AN EXPLORATION OF THE PRESENCE AND ENACTMENT

OF

CARING IN THE HUMAN RESOURCE MANAGEMENT

OF

NURSES IN KWAZULU-NATAL HOSPITALS.

ANSIE MINNAAR

DURBAN

DECEMBER 2000

ABSTRACT

AN EXPLORATION OF THE PRESENCE AND ENACTMENT OF CARING IN THE HUMAN RESOURCE MANAGEMENT OF NURSES IN KWAZULU-NATAL HOSPITALS

STUDENT: ANSIE MINNAAR

DEGREE: DOCTOR OF PHILOSOPHY in NURSING

SUPERVISOR: PROF. L R UYS

The aim of the study was to explore the practice of caring in human resource management of nurses. Both the qualitative and quantitative research approaches were used to ensure that the richness and the complexities of caring is reflected in the study. A qualitative analysis of the interviews with nurse managers and nurses indicated that they saw caring as an important part of their task. They saw caring in human resource management of nurses mainly as dealing with the interpersonal aspects- personal problem-solving-, development and growth-, welfare needs-, and HIV/AIDS issues related to nurses.

A quantitative survey of nurses from different levels was done to explore the presence and enactment of caring in the formulating strategies, structuring the work, workforce planning, staffing process and in the utilising and maintaining of nurses. It was found, according to respondents that caring was not present to satisfactory levels in the human resource management process of nurses, although caring

concepts, as well as Christian principles, were present and clearly described in the mission, philosophies and goals and objectives of the hospitals.

The fact that nurse managers are not solely responsible for the experiences of nurses and the way nurses expressed themselves on the caring issues in human resource management in the study should be emphasised. Organisational factors such as salaries and benefits of nurses, shortage of nurses at national and international levels, organisational structures and other financial constrains in hospitals, contribute to the experiences of nurses in this study. Health service administrators, nurse managers and nurses should all take the responsibility to find means to improve and instil caring in hospitals. Therefore the decision to train nurse managers and to upgrade the management knowledge and the implementation of caring concepts in nursing management with relevant care and support to HIV/AIDS nurses, is of the utmost importance to equip nurse managers to survive in these demanding circumstances in the hospitals.

Submitted in fulfilment of the academic requirements for the degree

of

DOCTOR OF PHILOSOPHY IN NURSING

IN THE

DEPARTMENT OF NURSING

UNIVERSITY OF NATAL

DECEMBER 2000

Student number: 991242375

I hereby indicate that this thesis, AN EXPLORATION OF THE PRESENCE AND ENACTMENT OF CARING IN THE HUMAN RESOURCE MANAGEMENT OF NURSES IN KWAZULU-NATAL HOSPITALS is my own original work, and that all the references are cited in the thesis.

AMinnaar

Ansie Minnaar

4/4/2001

Date

This thesis is dedicated with love and gratitude to:
Allan, and Lieze
and, most of all,
Brian

Acknowledgements

I want to thank the following people:

- My supervisor, Prof. L. R. Uys for her guidance, patience and caring;
- The Department of Health and the participating hospitals for their support and willingness to take part in the research:
- The nurse managers and all the nurses for their precious time that they spent on the research;
- My husband for his love and support and my family for understanding;
- Brian for computer support throughout the study;
- Patsy Clarke for training, assistance and patience regarding the computer programmes for the data analysis and statistical support during the entire research project;
- Mrs. R. Cadman and Mrs. Y. Stacey for presentation of the thesis;
- The Standard Bank of South Africa for financial assistance;
- The National Research Foundation for the scholarship;
- The School of Nursing: Decentralised programmes as well as all my colleagues for their support;
- God who has given me the courage to succeed.

