nurses than the other unions in nine provinces in South Africa. The total number of nurses who are registered amounts to 76000. KZN province has more than 13000 members. DENOSA is a voluntary organisation for South African Nurses and midwifery professionals. DENOSA aims to safeguard and promote the dignity, rights and socio-economic status of members in the nursing profession. It has both professional and union components which impact beyond the borders of South Africa and the rest of the world (DENOSA booklet, 2008). DENOSA is the only nurses' organisation in South Africa which is affiliated to the International Council of Nurses (ICN) which represents all nurses worldwide (www.icn.org).

3.4.6.2. Health & Other Service Personnel Trade Union of South Africa (HOSPERSA)

HOSPERSA is a trade union for employees in the Public Service as well as in the private sector. The union also organises members in non-governmental organisations and parastatals. HOSPERSA represents a variety of categories, e.g. nurses, doctors, clerks and allied professionals. Only membership from nurses will be included here because this study deals with nurses. In the public sector, all institutions under the national and provincial Departments of Health, e.g. hospitals, nursing colleges, are represented. Under the private sector, all private hospitals and health care institutions, e.g. Netcare, Life Healthcare, Medi-Clinic, independent hospitals, South African National Health, Blood Transfusion Services, National Health Laboratory Services, pharmacists, rehabilitation centres, etc. are represented (HOSPERSA newsletter, 2008).

3.4.6.3. National Health and Allied Workers' Union (NEHAWU)

Membership is open to nurses and general workers. Nurses form 15 % of this organisation. It is the most powerful organisation which is affiliated with the Congress of South African Trade Unions (COSATU). All the unions that have been mentioned in this study are affiliated to COSATU (www.cosatu.org.za).

3. 4.6.4. South African Democratic Nursing Union (SADNU)

SADNU falls under the leadership of COSATU. Membership amounts to 9300 and in KZN there are 1350 nurses (www.cosatu.gov.za).

3.5 INSTRUMENTS

The instruments used to collect quantitative data are the Revised Nursing Work Index (NWI-R) and Conditions of Work Questionnaire (CWEQII). The instruments were aligned to the South African context after the pilot study was conducted, and also according to the categories of professional nurses (PNs, CPNs and CNSMs) who participated in the study (see appendices E and F). An interview guide for the Chief Nursing Service Managers (CNSMs) was developed using the quantitative responses and also the conceptual framework (see appendix G). Open-ended questionnaires were developed to interview nurse managers, in order to understand

the nurse leadership's perception of the successful attributes in today's health care setting that foster job satisfaction among clinical nurses in their practice environments (see appendix H).

3.5.1. The Revised Nursing Work Index (NWI-R)

The Revised Nursing Work Index (NWI-R) and CWEQ 11 measurement tools were used in the majority of research studies on staff retention and Magnet hospitals (Cummings, Hayduck & Estabrooks, 2006, Kluska *et al.*, 2004, Budge *et al.*, 2003 Laschinger *et al.*, 2003; Manojlovich & Laschinger, 2002; Upenieks, 2002; Buchan, Havens, 2001, Aiken *et al.*, 2000, Aiken & Patrician, 2000; and Laschinger *et al.*, 1999). The NWI-R is an excellent tool for assessing a professional practice environment which allows for increased staff satisfaction, increased staff retention and numerous cost benefits to organisations (Wagner, 2004). A self-designed tool which covered the subscales of leadership style and staff retention was also utilised. The original Nursing Work Index (NWI) was designed by Kramer and Haven, who were the original Magnet hospital researchers through their extensive review of literature published between 1962 and 1986 (Wagner, 2004).

The NWI-R tool measures autonomy, nurse control over practice setting and relations between nurses and nurse managers . The higher the scores, the more satisfied the nurses are considered to be, owing to the organisational structures in their work settings (Upenieks, 2002). The NWR tool was further revised by Aiken and Patrician in 1994, by refining the instrument's ability to measure organisational attributes of an environment supportive of professional practice. This version is called a revised nursing work index (NWR-I) (Wagner, 2004), and is freely available on the public domain. The tool has been used as a valid and reliable instrument in numerous nursing studies such as McCormack & Slater (2006), Slater (2006), McCusker *et al.* (2004); Wagner (2004), Foley *et al.* (2002); Clarke *et al.* (2002); Upenieks (2002); Aiken *et al.* (2000) and Aiken *et al.* (1997).

The NWI-R instrument has four sections. A few items are indicated under each section so as to show how the instrument is integrated with the research questions and theoretical framework:

- Part 1= Selected individual items
    - Salaries
    - Opportunity
    - Autonomy
    - Career development opportunities
- Part 2= Index of work satisfaction
    - Decision-making
    - Autonomy
- Part 3= Job management and professional development
    - Career development opportunities
    - Support to pursue additional qualifications in nursing
    - Supportive nursing management
    - Equality in power
- Part 4= Intentions to stay in the organisation
    - Job plans for the next year, next three years, and next five years.

3.5.2. Revised Conditions of Work Effectiveness (CWEQ 11)

The researcher obtained written permission to use the CWEQ 11 instrument from the principal investigator (Professor Laschinger) of the Work Empowerment Research Program at the School of Nursing, University of Western Ontario and London, Ontario, Canada (see appendix I).The instrument which was utilised was designed by Kanter (1993) and modified by Chandler (1996) and later remodified by Laschinger *et al.* (2001).

The whole instrument includes the following components: Conditions of Work Effectiveness, Job Activities Scale and Managers Activities Scale which will be briefly described below.

- Conditions of Work Effectiveness (CWEQ 11) measures access to opportunity, resources, information and support.
- Job Activities Scale (JAS) measures a nurse's perception of formal power within the working environment. JAS measures access to formal power structures. High scores represent job activities that give high formal or position power.
- Managers Activities Scale (MAS) measures a manager's ability to mobilise resources to get things done in the organisation.

3.6 PILOT STUDY

A pilot study was conducted among professional nurses who had characteristics similar to the sample of the study. Permission was sought before data collection .The focus group discussion verified the instrument as valid in the South African context, because the instruments used originated from the United States of America and Canada. The selected respondents completed the questionnaires individually, and thereafter discussed the research questions in a focus group. Minor adjustments to the instrument were made based on the outcomes of the pilot group. Their responses helped to refine the questionnaires because the data guided the formulation of the in-depth interview guide with chief nursing service managers. The pilot group was not part of the main study.

3.7 DATA COLLECTION PROCESS

Data collection is the process of selecting subjects and gathering information about the variables in the study. A case study protocol was used as a guide to collect data. According to Yin (2003), a case study protocol is a major way to increase reliability of case study research and is intended to guide the researcher in carrying out data collection. Conducting a case study requires the use of multiple sources of evidence which include documents, in-depth interviews, and direct observation. Direct observation was guided by the checklist which was designed by the researcher.

3.7.1. Engagement with alliances

Interviews were held with some significant members of the South African Nursing Council (SANC). An inquiry was made about the verification of registration of professional nurses in the country from the SANC representative. Actual numbers and the movement patterns of professional nurses in the province were sought from the Human Resource Manager at the DOH. The Unions' representatives from DENOSA, NEHAWU, SADNU and HOSPERSA in KwaZulu-Natal were interviewed about the engagement held with professional nurses in the province.

3.7.2. Visits to the hospitals

The researcher visited the institutions and the data was guided by the following format:

Day one: Selection of professional nurses; filling in of questionnaires for both PN and unit managers.

Day two-three: Direct observation in the units; reviewing of unit documents and attending of meetings if available. The researcher was posted in different units.

Day four: Interviews with Chief Nursing Service Managers and reviewing of hospital documents. All public institutions are headed by one Chief Nursing Service Manager (CNSM).

3.7.3. Detailed data collection process

The researcher physically visited the health care institutions to observe the behaviour in natural settings. Measures were taken to ensure that all questionnaires were completed and returned during the researcher's visit to the institutions. In order to allow freedom of expression from the professional nurses, the chief nursing service officers were excluded from handling completed questionnaires.

The questionnaire package, along with a covering letter and consent forms were handed to the respondents. Questionnaires were filled in by the professional nurses and nurse managers working in those selected units. Nurse Managers were interviewed by the researcher during their tea and lunch breaks, so as not to disturb

the ward routine. According to Yin (2003), the researcher should cater for the interviewee's schedule and availability. Four chief nursing service managers were interviewed in depth. Qualitative researchers usually work with small samples of people, in their own context, and studied in depth (Crabtree & Miller, 1999).This sample is naturally too small because each hospital has only one chief nursing service manager.

The researcher was a direct observer, and therefore physically collected data in large and small hospitals, spending 5 days and 3 days respectively, so as to get valid information by observing nurse managers and professional nurses in the units. Direct observation is a process in which the researcher establishes many-sided and long term relationships with individuals and groups in their natural settings, for the purpose of developing an understanding of those individuals and groups. The researcher followed an overt strategy whereby respondents were fully aware of the researcher's intentions.

The methodology of direct observation consists of the following seven features which were addressed in this study:

- A special interest in human meaning and interaction as viewed from the perspective of professional nurses employed in the public health institutions.
- Location in the here and now of everyday life situations and settings as the foundation of inquiry and method.
- A form of theory and theorising, stressing interpretation and understanding of human existence, e.g. Kanter's theory.
- A logic and process of inquiry that is open-ended and flexible, redefining what is problematic.
- An in-depth, qualitative case study approach and design.
- The performance of a researcher's role establishing and maintaining relationships with respondents.
- The use of direct observation along with other methods of gathering information. Whilst collecting data, observations and document analysis were conducted (Jorgensen, 1989).

Preparation for data collection included the following:

- Prior skills of the investigator which consist of the ability to ask constructive questions and to be flexible and unbiased.
- Development of a case study protocol which guided data collection (see appendix D).
- Inclusion criteria so as to ensure proper screening of candidates.
- A pilot case study which is congenial and convenient. A pilot case study helps to refine data collection plans in terms of content and procedures and also provides conceptual clarification (Yin, 2003).

Qualitative data collection and analysis took place simultaneously, and the researcher had the freedom to redirect the research depending on the available information. A tape recorder was utilised for accuracy, and on completion of data transcription and analysis, tapes were to be destroyed after five years. During the research process, tapes were kept safely in a locked cabinet in the researcher's office.

3.8. ACADEMIC RIGOUR

Burns & Groove (1997) describe academic rigour as the logical accuracy and scientific adequacy of the research outcome with respect to adherence to a philosophical perspective and thoroughness in collecting data. Both quantitative and qualitative approaches will be discussed, although the study is mainly quantitative. The qualitative approach was used to verify the quantitative findings where the sample was small.

3.8.1. Validity

Validity is the extent to which an instrument actually measures what it sets out to measure.

3.8.1.1. Content validity Content validity and criterion-related validity were proposed as empirical procedures for establishing validity in a study (Polit & Hungler, 1999). Content validity is established by matching objectives with research questions on an instrument (Yin, 2003). The objectives look at the leadership and

organisational factors that prevail in the institutions under study, and the instrument measures support, opportunity, access to information and resources, which are the variables being researched in the study (See Table no 3.3).

Table 3. 3: Content validity

Research Objectives	Conceptual framework	Instrument
1.To describe different leadership styles in organisation	Formal power Informal power Autonomy Leadership	CWEQ 11 Interview with union managers NW1-R
2.To describe organisational factors that prevail in these institutions	**Organisational factors** -opportunity -support -information -resources	CWEQ 11
3 To examine retention trends in health care institutions	Retention of staff	NWI-R
4.To examine the relationship of organisational factors , leadership style and staff retention	Organisational factors Leadership behaviour Staff retention	JAS NWI-R

3.8.1.2. Construct validity

Construct validity is the extent to which scores on an instrument reflect the desired construct (Polit & Beck, 2006). Yin (2003) supports the idea of using multiple sources of evidence during data collection. Document reviews, interviews, questionnaires and direct observation methods were utilised to collect data in this

research project. Triangulation is the use of multiple methods of collecting and interpreting data about some phenomenon to determine the similarities of these data (Yin, 1994).Triangulation assisted the researcher in accordance with Yin's (2003) views to explore the same phenomenon in various settings with different individuals. The variables (access to support, access to information, and access to resources and access to opportunity) were used throughout the questionnaire, since they are part of the organisational factors which contribute to staff retention.

Nurses' perceptions of formal power within the working environment were measured through the Job Activity Scale (JAS). High scores represented job activities that gave high formal power or positions of power. Informal power within the work environment was measured through the unions' interviews. Managers' ability to mobilise resources to get things done in the organisation were measured by the Managers Activities Scale (MAS) (Laschinger *et al.*, 2001).

3.8.1.3 Internal validity

Internal validity refers to the extent to which it is possible to conclude that the independent variable is truly influencing the dependent variable. During data analysis, results from one case study were matched to other cases, using Kanter's theoretical model. Pattern matching was effected for different cases. According to Yin (1984), if patterns emerge which match an empirically based pattern, the results can help to strengthen the internal validity of the case study. Use of a tape recorder ensured concrete evidence which was matched with observation and the responses from the questionnaire. Variables from the case studies on access to opportunity, information, resources and support were matched with organisational and leadership qualities and significant relationships were identified. The respondents were accurately identified and described according to the set criteria. During data collection, verbal and non-verbal communications were observed by the researcher during data collection for congruency. The researcher was a direct observer in these institutions and was present in different units or wards where professional nurses were allocated.

3.8.1.4. External validity

This refers to the ability to generalise from the data (Yin, 2003). The sample was determined by statistical calculations, and the researcher did not get the determined power of the sample due to adhering to the ethical principles of allowing respondents to withdraw from the study. Qualitatively, the ability to generalise from the study was facilitated by ensuring that the thoughts and action processes of the researcher were clearly and comprehensively presented in the study. The inclusion of a theoretical framework which has been utilised by all researchers in Magnet hospital studies determined whether the findings were applicable or transferable to other settings. Kanter's theory deals with empowerment of staff, and all the major variables suggested by Kanter are covered in the theoretical framework of this study. Kanter's theory was tested by replicating the study in the following case study, where the theory has specified that the same results occurred.

3.8.1.5. Quality of the case study and instrument

Quality and construct validity was maintained by the use of triangulation during data collection. The professional nurses and chief professional nurses responded by means of the questionnaire; chief nursing service managers, stakeholders and union managers were interviewed, guided by an in-depth interview. Observations and document analysis were conducted by the researcher. Reliability was maintained by adhering to the case protocol in all four cases. Internal validity was observed because patterns of themes were matched during data analysis. See Table 3.4 for details of quality of the case study design and instruments.

Table 3.4: Quality of case study design and instruments

Case study		
Test	**Case study tactic**	**Phase**
Construct validity	Triangulation	Data collection
Internal validity	Pattern matching	Data analysis
External validity	Use of a conceptual framework	Data collection
Reliability	Use of case protocol	Data collection
Data collection instruments		
Instrument	**Instrument tactic**	**Phase**
Content validity	Aligning content to framework and objectives	Contextualising the instrument
Construct validity	Triangulation	Data collection
Reliability	Internal consistency	Data analysis

3.8.2. Reliability

According to Polit and Hungler (2001), reliability means the degree of consistency with which the instrument measures the attribute it is designed to measure. The objective of reliability is to be sure that if a later investigator followed the same procedures as described by the earlier investigator and conducted the same case study all over again, the later investigator would arrive at the same findings and conclusions. According to Pallant (2001), the reliability of the scale indicates how free it is from random error. The goal of reliability is to minimise the errors and biases in a study (Yin, 2003). The correlation coefficient of the used instruments was between 0.800 and 0.882 in the study similar to the scores in the studies by Laschinger (2003) Upenieks (2002), and Laschinger *et al.* (2000). This study had a correlation efficiency of 0.80. The conclusion is that the reliability of the scale

showed a minimal error, considering the fact that the instrument was initially administered in developed countries (see Table 3.5., 3.6., 3.7. and 3.8).

The same instruments were used in all four institutions on all respondents. The same procedure for data collection was adhered to in all institutions, as there was a case study protocol which guided the researcher. Once the results had been authenticated by the school research committee and experienced researchers, the researcher met the element of trustworthiness. A full description of how data were collected and analysed is provided. The use of the case study protocol was also verified. All the research material has been kept by the researcher for auditing purposes.

The researcher consulted the statistician from the University of KwaZulu-Natal. Minor changes were effected based on her comments. The entire instrument was submitted to the ethics committee after careful scrutiny by the supervisor and other experts from the School of Nursing.

3.8.2.1. Reliability scores on instruments

All other subscales had an internal consistency which was above 0.70 except access to opportunity. The mean figures were also within normal ranges, since the lowest was 1.46 and the highest was 3.47. See Tables 3.5 and 3.6.

Table 3.5 Reliability scale for Professional nurses (N= 122)

Scale	Item	Mean	SD	Chronbach's alpha
CWEQ : Conditions of Work effectiveness				
CWEQ Scale	28			0.947
Access to opportunity	3	2.80	2.81	0.663
Access to information	3	1.93	3.23	0.885
Access to support	3	2.17	3.47	0.841
Access to resources	3	1.70	2.98	0.793
JAS	3	1.46	2.89	0.825
MAS	11	2.93	1.10	0.946
Global empowerment	2	2.13	1.61	0.722
NWI-R: Revised Nursing Work Index :				
Leadership	4	2.19	2.74	0.851
Autonomy	3	2.90	1.72	0.840

Table 3.6. Reliability scores on Chief Professional Nurses (N=45)

Instrument	Items	Mean	Std Dev	Cronbach's Alpha
CWEQ 11: Conditions of work effectiveness				0.940
Subscales				
Opportunity	3	3.86	2.63	0.731
Information	3	3.10	2.37	0.812
Support	3	3.13	2.33	0.882
Resources	3	2.69	2.30	0.731
Manager Activity Scale (MAS)	11	2.90	0.70	0.876
Job Activity Scale (JAS)	3	2.87	3.12	0.830
Global Empowerment Scale	2	2.54	1.38	0.814
NWI-R: Revised Nursing Work Index				
Leadership	5	4.31	2.19	0.663

Means and standard deviations for CPNs (N=45) & PNs (N=122)

Generally, CPNs scored higher than PNs in all variables except 'access to resources' as indicated in Table 3.7.

Table 3.7 : Means and Standard Deviation for CPNs & PNs

	CPN (n=45)		PN (n=122)	
	Mean	**SD**	**Mean**	**SD**
CWEQ 11				
Opportunity	3.86	2.63	2.17	3.47
Information	3.10	2.37	1.93	3.23
Support	3.13	2.33	1.70	2.98
Resources	2.69	2.30	2.80	2.81
JAS	2.90	0.70	1.46	2.89
MAS	2.87	3.12	2.93	1.10
Global empowerment	2.54	1.38	2.13	1.61

When comparing the reliability of this study with other studies which utilised the same instrument, scores are within the accepted range except for 'access to support' which had a score below 0.70.

Table 3.8: Comparing reliability scores with other studies

	Current Study	Laschinger *et al.* (2003)	Miller *et al.* (2001)
CWEQ scale			
Opportunity	0.885	0.81	0.70
Information	0.793	0.86	0.75
Support	0.663	0.78	0.84
Resources	0.825	0.77	0.79
JAS	0.946	0.75	0.64
ORS	Not used	0.70	0.88
Global empowerment	0.841	0.86	Not done

When comparing the results of this study with others, it emerged that there was an internal consistency in all studies. The results of this study are within the acceptable range, which is above 0.70. According to Polit and Beck (2004) the higher the coefficient, the more stable is the measure. Reliability coefficients above 0.70 are usually considered satisfactory.

Table 3.9: Reliability scores of NWI-R

	Current study	Laschinger	Aiken	Slater	Wagner	Upenieks
NWI-R scale	0.928	0.88	0.96	0.78	0.96	0.82
Autonomy	0.77	0.79				0.882

3.8.3. Trustworthiness of qualitative data

Academic rigour of the data should fit in with the philosophical assumptions, purposes and goals of the qualitative paradigm (Polit & Hungler, 1999). Credibility, transferability, dependability and conformability are used as the criteria for substantiating the trustworthiness of qualitative studies (Polit & Beck, 2004).

Credibility refers to the truth value of findings and authentic quality of the data (Polit & Hungler, 1999). Credibility of research findings also deals with how well categories and themes cover data (Graneheim & Lundman, 2004). Establishing the credibility of this research was approached in several ways. The researcher bracketed and documented any personally held presuppositions and biases about the topic of study. Credibility was enhanced through triangulation, the researcher's credibility and purposive sampling. Triangulation was used as a technique to provide credible findings as more than one source of informants was used for data collection. Data was collected from experts in the field of nursing, and in-depth interviews from union managers. The researcher personally visited and collected data from the respondents and informants from the selected organisations. Simultaneous observation of each respondent and the surroundings throughout the interview further contributed to the credibility of the study.

Transferability refers to the extent to which the findings can be transferred to other settings (Polit & Hungler, 1999). By providing a thick description of the demographics of the individuals who participated in the study, and also in respect of each of their workplaces, experiences and context, the researcher facilitated the reader's ability to assess the transferability of findings (Krefting, 1991). Data was collected from different settings which were adequately described. Similar methods were utilised in all four cases, guided by the case protocol. Similar concepts emanated from the analysis, and could thus be deemed applicable from one setting to the other.

Dependability refers to the stability of data over time and over conditions. Dependability is crucial to the credibility of qualitative data. What is credible in qualitative studies is reliability in quantitative studies (Polit & Hungler, 1999). The dependability of this study was established by means of external checks and by a process of audit. Data analysis and conclusions drawn were authenticated by the

researcher's supervisor. Pilot testing was conducted prior to data collection. In-depth interviews and focus groups' discussions were guided by the conceptual framework. The instruments were scrutinised by the experts in the School of Nursing and also by the ethics committee. Feedback from experts was applied in the modification of the instrument.

Conformability refers to the objectivity or neutrality of data (Polit & Hungler, 1999). The conceptual framework guided data collection and data analysis throughout the study. Patterning was utilised to identify similarities and differences between the responses. Saturation was reached when similar responses were obtained in the study.

3.9. DATA ANALYSIS

Data analysis is the process of making sense out of one's data in order to come up with reasonable conclusions (Merriam, 1988). The purpose of both qualitative and quantitative data analysis is to organise, provide structure to, and elicit meaning from, research data. In qualitative studies, data analysis occurs simultaneously and the search for important themes and concepts begins when data collection begins (Polit & Beck, 2004).

3.9.1. Quantitative data analysis

Quantitative data was analysed by using SPSS Version 15 for Windows. A reliability analysis was done to check the relationship between the leadership styles, organisational factors and staff retention.

The correlation coefficient was calculated by use of Pearson's r. A correlation coefficient is a statistical measure which measures a degree of relationship or association between two variables in a standard form. It can range between +100 to -1.00 (Schwab, 1999). Pearson's r is the most widely used correlation coefficient, designating the magnitude of relation between two variables measured on at least an interval scale, also referred to as the product-moment correlation (Polit & Hungler, 2001). A strong correlation between two variables means that they are related, but not necessarily that the one variable causes the other. In most social science applications, we do not expect to find a very strong relationships between naturally

occurring variables, and correlations between r = 0.25 and r = 0.75 are typical, 0.25 being the weakest relationship and 0.75 being the strongest relationship (Terblanche, Durrheim & Painter, 2006).

Correlation looks at the relationship between two variables using a Chi-squared test. A Chi-squared test is a non-parametric test of statistical significance used to assess whether a relationship exists between two nominal-level variables. Measures of central tendency were used to describe the mean and standard deviations of the subscales. Computation of internal consistency of scoring was calculated using a Chronbach's alpha. This is a measure of internal reliability of multiple statements, measuring the same concept within the questionnaire. The rule of thumb is that the result should be 0.8 or above (McCormack & Slater, 2006). The scoring for this study was above 0.70 except on the leadership scale which was 0.65.

3.9.2. Qualitative data analysis

The analysis of qualitative data is an active and interactive process, especially at the interpretive end of the analysis style continuum (Polit & Beck, 2004). The data in this study was organised by using N-VIVO software. Qualitative data was analysed using a template analysis style, involving the development of a template based on the events and linguistic expressions. The use of a template manual and the software package allows the researcher to be more focused and organised. The template process reduces the amount of data being considered and brings together related pieces of text into meaningful data (Crabtree & Miller, 1999).The analysis of the resulting data, once sorted according to the template, is interpretive. Category and sub-category definitions were utilised for deductive analysis. Patterns and themes emerging from various categories of data were conceptualised into meaningful units of analysis. Taped interviews were transcribed and analysed using a matrix system for more precise information. The researcher was guided by the template and also followed the intellectual processes of Morse and Field (1995) as cited by Polit & Beck (2004).

The identified processes are:

- **Comprehending**: The researcher strove to make sense of data until saturation of data occurred.

- **Synthesising**: Data was sifted into different categories which brought more meaning to the study about the concept, and also about the respondents.
- **Theorising**: This involved systematic sorting of the data until the researcher developed a clearer explanation of the research concepts
- **Recontextualising**: The researcher explored the applicability to other groups. Since the researcher was not developing a theory for her study, there was no need for recontextualising (Polit & Beck, 2004).

3.9.3. Case study analysis

Data analysis consists of examining, categorising, tabulating, testing or otherwise recombining quantitative and qualitative evidence to address the initial propositions of a study. Each case was analysed by tabulating the information from the questionnaire as discussed by professional nurses. In-depth interviews from chief nursing service managers were examined and categorised into common themes which were later arranged into patterns. Findings from direct observations and document reviews were tabulated against the checklist that was designed by the researcher.

Cross-case analysis was done so as to enhance generalisability, and also to deepen understanding and exploration. Cross-case analysis searches for descriptions of factors which influence change. Generalisation of case study findings is limited to the case itself. Attention to selected details did however, enhance analysis and increase the clarity of reasoning. According to Yin (1994), analysis hinges on linking data to the propositions and explicating the criteria by which findings are to be interpreted. It is valuable to compare the cases systematically to see the factors that are present in all cases and those that are not present in other cases (Yin, 2003).

The working principles for cross-case analysis needs were observed as suggested by Miles and Huberman (1994). These principles included:

- Understanding the case in detail;
- Avoiding aggregates when looking at the similarities and differences of the cases.

- Preserving case configurations. The network of causes, effects, outcomes and their temporal sequence within each case were protected during analysis;
- Combining variable-oriented and case-oriented strategies. Valid explanation usually involves cycling back and forth between, and synthesising strategies aimed at understanding case dynamics.
- Inquiring into the deviant case. The cases that do not fit emerging explanations were not discarded, but required the researcher to rethink and expand. The case with fewer respondents was also included because the organisation is very small.
- Avoid forcing. One should not assume that all cases will have a standard set of independent variables and dependent variables. The researcher did not force the emerging variables within the themes

3.10 ETHICAL CONSIDERATIONS

When humans are used as study respondents, care must be exercised to ensure that the rights of those humans are protected. Research studies must be guided by ethical principles, regardless of any goal or paradigmatic orientation (Polit & Beck, 2006). The researcher was guided by the ethics committee format to address all the ethical issues involved. Principles of beneficence, respect for human dignity and privacy were observed and integrated into the study.

3.10.1. Ethical Clearance and Permission

Permission and approval to conduct the study were obtained from the following key individuals:

The Ethics Committee of the University of KwaZulu-Natal

The research proposal was presented to the School of Nursing to be examined for academic rigor. Ethical clearance and final permission to collect data was obtained from the UKZN Ethics Research Committee, Faculty of Humanities. Copies of

ethics approval, informed consent and information document are attached (see Annexure A, B and C).

The Department of Health in KwaZulu- Natal

Permission to collect data from health care institutions was sought from the Department of Health in KwaZulu-Natal, in order to gain entrance into the chosen public health institutions (see appendix K). The research proposal and the ethics clearance were submitted to the DOH.

Managers and professional nurses

Permission was also requested from hospital managers and professional nurses working in the selected public health facilities who met the selection criteria. The services of the public health facilities were not interrupted by the presence of the researcher. Information was collected at times convenient to the respondents' schedules such as during lunch-times, other breaks and even during their days off. The researcher ensured that there were no disturbances in the units where she was collecting data from the professional nurses (see appendices L, M, N and O).

Union managers and SANC

Permission to conduct research in the following alliance institutions, namely SANC, DENOSA, and HOSPERSA, SADNU AND NEHAWU was obtained from the Heads of Departments (see appendices P, Q, R and S). An ethics clearance from the University of KwaZulu-Natal, the research proposal, the informed consent documents and the information document were sent to the departmental heads for approval and signatures of individuals. A further explanation was given to the managers before data collection.

Ethical issues addressed in the study

All ethical issues underlying protection of human beings were recognised in this study.

Informed consent:

Informed consent is a prerequisite for all research involving identifiable respondents and informants. Any dialogue referencing informed consent must be grounded in the principle of autonomy that encompasses the notion of being a self-governing person with a decision-making capacity (Speziale & Carpenter, 2007). According to Polit & Beck (2004), informed consent means that respondents have adequate information regarding the research, are capable of comprehending the information, and have the power of free choice to enable them to consent voluntarily to participate in the research or to decline participation.

The respondents signed an informed consent form which was designed according to the UKZN ethics committee format. The informed consent allowed the respondents to withdraw if they felt uncomfortable about continuing with the study. General information about the nature and purpose of the study, including the background and contact details of the researcher were part of the respondent information sheet.

Confidentiality and anonymity

Confidentiality and anonymity were observed by using codes on the questionnaire instead of names, and treating any information with the strictest secrecy. The privacy of respondents was respected and appropriate measures were taken to ensure that it was observed throughout the study. The name of the particular institution did not appear in any written work. Institutions were coded as Cases A, B, C and D.

The principle of justice

The principle includes respondents' right to fair treatment and their right to privacy.

The right to fair treatment:

Study respondents have the right to fair and equitable treatment before, during and after their participation in the study. Fair treatment includes the following features:

- The fair and non-discriminatory selection of respondents.
- The fair treatment of those who decline to participate or withdraw from the study, or who withdraw from the study after agreeing to participate.

- The honouring of all agreements between researchers and respondents, including adhering to the procedures described to them.
- Respondents' access to research personnel at any point in the study to clarify information.
- Courteous and tactful treatment at all times (Polit & Beck, 2004).

All of the above features were observed by the researcher.

The right to privacy:

Respondents have the right to expect that any data they provide will be kept in the strictest confidence. Privacy can occur through anonymity or through other confidential procedures. Anonymity occurs when the researcher cannot link respondents to their data. Anonymity is almost never possible in qualitative studies because the researcher typically becomes closely involved with respondents (Polit & Beck, 2004). An information sheet with the researcher's contact details, full explanation of the study and the consent form were given to selected respondents before data collection.

Protection against disclosure

Permission was requested to interview informants using a tape-recorder. Ethical implications were explained before data collection. An agreement on the basis on which the study would be conducted was mentioned. Informants who refused to be taped were respected. Information was then collected in the form of notes. Names of informants and their organisations were not revealed.

The right to self-determination

Humans should be treated as autonomous agents, capable of controlling their own activities. The principle of self-determination means that respondents have the right to decide voluntarily whether to participate in a study, without risking any penalty or prejudicial treatment. It also means that people have the right to ask questions, to refuse to give information, to ask for clarification or to terminate their participation (Polit & Beck, 2004).The researcher respected individual rights on decisions made during data collection.

The right to full disclosure

The principle of respect for human dignity encompasses people's rights to make informed, voluntary decisions, which require full disclosure. Full disclosure means that the researcher has fully described the nature of the study, the person's right to refuse participation, the researcher's responsibilities, and likely risks and benefits. The right to self-determination and the right to full disclosure are two major elements on which informed consent is based (Polit & Beck, 2008).

Researcher Bias

The researcher's bias was avoided by adhering to a theoretical framework, formation of structured questions and the use of an in-depth interview guide. The theories and knowledge of the topic were based on the extensive literature review and not on the researcher's personal beliefs and opinions. This activity was carried out before the beginning of the study and was repeated throughout data collection.

3.11. DISSEMINATION OF FINDINGS

On completion of the study, the research report will be communicated to all institutions that participated in the research study, and to the Department of Health as a policy- making body. Seminars will be conducted nationally which will mainly target nurse managers. The findings of the study will be published nationally and internationally. Confidentiality and anonymity will be maintained throughout the research process. Names of hospitals which participated in the study will not appear in any thesis and also not during conference presentations. The names will be coded as Case A, B, C, and D.

4 CHAPTER FOUR: PRESENTATION OF FINDINGS

4.1. INTRODUCTION

This chapter presents the findings of the study, case by case and finally the cross-analysis of all the four cases. Each case includes both quantitative and qualitative data from various levels of professional nurses, namely, professional nurses, chief professional nurses and chief nursing service managers, including nurses with overseas experience. Qualitative and quantitative data will be linked so as to:

(a) enable confirmation of each other via triangulation;
(b) elaborate and provide a richer detail and
(c) initiate new lines of thinking thus providing fresh insights (Miles & Huberman, 1994).

Data from alliances (union managers) were also collected. Interviews (individual and group), questionnaires, document reviews and observations in the institutions were utilised to collect data. The Statistical Package for Social Sciences (SPSS Version 15.0) was used to analyse quantitative data while qualitative data was organised using N-VIVO but analysed manually. The quantitative data analysis includes descriptive statistics and cross-tabulations using Pearson's correlation test according to sample number. These statistics are presented in the form of tables and graphs designed from Excel package. Qualitative data was used where the sample was too small to allow statistical analysis, for example, each case had one Chief Nursing Service Manager (CNSM). All public health institutions in the country are headed by only one CNSM; therefore the qualitative approach is the best methodology to obtain data from the small sample. Furthermore, only one representative of the alliances was interviewed. The information about the Department of Health and the regulatory body (SANC) are documented as they were reported by the CNSMs. Presentation of data is guided by the following objectives which were to:

- distinguish and describe the different leadership styles;
- identify organisational factors in terms of access to support, information, resources and opportunity that prevail in these public health facilities;
- examine retention strategies in these public health care facilities;

- analyse the relationship between organisational factors, leadership styles and the retention of professional nurses.

4.2. SAMPLE DESCRIPTION

The researcher sampled twelve (12) out of seventy-two (72) institutions in the province of KwaZulu-Natal. Two cases declined, citing different reasons. One case stated that they were busy restructuring, and the other case had a conflict of interest between the chief nursing service manager and the chief executive officer. Six institutions did not respond despite several attempts to contact them. The research protocols were sent several times to these institutions, and follow-up calls were not successful.

Each case is made of all the professional nurses from that organisation. The total sample from all four cases was one hundred and seventy-one (171). The sample that was realised in the end included four institutions referred to as cases in this study, as reflected in Table 4.1 below.

Table 4.1: Number of respondents per case

Case	PN	CPN	CNSM	Total
A	35	16	1	**52**
B	33	13	1	**47**
C	30	9	1	**40**
D	24	7	1	**32**
Total	**122**	**45**	**4**	**171**

In addition to the above respondent/cases, interviews were conducted with professional nurses with overseas experience, the union's representatives and the SANC. This made the total number of respondents in the study sample 187 as indicated in Table 4.2 below.

Table 4.2: Total sample of respondents (N=187)

Respondents	Frequency	Percent
Professional Nurses	122	65%
Chief Professional Nurse	45	24%
Chief Nursing Service Manager	4	2%
Nurses with overseas experience	12	6%
Union Managers	4	2%
Total	187	100%

4.3. RESULTS OF CASE A: REGIONAL TERTIARY HOSPITAL

Case A is an 800 bed institution based in the urban area. There are 225 professional nurses in this organisation which had downsized from 1200 to 922 beds in order to make way for a new tertiary institution. The newly built hospital had to be staffed with skilled professional nurses in order to function as a tertiary hospital. More than 100 professional nurses moved to the new hospital. The case for discussion is the old hospital which had downsized.

4.3.1. Data collection process

The chief nursing service manager was informed about the research project. The research proposal and all the supporting documents were delivered to her office. The CNSM referred the researcher to her deputy because all human resource related issues were dealt with by the deputy nursing service manager. A short meeting was arranged to explain in detail the research study. Proper guidelines on conducting research in a public hospital were shared at the meeting. The research proposal was handed over to the research office of the hospital. Several follow-up visits were conducted with no positive response. Documents were resubmitted to the research office and finally a personal visit was made by the researcher to the research office. Another meeting was arranged with the deputy CNSM which culminated in the approval for data collection.

The project was discussed with the senior management and at a regional manager's meeting. The researcher identified all the units that she was going to visit. Random sampling of professional nurses was done in the selected units. The researcher explained the research protocol before each respondent signed the consent form if he/she agreed to participate in the study. The professional nurses were selected from the duty roster. The unit manager was purposively included in the sample. Questionnaires were left with the professional nurses in the unit to complete during their free time. Any verbal responses were documented as part of data collection. The researcher visited the ICU, theatres, and maternity section, medical and surgical wards, including the outpatient department of the institution. The researcher spent five days in this institution.

Observations of the unit were done simultaneously with data collection. The researcher had the opportunity to talk to nurses, to check selected documents, to peruse available policies, and to assess the organisation and utilisation of the ward policies whilst collecting completed questionnaires. The total number of professional nurses working in this institution is 225, and only 35 professional nurses, 16 CPN and 1 CNSM participated in the study making a total of 52 (23%) professional nurses from this organisation who participated.

4.3.2. Professional nurses in Case A

4.3.2.1 Demographics of professional nurses

Professional nurses were asked about their gender, age, nursing experience and educational qualifications. The demographics were presented as follows:

4.3.2.1.1. *Demographics: Age, gender, nursing experience*

The majority of respondents 13 (38 %) were between the ages of 31 and 40 years, whereas 5 (15%) of the respondents were between 21 and 30 years. Females (95%) were the majority of respondents compared to males who constituted only 5%. Fifteen (34%) of the professional nurses had more than fifteen years' nursing experience, and 26 (74%) of respondents had a diploma in nursing, while 9 (26%) respondents had a Bachelor's degree. The majority of the respondents, 13 (38%), worked in the ICU. Professional nurses who worked in high care were added to the

ICU because of the close proximity of the units and as some of the high care patients were nursed in the ICU. See Table 4.3.

Table 4.3: Demographic details of PNs (n= 35)

	Frequency	Percent
Age		
21-30 yrs	5	15%
31-40 yrs	13	38%
41-50 yrs	9	26%
Above 50 yrs	7	21%
Total	34	100%
Gender		
Male	1	5%
Female	33	95%
Total	34	100%
Years of nursing experience		
1-5 yrs	6	17%
6-10 yrs	8	23%
11-15 yrs	6	17%
Above 15 yrs	15	43%
Total	34	100%
Educational qualification		
Degree	9	26%
Diploma	26	74%
Total	35	100%
Unit representation/distribution		
Medical	4	11%
Surgical	2	6 %
Operating Theatre	6	17%
ICU	13	38%
OPD	4	11%
Maternity	6	17%
Total	**35**	**100%**

4.3.2.1.2 Demographic: Qualification of PNs

The total percentage for all qualifications is above 100% because some individuals had more than one qualification. Qualifications were arranged into basic, post-basic and management qualifications. Professional nurses were sampled from different units, but the ICU had the highest number of 7 (20%) counts. Only 9 (20 %) of respondents had a management qualification which is necessary to manage a unit or department. Refer to Table 4.4.

Table 4.4: Qualification of PNs (n=35)

Qualification	Frequency	Percent
Basic Qualification		
Midwifery	4	11%
Community	2	6%
Nursing (General, Community & Psychiatry) and Midwifery	7	20%
Post Basic Diploma		
ICU + High care	8	23%
OT	2	6%
PHC	3	9%
Advanced Midwifery	1	3%
Trauma	1	3%
Oncology	1	3%
Paediatrics	2	6%
Mixed Qualification	5	15%
Management qualification		
Management	9	20%
Management & Education	2	6%

4.3.2.1.3. Demographic: Union affiliation

DENOSA is the most popular union among nurses. Twenty-three (65%) of respondents were members of DENOSA as compared to only 3 (9%) members of each of the three unions, respectively. The union termed "Other " means unions like Nepwu and PSA which had fewer than 3, or no members, as indicated in Table 4.5 below

Table 4.5: Union affiliation by professional nurses (n=35)

Union	Frequency	Percent
DENOSA	23	65%
HOSPERSA	3	9%
NEHAWU	3	9%
SADNU	2	6%
Other	3	9%
None	1	2%
Total	**35**	**100%**

4.3.2.2 Leadership factors

Leadership factors that were addressed were the visibility and accessibility of the CNSM. Her contribution to top management was also assessed for authority, and for empowering the senior management team.

4.3.2.2.1. Perceived leadership behaviour

Professional nurses were asked about the leadership behaviour of their unit managers, and the chief nursing service managers. More than 46% of the professional nurses perceived their leader as visible and accessible to staff, which is an indicator of a transformational leader. See Table 4.6.

Table 4 .6: Perceived leadership behaviour

	Disagree	Neither	Agree	Total
	Frequency	**Frequency**	**Frequency**	**Frequency**
CNSM is visible to staff	6 (21%)	9 (31%)	14 (48%)	29 (100%)
CNSM is accessible to staff	4 (14%)	7 (24%)	1 8 (62%)	29 (100%)
CNSM has equal power with top executives	7 (23%)	8 (27%)	15 (50%)	30 (100%)
CNSM has equal authority with SMT	4 (15%)	10 (39%)	12 (46%)	26 (100%)

Key:

CNSM: Chief nursing service manager

SMT : Senior management team

4.3.2.2.2. The unit manager is a good leader

The unit manager is in charge of the unit where the professional nurses were allocated. Unit managers work closely with professional nurses. Of 35 respondents, 24 (69%) agreed that the nurse manager is a good manager compared to 9 (26%) who disagreed.

4.3.2.2.3. Understanding the vision of the organisation

The organisation has a vision and a mission statement which guide the functioning of the employees. The professional nurses understood the vision of their organisation because 29 (83%) agreed with this statement while 3 (9%) disagreed.

4.3.2.2.4. MAS by PNs in Case A

PNs [13 (39%)] stated that sometimes their CPNs intercede favourably on behalf of someone in trouble in the organisation, and 10 (30%) PNs believed that desirable placement was obtained for talented subordinate. It was a rare opportunity for CPNs to get approval beyond the budget. Eleven (34%) PNs agreed that CPNs never motivate for incentives as compared to only 3 (9%) who stated that CPNs always motivate for incentives. There was a split response on bringing in materials, money and resources to enable the department to achieve its goals, and also on initiating innovative activities without the approval of senior management. See Table 4. 7.

Table 4.7: MAS by PNs in Case A

Activity	Never	Rare	Sometimes	Often	Always
	Frequency	Frequency	Frequency	Frequency	Frequency
Intercede favourably on behalf of someone in trouble in the organisation	4 (12%)	8 (24%)	**13(39%)**	3(9%)	5(15%)
Get a desirable placement for a talented subordinate	5 (15%)	6(18%)	**10(30%)**	7 (21%)	5(15 %)
Get approval for expenditures beyond the budget	6(19%)	**10(31%)**	6(19%)	7(22%)	3(9%)
Motivate for incentives	**11(34%)**	4(13%)	9(28%)	5(16%)	3(9%)
Get items on the agenda at policy meetings	3(9%)	6(18%)	8(24%)	**10(30%)**	6(18%)
Get fast access to top decision-makers	3(9%)	**9(28%)**	**9(28%)**	6(19%)	5(16%)
Get regular, frequent access to top decision-makers	4(12%)	7(21%)	**14(43%)**	3(9%)	5(15%)
Get early information about decisions and policy shifts	4(12%)	7(22%)	**13(41%)**	2(6%)	6(19%)
Bring in materials, money and resources to enable the department to achieve its goals	**9 (27%)**	7(21%)	**9(27%)**	4(12%)	4(12%)
Initiate innovative activities without the approval of senior management	**10(30%)**	**10(30%)**	9(27%)	2(6%)	2(6%)
Get the backing for implementing innovative strategies	6(19%)	**9(28%)**	**9(28%)**	5(16%)	3(9%)

4.3.2.3 Organisational factors

Organisational factors are the major variables of the study which also influence retention of staff in their organisations. The organisational factors which were examined are access to information, access to support, access to opportunity and access to resources as indicated in Table 4.8.

4.3.2.3.1. Access to information

Seventeen (52%) respondents reported that they had little access to information on the current state of the hospital, compared to 10 (30%) of the respondents who said they had enough access to information. A similar pattern was noted among the same group of professional nurses when asked about access to information on the goals of top management. A majority of 16 (49%) respondents had little access to the values of top management, compared to only 10 (30%) who had enough access to information on the values of top management. Of 33 professional nurses, 15 (46%) respondents reported that they had little access to information on the goals of top management compared to 10 (30%) respondents who had enough access. Refer to Table 4.8.

4.3.2.3.2. Access to opportunity

Twenty (59%) professional nurses had access to opportunity on challenging work, but had little opportunity according to 15 (44%), to gain new knowledge and skills. There were 15 (44%) professional nurses who had enough access to opportunity on tasks that used their own skills and knowledge as indicated in Table 4.8 below. The majority of professional nurses were not satisfied with the opportunity for professional development. Nineteen (54%) disagreed, and only 12 (34%) agreed that they were satisfied with professional development opportunities, as is indicated in Table 4.9. below:

4.3.2.3.3. Access to support

Seventeen (53%) professional nurses reported that they had little support on specific comments about the need to improve, or information about the things they did well, compared to 8 (25%) and 10 (31%) who said they had enough access to support. Twenty PNs (63%) responded that they had little support such as helpful hints or

problem-solving advice compared to 7 (21%) respondents who felt they had enough support. There were 5 (16%) neutral respondents on both support on specific comments about things they would improve and also helpful hints on problem-solving advice. See Table 4.8 below.

4.3.2.3.4. Access to resources

The majority of professional nurses [19 (58%)] had little access to resources within the organisation in terms of accomplishing job requirements, compared to only 9 (27%) who had enough time to complete tasks. Nineteen (58%) of the professional nurses had little access to time required in order to do necessary paperwork, compared to 7 (21%) who had enough time. Eighteen (56%) professional nurses had little time available to get temporal help when needed, compared to only 8 (25%) who had enough access to resources within the time available to get temporal help when needed. See Table 4.8 below.

Table 4.8: Organisational factors

	A little	Some	Enough	All
	Frequency	**Frequency**	**Frequency**	**Frequency**
Access to information				
on the current state of the hospital	17 (52%)	6(18%)	10(30%)	33(100%)
on values of top management	16(49%)	7(21%)	10(30%)	33(100%)
on goals of top management	15(46%)	8(24%)	10(30%)	33(100%)
Access to opportunity on				
challenging work	5(15%)	9(26%)	20(59%)	34(100%)
gaining new skill & knowledge	15(44%)	6(18%)	13(38%)	34(100%)
tasks that use own skills & knowledge	7(21%)	12(35%)	15(44%)	34(100%)
Access to support				
on specific information about things you do well	17(53%)	7(22%)	8(25%)	32(100%)
on specific comments about things you could improve	17(53%)	5(16%)	10(31%)	32(100%)
on helpful hints on problem-solving advice	20 (63%)	5 (16%)	7 (21%)	32 (100%)
Access to resources on time available to				
do necessary paperwork	19(58%)	7(21%)	7(21%)	33(100%)
accomplish job requirements	19(58%)	5(15%)	9(27%)	33(100%)
get temporal help when needed	18(56%)	6(19%)	8(25%)	32(100%)

Table 4.9: Satisfied with opportunities for professional development

	Frequency	Percent
Disagree	19	54%
Neither	4	12%
Agree	12	34%
Total	35	100%

4.3.2.3.5. Job Activity Scale (JAS)

PNs in this organisation felt that they do not have power because the majority of them 24 (73%) had little access to rewards for innovative jobs. Nineteen (61%) had little flexibility and 15 (48%) had little visibility in their work. See Table 4.10.