TABLE OF CONTENTS

CHAPTER 1
AIM OF AND RATIONALE FOR THE STUDY

CHAPTER 2
LITERATURE SURVEY

CHAPTER 3
METHODOLOGY

CHAPTER 4
RESULTS OF THE FINDINGS ON THE PRESENCE AND ENACTMENT OF CARING IN THE HUMAN RESOURCE MANAGEMENT PROCESS OF NURSES

CHAPTER 5
DISCUSSION, CONCLUSIONS, RECOMMENDATIONS AND LIMITATIONS, FOR THE STUDY ON THE PRESENCE AND ENACTMENT OF CARING IN THE HUMAN RESOURCE MANAGEMENT PROCESS OF NURSES

ANNEXURES

LIST OF TABLES

LIST OF DIAGRAMS

LIST OF CHARTS

LIST OF FIGURES

CHAPTER 1

AIM OF AND RATIONALE FOR THE STUDY

1.1 INTRODUCTION

The intention of this study was to explore caring in the structure and outcome of human resource management process in nursing services. Nurse managers have a unique responsibility to ensure the well-being of nurses and patients and also to ensure that organisational objectives are met (Christensen, 1988). The principle of beneficence thus guides the nurse manager's actions and refers to the obligation resting on the nurse to do good to others and not to harm them. This principle of beneficence is often in contrast with bureaucratic systems where individuals experience depersonalisation (Christensen, 1988). In South Africa at the present time, for instance, nurses have to make do with so little and spend much of their time begging for supplies instead of caring for their patients. A poster on the walls of the Chris Hani Baragwanath hospital underlines this situation. It reads: " *Our skeleton staff has been reduced to a bag of bones*" *(*Gilbey, 2000*)*.

The question is now, who cares for the patients and who cares for these *bags of bones* ?

During the past year many examples of the hard life of nurses were cited in the media, and the lowering of standards in the health services was evident from the conditions in the hospitals. Thembi Mngomezulu from DENOSA (Democratic Nursing Organisation of South Africa) (cited in Gilbey, 2000) said that the culture of caring and compassion amongst nurses has been eroded. Bad publicity has contributed to making the nurses job harder. Nurses are the backbone of the health services and yet they are treated as slave labour. Dr. Trudi Thomas (cited in Gilbey, 2000) of the Eastern Cape blames declining nursing standards amongst other factors, on poor management that fails to provide effective supervision and encouragement.

Professor Philda Nzimande asked the question *Who cares? in* an article five years ago in the South African Nursing Times (1995). She indicated that the health services have been investigating violations of caring rights of patients on the grounds that rights of care givers were being violated. She suggested that we need to really examine "*who cares*" and what the ethics of caring really are (Nzimande, 1995).

1.2 THE AIM OF THE STUDY

The aim of the study was to explore the presence and enactment of caring practices in human resource management of nurses in the health services of provincial and private hospitals in KwaZulu-Natal.

The specific objectives for the study were to:

1. Explore the meaning of *human resource caring management* and the caring practices of nurse managers for the nurses in their services as well as the meaning of caring from the view of nurse managers and nurses (Phase 1).
2. Determine the expectations of professional nurses regarding caring as related to human resource management in nursing (Phase 1).
3. Determine the experiences of professional nurses regarding caring in the human resource management process in nursing (Phase 2).
4. Explore the presence and enactment of caring concepts and practices in human resource management of nursing in health services (Phase 2).
5. Explore the presence of caring concepts in the structure standards of human resource management in nursing (Phase 3).

Triangulation was done by combining research methods such as the qualitative phase with the quantitative phase of the research. The benefits and reasons for combining qualitative and quantitative methods in this study were as follows:

- The quantitative design strove to control bias so that facts could be understood objectively and the qualitative research design strove for understanding from the perspective of the people (in this case, nurse managers and nurses) to provide meaningful data.
- The experiences of nurses were addressed by the quantitative research method which strived to identify and isolate specific variables, correlations and relationships within the nursing management context. The changing

and dynamic nature of management was described by using the qualitative research method, with the focus on the holistic view by using interviews and documents which were used by nurse managers.

- By the combination of both methods, the advantages of each methodology complemented the other and made for a stronger research design with more valid and reliable findings.

It was decided to use in-dept interviews with nurse managers to gain access to the meaning of *caring and caring practices*, and to conduct one interview per participant. A preliminary guideline was developed to focus the study. Participants were asked to share any other information on caring. The research included interviews with nurse managers at all management levels and professional nurses in the health services. It was accepted that the number of participants would depend on the moment of saturation. Data collection and data analysis occurred simultaneously and findings directed the researcher to gain new insights on caring. Professional nurses were asked to complete a questionnaire and to describe a caring experience with a colleague. The last phase included a review of selected human resource management documents for caring, which were used by nurse managers in the management of the nursing department.

1.3 BACKGROUND TO THE PROBLEM

Steward as long ago as noted in 1929 (cited in Gormley 1996, p. 585) that *"Caring in nursing practice ... is not the mechanical details of any execution, nor the dexterity of the performer, but in the creative imagination and the sensitive and intelligent spirit lying at the back of these skills. Without these - nursing may become a highly skilled trade but it cannot be a profession or fine art..."*

Caring is generally described in terms of actions, behaviour and characteristics in nursing/patient relationships but caring can also be described in terms of structure, process and outcome (Shiber & Larson, 1991). Previous studies were inclined to concentrate on the process of caring with little or no emphasis on the aspects of structure and outcome of caring.

Benner & Wrubel (1989) stated that human competence, recovery and healing are central to caring. To ensure caring and healing of patients in health services it is of the utmost importance for nurse managers to ensure a caring environment in the human resource management in nursing. When caring is present in the human resource management environment and nurses experience caring in their working environment, they are more able to render caring nursing practices in the patient care environment. McNally (1977) made it clear that to become a caring person, one must be treated in a caring way and that caring could be impaired or

reinforced by the environment. The environment of interest to this study was the nursing management environment. The importance of this study was to explore the presence and enactment of caring in the human resource management of nurses. This study was built on the question of whether caring was a lost idea in nursing management and whether nurse managers really cared about the concept of caring in the philosophy and operation of the human resource management processes of nurses in health services.

Chipman (1991) is of the opinion that nursing in the United States adopted the model of Florence Nightingale. In that model, character and not skills were emphasized. The nurse was considered to be obedient to the physician with a selfless devotion to the patient. The fact that nursing was hard work with low pay attracted women from the working and lower middle classes. Nursing became the discipline of caring and physicians were responsible for curing which was considered to be more valuable. Yet caring and curing are both part of the healing process. Since the Middle Ages, curing has been seen as the more valuable commodity both in terms of prestige and fees for services. This perception is still perpetuated and could explain the apparent abandonment of caring from the practice of many nurses worldwide. At present nursing is being redefined by nurse leaders and the art of caring is receiving attention from researchers globally (Chipman, 1991). Another dilemma of nursing in general, as described by Reverby (cited in Radsma, 1994) is the fact that society expects

caring from nurses in a community where the emphasis is on rules and regulations with little sensitivity towards caring values.

1.4 CARING CONCERNS IN CONTEMPORARY HEALTH SERVICES

It was clear that nurse leaders have an important task ahead to emphasize caring in nursing and to ensure a caring environment for nurses and for patients. The following are international concerns about caring in the clinical practice of nurses according to Miller (1995):

- Financial aspects in the health services are over-emphasized with neglect of caring concepts in nursing. It is a constant challenge for nurse managers to ensure that economic issues do not take the place of human care as the most important issue in nursing (Nyberg, 1990). Nurse managers have a further responsibility to realize the realities of both human care and economics and integrate them into a system where the mission, philosophy and objectives of patient care and organizational survival are mutually supportive (Nyberg,1990).
- Computerization of nursing services may make computer operationalisation the main concern of nurses with a consequent possible neglect of patient care.
- The over emphasizing of acuity levels of patients and the allocation of nursing time according to the acuity of patients may lead to a lack of consideration of time and effort for caring of patients.