Table 4.10: Job Activity Scale (JAS)

Item	A little	Some	Enough	All
	Frequency	Frequency	Frequency	Frequency
Rewards for innovative job	**24 (73%)**	6 (18%)	3 (9%)	33 (100%)
Amount of flexibility	**19 (61%)**	5 (16%)	7 (23%)	31(100%)
Amount of visibility in my work	**15 (48%)**	8(26%)	8 (26%)	31(100%)

4.3.2.4. Individual factors

Individual factors included a sense of ownership, autonomy, achievement and growth by each individual nurse employed within the organisation.

4.3.2.4.1. Sense of commitment

Professional nurses were proud of their organisation and would love to bring more people to work in their organisation as was reflected in their response about recommending the hospital to other nurses. Twenty (67%) agreed that they would recommend this hospital to their friends compared to 7 (23%) respondents who disagreed.

4.3.2.4.2. Autonomy

Most professional nurses, 26 (79%) agreed that they needed more autonomy in their daily functioning compared to 12 (12%) who disagreed.

4.3.2.4.3. Growth

Growth was represented by the availability of opportunities in the workplace such as having career development opportunities, access to in-service programs, access to regional conferences, and support for pursuing a degree, access to continuing education programs and opportunities for advancement. The majority of the PNs, 18 (53%) in this organisation had access to career development, 15 (44%) had access to in-service programs, but 24 (71%) did not have access to regional and national conferences. Twenty (57%) did not have opportunities for advancement, compared to 13 (37%) who agreed.

4.3.2.5. Retention in hospital

Retention in hospital was measured by the following indicators: Recommending the hospital to a friend, staying in the hospital by not taking another job, career progression and satisfaction with the present salary.

4.3.2.5.1 Recommending and staying in the hospital

There were differences in terms of recommending the hospital to a friend as a place of employment because 16 (49%) professional nurses agreed, while the same number disagreed. It was noted that again 16 (49%) agreed that they would not consider taking another job. See Table 4.11 below.

Table 4.11: Indicators for retention of staff

	Disagree	**Neither**	**Agree**	**Total**
Would you	**Frequency**	**Frequency**	**Frequency**	**Frequency**
recommend this hospital to a friend	16 (49%)	1 (2%)	16 (49%)	33 (100%)
not consider taking another job	16 (49%)	5 (15%)	12 (36%)	33 (100%)

4.3.2.5.2 Career progression

In Case A, the majority did not respond to the questionnaire as indicated in Table 4.12. In year 1, there were 12 (34.3%) respondents who did not answer and 10 (28.7%) who indicated that they would like to be promoted to senior positions. In year 3, 10 (28.6%) stated that they would resign. During year 5, 8 (22.9%) stated that there would be no change in their careers, meaning that they would still be working in their organisation compared to 5 (14.3%) who were planning to resign. Twelve (34. 4%) stated that they would complete their educational qualifications, and 10 (28.7%) would like to be promoted to senior positions.

Table 4. 12: Career progression in all years

Variable	1 year	3 years	5 years	Future
No change	7 (20%)	5 (14.3%)	8 (22.9%)	3 (8.6%)
Education	3 (8.6%)	4 (11.5%)	4 (11.5%)	12 (34.4%)
Promotion	10 (28.7%)	5 (14.4%)	6 (17.2%)	10 (28.7%)
Resignation	3 (8.6%)	10 (28.6%)	5 (14.3%)	4 (11.6%)
Missing response	12(34.3%)	11(31.4%)	12 (34.3%)	6 (17.1%)

4.3.2.5.3 Satisfaction with salary

The majority (84%) of professional nurses verbalised that they were dissatisfied with their salary compared to 8 % who were satisfied with their salary.

4.3.3. CPN results in Case A

4.3.3.1. Demographic details of CPNs (n=16)

Professional nurses were asked about their gender, age, nursing experience and educational qualifications. The demographics will be presented as follows:

4.3.3.1.1. Demographic: Age, gender, experience (nursing & management) and unit distribution

Only 2 (12.5%) males were part of the study as compared to 14 (87.5%) females. The majority of respondents, 9 (60%) fell between 41 and 50 years of age, compared to only one (7%) CPN, who was between 21 and 30 years of age. Eight (50%) CPNs had Bachelor's degrees compared to 7 (44 %) who had diplomas in nursing science. Twelve (75%) respondents had more than 15 years' nursing experience. There were an equal number of respondents with nursing management experience for both 4 to 6 years and more than 9 years. Refer to Table 4.13.

Table 4.13: Demographic data of CPNs (N=16)

Item	Frequency	Percent
Gender		
Female	14	87%
Male	2	13%
Total	16	100%
Age		
21-30 years	1	7%
31-40 years	2	13%
41-50 years	9	60%
Above 50 years	3	20%
Total	15	100%
Years of nursing experience		
1-5 years	1	6%
6-10 years	1	6%
11-15 years	2	13%
Above 15 years	12	75%
Total	16	100%
Years of management experience		
1-3 years	2	15%
4-6 years	4	31%
7-10 years	3	23%
Above 10 years	4	31%
Total	13	100%
Educational qualification		
Master's degree	1	6%
Bachelors degree	8	50%
Diploma	7	44%
Total	16	100%
Unit representation /distribution		
ICU	5	31%
OT	4	25%
Surgical	2	13%
Medical	1	5%
OPD	2	13%
Maternity	2	13%
Total	**16**	**100%**

4.3.3.1.2. Demographic: Qualification of CPN (n=16)

As professional nurses progress in their careers they undertake different clinical and non-clinical courses. Most CPNs in charge of units had relevant clinical specialties,

except for trauma and PHC. However 8 (50%) of the respondents did not have a management qualification. Refer to Table 4.14.

Table 4.14: Qualification of CPNs (n=16)

Qualification	Frequency	Percent
Basic qualification		
Midwifery	8	50%
Community	4	25%
Nursing (General, Community & Psych) and Midwifery	2	13%
Post-Basic clinical qualification		
Advanced Midwifery	1	6%
ICU + High care	4	25%
OT	1	6%
PHC	0	0
Trauma	0	0
Oncology	1	6%
Mixed Qualification	7	44%
Management qualification		
Management	6	37%
Management & Education	2	13%

4.3.3.1.3. Demographic: Union affiliation

The most popular union is DENOSA, with 11 (69%) nurses affiliated to it. Managers did not associate themselves with NEHAWU and SADNU. It was significant that all CPNs were aware of the need for indemnity against litigations that prevail in their organisation because they all belonged to the union. Refer to Table 4.15.

Table 4.15: Union affiliation of CPNs (n=16)

Union	Frequency	Percent
DENOSA	11	69 %
HOSPERSA	2	12 %
NEHAWU	0	0
SADNU	0	0
Other	3	19%
None	0	0
Total	**16**	**100%**

4.3.3.2. Leadership factors

Leadership factors will be represented by self-leadership behaviour and Managers' Activity Scale.

4.3.3.2.1. Self-reported leadership behaviour

The visibility and accessibility of the CPN among staff is a sign of leadership behaviour, as well as allowing the staff to be part of the decision-making process in the unit. The responses from the CPNs demonstrated that they were transformational leaders because the majority, 12 (75%), agreed that they were visible, and 14 (87%) were accessible to staff, as is indicated in Table 4.16 below:

Table 4.16: Indicators for transformational leadership(CPN=16)

	Disagree	Neither	Agree	Total
	Frequency	**Frequency**	**Frequency**	**Frequency**
CPN is accessible to staff	2 (13%)	0 (0%)	14(87%)	16 (100%)
CPN is visible to staff	2 (12.5%)	2 (12.5%)	12 (75%)	16 (100%)
PN is part of the decision-making body	3 (12.5%)	3 (19%	10 (62%)	16 (100%)

4.3.3.2.2. MAS response by CPNs (n= 16) in Case A

The majority of the CPNs fell in the category of 'sometimes' in all variables except a split response on getting fast access to top decision-makers. Six CPNs, (37.5%) responded that 'sometimes' and 'often' they get fast access to decision-makers. Another split was on bringing in materials, money and resources to enable the department to achieve its goals. Six CPNs, (38%) stated 'never', and again 6 (38%) stated that 'sometimes' they do bring resources. Seven (44%) CPNs stated that it was rare to get approval for expenditure beyond the budget. See Table 4.17.

Table 4.17: MAS for CPNs in Case A

Activity	Never	Rare	Sometimes	Often	Always
	Frequency	Frequency	Frequency	Frequency	Frequency
Intercede favourably on behalf of someone in trouble in the organisation	1(7%)	1(7%)	**7(47%)**	4(26%)	2(13%)
Get a desirable placement for a talented subordinate	1(6%)	2(12.5%)	**6(38%)**	5(31%)	2(12.5%)
Get approval for expenditure beyond the budget	3(19%)	**7(44%)**	5(31%)	0(0%)	1(6%)
Motivate for incentives	3(19%)	2(12.5%)	**8(50%)**	2(12.5%)	1(6%)
Get items on the agenda at policy meetings	1(6%)	3(19%)	**6(38%)**	5(31%)	1(6%)
Get fast access to top decision-makers	1(6%)	3(19%)	**6(37.5%)**	**6(37.5%)**	0(0%)
Get regular, frequent access to top decision-makers	1(7%)	**5(33%)**	4(27%)	**5(33%)**	0(0%)
Get early information about decisions and policy shifts	2(12%)	3(19%)	**6(38%)**	4(25%)	1(6%)
Bring in materials, money and resources to enable the department to achieve its goals	**6(38%)**	2(12%)	**6(38%)**	2(12%)	0(0%)
Initiate innovative activities without the approval of senior management	5(31%)	3(19%)	**6(38%)**	2(12%)	0(0%)
Get the backing for implementing innovative strategies	3(19%)	0(0%)	**10(63%)**	2(12%)	1(6%)

4.3.3.3. Organisational factors

Organisational factors will be presented as access to information, access to opportunity, access to support and access to resources.

4.3.3.3.1 Access to information

Only 1 (6%) of the CPNs had access to information on the current state of the hospital, compared to 8 (50%) who had enough access to the current state. Seven (44%) of the CPNs had enough access to the values of top management whereas 8 (50%) had some access to the values of top management. Of 16 CPNs, 9 (56%) had enough access to the goals of top management compared to 2 (13%) who had little access.

4.3.3.3.2. Access to support

Eight (50%) of the CPNs had enough access for specific things they did well, and 7 (44%) had enough access on specific comments about things they could improve. Only 2 (12%) had little support on helpful things compared to 6 (38%) who had enough support on helpful things. See Table 4.18.

4.3.3.3.3. Access to opportunities

Most CPNs, 13 (81%) agreed that they had enough access to opportunities to do challenging work compared to 1 (6%) who had little access to opportunities to do challenging work. There were no CPNs who had little access to chances to gain new skills and also to utilise those skills and knowledge in their jobs. See Table 4.18.

4.3.3.3.4. Access to resources

Eight (50%) CPNs felt that they had little access to resources to do the necessary paperwork compared to 4 (25%) who had 'some', or enough access to resources to do paperwork. Only 1 (6%) CPN had enough access to resources to accomplish job requirements compared to 12 (75%) who had only 'some' access to accomplish job requirements. Seven (44%) respondents had 'some' access to resources to get temporal help when needed, compared to 5 (31%) who had little access. See Table 4.18.

Table 4.18: Access to organizational factors

	A little	Some	Enough	Total
Access to information on	**Frequency**	**Frequency**	**Frequency**	**Frequency**
current state of the hospital	1(6%)	7 (44%)	8 (50%)	16 (100%)
values of top management	1(6%)	8 (50%)	7 (44%)	16 (100%)
goals of top management	2 (13%)	5 (31%)	9 (56%)	16 (100%)
Access to support	**Frequency**	**Frequency**	**Frequency**	**Frequency**
on specific things you do well	0 (0%)	8 (50%)	8 (50%)	16 (100%)
on specific comments about things you could improve	1(6%)	8 (50%)	7 (44%)	16 (100%)
on helpful things	2 (12%)	8 (50%)	6 (38%)	16 (100%)
Access to opportunity	**Frequency**	**Frequency**	**Frequency**	**Frequency**
on challenging work	1 (6%)	2 (13%)	13 (81%)	16 (100%)
on chances to gain new skills and knowledge	0 (0%)	4 (25%)	12 (75%)	16 (100%)
on tasks that use all skills & knowledge	0 (0%)	6 (37%)	10 (63%)	16 (100%)
Access to resources on time available to	**Frequency**	**Frequency**	**Frequency**	**Frequency**
do necessary paperwork	8 (50%)	4 (25%)	4 (25%)	16 (100)
accomplish job requirements	3 (19%)	12 (75%)	1 (6%)	16 (100)
get temporal help when needed	5 (31%)	7 (44%)	4 (25%)	16 (100)

4.3.3.3.5. Job Activity Scale (JAS)

Ten (62.5%) CPNs stated that they had enough rewards for innovative jobs, and 7 (43%) had sufficient flexibility in their work environments, although 8 CPNs (53%) agreed that there was 'some' visibility in their work. See Table 4.19.

Table 4. 19: Job Activity Scale (JAS)

Item	A little	Some	Enough	All
	Frequency	**Frequency**	**Frequency**	**Frequency**
Rewards for innovative job	2 (12.5%)	4 (25%)	**10(62.5%)**	16 (100%)
Amount of flexibility	3 (19%)	6 (38%)	**7 (43%)**	16 (100%)
Amount of visibility in my work	4 (27%)	**8 (53%)**	3 (20%)	15 (100%)

4.3.4. ANALYSIS OF CNSM DATA

Each Case is headed by one chief nursing service manager; therefore data from the CNSM's interview were analysed qualitatively. The CNSM referred the researcher to the deputy CNSM. The deputy chief nursing service manager agreed to be interviewed, but declined to be audio-taped. The interview was held in the deputy's office and it lasted for 90 minutes. All data collection was done using a pen and paper. For clarification, probing and paraphrasing were conducted. Data were arranged into categories and the conceptual framework and objectives of the study guided the analysis.

4.3.4.1. Leadership factors

Leadership factors will be discussed under the leadership style of a CNSM, and the vision and mission statement.

4.3.4.1.1. Leadership style

The chief nursing service manager was not definite about her leadership style but the researcher noticed that the manager utilised a combination of leadership styles, based on the situation at any particular moment as indicated below

> *Mmm..... I am not sure which leadership style best suits me. But I think I am a democratic, plus a transformational leader. One cannot stick to one style.*

The manager was capable of linking her leadership behaviour to a leadership style as indicated below:

> *I allow nurses to verbalise their needs in a democratic way, although at times one needs to apply situational leadership. I listen to their requests and assist where I can.*

4.3.4.1.2. Vision and mission statement

The organisation operates and is guided by the vision and mission statement which is linked to the Provincial Department of Health's vision and mission statements. Organisations need to align themselves according to the legal framework of the country. Observations were done whilst visiting different wards, looking at the display of the vision at the entrance of the hospital and also on the notice boards in the wards. The vision and mission statement was only displayed at the management building and some of the units. The process of communicating the vision depended on the awareness and ability of the CNSM. There were no vivid feedback mechanisms as to how staff is encouraged to understand the vision and mission statement, as indicated below:

> *The vision and mission is well written, but one is not sure whether people really understand what is expected from them. Managers are always encouraged to include the vision and the mission statement in their daily activities with nurses. During meetings and any short discussions, managers emphasise the importance of integrating the vision and mission statement.*

The organisation is guided by values which are linked to the vision and mission statement. Functioning within the departmental values was evident from the CNSM's response:

> *We strive to ensure transparency within the institution, by following Batho Pele principles for our staff and also patients.*

4.3.4.2. Organisational factors

Organisational factors will be discussed under the topics of access to information, opportunity, support and resources.

4.3.4.2.1. Access to information

The organisation had a number of ways to give information to its members. Meetings were held at regular intervals with different categories of nurses so as to allow freedom of speech. There was a tendency to keep quiet in the meetings, even if the chance was given for people to verbalise their concerns. The means were made available to enhance access to information as indicated below:

> *Meetings are held with different categories, but professional nurses are scared to verbalise their feelings. Meetings are held separately for all categories so as to allow freedom of speech.*

There are organisational processes which track the dissemination of information to professional nurses working in different units.

> *Important information is shared through meetings and is also posted on notice boards. All unit managers are informed that they must ensure that all staff members sign the communication book. Day staff sign the book with black pens and the night staff use red.*

The PNs are updated about everything that happens in the organisation. The organisation was run in the manner of a private company, with booklets and newsletters to keep staff informed.

> *We have a dedicated PRO who keeps staff updated about the latest happenings in the institution.*

The symbols (pictures, slogans and monuments) which are part of the organisational culture were utilised in this organisation.

> *There is also a newsletter which is distributed quarterly, updating the staff about achievements and any events that affect the institution.*

*4.3.4.2.2. **Access to opportunity***

Views of the CNSM differed from the quantitative responses given by PNs about opportunities for continuing education. Professional nurses indicated that they were not given opportunities to attend conferences and workshops, but the CNSM emphasised that there were ample opportunities.

> *There is an allocation for staff continuing education, but due to the shortage of staff, sometimes staff members are not released. This is communicated to all staff members. Professional nurses are sent to conferences, if the conference is relevant to their clinical practice. But, due to limited resources, one cannot send many nurses to conferences.*

The number of sick patients in the wards exceeds the number of available nurses who are responsible and accountable for their care. Despite being affected negatively by staff shortages, opportunities were given to professional nurses for continuing education.

> *As much as there are great shortages, we invest in our nurses by empowering them with extra knowledge which they obtain when they participate in continuing education. As management we have organised selection criteria which are followed by all directorates on the selection of staff for continuing education.*

There are set criteria which need to be followed by all departments when PNs are released for continuing education. The professional nurses are expected to follow set criteria.

> *Nurses are permitted to attend workshops, seminars, congresses based on their speciality. Selection is based on experience and interest shown by the candidate.*

4.3.4.2.3. Access to support

Physical support is available in the form of accommodation from which professional nurses have a wide range to choose. Accommodation is one of the support strategies that is available in the organisation. If accommodation is not available, a PN is likely

to leave that institution. This organisation did not have a problem with accommodation because it was centrally located to many facilities, including flats and houses available for lease.

> *Accommodation is available to all staff members, although priority is given to student nurses. The area is well situated. There are plenty of flats and houses to be rented which are within reach. Professional nurses have a wide range of accommodation to choose from. There is plenty of accommodation within and around the hospital. The town is also within a short distance.*

As much as a professional nurse is employed to work in this organisation, one cannot focus on work alone; leisure activities should be available at one's disposal.

> *The area is within reach of all areas of entertainment, the beach and movie houses. The shopping malls are within walking distance. Professional nurses have a variety of places in which to spend their hard-earned money.*

Support is predominantly given in the form of extrinsic support.

> *Departments which have performed better are given a floating trophy which stays in their units for a month. Professional nurses are also encouraged to document any incidents, because the government has begun rewarding nurses for their performance.*

Access to physical support is provided within the premises of the organisation. There are buildings which have been converted for staff use, such as the Employment Assistance Program (EAP) dept and the support group seminar room.

> *There is a sick bay which caters for all sick staff. Nurses are free to access the sick bay at any time. There is also a support group for the infected and affected members of staff in our institution. Anyone is allowed to join the support group.*

The organisation provides all forms of support, including people who provide support to sick individuals.

The hospital has hired a chaplain who visits all sick personnel within the institution.

Ethical principles are adhered to when dealing with sick individuals. No one is forced to seek help; it is left up to the individual. Services are made available to all staff members.

Confidentiality is always maintained and I am not in a position to force any individual to talk about her/ his condition.

I had to turn away one nurse who was extremely ill. She had convinced herself that she was very strong

It emerged that assistance was provided by management in a variety of ways for professional nurses. For example, emotional support was provided by involving staff in different programmes which are available in the organisation, for example the Employee Assistance Programme (EAP).

We have established an Employee Assistance Programme which deals with sick staff. The majority of our staff members are suffering from different illnesses and they need to be assisted while on duty.

4.3.4.2.4. Access to resources

Resources can take the form of salaries, equipment, or human resources. The CNSM was aware that the major problem which made professional nurses leave the profession was poor salaries, which were unfortunately not within her scope of practice. She was concerned about lack of control from her side.

I am fully aware that professional nurses are underpaid, but unfortunately I do not have the power to give nurses more money. I would have loved to give them more money but salaries are controlled nationally by the Department of Health.

Salaries are the number one problem, and that's the reason why our nurses leave the country to go overseas. We do not even have a pool of professional

nurses as we used to have years ago. We work with limited staff and if one is off sick, it's a total disaster.

It emerged that there is consensus about the lack of equipment in the units, which inhibits smooth functioning within the units. The processes which are followed to acquire new equipment are also problematic.

Equipment is still an issue in the departments. We still have old machines which are outdated. As much as professional nurses are part of the finance decision-making body now, getting enough equipment is still a problem.

Control of equipment within the unit was also problematic. There are reported incidences of thefts within the organisation. People have formed syndicate teams for wrong reasons and it is very difficult to dissolve these theft networks

There is high theft within the institution which is so difficult to control because people have connections. There is also a syndicate which operates within the organisation and the team know everybody in higher places. No matter how hard you try to pursue the theft case, there is no follow up because of this connection.

4.3.4.3. Individual factors

Individual factors are discussed under the sense of commitment, autonomy and growth as seen by the CNSM among the professional nurses

4.3.4.3.1. *Sense of commitment*

The CNSM feels that some professional nurses have no sense of commitment; however the CNSM has also observed a great sense of commitment in other nurses who come to work even if they are not feeling well as indicated below:

One works with different individuals who show different strengths and capabilities. There are some disturbances in our daily operations like the high absenteeism rate. High absenteeism is influenced by the use of private doctors. You cannot tell a nurse that she must not be off sick because a doctor has checked her and found her not fit for duty.

Absenteeism was two-fold because there are those professional nurses who abuse the system by phoning in sick most of the time, whereas there are those who are committed to their work as shown below:

> *There are however, some professional nurses who come to work even if they are not feeing well. One thing I have noticed is that professional nurses do not want to admit to being sick.*

> *Nurses abuse this absenteeism system and there is no way to differentiate between the guilty and the not guilty.*

4.3.4.3.2. *Autonomy*

There were mixed responses about how autonomy prevails in the organisation. For example, professional nurses were not willing to take ownership of issues that directly affected them such as:

> *Professional nurses still need to be coerced to initiate activities within their departments. They cannot make decisions by themselves. They always wait for the sister-in-charge to finalise the decision. Sometimes it works negatively for the patient, because any mistake made by a nurse may cause grave harm to the patient.*

There are a few nurses who are willing to take responsibility themselves, although they sometimes abuse the system.

> *Nurses are allowed to report from home that they are not feeling well. They can stay on for many days as long as they have reported their illness and are have sick notes.*

4.3.4.3.3 Growth

According to the CNSM, PNs are given the opportunity to grow and develop in the workplace by attending in-service education programmes and continuing education programmes; although the PNs disagreed that they had access to continuing education.

4.3.4.4. Stakeholders

Professional nurses are protected by the organisation they work for and also by the external structures which contribute significantly to their daily activities. In this study, external support was derived from the alliances, which are the unions, SANC, and the DOH. The responses below were stated by the chief nursing service manager during the in-depth interview.

4.3.4.4.1. Department of Health

The Department of Health influences the functioning of professional nurses in the organisation. All the policies are developed at national level, diffused down to provinces, and operated at hospital level. Open communication facilitates the functioning of the department within the organisation.

> *The provincial department of health is responsible for transmitting the policies of the national department of health. We get the mandate from the head office and translate it into our strategic plan. The National DOH is responsible for salaries, and one has very limited influence on how salaries are packaged. As an organisation, we do not participate in policy development; we are expected to implement it.*

4.3.4.4.2. SANC

The SANC is seen to support nurses in terms of approval and standard of advancement courses. The control of training however is lacking. Private schools do not produce quality nurses.

> *The quality of the professional nurses who are produced by these schools is not up to standard. You cannot rely solely on these nurses in the units, yet due to the desperation brought about by the shortage of staff we end up hiring them.*

4.3.3.1.1. Demographic: Age, gender, experience (nursing & management) and unit distribution

Only 2 (12.5%) males were part of the study as compared to 14 (87.5%) females. The majority of respondents, 9 (60%) fell between 41 and 50 years of age, compared to only one (7%) CPN, who was between 21 and 30 years of age. Eight (50%) CPNs had Bachelor's degrees compared to 7 (44 %) who had diplomas in nursing science. Twelve (75%) respondents had more than 15 years' nursing experience. There were an equal number of respondents with nursing management experience for both 4 to 6 years and more than 9 years. Refer to Table 4.13.

Table 4.13: Demographic data of CPNs (N=16)

Item	Frequency	Percent
Gender		
Female	14	87%
Male	2	13%
Total	16	100%
Age		
21-30 years	1	7%
31-40 years	2	13%
41-50 years	9	60%
Above 50 years	3	20%
Total	15	100%
Years of nursing experience		
1-5 years	1	6%
6-10 years	1	6%
11-15 years	2	13%
Above 15 years	12	75%
Total	16	100%
Years of management experience		
1-3 years	2	15%
4-6 years	4	31%
7-10 years	3	23%
Above 10 years	4	31%
Total	13	100%
Educational qualification		
Master's degree	1	6%
Bachelors degree	8	50%
Diploma	7	44%
Total	16	100%
Unit representation /distribution		
ICU	5	31%
OT	4	25%
Surgical	2	13%
Medical	1	5%
OPD	2	13%
Maternity	2	13%
Total	**16**	**100%**

4.3.3.1.2. Demographic: Qualification of CPN (n=16)

As professional nurses progress in their careers they undertake different clinical and non-clinical courses. Most CPNs in charge of units had relevant clinical specialties,

except for trauma and PHC. However 8 (50%) of the respondents did not have a management qualification. Refer to Table 4.14.

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Advanced Midwifery	1	6%
ICU + High care	4	25%
OT	1	6%
PHC	0	0
Trauma	0	0
Oncology	1	6%
Mixed Qualification	7	44%
Management qualification		
Management	6	37%
Management & Education	2	13%

4.3.3.1.3. Demographic: Union affiliation

The most popular union is DENOSA, with 11 (69%) nurses affiliated to it. Managers did not associate themselves with NEHAWU and SADNU. It was significant that all CPNs were aware of the need for indemnity against litigations that prevail in their organisation because they all belonged to the union. Refer to Table 4.15.

Table 4.15: Union affiliation of CPNs (n=16)

Union	Frequency	Percent
DENOSA	11	69 %
HOSPERSA	2	12 %
NEHAWU	0	0
SADNU	0	0
Other	3	19%
None	0	0
Total	**16**	**100%**

4.3.3.2. Leadership factors

Leadership factors will be represented by self-leadership behaviour and Managers' Activity Scale.

4.3.3.2.1. Self-reported leadership behaviour

The visibility and accessibility of the CPN among staff is a sign of leadership behaviour, as well as allowing the staff to be part of the decision-making process in the unit. The responses from the CPNs demonstrated that they were transformational leaders because the majority, 12 (75%), agreed that they were visible, and 14 (87%) were accessible to staff, as is indicated in Table 4.16 below:

Table 4.16: Indicators for transformational leadership(CPN=16)

	Disagree	Neither	Agree	Total
	Frequency	**Frequency**	**Frequency**	**Frequency**
CPN is accessible to staff	2 (13%)	0 (0%)	14(87%)	16 (100%)
CPN is visible to staff	2 (12.5%)	2 (12.5%)	12 (75%)	16 (100%)
PN is part of the decision-making body	3 (12.5%)	3 (19%	10 (62%)	16 (100%)

4.3.3.2.2. MAS response by CPNs (n= 16) in Case A

The majority of the CPNs fell in the category of 'sometimes' in all variables except a split response on getting fast access to top decision-makers. Six CPNs, (37.5%) responded that 'sometimes' and 'often' they get fast access to decision-makers. Another split was on bringing in materials, money and resources to enable the department to achieve its goals. Six CPNs, (38%) stated 'never', and again 6 (38%) stated that 'sometimes' they do bring resources. Seven (44%) CPNs stated that it was rare to get approval for expenditure beyond the budget. See Table 4.17.

Table 4.17: MAS for CPNs in Case A

Activity	Never	Rare	Sometimes	Often	Always
	Frequency	Frequency	Frequency	Frequency	Frequency
Intercede favourably on behalf of someone in trouble in the organisation	1(7%)	1(7%)	**7(47%)**	4(26%)	2(13%)
Get a desirable placement for a talented subordinate	1(6%)	2(12.5%)	**6(38%)**	5(31%)	2(12.5%)
Get approval for expenditure beyond the budget	3(19%)	**7(44%)**	5(31%)	0(0%)	1(6%)
Motivate for incentives	3(19%)	2(12.5%)	**8(50%)**	2(12.5%)	1(6%)
Get items on the agenda at policy meetings	1(6%)	3(19%)	**6(38%)**	5(31%)	1(6%)
Get fast access to top decision-makers	1(6%)	3(19%)	**6(37.5%)**	**6(37.5%)**	0(0%)
Get regular, frequent access to top decision-makers	1(7%)	**5(33%)**	4(27%)	**5(33%)**	0(0%)
Get early information about decisions and policy shifts	2(12%)	3(19%)	**6(38%)**	4(25%)	1(6%)
Bring in materials, money and resources to enable the department to achieve its goals	**6(38%)**	2(12%)	**6(38%)**	2(12%)	0(0%)
Initiate innovative activities without the approval of senior management	5(31%)	3(19%)	**6(38%)**	2(12%)	0(0%)
Get the backing for implementing innovative strategies	3(19%)	0(0%)	**10(63%)**	2(12%)	1(6%)

4.3.3.3. Organisational factors

Organisational factors will be presented as access to information, access to opportunity, access to support and access to resources.

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Only 1 (6%) of the CPNs had access to information on the current state of the hospital, compared to 8 (50%) who had enough access to the current state. Seven (44%) of the CPNs had enough access to the values of top management whereas 8 (50%) had some access to the values of top management. Of 16 CPNs, 9 (56%) had enough access to the goals of top management compared to 2 (13%) who had little access.

4.3.3.3.2. Access to support

Eight (50%) of the CPNs had enough access for specific things they did well, and 7 (44%) had enough access on specific comments about things they could improve. Only 2 (12%) had little support on helpful things compared to 6 (38%) who had enough support on helpful things. See Table 4.18.

4.3.3.3.3. Access to opportunities

Most CPNs, 13 (81%) agreed that they had enough access to opportunities to do challenging work compared to 1 (6%) who had little access to opportunities to do challenging work. There were no CPNs who had little access to chances to gain new skills and also to utilise those skills and knowledge in their jobs. See Table 4.18.

4.3.3.3.4. Access to resources

Eight (50%) CPNs felt that they had little access to resources to do the necessary paperwork compared to 4 (25%) who had 'some', or enough access to resources to do paperwork. Only 1 (6%) CPN had enough access to resources to accomplish job requirements compared to 12 (75%) who had only 'some' access to accomplish job requirements. Seven (44%) respondents had 'some' access to resources to get temporal help when needed, compared to 5 (31%) who had little access. See Table 4.18.

Table 4.18: Access to organizational factors

	A little	Some	Enough	Total
Access to information on	**Frequency**	**Frequency**	**Frequency**	**Frequency**
current state of the hospital	1(6%)	7 (44%)	8 (50%)	16 (100%)
values of top management	1(6%)	8 (50%)	7 (44%)	16 (100%)
goals of top management	2 (13%)	5 (31%)	9 (56%)	16 (100%)
Access to support	**Frequency**	**Frequency**	**Frequency**	**Frequency**
on specific things you do well	0 (0%)	8 (50%)	8 (50%)	16 (100%)
on specific comments about things you could improve	1(6%)	8 (50%)	7 (44%)	16 (100%)
on helpful things	2 (12%)	8 (50%)	6 (38%)	16 (100%)
Access to opportunity	**Frequency**	**Frequency**	**Frequency**	**Frequency**
on challenging work	1 (6%)	2 (13%)	13 (81%)	16 (100%)
on chances to gain new skills and knowledge	0 (0%)	4 (25%)	12 (75%)	16 (100%)
on tasks that use all skills & knowledge	0 (0%)	6 (37%)	10 (63%)	16 (100%)
Access to resources on time available to	**Frequency**	**Frequency**	**Frequency**	**Frequency**
do necessary paperwork	8 (50%)	4 (25%)	4 (25%)	16 (100)
accomplish job requirements	3 (19%)	12 (75%)	1 (6%)	16 (100)
get temporal help when needed	5 (31%)	7 (44%)	4 (25%)	16 (100)

4.3.3.3.5. Job Activity Scale (JAS)

Ten (62.5%) CPNs stated that they had enough rewards for innovative jobs, and 7 (43%) had sufficient flexibility in their work environments, although 8 CPNs (53%) agreed that there was 'some' visibility in their work. See Table 4.19.

Table 4. 19: Job Activity Scale (JAS)

Item	A little	Some	Enough	All
	Frequency	**Frequency**	**Frequency**	**Frequency**
Rewards for innovative job	2 (12.5%)	4 (25%)	**10(62.5%)**	16 (100%)
Amount of flexibility	3 (19%)	6 (38%)	**7 (43%)**	16 (100%)
Amount of visibility in my work	4 (27%)	**8 (53%)**	3 (20%)	15 (100%)

4.3.4. ANALYSIS OF CNSM DATA

Each Case is headed by one chief nursing service manager; therefore data from the CNSM's interview were analysed qualitatively. The CNSM referred the researcher to the deputy CNSM. The deputy chief nursing service manager agreed to be interviewed, but declined to be audio-taped. The interview was held in the deputy's office and it lasted for 90 minutes. All data collection was done using a pen and paper. For clarification, probing and paraphrasing were conducted. Data were arranged into categories and the conceptual framework and objectives of the study guided the analysis.

4.3.4.1. Leadership factors

Leadership factors will be discussed under the leadership style of a CNSM, and the vision and mission statement.

4.3.4.1.1. Leadership style

The chief nursing service manager was not definite about her leadership style but the researcher noticed that the manager utilised a combination of leadership styles, based on the situation at any particular moment as indicated below

> *Mmm..... I am not sure which leadership style best suits me. But I think I am a democratic, plus a transformational leader. One cannot stick to one style.*

The manager was capable of linking her leadership behaviour to a leadership style as indicated below:

> *I allow nurses to verbalise their needs in a democratic way, although at times one needs to apply situational leadership. I listen to their requests and assist where I can.*

4.3.4.1.2. Vision and mission statement

The organisation operates and is guided by the vision and mission statement which is linked to the Provincial Department of Health's vision and mission statements. Organisations need to align themselves according to the legal framework of the country. Observations were done whilst visiting different wards, looking at the display of the vision at the entrance of the hospital and also on the notice boards in the wards. The vision and mission statement was only displayed at the management building and some of the units. The process of communicating the vision depended on the awareness and ability of the CNSM. There were no vivid feedback mechanisms as to how staff is encouraged to understand the vision and mission statement, as indicated below:

> *The vision and mission is well written, but one is not sure whether people really understand what is expected from them. Managers are always encouraged to include the vision and the mission statement in their daily activities with nurses. During meetings and any short discussions, managers emphasise the importance of integrating the vision and mission statement.*

The organisation is guided by values which are linked to the vision and mission statement. Functioning within the departmental values was evident from the CNSM's response:

> *We strive to ensure transparency within the institution, by following Batho Pele principles for our staff and also patients.*

4.3.4.2. Organisational factors

Organisational factors will be discussed under the topics of access to information, opportunity, support and resources.

4.3.4.2.1. Access to information

The organisation had a number of ways to give information to its members. Meetings were held at regular intervals with different categories of nurses so as to allow freedom of speech. There was a tendency to keep quiet in the meetings, even if the chance was given for people to verbalise their concerns. The means were made available to enhance access to information as indicated below:

> *Meetings are held with different categories, but professional nurses are scared to verbalise their feelings. Meetings are held separately for all categories so as to allow freedom of speech.*

There are organisational processes which track the dissemination of information to professional nurses working in different units.

> *Important information is shared through meetings and is also posted on notice boards. All unit managers are informed that they must ensure that all staff members sign the communication book. Day staff sign the book with black pens and the night staff use red.*

The PNs are updated about everything that happens in the organisation. The organisation was run in the manner of a private company, with booklets and newsletters to keep staff informed.

> *We have a dedicated PRO who keeps staff updated about the latest happenings in the institution.*

The symbols (pictures, slogans and monuments) which are part of the organisational culture were utilised in this organisation.

> *There is also a newsletter which is distributed quarterly, updating the staff about achievements and any events that affect the institution.*

*4.3.4.2.2. **Access to opportunity***

Views of the CNSM differed from the quantitative responses given by PNs about opportunities for continuing education. Professional nurses indicated that they were not given opportunities to attend conferences and workshops, but the CNSM emphasised that there were ample opportunities.

> *There is an allocation for staff continuing education, but due to the shortage of staff, sometimes staff members are not released. This is communicated to all staff members. Professional nurses are sent to conferences, if the conference is relevant to their clinical practice. But, due to limited resources, one cannot send many nurses to conferences.*

The number of sick patients in the wards exceeds the number of available nurses who are responsible and accountable for their care. Despite being affected negatively by staff shortages, opportunities were given to professional nurses for continuing education.

> *As much as there are great shortages, we invest in our nurses by empowering them with extra knowledge which they obtain when they participate in continuing education. As management we have organised selection criteria which are followed by all directorates on the selection of staff for continuing education.*

There are set criteria which need to be followed by all departments when PNs are released for continuing education. The professional nurses are expected to follow set criteria.

> *Nurses are permitted to attend workshops, seminars, congresses based on their speciality. Selection is based on experience and interest shown by the candidate.*

4.3.4.2.3. Access to support

Physical support is available in the form of accommodation from which professional nurses have a wide range to choose. Accommodation is one of the support strategies that is available in the organisation. If accommodation is not available, a PN is likely

to leave that institution. This organisation did not have a problem with accommodation because it was centrally located to many facilities, including flats and houses available for lease.

> *Accommodation is available to all staff members, although priority is given to student nurses. The area is well situated. There are plenty of flats and houses to be rented which are within reach. Professional nurses have a wide range of accommodation to choose from. There is plenty of accommodation within and around the hospital. The town is also within a short distance.*

As much as a professional nurse is employed to work in this organisation, one cannot focus on work alone; leisure activities should be available at one's disposal.

> *The area is within reach of all areas of entertainment, the beach and movie houses. The shopping malls are within walking distance. Professional nurses have a variety of places in which to spend their hard-earned money.*

Support is predominantly given in the form of extrinsic support.

> *Departments which have performed better are given a floating trophy which stays in their units for a month. Professional nurses are also encouraged to document any incidents, because the government has begun rewarding nurses for their performance.*

Access to physical support is provided within the premises of the organisation. There are buildings which have been converted for staff use, such as the Employment Assistance Program (EAP) dept and the support group seminar room.

> *There is a sick bay which caters for all sick staff. Nurses are free to access the sick bay at any time. There is also a support group for the infected and affected members of staff in our institution. Anyone is allowed to join the support group.*

The organisation provides all forms of support, including people who provide support to sick individuals.

The hospital has hired a chaplain who visits all sick personnel within the institution.

Ethical principles are adhered to when dealing with sick individuals. No one is forced to seek help; it is left up to the individual. Services are made available to all staff members.

Confidentiality is always maintained and I am not in a position to force any individual to talk about her/ his condition.

I had to turn away one nurse who was extremely ill. She had convinced herself that she was very strong

It emerged that assistance was provided by management in a variety of ways for professional nurses. For example, emotional support was provided by involving staff in different programmes which are available in the organisation, for example the Employee Assistance Programme (EAP).

We have established an Employee Assistance Programme which deals with sick staff. The majority of our staff members are suffering from different illnesses and they need to be assisted while on duty.

4.3.4.2.4. Access to resources

Resources can take the form of salaries, equipment, or human resources. The CNSM was aware that the major problem which made professional nurses leave the profession was poor salaries, which were unfortunately not within her scope of practice. She was concerned about lack of control from her side.

I am fully aware that professional nurses are underpaid, but unfortunately I do not have the power to give nurses more money. I would have loved to give them more money but salaries are controlled nationally by the Department of Health.

Salaries are the number one problem, and that's the reason why our nurses leave the country to go overseas. We do not even have a pool of professional

nurses as we used to have years ago. We work with limited staff and if one is off sick, it's a total disaster.

It emerged that there is consensus about the lack of equipment in the units, which inhibits smooth functioning within the units. The processes which are followed to acquire new equipment are also problematic.

Equipment is still an issue in the departments. We still have old machines which are outdated. As much as professional nurses are part of the finance decision-making body now, getting enough equipment is still a problem.

Control of equipment within the unit was also problematic. There are reported incidences of thefts within the organisation. People have formed syndicate teams for wrong reasons and it is very difficult to dissolve these theft networks

There is high theft within the institution which is so difficult to control because people have connections. There is also a syndicate which operates within the organisation and the team know everybody in higher places. No matter how hard you try to pursue the theft case, there is no follow up because of this connection.

4.3.4.3. Individual factors

Individual factors are discussed under the sense of commitment, autonomy and growth as seen by the CNSM among the professional nurses

4.3.4.3.1. *Sense of commitment*

The CNSM feels that some professional nurses have no sense of commitment; however the CNSM has also observed a great sense of commitment in other nurses who come to work even if they are not feeling well as indicated below:

One works with different individuals who show different strengths and capabilities. There are some disturbances in our daily operations like the high absenteeism rate. High absenteeism is influenced by the use of private doctors. You cannot tell a nurse that she must not be off sick because a doctor has checked her and found her not fit for duty.

Absenteeism was two-fold because there are those professional nurses who abuse the system by phoning in sick most of the time, whereas there are those who are committed to their work as shown below:

> *There are however, some professional nurses who come to work even if they are not feeing well. One thing I have noticed is that professional nurses do not want to admit to being sick.*

> *Nurses abuse this absenteeism system and there is no way to differentiate between the guilty and the not guilty.*

4.3.4.3.2. *Autonomy*

There were mixed responses about how autonomy prevails in the organisation. For example, professional nurses were not willing to take ownership of issues that directly affected them such as:

> *Professional nurses still need to be coerced to initiate activities within their departments. They cannot make decisions by themselves. They always wait for the sister-in-charge to finalise the decision. Sometimes it works negatively for the patient, because any mistake made by a nurse may cause grave harm to the patient.*

There are a few nurses who are willing to take responsibility themselves, although they sometimes abuse the system.

> *Nurses are allowed to report from home that they are not feeling well. They can stay on for many days as long as they have reported their illness and are have sick notes.*

4.3.4.3.3 Growth

According to the CNSM, PNs are given the opportunity to grow and develop in the workplace by attending in-service education programmes and continuing education programmes; although the PNs disagreed that they had access to continuing education.

4.3.4.4. Stakeholders

Professional nurses are protected by the organisation they work for and also by the external structures which contribute significantly to their daily activities. In this study, external support was derived from the alliances, which are the unions, SANC, and the DOH. The responses below were stated by the chief nursing service manager during the in-depth interview.

4.3.4.4.1. Department of Health

The Department of Health influences the functioning of professional nurses in the organisation. All the policies are developed at national level, diffused down to provinces, and operated at hospital level. Open communication facilitates the functioning of the department within the organisation.

> *The provincial department of health is responsible for transmitting the policies of the national department of health. We get the mandate from the head office and translate it into our strategic plan. The National DOH is responsible for salaries, and one has very limited influence on how salaries are packaged. As an organisation, we do not participate in policy development; we are expected to implement it.*

4.3.4.4.2. SANC

The SANC is seen to support nurses in terms of approval and standard of advancement courses. The control of training however is lacking. Private schools do not produce quality nurses.

> *The quality of the professional nurses who are produced by these schools is not up to standard. You cannot rely solely on these nurses in the units, yet due to the desperation brought about by the shortage of staff we end up hiring them.*

the consenting professional nurses and leaving the questionnaires for later collection, the regional manager informed the next unit. The researcher was accompanied from point A to point B.

A convenience sampling technique was followed, because the researcher collected data from the available and consenting professional nurses in the unit. Appointments were made with those professional nurses who were busy in their units. An informed document was given to the selected professional nurses. Information consent was obtained before data collection. Respondents were given time to fill in the questionnaires at their own convenience. Ward routine was not disturbed. The researcher spent three days in this hospital. Questionnaires were collected later by the researcher.

4.4.2. Professional Nurses in Case B

4.4.2.1. Demographic details of PNs(n=30)

Professional nurses' demographic details were presented as follows:

4.4.2.1.1. Demographic: Age, gender, nursing experience

All respondents were female, and the majority, 11 (37%) were between the ages of 31 to 40 years, and also 41 to 50 years. Professional nurses who had 16 or more years of nursing experience numbered 10 (33%). Only 5 (17%) professional nurses had a Bachelor's degree, compared to 24 (83%) who had a diploma in nursing science. See Table 4.20 below.

Table 4.20: Demographic: Age, gender, nursing experience and unit distribution

	Frequency	Percent
Age		
21-30 yrs	3	10%
31-40 yrs	11	37%
41-50 yrs	11	37%
Above 50 yrs	5	16%
Total	30	100%
Gender		
Male	0	0%
Female	30	100%
Total	30	100%
Years of nursing experience		
1-5 yrs	5	17%
6-10 yrs	9	30%
11-15 yrs	6	20%
Above 15 yrs	10	33%
Total	30	100%
Educational qualification		
Degree	5	17%
Diploma	24	83%
Total	29	100%
Unit representation/distribution		
Medical	5	17%
Surgical	5	17%
Theatre	4	12%
ICU	6	20%
OPD	5	17%
Maternity	5	17%
Total	**30**	**100%**

4.4.2.1.2. Demographic: Qualification

The majority of respondents 10 (30 %) were the products of the comprehensive basic nursing diploma, and only 7 (21%) had a management diploma. It is expected that at CPN level the manager should have a management diploma in order to manage the department effectively. Promotion to unit manager is based on the nurse's qualification. See Table 4.21.

Table 4.21: Qualification of PNs (n= 30)

Qualification	Frequency	Percent
Basic qualification		
Midwifery	1	3%
Community	0	0%
Psychiatry	1	3%
Nursing (General, Community & Psych) and Midwifery	10	30%
Post-Basic qualification		
Advanced Midwifery	4	12%
ICU + High care	0	0%
OT	1	3%
PHC	1	3%
Trauma	1	3%
Oncology	3	10%
Mixed Qualification	4	12%
Management qualification		
Management	7	21%
Management & Education	0	0%
Total	33	100%

4.4.2.1.3. Union affiliation

Of six unions, DENOSA remained the only union with the majority of respondents 18 (60%), followed by NEHAWU with 5 (17%) members. "Other" refers to people who are affiliated to more than one union including DENOSA & HOSPERSA, DENOSA & NEHAWU and PSA. They are recorded as "other". It was noted that all nurses are members of a union. Refer to Table 4.22.

Table 4.22: Union affiliation of PNs (n=30)

Union	Frequency	Percent
DENOSA	18	60%
HOSPERSA	3	10%
NEHAWU	5	17%
SADNU	0	0
Other (DENOSA & NEHAWU , DENOSA & HOSPERSA)	4	13%
None	0	0
Total	**30**	**100%**

4.4.2.2. Leadership factors

4.4.2.2.1. Perceived leadership behaviour

Fifteen (50%) respondents agreed that the CNSM is accessible, (50%) and visible (50%) to staff, and also had equal power (50%) with top management, as indicated in the Table 4.23 below.

Table 4.23: Perceived leadership behaviour by PNs

	Disagree	Neither	Agree	Total
	Frequency	**Frequency**	**Frequency**	**Frequency**
CNSM is visible to staff	8 (27%)	7(23%)	15(50%)	30(100%)
CNSM is accessible to staff	7(23%)	8(27%)	15(50%)	30(100%)
CNSM has equal power with SMT	2(7%)	13(43%)	15(50%)	30(100%)
CNSM has equal authority with SMT	7(23%)	9(30%)	14(47%)	30(100%)

SMT: Senior Management Team (CEO, CNSM, CFO, Medical Manager and systems manager)

CEO: Chief Executive Officers

CFO: Chief Finance Officer

4.4.2.2.2. Unit manager is a good leader

Twenty-three (77%) respondents viewed their manager as a good leader compared to 5 (17%) who disagreed. Only 2 (6%) were unsure of this statement.

4.4.2.2.3. Understand the vision and mission of the hospital

All 30(100%) respondents agreed that they understood the vision of the institution.

4.4.2.2.4. MAS for PNs in Case B

Most of the responses indicated 'sometimes' for all the variables except the following variables - there was a split for the responses by PNs about getting items on the agenda at policy meetings. In this instance, 11 (38%) stated 'sometimes' and also 'often' on the variable. The majority of PNs, 10 (35%) agreed that CPNs often get early information about decisions and policy shifts. Ten (35%) PNs stated that their CPN had never initiated activities without the approval of senior management. See Table 4. 24.

Table 4.24: Manager Activity Scale (MAS) for PNs in Case B

Activity	Never	Rare	Sometimes	Often	Always
	Frequency	Frequency	Frequency	Frequency	Frequency
Intercede favorably on behalf of someone in trouble in the organisation	2 (7%)	4 (14%)	**13 (45%)**	7 (24%)	3 (10%)
Get a desirable placement for a talented subordinate	4 (14%)	3 (10%)	**12 (42%)**	9 (31%)	1(3%)
Get approval for expenditures beyond the budget	6 (21%)	4 (14%)	**13 (45%)**	5 (17%)	1 (3%)
Motivate for incentives	5 (17%)	3 (10%)	**13 (45 %)**	7 (24%)	1 (4%)
Get items on the agenda at policy meetings	3 (10%)	2 (7%)	**11 (38%)**	**11 (38%)**	2 (7%)
Get fast access to top decision makers	3 (10%)	1 (3%)	**18 (62%)**	6 (21%)	1 (3%)
Get regular, frequent access to top decision-makers	3 (10%)	4 (14%)	**11 (38%)**	9 (31%)	2 (7%)
Get early information about decisions and policy shifts	4 (14%)	5 (17%)	9 (30%)	**10 (35%)**	1 (3%)
Bring in materials, money and resources to enable the department to achieve its goals	6 (21%)	6 (21%)	**9 (31%)**	6 (21%)	2 (7%)
Initiate innovative activities without the approval of senior management	**10 (35%)**	5 (17%)	7 (24%)	6 (21%)	1 (3%)
Get the backing for implementing innovative strategies	5 (17%)	5 (17%)	**12 (42%)**	6 (21%)	1 (3%)

4.4.2.3. Organisational factors

The organisational factors that were discussed were access to information, access to support, access to opportunities and access to resources.

4.4.2.3.1. Access to information

Fourteen (48%) professional nurses in this organisation did not have access to information for both the values and goals of top management, and 17 (61%) did not have access to the current state of the hospital, compared to only 7 (25%) respondents who had enough access to information.

4.4.2.3.2. Access to opportunity

Most of the respondents, 14 (48%) had sufficient opportunity to do challenging work, compared to 7 (24%) who had little opportunity. Sixteen (53%) professional nurses had enough opportunities to undertake tasks that used their own skills and knowledge compared to only 6 (20%), who had little access to such opportunities. Most professional nurses had an opportunity to develop their careers because 21 (70%) had access to career development opportunities, and also 26 (87%) had access to in-service programs, compared to only 3 (10%) who did not have such access. Fourteen (47%) professional nurses had little access to support on specific information about things they did well, compared to 7 (23%) who had enough access in terms of this support.

4.4.2.3.3. Access to support

Twelve respondents (40%) had enough support about things they could improve, compared to 9 (30%) who had little support. Of 30 (100%) respondents, 13 (43%) had enough support on helpful hints about problem-solving advice compared to 9 (30%) who did not have support, and 8 (27%) who had 'some' support.

4.4.2.3. Access to resources

Most of the respondents, 22 (76%) had little access to resources for necessary paperwork, 19 (65%) accomplished job requirements, and 16 (55%) got temporal help when needed as indicated in Table 4. 25 below.

Table 4.25: Organisational factors by PNs

	A little	Some	Enough	All
Access to information on	**Frequency**	**Frequency**	**Frequency**	**Frequency**
current state of the hospital	17 (61%)	4 (14%)	7 (25%)	28 (100%)
values of top management	14 (48%)	9 (31%)	6 (21%)	29 (100%)
goals of top management	14 (48%)	8 (27%)	7 (25%)	29 (100%)
Access to opportunity on	**Frequency**	**Frequency**	**Frequency**	**Frequency**
challenging work	7 (24%)	8 (28%)	14 (48%)	29 (100%)
gaining new skills & knowledge	14 (47%)	4 (13%)	12 (40%)	30 (100%)
tasks that use own skills & knowledge	6 (20%)	8 (27%)	16 (53%)	30 (100%)
Access to support	**Frequency**	**Frequency**	**Frequency**	**Frequency**
specific information about things well done	14 (47%)	9 (30%)	7 (23%)	30 (100%)
specific comments about things which could be improved	9 (30%)	9 (30%)	12 (40%)	30 (100%)
helpful hints on problem-solving advice	9 (30%)	8 (27%)	13 (43%)	30 (100%)
Access to resources on time available to	**Frequency**	**Frequency**	**Frequency**	**Frequency**
do necessary paperwork	22 (76%)	5 (17%)	2 (7%)	29 (100%)
accomplish job requirements	19 (65%)	6 (21%)	4 (14%)	29 (100%)
get temporal help when needed	16 (55%)	5 (17%)	8 (28%)	29(100%)

4.4.2.3.5 Job Activity Scale (JAS)

The majority of PNs in this organisation asserted that they had few rewards in all variables. There were 23 rewards (80%) innovative jobs, 17 (59%) for the amount of flexibility and also 15 (52%) for the amount of visibility. See Table 4.26.

Table 4.26: Job Activity Scale (JAS) Formal power

Item	A little	Some	Enough	All
	Frequency	**Frequency**	**Frequency**	**Frequency**
Rewards for innovative job	**23 (80%)**	5 (17%)	1(3%)	29 (100%)
Amount of flexibility	**17 (59%)**	7 (24%)	5 (17%)	29 (100%)
Amount of visibility in my work	**15 (52%)**	10 (34%)	4 (14%)	29 (100%)

4.4.2.4. Individual factors

Individual factors were represented as a sense of commitment, autonomy and growth.

4.4.2.4.1. Sense of commitment

Fifteen (50%) respondents were committed to the organisation, as they said that they would not consider taking another job, compared to 10 (33%) who disagreed with that statement. Forty percent were not sure about taking another job.

4.4.2.4.2. Autonomy

That professional nurses lacked autonomy in their daily practice was indicated by the quantitative analysis. Of 30 respondents, 17 (57%) agreed that they needed more autonomy in their daily practice, 5 (17%) disagreed, and 8 (26%) were not sure of their autonomy.

4.4.2.4.3. Growth

Access to opportunity refers to growth, mobility and the chance to increase knowledge and skills. Most respondents, 14 (48%) had enough opportunity to undertake challenging work compared to 7 (24%) who had little opportunity. There were 16 (53%) professional nurses who had enough opportunities to perform tasks that used their own skills and knowledge, compared to only 6 (20%) who had little access to such opportunities.

4.4.2.5. Retention in hospitals

Retention was presented using the following variables; recommending the hospital, considering taking another job, and growth opportunities.

4.4.2.5.1. Recommending and staying in the hospital

Respondents in this organisation were positive about their stay, because the majority, 20 (67%) agreed that they would recommend the hospital to their friends, and 15 (50%) also agreed that they would not consider taking another job. See Table 4.27.

Table 4.27: Retention of professional nurses

	Disagree	**Neither**	**Agree**	**Total**
Would you	**Frequency**	**Frequency**	**Frequency**	**Frequency**
recommend this hospital to a friend	7 (23%)	3 (10%)	20 (67%)	30 (100%)
not consider taking another job	10 (33%)	5 (17%)	15 (50%)	30 (100%)

4.4.2.5.2. Career progression in all years

During year 1, there was an overwhelming majority of respondents, 17 (57%) who wanted to be promoted. There was also a split on the respondents who did not respond to the question, those who indicated that they would not change their working career, and those who wanted to further their educational qualification. See Table 4.36. Thirteen respondents (43.3%) indicated that they would like to be promoted, compared to only 1 (3.3%) who stated that she would resign in three years. There were 15 respondents (50%) who indicated that they would not change their careers. Eleven (36.7%) indicated that they would like to be promoted to senior positions, and 8 (26.7%) stated that they were planning to resign from the profession.

Table 4. 28: Career progression in all years

Variable	1 year	3 years	5 years	Future
No change	4 (13%)	7 (23.3%)	15 (50%)	15(50%)
Education	4 (13%)	2 (6.6%)	3 (10%)	3 (10%)
Promotion	17 (57%)	2 (6.6%)	3 (10%)	11(37%)
Resignation	1 (3.3%)	1 (3.3%)	2 (6.6%)	8 (26.7%)
Missing response	4 (13%)	7 (23.3%)	7 (23.3%)	3 (10%)

4.4.2.5.3. Satisfaction with salary

The majority (90%) of professional nurses were dissatisfied with their salaries as compared to 7% who were satisfied, and only 3 % who were not sure about satisfaction with their salaries.

4.4.3. Chief Professional Nurses in Case B

4.4.3.1. Demographic details of CPNs

4.4.3.1.1 Demographic details: Age, gender, nursing experience, nursing management experience & educational qualification

There were no respondents between the ages of 21 and 30 years who were CPNs. This is attributed to the fact that the specified age group is at the entry level to the nursing profession. It is not uncommon to find CPNs in the next age categories. The age of respondents tallies with their years in the nursing profession, as the majority, 10 (77%) respondents had nursing experience of more than 15 years. Only one (8%) respondent had a Master's degree, and 10 (77%) had diplomas in nursing science.

The total percentage is above 100% because the qualification is not per individual respondent, but there is inclusive calculation. Respondents with mixed qualifications and also management were above 60%, as per Table 4.29 below.

Table 4. 29 :Demographic details of CPNs (n=13)

	Frequency	Percent
Age		
21-30 yrs	0	0
31-40 yrs	6	46%
41-50 yrs	5	39%
Above 50 yrs	2	15%
Total	13	100%
Gender		
Male	1	8%
Female	12	92%
Total	13	100%
Years of nursing experience		
1-5 yrs	0	0
6-10 yrs	0	0
11-15 yrs	3	23%
Above 15 yrs	10	77%
Total	13	100%
Educational Qualification		
Master's degree	1	8%
Bachelor's Degree	2	15%
Diploma	10	77%
Total	13	100%
Unit representation /distribution		
Medical	1	9%
Surgical	3	28%
Operating Theatre	2	18%
ICU	1	9%
OPD	2	18%
Maternity	2	18%
Total	**12**	**100%**

4.3.3.1.2. Demographic: Qualification of CPN(n=13)

There was an equal number of respondents, 8 (61%), who had more than one post-basic qualification and also a nursing management qualification. Refer to Table 4.30.

Table 4.30: Qualifications of CPNs (n=13)

Qualification	Frequency	Percent
Basic qualification		
Midwifery	6	46%
Community	2	15%
Psychiatry	0	0
Nursing (General, Community & Psych) and Midwifery	5	38%
Post-Basic qualification		
Advanced Midwifery	2	15%
ICU + High care	3	23%
OT	1	7%
PHC	2	15%
Trauma	0	0
Oncology	3	23%
Mixed Qualification	8	61%
Management qualification		
Management	8	61%
Management & Education	2	15%
None	1	7%

4.4.3.1.3. Demographic: Union Affiliation

Six (46%) respondents belonged to DENOSA compared to only 1 (7.7%) respondent each who belonged to HOSPERSA, NEHAWU or both unions. Refer to Table 4.31.

Table 4.31: Union affiliation of CPNs (n=13)

Union	Frequency	Percent
DENOSA	6	46.2%
HOSPERSA	3	23%
NEHAWU	1	7.7%
SADNU	0	0%
DENOSA & HOSPERSA	1	7.7%
DENOSA & NEHAWU	1	7.7%
Other	1	7.7%
Total	**13**	**100%**

4.4.3.2. Leadership factors

4.4.3.2.1. Self-reported leadership behaviour

Thirteen CPNs (100%) were accessible and 13 (100%) were visible to the staff, while 12 (92%) PNs to participate in decision-making within the unit, as indicated in Table 4.32 below.

Table 4.32: Indicators for transformational leadership

	Disagree	Neither	Agree	Total
	Frequency	Frequency	Frequency	Frequency
CPN is accessible to staff	0 (0%)	0 (0%)	13 (100%)	13 (100%)
CPN is visible to staff	0 (0%)	0 (0%)	13 (100%)	13 (100%)
PN are part of the decision-making body	0 (0%)	1 (8%)	12 (92%)	13 (100%)

4.4.3.2.2. MAS by CPNs in Case B

The majority of CPNs responded with 'sometimes' to all variables, except those detailed below. There was a split response between 'rare' 5 (38.5%), and 'sometimes' 5 (38.5%) about motivation for incentives. Another split 5 (38.5%) was observed on the response to the issue of bringing in materials, money and resources to enable the department to achieve its goals. Six (46%) CPNs stated that they often get fast access to top decision-makers. Seven (54%) CPNs often got items on the agenda at policy meetings. Refer to Table 4.33.

Table 4.33: MAS by CPNs in Case B

Activity	Never	Rare	Sometimes	Often	Always
	Frequency	Frequency	Frequency	Frequency	Frequency
Intercede favourably on behalf of someone in trouble in the organisation	0 (0%)	1(8%)	**7 (59%)**	4 (33%)	0 (0%)
Get a desirable placement for a talented subordinate	2 (18%)	2 (18%)	**5 (46%)**	2 (18%)	0 (0%)
Get approval for expenditures beyond the budget	0 (0%)	3 (23%)	**10 (77%)**	0 (0%)	0 (0%)
Motivate for incentives	3 (23%)	**5(38.5%)**	**5 (38.5%)**	0 (0%)	0 (0%)
Get items on the agenda at policy meetings	2 (15%)	0 (0%)	2 (15%)	**7 (54%)**	2 (15%)
Get fast access to top decision-makers	0 (0%)	2 (15%)	4 (31%)	**6 (46%)**	1 (8%)
Get regular, frequent access to top decision-makers	0 (0%)	2 (18%)	**5 (46%)**	3 (27%)	1 (9%)
Get early information about decisions and policy shifts	0 (0%)	1 (8%)	**10 (77%)**	2 (15%)	0 (0%)
Bring in materials, money and resources to enable the department to achieve its goals	1 (8%)	**5 (38%)**	**5 (38%)**	1 (8%)	1 (8%)
Initiate innovative activities without the approval of senior management	0 (0%)	3 (23%)	**6 (46%)**	4 (31%)	0 (0%)
Get the backing for implementing innovative strategies	2 (15%)	1 (8%)	3 (23%)	**7 (54%)**	0 (0%)

4.4.3.3. Organisational factors

4.4.3.3.1. Access to information

It is evident from Table 4.34 that 9 (69%) CPNs felt that they had some access to information on the current state of the hospital, while 7 (54%) had access to information on the values of top management and 5 (38.5 %) had access to the goals of the organisation. Refer to Table 4.34.

Table 4.34: Access to information

	A little	Some	Enough	Total
Access to information on	**Frequency**	**Frequency**	**Frequency**	**Frequency**
current state of the hospital	1 (8%)	9 (69%)	3 (23%)	13 (100%)
values of top management	3 (23%)	7 (54%)	3 (23%)	13 (100%)
goals of top management	3 (23%)	5 (38.5%)	5 (38.5%)	13 (100%)
Opportunity for	**Frequency**	**Frequency**	**Frequency**	**Frequency**
challenging work	1 (8%)	2 (15%)	10 (77%)	13 (100%)
gaining new skills & knowledge	1 (8%)	3 (23%)	9 (69%)	13 (100%)
tasks that use own skills & knowledge	1 (8%)	3 (23%)	9 (69%)	13 (100%)
Access to support on	**Frequency**	**Frequency**	**Frequency**	**Frequency**
specific information about things done well	2 (15%)	7 (54%)	4 (31%)	13 (100%)
specific comments about things which could be improved	3 (23%)	6 (46%)	4 (31%)	13 (100%)
helpful hints on problem solving advice	2 (15%)	6 (46%)	5 (39%)	13 (100%)
Access to resources on time available to	**Frequency**	**Frequency**	**Frequency**	**Frequency**
do necessary paperwork	7 (54%)	4 (31%)	2 (15%)	13 (100%)
accomplish job requirements	6 (46%)	4 (31%)	3 (23%)	13 (100%)
get temporal help when needed	5 (39%)	6 (46%)	2 (15%)	13 (100%)

4.4.3.3.2. Access to opportunity

Generally, most, 9(69%) CPNs had access to some, or enough opportunity to gain new skills and knowledge, and to utilise their own skills and knowledge, while only 1 (8%) CPN had little access to these opportunities. Ten CPNs, (77%) had enough access to opportunities to deal with challenging work compared to 1 (8%) who had little access to such opportunities. See Table 4.34.

4.4.3.3.3. Access to support

The majority 7 (54%) of the respondents had some access to support on the specific information about things they did well, compared to 2 (15%) who had little support. Six (46%) respondents had specific comments about things they could improve, and also had helpful hints on problem-solving advice, as reflected in Table 4.34.

4.4.3.3.4. Access to resources

According to the CPNs' responses, they had little access to resources or time available to do the necessary paperwork, 7 (54%), to accomplish job requirements, 6 (46%), and to get temporal help when needed, 5 (39%). See Table 4.34.

4.4.3.3.5 Job Activity Scale (JAS)

Ten (77%) CPNs received little reward for innovative jobs compared to 3 (23%) who had sufficient reward. Seven (54%) CPNs had little flexibility and 6 (46%) had enough visibility in their work.

4.4.4. ANALYSIS OF CNSM DATA

The CNSM agreed to be interviewed and also audio-taped. The informed consent was obtained before data collection. The interview guide was used to get responses from the CNSM.

4.4.4.1. Leadership factors

4.4.4.1.1. Leadership style

Managers use different leadership styles to deal with situations at a particular given time. It did not seem possible to stick to one leadership style; therefore various styles were used as indicated below.

> *I believe I am a democratic leader because I allow nurses to verbalise their concerns. I do not judge, I have a good listening ear. Sometimes I am forced to use other leadership styles because days are not the same.*

The CNMS was hailed as a visible and accessible manager as was indicated by the professional nurses in the quantitative data.

4.4.4.1.2. *Vision and mission statement*

The vision of the hospital was well understood by the professional nurses in this organisation.

> *Theoretically, the vision and mission statement involves everybody in the organisation, but the lower categories are not involved in the beginning. It's a cumbersome job to include others when they were not initially involved.*

4.4.4.2. Organisational factors

4.4.4.2.1. Access to information

Meetings are held in the organisation for different categories, but the professional nurses sometimes miss the opportunity to speak up, as is indicated the following statement:

clerk introduce the researcher to all units. Appointments were made with unit managers for appropriate times to visit the wards and units. The professional nurses working in other wards and units were given questionnaires. The researcher spent three days in the hospital. Completed questionnaires were collected daily before the end of the shift.

4.5.2. Professional Nurses in Case C

4.5.2.1. Demographic details of PNs

4.5.2.1.1. Demographic details of PN: Age, gender, nursing experience, educational qualification

The majority of respondents, 12 (36%), were over 40 years of age compared to the younger 5 (15%) professional nurses who were between 21 and 30 years of age, and 6 (18%) respondents who were between 31 and 40 years. There were 27 (82%) females and 6 (18%) male respondents. Sixteen (50%) respondents had nursing experience of more than 15 years compared to 7 (22%) professional nurses who had nursing experience of between 1-5 years. Only 2 (6%) had a Bachelor's degree, and 29 (94%) had diplomas in nursing science. The majority, 8 (24 %) professional nurses, were working in the obstetrics department at the time of the research. See Table 4.35.

Table 4.35: Demographic details of Professional Nurses (n=33)

	Frequency	Percent
Age		
21-30 yrs	5	15%
31-40 yrs	6	18%
41-50 yrs	12	36%
Above 50 yrs	10	31%
Total	33	100%
Gender		
Male	6	18%
Female	27	82%
Total	33	100%
Years of nursing experience		
1-5 yrs	7	22%
6-10 yrs	3	9%
11-15 yrs	6	19%
Above 15 yrs	16	50%
Total	32	100%
Educational qualification		
Degree	2	6 %
Diploma	29	94%
Total	31	100%
Units representation /distribution		
Medical	4	12%
Surgical	7	21%
Operating Theatre	7	21%
ICU	4	12%
OPD	3	10%
Maternity	8	24%
Total	**33**	**100%**

4.5.2.1.2. Demographic: Qualifications of PNs

As to qualifications, 7 (29%) professional nurses had a comprehensive diploma in nursing and 13 (39%) nurses who had mixed qualifications. See Table 4.36.

Table 4.36: Qualification of PNs (n=33)

Qualification	Frequency	Percent
Basic Nursing qualification		
Midwifery	2	6%
Community	2	6%
Psychiatry	3	9%
Nursing (General, Community & Psych) and Midwifery	7	29%
Post-Basic qualification		
Advanced Midwifery	3	9%
ICU + High care	1	3%
OT	2	6%
PHC	3	9%
Trauma	3	9%
Oncology	4	12%
Mixed Qualification	13	39%
Management qualification		
Management	1	3%
Management & Education	1	3%

4.5.2.1.3. Demographic: Union affiliation

Only 1 (3%) professional nurse was not affiliated to any union. DENOSA was the most popular union, with 14 (42%) respondents, compared to NEHAWU with 8 (25%), HOSPERSA with 5 (15%), and other unions with an affiliation of 5 (15%). Refer to Table 4.37.

Table 4.37: Union affiliation of PNs (n=33)

Union	Frequency	Percent
DENOSA	14	42%
HOSPERSA	5	15%
NEHAWU	8	25%
SADNU	0	0%
Other	5	15%
None	1	3%
Total	**33**	**100%**

4.5.2.2. Leadership factors

4.5.2.2.1. Leadership behaviour

Most of the respondents agreed that their CNSM was visible, 10 (30%), accessible, 12 (36%) and had power 11 (34%) and authority 9 (27%) equal to that of other senior managers. This is indicated by having more than 42 % of the respondents agreeing in all four responses compared to only 10% of the respondents who disagreed with the same questions. See Table 4.38.

Table 4.38: Perceived leadership behaviours of CNSM

	Disagree	Neither	Agree	Total
	Frequency	**Frequency**	**Frequency**	**Frequency**
CNSM is visible to staff	10 (30%)	9 (28%)	13 (42%)	32 (100%)
CNSM is accessible to staff	12 (36%)	6 (18%)	15 (46%)	33 (100%)
CNSM has equal power with top executives	11 (34%)	7 (22%)	14 (44%)	32 (100%)
CNSM has equal authority with SMT	9 (27%)	9 (27%)	15 (46%)	33 (100%)

4.5.2.2.2. Unit manager is a good leader

Most of the professional nurses, 29 (88%), viewed their unit managers as good managers compared to only 1 (3%) who disagreed. Only 3 (9%) respondents were unsure whether the unit manager was good or not.

4.5.2.2.3. Understand the vision and mission of the hospital

The majority of respondents, 31(94%), understood the vision of the hospital, compared to only 1 (3%) respondent who did not.

4.5.2.2.4. MAS by PNs in Case C

The majority of PNs agreed in almost all variables that CPNs were powerful in their organisation except in respect of the following two variables. There was a split response on 'bringing materials, money and resources to enable the department to achieve its goals'. Nine respondents (28%) stated that 'sometimes' they bring in materials, and 9 (28%) stated that they 'always' bring in materials and resources. The majority of PNs, 12 (38%) stated that CPNs had never initiated innovative activities without the approval of senior management. See Table 4.39.

Table 4.39: MAS by PNs in Case C

Activity	Never	Rare	Sometimes	Often	Always
	Frequency	Frequency	Frequency	Frequency	Frequency
Intercede favourably on behalf of someone in trouble in the organisation	2 (6%)	7 (22%)	3 (9%)	4 (13%)	**16(50%)**
Get a desirable placement for a talented subordinate	4 (13%)	2 (6%)	7 (23%)	2 (6%)	**16(52%)**
Get approval for expenditures beyond the budget	5 (16%)	5 (16%)	4 (12%)	4 (12%)	**14(44%)**
Motivate for incentives	9 (28%)	2 (6%)	4 (13%)	2 (6%)	**15(47%)**
Get items on the agenda at policy meetings	3 (9%)	0 (0%)	5 (16%)	9 (28%)	**15(47%)**
Get fast access to top decision-makers	6 (19%)	4 (12%)	3 (9%)	7 (22%)	**12(38%)**
Get regular, frequent access to top decision-makers	4 (12%)	6 (19%)	4 (12%)	5 (16%)	**13(41%)**
Get early information about decisions and policy shifts	3 (9%)	2 (6%)	9 (28%)	5 (16%)	**13(41%)**
Bring in materials, money and resources to enable the department to achieve its goals	6 (19%)	3 (9%)	**9 (28%)**	5 (16%)	**9 (28%)**
Initiate innovative activities without the approval of senior management	**12(38%)**	3 (9%)	3 (9%)	5 (16%)	9 (28%)
Get the backing for implementing innovative strategies	7(23%)	5(16%)	4(13%)	4(13%)	**11(35%)**

4.5.2.3. Organisational factors

4.5.2.3.1. Access to information

Two respondents did not respond to the three questions, bringing the total sample of PNs in this organisation to 31. The majority of professional nurses had enough access to information about the current state of the hospital, 12 (39%), the goals of top management, 16 (51%), and top management's values, 13 (42%), compared to those who had little access to information on the current state, 10 (32 %), values, 10 (32%), and goals, 8 (26%) as indicated in Table 4.40 below:

Table 4. 40: Access to organizational factors

	A little	Some	Enough	Total
Access to information	**Frequency**	**Frequency**	**Frequency**	**Frequency**
on current state of hospital	10 (32%)	9 (29%)	12 (39%)	31 (100%)
on the values of top management	10 (32%)	8 (26%)	13 (42%)	31 (100%)
on goals of top management	8 (26%)	7 (23%)	16 (51%)	31 (100%)
Opportunity for :	**Frequency**	**Frequency**	**Frequency**	**Frequency**
challenging work	10 (31%)	2 (6%)	20 (63%)	32 (100%)
gaining new skills & knowledge	0 (0%)	3 (10%)	28 (90%)	31 (100%)
tasks that use their own skills & knowledge	1 (3%)	5 (16%)	26 (81%)	32 (100%)
Access to support on	**Frequency**	**Frequency**	**Frequency**	**Frequency**
specific information about things you do well	3 (10%)	2 (6%)	26 (84%)	31 (100%)
specific comments about things you could improve	7 (22%)	8 (25%)	17 (53%)	32 (100%)
helpful hints on problem solving advice	5 (16%)	5 (16%)	22 (68%)	32 (100%)
Access to resources on time available to	**Frequency**	**Frequency**	**Frequency**	**Frequency**
do necessary paperwork	19 (59%)	4 (13%)	9 (28%)	32 (100%)
accomplish job requirements	10 (31%)	14 (44%)	8 (25%)	32 (100%)
get temporal help when needed	2 (6%)	9 (28%)	21 (66%)	32 (100%)

4.5.2.3.2. Access to opportunity

Most of the respondents had enough opportunity to do challenging work, 20(63%), and to utilise skills, 26 (81%), and knowledge gained, 28 (90%) whilst employed in this organisation. In all three responses, the respondents scored above 60%. See Table 4.40.

4.5.2.3.3. Access to support

Almost all professional nurses, 26 (84%), felt that they had access to support in things they did well. Most also appreciated being given specific comments and hints on problem-solving advice. Only 2 (6%) PNs said they did not have this kind of support. Twenty-two (68%) respondents had enough support on helpful hints on problem- solving advice compared to only 5 (16%) who had little or some support on problem- solving advice. Refer to Table 4.40.

4.5.2.3.4. Access to resources

Professional nurses responded differently to access of resources, because more professional nurses felt that they had little time to do the necessary work compared to the minority who had enough time. Most professional nurses had enough time to get temporal help compared to only 2 (6%) who had little temporal help when needed. See Table 4.40.

4.5.2.3.5 Job Activity Scale (JAS)

The majority of PNs, 25 (78%) received little reward for innovative jobs compared to 4 (13%) who had sufficient reward. Some, 13 (41%) amount of flexibility was exercised in their jobs. There was little variation in the responses about the amount of visibility in their work, 12 (38%) had enough, 9 (28%) had some visibility, and 11 (34%) had little visibility. See Table 4. 41.

Table 4.41 Job Activity Scale (JAS)

Item	A little	Some	Enough	All
	Frequency	Frequency	Frequency	Frequency
Rewards for innovative job	**25 (78%)**	3 (9%)	4 (13%)	32 (100%)
Amount of flexibility	10 (31%)	**13 (41%)**	9 (28%)	32 (100%)
Amount of visibility in my work	11 (34%)	9 (28%)	**12 (38%)**	32 (100%)

4.5.2.4. Individual factors

The individual factors included a sense of ownership, autonomy, achievement and growth by each individual/nurse employed within the organisation.

4.5.2.4.1. A sense of commitment

A total of 19 (56%) respondents agreed that they would recommend this hospital to their friends compared to 7 (21%) who disagreed. This high number shows the commitment of professional nurses in this organisation.

4.5.2.4.2. Autonomy

Only 8 (24%) professional nurses were not sure whether they needed autonomy or not, compared to 23 (70%) nurses who agreed that they needed more autonomy in their daily practice.

4.5.2.4.3. Growth

The majority of the respondents, 19 (59%), agreed that they experience career development and 12 (66%) respondents received opportunities to grow. Only 10 (3%) agreed that they had access to conferences compared to 13 (40%) who disagreed. The majority of respondents, 19(58%), agreed that they are supported in pursuing degrees, compared to 7 (21%) who disagreed. The 20 (62%) PNs in this Case agreed that they received opportunities for advancement.

4.5.2.5. Retention of staff

Retention of staff is represented by 'recommending the hospital' and 'career progression' of professional nurses in this institution.

4.5.2.5.1. Recommending and staying in the hospital

Nineteen (56%) respondents agreed that they would recommend this hospital to their friends compared to 7 (21%) who indicated that they would not recommend it. Similarly, 20 (61%) respondents agreed that that they would not consider another job, while 12 (36%) respondents disagreed. See Table 4.42.

Table 4. 42: Indicators for the retention of staff

	Disagree	Neither	Agree	Total
Would you	**Frequency**	**Frequency**	**Frequency**	**Frequency**
recommend this hospital to a friend	7 (21%)	7 (21%)	19 (58%)	33 (100%)
not consider taking another job	12 (36%)	1 (3%)	20 (61%)	33 (100%)

4.5.2.5.2. Career progression in all years

In year 1, results should be read with caution, because although there was no resignation, 29 (12.1%) respondents did not respond to the question. Fourteen respondents (42.4%) indicated that they would like to be promoted. In year 3, 17 (51.5%) respondents wanted to be promoted, and 11(33.4%) respondents indicated that they would stay in their present positions, there would be no change. During year 5, 13 (39.4%) respondents indicated that they would like to further their educational qualifications. Twelve (36.4%) respondents stated that they would like to be promoted, and 7 (21.2%) respondents wanted to further their educational qualifications. See Table 4.43.

Table 4 .43: Career progression in all years

Variable	1 year	3 years	5 years	Future
No change	13 (39.4%)	11 (33.3%)	11 (33.3%)	0 (0%)
Education	2 (6%)	0 (0%)	13 (39.4%)	7 (21.2%)
Promotion	14 (42.4%)	17 (51.5%)	1 (3%)	12 (36.4%)
Resignation	0 (0%)	1 (3%)	2 (6%)	6 (18.1%)
Missing response	29 (12.1%)	4 (12.1%)	6 (18.2%)	8 (24.2%)

4.5.2.5.3. Satisfaction with salary

There were mixed feelings about satisfaction with salaries, because 43% of the PNs were satisfied, compared to 33% who were not satisfied, while 24% were not sure about their salaries.

4.5.3 CHIEF PROFESSIONAL NURSES in Case C

4.5.3.1. Demographic details

4.5.3.1.1. Demographic details: Age, years of nursing experience and nursing experience

Four (50%) CPNs fell between the ages of 41 and 50 years, and 3 (37%) were over 50 years, while only 1 (13%) respondent was between 20 and 30 yrs of age. Five (56%) respondents had more than 15 years of nursing experience. The majority of respondents, 4(50%), had between 1 and 3 years management experience. Refer to Table 4.44.

Table 4.44: Demographic details of CPNs (n=9)

	Frequency	Percent
Age		
21-30 yrs	1	13%
31-40 yrs	0	0%
41-50 yrs	4	50%
Above 50 yrs	3	37%
Total	8	100%
Gender		
Male	1	11%
Female	8	89%
Total	9	100%
Years of nursing experience		
1-5 yrs	1	11%
6-10 yrs	1	11%
11-15 yrs	2	22%
Above 15 yrs	5	56%
Total	9	100%
Years of management experience		
6months – 1 yr	1	12.5%
1-3 yrs	4	50%
4-6 yrs	1	12.5%
7-9yrs	1	12.5%
Above 10 yrs	1	12.5%
Total	8	100%
Educational Qualification		
Degree	0	0%
Diploma	9	100%
Total	9	100%
Unit representation /distribution		
Medical	2	22%
Surgical	1	11%
Theatre	2	22%
ICU	1	11%
OPD	0	0%
Maternity	3	34%
Total	**9**	**100%**

4.5.3.1.2. Demographic: Qualification of CPNs

CPNs who participated in the study in this organisation do not have nursing management as a non-clinical course. See Table 4.45.

Table 4.45: Qualification of CPNs (n= 9)

Qualification	Frequency	Percent
Basic qualification		
Midwifery	6	67%
Community	2	22%
Psychiatry	1	11%
Mid, Psych, Community (Comprehensive)	2	22%
Post-Basic qualification		
Advanced Midwifery	2	22%
ICU + High care	0	0
OT	0	0
PHC	1	11%
Trauma	0	0
Oncology	1	11%
Mixed Qualification	6	67%
Management qualification		
Management	0	0
Management & Education	0	0

4.5.3.1.3. Demographic: Union affiliation

DENOSA is the most popular union with an affiliation of 3 (34%) chief professional nurses. The latest trend is for nurses to join two unions, as is indicated in Table 4.46 below.

Table 4.46: Union affiliation of CPNs (n= 9)

Union	Frequency	Percent
DENOSA	3	34%
HOSPERSA	0	0%
NEHAWU	1	11%
SADNU	0	0
DENOSA & HOSPERSA	1	11%
DENOSA & NEHAWU	2	22%
Other	2	22%
None	0	0%
Total	**9**	**100%**

4.5.3.2. Leadership factors

4.5.3.2.1. Perceived leadership behaviours

All (100%) CPNs identified themselves as accessible (100%) and visible (100%) to staff, and also allowed their staff to take part in decision-making (89%) in the organisation. Refer to Table 4. 47.

Table 4. 47: Perceived leadership indicators

	Disagree	Neither	Agree	Total
	Frequency	**Frequency**	**Frequency**	**Frequency**
CPN is accessible to staff	0 (0%)	0 (0%)	9 (100%)	9 (100%)
CPN is visible to staff	0 (0%)	0 (0%)	9 (100%)	9 (100%)
PNs are part of the decision making body	0 (0%)	1 (11%)	8 (89%)	9 (100%)

4.5.3.2.2. MAS for CPNs in Case C

The majority of CPNs had never had access to almost all of the variables with the exception of three. Four (50 %) CPNs often interceded favourably on behalf of someone in trouble in the organisation, and were also able to get items on the agenda at policy meetings. There was a split response by 2 (29%) CPNs for getting regular frequent access to top decision-makers. See Table 4.48.

Table 4.48: MAS for CPNs in Case C

Activity	Never	Rare	Sometimes	Often	Always
	Frequency	Frequency	Frequency	Frequency	Frequency
Intercede favourably on behalf of someone in trouble in the organisation	2 (25%)	1 (12.5%)	0 (0%)	**4 (50%)**	1 (12.5%)
Get a desirable placement for a talented subordinate	2 (25%)	**3 (37.5%)**	1 (12.5%)	1 (12.5%)	1 (12.5%)
Get approval for expenditure beyond the budget	**6 (75%)**	0 (0%)	1 (12.5%)	0 (0%)	1 (12.5%)
Motivate for incentives	**4 (50%)**	0 (0%)	1 (12.5%)	1 (12.5%)	2 (25%)
Get items on the agenda at policy meetings	1 (12.5%)	0 (0%)	2 (25%)	**4 (50%)**	1 (12.5%)
Get fast access to top decision-makers	**3 (38%)**	2 (25%)	1 (12 %)	1 (12 %)	1 (12. %)
Get regular, frequent access to top decision-makers	**2 (29%)**	**2 (29%)**	**2 (29%)**	0 (0%)	1 (14%)
Get early information about decisions and policy shifts	**3 (38%)**	1 (12%)	2 (25%)	1 (12%)	1 (12 %)
Bring in materials, money and resources to enable the department to achieve its goals	**3 (38%)**	1 (12%)	2 (25%)	2 (25%)	0 (0%)
Initiate innovative activities without the approval of senior management	**6 (75%)**	1 (12.5%)	0 (0%)	0 (0%)	1 (12.5%)
Get the backing for implementing innovative strategies	**5 (62.5%)**	1 (12.5%)	1 (12.5%)	0 (0%)	1 (12.5%)

4.5.3.3. Organisational factors

4.5.3.3.1. Access to information

From the total respondents who were asked questions, no CPN had enough information on the current state of the hospital, and values and goals of top management. Only 4 (57%) had a little access to information on the current state of the hospital and the values of top management. See Table 4.49 below.

4.5.3.3.2. Access to opportunity

It was evident from all the responses that the CPNs had some access to opportunities for challenging work 5 (56%), gaining new skills, 6 (67%), and also using those skills and knowledge, 5 (56%). There was not a single CPN who had enough opportunities to do challenging work and gain new skills and knowledge. Only 2 (22%) had enough support with regard to tasks that used their own skills and knowledge. See Table 4.49.

4.5.3.3.3. Access to support

There were mixed responses about access to support. Five (62%) of the CPNs had enough support on specific comments and helpful hints on problem-solving compared to only 4 (50%) CPNs who received little support on specific information about things well done. See Table 4.49.

4.5.3.3.4. Access to resources

CPNs had some access to resources on time available to do necessary paperwork, 5 (63%), accomplishing job requirements, 5 (63%), and also getting temporal work, 6 (75%) when needed. See Table 4.49.

Table 4.49: Organisational factors

	A little	Some	Enough	Total
Access to information	**Frequency**	**Frequency**	**Frequency**	**Frequency**
on current state of hospital	4 (57%)	3 (43%)	0 (0%)	7 (100%)
on the values of top management	4 (57%)	3 (43%)	0 (0%)	7 (100%)
on goals of top management	3 (43%)	4 (57%)	0 (0%)	7 (100%)
Opportunity on :	**Frequency**	**Frequency**	**Frequency**	**Frequency**
challenging work	4 (44%)	5 (56%)	0 (0%)	9 (100%)
gaining new skills & knowledge	3 (33%)	6 (67%)	0 (0%)	9 (100%)
tasks that use own skills & knowledge	2 (22%)	5 (56%)	2 (22%)	9 (100%)
Access to support on	**Frequency**	**Frequency**	**Frequency**	**Frequency**
Specific information about things you do well	4 (50%)	2 (25%)	2 (25%)	8 (100%)
Specific comments about things you could improve	1 (13%)	2 (25%)	5 (62%)	8 (100%)
Helpful hints on problem-solving advice	2 (25%)	2 (25%)	5 (50%)	8 (100%)
Access to resources on time available to	**Frequency**	**Frequency**	**Frequency**	**Frequency**
do necessary paperwork	2 (25%)	5 (63%)	1(12%)	8 (100%)
accomplish job requirements	2 (25%)	5 (63%)	1(12%)	8 (100%)
get temporal help when needed	1 (12.5%)	6 (75%)	1(12.5%)	8 (100%)

4.5.3.3.5. Job Activity Scale (JAS)

In all variables, CPNs had little rewards for innovative jobs, 7 (88%), and visibility, 6 (75%) in their work, although there was a split response on the amount of flexibility, 4 (50%). See Table 4.50.

Table 4. 50: Job Activity Scale (JAS) Formal power

Item	A little	Some	Enough	All
	Frequency	Frequency	Frequency	Frequency
Rewards for innovative job	**7 (88%)**	1 (12%)	0 (0%)	8 (100%)
Amount of flexibility	**4 (50%)**	**4 (50%)**	0 (0%)	8 (100%)
Amount of visibility in my work	**6 (75%)**	2 (25%)	0 (0%)	8 (100%)

4.5.4. ANALYSIS OF CNSM DATA

4.5.4.1. Leadership factors

4.5.4.1.1. Leadership style

The deputy CNSM was hailed by staff as very approachable and knowledgeable. She operated within the legal framework of the country and knew her management agenda very well. Her office was well organised with all policies and the filing cabinet labelled. She integrated the vision of the institution in line with the vision of the KZN Department of Health. Her leadership style was that of a transformational leader.

> *I am transformational in the sense that I believe that I am the nurse manager of the 21st century. A nurse manager of the 21st century operates within the supreme law of the constitutional act which comes with the legal framework under which the management operates. Therefore, it is impossible to simply operate randomly. All the facts that are taken by up managers in the nursing profession are guided by the legal framework; hence I say I am a*

transformational leader because everything that you put into practice is guided by the legal framework that guides nursing practice.

There were mixed feelings about the visibility and accessibility of the CNSM. The CNSM relied heavily on, and delegated most of the duties to the deputy CNSM; this was also noted during the interview with the researcher. Most of the work was done by the deputy CNSM. There was no significance in the differences between both responses.

4.5.4.1.2. Vision and mission statement

The vision and mission statement of the organisation was well displayed in all the units and also in the management building. The deputy CNSM demonstrated clearly how the vision and mission is communicated to the whole organisation, as indicated below:

We have got a system of ensuring that each and every dept has a checklist for everything that they do, and again, for reporting on achieving the mission and vision of the institution which is linked in with the vision and mission of the district. Now and again we go back to the checklist to check that we have said is what we are achieving.

4.5.4.2. Organisational factors

4.5.4.2.1 Access to information

The processes on how the information filters from top to bottom were made clear. The hospital follows Batho Pele principles where everything is made transparent. Meetings are held regularly with staff.

There is a general meeting which is held every Thursday of the month. This meeting is for all categories of staff. Every third Tuesday of the month, there is an operational meeting. Quality and policy meetings are held bi-weekly. The health and safety meeting is held every month. The infection control meeting is also held every month.

There is also an institutional policy which guides the top, middle and lower management on dissemination of information

> *There is a policy whereby in any dept when a new policy comes in, a manager ensures that it is read, and that people sign it, and she ensures that people understand the context of that circular.*

4.5.4.2.2. Access to opportunity

Professional nurses were given an opportunity to grow, but did not utilise it to the maximum. They are exposed to different opportunities of learning but allow good opportunities to pass them by.

> *But I rarely see nurses do not attend telemedicine, nor do I see them coming to watch programmes to which they are invited for telemedicine.*

4.5.4.2.3. Access to support

The professional nurses are supported fully in all spheres, academic, physical or emotional. There are structures in places which were implemented to provide extra support to staff. Academic support is provided through study leave and staff development programs.

> *The biggest support that I give to the staff is that I have a wider staff development programme that encompasses all categories, linked to the institutional human resource development (HRD) training program. I also do the administration of nursing matters, and am involved in dealing with personal issues which will, at the end of the day, provide support to staff individually, and as a group.*

Physical support is provided by means of world class accommodation which caters for all categories of staff.

> *Mmm.....in my institution we have a world class nurse's home. I think it's one of the strengths that this institution has. The nurses' home is world class and it's for all genders (males and females stay together). I have no better way of explaining it except that it's world class.*

Professional nurses are taken care of holistically. They are not expected to focus only on work, entertainment is also provided in different areas.

> *The residence has a lot of space. There is a tennis court, swimming pool and entertainment area.*

Security is provided for all nurses working in this hospital. Extra precautions are taken for live-in staff.

> *Once your car is well parked, you have a reason to stay; you have a house, a bed, security at all the gates at all times in the residence.*

Emotional support is offered to the needy by means of counselling and rehabilitation.

> *Our staff, for example, all those who become ill are supported and are channelled correctly. Those who become depressed are not looked down upon, but are brought back to life.*

> *Those who deviate are not cast-out, but are rehabilitated and go back to action, while those who need counselling and drastic action from labour relations receive justice as well.*

4.5.4.2.4. Access to resources

There is always a shortage of equipment and supplies because the procurement department delays in bringing requested goods. The organisation follows a tendering procedure which works negatively at the institution. The purchasing department orders the cheapest available products, despite being informed by professional nurses about the poor quality. Patient care is compromised due to these poor quality products.

> *That's a great challenge, the reason being that we do not procure the items. The hospital depends on the stores department which follows the DOH guidelines in terms of procurement. Hospitals are to follow the procurement procedures which lead to the purchase of the lowest code. Nurses are using third grade items because we are expected to support the BEE companies----*

Black Economic Empowerment, no matter how bad their items are. We cannot buy from Johnsons, and Smith and Nephew, because they do not meet the BEE criteria. It's really bad. Recently there are these cheap Oxygen masks which are made of a poor quality material. The mask fits too snugly on the face of the patient, and the patient is even deprived of oxygen.

4.5.4.3. Individual factors

4.5.4.3.1. Sense of commitment

Professional nurses are motivated positively when they do well. They are also featured in the newsletter so as to encourage others to excel or attempt to mirror their achievements.

If there is a particular nurse who has been identified as the best caring nurse, her/his name and picture is placed in the newsletter. We have a newsletter called ***Indaba yethu*** *and we are very proud of it. This initiative has been implemented in order to appraise the organisation of the commitment of these nurses.*

Nurse Managers are always striving to instil a sense of commitment among professional nurses but unfortunately this is missed, as indicated below.