- The over emphasizing of recording of nursing interventions and the nursing process may cause nurses to *nurse* multiple records instead of nursing and caring for the patient.
- Complicated nursing care standards in high technological environments are contributing factors to the low value placed on caring by nurses.

1.5 CARING IN HEALTH SERVICES IN SOUTH AFRICA

It was documented in a special report by Sherriffs (1995) on nursing in South Africa, under the sub-heading "*The nurses from hell* " that nurses display a lack of caring towards other women and towards their patients. Why should nurses act like that? According to Sherriffs (1995) the answer lies most probably in the fact that nurses see their work only as a career and not as a calling. Another contributing factor, according to this article, was the hierarchical structure of most of the health services, that followed an autocratic management style. In such environments the individual needs of nurses were not considered and a lack of adequate support and direction for nurses during times of violence was a real source of concern. According to Sherriffs (1995) rough handling of patients was often the result of frustration caused by unsympathetic management that treated nurses without empathy. In the end it was the patient that suffers (Sherriffs, 1995).

Erasmus (1998) investigated nursing professionals' views on the workplace, with the target population of registered nurses, enrolled nurses and auxiliary nurses from the South African Nursing Council. A random sample of 400 registered nurses and 800 enrolled and auxiliary nurses was drawn. The main focus of the research was to obtain information on certain experiences in the workplace. One of the aspects that was investigated was career expectation. Nurses were asked to identify their career expectations. Ninety three (93,4%) nurses chose job satisfaction as the most important aspect, then 81,5% choose recognition as important. Professional support received 75,4% and promotion 73,9% were ranked high, with balanced professional and private life 67,8%, remuneration 60,7% as moderate, and power and status was not important and received 36,0%. The above findings indicate, in contrast to those of Sherriffs (1995) that nurses in South Africa are not doing the job for the sake of money but as a service to the community (Erasmus, 1998). The findings indicated that caring aspects, such as recognition and professional support were high on the priority lists of nurses.

In view of the conflicting findings given above, it was important to explore the presence and enactment of caring concepts in human resource management of nurses in health services. The importance of an investigation into caring in nursing management of the health services of hospitals in KwaZulu-Natal is also underlined when one looks at the large number of nurses who are exposed to human resource management practices. In the provincial hospitals in the health

services of region F of KwaZulu-Natal (the greater Durban area) there are 7 071 authorised patient beds and 2826 patient beds in the private hospitals.

The above discussion highlighted caring as a complex phenomenon and the importance of caring concepts in human resource management in the health services.

1.6 SIGNIFICANCE OF THE STUDY TO NURSING

In the current health care services in South Africa more emphasis is being placed on quality care. The key to health care quality in nursing is, according to Molzahn (1997), creating a caring culture in health care organizations. Within a caring culture human dignity of both patients and staff will be preserved. Bringing the ethic of care and responsibility into the dialogue with the general public will ensure human rights, a practice of commitment and quality nursing care (Molzahn 1997).

It was the intention of this study to explore the presence and enactment of caring in human resource management in certain health services and therefore contributed to creating a caring awareness in health services. The research findings of a survey done by Minnaar (1994) on the nature of caring among nursing personnel indicated that nurse managers are aware of the importance of caring in nursing management but that nurses did not experience being cared for

in the management environment of the health services. Nurses indicated that their experience of caring in the nursing management environment was only moderate to poor. One of the recommendations for further research was to investigate the implementation of caring concepts in human resource management for nurses.

A careful analysis of the presence and enactment of caring in human resource management in nursing would contribute to better understanding and sensitivity towards caring and the implementation of caring in nursing. This research provided a framework for implementation of caring in human resource management in nursing.