I have organised a library by converting the old office into a library. This library is intended for use by professional nurses and other nursing categories, but professional nurses hardly use this library.

4.5.4.3.2. Autonomy

It emerged that nurses do not have autonomy in their daily practices. This is reflected in the responses from 33 professional nurses of whom 23 (70%) agreed that they need autonomy in their daily practice.

4.5.4.3.3. Growth

Professional nurses are sent to different education centres for academic growth. There are structures for staff development and growth which are available in this organisation. The deputy CNSM has a vision for growth in her institution. She

ensures that the professional nurses are nurtured and mentored in every possible manner.

> *I have a wider staff development programme that encompasses all categories and is linked to the institutional HRD training programme.*

4.5.4.4.Alliances/ Stakeholders

The chief nursing service manager was asked about the role of the stakeholders and her responses were as follows:

4.5.4.4.1. DOH

The role of the DOH was to ensure that any given policies are implemented, even if these worked against the needs of the organisation.

> *The policy of the DOH in retaining staff is not in line with the organisation policy. A professional nurse is allowed to work in any organisation within the province of KwaZulu-Natal. One cannot oppose any statement that is issued by DOH because it's our Head Office. Once the instruction comes from the Head Office, as a manager, I cannot oppose it, regardless of how badly it affects my organisation.*

4.5.4.4.2. SANC

The role of the SANC was to guide the institution in training their staff because the training department relied on SANC policies.

> *As a statutory body, the organisation assists in the training of staff according to the policies of South African Nursing Council.*

4.5.4.4.3. Unions

Union representatives were working closely with management because they were involved in many hospital activities such as interviews. The responsibilities of the stewards were also acknowledged; because stewards were given time to attend their meetings.

The institution works closely with the unions where nurses are affiliated. Union representatives are also involved during interviews. They are also given time off for meetings with members of staff.

4.6. RESULTS OF CASE D: A SMALL RURAL DISTRICT HOSPITAL

The organisation is a very small hospital and therefore has fewer staff numbers. It has 184 beds with 85 professional nurses. It is based in the deepest rural areas of Northern KwaZulu-Natal. It is one of the five hospitals in the Umkhanyakude District. Permission was granted by the CNSM on the first application. The researcher was given suitable days to visit. Dress code was emphasised because the area is very rural. The organisation still followed, and was guided by Christian beliefs under the local Lutheran mission, despite having been taken over by the Department of Health in 1978.

4.6.1. Data collection process

Data collection was done by convenience sampling; all professional nurses who were in the wards during the day of data collection were included in the sample. On arrival at the hospital, the CNSM and her deputy had a meeting with the researcher for further explanation of the research. The researcher was briefed about the layout of the hospital, and was also given a map of the hospital. She was allowed to visit the wards on her own. The researcher encountered minor problems with access to the different wards and departments because she was not familiar with the area; nevertheless data was collected despite all of these obstacles.

Professional nurses working in the communities were the first to be seen by the researcher, because the hospital transport to remote clinics departed at 08h00. The other units were visited after 11h00 so as not to disturb the ward routine. The researcher stayed for three days within the hospital premises in order to complete data collection.

The professional nurses were very reluctant to participate in the research. They cited many reasons for not wanting to involve themselves in the research, such as that the researcher was a spy sent by the government to look into the problems within the organisation. Autonomy was adhered to by allowing PNs to participate in the study

without coercing them to be involved in the project. Principles of confidentiality and anonymity were strongly emphasised by coding the questionnaires and not revealing the identity of respondents.

4.6.2. Professional Nurses in Case D

4.6.2.1. Demographic details of PNs

Biographical information on all PNs in this institution will be presented according to age, gender, qualifications, nursing experience, unit representation, educational qualification and union affiliation.

4.6.2.1.1. Demographic details of PNs: Age, gender, qualifications, nursing experience and unit representation

Of 24 (100%) respondents, 14 (58%) were between the ages of 31 and 40 years of age. There were 5 (21%) males and 19 (79%) females. Nine (38%) respondents had nursing experience of between 1 and 5 years. Only 1 (4%) respondent had a Bachelor's degree compared to 23 (96%) who had diplomas in nursing science. The majority of professional nurses 8 (33%) were working in medical units, followed by the Out-patient department with 6 (25%).The hospital does not have an ICU, and all the critical patients are nursed in a high care section in the surgical unit. See Table 4.51.

Table **4.51: Demographics of professional nurses (n= 24)**

	Frequency	Percent
Age		
21-30 yrs	4	16 %
31-40 yrs	14	58%
41-50 yrs	3	13%
Above 50 yrs	3	13%
Total	24	100%
Gender		
Male	5	21%
Female	19	79%
Total	24	100%
Years of nursing experience		
1-5 yrs	9	38%
6-10 yrs	7	29%
11-15 yrs	3	12%
Above 15 yrs	5	21%
Total	24	100%
Educational qualification		
Degree	1	4%
Diploma	23	96%
Total	24	100%
Unit representation /distribution		
Medical	8	33%
Surgical	4	17%
Operating Theatre	2	8%
ICU	0	0%
OPD/ Community	6	25%
Maternity	4	17%
Total	**24**	**100%**

4.6.2.1.2. Demographic: qualification of PNs

Many professional nurses had mixed qualifications and these were counted more than once. Seven (29%) professional nurses were registered as comprehensive nurses. Refer to Table 4.52.

Table 4.52: Qualification of PNs (n=24)

Qualification	Frequency	Percent
Basic qualification		
Midwifery	4	17%
Community	1	4%
Psychiatry	1	4%
Nursing (General, Community & Psychiatry) and Midwifery	7	29%
Post Basic qualification		
Advanced Midwifery	1	4%
ICU + High care	2	8%
OT	1	4%
PHC	2	8%
Trauma	1	4%
Oncology	2	8 %
Mixed Qualification	6	25%
Non- clinical qualification		
Management	3	13%
Management & Education	1	4%

4.6.2.1.3. Demographic: Union affiliation

The majority of respondents 17 (71%) belonged to DENOSA, followed by HOSPERSA with 4 (17%), and then NEHAWU which had only 2 (8%) members. See Table 4.53.

Table 4.53: Union affiliation of PNs (n= 24)

Union	Frequency	Percent
DENOSA	17	71%
HOSPERSA	4	17%
NEHAWU	2	8%
SADNU	0	0
Other	1	4%
None	0	0%
Total	**24**	**100%**

4.6.2.2. Leadership

4.6.2.2.1 Leadership factors

The CNSM was accessible to staff because 12 (55%) respondents agreed on this, compared to 4 (17%) who disagreed. There was a split opinion on the visibility of the CNSM. The responses were spread out as to whether the CNSM had equal power and authority with top management as indicated in Table 4.54 below.

Table 4.54: Accessibility and visibility of the CNSM

	Disagree	Neither	Agree	Total
	Frequency	Frequency	Frequency	Frequency
CNSM is accessible to staff	4 (17%)	6(28%)	12(55%)	22(100%)
CNSM is visible to staff	10 (45.5%)	2(9%)	10(45.5%)	22(100%)
CNSM has equal power with top executives	5(23%)	8(36%)	9(41%)	22(100%)
CNSM has equal authority with SMT	6(29%)	7(33%)	8(38%)	21(100%)

4.6.2.2.2. The unit manager is a good leader

The unit manager was not regarded as a good manager and leader because the majority of respondents, 12 (50%) disagreed, compared to 8 (33%) who agreed that the unit manager was a good leader.

4.6.2.2.3. Understand the vision and mission of the organisation

The majority of professional nurses, 17 (71%) understood the vision and mission of the organisation compared to 2 (8%) who did not understand them.

4.6.2.2.4. MAS for PNs in Case D

In almost all variables, the majority of PNs stated that CPNs had never had acted on the stated variables except for three variables. There was a split response on 'interceding favourably on behalf of someone in trouble in the organisation'. Eight (33%) PNs stated that CPNs 'sometimes' get fast access to top decision-makers and get early information about decisions and policy shifts. See Table 4.55.

Table 4.55: MAS for PNs in Case D

Activity	Never	Rare	Sometimes	Often	Always
	Frequency	Frequency	Frequency	Frequency	Frequency
Intercede favourably on behalf of someone in trouble in the organisation	6 (25%)	**7 (29%)**	**7 (29%)**	3 (13%)	1 (4%)
Get a desirable placement for a talented subordinate	**8 (33%)**	6 (25%)	7 (29%)	2 (8%)	1 (4%)
Get approval for expenditure beyond the budget	**11 (46%)**	3 (13%)	7 (29%)	2 (8%)	1 (4%)
Motivate for incentives	**13 (54%)**	4 (17%)	4 (17%)	1 (4%)	2 (8%)
Get items on the agenda at policy meetings	**8 (33%)**	4 (17%)	6 (25%)	5 (21%)	1 (4%)
Get fast access to top decision-makers	6 (25%)	5 (21%)	**8 (33%)**	3 (13%)	2 (8%)
Get regular, frequent access to top decision-makers	**10 (42%)**	3 (13%)	7 (29%)	2 (8%)	2 (8%)
Get early information about decisions and policy shifts	6 (25%)	5 (21%)	**8 (33%)**	2 (8%)	3 (13%)
Bring in materials, money and resources to enable the department to achieve its goals	**10 (42%)**	4 (17%)	5 (20%)	4 (17%)	1 (4%)
Initiate innovative activities without the approval of senior management	**9 (38%)**	7 (29%)	4 (17%)	3 (12%)	1 (4%)
Get the backing for implementing innovative strategies	**9 (37%)**	4 (17%)	5 (21%)	5 (21%)	1 (4%)

4.6.2.3. Organisational factors

4.6.2.3.1. Access to information

In general, professional nurses had access to information, although 11 (46%) had little access compared to 7 (29%) who had enough access, but when asked about access to information regarding the current state of the organisation, 12 (50%) had

enough access, compared to only 9 (38%) who had little access. There was an equal split with access to information about the goals of top management. Refer to Table 4.56.

4.6.2.3.2. Access to opportunity

There was a clear majority, 21 (88%) of respondents who had enough access to opportunities for challenging work, 12 (50%) of the respondents had opportunities to gain new skills, and 16 (68%) also had opportunities to deal with tasks that used their skills and knowledge as is indicated in Table 4.56 below.

4.6.2.3.3. Access to support

There were mixed responses about access to support. Twelve (50%) respondents had enough support on specific information about things they did well, 12 (50%) had 'some' support on specific comments about things they could improve, whereas 13 (54%) had 'little' support on helpful hints concerning problem-solving advice. See Table 4.56.

4.6.2.3.4. Access to resources

The majority of respondents felt that they did not have enough access to resources on time because 13 (54%) felt that they did not have the time to do necessary work compared to 3 (13%) of professional nurses who had enough time. There were 14 (58%) professional nurses who had 'little' access to temporal help. There was an equal split regarding time available to accomplish job requirements as indicated in Table 4.56.

Table 4.56: Organisational factors by PNs(n=24)

	A little	Sometimes	Enough	All
Access to information	**Frequency**	**Frequency**	**Frequency**	**Frequency**
on values of top management	11(46%)	6 (25%)	7 (29%)	24 (100%)
on goals of top management	9 (37%)	6 (26%)	9 (37%)	24 (100%)
on current state of the org.	9 (38%)	3 (12%)	12 (50%)	24 (100%)
Opportunity for :	**Frequency**	**Frequency**	**Frequency**	**Frequency**
challenging work	1 (4%)	2 (8%)	21(88%)	24 (100%)
gaining new skills & knowledge	6 (25%)	6 (25%)	12 (50%)	24 (100%)
tasks that use their own skills & knowledge	4 (16%)	4 (16%)	16 (68%)	24 (100%)
Access to support on	**Frequency**	**Frequency**	**Frequency**	**Frequency**
specific information about things you do well	9 (37%)	3 (13%)	12 (50%)	24 (100%)
specific comments about things you could improve	6 (25%)	12 (50%)	6 (25%)	24 (100%)
helpful hints on problem-solving advice	13 (54%)	4 (17%)	7 (29%)	24 (100%)
Access to resources on time available to:	**Frequency**	**Frequency**	**Frequency**	**Frequency**
do necessary paperwork	**13 (54%)**	8 (33%)	3 (13%)	24 (100%)
accomplish job requirements	**9 (38%)**	9 (38%)	6 (24%)	24 (100%)
get temporal help when needed	**14 (58%)**	6 (25%)	4 (17%)	24 (100%)

4.6.2.3.5. Job Activity Scale (JAS)

In all variables, the majority of PNs received 'little' reward for innovative jobs, the amount of flexibility and also the amount of visibility in their work. See Table 4.57.

Table 4. 57: Job Activity Scale (JAS)

Item	A little	Some	Enough	All
	Frequency	**Frequency**	**Frequency**	**Frequency**
Rewards for innovative jobs	**18 (75%)**	2 (8%)	4 (17%)	24 (100%)
Amount of flexibility	**14 (58%)**	6 (25%)	4 (17%)	24 (100%)
Amount of visibility in my work	**13 (54%)**	6 (25%)	5 (21%)	24 (100%)

4.6.2.4. Individual factors

4.6.2.4.1. A sense of commitment

Not all professional nurses were committed to the organisation. Eleven (46%) professional nurses agreed that they would recommend the hospital to their friends, but 9 (37%) disagreed. Only 5 (21%) agreed that they would not take another job, whereas 13 (54%) disagreed.

4.6.2.4.2. Autonomy

It was evident that professional nurses needed more autonomy in their daily practice, because 16 (67%) indicated that they needed more autonomy while only 5 (21%) disagreed. Only 3 (12%) were unsure of whether they needed autonomy or not.

4.6.2.4.3. Growth

Eleven (46%) respondents were given career development opportunities compared to 9 (38%) who disagreed on this. There was a split response regarding access to in-service programs. A clear majority prevailed on access to continuing education. The organisation did not have a clear view on opportunities for advancement based on the even spread of the responses as indicated in Table 4.58.

Table 4.58: Growth opportunities for Case D

	Disagree	Neutral	Agree
Career development opportunities	9 (38 %)	4 (16 %)	11 (46 %)
Access to in-service programs	9 (39%)	9 (22%)	9 (39 %)
Access to regional conferences	10 (43 %)	10 (37%)	4 (17 %)
Support for pursuing a degree	13 (54 %)	4 (21 %)	6 (25 %)
Access to continuing education	12 (50%)	6 (25%)	6 (25 %)
Opportunities for advancement	8 (35%)	7 (33%)	6 (32 %)

4.6.2.5. Retention of staff

Retention of staff will be presented by variables which address 'recommending the hospital' and also 'considering another job'. Professional nurses were also asked about career progression as part of determining whether they would stay in their organisation.

4.6.2.5.1 Recommending and staying in the hospital

Mixed responses were reported by professional nurses, as 11 (46%) professional nurses agreed that they would recommend the hospital to their friends, while 9 (37%) disagreed. Thirteen (54%) respondents disagreed that they would not take another job compared to only 5 (21%) PNs who agreed that they would not take another job. See Table 4.59.

Table 4.59: Indicators for retention of staff

	Disagree	Neither	Agree	Total
Would you	**Frequency**	**Frequency**	**Frequency**	**Frequency**
recommend this hospital to a friend	9 (37%)	4 (17%)	11(46%)	24 (100%)
not consider taking another job	13 (54%)	6 (25%)	5 (21%)	24 (100%)

4.6.2.5.2. Career progression

PNs were asked about where they would like to be in one, three, and five years. They gave different responses, ranging from improving their educational qualifications to being promoted to senior positions. In year 1, 9 (37, 5%) respondents wanted to be promoted to chief nursing service managers, while 4 (16.7%) were interested in completing a degree or diploma in nursing administration. Three (12.5%) saw themselves as supervisors or holding positions as senior professional nurses.

The majority of the respondents, 16 (66.7%) were interested in moving up to management positions compared to 1 (4.2%) each, who stated that there would be no change in their career and also those who would be working in another hospital. In year 5 there was a positive response, because 9 (37, 5%) respondents stated that they would still be working in this organisation. There was an equal response by those who wanted to be matrons and also to further their educational courses. The future career plans of PNs showed that they are optimistic about their future because 10 (41, 7%) wanted to be in management positions, 5 (20.8%) wanted to further their studies, and 3 (12.5%) were specific about doing PHC. See Table 4.60.

Table 4.60: Career progression in all years

Variable	1 year	3 years	5 years	Future
No change	1 (4.2%)	1 (4.2%)	10 (41.7%)	0 (0%)
Education	5 (20.9%)	3 (12.5%)	7 (29. 3%)	10 (41.7%)
Promotion	12 (50%)	16 (66.7%)	5 (20.9%)	10 (41.7%)
Resignation	2 (8.3%)	1 (4.2%)	1 (4.2%)	1 (4.2%)
Missing response	4 (16.7%)	3 (12.5%)	1 (4.2%)	3 (12.5%)

4.6.2.5.3. Satisfaction with salary

Seventy percent were satisfied with their salaries compared to 17% who were dissatisfied with their salaries.

4.6.3. CPN results in Case D

4.6.3.1. Demographic details of CPNs(n=7)

4.6.3.1.1. Demographic details of CPNs: Age, gender, years of nursing experience, years of management experience, educational qualification and unit representation

There were 5 (71%) females and 2 (29%) males. The majority of 5 (72%) CPNs were between 41 and 50 years of age. Four CPNs (57%) had more than 15 years nursing experience compared to only one (14%) CPN who had nursing experience of between 6 and 10 years. There was not a single CPN who had between 1 and 5 years nursing experience. All of the CPNs were very experienced, because they had more than 6 years nursing experience. Only 1 (17%) CPN had more than 6 years nursing management experience. Only 1 (14%) CPN had a Bachelor's degree, while 6 (86%) had a diploma in nursing science. Refer to Table 4.61.

4.6.3.1.2. Demographic: Qualification of CPNs

Only two (28%) CPNs had a non-clinical qualification of nursing management which is a requirement to run a unit or department in an organisation. One (14%) CPN had both management and education as indicated in Table 4.62.

4.6.3.1.3. Demographic: Union affiliation of CPNs

DENOSA and NEHAWU had an equal number of respondents, 2 (33%), as affiliates to the unions; the rest of the unions had one each. Refer to Table 4.63.

Table 4.61: Demographic details of CPNs (n=7)

	Frequency	Percent
Age		
21-30 yrs	0	0
31-40 yrs	1	14%
41-50 yrs	5	72%
Above 50 yrs	1	14%
Total	7	**100%**
Gender		
Male	2	29%
Female	5	71%
Total	7	**100%**
Years of nursing experience		
1-5 yrs	0	0
6-10 yrs	1	14%
11-15 yrs	2	29%
Above 15 yrs	4	57%
Total	7	100%
Years of nursing management experience		
6month-1 year	1	17%
1-3 yrs	2	33%
4-6 yrs	2	33%
Above 6 yrs	1	17%
Total	**6**	**100%**
Educational Qualification		
Degree	1	14%
Diploma	6	86%
Total	7	**100%**
Unit representation /distribution		
Medical	2	28%
Surgical	1	16%
Operating Theatre	2	28%
ICU	0	0
OPD	2	28%
Maternity	0	0
Total	7	**100%**

Table 4.62: Qualification of CPNs (n=7)

Qualification	Frequency	Percent
Basic nursing qualification		
Midwifery	3	43%
Community	0	0
Psychiatry	0	0
Nursing (General, Community & Psychiatry) and Midwifery	2	28%
Post-Basic qualification		
Advanced Midwifery	0	0
ICU + High care	0	0
OT	0	0
PHC	1	14%
Trauma	1	14%
Oncology	2	28%
Mixed Qualification	2	28%
Non-clinical qualification		
Management	2	28%
Management & Education	1	14%

Table 4.63: Union affiliation of CPNs (n=7)

Union	Frequency	Percent
DENOSA	2	33%
HOSPERSA	1	17%
NEHAWU	2	33%
SADNU	0	0
Other	1	17%
None	0	0
Total	**6**	**100%**

4.6.3.2. Leadership factors

4.6.3.2.1. Perceived leadership behaviour of CPNs

The CPNs perceived themselves as transformational leaders because they were accessible 7 (100%), and visible, 6 (86%) to staff, and also allowed the PNs to take part in decision-making in the organisation, 6 (86%), as is indicated in Table 4.64 below.

Table 4.64: Perceived leadership behaviour of CPNs

	Disagree	Neither	Agree	Total
	Frequency	Frequency	Frequency	Frequency
CPN is accessible to staff	0 (0%)	0 (0%)	7 (100%)	7 (100%)
CPN is visible to staff	0 (0%)	1 (14%)	6 (86%)	7 (100%)
PNs are part of the decision-making body	0 (0%)	1 (14%)	6 (86%)	7 (100%)

4.6.3.2.2. MAS for CPNs in Case D

The majority of CPNs verbalised that sometimes they are able to mobilise resources to get things done in the organisation, although they had never motivated for incentives as indicated in Table 4. 65.

Table 4.65: MAS for CPN in Case D

Activity	Never	Rare	Sometimes	Often	Always
	Frequency	Frequency	Frequency	Frequency	Frequency
Intercede favourably on behalf of someone in trouble in the organisation	0 (0%)	1 (14%)	1 (14%)	**4 (58%)**	1 (14%)
Get a desirable placement for a talented subordinate	0 (0%)	2 (29%)	1 (14%)	**3 (43%)**	1 (14%)
Get approval for expenditure beyond the budget	1 (14%)	0 (0%)	**4 (57%)**	2 (29%)	0 (0%)
Motivate for incentives	**3 (43%)**	1 (14%)	2 (29%)	1 (14%)	0 (0%)
Get items on the agenda at policy meetings	0 (0%)	1 (14%)	**3 (43%)**	**3 (43%)**	0 (0%)
Get fast access to top decision-makers	1 (14%)	**3 (43%)**	1 (14%)	2 (29%)	0 (0%)
Get regular, frequent access to top decision-makers	1 (20%)	0 (0%)	**3 (60%)**	1 (20%)	0 (0%)
Get early information about decisions and policy shifts	0 (0%)	0 (0%)	**6 (86%)**	1 (14%)	0 (0%)
Bring in materials, money and resources to enable the department to achieve its goals	0 (0%)	2 (29%)	**4 (57%)**	1 (14%)	0 (0%)
Initiate innovative activities without the approval of senior management	1 (14%)	2 (29%)	**4 (57%)**	0 (0%)	0 (0%)
Get the backing for implementing innovative strategies	0 (0%)	**3 (43%)**	**3 (43%)**	1 (14%)	0 (0%)

4.6.3.3. Organisational factors

4.6.3.3.1. Access to information

One cannot clearly say that the CPNs had access to information owing to split responses. There was no difference in the responses to 'having access to information on values and goals of top management'. The majority of respondents, 4 (57%) had 'enough' access to information on the current state of the organisation. See Table 4.66.

4.6.3.3.2. Access to opportunity

There was a split response on access to opportunity on 'challenging work', 3 (42%), and 'tasks that use own skills and knowledge', 2 (29%). Four respondents (57%) had little 'access to opportunity on gaining new skills and knowledge' compared to only 2 (29%) who had enough access. See Table 4.66.

4.6.3.3.3. Access to support

The majority of CPNs, 4 (57%), had 'some' access to support on 'specific information about things they did well', 6 (86%) respondents had access to comments on how they could improve, and a 4 (57%) indicated access to 'helpful hints on problem-solving advice'. See Table 4.66.

4.6.3.3.4. Access to resources

CPNs had mixed responses in terms of access to resources, because 3 (42%) had 'some' access to resources on time available to do necessary paperwork, and to accomplish job requirements, whereas 3 (42%) had little access to time available to get help when needed. There was an equal split response regarding having 'enough' and 'little' time on access to resources on time to do necessary paperwork. See Table 4.66.

Table 4.66: Organisational factors

	A little	Some	Enough	Total
Access to information	**Frequency**	**Frequency**	**Frequency**	**Frequency**
on values of top management	3 (43%)	1 (14%)	3 (43%)	7 (100%)
on goals of top management	2 (29%)	3 (42%)	2 (29%)	7 (100%)
on current state of the organisation	0 (0%)	3 (43%)	4 (57%)	7 (100%)
Opportunity on :	**Frequency**	**Frequency**	**Frequency**	**Frequency**
challenging work	3 (42%)	1(14%)	3 (42%)	7 (100%)
gaining new skills & knowledge	4 (57%)	1(14%)	2 (29%)	7 (100%)
tasks that use own skills & knowledge	2 (29%)	3 (43%)	2 (29%)	7 (100%)
Access to support on	**Frequency**	**Frequency**	**Frequency**	**Frequency**
specific information about things you do well	1 (14%)	4 (57%)	2 (29%)	7 (100%)
specific comments about things you could improve	0 (0%)	6 (86%)	1 (14%)	7 (100%)
helpful hints on problem-solving advice	1 (14%)	4 (57%)	2 (29%)	7 (100%)
Access to resources on time available to	**Frequency**	**Frequency**	**Frequency**	**Frequency**
do necessary paperwork	2 (29%)	3 (42%)	2 (29%)	7 (100%)
accomplish job requirements	2 (29%)	3 (42%)	2 (29%)	7 (100%)
get temporal help when needed	3 (42%)	2 (29%)	2 (29%)	7 (100%)

4.6.3.3.5. Job Activity Scale (JAS)

In this organisation, CPNs' responses showed a split for two variables, 2 (29 %) respondents received rewards for innovative jobs and amount of flexibility. There were 4 (57%) CPNs who had 'enough' visibility in their work compared to only 1 (14%) who had 'little' visibility. See Table 4.67.

Table 4. 67: Job Activity Scale (JAS)

Item	A little	Some	Enough	All
	Frequency	Frequency	Frequency	Frequency
Rewards for innovative job	2 (29%)	3 (42%)	2 (29%)	7 (100%)
Amount of flexibility	2 (29%)	2 (29%)	4 (42%)	7 (100%)
Amount of visibility in my work	1 (14%)	2 (29%)	**4 (57%)**	7 (100%)

4.6.4. ANALYSIS OF CNSM DATA

The CNSM agreed to be interviewed using a tape-recorder. Informed consent was obtained after she had read the information document.

4.6.4.1. Leadership factors

Leadership factors are discussed under leadership style and vision and mission of the institution

4.6.4.1.1. Leadership style

The CNSM believed in democratic and also situational leadership styles. She worked closely with her staff and allowed them to initiate activities within their departments.

> *I try by all means to use a leadership style that will bring productivity to the organisation. Most of the time I allow my nurses to verbalise their feelings. I listen to their problems and intervene to the best of my capability.*

However, the responses from professional nurses showed that the CNSM was visible, but not accessible to staff.

4.6.4.1.2. The vision and mission statement

The vision and mission statements of the organisation were well displayed at the management building, and all wards and departments had their own vision and mission statements displayed at the entrances. The organisation based its nursing care on the values of the organisation.

> *The vision was created in consultation with all members of staff, and we try by all means to adhere to the values of the organisation. The vision is incorporated in our nursing care.*

4.6.4.2. Organisational factors

4.6.4.2.1. ***Access to information***

There were regular meetings which are held for each category and there is also a joint meeting for all nurses. It is during these meetings that information is discussed.

> *The hospital is very small, and information is disseminated easily throughout the hospital within a short period.*

4.6.4.2.2. Access to opportunity

Opportunities were made available to staff to further their education, but were prioritised, based on areas and size of the institution. Priority is given to specialised areas like theatre and HIV units.

> *Most of the professional nurses indicate their educational needs and I prioritise in areas of need. You are aware that this is a small institution and sending nurses for extra courses needs to be considered carefully.*

4.6.4.2.3. Access to support

The CNSM was very involved in sending staff on extra courses and in-service education. The CNSM liaised directly with universities and colleges for any available courses which were relevant to her staff. She is a liaison person with the university.

People are supported whilst at school, and this programme continues even after graduation.

The hospital initiated a Health professional student's promotion project to assist students to study further. They were also supported when they had completed their training.

The hospital is very instrumental in supporting the local community to prosper in life. There is also a group called "Friends of Mosvold "which work collaboratively with the hospital community.

Professional nurses were sent for extra courses, but ended up not returning to the institution. The DOH policy works against the hospital because professional nurses are allowed to go and work in any hospital within the province on completion of their training, leading to rural hospitals running at a greater loss than before.

It's a pity that I cannot overrule this DOH policy about serving anywhere in the province after completion of training, because I sent nurses for further training, and on completion they can work in any provincial hospital of their choice.

Professional nurses were accommodated at the nurses' home and also in rented houses around the hospital, but the accommodation is inadequate to accommodate all staff because the hospital is an attraction for foreign visiting doctors.

There is a residence, but the first preference is given to doctors and other allied professionals, before nurses are accommodated. Available houses are reserved for international doctors.

The hospital wished to extend the residence, but the area belonged to the local chief. Even if the hospital wants to provide more accommodation; the onus lies with the local chief.

We will be meeting with the chief to discuss possible hospital expansion. The obstacle is that the hospital belongs to the KZN Health, and the land belongs to the chief. Everything must be approved by the chief.

Various forms of entertainment were available within the hospital and the surroundings in order to keep professional nurses within the hospital.

> *Our hospital admits international medical students and foreign doctors. Available entertainment is for everybody working in our organisations. Professional nurses are also allowed to utilise the available services .There is a lake, a fishing spot, a game reserve and a scuba diving spot.*

The hospital was built on strong evangelical Christian principles and there is a church within the hospital. Emotional support is provided by management to all members of staff.

> *There are bible study groups and also counselling groups which cater for the sick and depressed. Professional nurses are referred to the support services within the area.*

4.6.4.2.4. Access to resources

Resources can take the form of human resources and equipment. The shortage of staff is a problem in all public institutions, but the trend in this organisation is different because the majority of professional nurses are local people who are not willing to leave their residences. Newly qualified professional nurses join the organisation and leave shortly after they have been sent for educational courses.

> *On completion of training, professional nurses leave our organisation or do not come back at all. It is only the local nurses who return to the institution because they have families in the area.*

The hospital followed the DOH policy on good procurement. There were always delays in the delivery of goods, although the infrastructure had improved. The professional nurses usually improvised on the equipment. Patient care was compromised because the supply of goods was delayed and also not up to standard.

> *Things are much better now than before. There is a slight improvement in the delivery of goods although we are not there yet.*

The new BEE policy brought good and bad to the country. Disadvantaged communities now have access to government finance. Owing to inefficiency, and lack of experience of the new companies, goods procured are usually of poor quality.

> *The government did a good thing in promoting new BEE companies, but their products are not up to standard. Sometimes they do not deliver goods as requested. There are lots of delays.*

4.6.4.3. Individual factors

4.6.4.3.1. Sense of commitment

The hospital has a quarterly newsletter which promotes individual and collective achievement. Professional nurses who excel in their activities are named on the notice board and are also featured in the newsletter.

> *Our newsletter features all health care workers who excel in their wards and units. They are given incentives like certificates and trophies.*

The hospital was initially a missionary property, but later on it was taken over by the provincial Department of Health. The land on which it was built was donated by the local chief. The surrounding people have ownership of the land. The majority of the health workers are from the local area. They are very proud of the hospital and they treat it as if it belongs to them.

> *Any plans to expand the hospital are discussed with the local chief and the hospital board which is made up of some professional nurses within the institution.*

4.6.4.3.2. Autonomy

Professional nurses did not have autonomy in their daily practice because they were unable to initiate activities within their scope of practice.

> *During my tenure, I have noted that PNs do not fully engage themselves in initiating productive activities in their departments. They also wait for my input or for a domain manager to act.*

The statement is further supported by the PN's responses because 16 (67%) respondents agreed that they needed more autonomy, compared to 5 (21%) respondents who disagreed. Only 3 (12%) respondents were not sure whether they needed autonomy or not.

4.6.4.3.3. Growth

There were conflicting statements from the CNSM and from the PNs. PNs verbalised that they did not have adequate opportunities to attend conferences and other in-service education programmes, whereas the CNSM said that she allowed PNs to attend various courses.

I allow all categories of nurses to attend several educational courses.

4.7 UNION MANAGERS

Union managers were included in the study as part of the alliances which are the source of informal power to the professional nurses whereas the organisation brings the formal power. Professional nurses belong to many unions, but the study will only focus on the unions that agreed to be interviewed. The term '**other**' will refer to the unions that are not part of those mentioned. Four union managers who were interviewed belonged to the following unions, Democratic Nursing Organisation of South Africa (DENOSA), Health & other service personnel trade union of South Africa (HOSPERSA), South African Democratic Nurses (SADNU) and National and Health Allied Workers Union (NEHAWU). Interviews were held in their offices and it took at least 90 minutes for each manager. See Table 4.68.

Table 4.68: Comparative table of PNs' & CPNs' affiliation to unions

UNION	Professional nurses	Chief Professional Nurses
	Frequency	Frequency
DENOSA	67 (55%)	21 (49%)
HOSPERSA	15 (12%)	6 (14%)
NEHAWU	18 (15%)	4 (9%)
SADNU	2 (2%)	0 (0)
Others	17 (14%)	12 (28%)
None	2 (2%)	0 (0)
Total	**121 (100%)**	**43 (100%)**

DENOSA has more members, both CPNs and PNs than any other union in the sample. DENOSA is more popular among nurses in the country, because it is the only union which caters solely for nurses. Other unions mix their categories. It was significant that the chief professional nurses did not join SADNU, and also that all CPNs joined a union. Only 2 (2%) professional nurses had not joined any union.

This information is based on the responses by the union managers who were interviewed about their role among nurses who are working in public hospitals in four hospitals in KwaZulu-Natal province. The union managers also reported on their engagement with the nurses. The themes which emanated from the interview also spell out what was stated by professional nurses when union meetings were held in each institution. The union managers' excerpts are written verbatim, no editing was effected in regard to their responses, except that of a consistent grammatical nature. The analysis is guided by the conceptual framework of the study. The themes which emanated from the analysis of the interviews were similar from all four union managers. There were no major differences in their analysis.

The analysed information will be presented according to organisational factors which are as follows:

- Access to information
- Access to opportunities
- Access to support
- Access to resources
- Recognition of achievement

4.7.1. Organisational factors

4.7.1.1. Access to information

Unions are very vocal in terms of updating their members. These updates are done during regular meetings which are held during tea-times and lunch-breaks. The high number of litigations among nurses in the country has made unions aware of their responsibilities.

> *Information is shared through meetings that are held by members within an organisation. Feedback is given by shop stewards during lunch breaks or after hours of work. Meetings are held weekly during lunch breaks in organisations and also monthly in the regions. As a regional manager I visit any organisation whenever the need arises.*

The unions have embarked on a strategy to disseminate information through journals and magazines. DENOSA and HOSPERSA have journals which are available to members, although the majority of members are from the higher education institutions for DENOSA and a few clinical nurses for HOSPERSA.

> *The journal membership has increased in the past five years although we still need to recruit. A nursing update magazine is available for free to all paid-up members. The magazine has recent updated information which is of relevance to the nursing profession in the country.*

Unions encourage nurses to read more about health-related issues. Books are sold at a discount for union members.

New and edited books are advertised on the Nursing Update magazine. Members are given a 10% discount when buying books.

4.7.1.2. Access to opportunity

DENOSA and HOSPERSA gave nurses an opportunity to attend conferences locally and internationally, on condition that the nurses present an oral paper or a poster.

As DENOSA we have identified that nurses are not keen to lead in research, that's why we are sponsoring them to go to conferences and share information with other nurses and other health workers.

Available programs are taken over by management who is not involved in the implementation of decisions taken.

New programs are taken over by people at management level who are not going to utilise the knowledge gained. There seems to be the same pool of senior managers who always go to conferences and seminars. No feedback is given to the implementers. There is also no policy which guides the feedback mechanism.

However, opportunities for development which are supposed to be given to professional nurses are taken over by the nurse managers, as stated below,

The ordinary professional nurse is not given an opportunity to develop herself. The unit managers and regional managers are the ones who attend all the conferences and workshops on issues that are relevant to the professional nurse. It's so surprising that even when new equipment is available; the unit manager will first discuss it with doctors before the users are involved.

Unions recognise and motivate those professional nurses who are interested in disseminating new knowledge through research. Each year, three awards are presented to promote research in the field of nursing at undergraduate and postgraduate levels. These awards are offered for the best research projects.

As much as nurses are still novices in research, support and motivation is done through annual awards for the best research project.

4.7.1.3. Access to support

Support from the unions was provided through the structures and policies that were placed within the union and included empowering nurses to deal with newly developed policies. The union managers and shop stewards were responsible for translation of these policies to the nurses.

Support of nurses is done by shop stewards and the branch coordinator. All union policies from national level are cascaded down to the provincial level then local branches of unions.

The unions also offered support during salary negotiations. All unions were fully responsible for salary negotiations for their employees, as much as DENOSA was very instrumental in steering the negotiations between the government and other unions.

The outcome of the negotiations yielded positive results because the nurses had their salary scales upgraded. Although the negotiations took more time than expected at the end, the outcome was positive.

The cost of living has escalated, and professional nurses are also affected like any ordinary person who is living in the country. The unions offered support to professional nurses on how to reduce debt and live within their means as indicated below.

Hospersa has a division called Umcebo financial services which is responsible for debt counselling. This service is available to all Hospersa members.

Nehawu and Denosa provide financial services to improve their economic and social wellbeing by having a group insurance scheme at very affordable rates.

Another form of support was afforded during SANC hearings. During these hearings the unions represent the professional nurses till the end of the case.

> *Professional nurses are represented by their union during SANC hearings or any court cases. As a provincial manager I am fully responsible for representing our members during hearings.*

It emanated from the interviews that the CPN and CNSM are not very knowledgeable about labour law. The unions support professional nurses by giving courses in the translation of labour law. These courses are offered free of charge.

> *During the meetings, labour relation acts are discussed and shared among members.*

Nurse Managers are updated on the latest labour relations legislation, by attending courses initiated by union managers.

> *I have initiated a course on management, because many nurse managers are not competent in dealing with management issues. The only drawback is that you need to be a member of our organisation in order to benefit from this course.*

Nurses were given full support during strikes because there is always a fear of losing one's job.

> *During the strike, nurses were reassured of their jobs and they were reminded about their commitment to service. Regular updates about the progress of the strike were given to the professional nurses. Extra precautions were taken so that they did not expose themselves to dangerous situations. In as much as they are public servants, their safety was also a priority.*

HOSPERSA believed that all categories must be represented by their own staff members, who are shop stewards. The nurses were represented by a nurse, unlike some of the unions where a non-nursing staff member represents the nurse.

There are shop stewards in all departments and professional nurses do not even need to leave the premises to have their problems solved.

Another form of support was through recognising hard-working nurses in all provinces.

The professional nurses are recognised for their exceptional commitment to their work. The provincial and national awards are held yearly for these nurses. They are really applauded for their hard work.

There are incentives for being a paid-up member of the union.

We have negotiated with certain companies like car dealers and bookshops to give 10% discounts for paid-up members of the union. At least a person knows that belonging to a union has its benefits.

4.7.1.4. Access to resources

It is a known fact that nurses are leaving the country in great numbers due to poor working conditions and salaries. Payment of decent salaries and the provision of good working conditions is the responsibility of the Department of Health (DOH). While the unions do not pay the nurses' salaries, they are involved in negotiating their salaries.

One thing that will definitely keep nurses in the country is to offer them competitive salaries. Negotiations on behalf of all nurses working in public health care organisations with the dept of public services seem to be moving in a positive direction.

The union managers concluded that there were gaps in the nursing managers' leadership. This will be covered under the following: Dealing with grievances, handling of absentees in the workplace, knowledge of labour relations act and decision-making.

From the union managers' interviews, it emanated that nurse managers lack knowledge about the Labour Relations Act. There were minor issues that should have been dealt with at unit level but which were passed on to the unions. Also,

grievances were not handled well. Managers did not handle grievances very well. This showed that they lacked labour relations knowledge.

> *The gap in knowledge prompted me to design a management course that will benefit both nurses and union managers in dealing with labour issues in the workplace. I have also formed a Management Labour Forum that will have both nurse managers and union managers under one roof.*

The union managers felt that the nurse managers did not do justice to the professional nurses they represented. Their grievances were not carried forward to top management.

> *Minutes taken at the domain level are not forwarded to top management as they should be. This led to the nurses being unhappy about decisions that were taken.*

The professional nurses have vast knowledge in their departments but they still serve under doctors. Professional nurses are not acknowledged for the good work done, especially by doctors.

> *Doctors are still reluctant to serve under nurses. They do not see nurses as equals, but only as subordinates.*

Nurse Managers are responsible for decision-making which impacts on the lower level categories. The professional nurses are not invited to air their views. The management approach is totally top-down. When mistakes happen at operational level, there is a lot of blaming.

> *There is poor implementation of decisions taken, which impacts negatively on service delivery. There is a lot of talking at the decision-making level and people at the operating level are seen to be at fault.*

4.8. FOCUS GROUP FROM THE SOUTH AFRICAN NURSES WHO ARE WORKING OVERSEAS

The focus group interviews were held with professional nurses who had overseas experience in November 2006, December 2006 and July 2007. The aim was to identify different retention strategies which are utilised by these countries. Professional nurses were invited to participate in the study so as to share their experience of nursing in a foreign country. Information documents were given to the professional nurses before obtaining their consent. Participation was voluntary, because the nurses were informed that they were free to withdraw at any time. Snowballing sampling was followed to inform the researcher of other professional nurses who were on leave.

Data was collected in three settings. The first group was interviewed while the researcher was attending training in November 2006 in Australia. The second and third groups were interviewed in November and December 2006, while they were on holiday in South Africa. The fourth group was interviewed while the researcher attended a conference in July 2007 in London. All the respondents were South African nurses who worked in developed countries.

Four groups of professional nurses participated in the focus groups. The first and second groups were working in one country and the third and fourth groups consisted of nurses working in different countries. The first group worked in Australia, the second group was from Ireland and Saudi Arabia. The third group included professional nurses from Oman and the United Kingdom (UK). The fourth group was from Ireland and the UK. Twelve professional nurses participated in the focus group. Each group ranged between 2 and 6 professional nurses. Pseudonyms were used to conceal the identity of the respondents and also to ensure the principle of confidentiality.

Findings were organised into themes which were informed by the conceptual framework and objective number three, which was to examine the retention strategies among professional nurses.

Most of the respondents were between the ages of 36 to 54 years of age. The youngest respondent was 36 years old and the oldest was 54 years old. The average

age of all the respondents was 46 years. All the respondents worked in various areas of speciality like Intensive Care Units (ICU), Cardiac Care Unit (CCU), Operating Theatre (OT), Renal Unit, Emergency Unit, and Trauma and Psychiatry Units.

All professional nurses had diplomas in nursing, and two had a Bachelor's degree in nursing. They specialised in nursing education and community health nursing science. All respondents had a post-basic qualification of midwifery, and community nursing science. Four respondents were ICU trained, three were trained in OT and one respondent had a diploma in trauma and emergency care. One respondent was a specialist in CCU and one had done a renal course. One PN was an advanced midwife, and another was an advanced psychiatric nurse. All these PNs were specialists in their fields. All these post-basic courses took one year to complete and were undertaken in South Africa before the nurses moved to developed countries.

As registered nurses, their combined years of experience were two-hundred-and-twenty-three years. This is a wealth of experience that South Africa is losing to developed countries. The youngest nurse had 13 years experience, and the oldest nurse had 32 years experience as a professional nurse. It is evident that the country is losing highly experienced and well-qualified individuals.

The majority of respondents earned between twenty-eight thousand rand (R28000.00) and forty-five thousand rand (R45000.00) per month. Most of them reported that they had trebled and quadrupled their salaries by comparison with what they had earned at home.

All of the respondents had been working in public hospitals before they left the country except one RN who had been working in a private hospital. This evidence shows that the public hospitals are the most affected organisations when it comes to staff turnover.

4.8.1. Access to information

Access to information is facilitated by adhering to a decentralised structure. In developed countries, information is cascaded from top management to lower levels at a faster rate than at home. Meetings are held at regular intervals and decisions are

implemented as taken. There is a faster turnover on implementation. Access to computers for all staff members facilitates communication within the organisation.

> *The decentralised structure of management ensures that there is less distancing of control, and information is easily transmitted from top management to the lower levels. Availability of emails has made life easy, because minutes of the meetings are forwarded to us all within two days. One is always kept abreast of the latest information within the institution* ***(Roberta).***

> *One of the strengths of the institution I am working for is its decentralised approach. All the directorates have a team manager who ensures that everybody is well informed about the information in the unit. Everybody is included in the ward development. Giving updated information is the responsibility of all domain managers in the directorate* ***(Pat).***

> *Meetings are held twice so as to accommodate all staff members. Day and night staff members are treated equally; unlike at home where the night staff was like a non-existing part. Educational talks are also held at night. The night matron updates the night staff about what has happened during the day* ***(Jane).***

The organisation uses different media to communicate with staff members, which can be positive or negative depending on the literacy levels of staff. Means are made to empower staff.

> *The communication book is utilised to keep staff members informed about the latest developments in the department. Time is allocated for updating staff who did not attend meetings. Because there are fewer patients in the unit, one has ample time to read the latest notices and policies* ***(Mandy).***

> *The information was sent via emails, and if one was not computer literate, he or she did not have access to that information. There was definitely no babysitting of individuals in the unit* ***(Cindy).***

4.8.2. Access to opportunity

It was obvious that the majority of respondents had many opportunities to develop in terms of personal and professional growth. They were given opportunities to attend workshops and conferences.

> *Since I joined the hospital I have been invited to attend many educational seminars and international conferences, an opportunity I never had at home. The Chief Nursing Service Manager allowed all staff to be given an opportunity to develop* ***(Mary).***

It was also easy to progress from one level to another without working in the institution for time. Promotion followed set criteria which were fair and unbiased.

> *During my second year I was promoted to the position of a unit manager. During weekends I am in charge of the entire hospital and this has really boosted my ego. I am really proud because I had the chance to utilise my skills and expertise in a foreign country. In South Africa, I was not given the opportunity to be in charge of the hospital* ***(Jane).***

> *During my third month, the regional manager was impressed by my skills and she promoted me to be the shift leader in the Intensive Care Unit. Even my salary scale was upgraded* ***(Kim).***

The input of staff members was highly appreciated, because during ward rounds the doctors expected nurses' input. Professional nurses felt that they were acknowledged which made them feel honoured and proud to be nurses. See responses below:

> *I am a night superintendent of an 80 bed psychiatric institution. I am also a member of the team which makes decisions about patient care. My input is highly appreciated and that makes me grow every day. I am always looking forward to the progress of my patients. My colleagues also want to hear about our programs at home and try to find similarities or differences in managing psychiatric patients* ***(Pat).***

> *I am not sure whether at home I would be given such a high position as I am enjoying here. I am the Director of the Magnet Institute. I coordinate all the*

activities and the processes of the Magnet journey. It's a steep journey but I am glad I am part of it ***(Kate).***

As much as most professional nurses were given an opportunity to develop, there are some who did not feel accepted, which prompted them to come back home, as indicated below:

Unfortunately, it was very difficult for me to grow in this strange environment that's why I decided to come back to this country for good. Life was not conducive for me. I was left to fend for myself and no one was willing to help me grow ***(Cindy).***

4.8.3. Access to support

Nurses are treated holistically, and even when there are emergencies at home, nurses are released immediately. The Chief Nursing Service Managers do not wait for a replacement. The whole management team is supportive of their staff. They follow the vision and the mission of their organisations.

One thing I have realised is that the hospital caters for the staff holistically. When I lost my brother, the managers allowed me to go home immediately, and even assisted with the flight booking. In December 2006, I was emotionally and physically traumatised because my husband was shot eight times and I was also shot thrice by robbers. The management gave me extended leave. I could not believe my manager when she informed me telephonically that I would be paid for my sick leave. I am grateful for what they did for me ***(Kim).***

The senior management always wants to ensure that you are performing to the best of your ability. I see providing all the necessary resources as the best way of supporting staff ***(Pat).***

The vision of the institution is shared by all staff. The senior management supports all staff because they believe that the success of the organisation lies with all, not just some individuals ***(Kate).***

A different view was stated by one professional nurse where they only allowed professional relationships. After hours, an individual is on her/his own, but the superior gives support in need.

> *We are from different countries in my unit and there seems to be a strictly bureaucratic way of managing the unit. There is no personal involvement. One just works and goes home afterwards. There is little interaction between staff members* ***(Jane)***.

One professional nurse stayed for a short period because she felt that she was not supported enough. On probing during the focus group, it became clear that she was not prepared psychologically to leave South Africa.

> *I was left on my own to perform according to their high standards and did not feel supported, that's why I came back after six months* ***(Cindy).***

4.8.4. Access to resources

Developed countries have the latest technology which encourages nurses to work and stay in their jobs. On arrival, all nurses are given an induction course for two weeks, and computer literacy is integrated during this induction period. The availability of the latest equipment facilitated the delivery of health care. Equipment is updated regularly, and professional nurses' working progress is not limited. Patient care information is loaded on computers and only the multidisciplinary team has access to it.

> *The equipment is available and in good order. The latest equipment is ordered because money is not a problem. Whatever is requested in the unit will be made available as long as it will improve patient care delivery. All faulty equipment is replaced as soon as possible. I remember the days when I was still a nurse at home, we had a faulty BP machine for eight months and that was a shame* ***(Roberta)***.

> *The country is very rich, and health care is their number one priority. All the units have the latest technological instruments. One is always at peace because all that is needed in the unit is available. Money is not a problem; we are even reminded to utilise our budgets to the fullest* ***(Kim)***.

Resources are abundant; you perform procedures as written in the book. There is no compromising in-patient care. Less harm is inflicted on the patient because as nurses, we nurse few patients with adequate resources ***(Mandy)***.

The information was of high technology, and one was expected to go the extra mile in updating information with the utilisation of equipment. The institution sets high standards and also provided the latest gadgets, as staff we were expected to know it all. On arrival, I went for computer literacy classes since I did not know how to work with computers ***(Cindy).***

Professional nurses are also involved in managing their budgets which improves their financial management skills. The organisation follows a decentralised structure where decisions are made locally, and all nurses at operational levels have input.

Resources are not a problem at all. There is budget allocated for the equipment. One is even punished for under-utilising the budget. All units are fully equipped with the latest technology ***(Pat)***.

I was given a very healthy budget to work on all the needs of the project. Any failure of the project would definitely be my fault because I would have all the necessary resources. I was also given the opportunity to meet with the organisers of the Magnet Model. To date, I have attended three overseas conferences and will also visit a partner hospital for two weeks ***(Kate).***

Recommendations from professional nurses with overseas experience

The professional nurses were asked to recommend strategies that they would give to their peers at home about working in a developed country. Suggestions were also sought about the changes they expected to see when they returned to South Africa.

Would you recommend that your friend come and work in a developed country?

Everybody felt that each individual had choices and they would not interfere with their friends' decisions, but that there were common concerns that needed to be imparted before a nurse left her country of origin.

- To be conversant with the culture of the new country
- To study the health system of the country before arrival
- To identify their own goals
- To have financial knowledge
- To understand the legal system of the developed country
- To be familiar with international policies of migration

What would you change if you came back to South Africa?

- Improve nurses' salaries
- Promote staff fairly
- Give equal opportunities to all my staff
- Ensure that good working equipment is available
- Send nurses on developmental courses
- Provide a safe environment
- Offer incentives for good work
- Incorporate computer literacy in the nursing curriculum
- Introduce computer literacy among nurses
- Orientate staff fully on employment
- Allocate a mentor for newly qualified nurses and also for the newly employed and
- Introduce student nurse exchange programs abroad.

4.9. CROSS-CASE ANALYSIS OF ALL CASES

This section of the study presents cross-case analyses of all four cases for PNs, CPNs and CNSMs. Demographic details will be described in detail, and all the major variables will also be discussed. Analysis will be guided by the cross-case analysis which enhances the possibility of generalisability. The researcher would like to find relevance or applicability of the findings to other similar settings. The other reason for cross-case analysis is to deepen understanding and explanation (Miles and Huberman, 1994). A replication strategy which is supported by a conceptual framework which guides case analysis will be followed (Yin, 1984). Cases will be presented in matrices so as to explore similarities and differences in all cases. The total number of professional nurses was 122, CPNs (45) and CNSMs (4). Scoring of the instruments that were utilised to collect data adhered to detailed information from Laschinger (2001). This section will follow the format hereunder:

Demographic details of PNs & CPNs

Leadership

- Visibility of CNSM, accessibility of CNSM, equal power to senior management and equal authority to senior management.

Organisational factors

- Access to opportunity, access to information, access to support and access to resources

Individual factors

- Autonomy, sense of commitment and growth which are represented by the following:

I have career development opportunities, access to regional and national conferences, access to active in-service programs for nurses, access to continuing education programs for nurses, opportunities for advancement, and I am satisfied with opportunities for professional development.

Retention

- Would you recommend this hospital to your friend as a place of employment? Where do you see yourself in one, three and five years? Would you consider taking another job, and are you satisfied with your salary?

Relationship among the variables

- Organisational factors vs. retention, leadership factors vs. retention, retention factors and comparison among scores of PNs and CPNs.

4.9.1. Demographic details

This section consists of demographic details of all nurses who participated in the study, years of nursing experience, age, gender qualifications and the units where they were allocated at the time of the study.

4.9.1.1 Demographic details of PNs

A total number of 122 professional nurses from four public hospitals participated in the study. Case D had the smallest numbers because the hospital is very small and has a total of 65 PNs. Case A had the largest number of professional nurses because the hospital is the biggest in the province. See Table 4.69.

Table 4.69: Total number of PNs in each case

CASE	Frequency	Percent
A	35	29%
B	30	25%
C	33	26%
D	24	20%
Total	**122**	**100%**

Female respondents 110 (90%) were the majority, compared to 12 (10%) male respondents, although it was noted that the hospitals in rural areas had an unusually high number of males in their organisation. Respondents between the ages of 31 and 40 years were in the majority in three institutions. Only one institution had a majority of respondents between the ages of 41 and 50 years. All three institutions

had respondents who had more than 15 years nursing experience. Not a single respondent from all four organisations had a Master's degree; Case A had a higher number, 9 (26%) graduates compared to Case D which had only 1 (4%) respondent with a Bachelor's degree.

The distribution of professional nurses in the allocated units was influenced by the services provided by their organisation. Case D did not have respondents who were working in an ICU because the organisation did not have an ICU, whereas Case A had 13 (38%) respondents who were working in an ICU at the time of data collection. Case D had 6 (25%) respondents working in an OPD, because the organisation is linked to eight clinics which are serviced by this organisation. Refer to Table 4.70.

4.9.1.2. Demographic details of CPNs (N=45)

In all four institutions the males were outnumbered by the females. Of 45 respondents, 39 (87%) were female and 6 (13%) were male. There were fewer respondents in two cases, and the other two cases did not have respondents between the ages of 21 and 30 years of age. The majority of respondents, 23 (53%) were between the ages of 41 and 50 years of age. All four Cases recorded more respondents between the ages of 41 and 50. Only 2 (4%) had nursing experience between 1 and 5 years, and the majority, 31(69 %) had more than 15 years nursing experience. Four (33%) respondents from Case A and B had management experience of more than 10 years compared to Cases C and D who recorded 25% of respondents with management experience between 1 and 3 years. Cases A & B correspond with the ages of respondents, and also with the years of nursing experience. Only 2 (4%) respondents from Cases A and B each had a Master's degree. Cases C and D did not attract any Master's graduates, probably because these hospitals are situated in deep rural areas. Case C did not have any Bachelor's degree respondents. Professional nurses from four Cases were evenly distributed in all units except Case A, which had 5 (31%) respondents in the ICU and 4 (25%) in theatre. Refer to Table 4.71.

Table 4.70: Demographic data of PNs (N= 122)

	Case A (n=35)	Case B (n=30)	Case C (n=33)	Case D (n=24)	All (N=122)
Gender					
	Frequency	**Frequency**	**Frequency**	**Frequency**	**Frequency**
Female	33 (95%)	30 (100%)	27 (82%)	19 (79%)	109 (90%)
Male	1 (5%)	0 (0%)	6 (18%)	5 (21%)	12 (10%)
Total	34 (100%)	30 (100%)	33 (100%)	24 (100%)	121 (100%)
Age					
21-30 yrs	5 (15%)	3 (10%)	5 (15%)	4 (16%)	17 (14%)
31-40 yrs	13 (38%)	11 (37%)	6 (18%)	14 (58%)	44 (36%)
41-50 yrs	9 (26%)	11 (37%)	12 (36%)	3 (13%)	35 (29%)
Above 50	7 (21%)	5 (16%)	10 (31%)	3 (13%)	25 (21%)
Total	34 (100%)	30 (100%)	33 (100%)	24 (100%)	121 (100%)
Years of nursing experience					
1-5 yrs	6 (17%)	5 (17%)	7 (22%)	9 (38%)	27 (22%)
6-10 yrs	8 (23%)	9 (30%)	3 (9%)	7 (29%)	27 (22%)
11-15 yrs	6 (17%)	6 (20%)	6 (19%)	3 (12%)	21 (18%)
Above 15	15 (43%)	10 (33%)	16 (50%)	5 (21%)	46 (38%)
Total	35 (100%)	30 (100%)	32 (100%)	24 (100%)	121 (100%)
Educational qualification					
Master's Degree	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Bachelor's degree	9 (26%)	5 (17%)	2 (6%)	1 (4%)	17 (14%)
Diploma	26 (74%)	24 (83%)	29 (94%)	23 (96%)	102 (86%)
Total	35 (100%)	29 (100%)	31 (100%)	24 (100%)	119 (100%)
Unit representation/ distribution					
ICU	13 (38%)	6 (20%)	4 (12%)	0 (0%)	23 (19%)
OT	6 (17%)	4 (12%)	7 (21%)	2 (8%)	19 (16%)
Surgical	2 (6%)	5 (17%)	7 (21%)	4 (17%)	18 (15%)
Medical	4 (11%)	5 (17%)	4 (12%)	8 (33%)	21 (17%)
OPD	4 (11%)	5 (17%)	3 (10%)	6 (25%)	18 (15%)
Maternity	6 (17%)	5 (17%)	8 (24%)	4 (17%)	23 (19%)
Total	35 (100%)	30 (100%)	33 (100%)	24 (100%)	122 (100%)

Table 4.71: Demographics of CPNs (N= 45)

	Case A (n=16)	Case B (n=13)	Case C (n=9)	Case D (n=7)	All
Gender					
	Frequency	**Frequency**	**Frequency**	**Frequency**	**Frequency**
Female	14 (87%)	12 (92%)	8 (89%)	5 (71%)	39 (87%)
Male	2 (13%)	1 (8%)	1 (11%)	2 (29%)	6 (13%)
Total	**16 (100%)**	**13 (100%)**	**9 (100%)**	**7 (100%)**	**45 (100%)**
Age of respondents					
21-30 yrs	1 (7%)	0 (0)	1 (13%)	0 (0)	2 (5%)
31-40 yrs	2 (13%)	6 (46%)	0 (0)	1 (14%)	9 (21%)
41-50 yrs	9 (60%)	5 (39%)	4 (50%)	5 (72%)	23 (53%)
Above 50 yrs	3 (20%)	2 (15%)	3 (37%)	1 (14%)	9 (21%)
Total	**15 (100%)**	**13 (100%)**	**8 (100%)**	**7 (100%)**	**43 (100%)**
Years of nursing experience					
1-5 yrs	1 (6%)	0 (0)	1 (11%)	0 (0)	2 (4%)
6-10 yrs	1 (6%)	0 (0)	1 (11%)	1 (14%)	3 (7%)
11-15 yrs	2 (13%)	3 (23%)	2 (22%)	2 (29%)	9 (20%)
Above 15	12 (75%)	10 (77%)	5 (56%)	4 (57%)	31 (69%)
Total	**16 (100%)**	**13 (100%)**	**9 (100%)**	**7 (100%)**	**45 (100%)**
Years of management experience					
1-3 yrs	2 (15%)	3 (25%)	5 (64%)	3 (50%)	13 (33%)
4-6 yrs	4 (31%)	3 (25%)	1 (12%)	2 (33%)	10 (26%)
7-10 yrs	3 (23%)	2 (17%)	1 (12%)	1 (17%)	7 (18%)
Above 10	4 (31%)	4 (33%)	1 (12%)	0 (0)	9 (23%)
Total	**13 (100%)**	**12 (100%)**	**8 (100%)**	**6 (100%)**	**39 (100%)**
Educational qualification					
Master's	1 (6%)	1 (8%)	0 (0)	0 (0)	2 (4%)
Bachelors	8 (50%)	2 (15%)	0 (0)	1 (14%)	11 (25%)
Diploma	7 (44%)	10 (77%)	9 (100%)	6 (86%)	32 (71%)
Total	**16 (100%)**	**13 (100%)**	**9 (100%)**	**7 (100%)**	**45 (100%)**
Unit representation/ distribution					
ICU	5 (31%)	1 (9%)	1 (11%)	0 (0)	7 (16%)
OT	4 (25%)	2 (18%)	2 (22%)	1 (14%)	9 (21%)
Surgical	2 (13%)	3 (28%)	1 (11%)	1 (14%)	7 (16%)
Medical	1 (5%)	1 (9%)	2 (22%)	2 (29%)	6 (15%)
OPD	2 (13%)	2 (18%)	1 (11%)	2 (29%)	7 (16%)
Maternity	2 (13%)	2 (18%)	2 (22%)	1 (14%)	7 (16%)
	16 (100%)	**11 (100%)**	**9 (100%)**	**7 (100%)**	**43 (100%)**

4.9.1.3. Union affiliation of PNs

DENOSA is the most popular union in all four cases, with an overall affiliation of 72 (59%) respondents. NEHAWU had 18 (15%) respondents compared to SADNU which only had 3 (2%) respondents and was found in Case A only. See Table 4.72.

Table 4.72: Union affiliation of PNs (N=122)

	Case A (n=35)	**Case B** (n=30)	**Case C** (n=33)	**Case D** (n=24)	**Total** (N=122)
Union	**Frequency**	**Frequency**	**Frequency**	**Frequency**	**Frequency**
DENOSA	23 (66%)	18 (60%)	14 (42%)	17 (71%)	72 (59%)
HOSPERSA	3 (9%)	3 (10%)	5 (15%)	4 (7%)	15 (12%)
NEHAWU	3 (9%)	5 (17%)	8 (25%)	2 (8%)	18 (15%)
SADNU	3 (9%)	0 (0)	0 (0)	0 (0)	3 (2%)
DENOSA & HOSPERSA	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)
DENOSA & NEHAWU	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)
Other	2 (5%)	4 (13%)	5 (15%)	1 (4%)	12 (10%)
None	1 (2%)	0 (0)	1 (3%)	0 (0)	2 (2%)
TOTAL	**35 (100%)**	**30 (100%)**	**33 (100%)**	**24 (100%)**	**122 (100%)**

4.9.1.4. Union affiliation of CPNs

It was noted that all CPNs belonged to a union, although no member in all four Cases was affiliated to SADNU, and 5 (11%) CPN had dual membership. DENOSA is the most popular union in all four Cases, with 23 (51%) members compared to 4 (9%) who belonged to Nehawu. See Table 4.73.

Table 4. 73: Union affiliation by CPNs (n = 45)

	Case A(n=16)	Case B(n=13)	Case C(n=9)	Case D (n=7)	Total(N=45)
Union	**Frequency**	**Frequency**	**Frequency**	**Frequency**	**Frequency**
DENOSA	11(69%)	6 (46%)	3 (34%)	3 (43%)	23 (51%)
HOSPERSA	2 (12%)	3 (23%)	0 (0)	1 (14%)	6 (13%)
NEHAWU	0 (0)	1 (8%)	1 (11%)	2 (29%)	4 (9%)
SADNU	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)
DENOSA & HOSPERSA	0 (0)	1 (8%)	1 (11%)	0 (0)	2 (4%)
DENOSA & NEHAWU	0 (0)	1 (8%)	2 (22%)	0 (0)	3 (7%)
Other	3 (19%)	1 (8%)	2 (22%)	1 (14%)	7 (16%)
None	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)
TOTAL	**16 (100%)**	**13 (100%)**	**9 (100%)**	**7 (100%)**	**45 (100%)**

4.9.2. Leadership

Leadership was analysed according to the variables which measured leadership as alluded to at the beginning of the section. Leadership variables were computed and analysed on SPSS. The neutral variables were not included in the table. It was noted that leadership was stronger in Case A and B as both CNSMs in Cases A and B were more visible and accessible to staff. Case A PNs felt that their CNSM was more accessible and that they could get to her office with ease. Case B's CNSM had equal power to all the other senior managers in the organisation. Case A respondents verbalised that their CNSM had equal authority to the senior management team. All cases found their CNSMs to be good leaders, but Cases B and C had clear majorities as indicated in Table 4.74.

Table 4. 74: Leadership variables per case

	CASE A		CASE B		CASE C		CASE D	
	Agree	**Disagree**	**Agree**	**Disagree**	**Agree**	**Disagree**	**Agree**	**Disagree**
Visibility	**48%**	21%	**50%**	27%	42%	30%	46%	46%
Accessibility	**62%**	14%	50%	23%	46%	36%	55%	17%
Power	**50%**	23%	**50%**	7%	44%	34%	41%	23%
Authority	**46%**	15%	**47%**	17%	46%	27%	38%	29%
Good leader	69%	23%	**77%**	17%	**88%**	3%	50%	33%

4.9.2.1. Years of nursing experience vs. leadership variable

According to Table 4.75 below, respondents with more years of experience viewed unit managers as good leaders compared to respondents with 10 years of experience or less. They both scored 22.5%. Overall scores showed that respondents agreed that their unit managers were good leaders.

Table 4.75: Years of nursing experience vs. leadership

Years of experience	**Unit manager is a good leader**			**Total**
	Disagree	**Neither**	**Agree**	
1-5 yrs	9 (33%)	4 (15%)	14 (52%)	27 (100%)
6-10 yrs	5 (18.5%)	5 (18.5%)	17 (63%)	27 (100%)
11-15 yrs	4 (19%)	2 (10%)	15 (71%)	21 (100%)
Above 15 yrs	7 (16%)	10 (22%)	28 (62%)	**45 (100%)**
Total	25 (21%)	21 (17.5%)	**74 (61.5%)**	120 (100%)

4.9.2.2. Leadership responses by PNs

The majority of PNs, 68 (56%), did not have an opportunity to participate in the hospital decision-making process. A high number, 82 (67%), indicated that they needed more autonomy in their daily practice. The majority, 111 (91%), however, understood the vision of their hospital. Case D scored higher than all other centres in disagreeing that they did not have the opportunity to participate in decision-making and needed more autonomy in their work. Cases A and C had more respondents who needed more autonomy in their daily practice. Case B agreed unanimously that they understood the vision of the hospital. Refer to Table 4.76.

Table 4.76: Leadership responses by all PNs (N=122)

Item		Case A	Case B	Case C	Case D	All
Opportunity to participate in hospital decision-making process	Disagree	23(68%)	17 (57%)	7 (22%)	**16(70%)**	**68 (56%)**
	Neither	3 (9%)	2 (7%)	13(39%)	2 (8%)	17 (14%)
	Agree	8 (23%)	11 (36%)	**13(39%)**	5 (22%)	35 (30%)
Needed more autonomy in daily practice	Disagree	4 (12%)	5 (17%)	2 (6%)	5 (21%)	19 (16%)
	Neither	3 (9%)	8 (27%)	8 (24%)	3 (12%)	21 (17%)
	Agree	**26(79%)**	17 (56%)	23(70%)	16(67%)	**82 (67%)**
Understood the vision of the hospital	Disagree	3 (9%)	**0 (0%)**	1 (3%)	2 (8%)	8 (7%)
	Neither	3 (9%)	0 (0%)	1 (3%)	5 (21%)	3 (2%)
	Agree	29(82%)	**30(100%)**	31(94%)	17(71%)	**111(91%)**

4.9.2.3. MAS by all PNs (N=122) & CPNs (N=45)

The CPNs and PNs responses were almost similar, because they responded with the rating of 'sometimes' for all variables except the following; 'when someone was in trouble in the organisation', the majority 17 (40%) of CPNs stated that they 'often' interceded favourably, compared to 17 (14%) PNs who agreed with the CPNs. There was a clear distinction on 'motivate for incentives', because 38 (32%) PNs stated that CPN 'never' motivate, whereas 16 (37%) CPNs stated that 'sometimes' they motivate for incentives. Seventeen (39%) CPNs asserted that 'sometimes' they initiate innovative activities without the approval of senior management, whereas 41 (35%) PNs disagreed with the statement by CPNs. See Table 4.77.

Table 4. 77: MAS from both PNs and CPNs

Activity	Categories	Never	Rare	Sometimes	Often	Always
		Frequency	Frequency	Frequency	Frequency	Frequency
Intercede favourably on behalf of someone in trouble in the organisation	PN	14 (12%)	26 (22%)	36 (31%)	**17 (14%)**	25 (21%)
	CPN	3 (7%)	4 (10%)	14 (33%)	**17 (40%)**	4 (10%)
Get a desirable placement for a talented subordinate	PN	21 (18%)	17 (14%)	**36 (31%)**	20 (17%)	23 (20%)
	CPN	5 (12%)	11 (26%)	**12 (29%)**	10 (24%)	4 (9%)
Get approval for expenditure beyond the budget	PN	28 (24%)	22 (19%)	**30 (26%)**	18 (15%)	19 (16%)
	CPN	11 (25%)	9 (21%)	**20 (46%)**	2 (4%)	2 (4%)
Motivate for incentives	PN	**38 (32%)**	13 (11%)	30 (26%)	15 (13%)	21 (18%)
	CPN	12 (27%)	8 (18%)	**16 (37%)**	5 (11%)	3 (7%)
Get items on the agenda at policy meetings	PN	17 (15%)	12 (10%)	30 (25%)	**35 (30%)**	24 (20%)
	CPN	4 (9%)	4 (9%)	14 (32%)	**19 (43%)**	3 (7%)
Get fast access to top decision-makers	PN	18 (15%)	19 (16%)	**38 (33%)**	22 (19%)	20 (17%)
	CPN	5 (11%)	10 (23%)	**14 (32%)**	13 (30%)	2 (4%)
Get regular, frequent access to top decision-makers	PN	21 (18%)	20 (17%)	**36 (30%)**	19 (16%)	22 (19%)
	CPN	4 (11%)	9 (24%)	**13 (34%)**	10 (26%)	2 (5%)
Get early information about decisions and policy shifts	PN	17 (15%)	19 (16%)	**39 (33%)**	19 (16%)	23 (20%)
	CPN	4 (9%)	5 (11%)	**25 (57%)**	8 (18%)	2 (5%)
Bring in materials, money and resources to enable the department to achieve its goals	PN	31 (26%)	20 (17%)	**32 (27%)**	19 (16%)	16 (14%)
	CPN	11 (25%)	10 (23%)	**17 (39%)**	5 (11%)	1 (2%)
Initiate innovative activities without the approval of senior management	PN	**41 (35%)**	25 (21%)	23 (19%)	16 (14%)	13 (11%)
	CPN	12 (27%)	9 (21%)	**17 (39%)**	5 (11%)	1 (2%)
Get the backing for implementing innovative strategies	PN	27 (23%)	23 (20%)	**30 (26%)**	20 (17%)	16 (14%)
	CPN	9 (21%)	6 (13%)	**18 (41%)**	9 (20%)	2 (4%)

4.9.3 Organisational factors

The organisational factors which guided the study were access to resources, access to opportunity, and access to support and access to information. Opportunity is a workplace situation that reflects the possibilities for learning and advancement within the organisation. The expertise and technical knowledge required to work effectively within the organisation constitutes the information structure. Support includes the feedback and helpfulness received from colleagues, managers and subordinates, and access to resources refers to the necessary time and materials to get the job done effectively and efficiently. Laschinger *et al.* (2001) maintain that the abovementioned organisational factors are influenced by both formal and informal power.

Formal power stems from workplace positions that are visible and essential for achieving organisational goals, while informal power evolves from peer relationships and alliances in the organisation that facilitate organisational goal achievement (Kanter, 1977, 1993 and Faulkner & Laschinger, 2008). Scoring the instruments followed Laschingers' (2001) description which includes the Job Activity Scale (JAS), the Revised Conditions of Work Effectiveness (CWEQ11) and the Manager Activity Scale (MAS).

4.9.3.1. Access to information

Cases A, B and D had 'little' access to information on the current state of the hospital compared to Case C who had 'enough' access to information. Cases A and B had 'little' access to information on the values of top management, except for Case C. Case D had a split between 'little' and 'enough' access to the values of top management. Cases C and D had access to information on the goals of top management compared to Cases A and B.

Table 4. 78: Access to information

Access to information	A little	Some	Enough
on the current state of the hospital			
Case A	17 (52%)	6 (18%)	10 (30%)
Case B	17 (61%)	4 (14%)	7 (25%)
Case C	10 (32%)	9 (29%)	12 (39%)
Case D	11 (46%)	6 (25%)	7 (29%)
on values of top management			
Case A	16 (49%)	7 (21%)	10 (30%)
Case B	14 (48%)	9 (31%)	6 (21%)
Case C	10 (32%)	8 (26%)	13 (42%)
Case D	9 (37%)	6 (26%)	9 (37%)
on goals of top management			
Case A	15 (46%)	8 (24%)	10 (30%)
Case B	14 (48%)	8 (27%)	7 (25%)
Case C	8 (26%)	7 (23%)	16 (51%)
Case D	9 (38%)	3 (12%)	12 (50%)

4.9.3.2. Access to opportunity

All cases had enough access to opportunities for challenging work and to tasks which used their own skills and knowledge. Cases A and B had 'little' access to opportunities for gaining new skills and knowledge compared to Cases C and D.

Table 4.79: Access to opportunity

Access to opportunity	A Little	Some	Enough
For challenging work			
Case A	5 (15%)	9 (26%)	20 (59%)
Case B	7 (24%)	8 (28%)	14 (48%)
Case C	10 (31%)	2 (6%)	20 (40%)
Case D	1 (4%)	2 (8%)	21 (88%)
Gaining new skills and knowledge			
Case A	15 (44%)	6 (18%)	13 (38%)
Case B	14 (47%)	4 (13%)	12 (40%)
Case C	0 (0%)	3 (10%)	28 (90%)
Case D	6 (25%)	6 (25%)	12 (50%)
Tasks that use their own skills and knowledge			
Case A	7 (21%)	12 (35%)	15 (44%)
Case B	0 (0%)	3 (10%)	28 (90%)
Case C	1 (3%)	5 (16%)	26 (81%)
Case D	4 (16%)	4 (16%)	16 (68%)

4.9.3.3. Access to support

Cases A and B had 'little' access to support on specific information about things they did well compared to Cases C and D who had 'enough'. Case C had 'enough' support on specific comments about things they could improve, compared to Cases A and B who had 'little' access to support. Cases A, B and D had 'little' access to support in terms of helpful hints on problem-solving as compared to Case C which had 'enough' access to support.

Table 4. 80: Access to support

Access to Support	A Little	Some	Enough
On specific information about things you do well			
Case A	17 (53%)	7 (22%)	8 (25%)
Case B	14 (47%)	9 (30%)	7 (23%)
Case C	3 (10%)	2 (6%)	26 (84%)
Case D	9 (37%)	3 (13%)	12 (50%)
On specific comments about things you could improve			
Case A	17 (53%)	5 (16%)	10 (31%)
Case B	9 (30%)	9 (30%)	12 (40%)
Case C	7 (22%)	8 (25%)	17 (53%)
Case D	6 (25%)	12 (50%)	6 (25%)
Re helpful hints on problem-solving			
Case A	20 (63%)	5 (16%)	7 (21%)
Case B	9 (30%)	8 (27%)	13 (43%)
Case C	5 (16%)	5 (16%)	22 (68%)
Case D	13 (54%)	4 (17%)	7 (29%)

4.9.3.4. Access to resources

In general, access to resources in all cases was generally low. All cases had 'little' access to resources on time available to do necessary work. Cases A and B had 'little' access to resources on time to accomplish job requirements compared to Case C who had 'some' access. Case D had a split response on access to resources on

time to accomplish job requirements. Case C was the only case which had access to resources on time to get temporal help when needed.

Table 4.81: Access to resources

Access to resources	A Little	Some	Enough
On time available to do necessary work			
Case A	19 (58%)	7 (21%)	7 (21%)
Case B	22 (76%)	5 (17%)	2 (7%)
Case C	19 (59%)	4 (13%)	9 (28%)
Case D	13 (54%)	8 (33%)	3 (13%)
On time to accomplish job requirements			
Case A	19 (58%)	5 (15%)	4 (27%)
Case B	19 (65%)	6 (21%)	4 (14%)
Case C	10 (31%)	14 (44%)	8 (25%)
Case D	9 (38%)	9 (38%)	6 (24%)
On time to get temporal help when needed			
Case A	18 (56%)	6 (19%)	8 (25%)
Case B	16 (55%)	5 (17%)	8 (28%)
Case C	2 (6%)	9 (28%)	21 (66%)
Case D	14 (58%)	6 (25%)	4 (17%)

4.9.3.5. Job Activity Scale for both PNs (N=122) & CPNs (N=45)

Both PNs and CPNs agreed that there was 'little' reward given for innovative jobs. PNs had a 'little' amount of flexibility in their work compared to CPNs who stated that they had enough 'flexibility' in their jobs. PNs had 'little' flexibility in their work compared to CPNs who had 'enough' visibility. See Table 4.82 below.

Table 4.82: Job Activity Scale for both PNs (N=122) & CPNs (N=45)

Item	Category	A little	Some	Enough
		Frequency	Frequency	Frequency
Reward for innovative jobs	PN	**90 (76%)**	16 (14%)	12 (10%)
	CPN	**21 (49%)**	12 (28%)	10 (23%)
Amount of flexibility	PN	**60 (51%)**	31 (27%)	25 (22%)
	CPN	14 (32%)	11 (25%)	**19 (43%)**
Amount of visibility in my work	PN	**54 (47%)**	33 (28%)	29 (25%)
	CPN	14 (32%)	11 (25%)	**19 (43%)**

4.9.3.6. Scores on organisational factors

When comparing the scores between the professional nurses and the chief professional nurses, all Cases included, CPNs had higher scores in all organisational factors than the professional nurses, probably because they are managers already, and are involved with these factors. Refer to Figure 4.1 below:

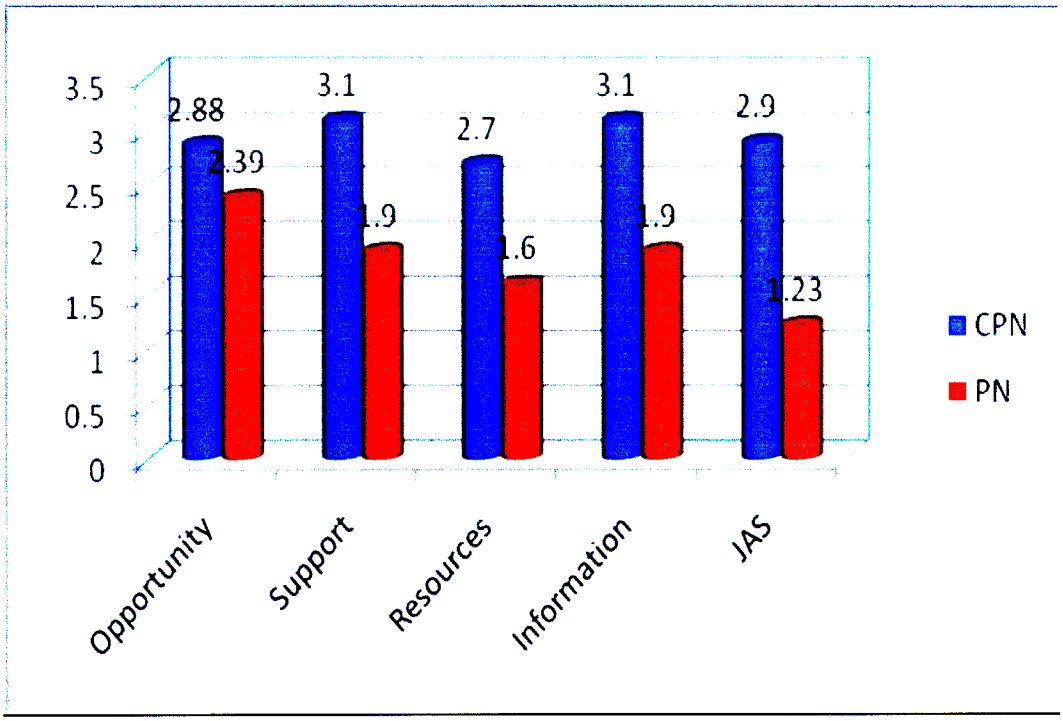

Fig 4.1 Scores of organisational factors for both PNs & CPNs

4.9.3.6.1. Scores of organisational factors per case

The scores are calculated by adding and calculating an average of all items for each particular variable yielding a score ranging from 1-5 (Laschinger *et al.*, 2001), 1 being the lowest and 5 the highest. The scores showed that Case C had high scores for all the organisational factors, job activity scales, manager activity scales and also global empowerment. The professional nurses in this organisation had access to different opportunities given by the unit managers. Information was made available to all professional nurses in Case C. They were also supported by their unit managers and the resources were made available to all. High scores on JAS indicated job activities that give high formal power. Managers in Case C had the ability to mobilise resources to get things done and they are powerful managers. See Table 4.83.

Table 4.83: Scores of organisational and leadership factors per case

	CASE A	CASE B	CASE C	CASE D
Access to opportunity	2.37	2.2	3.2	2.96
Access to information	1.92	1.5	2.1	2.0
Access to support	1.6	2.0	4.0	2.0
Access to resources	1.5	1.2	2.26	1.6
JAS	1.4	1.1.	1.6	1.4
MAS	2.99	2.88	3.6	2.3
Global	1.95	2.0	2.45	1.95

4.9.3.6.2. Comparing scores of organisational factors between PNs and CPNs

The CPNs' scores were not separated in their respective cases, because the respondents were fewer than ten in Cases B and D. Statistical analysis is only valid if there are more than 30 subjects per analysis.

CPNs performed better than the PNs probably because of the power they have in the units. PNs work under CPNs and this is well reflected in the scores below. MAS were different, as the PNs scored higher than the CPNs because they were reporting the managers' activities based on their own observations. Refer to Table 4.84.

Table 4.84: Comparing scores of organisational and leadership factors between PNs and CPNs in all cases

	PN (N=122)	CPN (N=45)
CWEQ 11	**2.39**	**2.88**
Access to opportunity	**2.7**	**3.8**
Access to information	**1.9**	**3.1**
Access to support	**2.0**	**3.0**
Access to resources	**1.6**	**2.7**
JAS	**1.23**	**2.9**
MAS	**3.11**	**2.7**
Global	**2.2.**	**2.5**

4.9.3.6.3. Comparing scores with other studies which used CWEQ 11

The CPNs in this study scored higher than in other studies that were done in developed countries in three aspects, namely, access to information, support and job activity scales. The difference between this study and TuerHodes' (2001) study was only 0.01, which is not significant at all. The PNs had lower scores than other professional nurses in other studies except for the MAS score. See Table 4.85.

Table 4.85: Comparing scores with other studies that used CWEQ11

All subscale scores range from 1-5

		Opportunity	Information	Support	Resources	JAS	MAS	GE
Current study	**PN**	**2.66**	**1.86**	**2.0**	**1.56**	**1.23**	**3.11**	**2.2**
	CPN	**3.83**	**3.1**	**3.06**	**2.66**	**2.9**	**2.7**	**2.5**
Laschinger *et al.* (2001)		**3.29**	**2.53**	**2.55**	**3.00**	**2.51**	**3.46**	**3.05**
Upenieks (2001)	**Magnet**	**4.04**	**3.00**	**3.40**	**3.02**	-	-	**3.54**
	Non-Magnet	**3. 88**	**2.83**	**2.85**	**2.37**	-	-	**2.62**
Tuer-Hodes (2001)		**3.82**	**2.76**	**2.75**	**2.91**	**2.63**	**3.49**	**3.19**
Kluska (2002)		**4.14**	**2.74**	**2.68**	**2.91**	**2.63**	**3.49**	-

4.9.4. Individual factors

Individual factors are discussed under autonomy and growth as alluded to in the introduction

4.9.4.1. Autonomy among PNs

Professional nurses are responsible for decision making on behalf of their clients in their units. If they have autonomy, they are capable of finding meaning in their work. PNs in Cases A and C had 70% and above on those who agreed that they needed autonomy in their workplace. See Table 4.86.

Table 4.86: Need more autonomy in my daily practice among PNs

CASE	DISAGREE		NEUTRAL		AGREE	
	Frequency	Percent	Frequency	Percent	Frequency	Percent
A	4	12%	3	9%	26	79%
B	5	17%	8	26%	17	57%
C	2	6%	8	24%	23	70%
D	5	21%	3	12%	16	67%
ALL	16	13%	22	18%	82	68%

4.9.4.2. Growth

Growth is an ability to develop in your chosen career. Opportunities given by supervisors allowed professional nurses to develop in the workplace. When one is exposed to many opportunities, a chance to grow in one's career is noted. Cases C and D indicated that they had more opportunities for growth. All cases agreed that they had career opportunities. Cases B and C showed high percentages on career development opportunities, Case B had 26 (87%) PNs who had access to in-service programs. All cases had high scores on lack of access to regional and national conferences, with Case A having an extremely high response of 24 (71%). All cases disagreed that they were supported in pursuing a degree, except Case C where 19

(58%) PNs agreed that they were supported. Cases A and D disagreed that they had access to continuing education, compared to Cases B and C who agreed. Opportunities for advancement were not available in all Cases except Case C who had 20 (62%) respondents who agreed that they were given opportunities for advancements. Case C was consistent in all its responses because they agreed on all variables except access to regional and national conferences. See Table 4. 87.

Table 4.87: Variables of growth in all cases

	CASE A	CASE B	CASE C	CASE D
Having career development				
Disagree	11(32%)	9 (30%)	3 (9%)	8 (33 %)
Neutral	5 (15%)	2 (7%)	10 (32%)	6 (25 %)
Agree	**18 (53%)**	**19 (63%)**	**19 (59%)**	10 (42 %)
Career development opportunities				
Disagree	10 (31%)	6 (20%)	5 (15%)	9 (38 %)
Neutral	8 (25%)	3 (10%)	6 (19%)	4 (16 %)
Agree	14 (44%)	**21 (70%)**	**21 (66%)**	11(46%)
Access to in-service programs				
Disagree	14 (41%)	3 (10%)	4 (12%)	9 (39%)
Neutral	5 (15%)	1 (3%)	5 (15%)	5 (22%)
Agree	15 (44%)	**26 (87%)**	**24 (73%)**	9 (39%)
Access to regional and national conferences				
Disagree	**24 (71%)**	15 (50%)	13 (40%)	10 (43%)
Neutral	4 (12%)	2 (7%)	10 (30%)	9 (37%)
Agree	6 (17%)	13 (43%)	10 (30%)	4 (17%)
Support for pursuing a degree				
Disagree	17 (49%)	14 (47%)	7 (21%)	13 (54%)
Neutral	3 (8%)	6 (20%)	7 (21%)	4 (21%)
Agree	15 (43%)	10 (33%)	**19 (58%)**	6 (25%)
Access to continuing education programs				
Disagree	16 (47%)	9 (30%)	4 (12%)	12 (50%)
Neutral	6 (18%)	2 (7%)	4 (12%)	6 (25%)
Agree	12 (35%)	**19 (63%)**	**25 (76%)**	6 (25%)
Opportunities for advancement				
Disagree	**20 (57%)**	9 (30%)	4 (13%)	8 (35%)
Neutral	2 (6%)	5 (17%)	8 (25%)	7 (33%)
Agree	13 (37%)	16 (53%)	**20 (62%)**	6 (32%)

4.9.5 Retention

The retention will be discussed under the following headings: satisfaction with salary, career progression and turnover rates. Retention indicators such as recommending a hospital to others, considering another job, being satisfied with salaries and with unit managers will be discussed where relevant under the following headings.

4.9.5.1. Satisfaction with salary

The majority of respondents, 85 (70%), were dissatisfied with their salaries: 21 (17%) respondents were satisfied and only 16 (13 %) were indifferent about the salaries which they were receiving. The majority in all cases except Case C were dissatisfied with their salaries. Most of Case C's respondents had a split opinion about their salaries. See Figure 4.2 below.

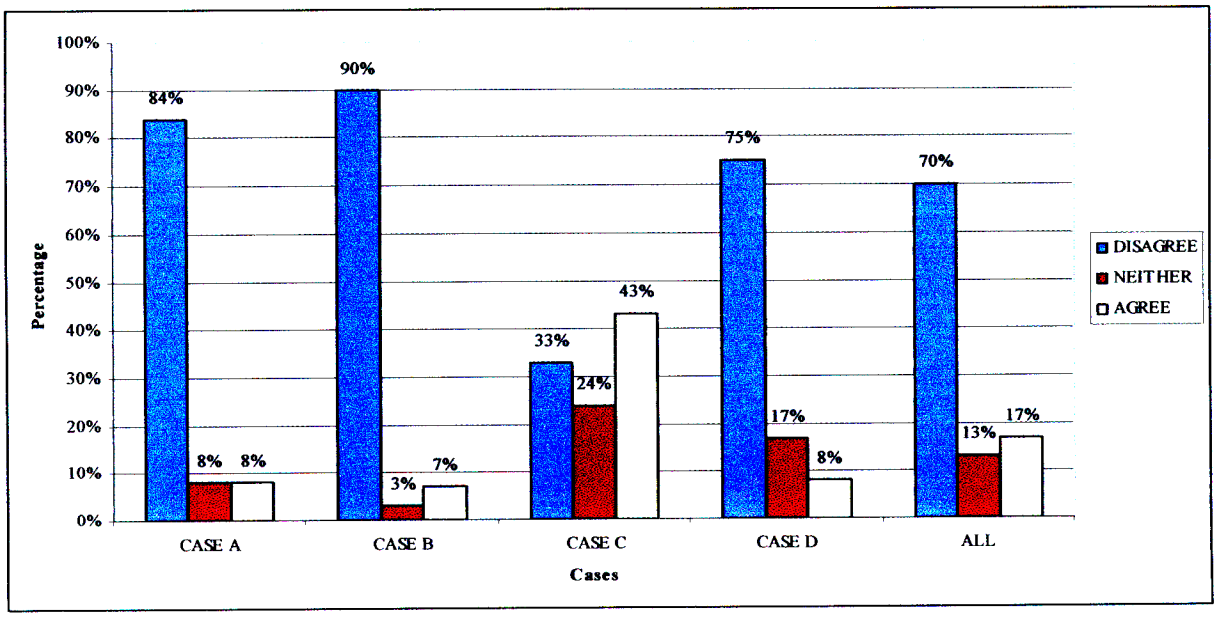

Fig 4.2: Salary satisfaction for professional nurses (N=122)

4.9.5.2. Recommending this hospital to others

The respondents were asked whether they would recommend the hospital to their friends. This was one of the indicators that showed that the respondents were happy with their institutions. All cases agreed that they would recommend the institution to their friends as a place of employment. Case A did not show any difference because both groups of respondents had equal scores on disagreeing or agreeing about recommending the hospital to friends. Case B was very clear about recommending the hospital because 20 (67%) respondents agreed, compared to 7 (23%) who disagreed. The overall perception is that professional nurses were willing to recommend their institutions to friends, because 63 (52%) respondents agreed to this proposition, compared to 47 (39%) who disagreed about recommending the hospital to their friends.

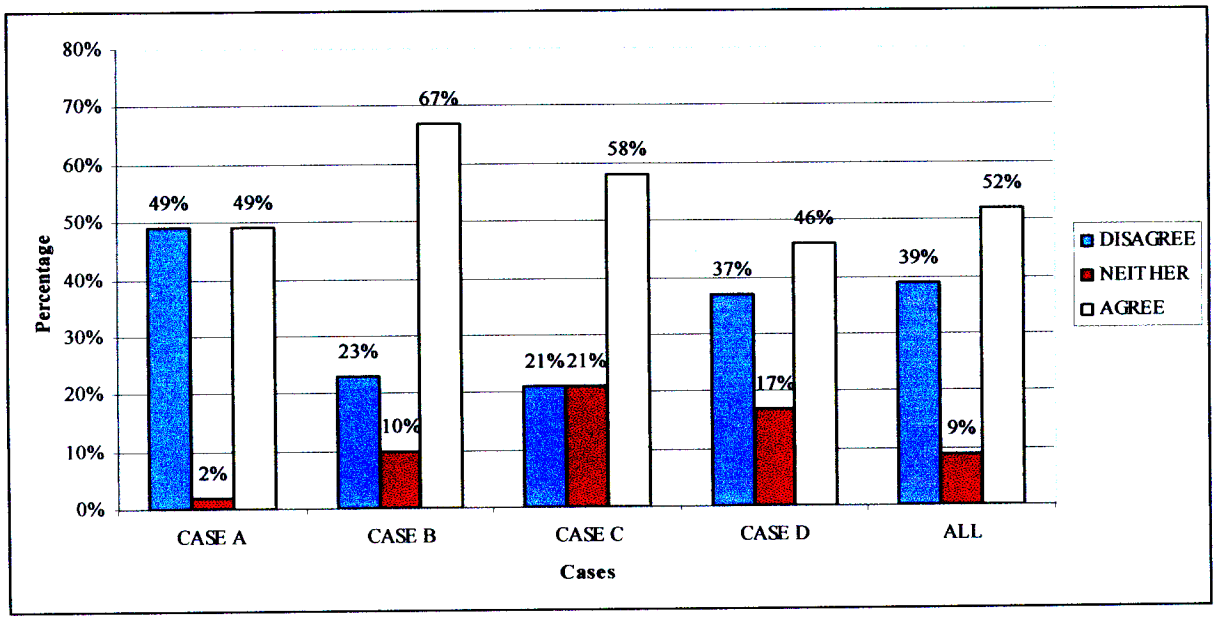

Fig 4.3. : Recommending the hospital by cases

4.9.5.3. Age vs. recommending a hospital to a friend

When analysing the retention variable of recommending the hospital to a friend based on age, as indicated in Table 4.112, the majority of respondents, 24 (54%), between 31 and 40 years of age agreed that they would recommend their hospitals to their friends compared to those who were over 50 years of age, of whom 7 (32%) respondents stated that they would not recommend the hospital to their friends. Sixty-two (52%) respondents agreed that they would recommend the hospital to their friends, compared to 47 (39 %) who stated that they would not recommend the hospital to their friends. This indicates a positive sign for retention of staff. See Table 4.88.