1.7 DEFINITION OF KEY CONCEPTS

1.7.1 The nature of caring

There are many definitions of caring. Watson (1985, p.7) defines caring as a transpersonal value " *caring is the essence of nursing and the most central and unifying focus for nursing practice."* Watson (1985, p.7) also said that " *care and love are the most universal, the most tremendous, and most mysterious of cosmic forces; they comprise the primal and universal psychic energy."*

Morse, Solberg, Neander, Bottorff and Johnson (1990) describe caring as a human trait, a moral imperative, an affect, an interpersonal interaction and as a therapeutic intervention.

Some persons are caring, others uncaring, and Watson (1985) defines an uncaring person as follows:

1.7.2 An uncaring person

Such a person is insensitive to another as a unique individual, imperceptive of the other's feelings and does not necessarily distinguish one person from another in any significant way. (Watson, 1985).

1.7.3 Nurse manager

For the purpose of this study the term *nurse manager* refers to the person in charge of the nursing care services of a hospital or health service. The nurse manager is a person who is registered at the South African Nursing Council as a nurse according to article 16(1) and (2) of The Nursing Act, 1978 as amended.

1.7.5 Enrolled nurse

Enrolled nurse means a person enrolled as a nurse under section 16 (6) of The Nursing Act, 1978 as amended.

1.7.6 Middle management

Middle management is responsible for specific departments in the organisation and is concerned with the implementation of the policies, plans and strategies. It includes functional heads such as unit managers and area supervisors in nursing and is responsible for the monitoring of the quality of care. Middle management is necessary to link the upper and lower levels of the health services and to implement the strategies developed at the top (Smith and Cronje, 1997).

1.7.7 Hospital

A hospital is an institution where medical treatment and care of ill persons are offered according to Government notice R157, paragraph 1, of 1 February 1980. For the purpose of this study, only hospitals with 200 beds or more were selected to participate in the study.

1.7.8 Human resource management

This part of the management process specializes in the management of people in the work organization. Human resource management emphasizes the efficiency and equity objectives of an organization. According to Bratton (1999) the human resource management process covers five functional areas, namely staffing, rewards, employee development, employee maintenance and employee relations. Human resource management, according to Swanepoel, (Ed. 1998) is in agreement on the above processes of human resource management, and refers to the various processes and management structures which represent a very specific way or style of managing people at work. The structures include the formulating strategies, the structuring the work, the workforce planning, staffing and in the utilizing and maintaining human resources.

1.7.9 Structure standards in human resource management

The documents under investigation in this study included the mission statement, the philosophy and/or goals and objectives, job descriptions, performance management tools, for example career development sessions with staff, individual goal setting together with the staff and goal achievement measurement, induction and in-service training programmes and grievance and disciplinary procedures.

1.8 OVERVIEW OF THE STUDY

The study comprises the following chapters:

CHAPTER 1 THE AIM AND RATIONALE FOR THE STUDY

In this chapter the background to the study is described. The significance of the study for nursing management was emphasized. International views on caring in nursing in general as well as in the human resource nursing management are explained.

CHAPTER 2 LITERATURE SURVEY

In this study theoretical perspectives on caring from the theorists, Watson (1985), Leininger (1984), Nyberg (1989), Morse et al (1991) as well as Larson (1981), Wolf (1986), Mayeroff (1971), Valentine (1989), Ray (1989) and Morath and Mantley (1993) are discussed. The human resource management perspectives of Swanepoel (Ed. 1998) Covey (1996), Carrel et al. (1998), Plunkett & Attner (1992) and Bratten (1999) are also examined.

CHAPTER 3 RESEARCH METHODOLOGY

The research methodology for the exploration of caring in the human resource management process of nurses is discussed in this chapter. The target population and the three phases of the research are explained in detail as well as the ethical considerations for each phase. An overview of the research instruments is discussed. An outline of the data analysis methods for each of the phases is provided. Reliability and validity of the questionnaire are discussed. The preconceptions of the researcher are described in Annexure 2 of this study.