Table 4: 88: Age vs. recommending this hospital to my friend

Age of the respondent	**Recommend this hospital to a friend**			**Total**
	Disagree	**Neither**	**Agree**	
21-30 yrs	8 (50%)	1 (6%)	7 (44%)	16 (100%)
31-40 yrs	15 (33%)	6 (13%)	24 (54%)	45 (100%)
41-50 yrs	16 (46%)	3 (8%)	16 (46%)	35 (100%)
51-60 yrs	7 (32%)	0 (0%)	15 (68%)	22 (100%)
Over 60 yrs	1 (100%)	0 (0%)	0 (0%)	1 (100%)
Total	**47 (39%)**	**10 (9%)**	**62 (52%)**	**119 (100%)**

4.9.5.4. Career progression

Professional nurses were asked where they would be in a year, three years and five years' time. Their responses were an indication to the management to work on some constructive retention strategies. More than 156 (129 %) professional nurses' responses indicated that they aspired to be better people in the future. Eighty-five (70%) PNs wanted to improve their educational qualifications by studying towards a post-basic diploma or a degree. More than 23 (20 %) respondents who did not complete this part of the questionnaire might be undecided, or might not have wanted to share their future plans. It was also noted that PNs were unsure about their careers in Years 1, 3 and 5, as reflected in Table 4.89. The percentage is above 100%, because professional nurses had more than one option to choose in terms of their careers.

Table 4.89: Total scores of all PNs (N=122) about their careers

	1 year	3 years	5 years	Future	Total
	Frequency	**Frequency**	**Frequency**	**Frequency**	**Frequency**
No change	**20 (21%)**	**22 (18%)**	**18 (19%)**	**2 (2%)**	**58 (48%)**
SPN	14 (11%)	0 (0%)	0 (0%)	0 (0%)	14 (11%)
CPN	7 (8%)	6 (5%)	0 (0%)	0 (0%)	13 (10%)
Assistant Manager	**30 (25%)**	**1 (1%)**	**1 (1%)**	**0** (0%)	**32 (26%)**
CNSM	0 (0%)	0 (0%)	0 (0%)	1 (1%)	1 (1%)
Director	0 (0%)	0 (0%)	0 (0%)	1 (1%)	1 (1%)
Management	**0 (0%)**	**43 (35%)**	**12 (10%)**	**41 (33%)**	**95 (78%)**
Post basic Diploma	**14 (12%)**	**6 (5%)**	**22 (18%)**	**32 (26%)**	**74 (61%)**
Degree	0 (0%)	3 (2%)	7 (6%)	4 (3%)	11(9%)
Private hospital	2 (2%)	0 (0%)	1 (1%)	0 (0%)	3 (2%)
Still working	5 (4%)	2 (2%)	25 (20%)	2 (2%)	34 (28%)
Different work	1 (1%)	1(1%)	3 (2%)	9 (7%)	14 (11%)
Skilled person	1 (1%)	0 (0%)	0 (0%)	0 (0%)	1 (1%)
Other hospital	2 (2%)	8 (7%)	0 (0%)	1(1%)	11(9%)
Early retirement	1(1%)	1(1%)	2 (2%)	3 (2%)	7 (6%)
Resignation	0 (0%)	2 (2%)	2(2%)	3 (2%)	7 (6%)
Unsure	0 (0%)	0 (0%)	0 (0%)	3 (2%)	3 (2%)
Community development	0 (0%)	0 (0%)	0 (0%)	2 (2%)	2 (2%)
Working overseas	0 (0%)	2 (2%)	2 (2%)	1(1%)	5 (4%)
Missing	**24 (20%)**	**25 (21%)**	**26 (22 %)**	**19 (16%)**	**22 (19%)**

4.9.5.4.1. Career in one year for all cases together

PNs were asked about their plans in a year's time. The majority, 51 (43%) indicated that they wanted to be promoted to senior positions. Common trends were to be a senior nurse or an assistant manager, while 14 (12%) respondents wanted to pursue their studies. More than 25 (21%) respondents indicated that there would be no change in their careers compared to 6 (5%) who were planning to resign from their present institutions at the end of the year to work in another organisation, or to leave the nursing profession. Two (4%) PNs were planning to move, either to private hospitals or to corporate companies. Professional nurses who did not respond to this question numbered 24 (20%). Refer to Figure 4.4.

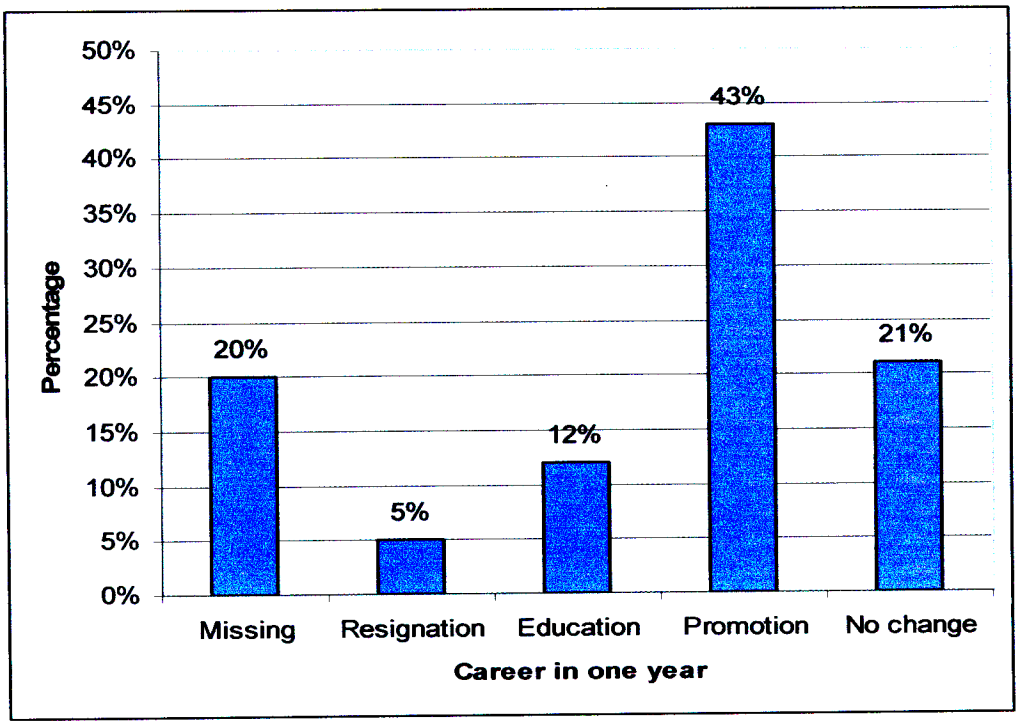

Fig 4.4 PNs' careers in one year among all cases

4.9.5.4.2. Careers in three years among all cases

A total of 53 (43%) PNs indicated that they would like to be promoted to senior positions with 43 (35%) of them indicating management positions. Only 9 (10.8%) PNs responded that they would leave the nursing profession or move to another country within three years. Twenty-three (19%) PNs indicated that they would remain in the same position. Refer to Figure 4.5.

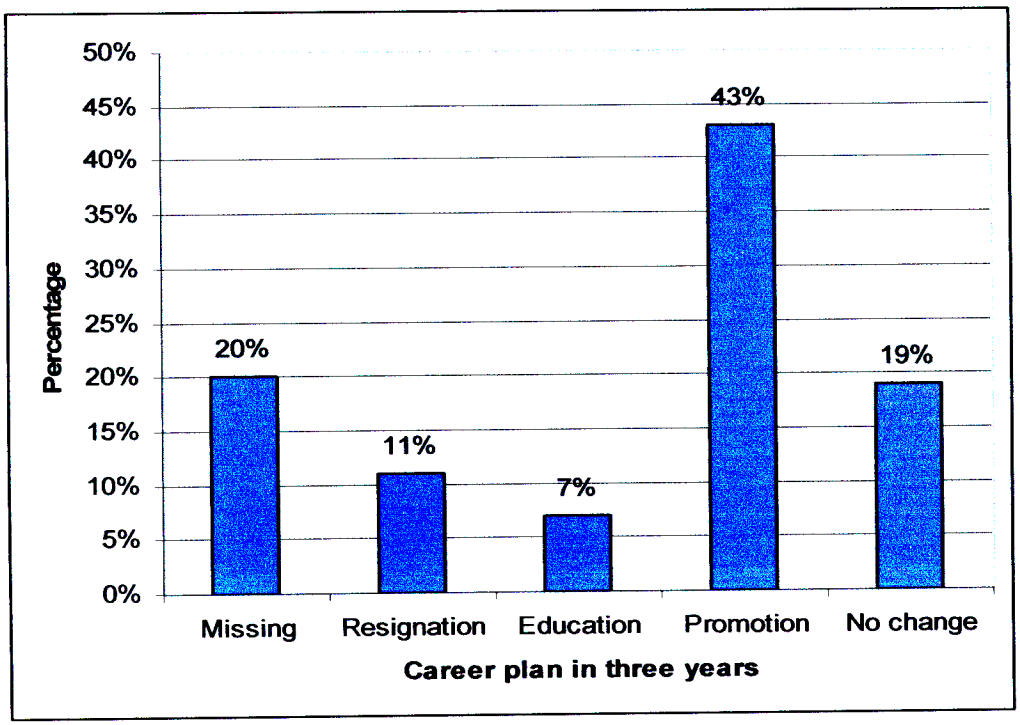

Fig 4.5: PNs' careers in three years among all cases

4.9.5.4.3. Career planning in five years

Most respondents, 44 (36%) indicated that they would stay with their organisation, 27 (22%) wanted to study for a diploma or degree, and 15 (12%) were looking forward to being promoted to senior positions. The common area was the management position. Twenty-six (21%) respondents were missing from this study. Ten (8%) respondents indicated that they would resign in five years. Refer to Fig 4.6.

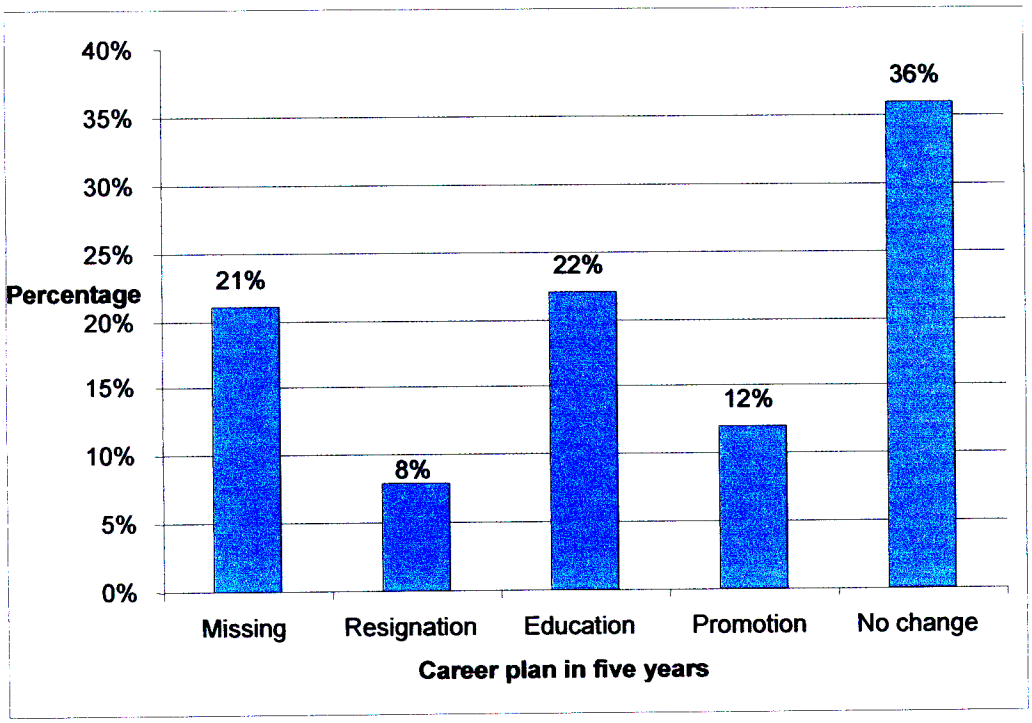

Fig 4:6 PNs' careers in five years among all cases

4.9.5.4.4. Future career plans

The professional nurses wanted to be promoted to senior positions and they were also eager to pursue their studies as indicated in Fig 4.7.There were 19 (16%) missing subjects from the study who possibly did not want to share their future plans, or did not have any future plans at all.

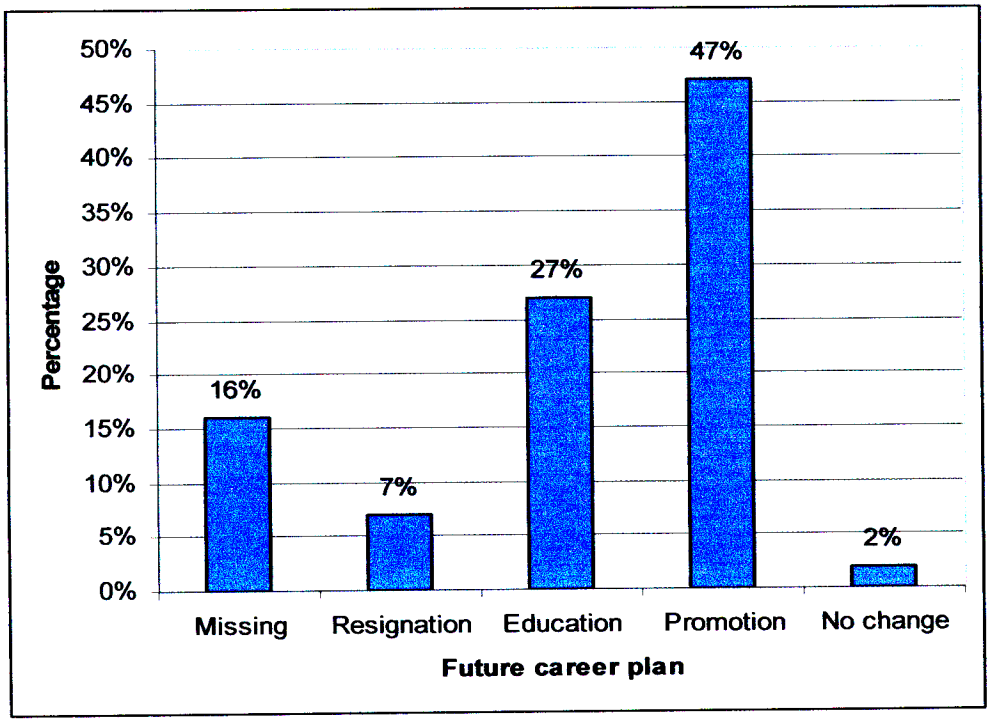

Fig 4.7: PNs' future career plans

4.9.5.4.5. Turnover rates from CNSM

Chief Nursing Service Managers were asked about the number of nurses who had left their posts from the 1st of January 2006 until December 31, 2006. The turnover rate was calculated using the formula:

$$\text{Turnover rate} = \frac{\text{Nurses who have left the organisation}}{\text{Total numbers of nurses in the organisation}} \times 100$$

Case A had a higher staff turnover compared to the other cases. The CNSM stated that conditions were better than before. Telephonic follow-up showed that the staff turnover is really coming down, except in Case B which had an increase of 1 %. There are so many factors which have contributed to a lower turnover, for e.g. salary upgrades by the National Department of Health (NDOH) through occupational specific dispensation (OSD), changes in the working conditions and leave packages, to mention but a few. The statistics were for 2006 and 2007. Refer to Figure 4.8.

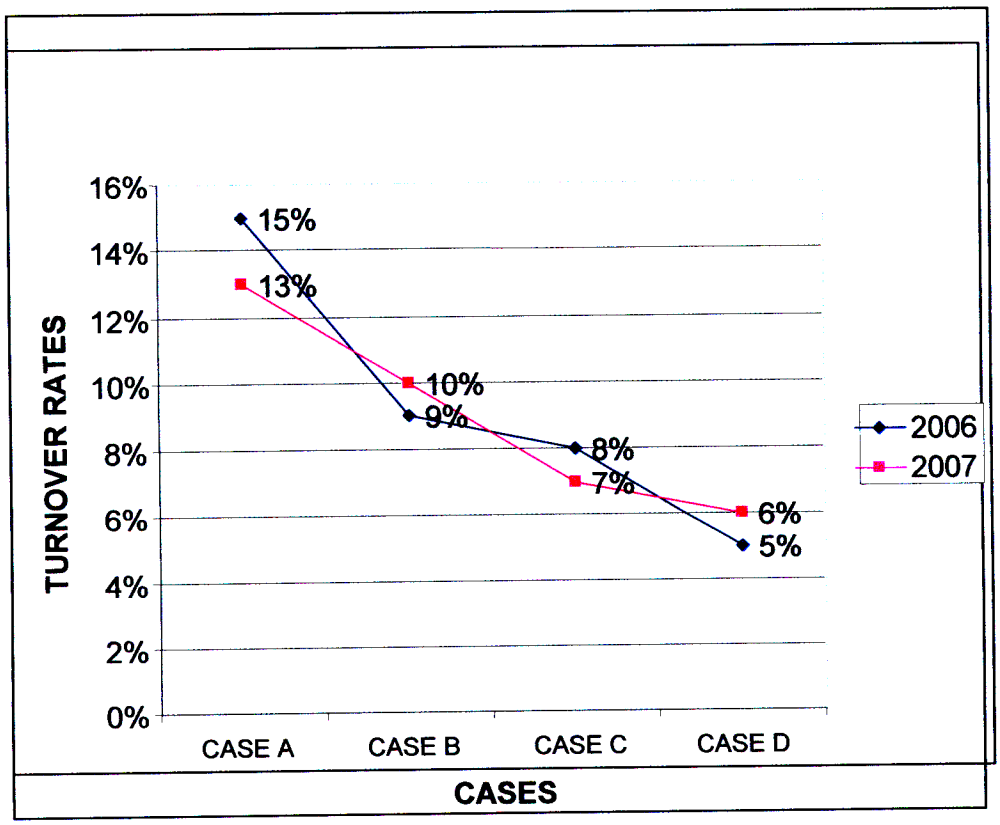

Fig 4.8: Turnover rates in all four cases

4.10. RELATIONSHIP AMONG LEADERSHIP SCORES, ORGANISATIONAL FACTORS AND RETENTION SCORE

The fourth objective of the study was to analyse the relationship of the organisational factors and leadership factors towards staff retention of professional nurses working in public hospitals. The organisational factors are represented by the following variables which are access to opportunity, resources, information and opportunities. The scores were computed on the SPSS 15.

Leadership scores were obtained by summing up the variables which were indicators of leadership. The variables are as follows:

1. CNSM is visible to staff
2. CNSM is accessible to staff
3. CNSM is equal in power to other top level hospital executives
4. CNSM is equal in authority to senior management team

The retention score was computed from the following variables:

1. Would you recommend this hospital to your friend as a place of employment?
2. Where do you see yourself in one, three and five years' time?
3. Would you consider taking another job?

The Cases were combined so as to allow for accurate and significant analysis. Analysis is valid if there are more than thirty respondents. Some cases had few subjects which affected individual analysis on certain tests. The mean scores of CWEG, JAS and MAS were calculated. The relationship between the total empowerment scores and the organisational factors were examined using the Pearson correlation analyses. The relationship between the scores of formal and informal power (JAS & ORS) and total empowerment were examined using regression analysis. Correlations of major variables were analysed using bivariate analysis. Leadership was correlated with visibility to staff and accessibility to staff. Involving staff in the decision-making process was found to be significant, because the p value was at 0.01.

4.10.1. Correlation of variables

The correlation coefficient is a numerical estimate of the degree to which the points on a scatter plot cluster around the regression line. A strong relation between two variables means that they are related, but not necessarily that the one variable causes the other. The correlation coefficient represents the strength of co-variation between two variables by means of a number that can range from -1 to +1. The correlation coefficient for the strong relationship is approximately r =0.90, while that for a weak relationship is in the region of r=0.20. In most social science applications, it is not usual to find very strong relationships between naturally occurring variables, and correlations between r= 0.25 and r=0.75 are typical (Terreblanche *et al.*, 2006). The relationship among three variables proved to be significant, because the p value for the variables were all either at p= 0.000 or less.

4.10.1.1 Significant relationship between organisational factors vs. leadership variables among PNs

Variables were analysed to see whether a relationship existed between the leadership variables and the organisational factors, using the Pearson test. Two- tailed Pearson correlation was done on leadership variables and the results were as follows:

The relationship between access to information and all leadership variables was significant because the analysis was p=0.000. Access to opportunity with the visibility of CNSM was not significant, because the results were p= 0.658 and p=0.574 when correlating access to opportunity with CNSM having equal authority to SMT. No significant relationship on access to support vs CNSM is accessible to staff as the results were p= 0.27. The results were also not significant (p= 0.122) when correlating access to resources with the accessibility of the CNSM. See Table 4.90 below.

Table 4.90: Relationship between organisational factors and leadership variables

Item	p-value
Access to information vs. CNSM is accessible to staff	0.05
Access to information vs. CNSM is visible to staff	0.01
Access to information vs CNSM has equal power to SMT	0.00
Access to information vs. CNSM has equal authority to SMT	0.01
Access to opportunity vs CNSM is accessible to staff	0.00
Access to opportunity vs CNSM is visible to staff	**0.658**
Access to opportunity vs CNSM has equal power to SMT	0.001
Access to opportunity vs CNSM has equal authority to SMT	**0.574**
Access to support vs CNSM is accessible to staff	**0.27**
Access to support vs CNSM is visible to staff	0.000
Access to support vs CNSM has equal power to SMT	0.004
Access to support vs CNSM has equal authority to SMT	0.006
Access to resources vs CNSM is accessible to staff	**0.122**
Access to resources vs CNSM is visible to staff	0.003
Access to resources vs CNSM has equal power to SMT	0.001
Access to resources vs CNSM has equal authority to SMT	0.098

When correlating access to information with accessibility to staff, there is a moderate significance, compared to a strong positive significance with the visibility of the CNSM, and also with the equal power shared by the CNSM with other senior management team members.

4.10.1.2 Correlation scores of organisational factors between the PNs to retention and leadership scores

There was a strong significant relationship between the opportunity score and retention of professional nurses and the leadership score ($p< 0.001$). The resources were available for staff to fulfil their duties, because the score shows a strongly significant relationship to the retention score, but the relationship was only slightly significant between the resource score and leadership score ($p<0.005$).

Professional nurses had access to the organisation because the score showed a strong relationship to retention and also to leadership ($p<.000$ and .002) respectively. All variables showed that the relationships were statistically significant because the p value was less than 0.001. as indicated in Table 4.91.

Table 4. 91: Correlation scores of organisational factors between the PN to retention and leadership scores

	PROFESSIONAL NURSES			
	Retention score		Leadership Score	
Organisational factors	r	p	r	p
Opportunity score	0.545**	.000	0.431**	.000
Resource score	0.367**	.000	0.254**	.007
Information score	0.459**	.000	0.289**	.002
Support Score	0.408**	.000	0.406**	.000

r= Pearson Correlation

p= significance

**** Correlation is significant at the 0.01 level**

4.10.1.3. Correlation of CPN scores with organisational factors, leadership and retention

The leadership score showed a negative relationship with all organisational factors, JAS and MAS, whereas the MAS score had a positive relationship with all other scores. All leadership results showed no significance with other variables except the resources score which also had a negative weak relationship (p= .040, r= -311). See Table 4.92.

MAS is part of the CWEQ 11 scale which has 13 items. The higher the MAS score, the more powerful the manager in that organisation (Laschinger *et al.*, 2001). All other scores had a positive strong relationship with each other .The weakest but significant relationship was between the opportunity score and the resources score which was (r=.298, p= 0.05). Refer to Table 4.92.

Table 4. 92: Correlations of CPN scores

		Opportunity score	Access score	Support score	Resource score	Manager score	Global score	Leadership	Jas score
Opportunity score	Pearson Correlation	1	.635(**)	.507(**)	.298(*)	.435(**)	.242	-.096	.449(**)
	Sig. (2-tailed)		.000	.000	.050	.003	.109	.531	.002
	N	45	45	44	44	44	45	45	44
Access score	Pearson Correlation	.635(**)	1	.476(**)	.474(**)	.554(**)	.384(**)	-.176	.689(**)
	Sig. (2-tailed)	.000		.001	.001	.000	.009	.249	.000
	N	45	45	44	44	44	45	45	44
Support score	Pearson Correlation	.507(**)	.476(**)	1	.327(*)	.554(**)	.345(*)	-.154	.600(**)
	Sig. (2-tailed)	.000	.001		.030	.000	.022	.318	.000
	N	44	44	44	44	44	44	44	44
Resource score	Pearson Correlation	.298(*)	.474(**)	.327(*)	1	.523(**)	.333(*)	-.311(*)	.712(**)
	Sig. (2-tailed)	.050	.001	.030		.000	.027	.040	.000
	N	44	44	44	44	44	44	44	44
Manager score	Pearson Correlation	.435(**)	.554(**)	.554(**)	.523(**)	1	.417(**)	-.124	.593(**)
	Sig. (2-tailed)	.003	.000	.000	.000		.005	.422	.000
	N	44	44	44	44	44	44	44	44
Global score	Pearson Correlation	.242	.384(**)	.345(*)	.333(*)	.417(**)	1	-.235	.298(*)
	Sig. (2-tailed)	.109	.009	.022	.027	.005		.120	.050
	N	45	45	44	44	44	45	45	44
leadership	Pearson Correlation	-.096	-.176	-.154	-.311(*)	-.124	-.235	1	-.369(*)
	Sig. (2-tailed)	.531	.249	.318	.040	.422	.120		.014
	N	45	45	44	44	44	45	45	44
Jasscore	Pearson Correlation	.449(**)	.689(**)	.600(**)	.712(**)	.593(**)	.298(*)	-.369(*)	1
	Sig. (2-tailed)	.002	.000	.000	.000	.000	.050	.014	
	N	44	44	44	44	44	44	44	44

** Correlation is significant at the 0.01 level (2-tailed).*Correlation is significant at the 0.05 level (2-tailed).

The relationship between organisational factors and manager scores was highly significant at $p < .000$ and strongly correlated to all factors except the opportunity score which had a weaker relationship at ($r = .297$, $p=.001$). The resources score had a stronger positive relationship with the JAS score. Professional nurses had access to information and were able to be rewarded for good work done. Refer to Table 4.93.

Table 4. 93: Correlation of PN scores on organisational factors, JAS & MAS

		Manager score	Opportunity score	Resource score	Support score	Jasscore	Info score
Manager score	Pearson Correlation	1					
	Sig. (2-tailed)						
	N	118					
Opportunity score	Pearson Correlation	.297(**)	1				
	Sig. (2-tailed)	.001					
	N	118	120				
Resources score	Pearson Correlation	.429(**)	.420(**)	1			
	Sig. (2-tailed)	.000	.000				
	N	118	118	118			
Support score	Pearson Correlation	.586(**)	.492(**)	.568(**)	1		
	Sig. (2-tailed)	.000	.000	.000			
	N	117	118	117	118		
Jasscore	Pearson Correlation	.420(**)	.486(**)	.719(**)	.483(**)	1	
	Sig. (2-tailed)	.000	.000	.000	.000		
	N	118	118	118	117	118	
Info score	Pearson Correlation	.457(**)	.565(**)	.515(**)	.520(**)	.586(**)	1
	Sig. (2-tailed)	.000	.000	.000	.000	.000	
	N	116	117	116	115	116	117

** Correlation is significant at the 0.01 level (2-tailed).

There is a strong positive relationship between organisational factors, satisfaction and growth of professional nurses (p = .000 and r > 400 in all variables) as indicated in Table 4.94 below.

Table 4. 94: PN scores between organisational factors and growth scores

		Resources score	Support score	Info score	Opport Score	Growth
Resources score	Pearson Correlation	1	.568(**)	.515(**)	.420(**)	.400(**)
	Sig. (2-tailed)		.000	.000	.000	.000
	N	118	117	116	118	118
Support score	Pearson Correlation	.568(**)	1	.520(**)	.492(**)	.557(**)
	Sig. (2-tailed)	.000		.000	.000	.000
	N	117	118	115	118	118
Info score	Pearson Correlation	.515(**)	.520(**)	1	.565(**)	.515(**)
	Sig. (2-tailed)	.000	.000		.000	.000
	N	116	115	117	117	117
Opportunity Score	Pearson Correlation	.420(**)	.492(**)	.565(**)	1	.556(**)
	Sig. (2-tailed)	.000	.000	.000		.000
	N	118	118	117	120	120
Growth	Pearson Correlation	.400(**)	.557(**)	.515(**)	.556(**)	1
	Sig. (2-tailed)	.000	.000	.000	.000	
	N	118	118	117	120	122

**** Correlation is significant at the 0.01 level (2-tailed).**

Correlation among leadership and growth

There is a positive moderate to strong relationship among growth scores and leadership scores. Similar trends were noted between leadership score and satisfaction scores. There is a strong positive correlation between satisfaction and growth scores (p= .000, r= .544).

Table 4.95: Correlations of PN scores among leadership and growth

		Growth	Leadership score
Growth	Pearson Correlation	1	.477(**)
	Sig. (2-tailed)		.000
	N	122	115
Leadership score	Pearson Correlation	.477(**)	1
	Sig. (2-tailed)	.000	
	N	115	115

** Correlation is significant at the 0.01 level (2-tailed).

There is a weak relationship between the resources scores and the leadership scores compared to a strong positive relationship between the support scores and resource scores.

Table 4. 96: PN correlation among organisational factors, leadership and retention scores

		Leadership score	Retention score	Resources score	Support score	Info score	Opport Score
Leadership score	Pearson Correlation	1	.381(**)	.254(**)	.406(**)	.392(**)	.289(**)
	Sig. (2-tailed)		.000	.007	.000	.000	.002
	N	115	115	112	113	111	113
Retention score	Pearson Correlation	.381(**)	1	.367(**)	.408(**)	.383(**)	.459(**)
	Sig. (2-tailed)	.000		.000	.000	.000	.000
	N	115	121	117	117	117	119
Resources score	Pearson Correlation	.254(**)	.367(**)	1	.568(**)	.515(**)	.420(**)
	Sig. (2-tailed)	.007	.000		.000	.000	.000
	N	112	117	118	117	116	118
Support score	Pearson Correlation	.406(**)	.408(**)	.568(**)	1	.520(**)	.492(**)
	Sig. (2-tailed)	.000	.000	.000		.000	.000
	N	113	117	117	118	115	118
Info score	Pearson Correlation	.392(**)	.383(**)	.515(**)	.520(**)	1	.565(**)
	Sig. (2-tailed)	.000	.000	.000	.000		.000
	N	111	117	116	115	117	117
Opportunity Score	Pearson Correlation	.289(**)	.459(**)	.420(**)	.492(**)	.565(**)	1
	Sig. (2-tailed)	.002	.000	.000	.000	.000	
	N	113	119	118	118	117	120

Correlation Correlation is significant at the 0.01 level (2-tailed).**

4.11. DOCUMENT REVIEW FROM ALL FOUR CASES

Documents were reviewed in all cases and the findings are indicated and discussed hereunder.

4.11.1. Document review in all cases

In each institution, the researcher had an opportunity to review the documents. Most of the documents were reviewed in the CNSM office and in some units. More clarification was given during the discussion with the CNSM or the deputy CNSM. All four institutions performed more or the less the same except for Case C who fulfilled all the items on the checklist. Results are represented in Table 4.98 as they were reviewed in all four hospitals.

Table 4.97: Document review

Type of document	Available				Unavailable				Maintained			
CASE	A	B	C	D	A	B	C	D	A	B	C	D
1. Policy manuals	Y	Y	Y	Y					N	N	N	N
2. Job Description	Y	Y	Y	Y					Y	Y	Y	Y
3. Duty Roster	Y	Y	Y	Y					Y	Y	Y	Y
4. Qualifications			Y		Y	Y		Y				
5.In-service education within the unit	Y	Y	Y	Y					N	N	N	N
6.In-service education outside the hospital	Y	Y	Y					Y	N	Y	N	N
7. Application for study leave	Y	Y	Y	Y								
8. Selection of candidates	Y	Y	Y	Y					N	N	Y	N
9. Minutes of the meetings	Y	Y	Y	Y					N	N	N	N
10. Communication within the unit	Y	Y	Y	Y					N	Y	N	N
11 Servicing the equipment	Y	Y	Y	Y					N	N	N	N

Y = YES

N=NO

4.11.2. Discussion on document review

Policy manuals

Policy manuals are available in the wards but are not updated regularly. All four cases have a similar pattern, and no particular case performed better in this aspect.

Duty Roster

Off-duty lists are well-kept and are displayed in the unit. The loose duty roster copies are kept in the file for three years. All cases are fully aware of the importance of keeping the duty roster. Any changes in the duty roster are indicated with a red pen.

Job description

All job descriptions are kept in the filing cabinet, but are not updated for career planning.

Qualification of staff

Only Case C had records of qualifications of staff in the matron's office. Other organisations kept their documents in the secretary's office.

Application for study leave

Documentation for applications for study leave is kept by the Human Resource Department. The CNSM did not have evidence of the applicants.

Selection of candidates

In three institutions, there were no selection criteria. Only one institution had a policy on selection of staff for study purposes.

Minutes of the meeting

In all four institutions, minutes of meetings were available, but were not consistently kept. There were also gaps in the minute record book.

Communication within the unit

It's a common practice that staff members communicate through the black book which is signed after reading any information. Some PNs did not sign the book. Notices were circulated in the wards through the use of managers. Cases B and C had messengers who delivered messages.

Case C was the only institution which kept a file containing the qualifications of staff at the CNSM's office. All other CNSMs referred the researcher to Human Resource personnel.

In-service education within the unit

Professional nurses in all cases verbalised that they were given opportunities to participate in in-service education within their wards and units, especially in Cases B and C who had more than 26 (87%) and 24 (73 %) PNs who agreed. Those nurses working in the ICU and theatre had in-service education sponsored by company representatives in return for goods purchased, or to demonstrate goods in the hope that the organisation would buy their products. Documentation of demonstrations which were held in the unit has still not been kept up to date. Case C was consistent in all growth opportunities except in the access to regional and national conferences.

In-service education outside the hospital

It was apparent that in-service education outside the hospital was lacking in all cases. The majority of people who had an opportunity to attend conferences were management staff according to records.

Servicing the equipment

The equipment was available in all cases, although it took time to service the equipment due to financial constraints. Maintaining the available equipment is remains a weakness in all institutions.

4.12. SUMMARY

In conclusion, cases showed some similarities although there were minor differences. Case C was distinct because the analysis of all the variables gave a clear indication of the organisation.

The majority of respondents were females, showing consensus about the gender in the nursing profession. Most PNs were between the ages of 31 and 50 years old with the majority having 15 years nursing experience. It was noted that most of the PNs and CPNs were diploma prepared, with only two CPNs who had a Master's degree. The majority of CPNs were between 41 and 50 years of age and their management experience ranged between 3 and 6 years. The ICU, OT, obstetrics and medical wards had more respondents than the surgical wards and OPD. Denosa was the common union with a high number of affiliates for both PNs and CPNs in all cases.

PNs agreed that their leaders are visible, yet not accessible except for Case C. All CNSMs were regarded as good leaders in their institutions. When analysing retention variables with age, the older nurses agreed that they would recommend the hospital to their friends compared to the younger generation.

In terms of having access to organisational factors, the CPNs scored higher than the PNs. Professional nurses working in Case C scored higher in all the subscales which measured the organisational factors, power and management activities. Case C demonstrated that they had all the opportunities for development. The scores were consistent in all aspects except on the access to regional and national conferences. CNSM sends management staff to these conferences and it was evident in the response of the PNs

Most respondents in all cases except Case C were unhappy with their salaries, and the implementation of OSD amplified their unhappiness. Although there are those PNs who benefited from OSD, the majority were not considered.

It emanated that PNs are optimistic about their future. They see themselves as future nurse managers, directors and tutors. They also verbalised that they would like to improve their educational qualifications, although there are some who did not even complete that part of the questionnaire.

The turnover rate was between 5 % and 15 % in all centres which was within the limits. The literature stated that turnover rates between 15% and 20 % are acceptable. More research is needed because these studies were from developed countries.

CPNs did not have any relationship between leadership and organisational factors, whereas the PNs showed a significant and positive relationship in all variables.

CHAPTER FIVE: DISCUSSION, CONCLUSIONS AND RECOMMENDATIONS

5.1. INTRODUCTION

The purpose of this study was to analyse the relationship between leadership styles of nurse managers and organisational factors within hospitals and the retention of professional nurses working in public hospitals in KwaZulu-Natal province, using a case study design.

This chapter focuses on interpreting and discussing the main findings of the study. The discussion also attempts to relate the findings to the study objectives and describe these findings within the context of the conceptual framework which includes organisational, individual, leadership factors and retention. Findings were derived from questionnaires which were filled in by professional nurses and chief professional nurses, interviews with chief nursing service managers and union managers. Document reviews in the public institutions where data were collected and focus groups with professional nurses who had had nursing experiences outside this country were conducted. Follow-up interviews which were done telephonically with the CNSMs were integrated in this section of the study.

Related studies will be cited in order to support evidence revealed in the findings.

5.2. DISCUSSION OF THE FINDINGS

5.2.1. Demographic details

The demographic details include data from both the PNs and CPNs in all cases such as gender, nursing experience and educational qualifications.

5.2.1.1. Gender distribution

The nursing profession is generally known as a female profession although the number of males is gradually increasing. Trends are comparable to the international trends in other countries. Females still dominated the current study with 166 (90%) females and 17 (10 %) males. Other studies, such as Mathena (2002), reflected 52 (93 %) females and 3 (7%) males. Kleinman (2003) researched among 112 (94%)

females and 8 (6 %) males. Chen, Beck & Amos (2005) from Taiwan found 33 (94%) females and 2 (6.3%) males. Leach (2005) found 141 (95 %) females and 7 (5%) males in a total of 148 nurse managers. The professional nurses who had overseas nursing experience were all female except for one. The study by Munjanja, Kibuka & Dovlo (2005) asserted that males constitute only 10% of the nursing population in sub-Saharan Africa.

5.2.1.2. Marital status

While marital status was not a variable of interest in the study, it became evident among professional nurses who were working abroad and who participated in the focus group that the majority 8 (66%) were married, and only 4 (33%) were single. This confirms the studies by Pang *et al.* (2002) and Buchan (2001) who revealed that married nurses also go overseas when their children start education at tertiary institutions. However, Yin & Yang (2002) in their study argued that married professional nurses would not leave their employment because of marital responsibilities.

5.2.1.3. Nursing experience

The respondents (above 30%) from both the PNs and CPNs had nursing experience of greater duration than 16 years, and those PNs who had left the country were also more experienced in the nursing profession. The total nursing experience for twelve professional nurses who were working abroad was 124 years. This showed that the country is losing the most experienced professional nurses to developed countries, as was also revealed by Thom (2003), who did a study on professional nurses in South Africa and found a similar result.

5.2.1.4. Educational qualification

The majority of the PNs in South Africa in the current study still had a diploma in nursing, with only 2 (1%) CPNs having a Master's degree, compared to 165 (99%) who had either a Bachelor's degree or a Diploma in nursing science. This is in contrast with what studies in developed countries revealed, for example, Kleinman (2003) in the USA observed that 35 (31 %) CPNs had a master's degree, while Mathena's (2002) study showed 1 (2%) doctorally qualified nurse and 41 (75 %)

Masters-qualified PNs in a total sample of 55 professional nurses. Chen *et al.* (2005) from Taiwan had 30 (10.5 %) doctorally and 245 (85, 7%) Master's degree-qualified nurses in a total sample of 286.

According to Tzeng (2002) in Taiwan, a lower educational background is significant in predicting a nurse's intention to quit in pursuit of greener pastures. This author further asserts that those nurses who were most dedicated to and involved in their profession, were the ones who had taken the time and trouble to study further in their chosen field. These nurses were unlikely to quit unless their efforts were not recognised. It was noted that the majority of professional nurses from South Africa who were working in developed countries had Bachelors' degrees in nursing, and all had specialised in ICU, operating theatre, trauma, oncology or advanced psychiatry. South Africa therefore is losing the most skilled and educated nurses to the developed world, as is supported by a study done by Thom (2003) in South Africa.

5.2.2. The organisation

The organisation was discussed under the leadership factors and organisational factors influencing retention among professional nurses. Input from the CNSMs and union managers' interviews were also integrated in the discussion in an effort to triangulate data.

5.2.2.1. Leadership style

The professional nurses in the current study revealed very different perceptions about the leadership styles of their CNSMs, especially in one particular case. The majority of PNs in all cases observed their CNSM as visible, accessible, with equal power and authority to senior management, however there were splits in their observations. For example, the PNs in Case D had an equal split between agreeing (46%) and disagreeing (46%) on the visibility of their CNSM. Case C on the other hand revealed a clear majority who agreed with the fact that their CNSM was a good leader. Meanwhile, the CNSMs described themselves as transformational, democratic, autocratic or situational in their leadership styles. Only Case C seemed to agree in the description of her leadership style with her PNs.

CPNs in all four cases agreed that they were accessible and visible to staff, and they also allowed professional nurses to be part of the decision-making body. In terms of the manager's activity scale, there were differences in how they viewed themselves as compared to how the PNs observed their management activities, although the majority of both PNs and CPNs agreed that they were never motivated for incentives. In Cases C and D, PNs and CPNs differed greatly in almost all variables.

Observations of PNs were confirmed by Coomber & Barriball (2007) who stated that the main motive to leave the organisation was job dissatisfaction because of lack of empowerment perceived by nurses to be the result of an autocratic leadership style.

It appears in the current study that no clear leadership style dominates among CNSMs. The literature reveals that transformational leadership has proved to be most effective in staff retention compared to other leadership styles (Robbin & Davidhizar, 2007, Acree, 2006 and Larabee *et al.*, 2003). Findings from McGuire & Kennerly (2006) and Leithwood & Jantzi (2000) support this assertion as their studies revealed that transformational leaders were more likely to have committed nurses than transactional leaders.

While the CNSMs were seen to have equal power and authority to their senior management, their PNs were not given an opportunity to participate in hospital decision-making except in Case C. Furthermore, Boyle *et al.* (1999) maintained that a manager's leadership style which promotes a climate of information sharing and shared decision-making has a positive influence on staff retention. Hence the majority of PNs agreed that they needed more autonomy although Case C showed an equal split on this variable.

As a consequence, Jooste (2004) recommends that a different kind of leader should emerge in the 21st century, which demands different leadership approaches. Similar findings were reported by Thyer (2003) who asserted that women's leadership styles for the 21st century focus on good management skills in a changing workplace.

The current study showed that the chief nursing service manager's position, power and influence over work coordination had a direct link with nurses' intent to stay. The CNSM's position determines who would go to certain courses and conferences.

The CPNs also utilised their power as being in charge of the wards and units. They were the main decision-makers in the wards. The manager's influence and power have been identified as factors that affect professional staff satisfaction and retention (Taunton, Krampitz & Woods, 1989). A manager's leadership style which promotes a climate in which information is shared effectively and also promotes decision-making has a positive influence on staff retention (Boyle *et al.*, 1999).

The literature maintains that the leaders should communicate the future of the service effectively by sharing the vision and mission of the organisation (Jooste, 2004). PNs in the current study had an understanding of the vision of their organisation. Zurn, Dolea & Stilwell (2005) however argue that the challenge in health sectors is to be able to build and sustain a long-term vision and commitment to it among staff.

5.2.2.2. Organisational factors

Kanter's theory stated that access to support, information, opportunities and resources enhances staff retention (Laschinger *et al.*, 1999). Manojlovich & Laschinger (2002) echoed this idea by stating that access to all organisational factors leads to a greater sense of meaning in one's work, greater confidence, greater autonomy and a greater belief that one can have an impact on work and work settings. Therefore the current study used access to information, support, opportunity and resources as variables influencing staff retention as will be discussed hereunder. Organisational climate, culture and structure were also integrated in the description of organisational factors.

5.2.2.2.1.Access to information

It was evident from the findings that professional nurses had limited access to information, which according to Buchan *et al.* (2001) threatens quality patient care.

Meetings held at regular intervals with different categories of nurses, were platforms for sharing information and addressing concerns of staff members. From all four cases it appeared that meetings were held with different categories to diffuse power relations. At times PNs did not want to express their views and needs during meetings.

All cases used different forms of disseminating information e.g. emails, telephones, minutes, notices, memoranda, meetings, newsletters and bulletins. The paper communication was easily available, but not well maintained. If notices from the CNSM's office were not delivered to individual wards, the information would not be available.

While one of the communication means was the email, most of the PNs were not computer literate and the wards did not have computers. Computers were kept in the doctors', unit managers' and secretaries' offices. Email was available only to CPNs and CNSMs; the other categories did not have access. The developed countries made it a requirement that all health workers undergo computer literacy. As most of their professional nurses are from developing countries, the PNs went for computer literacy training until they were proficient. Lack of computers is also a hindrance in public hospitals (Willmer, 2007).

Lines of communication were not always properly followed, because some of the professional nurses in Case C left the workplace without giving adequate notice to their line managers. Others even reported directly to the Human Resource Management personnel without following adequate lines of communication. Policies which governed the functioning of professional nurses were not followed properly. Similar findings were echoed by Gerein *et al.* (2006) in that nurses left their workplace without giving the required period of notice.

5.2.2.2.2.Access to opportunity

Professional nurses in this study felt that they needed the opportunity to participate because this would help them feel part of the larger system. Such nurses feel empowered and are more satisfied (Upenieks, 2002) whereas in the current study, the majority of professional nurses felt that they were not given an opportunity to participate in hospital activities. Findings from Gerein *et al.* (2006) stated that if less flexibility were available to participate in staff development and training activities this would have a damaging effect on both quality of care and opportunities for career development.

Among the four cases, only Case A had a tertiary institution where nurses were trained for post-basic courses. The other three cases did not have training facilities

which prompted the CNSMs to send their professional nurses to urban areas. Training facilities were available only in urban areas and the nurses in rural areas were disadvantaged and inhibited from achieving a post-basic qualification. These professional nurses had to move away from their families for a period of twelve to eighteen months. Although they visited their families regularly, the parental bond and responsibilities were tampered with and this affected the retention of professional nurses.

The CNSMs stated that professional nurses had the opportunity to advance in their careers via the career ladder programmes, but few nurses took advantage of this, as was reflected in a study by Stolzenberger (2003).He showed that because most of the post-basic courses were available only in the urban areas, professional nurses from the rural areas did not participate in post-basic training because they were reluctant to leave their families.

According to the CNSM in Case D, younger professional nurses seized the opportunity to study further, and in many cases, they did not return to their rural hospitals. They were supported by the KZN DOH policy which allowed the learners to practice in any institution on completion of training, as long as it was within the KZN province. This was seen as an abuse of opportunity because they were sent for post-basic training so as to obtain information and then to utilise this in their hospitals.

Professional nurses in all cases agreed that they were given career opportunities, although they did not have access to regional and national conferences. PNs in Case C were the only professional nurses in this study who were supported in pursuing a degree and accessing continuing education programmes. The literature shows that many professional nurses reported that a lack of professional development opportunities and not necessarily higher wages had caused them to migrate (Ross, Polsky & Sochalski, 2005 and Buchan *et al.*, 2003). Autonomy and professional growth opportunities were noted as important factors affecting turnover (Kudo *et al.*, 2006; Zurn *et al.* 2005).

Nurses with overseas nursing experience verbalised that they were given greater opportunities to develop, compared to when they were in South Africa. It was also evident that the developed countries were giving professional nurses an opportunity

to develop by sending them on educational courses and to conferences. Most of the training facilities were within reach and were also in-house. Nurses do not want to move away from their places of employment.

Most professional nurses in South Africa felt that there were poor promotion opportunities .This was also expressed by Yin & Yang (2002) in a study where poor promotion opportunities topped the list of factors which contributed to staff turnover. The criterion which was used to promote professional nurses was not transparent. This was also mentioned by union managers as one of the complaints frequently brought forward by professional nurses in their meetings. Nurses who had had overseas nursing experience benefited a lot by working in developed countries because they were promoted to senior positions within a shorter period of time.

There were differences in the promotion opportunities among cases in this study. Professional nurses in Case D were aware of the promotion criteria as compared to other cases. There were more nurses in Case D who were at peace with who would be promoted or not. Unfairness in promotion opportunities was reported by union managers. These participants reported that promotions were based on a good relationship between the PN and CPN. This concern compares with an observation by Swearingen (2004), who asserted that professional nurses were unhappy about promotion processes in their workplace because one needed to know someone, or be part of the "good girl" group.

5.2.2.2.3.Access to support

Professional nurses commented differently about access to support for things they did well, things they could improve and on helpful hints or problem-solving advice. There were mixed responses among the respondents about access to support. Case C was mainly supportive of all staff members working in the organisation compared to Case D who had a CNSM who was described as not supportive of staff. Cases A and B had split responses among PNs. Management which was not supportive and the fact that they had no opportunities for advancement were some of the reasons that made nurses leave their employment as asserted in the study in the USA by Strachota *et al.* (2003).

In Case D, PNs were left to run the wards on their own because the wards were short-staffed. A newly-qualified PN often had to run a ward on his/her own. There were many risks involved in allowing newly-qualified nurses to be in charge of wards because they lacked expertise and experience, and that affected retention. There was a great need to orientate newly-appointed professional nurses in the wards. Providing support for nurses' work by demonstrating concern and understanding about the problems encountered by nursing staff is an important part of the manager's role (Laschinger *et al.*, 2003).

Mentoring was identified by union managers as one strategy which could assist newly- qualified and newly-appointed nurse managers by transmitting knowledge on a one-to-one basis, as also asserted by Kleinman (2003). Fletcher (2001), in a study done among nurses, suggested that job dissatisfaction ensues when nurse managers fail to give due recognition and support. Emotional and physical support were offered at some institutions. PNs under study had access to programmes such as the Employee Assistance Program (EAP) and support groups were also available in three institutions for those who were infected and affected by HIV/AIDS.

Unions in the current study emphasised the importance of empowering new nurse managers in the units. Kleinman (2003) endorsed the view that there was a need to educate nurse managers and involve them in educational leadership programmes. There were educational conferences and seminars where nurse managers could be empowered.

Most PNs with overseas experience felt that they were supported by their managers at work, and also outside their work environment. Those PNs who were not supported were left to fend for themselves, which prompted them to leave the developed countries and come back to South Africa. The PNs with overseas experience were orientated for two weeks and they were also allocated a mentor who worked with them for a whole month. One PN did not receive adequate orientation in her unit and this prompted her return to South Africa.

5.2.2.2.4.Access to resources

Access to resources included time to do work, getting extra help when needed, and having all available equipment. PNs in all cases verbalised that they did not have enough time to complete their tasks, and that extra help was not available. Hospitals used to have pools of nurses who were reserved for emergencies. Owing to shortages of staff, these pools were no longer available.

Professional nurses in this study scored higher on access to resources compared to the study by McCusker *et al.* (2004), where nurses scored the lowest on resource adequacy. According to both the CNSMs and the PNs, remuneration was not commensurate with their years of training and experience. They also felt that their salaries were not market related.

Eighty-three percent of respondents from the current study were unhappy about their salaries, and 88% of professional nurses expressed their unhappiness at the level of remuneration as was also reported by Zurn *et al.* (2005) and Cowin (2002). Salary was the second most mentioned resource problem by Strachota *et al.* (2003). A study in Taiwan by Yin and Yang (2001), and in Canada by Zeytinoglu *et al.* (2006), indicated that salary and fringe benefits were the strongest factors influencing nursing turnover. A study done in Jordan by Mrrayan (2005), however, indicated that nurses in private hospitals were more satisfied with their salaries and had more intention to stay, than nurses in public hospitals. In a study by Tzeng (2002), low salaries and lack of promotion were found to be significant predictors of nurses' intentions to quit. Dissatisfaction with salary was among the top ten factors which cause high turnover among Taiwanese nurses (Yin & Yang, 2002).

Many professional nurses with overseas experience reported that they found that adequate equipment contributed positively to quality patient care, as was also asserted by Strachota *et al.* (2003) from the USA. In the current study, it was evident from all four cases that the professional nurses were not involved in making decisions regarding obtaining supplies and equipment. Nedd (2006) also suggested that one way to facilitate access to resources was to involve nurses in decisions regarding obtaining supplies and equipment for the unit. Nurses were willing to stay in their organisations provided that the working conditions were improved. Gifford,

Zammuto, Goodman & Hill (2002) from the USA support these findings. They found that the best way to retain nurses was to improve the quality of work life.

Lack of resources had a negative impact on the delivery of quality patient care. Professional nurses ran short of equipment in their units. Even if they wanted to do a procedure, they were prevented by a lack of resources. PNs ended up compromising when rendering patient care, because materials were not adequate, or were not in good working order. The situation negatively affected the ability of professional nurses to deliver quality service to their patients. The nurses were reduced to having to improvise, and to reuse 'single use' disposable items, as stated by the CNSMs.

Nurses with overseas experience commented about the abundance of the latest equipment which is always kept in good working order. There was a big contrast between the local public hospitals and hospitals in developed countries. It has been proven that quality patient care is linked to cost-effectiveness, which is linked to good management decisions on cost (Litvak & Long, 2000). Availability of good working equipment showed that professional nurses were more willing to stay in their jobs and thus conditions were conducive to retain staff.

As much as the government was doing a good deed in empowering small companies, these companies tended to supply sub-standard goods. Quality patient care was thus compromised, by having BEE companies which derailed quality care by supplying goods of sub-standard quality. In Cases B and D, one company was liquidated, and the hospitals did not have the goods that they had requested. It took the hospitals six months for the goods to be reordered and delivered.

There were positive points to BEE, however as stated by Shevel (2005), who had a different perspective when he awarded a R1 billion BEE deal. He asserted that the BEE deal would improve Netcare's shareholding to over 25 %, with the strategic advantage of having management, staff, health care professionals and a BEE group ultimately owning more than 30 % of the deal. The professional nurses had an opportunity to benefit from this deal, thus strengthening the possibility of them being retained in the country.

It was noted that most of the professional nurses in Case C and D were not local people, thus accommodation was needed desperately. Organisations which offered

accommodation within their premises stood to retain more nurses. Professional nurses felt comfortable working in hospitals which had accommodation within the premises. They felt safe and needed. According to the CNSM in Case C, the PNs did not worry about where to park their cars and doing late shifts, because they were aware that they would walk only a few blocks within the hospital premises.

Two cases had agreements with estate agents within the area to lease accommodation for their professional nurses. These accommodations were near the hospital and made it easier for professionals to travel to and from their flats to the hospitals. The rural hospitals did not have nurses' accommodation and professional nurses had to live near the hospital. The area did not have places of entertainment, leading to boredom and frustration among the nurses. These reasons led to the movement of professional nurses from rural to urban areas. Case D had a variety of entertainments like scuba diving, mountain climbing and abseiling, which were used mainly by doctors.

Professional nurses form the backbone of the health profession, but the hospital management regarded doctors as the most important cadre of health workers. Doctors were given first preference when it came to accommodation. Professional nurses were considered last, and if there were many foreign doctors, nurses were not considered at all.

According to the CNSM in Case D, accommodation was a problem because the area was very rural and the majority of professional nurses come from urban areas. There was no space to extend the hospital because the land belongs to the chief. The Department of Health needed to negotiate with the chief because the hospital was built on the chief's land. According to Case B, the chief nursing service manager had a plan for providing accommodation for nurses; but the hospital did not have space to build extra accommodation. The available space was utilised for an ARV centre which was also a Department of Health priority.

In Case A, the CNSM gave accommodation preference to student nurses and professional nurses were not considered. As much as professional nurses were needed in hospitals, accommodation was not provided within the hospital premises. PNs were reminded that they were working, and therefore could afford to rent outside the hospital.

It is not only the developing countries which have accommodation problems; even the developed countries experience problems, though in a different way. According to Finlayson, Dixon, Meadows and Blair (2002) accommodation and expensive transport were one of the problems in the city of London, with the NHS failing to retain nurses. Accommodation was more expensive in the inner city, and nurses preferred to stay outside the city to find cheaper accommodation. Commuting from the outskirts cost more, and so the nurses resigned and looked for employment nearer home.

5.2.2.3. Individual factors

Demographics such as age, experience and qualifications are individual factors that could affect retention. For example, the older you are, the more stable you may be and therefore want to stay in the organisation. For the purpose of this study individual factors will be discussed under the following variables: autonomy, sense of commitment and growth.

Most respondents in all four cases expressed that they lacked autonomy in their workplace. Work autonomy can be defined as a non-monetary incentive that has control over one's own work, and is among the key variables explaining job satisfaction (Zurn, Dolea & Stilwell, 2005). A study conducted by King & McInerney (2007) in KwaZulu-Natal province and Khowaja, Merchant & Hirani (2005) in Pakistani, also revealed that professional nurses in both public and private hospitals lacked autonomy in their workplace, which encouraged resignation among nurses.

There was limited growth for an individual related to a bureaucratic organizational structure as it had restricted flexibility. Literature says that decentralised organisational structure accommodates more flexibility (Gerein *et al.*, 2006). This study showed that most organisations were not following a decentralised structure as advocated in the District Health System (DHS).

In all four cases, professional nurses were recognised when they achieved something. Their names and pictures were displayed in the halls of their organisations and articles were written about them in newsletters. In order to achieve

such high recognition, all professional nurses agreed that one had to expend a lot of effort in their work.

A sense of commitment was described by CPNs in how PNs initiated activities in their workplace. In almost all cases PNs were noted as not having initiative although they were expected to be creative in their workplaces. They relied on instructions from unit managers. They were more likely to be followers, rather than initiators. The majority of CPNs agreed that they were not given opportunities to show initiative in their organisation. This also concurs with the responses by PNs about management activities by CPNs.

According to the CNSMs, the high absenteeism rate showed that PNs did not have a sense of commitment. The PNs also abused the system by having repeated absences which were not accounted for. This was noted by the pattern of absenteeism which usually followed or preceded a day off.

Growth in any organisation is based on access to opportunity and development. There were mixed feelings about professional development in the workplace. Professional nurses from Cases B and C confirmed that they were given opportunities to grow, compared to Case D who reported that they did not have this opportunity. Case A had mixed responses about the opportunities they had for professional development.

The possibility of career development for nurses is crucial, especially in an environment characterised by a phenomenal growth in knowledge related to health sciences, coupled with technological advances. Evidence suggests that career development opportunities encourage the retention of nurses (Zurn, Dolea & Stilwell, 2005).

5.2.2.4. The alliances

The alliances were included as a source of informal power of professionals. Representatives from SANC, union managers and the Department of Health formed part of the alliances.

5.2.2.4.1. The South African Nursing Council (SANC)

The SANC contributes to formal power as an alliance because it is responsible for giving direction as far as standards of practice are concerned. It also evaluates and monitors the compliance of organisations with the standards, in so far as delivery of care is concerned. This SANC role should alert the nursing profession to the type of nurses who are leaving the country to work in other sectors or other countries.

The 2008 statistics on the growth of professional nurses in the SANC register revealed a shortage of PNs. The statistics showed that the supply of PNs did not meet the demands of the country because one (1) PN is responsible for 450 people, which is below the recommended rate of 200 per 100 000 as advanced by WHO (Venter, 2005).

If the SANC does not keep statistics on nurses who have left the country to work in developed countries or who left the nursing profession to venture into other avenues (Kingma, 2006, Hall, 2004 and Buchan, 1999), health care measurement will be inaccurate. The statistics also inform the country about the number of nurses who should be trained in order to meet the health needs of the country.

5.2.2.4.2. Unions

Professional nurses were empowered by their unions to have access to information by the availability of newsletters and journals for them. There were also forums where new Labour Relation Acts were discussed. The lack of labour relations knowledge was an obstacle in the nursing component. All union managers felt that there were cases that were reported to them instead of the CPNs and CNSMs solving them. These minor cases did not need the attention of union managers, but because both PNs and CPNs were not well informed about labour relation issues, these cases ended up on the union managers' desks. Efforts to bridge the gap were being made by one of the unions. The union manager had initiated a forum which would unite the CNSMs and union managers. CPNs in charge of units and CNSMs were empowered to solve labour relation issues by being allowed to join the management-labour forum.

The unions empowered professional nurses by supporting them when they lobbied for better salaries and working conditions. The unions represented the members during bargaining, and fortunately won their case, because salaries were improved for all nurses in the country. The professional nurses were also supported by the unions during court and SANC hearings, where they were represented by union officials.

Opportunities for advancement were made available by union members because professional nurses were given opportunities to attend workshops, seminars and conferences. They were sponsored financially to attend conferences locally and internationally, provided they were presenting a paper.

Professional nurses were also empowered to conduct research in their settings by being rewarded for the best research projects. These awards motivated PNs to conduct more research.

5.2.2.4.3. Responses of CNSM about Department of Health (DOH)

The Department of Health is responsible for employing health care workers in the country. They are responsible for the payment of these nurses which means they influence directly whether nurses will stay in the organisation or not.

All four CNSMs were unhappy with the DOH policy which allowed professional nurses, on completion of their training, to seek work in any public hospital as long as it was within the KwaZulu-Natal province. Most of these training institutions were in urban areas. Nurses from rural areas enjoyed urban life and did not want to go back to their original hospitals causing more staff shortages. The CNSMs were in a dilemma, because they wanted to upgrade the skills and knowledge of their staff, but the choice lay with the individual as to whether s/he would come back or not. The individual was protected by the DOH policy, because as long as s/he remained working within the province, s/he did not break a contract.

The CNSMs verbalised that there was a delay in the advertisements of posts in national newspapers because of the systems which needed to be adhered to before posts were advertised. It took more than a year to advertise a post. Informing a successful candidate that she or he had been appointed was also performed very

slowly. This impacted negatively on staff retention, because PNs moved to other institutions of choice.

All CNSMs verbalised that professional nurses were chasing posts from one institution to another in pursuit of a higher post. If posts could be advertised simultaneously in all institutions, it would curb this gross movement of professional nurses.

5.2.3. The retention of professional nurses in the KZN province

The majority of PNs except in Case C were dissatisfied with their salaries although indicators for retention in their institutions were positive. Several studies have shown that salaries have an influence on retention of staff (Msidi, 2008, Kingma, 2006 & Buchan, 2004).

The respondents were asked whether they would recommend the hospital to their friends. This was one of the indicators that showed that the respondents were happy with their institutions. All professional nurses from all cases agreed that they would recommend the institution to their friends as a place of employment. Case A were not sure because both groups of respondents had equal scores on disagreeing and agreeing to recommend the hospital to friends. Case B was very clear about recommending the hospital, because the majority agreed that they would recommend the hospital to others. This coincides with the assertion by Beurhaus *et al.* (2005) that professional nurses were willing to work with the organisation in programs that would encourage other nurses to work in this organisation.

On exploring the career progression issue over 1 year, 3 years, 5 years and in the future, some professional nurses indicated that they would leave their present employment; others even indicated that they were looking forward to working abroad. The union managers affirmed that nurses have a democratic right to move to any country. This response was similar to that of Kingma (2007) who posed the question as to whether migration can be controlled or managed without infringing on an individual's freedom of movement.

The majority of professional nurses wanted to improve their studies and career positions. They indicated that they would love to be senior managers in their

departments and others wanted to improve their educational qualifications. A minority indicated that they would resign from the nursing profession and work in their areas of interest. According to Ulrich *et al.* (2006), professional nurses in the USA who indicated that they would resign in three years, stated that they wanted to pursue additional nursing education qualifications and higher clinical positions. In this study it was noted that there was a high number of respondents who did not respond to this question.

All turnover rates were above 5 %, but were stagnant for two years except in Case B which showed a slight increase by 1%. The results appeared to be a good sign that nurses were not leaving their institutions in great numbers. According to CIPD (2007) in the UK, the highest level of turnover (20.4%) is found in private sector organisations while the public sector has an average turnover rate of 13.5 %. The USA has documented the turnover rate among nurses as ranging between 15% and 30 %.

The implementation of community service among professional nurses was a retention strategy to reduce the shortage of staff. Although these newly qualified nurses were novices, they could contribute to the delivery of patient care. Professional nurses were posted based on the needs of the community.

5.2.4 Conclusions

The results of this study support Kanter's theory of work empowerment and the instruments that measure work effectiveness in relation to the professional nurses' job which will culminate in staff retention. Kanter's theory informed the conceptual framework of this study. The focus of this study were leadership behaviour and the organisational factors which provided access to information, support, resources and opportunity with the hope that these would empower professional nurses and positively affect and retention.

All leaders (CSNMs) were visible and accessible to their staff as perceived by PNs except in one case where the leader obviously did not align herself to the aforementioned indicators. There was an agreement between the reports by

professional nurses and the statements by leaders in terms of communicating the vision of the organisations.

While the majority of professional nurses reported that they did not have enough access to resources such as time to do necessary work, to accomplish job requirements and to acquire temporal help, their responses varied. This could be related to staff shortages because there was no more extra pool of staff to source temporary help from. It was evident that all cases were affected similarly, regardless of whether the case was in an urban or rural setting, for example, the issue of accommodation as a retention strategy.

The manager's response in assuming their information- giving role, does not reflect in the documents that were analysed nor were the PNs in agreement with the managers' claim. This could be due to the lack of human resources and time to fulfil the expected tasks. Limited access to information threatened quality patient care. Meetings were available but professional nurses did not assert themselves.

The study showed that newly qualified nurses were left to run the wards without adequate support because there were staff shortages. According to CNSMs, professional nurses missed some of the opportunities even if they were given in their workplace, whereas the PNs felt that they had limited access to educational and promotional opportunities.

There was a relationship among variables, especially organisational factors and retention. Leadership variables showed a weak negative relationship with the organisational factors among CPNs. The relationship ranged from strong to weaker in different variables, although all variables were significant among the PNs.

The access to resources scores showed a strongly significant relationship to the retention scores. The relationship was only slightly significant between the resource scores and leadership scores. This might have been contributed to by the fact that CPNs were in charge of units where PNs were working. There was also a weak relationship between resources scores and leadership scores compared to a strong positive relationship among support scores and resource scores. There was a positive moderate to strong relationship among growth scores and leadership scores. There

was a strong significant relationship among PNs between the opportunity scores and retention of professional nurses and the leadership scores.

5.3. RECOMMENDATIONS

Recommendations in this study are based on the findings from the respondents in different settings, and are geared towards informing policy makers and are discussed under the organisation, individual, alliances and further research.

5.3.1. Recommendation 1: The organisation

Educational opportunities

- Professional nurses could be given more support in terms of educational, growth and development opportunities. This support could be coordinated and offered by the staff development units based in all institutions.
- All the institutions must have planned careers which are guided by educational opportunities.
- Training of managers in hospitals for positions on leadership should be implemented including life coaching in hospital settings.

Appropriate implementation of policies

- There could be more explicit policies which guide the release of professional nurses to further their studies, for example, the policy that specifies the criteria determining whether professional nurses go on courses based on their clinical placements.
- When dealing with promotions and incentives, fairness should be applied. This could be achieved by adhering to the policies and procedures of recruitment and retention.
- Policies must also be transparent for all who work in that organisation especially those that deal with promotion of staff from junior levels to senior levels.

Bilateral agreements with developed countries

- Developed countries which recruit professional nurses from developing countries could help build a sustainable nursing education infrastructure in developing countries.
- The Department of Health could be approached to negotiate with developed countries about ethical recruitment of staff from developing countries, for example, staff exchanges.
- The Department of Health policy on placement after study leave should be revised.

Opportunities for growth and development

- Nurse leaders should attend leadership courses which would upgrade their knowledge and skills, because the majority of nurse leaders were promoted without the necessary qualifications.
- Nurse Managers could utilise opportunities to upgrade themselves, and could also be empowered with management skills, especially in the area of labour relations, as identified by the union managers.
- References sources could be established in the units such as mini-libraries and sponsoring to conferences.

Improvement of working conditions

- Findings showed that the nurses were unhappy about working conditions; therefore government should improve working conditions. The professional nurses expect good working equipment and utilities which will facilitate their performance when dealing with patients and clients.

Improvement on salaries

- Salaries need to be revisited, because the majority of nurses responded that they were not satisfied with their salaries. The CNSM commented that salaries should be market related.

Decentralised structure

- Organisations should follow a decentralised structure which is more participatory, and also involve the respondents at a lower level. Information took a long time to reach people at the lower levels. The decentralised structure has proved that people are easily reached.

Visibility of CNSM

- Leaders in the 21st century should be more visible and accessible to staff (Jooste, 2004). If all nurse leaders were visible and accessible to staff, this would facilitate identification of management problems early. Professional nurses would be able to share their feelings with the nurse leaders because they were aware of what was happening on the ground.

Mentoring

- If all institutions had mentoring programs, whereby the newly qualified professional nurses could have mentors who would guide them in their practice retention of the newly qualified staff would take place.

5.3.2. Recommendation 2: The individual

Professional autonomy

- Professional nurses need to be more open and autonomous in handling nursing affairs. If PNs had greater autonomy in their daily work, they would be able to make informed decisions about their patients. Professional nurses would achieve greater autonomy by being offered educational courses on professional autonomy.

Seizing available educational opportunities

- Professional nurses could take advantage of educational opportunities given to them by their managers, and there should be a policy which guides the release of staff for educational growth and development. The criteria should be based on individual and organizational needs and be context-driven.

Participating in self development activities

- Professional nurses could focus on their growth and development by studying only those educational courses which are of relevance to their line of work. For the past ten years it has been noted that PNs are completing many courses which will not even be used in their line of work, for example, an orthopaedic nurse may study community nursing science which is relevant to a PN working in a clinic.

5.3.3. Recommendation 3: The alliances

Unity among the unions

- Forums which include management and the unions should be operational and should be included in the organisational strategy. They should not only meet when there are problems in the workplace. These forums should meet regularly and should be known to all members of the organisation.
- Unions should assume a more empowering role towards the professional nurses because this would benefit PNs in their delivery of care.
- By keeping accurate statistics, the SANC would be able to guide and inform education and training of nurses based on the health needs of the country.

DOH

- The researcher recommends a policy for sending nurses for post-basic courses. The present policy which allows the nurse to work in any organisation within the province poses a disadvantage to the institutions. The policy will be presented in the KZNDOH (See appendix Y).

Retention

- The Magnet retention model could be adopted in South Africa by strengthening COHSASA which appears to be following this model.

5.3.4. Recommendation 4: Further research

- There is a need for a longitudinal study that will follow nurses for 3 to 5 years in order to see if their intentions translate into action. For example, it would be valuable to observe whether the nurses who stated that they would leave the profession are still working, or have already left for their desired employment sectors.

- Managers' leadership styles need to be explored in greater depth. Managers at all levels need to be included.
- Turnover rates need to be established in the health sector in the developing countries. Available rates were obtained from the developed countries which operate in a different context. Norms of acceptable retention or turnover rates should be explored.
- A comparative study on retention of professional nurses in different settings like clinics and private hospitals should be explored. This study was done only in public hospitals in KZN.

5.4 STUDY LIMITATIONS

While every effort was made to ensure academic rigour, the following limitations were identified and these limitations are hoped to inform readers when they are reviewing this study:

Compliance from public hospitals

- There was poor compliance from some randomised cases despite repeated reminders by telephone, email and resubmission of proposals.
- There was also poor compliance from staff, because of staff shortages in the units.

- The big tertiary institution in the province declined to participate due to the process of finalising its organisational structure with organisational development and evaluation as an internal matter. The institution did not want an outsider to infiltrate their premises during this critical phase.
- Other institutions were scared of the research title. Respondents verbalised that it was very difficult to open up for fear that they might be victimised.

Conflict of interest

- There was conflict of interest between the Chief Nursing Service Manager and the CEO. When the researcher was ready to collect data, she was denied access to the institution because the CEO had not been informed by the CNSM.

Methodology

- The methodology used for the study was limiting, because case study findings cannot be generalised to other contexts. The study focused only on one province, which is KwaZulu-Natal.
- Small numbers of respondents limited the researcher from applying some statistical tests. Findings from all CPNs were analysed together so as to give meaning.
- Since each institution has only one CNSM, qualitative approach was the only appropriate method to collect data. In-depth interviews were conducted in all four institutions.

Time frame

- The researcher was given a limited time to be present in the institutions. In one organisation, the CNSM felt that the presence of the researcher was disturbing the normal functioning of the institution, despite data being collected during tea-times and lunch-breaks.

Research process among professional nurses

- Professional nurses are still not familiar with the research process. There were some spoilt papers because of respondents not following instructions, despite the instructions having been written down clearly.

- Others did not want to participate because they did not see the benefit of the research. They had their own interpretations about why the research was conducted.

SANC

Statistics are not kept on nurses who leave the country. The register is not updated to enable one to check how many nurses are practising in the country. The system cannot verify the numbers that are on the register, indicating whether they are still practising in the country, or have changed employment status.

CONCLUSION

The study was conducted in four organizations using a case study method. Participants included the professional nurses, union managers and the professional nurses who were working abroad at the time of data collection.

Findings from both the nurse managers and the alliances highlighted that the nursing profession would improve if professional nurses took ownership of their profession.

The majority were unhappy about their salaries although salaries were not the main factor that would make them leave their organization. Professional nurses were motivated to stay in their organizations provided they were developed in terms of educational and promotional opportunities.

The application of Kanter's theory could be an effective recruitment and retention strategy in the current health care work settings which are experiencing shortages of staff. To retain nurses, we need to develop policies according to their needs and interests.

The findings of the study culminated in the drafting of the working document for the policy on staff retention of professional nurses in the public hospitals in KwaZulu-Natal. The findings will also inform the establishment of communities of practice for nurse managers .

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APPENDIX A

UNIVERSITY OF
KWAZULU-NATAL

RESEARCH OFFICE (GOVAN MBEKI CENTRE)
WESTVILLE CAMPUS
TELEPHONE NO.: 031 – 2603587
EMAIL : ximbap@ukzn.ac.za

23 FEBRUARY 2006

MS. Z NKOSI (971165875)
NURSING SCHOOL

Dear Ms. Nkosi

ETHICAL CLEARANCE APPROVAL NUMBER : HSS/06001A

I wish to confirm that ethical clearance has been granted for the following project:

"The analysis of the relationship between leadership styles, organizational factors and retention of professional nurses in public health care facilities in KwaZulu-Natal"

Yours faithfully

.....
MS. PHUMELELE XIMBA
RESEARCH OFFICE

PS: The following general condition is applicable to all projects that have been granted ethical clearance:

THE RELEVANT AUTHORITIES SHOULD BE CONTACTED IN ORDER TO OBTAIN THE NECESSARY APPROVAL SHOULD THE RESEARCH INVOLVE UTILIZATION OF SPACE AND/OR FACILITIES AT OTHER INSTITUTIONS/ORGANISATIONS. WHERE QUESTIONNAIRES ARE USED IN THE PROJECT, THE RESEARCHER SHOULD ENSURE THAT THE QUESTIONNAIRE INCLUDES A SECTION AT THE END WHICH SHOULD BE COMPLETED BY THE PARTICIPANT (PRIOR TO THE COMPLETION OF THE QUESTIONNAIRE) INDICATING THAT HE/SHE WAS INFORMED OF THE NATURE AND PURPOSE OF THE PROJECT AND THAT THE INFORMATION GIVEN WILL BE KEPT CONFIDENTIAL.

cc. Faculty Officer
cc. Supervisor (Dr. BR Bhengu)

APPENDIX B

INFORMATION DOCUMENT

Study title: The analysis of the relationship between leadership styles, organizational factors and retention of professional nurses in health care facilities in KwaZulu- natal

Greetings: Your participation in this research will contribute towards further development of knowledge which is useful to the health care delivery of the country.

Introduction:
I am, **Zethu Zerish Nkosi**., from the University of KwaZulu- Natal, Howard College Campus, Durban, doing research on **The analysis of the relationship between leadership styles, organizational factors and retention of professional nurses in health care settings**.

Research is just the process to learn the answer to a question. In this study we want to learn about different leadership styles with organizational factors and how they influence retention of professional nurses in your institution.

Invitation to participate: I am therefore asking for your permission to participate in this research study

What is involved in the study – You will be asked to fill in the provided questionnaire, answer few questions and also join a focus group. It should take at least twenty minutes to complete this form. I will also ask you about four questions which might take six minutes. The study only involves professional nurses in KwaZulu- Natal public hospitals and your hospital is one of the chosen.

Risks of being involved in a study: This study does not involve any harm or risk.

I may inconvenience you in terms of time, but I will not compel you to fill it on duty.

Benefits: In the long term, you may see the benefit of the study in terms of future evidence based retention strategies.

Alternative: If you do not find time during breaks, you may take the questionnaire home, but I would appreciate if you kindly bring it back within a week. I will be collecting it personally.

You will be kept informed about the process and the outcome of the study.

Participation is voluntary, refusal to participate will involve no penalty or loss of benefits to which you are entitled to , and you may discontinue participation at any time without penalty, loss of benefits to which you are otherwise entitled.

Reimbursements: There is no reimbursement involved in this study but it is hoped that you will benefit from the findings.

Confidentiality: Efforts will be made to keep personal information confidential. Absolute confidentiality cannot be guaranteed. Personal information may be disclosed if required by law.

Organizations that may inspect and/or copy your research records for quality assurance and data analysis include groups such as the Research Ethics Committee. Results will be published but no names of people or institutions will be divulged.

I will be available to answer any questions that you may have

My contact details are Ms Z.Z.Nkosi, School of Nursing at 031- 260 2901– **for further information / reporting of study related adverse events.**

My supervisor's details are Dr B.R.Bhengu, School of Nursing at 031-260 1134

APPENDIX C

INFORMED CONSENT

Study title : The analysis of the relationship between leadership styles, organizational factors and retention of professional nurses in public health care facilities in KwaZulu- Natal

Consent to Participate in Research

You have been asked to participate in a research study.

You have been informed about the study by Ms Z.Z. Nkosi

Where applicable: You have been informed about any available compensation or medical treatment if injury occurs as a result of study-related procedures;

You may contact Dr B.R.Bhengu at 031-2601134 any time if you have questions about the research or if you are injured as a result of the research.

You may contact the Research Office at the Westville Campus at 031-260 3587 if you have questions about your rights as a research subject.

Your participation in this research is voluntary, and you will not be penalized or lose benefits if you refuse to participate or decide to stop.

If you agree to participate, you will be given a signed copy of this document and the participant information sheet which is a written summary of the research.

The research study, including the above information, has been described to me orally. I understand what my involvement in the study means and I voluntarily agree to participate.

_____ _____

Signature of Participant Date

_____ _____

Signature of Witness (Where applicable) Date

_____ _____

Signature of Translator (Where applicable) Date

APPENDIX D: CASE STUDY PROTOCOL

Variable	Participants	Foci of data collection	Data collection method
Leadership style	Chief Nursing Service Managers Chief Professional Nurses	Visibility and Accessibility Professional development Manager Activities	Interview guide Manager Activity Scale
Retention strategies	Chief Nursing Service Managers Chief Professional Nurses Professional Nurses Union managers South African Nurses with overseas experience	Impact of available retention strategies Turnover rates Support given to Professional nurses Career development opportunities Role in supporting professional nurses	Interview guide CWEQ 11 NWI-R Interview guide Questionnaire Focus groups
Organizational factors	Professional nurses Chief Professional Nurses	Access to information Access to opportunity Access to support Access to resources Job Activity Manager Activity	CWEQ 11 NWI-R
Relationship among the variables	Chief Professional Nurses Professional Nurses Chief Nursing Service Manager	Organizational factors scores Qualitative data analysis	CWEQ 11 NWI-R Responses from the in-depth interviews

APPENDIX E

PROFESSIONAL NURSE QUESTIONNAIRE

Hospital code	
Participant code	

DEMOGRAPHIC DETAILS

Please insert X in the space provided.

1. Gender

Female		1
Male		2

2. Age

21-30		1
31-40		2
41- 50		3
51- 60		4
60+		5

3. Highest Nursing Qualification

Diploma		1
Bachelor Degree		2
Honours Degree		3
Masters Degree		4
PhD		5

4. Non-Clinical Qualification

None		0
Management/ Administration		1
Education		2
Other, please specify		3

5. Clinical Qualification

None		1
ICU		2
OT		3
PHC		4
Orthopaedics		5
Advanced Midwifery		6
Midwifery		7
Oncology		8
Psychiatry		9
Trauma		10
Community		11
Paediatrics		12
Other, please specify		13

6. Years of nursing experience

1-5 yrs		1
6-10 yrs		2
11-15 yrs		3
16 & above		4

7. Union affiliation

None		0
Denosa		1
Hospersa		2
Nehawu		3
Other, please specify		4

Below is a list of statements. Read each one carefully, then using the scale below, decide the extent to which it actually applies to you.

Item	Strongly disagree 1	Disagree 2	Neither 3	Agree 4	Strongly agree 5
8. My present salary is satisfactory					
9. There is opportunity for me to participate in hospital decision –making process					
10. I need more autonomy in my daily practice					
11. I understand the vision of the hospital					
12. I have career development opportunities					
13. My nurse manager is a good manager and leader					
14. I am satisfied with my job					
15. I am satisfied with the CNSM					
16. I would recommend this hospital to a friend as a place of employment					
17. I have access to regional and national conferences					
18. I have access to active in-service programs for nurses					
19. I have support for pursuing degrees in nursing					
20. I have flexible work schedules					
21. I have access to continuing education programmes for nurses					
22. I have opportunities for advancement					
23. I am satisfied with opportunities for professional development					
24. The unit manager is a good manager and leader					

Item	Strongly disagree 1	Disagree 2	Neither 3	Agree 4	Strongly agree 5
25. The unit manager is supportive to nurses					
26. The unit manager backs up nurses in case there are conflicts with doctors					
27. I am satisfied with the unit manager					
28. The unit manager consults with staff on daily problems					
29. The CNSM is equal in authority to senior management team					
30. The CNSM is visible to staff					
31. The CNSM is equal in power to other top level hospital executives					
32. The CNSM is accessible to staff					
33. I am satisfied with my job					
34. I would not consider taking another job					
35. I have to force myself to come to work much of the time					
36. I like my job better than other nurses					
37. I feel that each day on the job will never end					
38. I find real enjoyment on my work					
39. Overall, my current work environment empowers me to accomplish my work in an effective manner					
40. Overall, I consider my workplace to be an empowering environment					

Please rate how much opportunity you have in your present job for the following:

Item	None 1	A little 2	Some 3	Enough 4	A lot 5
41. Challenging work					
42. The chances to gain new skills and knowledge on the job					
43. Tasks that use all of your own skills and knowledge					

Please rate how much access to information you have in your present job.

Item	None 1	A little 2	Some 3	Enough 4	A lot 5
44. The current state of the hospital					
45. The values of top management					
46. The goals of top management					

Please rate how much access to support you have in your present job.

Item	None 1	A little 2	Some 3	Enough 4	A lot 5
47. Specific information about things you do well					
48. Specific comments about things you could improve					
49. Helpful hints or problem solving advice					

Please rate how much access to resources you have in your present job.

Item	None 1	A little 2	Some 3	Enough 4	A lot 5
50. Time available to do necessary paperwork					
51. Time available to accomplish job requirements					
52. Acquiring temporary help when needed					

Please rate the following in your present job.

Item	None 1	A little 2	Some 3	Enough	A lot 5
53. Rewards for innovation on the job					
54. Amount of flexibility					
55. Amount of visibility of my work related activities within the institution					

Where do you see yourself in the following years as far as the nursing career?

56. One year ----------

57. Three years----------

58. Five years----------

59. What are your future career plans?

_____

_____

_____

_____

To what extent do you feel that your manager is able to?

Item	Never 1	Rare 2	Sometimes 3	Often 4	Always 5
60. Intercede favourably on behalf of someone in trouble in the organization					
61. Get a desirable placement for a talented subordinate					
62. Get approval for expenditures beyond the budget					
63. Motivate for incentives					
64. Get items on the agenda at policy meetings					
65. Get fast access to top decision makers					
66. Get regular, frequent access to top decision makers					
67. Get early information about decisions and policy shifts					
68. Bring in materials, money and resources to enable the department to achieve its goals					
69. Initiate innovative activities without the approval of senior management					
70. Get the backing for implementing innovative strategies					

THANK YOU

APPENDIX F

QUESTIONNAIRE FOR CHIEF PROFESSIONAL NURSE

Hospital code	
Participants code	

DEMOGRAPHIC DETAILS

Please insert X in the space provided.

1. Gender

Female		1
Male		2

2. Age

21-30		1
31-40		2
41- 50		3
51- 60		4
60+		5

3. *Highest Nursing Qualification*

Diploma		1
Bachelor Degree		2
Honours Degree		3
Masters Degree		4
PhD		5

4. Non-Clinical Qualification

None		0
Management/ Administration		1
Education		2
Other, please specify		3

5. Clinical Qualification

None		1
ICU		2
OT		3
PHC		4
Orthopaedics		5
Advanced Midwifery		6
Midwifery		7
Oncology		8
Psychiatry		9
Trauma		10
Community		11
Paediatrics		12
Other, please specify		13

6. Years of nursing experience

1-5 yrs		1
6-10 yrs		2
11-15 yrs		3
16 & above		4

6.a. Years of management experience

Less than 1 year		1
1-3 yrs		2
4-6 yrs		3
7 -9 yrs		4
10 & above		5

7. Union affiliation

None		0
Denosa		1
Hospersa		2
Nehawu		3
Other, please specify		4

Below is a list of statements. Read each one carefully, then using the scale below, decide the extent to which it actually applies to you.

Item	Strongly disagree 1	Disagree 2	Neither 3	Agree 4	Strongly agree 5
8. Nurses have access to continuing education programmes for nurses					
9. There is a schedule for advancement					
10. There is a roster for staff development					
11. Nurses are sent for in-service programs					
12. There are regular ward meetings					
13. Nurses are part of the decision making process in the unit					
14. I support nurses in all they do					
15. I am visible to staff					
16. I am accessible to staff					
17. There is opportunity for growth in my unit					
18. I encourage my team to participate in decision-making					
19. Overall, my current work environment empowers me to accomplish my work in an effective manner					
20. Overall, I consider my workplace to be an empowering environment					

Please rate how much opportunity you have in your present job for the following:

Item	None 1	A little 2	Some 3	Enough 4	A lot 5
21. Challenging work					
22. The chances to gain new skills and knowledge on the job					
23. Tasks that use all of your own skills and knowledge					

Please rate how much access to information you have in your present job.

Item	None 1	A little 2	Some 3	Enough 4	A lot 5
24. The current state of the hospital					
25. The values of top management					
26. The goals of top management					

Please rate how much access to support you have in your present job.

Item	None 1	A little 2	Some 3	Enough 4	A lot 5
27. Specific information about things you do well					
28. Specific comments about things you could improve					
29. Helpful hints or problem solving advice					

Please rate how much access to resources you have in your present job.

Item	None 1	A little 2	Some 3	Enough 4	A lot 5
30. Time available to do necessary paperwork					
31. Time available to accomplish job requirements					
32. Acquiring temporary help when needed					

Please rate the following in your present job.

Item	None 1	A little 2	Some 3	Enough	A lot 5
33. Rewards for innovation on the job					
34. Amount of flexibility					
35. Amount of visibility of my work related activities within the institution					

To what extent do you feel that you as a manager is able to?

Item	Never 1	Rare 2	Sometimes 3	Often 4	Always 5
36. Intercede favourably on behalf of someone in trouble in the organization					
37. Get a desirable placement for a talented subordinate					
38. Get approval for expenditures beyond the budget					
39. Motivate for incentives					
40. Get items on the agenda at policy meetings					
41. Get fast access to top decision makers					
42. Get regular, frequent access to top decision makers					
43. Get early information about decisions and policy shifts					
44. Bring in materials, money and resources to enable the department to achieve its goals					
45. Initiate innovative activities without the approval of senior management					
46. Get the backing for implementing innovative strategies					

THANK YOU

APPENDIX G

INTERVIEW GUIDE FOR CHIEF NURSING SERVICE MANAGER (CNSM)

Probing will be done to obtain depth and breadth of the response.

1. What changes have you made since you started in this position?
2. How do you operationalize your vision?
3. What kind of a leader are you?
4. How would you describe your leadership style?
5. What support do you give your staff?
6. How often do you give incentives to your staff?
7. What is the staff turnover in your institution, especially among professional nurses, in a month over the last twelve months?
8. How do you encourage professional nurses to stay in your organization?

APPENDIX H

TITLE: Analysis of leadership styles, organizational factors and staff retention among professional nurses in public health care institutions in KwaZulu-Natal province.

INTERVIEW GUIDE FOR UNION LEADERS

1. How many nurses are affiliated to your organization?
2. How many professional nurses are part of the above number?
3. How often do you hold meetings?
4. What activities are done in your meetings?
5. What are the common grievances which are raised by professional nurses?
6. What support do you give to your members?
7. What problems are raised by professional nurses?
8. How do you deal with problems?
9. How can we retain nurses in our country?
10. Would you like to share any information which you feel will be of good use to my study

APPENDIX I

Western
Dr. Heather K. Spence Laschinger
Professor
Associate Director Nursing Research
School of Nursing
The University of Western Ontario
London, Ontario N6A 5C1

Ms. Zethu Nkosi
School of Nursing, Howard College Campus
University of KwaZulu-Natal
Durban, 4041, South Africa

SCORING of NURSING WORK EMPOWERMENT SCALES

CWEQ-I, CWEQ-II, JAS, ORS, AND MAS

I am pleased to give permission to use these instruments in your study. A request form is available at http://publish.uwo.ca/~hkl/request.html. I would ask that you provide me with a copy of the data (on disk) to enable me to add your data to the existing database.

Based on confirmatory factor analyses on 2 independent data sets (Sabiston, 1994 and Kutzscher, 1994), the combination of the Conditions of Work Effectiveness scale (CWEQ), The Job Activities Scale (JAS), and the Organizational Relationships Scale (ORS) provides a measure of Kanter's concept of work empowerment. That is, if individuals score highly on these scales, they perceive themselves to be working in an empowered work environment. The JAS and ORS have been found to be strong predictors of the CWEQ scores in several independent studies (Kutzscher & Laschinger, 1994; Sabiston & Laschinger, 1995; Dubuc, 1995; McKay, 1995; Huffman, 1995; Whyte, 1995; Laschinger & Havens, 1996; Govers, 1997; O'Brien, 1998; Sproule, 1998; McBurney, 1998; Laschinger, Wong, McMahon, & Kaufmann, 1999; Baguley, 1999; Casier, 2000; Shephard, 2000) and can be used as separate scales to measure particular aspects of job-related empowerment if the researcher is interested in these components.

The 31-item Conditions for Work Effectiveness Questionnaire (CWEQ) is used to measure nurses' perceptions of their access to the four work empowerment structures described by Kanter: opportunity, information, support, and resources. Items were derived from Kanter's original ethnographic study of work empowerment and modified by Chandler (1986) for use in a nursing population. Chandler (1986) conducted a factor analysis on the questionnaire items to establish construct validity with a nursing population with three factors emerging – support, information, and opportunity. The resources subscale was considered unreliable and was modified by Laschinger and a panel of nursing experts. Face and content validity for this subscale has since been established (Wilson, 1993). Subscale mean scores are obtained by summing and averaging items (range 1-5) with high scores indicating higher levels of perceived access to information, support, resources and/or opportunity. An overall empowerment score is calculated by summing the four subscales of the CWEQ (score range 4 to 20). High scores represent strong access to opportunity and power structures in the organization. Alpha reliabilities have been strong (see attached table) with the Resource subscale needing strengthening. The test-retest has been found to be acceptable, and the CWEQ has been shown to be able to discriminate meaningfully among incumbents in various levels of the organizational hierarchy. For instance, senior administrators scored higher than middle managers who, in turn, were higher than staff professionals (Laschinger, 1996; Kutszcher, Nish, Laschinger, & Sabiston, 1997). Scores ranging from 4 to 9 are described as low levels of empowerment, 10 to 14 as moderate levels of empowerment, and 16 to 20 as high levels of empowerment. In 1995, a global measure of empowerment (GE) was added to the questionnaire as a validation index. The GE score is obtained by summing and averaging the two global empowerment items at the end of the questionnaire.

The Job Activities Scale (JAS) (Laschinger, 1996) has been revised to improve internal consistency and is now a 9-item scale that measures staff nurses' perceptions of formal power within the work

The Organizational Relationships Scale (ORS) (Laschinger, 1996) is an 18-item instrument that measures staff nurses' perceptions of informal power within the work environment. Items are designed to measure perceptions of political alliances, sponsor support, peer networking, and subordinate relationships in the work setting. Content validity was established through pilot testing of the instrument with a convenience sample of registered nurses. Items are summed and averaged to yield a score ranging from 1-5. This scale has been found to have strong internal consistency (see attached tables). High scores represent a strong network of alliances in the organization or high informal power.

The Conditions of Work Effectiveness Questionnaire-II (Laschinger, Finegan, Shamian, & Wilk, 2001), a modification of the original CWEQ, consists of 19 items that measure the 6 components of structural empowerment described by Kanter (opportunity, information, support, resources, formal power, and informal power), and a 2-item global empowerment scale which is used for construct validation purposes. Items on each of the six subscales are summed and averaged to provide a score for each subscale ranging from 1-5. These scores of the 6 subscales are then summed to create the total empowerment score (score range: 6-30). Higher scores represent higher perceptions of empowerment. The construct validity of the CWEQ-II was substantiated in a confirmatory factor analysis that revealed a good fit of the hypothesized factor structure (χ^2 = 279, df = 129, CFI = .992, IFI = .992, RMSEA = .054). The CWEQ-II also correlated highly with the global measure of empowerment (r = 0.56), providing additional evidence of construct validity. Details of this analysis can be found in Laschinger, Finegan, Shamian and Wilk (2001). Scores ranging from 6 to 13 are described as low levels of empowerment, 14 to 22 as moderate levels of empowerment, and 23 to 30 as high levels of empowerment. The 2 global empowerment items are summed and averaged to create a score ranging from 1-5. This score is not included in the structural empowerment score. The correlation between this score and the total structural empowerment score provides evidence of construct validity for the structural empowerment measure.