CHAPTER 4 RESULTS AND DESCRIPTION OF THE FINDINGS ON THE PRESENCE AND ENACTMENT OF CARING IN THE HUMAN RESOURCE MANAGEMENT OF NURSES

In this chapter, the results are described according to the different phases of the study. The description reflects descriptions of first phase, the qualitative research analysis of the interviews with nurse managers and nurses, the results on the quantitative research phase, (phase 2) including the questionnaire, and the third phase, that entails a description of caring in the human resource management document of the nursing department.

CHAPTER 5 DESCRIPTION OF THE CONCLUSIONS, LIMITATIONS AND RECOMMENDATIONS FOR THE STUDY ON THE PRESENCE AND ENACTMENT OF CARING IN THE HUMAN RESOURCE MANAGEMENT OF NURSES.

In this chapter the findings are discussed, with the conclusions, recommendations and the limitations for the combined quantitative and qualitative phases of the research. This chapter explains the caring attributes that are recommended for nurse managers and professional nurses for a caring human resource management model in nursing.

1.9 CONCLUSION

In this chapter the aim and rationale for the study is described. The responsibility of the nurse managers regarding caring is emphasised in the human resource management environment. Caring concerns are highlighted in the health services with special attention to caring in health services in South Africa. The literature search describes the caring concepts as well as important human resource management processes.

CHAPTER 2

LITERATURE SURVEY

2.1 INTRODUCTION

The framework that was used for this study was the Caring Theory of Watson (1985). Watson (1985) identified ten (10) carative factors which encourage health and development of individuals, families and communities as described under the theoretical perspectives on caring of this study. The human resource management process as described in Swanepoel (Ed. 1998) and others also guided the choice of management processes that were identified as important in human resource management of nurses, and were investigated in this study.

The management process entails four basic functions namely, planning, organizing, leading and controlling. These functions are being used to accomplish the human resource functions. Perspectives from various authors on the human resource management process are important for this study but the human resource structures as described in Swanepoel (Ed. 1998) were studied in relation to the theory of Watson (1985) :

- *Formulating strategies*: mission statement, goals and objectives, philosophy of service;
- *Structuring the work* : job analysis, job design, organizational structures;

- *Workforce planning:* job descriptions, job specifications, matching supply to demand;
- *Staffing:* recruitment methods, the process of selection of staff, hiring methods, the level and contents of induction training, socializing and team concept within the nursing units;
- *Utilizing and maintaining human resources:* performance appraisal system and aspects of evaluation, leadership styles of managers and level of guidance to nursing staff, in-service training, development of career paths for nurses, employee well-being which includes work and human behaviour, rewarding system in terms of praise for work well done, grievance procedures for nurses, disciplinary procedures, communication, decision-making, elements of organizational culture such as the hierarchical structure of leadership, and the informal structure which includes networks and relationships.

The research study explored the above perspectives of human resource management for caring concepts in management of nurses.

2.2 THEORETICAL PERSPECTIVES ON CARING

Caring concepts in health services are well defined and described in the literature. The nature of caring with emphasis on nurse/patient interaction has been researched and described by various authors. For the purpose of this study

the views of various authors will be discussed but the main emphasis will be on the views of Watson (1985), and to a lesser extent the work of Leininger (1984), Nyberg (1989) and Morse, Bottroff, Neander and Solberg (1991).