The Manager's Activities Scale (MAS), formerly ODO-B, measures managers' ability to mobilize resources to get things done in the organization. Items are based on behaviours described by Kanter as representative of powerful managers. The instrument can be used to measure either staff's perceptions of their manager's power or managers' own perception of their power (the stem of the questionnaire should be changed depending on what group is being measured). Items are summed and averaged to yield a score ranging from 1-5. Reliability (internal consistency) has been found to be high, as has test-retest.

Last Updated August, 2004

NURSING WORK EMPOWERMENT SCALE

Request Form

I request p mission to copy the Nu sing Work Empowerment Scale as developed by Dr. G. Chandler and Dr. He ther K. Spence Laschinger. Upon completion of the research, I will provide Dr. Laschinger with a brie summary of the results, including information related to the use of the Nursing Work Empowerment Scale used in my study.

Questionnaires Requested

- ✓ Co ditions of Work Effectiveness-I (staff version) (includes JAS and ORS)
- ✓ Co ditions of Work Effectiveness-II (includes JAS-II and ORS-II)
- ✓ CW Q (manager version)
- ✓ Job Activity Scale (JAS)
- ✓ Organizational Relationship Scale (ORS)
- Manager Activity Scale)

The Organizational Relationships Scale (ORS) (Laschinger, 1996) is an 18-item instrument that measures staff nurses' perceptions of informal power within the work environment. Items are designed to measure perceptions of political alliances, sponsor support, peer networking, and subordinate relationships in the work setting. Content validity was established through pilot testing of the instrument with a convenience sample of registered nurses. Items are summed and averaged to yield a score ranging from 1-5. This scale has been found to have strong internal consistency (see attached tables). High scores represent a strong network of alliances in the organization or high informal power.

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Last Updated August, 2004

NURSING WORK EMPOWERMENT SCALE

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Questionn rs Requested

- ✓ Co li ions of Work effectiv eness-I (staff version) (includes JAS and ORS)
- ✓ Co li ions of Work effectiv eness-II (includes JAS-II and ORS-II)
- ✓ CW 0) (man ager ve sion)
- ✓ Job Activity Scale (JAS)
- ✓ Or; ni zation al Relationship Scale (ORS)
- ✓ OE) B or MAS (M nager ctivity Scale)

Population Under Study: SOUTH AFRICAN NURSE MANAGERS

Name: ZETHU NKOSI Signature: [signature]

Title: MISS Date: 11 APRIL 2005

Address: SCHOOL OF NURSING, UNIVERSITY OF KWAZULU NATAL

Phone: 27 31 2602901

SOUTH AFRICA

Permissi on is here by granted to co py the Nursing Work Empowerment Scale

Date: April 11/05 Signature: [signature]

Di Heat e K. Spence Laschinger
Professo
School o Nursing
The Uni ersity of Western Ontario
London, Ontario, Canada N6A 5C1
Tel (51) 661-4065 FAX (519) 661-3410
EMAIL: [illegible]

Return to Table of Contents

APPENDIX J

UNIVERSITY OF
KWAZULU-NATAL

06 March 2006

The Superintendent- General
Department of Health
P.O.Box x9051
Pietermaritzburg
3200

Dear Mr. Tromp

RE: APPLICATION FOR PERMISSION TO COLLECT DATA IN SELECTED PUBLIC HOSPITALS IN KWAZULU- NATAL

TITLE: The analysis of the relationship between leadership styles, organizational factors and retention of professional nurses in public health care facilities in KwaZulu- Natal

I hereby wish to obtain permission collect data in selected public hospitals and Department of Health in KwaZulu –Natal. I am a PHD candidate studying at the School of Nursing, University of KwaZulu- Natal. Further permission will be sought from the Head of selected institutions and the participants. Enclosed are the following:

- Ethical clearance from the Ethics Committee at the University of KwaZulu- Natal
- Information document
- Informed consent
- Research Proposal
- Research Instruments (Questionnaires and Interview Guide)

Yours faithfully

Ms Z.Z.Nkosi
PHD student

Dr B.R Bhengu
Research Supervisor

School of Nursing
Decentralised Programmes

Postal Address: Durban 4041, South Africa

hone: +27 (0)31 260 2901 Facsimile: +27 (0)31 260 1543 Email: nkosizz@ukzn.ac.za Website: www.ukzn.ac.za

Founding Campuses: Edgewood Howard College Medical School Pietermaritzburg Westville

DEPARTMENT OF HEALTH

PROVINCE OF KWAZULU-NATAL

SPECIAL SUPPORT SERVICES

Natalia, 330 Longmarket Street, Pietermaritzburg, 3201
Private Bag X9051, Pietermaritzburg, 3200
Tel.: 033 395 2813, Fax.: 033 345 4433

Enquiries: Ms A. Kopman
Extension: 2813
Reference: 9/2/3/R

22 MAR 2006

Ms Z. Nkosi
University of KwaZulu-Natal
~~Research Office(Govan Mbeki Centre)~~
Westville Campus
DURBAN
4041

Dear Madam

APPLICATION FOR PERMISSION TO COLLECT DATA IN SELECTED PUBLIC HOSPITALS IN KWAZULU-NATAL

Your letter dated 06 March 2006, refers.

Please be advised that authority is granted for you to conduct a data collection on " **The analysis of the relationship between leadership styles, organizational factors and retention of professional nurses in public health care facilities in KwaZulu-Natal**" at various hospital in KwaZulu-Natal, provided that :-

(a) Prior approval is obtained from the Heads of the institutions;

(b) Confidentiality is maintained;

(c) There is no disruption of service delivery and patient care is not compromised;

(d) The Department is acknowledged; and

(e) The Department receives a copy of the report on completion.

Yours sincereiy

22/03/06

HEAD : DEPARTMENT OF HEALTH
KWAZULU-NATAL
AJK/nkosi

APPENDIX L

HEALTH
KwaZulu Natal

KING EDWARD VIII HOSPITAL
Private Bag X02, CONGELLA 4013
Corner of Francois & Sydney Road
Tel.:3603853, Fax.:031 2061457
Email.:khuzwayo@.kznil.gov.za
www.kznhealth.gov.za

Enquiries : Miss. R. Khuzwayo
Reference : KE 2/7/1 (26/2006)
Research Programming

27 July 2006

Ms. ZZ Nkosi
School of Nursing
University of KwaZulu-Natal
Westville Campus
DURBAN

Dear Ms. Nkosi

Request to conduct research at King Edward VIII Hospital
Protocol: The Analysis of the relationship between leadership styles, organisazational factors and retention of professional nurses in the public health facilities in KZN

Your request to conduct research at King Edward VIII Hospital has been approved.

Please ensure the following:

- That King Edward VIII Hospital receives full acknowledgment in the study on all publications and reports and also kindly present a copy of the publication or report on completion.
- Before commencement:
  - Discuss your research project with our relevant Directorate Managers
  - Sign an indemnity form at Room8, CEO's Complex, Admin. Block.

The Management of King Edward VIII Hospital reserves the right to terminate the permission for the study should circumstances so dictate.

Yours faithfully

MR. M. BHEKISWAYO
CHIEF EXECUTIVE OFFICER 28/7/06

cc: *All Directorate Managers: A&E/Critical Care/General Surgery/Internal Medicine/O&G/Orthopaedics/Paediatrics /Radiology/Specialty Services/Theatre*

DEPARTMENT OF HEALTH

PROVINCE OF KWAZULU-NATAL

PORT SHEPSTONE REGIONAL HOSPITAL

Cnr Bazley and Colley Street
Private Bag X5706, Port Shepstone, 4240
Tel.: 039 6886000, Fax.: 039 6825404

FAX TRANSMISSION

TO : Ms Z.Z. Nkosi
University of KwaZulu-Natal

FAX NO : 031 - 2601543

FROM : Mr B.L. Ngcobo

PAGES TRANSMITTED (INCLUDING COVERSHEET) : 2

RE : PERMISSION TO COLLECT DATA FOR PHD STUDIES

MESSAGE :

LADYSMITH PROVINCIAL HOSPITAL

PRIVATE BAG X9928
LADYSMITH
3370

TEL: (036) 637 2111
FAX: (036) 637 6457

21 April 2006

Enquiries: Mrs L.P. Zikalala
Extension: 201

Attention: ***Miss Z Nkosi***

University of KwaZulu Natal
School Of Nursing
Westville Campus
DURBAN
3370

Dear Madam

Consent for the aforementioned research is hereby granted.

Thank You,

Mrs L.P. Zikalala
Nursing Services Manager

APPENDIX O

PROVINCE OF KWZULU NATAL HEALTH SERVICES	ISIFUNDAZWE SAKWAZULU NATAL EZEMPILO	PROVINSIE VAN KWAZULU NATAL GESONDHEIDSDIENST

TEL: 035-5741004
FAX: 035-5741003
ENQUIRIES: MRS C.T. FAKUDE
IMIBUZO:

MSELENI HOSPITAL
P.O.SIBHAYI

DATE: 10.04.2006

Ms Z.Z. Nkosi
University of KwaZulu Natal
Durban
4041
SOTUH AFRICA

RE AUTHORITY TO COLLECT DATA FOR PHD STUDIES AT MSELENI HOSPITAL

We wish to state that you have been granted authority by Mseleni Hospital Management to conduct your research in our institution

Thank you

NURSING MANAGER
FOR HOSPITAL MANAGER

UMNYANGO WEZEMPILO
UNDAZWE SAKWA-ZULU NATAL
MSELENI HOSPITAL
NURSING MANAGER
DATE: 2006/04/14
P.O. SIBAYI 3967
PROVINCE OF KWA-ZULU NATAL
DEPARTMENT OF HEALTH

APPENDIX P

DENOSA

Democratic Nursing Organisation of South Africa

Provincial Office
1320 Durdoc Centre
460 Smit Street
Durban, 4001

PO Box 23
Durban
4000

Tel (031) 305-1417/8
Fax (031) 304-5897
E-mail: cassiml@denosa.org.za

17 December 2008

To : University of KZN
School of Nursing

Attention : Ms Z.Z. Nkosi

Per facsimile : 031-260 1543

Dear Ms Nkosi

PERMISSION TO COLLECT DATA FOR PHD STUDIES

Kindly be informed that permission has been granted as per your request to collect data for your PHD studies. For any further clarity do not hesitate to contact the writer on the mobile number 082 8211 465.

Thank you,

Yours sincerely

.....
Cassim Lekhoathi (Mr.)
Provincial Secretary – KZN

CL/nb

APPENDIX Q

HOSPERSA

FOR SERVICE - WORKER EMPOWERMENT

HEALTH AND OTHER SERVICE PERSONNEL
TRADE UNION OF SOUTH AFRICA

KWAZULU/NATAL PROVINCIAL OFFICE
44 Henrietta Street
PIETERMARITZBURG
3201
P O Box 364
PIETERMARITZBURG
3200

☎ (033) 342-6847
F (033) 394-5768

08 May 2006

University Of KZN
School Of Nursing

Attention: Ms Z.Z Nkosi

RE: PERMISSION TO COLLECT DATA FOR PHD STUDIES

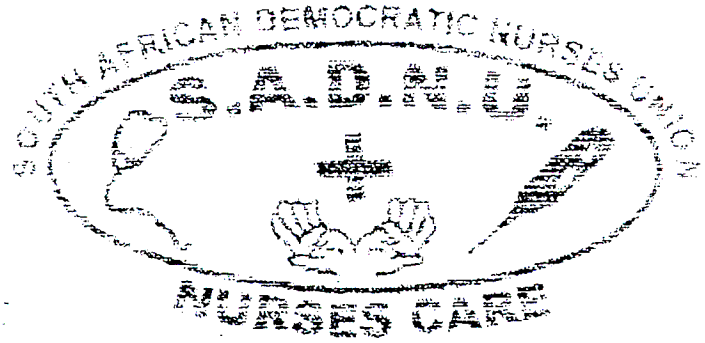
Dear Ms Nkosi

I hereby wish to confirm that your request to collect data for your PHD studies has been granted. Should you require more information you can contact our offices, we open from 07h30 to 16H30.

Regards

Mike Ryan
Provincial Secretary

APPENDIX R



Fourth Floor Room 2
Stabilitas Building
39A Maitland Street
P.O Box 9637
BLOEMFONTEIN
Tel: +27 51 448 7551
Fax + 27 51 448 6365
Email sadnu@iafrica.com

10 March 2008

University of KZN
School of Nursing

Attention : Miss Z.Z. Nkosi,

Re: Permission to Data for PHD Studies

Madam,

I hereby wish to confirm that your request to collect data for your PHD studies has been granted. Should you require more informatio you can contact our offices we open from 07H30 to 16H30.

Regards

NOMUSA ZULU
2nd Deputy President

APPENDIX S

NEHAWU

National Education Health & Allied Workers Union

BHEKI MKHIZE REGION
E-Mail:siyandazungu@ananzi.co.za

Regional Office
EMPANGENI
P/Bag x 2002
EMPANGENI, 3880

Tel: (035) 901 7789
(035) 901 6512
Fax:(035) 794 1905

Website: www.nehawu.org.za

Sir/Madam

REQUEST TO INTERVIEW NEHAWU MEMBERS

Your are granted a permission to interview Nehawu members as per your request

We wish you all the best.

WS Zungu

Regional - Chairperson

APPENDIX T

The South African Nursing Council

18 July 2006

For Attention: Ms Z Z Nkosi
PHD Candidate

University of Zululand
Private Bag X 54001
Durban
4000

Dear Ms Nkosi

RE: PERMISSION TO COLLECT DATA FOR PHD STUDIES

Your letter dated 28 March, 2006 has reference.

The data required by your research does not exist at Council.

Council only have data on nurses applying for verifications (indicating intention to leave the country) but it does not have information on nurses who have actually left the country.

Statistics on the number of applications received/processed can be obtained from the Registration Section.

Contact person: Ms L Hlaisi
Tel no: (012) 420 1047

Kind regards

DR GRACE RAMADI
DEPUTY REGISTRAR

Eastlake Street Arcadia Tshwane 0083 Box 1123 Tshwane 0001
Tel + 27 12 420 1000 Fax + 27 12 323 5400

APPENDIX C

DEPARTMENT OF HEALTH

PROVINCE OF KWAZULU-NATAL

ST MARY'S KWAMAGWAZA HOSPITAL

Private Bag X 808, Melmoth, 3835
Tel.: 035 450 2071, Fax.: 035 450 2050
Email.:h020398@dohho.kzntl.gov.za

Dear Ms Nkosi

I acknowledge the receipt of your letter requesting to do the research in our Hospital

Permission has been granted but I regret to inform you that we don't have accommodation.

Ms T. J. Vezi

Ms T.J. Vezi
Nursing Service Manager

APPENDIX V

DEPARTMENT OF HEALTH

PROVINCE OF KWAZULU-NATAL

INKOSI ALBERT LUTHULI CENTRAL HOSPITAL

DEPARTMENT:
800 Bellair Road, Mayville, 4091
Private Bag X03, Mayville, 4058
Tel.: 031 240 1000, Fax: 031 240 1050
Email.: @ialch.co.za

Enquiries: Mrs P.P. Zungu

Date: 18th April 2006

Ms Z.Z. Nkosi
PHD Candidate
Research Office (Govan Mbeki Centre)
Westville Campus

Attention:

Re: PERMISSION TO COLLECT DATA IN PUBLIC HOSPITALS.

Dear Ms Nkosi

With reference to your letter dated 28/03/06-requesting permission to collect data for PHD studies, please note that your request has not been approved because IALCH is in the process of finalizing the organizational structure with OD&E, as an internal matter.

We, however, appreciate the interest.

Thank you

On behalf of Mrs F.G. Zondi

Yours sincerely,

Mrs. P.P. Zungu
Acting Nursing & Quality Manager
Inkosi Albert Luthuli Central Hospital

INKOSI ALBERT LUTHULI CENTRAL HOSPITAL
2006 -04- 18
NURSING & QUALITY MANAGEMENT

APPENDIX W

DOCUMENT REVIEW

Type of document	Available				Unavailable				Maintained			
1. Policy manuals												
2. Job Description												
3. Duty Rooster												
4. Qualifications												
5.In-service education within the unit												
6.In service education outside the hospital												
7. Application for study leave												
8. Selection of candidates												
9. Minutes of the meeting												
10. Communication within the unit												
11 Servicing the equipment												

APPENDIX Y: WORKING DOCUMENT ON RETENTION OF PROFESSIONAL NURSE

PREAMBLE: The Department of Health strives to offer optimal health for all persons in KwaZulu- Natal by fighting disease, fighting poverty and giving hope. In order to attract and retain top calibre staff, the DOH will offer competitive conditions of employment and opportunities to achieve career goals and develop the full potential of staff. Development of knowledge, skills and attitudes enhances the performance of staff in their current tasks and prepares them for the emerging roles to which they will need to adapt. One of the core values of the DOH is to encourage the employees to learn, change and bring innovative ideas to the services within the South African Health Care System.

PURPOSE: The purpose of this document is to inform the policy which will guide the education and training needs and activities of all professional nurses within the KZN province.

OBJECTIVES

- To encourage individual staff members to acquire knowledge and skills that allow them to carry out their current duties with maximum effectiveness and efficiency;
- To enable individuals or groups of staff to be innovative, creative, and productive and to deal positively with the demands placed on them by transformation , institutional change and geographical imbalances;
- To provide mechanisms for individuals to develop skills, knowledge and/or gain qualifications and expertise, in order to contribute to the development of the DOH as well as their own professional and career development.

PROCEDURE:

- All professional nurses must be allowed to further their studies in the chosen educational institutions by the Department of Health
- The Heads of the Institutions should comply with the set selection criteria. On completion of training, students should return to their original hospitals and work the equal number of training years.
- In case, the student resigns immediately after completing training, she/he must pay the DOH all the training fees incurred.
- The agreement form between the employer and the employee should be signed before commencement of training.

DEFINITION OF TERMS

Learning: Activities focused on the acquisition of knowledge, skills, attitudes and values that reflect and resonate with the vision and mission of the Department of Health (DOH), including the concept of life-long learning, building a positive organizational culture and encouraging innovation.

Training: Activities focused on acquiring and improving specific competences and capacities to improve performance in current jobs and positions, especially toward achieving the goals of the DOH.

Development: Activities focused on continuous education and training to stay abreast with a changing work environment and enhance career progression, incorporating opportunities for both personal and professional development by realizing individual potential and a future role in the organization.

Retention: The term is applied to professional nurses who stayed in the country and did not leave their health organizations to go.

SCOPE

This policy shall apply to all permanent staff members who are employed by Department of Health.

POLICY PROVISIONS

Policy Statement

The DOH is committed to creating an enabling, equitable, supportive, challenging and stimulating working environment, which values and empowers its staff at all levels. Staff learning, training and development is seen as an integral factor in achieving this commitment.

Principles

Staff learning, training and development will be based on the following principles:
Equal opportunity for all staff,
Adherence to principles of employment equity,
Cost effectiveness,
Fairness, transparency and consistency in treatment of staff.

Interview with DENOSA representative

Z: How many nurses are affiliated to your organization?

C...numbers today are ...+-12 000-13000 nurses in the province, nationally we've got 76000 in the country.

Z: 14000 nurses in the public hospital?

C: From the 76000, there are 50000 who belong to the public sector and the rest belong to the private sector.

Z. How many professional nurses are part of the above number?

C...mmm..... I do not have a figure right now ....

Z: How often do you hold meetings with your members?

C: Meetings within the province, locally in the institution, they are held regions (8) and also provincially. This takes in the form where I meet a number of shop stewards at a shop steward council. When the need arise for me to address them I do visit

in the regions and institution. Due to the vastness of the problem and the numbers of members in the province it's also impossible to meet them all.

Z: Each institution has their own shop stewards and the shop stewards are doing everything delegated by you and according to the job descriptions

C: They hold their meetings and give feedback.

Z: What activities are done in these meetings?

C: These meetings recruit those members who have left the organizations back to the organization and also for those members who are not part of the organizations we recruit members to our organization.

Other things is to discuss problems issues and experiences with specific reference and how best to resolve them. The common problems are labour relation issues and the working conditions.

Z: With my traveling, going to different areas, I have noticed that other union members are very powerful and they can even challenge what is being done by the government.

C: How we get involved in the challenging issues? At macro level we have Institutional Labour and Management Forum (ILMF) where Issues of mutual interest concerning the institution are dealt with. Management is advised to consult with the recognized unions. If these issues are not revolved they declare a dispute. Issues of mutual issues are discussed

Z: what are common grievances that are raised? What are common problems that are faced by professional nurses?

C: There are a vast number of complaints raised by nurses No1 is working conditions

(2) Shortage of staff----------comes high on the agenda and lack of equipment resources. The other staff is the non-remuneration of staff, especially staff nurses are holding the fort but at the end are not being remunerated for that. This has specific reference to rural and scarce skill allowance .We have noticed over the past few years that there has been a major migration of urban nurses to rural areas. Migration is the cause of this incentive which is the rural allowance. In no time these nurses come back because they cannot stand the conditions.

The other problems that are being discussed are attitude problems between junior members and senior members. We, as the organization try to dissolve this issue.

We encourage them to find ways of resolving problems because senior members are also members of the organization. Nursing is still enjoyed in a military style where matrons are still having the power to pull down the nurses.

Until we find a synergy between matrons and junior staff we will minimize quite a lot of problems.

Other difficulties we find that contribute to this problem is that lots of manager's lack of empowerment managers are deprived of. They do not have the necessary knowledge.

Managers lack knowledge to either management or labour relations. Because .....You will find that in one of the institutions some of our shop stewards are very conversant about the labour relations act, this makes the nurse managers or supervisors feel out of place. There is a need for them to be empowered in order to manage and also to manage labour relation to minimize unnecessary strikes. Managers need to be empowered

Z; Do you say managers lack skills, lack information. Is there anything that Denosa is doing to support those members of Denosa who are in management positions? but lacks information.

C: In my yearly year plan I do have a programme called Risk management to deal with common problems and malpractices especially in Maternity and OT. These are the common areas where we flawed as nurses where we had to face the rest of the SANC.

Within risk management we also arrange to have management trained..... to train and empower nurse manager and supervisors in how to instill discipline within the institution. We believe that the manager has a prerogative to manage and part of this management is to discipline and If you do not know how to discipline you end up not..., you coming just mmm.... Somebody not to be recognized with and we also at the same time we as a shop steward you have the right to defend your colleagues. So both people need to be empowered, so I do have two shop stewards training which is done twice a year. There is also one advanced shop steward training. We train them to represent nurses at disciplinary hearings up to the level of represent nurse during SANC hearing. Equally we train and empower our nurse managers and supervisors.

Z: Do you offer support during SANC hearings?

C: I must also mention that response is very poor when one advertises such workshops. The department says that they are training managers. The members come back to us and say Denosa we are not equally empowered in terms of dealing with these things. We believe that either DOH provincially is not honest with us because they do not release these people for empowerment. But there is a consenting effort and we believe that we will be able to deal with this issue in the long run, because it is important to have these workshops.

Z: If a member is engaged to any problem they are free to come and report the case to you and represent them. Let me just give an example of a nurse who gave pitocin to the patient and membranes or uterus rupture. What she did was beyond her scope of practice. How do you deal with such cases?

C: What happens is that our line of communication is that when the nurse has a problem in the institution she consults a local shop steward. If the matter is above the scope of shop steward then the regional office will be consulted. The type of cases that you have mentioned, unfortunately you will find that in institutions the standards are different.

Some nurses are performing things that are beyond their scope of practice because of the lack of medical assistance. They take those risks irrespective of them going to be disciplined tomorrow. It is with concern that most of these nurses are doing these things with the aim they it make them better persons at the end of the day or are just enjoying doing such critical activities. We sometimes get report that nurses are assisting in giving of anesthesia and are not trained in giving anesthesia, except that they can assist the anesthetic. They can assist the anesthetic with giving of anesthesia even in the absence of an anesthetic and are advised by the surgeon. Nurses are doing especially it in small hospitals. We do get reports that these things are happening.

With regard of giving of pitocin and the likes or so, that is usually the misinterpretation of the scope of practice especially when the advanced midwife comes in, As long as I get the opinion of another the advanced midwife, our opinion stays and we go on and decide on line of action. The frustration and difficulties is that they call the doctors and doctors do not respond. In small hospitals doctors in do not stay on site, they stay far away and when they leave they switch off their cell phones. If they are fortunate to have a nurse midwife, the midwife is forced to take care of the situation and at times things go bad.

Of recent ....mmm.... There are a lot of cases which at times I ask myself what has gone wrong with our nurses. There was a case of a nurse who was negligent in handling of a stillborn to the extent that nobody knows what happened to the stillborn. It must have been thrown in the bin by the porters because it was left in the sluice room.

Z: Nursing profession is in crisis in terms of staff shortages, high level migration of nurses and the negative report from the media. What are the unions dealing with these issues?

C: The issue of shortage of staff, we have been very vocal on that one whereby... we are knocking at the door of DOH as the biggest employer of the health sector especially nurses. and saying the reality is, that there is a serious shortage of nurses, together with the DOH we have influenced the DOH to increase the intake of nurses to make up for this loss. You increase the intake, you upgrade staff nurses and we are saying to the DOH, the quota you are using now in terms of how many staff nurses should go on training to upgrade staff nurses should be increased and at the same time we say this should work parallel to increasing the number of colleges in the province and ALSO the number of nurse educators, but we are saying as Denosa at the same breadth , we say you must also upgrade their salaries to give them the reason to stay as educators because what we have noticed over the past years .A lot has left the college to go back to service because there is no upward mobility in the education department .

Z: Because the scale.... you know that....

C: The salary scale for level 8 is so stagnant and you cannot go to level 9 it stops there , unless you are a principal or whatever : That has been addressed by next year and hopefully they will be considered moving from level 8-9. We made a proposal that their level needs to be reviewed.

Z: and with the closure of KEH colleges, the number of graduates that are circulating in the province has been depleted.

C: We have noticed that with the closure of colleges there has been a massive mushrooming of the private colleges where they qualify as ENA, EN. We have said the number of nurses we need in this province and this country are RN. The govt must put more money into the development of nurses. Once you have developed staff nurses, you must then allow people.... Because the government had a moratorium that those who trained in private sector will not be taken in to the public hospitals. We said .....Lift that moratorium because if staff nurses have qualified they move on. Take these staff nurses and bring them on because we need a lot of nurses unfortunately and our outcry for the need for more nurses is the scourge of HIV/AIDS. The care, what we call acuity and the amount time and assistance you need to give to the patient now is more than before HIV /AIDS came in to place because people are weaker.

This shortage of staff is resulting into the severity of malpractice and the nurses are either doing more than they are supposed to do or they neglect some of their functions.

Z: .....and it's a problem----------

C: With regarding to migration our position has been always... and I believe we are in line with the constitution of the country. Everybody has the right to movement and the right to employment of his choice and nobody can stop that. And we noted with concern that lately the government was talking to the European government that they should limit the intake of nurses. In a way we are agree with the government of South Africa in the sense that the world developed countries are guilty of criminal activities , what I mean by that is that they are poaching the nurses of south Africa who are skilled. And it is not a disputed fact that the nurse from South Africa is world skilled. The outcry is that the government spends a lot of money in developing a nurse and the developed country just take this nurse well baked and just use her without remunerating her at the rate she is supposed to be given.....A year ago ...I was in Taiwan and the MOH joined us when we welcomed nurses to join us for the World Congress that will be held in South Africa in 2009. In that congress Minister Manto Tshabalala Msimang indicated to the congrants that the WHO is taking serious about the issue of poaching. There is serious consideration to curb this poaching of nurses from developing countries. South Africa has set an example that they will not take nurses from African countries to come and work here. If the need arise, we can bring them here to sister them ...Like twinning

Z: Twinning of hospital---------- What's so contradictory in Denosa update is advertising for international agency who recruit nurses and at the same time saying you are fighting for nurses not to leave the country.

C: I don't think it's a not a contradictory statement because as you recall from the first input earlier. I said we are in line with the constitution of the country .government mandate because everybody has a right to movement and also as an organization having this publication we generate revenue from this.

WE cannot say by the fact that you, Agency X, if you wants to advertise, we will not allow your advert. We do not have restrictions in terms of advertisement, it is for financial viability. From this publication and adverts it makes us to survive.

Z: ok I understand.

C: Many people are saying...you Denosa are talking from both sides of the mouth, one minute you said nurses must not leave the country

Z...but the numbers, I feel you need to control the numbers.

C: There is no way we can control the numbers, we are not the employer .We cannot stop the nurses from going. What we advocate for nurses is that their working conditions to be improved. And we cannot stop people from going but at the same time we talk to our nurses that leaving the country is not a wise idea because nursing is predominantly a female organization, it's a female profession

When you leave as a female, in most cases you leave dependants behind. Some leave husbands behind .When they come back there is disintegration of family

Husband has either increased the family to the left and children have gone astray because of free flow of dollars from overseas. These things you need to be conscious about them.

We have been inundated by calls from nurses outside the country and they want to come back home but they would also like the situation to be improved. The government t is taking note of that and Denosa is speaking to the government ....mmm..... surfice to say that the minister also mentioned not so long ago that she has met 200 nurses from overseas and has promised them that they can come back but the wrong message that was sent there as if those nurses when they come back they would be going to senior post which they have left and that is not good reporting because that will create an outcry.

Z: especially from those who were loyal to the organization

C: Yes, those who were loyal to the government and stood behind. What we are saying is that they should review how they take nurses back. We are not saying that they should not be given into position that they must be sensitive of to the reality of those who were left behind .What's happening in the true sense is that if you left as CPN, when you come back the entry grade is at PN level. It not what we call----mmm

Z: Is it a punitive strategy / measure?

C: It sounds fair but is not competitive. That person is not going to function unfortunately as a Professional Nurse with the vast experience that the person has. We cannot be ignorant that the person has extra knowledge so it's exploitation in a sense rather take the person and put her at the correct level or change the entry level completely and put the person in the proper level so that person perform at her ultimate maximum level

Z: ya …but ----I am thinking about those who have been here.

C: That's why I said ---review nurse's salary and we as Denosa we are happy to know that government is looking at that.

Z; There was a Carteblance insert----- showing a TOP procedure and the whole insert was so disgusting. Patients were removing their own fetuses because the nurses did not want to touch their fetuses. When the matron was asked she said she couldn't do a thing because these two nurses are the only professional nurses in this entire hospital to agree to deal with TOP. Isn't it's our responsibility to nurse the patient in totality?

C: unfortunately i did not see that insert,

Z: OK

C: I disagree with the matron; it is a prerogative of the management to discipline the nurse. It's a prime function of a nurse manager to discipline. As a nurse you do not become judgmental in any patients decision. A nurse should make sure that the patient is nursed in totality. I will follow up the case. If those two professional nurses belong to our organization I will ensure that they are called to order and disciplined accordingly.

Z: There is a lot of negative publicity from the media

C: Media------Let me go back to your point about the nursing profession being in crisis. One of the things we have noticed is that the media is out there to tarnish the image of the nurses and thina (we) as Denosa we are having a campaign which we call ***A pride of nurses.*** The objective of this campaign is to educate the community out there about the difficulties nurses find themselves in .Many a times; the nurses will be accused for each and every thing that go wrong with the department of health ***(tape finished). Change of tape.***

One person was actually making a remark and saying that it's no wonder that we are called general nurses because we know basically everything and that's why we can be blamed for everything.

When the food comes short in the ward the nurse is blamed. When there is no medication in the clinic, which is not the responsibility of a nurse to supply the clinic, the community fights with a nurse.

When the patients wait from the morning at 08h00 and get to be seen at 15h00 in the afternoon, the blame comes at the doorstep of the nurse and the nurse is not the employer at this Case

When the Linen is not sufficient … When the doctors do not do the round, the nurse get blamed for that

So this campaign is to highlight the difficulties nurses find themselves within , where we find the in the ward situation of 40 beds and two nurses to run that ward and in most Cases you are not in a position to give adequate and quality nursing care to these patient.

I 've been to one of the clinic, in KwaDabeka clinic where there were two Registered nurses seeing almost 300 patients and that was impossible to the extent that the nurse cannot even go to the toilet, cant go to lunch because those patients ----------rightfully so are very agitated by the delay and they shouted the nurse calling all derogative names and insults and demands to be seen and this is becoming impossible, you cannot see so many patients and in the process not make mistakes

Z: It is true.

C: The dedication the nurses displayed over time has shown that they are there for the community and we just need to reinforce and talk to the community because there is no one who talks on behalf of nurses and definitely as the union we are there for them. We are advocates for the nurses. We will advocate for the nurses both to the employer and to the community because we also want to see the violence which is perpetrated against the nurses being reduced. You find nurses being mugged in the streets; you have seen the nurses being raped. You have seen the incidence last year where the nurses were in the juvenile care institution in Limpompo where the nurse was raped.

We are saying that is unbecoming and the community should be out there to protect the nurses. We want to gain and win back the image of nursing which was there in those years where a nurse will be seen as somewhat very important and we want to believe that situation has not changed. The importance of a nurse in society has not changed and the need for the nurse out there is still there

Z: Thank you very much for your time would you like to tell me anything that will bring back our nurses and also what can be good retention strategies

C: Based on your role..... your objective in terms of your research , it will be nice if this information is given to relevant stakeholders. Fortunately of late when we had our tenth year anniversary, the president of the country was around to share with us that moment. Fortunately the president of the country Thabo Mbeki, are looking at the request of having a nurse at a higher level. Nurses need to be represented at a higher level of government. The president is having a plan to create a post of Chief Nursing Officer (CNO). That type of research should be not something to be read in classes. It should be communicated to hospital managers at a district level. It should assist us, as unions to strategies based on your findings.

You are out there; you might see things that we do not see

Z: The findings will be shared among nurse managers, DOH; will be having workshops with managers of institutions which participated in the study. I will be presenting my findings in a conference .Very rare, do I see public manager attending conferences, and the majority is private managers.

C: When we look at statistics within KZN 10322 PN that figure is very below

Unfortunately we do not have statistics of ratio of nurses to patients. We do not have the statistics of nurses to patients like in India is 1: 30 is or 1: 50. Student nurses are 1802 from public training

Z: Students from all over the country including public and private colleges?

C: Staff nurse, we've got 7762.Looking at the amount of patients-nurses has to take care of ----------these figures are very low

Z: … very low. One thing I have noticed about government, you must understand that governments are politicians .Government makes empty promises to people. I have been inundated by call from the community .They wanted to convert a clinic into 24 hours without necessary human resources and equipment. In two occasions I had to personally advise my members not to adhere to those call and to defy management in opening a clinic for 24 hrs.

In one clinic, they wanted to start performing deliveries there was not even a scale, no oxygen, no screening. The same old clinic which was seeing a patient for minor ailments was expected to perform deliveries. And I said, not on a Sunday are you going to insult our patients because women should be treated with dignity and respect. Our nurses are not going to perform any

C/S .Nurses are expected to work at night in a location whereas there is no proper security .until there is security provided and proper infrastructure set up and hospitals which are linked to these clinics should improve their communication and support system with the clinic. You will find a situation where a nurse in the clinic is stuck in a situation where there is no doctor to talk to, the ambulance services does not even know where that clinic is?

This nurse will have to find the way to deal with the patient and in a case when the patient demise, the nurse at the end will have to face the SANC.

Look at the total number of nursing assistants is 6474,

There are 951= pupil nurses

The total number of all nurses in the province is 27847

This is a drop in the ocean

Z: -----drop, drop, drop in the ocean

C: I was fortunate to be part of people invited in the presentation of the two hospitals. There are two new hospitals are going to be built.

Z: KwaMashu and Inanda area.

C: I then asked the ex MEC for health (Dr Zweli Mkize) that: Where are we going to get the nurses? At the moment we are having problems with IALCH. The number of nurses at IALCH required one of the hospitals to be closed in order to equip this hospital efficiently. When it was opened one hospital has to close because a number of staff was deployed to IALCH. He said we will double the intake of students

Doubling intake of students is not answering the problem of shortage of staff; it's a serious problem. It's a serious problem because we do not have enough tutors

Z: Doubling of students we need to have clinical sites where we can place these students

C: It is multipronged, it's too involved. What we are saying, also with these private nursing schools you need to find a way around these private colleges of controlling this. I've been talking to the DOH about this and I spoke to the SANC and they are looking the other way when you talk to them.

Z: We are having a problem.

C: I have this funny suspicion that there is some serious corruption going in at the SANC. They just approve opening of new nursing schools without looking at how these students are going to be managing throughout.

They send students to hospitals and there is no clinical accompaniment of students. What do you expect the student to learn because you can't expect the RN in that ward to look after 4 students?

Z … to look after 20 patients

C: We say to hospitals if you accept these students over and above ask the students to sign the indemnity, you must insist on that particular school to provide clinical facilitation to come and assess these students .At the end of the day I am faced with lot of problems whereby Nurses are theoretical qualifying but practically they are not qualified. Somebody signing for them .In the past years I have seen SANC taking away certificates from people and saying. You are not properly qualified because we have rumours that you did not do your practica and I fully agree with the SANC. A nurse ….. a theory is something that you can do overnight but the practica is the core business of the nursing profession and that a nurse who does not have a scope of practice is a danger and that is a concern to us as

Denosa because of professional indemnity, the insurances are threatening not to take us anymore because of the huge lawsuit faced with us.

Z: It's a huge problem and I do not know how it can be solved because SANC gave permission to these schools and they are supposed to be checking the standards and we are need of nurses, you know. It's something that needs to be looked into....

C: and managed properly

Z...properly because it's no use to say, open a school whereas there is only one teacher with 40 students. It's like money generating initiative

C: In this province we had a scandal Newlands school. Their intake is four times a year without proper educators taking care of children, no proper facilities. In times of exams students are told to wait another years in the long time students are loosing out financially

Z: Thank you very much for you time

C: Good luck in your studies

Interview with the deputy nurse manager:

Z: What changes have you made since you join the institution?

D: There are different changes that I have made in this organization. One of them is influencing management to course grant our neophyte nurses a four year study training programme on a study leave basis. Secondly, It is to provide a training programme to unit managers as a point of departure before they assume their duties, they needed a drastic orientation background of management, apart from that using a staff..... programme from HR to do our workforce demographics monthly so that we can implement advertisement procedures perfectly when our demographics are in order.

Z: hhhhhhh... how do you operationalise your vision. During my data collection, I noticed that all dept have the vision and mission placed in their units. How do you operationalise and interpret the vision?

D: We have got a system of ensuring that each and every dept has got a checklist for everything that they do and again purporting the achieving mission and vision of the institution which is in linked with the vision and mission of the district

Now and again we go back to the checklist to check that we a have said is are they achieving it

Z: Are you achieving positively?

D: Yes we are, if I can make an example. There are so many allegations that normally come out when patients are admitted but each time there have been so many allegations we use that method whereby a complaint comes with an action plan and an improvement strategy which mean, if somebody has procured that mistake does an action plan. We see to it that an action plan is available against that complaint

Z: What type of the leader are you?

D: Transformational leader

Z: Kindly explain why do you say you are a Transformational Leader

D: I m transformational in the sense that, I believe that I am the nurse manager of the 21st century. A nurse manager of the 21st century operates within the supreme law of the constitutional act, comes with the nitty gritty of the legal framework under which the management operates. Therefore it is impossible to operate just from randomly all the facts that are taken by managers in the nursing profession are guided by the legal framework; hence I say I am a transformational leader because everything that you put into practice is guided by the legal framework that guides the management

Z: What kind of support do you give to the staff?

D: support-------

Z: I mean the professional nurses -The zonal matrons -----

D: The biggest support that I give to the staff is that I have a wider staff development programme that encompasses all categories that is linked to the institutional HRD training programme.I Also do administration of the nursing matters, each involve dealing with personal issues which will at the end of the day gives support to staff individually and as groups and lastly, group effort in terms of –us as a team in the nursing management in trying to meet halfway our staff for example all those who get sick are supported and are channeled correctly,

All those that get depressed are not looked down upon but are brought back to life

All those they deviate they are not casted out but are given rehabilitation and they go back to action

And all those that need counseling and drastic action by the labour relation, justice is being done to them as well

Z: Do nurses have access to information also .....others struggle to get that information?

D: I think you are touching an important point of information. Luckily my institution has telemedicine dept, doctors go to in and out of that telemedicine dept to go to the internet and what have you...

But rarely do I see nurses go to telemedicine neither do I see them coming to watch programme in which they are invited for in the telemedicine. Their participation ends up clinically and apart from that our institutions does not have an identified block for putting a library for clinicians. We are trying to make ends meet but it is not up to standards so In terms of accessing information I can say we have a huge gap and we have a long way to go.

Z: Ok… that one I understand. I mean there is a notice or advertisement from the head office and the nurses need to know. How do they get that information? Does it go via zonal matrons or through the meetings?

D: apart from it being shared from the meeting, it shall have been cascaded to the dept. Even before it is discussed in the meeting. It shall have reached the department.

Z:mmm….it reaches them…..ok

D: there is a policy whereby in any dept when a new policy comes, a manager ensures that it is read and people sign and she ensures that people understand the context of that circular

Z: how is the staff turnover in your institution? Especially among the professional nurses?

D: ya... mmmm… There are quite a various grades of PN, CPN, senior professional, PN. The turnover among PN is not that huge per month but the turnover that is quite alarming is among other categories especially EN, ENA

Z: mmmmmmmm

D: Reason being that they had to go to their own homes. Most of them find jobs after a long time after they have been searching for it and they will go anywhere. So you find that what you have is not somebody from local. So that at any rate when the job comes where she wants to be there would be movement. But most of them are not the professional nurses. The biggest problem among professional nurses is not actually the attrition, but it's the recruitment itself. Our numbers are not big, correctly. The going out is not that huge. It is the recruitment that is difficult.

Z: Another thing, do you have figures. Just checking the numbers in the past three months how many nurses have left the organization

D: That you can get…professional nurse—not one had left in the past three months

Senior professional nurse- 1 left in October

Chief professional nurse- yes they did transferred to 3 hospitals respectively, that was Port Shepstone, Newcastle, as well as provincial hospital Madadeni. Reason being that they have specialized and well everybody wants to have someone who have been long in ICU and that was the sole reason for moving. Either than that it has been two senior professional nurses, 3 chief professional nurses and none of professional nurses.

Z: How do you encourage professional nurses to stay in your institution, because it seems as if people are staying in your organization?

D....mmm.....in my institution we have a world class nurses home. I think its one of the strength that this institution has. The nurses' home is world class and it's for all genders (males and females stay together) .I have no better way of explaining it except that It a world class.

Z: it's like a home away from home

D: But there are people but in their homes are fine and in their flats are also fine. Those that have an opportunity of staying in the residence then world class apartment. I do not fear of that.

Z: there is one strength that you have accommodation is available

D: It is not enough those that stay, although it is not enough.

Z; what are other factors that you think make professional nurses stay

D: Even though the entry is far away, yes I agree. The shopping mall is nearby. There are fresh fruits from Pick n Pay, Shop rite, Game, Truworths, Woolies,

The town is around. Nearer home here is parking for staff. Once your car is well parked, you have a reason to stay, you a house, a bed, security in all the gates at all times in the residence. The residence has a lot of space. There is a tennis court, swimming pool and entertainment area. Remember, this hospital used to belong to Whites, all facilities are available.

Z: What about workload within the dept. Is it fairly distributed? Have you had a complaint about this because now we have a crisis because people are living

D: ya... of course yes, workload is quite huge.mmm... not because it is not fairly distributed I think what makes the workload huge is our disease profile. I want to make an example about medical unit. Medical units have 48 beds, each one of them, male and female. What you will discover when you go around those units is that any of these patients that are lying in these units must be given water to drink, must be washed, must be fed. Now, you know--20 years ago, not all pts in the 48 bedded wards would be fed or washed needed extra care as it is happening now.

At least three or four patients will be critically ill but the status qou is such that if you are lying in the 48 bedded by 09h00 all the every nurse is in the ward is joining hands to bath the patients

Z: Are resources available in the units?

D; I have organized a library, by converting the old office into a library. The students who usually request to do their life orientation in the hospital are allocated to cover books and pack books following Dewey systems. Journals are also available although they are not up to the standard. Doctors have their mini library upstairs. This is only catering for nursing staff.

Z; Do nurses utilize this service?

D: They do, although it's not up to the level that I would love to see.

Z: Let's go back to availability of resources that are utilized in the units

D: That's a great challenge... reason being we do not procure item. The hospital depends on the stores department which follows the DOH guidelines in terms of procurement. Hospitals are to follow the procurement procedures which lead to buying of the lowest code. Nurses are using third grade items because we are expected to support the BEE companies---------Black Economic Empowerment, no matter how bad their items are. We cannot buy from Johnson and Smith and Nephew because they do not meet the BEE criteria. It's really bad. Recently there are these cheap Oxygen masks which are made of

poor quality. The mask just fit snugly on the face of the patient, and the patient is even deprived of oxygen.

Z: How often are meetings held in your institution?

D: There is a general meeting which is held every Thursday of the month. This meeting is for all categories of staff. Every third Tuesday of the month, there is an operational meeting. Quality and policy meetings are held bi-weekly. The health and safety meeting is held every month. The infection control meeting is also held every month.

Z: Do you invite all the categories simultaneously in one meeting?

D: No, lay counselors, ward clerks and general orderlies are invited separately from the nursing categories. The professional nurses, enrolled nurses and nursing auxiliaries are invited collectively to one meeting.

Z: Are other categories free to talk when their superiors are around.

D: In my institution we allow everybody to be free and verbalize him/herself in front of everybody. Nurses are buying in to the idea of freedom of speech. They are reassured that there is nothing wrong with free verbalization.

Z: What incentives are given to staff?

D: Nurses are given study leaves….. which I regard as the greatest incentive to any nurse. These study leaves are given free of charge. It's a package which is available to all grades without expecting a refund. The responsibility of a nurse is to make good use of that study leave by studying hard. Unfortunately we do not provide monetary incentive. That is the area of the DOH, but the nurse who commit themselves and perform exceptionally qualify for the salary notch based on the performance management system.

Z: Apart from the salary notch given every year.

D: Yes of course….. The annual salary notch is across the board, but the nurse always qualifies for the salary notch based on her productivity. If you don't follow the key performance areas as stated in your PMDS you do not qualify for the salary notch.

Z: How do you monitor that the incentives are awarded accordingly?

D: Unit Managers are fully trained on the system. The supervisor rates the candidate according to the given criteria. Both parties agreed on the rating. The form is submitted to HR. This exercise is done yearly.

Z: Do you give other incentives?

D: We really on the patient and family feedback. If there is a particular nurse who has been identified as the best caring nurse, her/his name and picture is placed on the newsletter. We have a newsletter called ***Indaba yethu*** and we are very proud of you have Z: Any floating trophies for the best unit?

D: Unfortunately we are not yet there, but we are planning to improve on it.

Z: As a recruitment and retention personnel, are the numbers in your institution growing or depleted. Can you say turnover is worse or better than last year?

D: I can say that we are very good in keeping our nurses. The three professional nurses who transferred to other hospitals are back again. They are now CPN. Their aim was to get the CPN post and they are back to us. There was not a need to interview them because they were part and parcel of us.

Z: How many professional nurses are in your institution?

D: I have 96 CPN, 37 SPN & 54 PN. Vacant posts are as follows:

CPN= 5, SPN =47 and PN= 18. We definitely need nurses to come and fill these posts. Hoping that the community service act will assist in the filing up posts.

Z: Thank you very much for your time and vast knowledge shared with me.

D: I must just thank you and also wish you good luck in your studies. I am still available if you need more information.