Watson's (1985) views on caring are in contrast with Leininger's (1984). Watson (1985) (cited in Kyle 1995), views caring in nursing practice as a therapeutic interpersonal process with the assumption that caring can be effectively demonstrated and practised only interpersonally. Watson (1985) emphasized the fact that caring is a deeply human activity as (cited in Kyle, 1995). Watson (1985) identifies basic assumptions for a science of caring as set out in Table 2.1:

TABLE 2.1 THE SEVEN BASIC ASSUMPTIONS FOR A SCIENCE OF CARING OF WATSON (1985)

1. *Caring can be effectively demonstrated and practiced only interpersonally.*
2. *Caring consists of carative factors that result in the satisfaction of certain human needs.*
3. *Effective caring promotes health and individual or family growth.*
4. *Caring responses accept a person not only as he or she is now but also as what he or she may become.*
5. *A caring environment is one that offers the development of potential while allowing the person to choose the best action for him or herself at a given point in time.*
6. *Caring is more healthogenic than curing.*
7. *The practice of caring is central to nursing.*

Watson (1985) views caring as a therapeutic interpersonal process and identifies ten carative factors in nursing practice as indicated in Table 2: These ten factors form the structure for understanding and studying the science of caring.

TABLE 2.2 THE TEN CARATIVE FACTORS FOR A SCIENCE OF CARING OF WATSON (1985)

Factor 1	*The formation of a humanistic-altruistic system of values.*
Factor 2	*The installation of faith and hope.*
Factor 3	*The cultivation of sensitivity to one's self and to others.*
Factor 4	*The development of a helping-trust relationship between the care-receiver and the caregiver to ensure a relationship of quality.*
Factor 5	*The promotion and acceptance of the expression of positive and negative feelings.*
Factor 6	*The systematic use of the scientific problem-solving method for decision-making.*
Factor 7	*The promotion of interpersonal teaching and learning.*
Factor 8	*The provision of a supportive, protective, and (or) corrective mental, physical, socio-cultural, and spiritual environment.*
Factor 9	*Assistance with the gratification of human needs.*
Factor 10	*The allowance for existential-phenomenological forces.*

Watson (1985) emphasized that no one of the factors could be implemented on its own, and stressed the importance of the first three carative factors in providing a philosophical foundation for caring in nursing. The provision of a human value system in nursing management would give nurses an environment conducive to quality nursing care. Nurses should nurture hope in their patients and the nurturing of hope in the management environment could contribute to the willingness of nurses to instil hope in their patients and contribute to the recovery process. Watson (1985) stated that the recognition and development of feelings helped in the self-actualization and growth of a person. She singled out the main responsibility of human resource management as being to help nurses towards growth and self-actualization and to enable them to encourage growth in others. According to Watson (1985), the first three factors are interdependent and

function together in a process that promotes positive changes in the individual. These first three carative factors form the basis for the implementation of the other factors.

Factor 1 *The formation of a humanistic-altruistic system of values.*

The formation of a humanistic-altruistic system of values in nursing management is the basis for caring and should guide all management decisions. Caring leaders establish with each nurse a dynamic process of exchanges, interaction and open communication. Caring has been found to be a complex set of affective, cognitive and interactional elements which are put into purposeful action between nurse managers and nurses. Nurse managers should work at remembering nurses' names and discovering each one's unique professional and personal needs. The following are universal human needs in any interactive situation:

Friendliness In the human resource environment friendliness is a basic and sometimes neglected caring concept. Greeting the nurses in a friendly way or addressing them by their names shows the nurses that nurse managers are interested in them as individuals.

Kindness To say that caring is *being nice* or *kind* is to miss the cognitive aspects of caring (Valentine, 1989, p. 30-31). Kindness forms a part with the other caring elements in a

caring relationship. Nurse managers could show kindness by accepting the nurse as an individual with specific needs. Nurse managers should assess the needs of nurses and try to accommodate these needs.

Concern

People are the greatest asset of any organisation. Caring human resource management affirms the uniqueness, importance and potential of every individual nurse. Caring for and about the nurses combines justice, equity and respect with genuine concern. When nurses feel valued and appreciated by the nurse manager, they are motivated to give their best when they care for patients.

Love

According to Brandt (1994) good management is largely a matter of love. Managers must have the courage to care for the good things the health service can do in the community, as well as caring for the caregivers. Dedication to the common goal of nursing is what patient care is all about. Management of nurses is like being in love... the courage to care is the challenge for health services of today. Nurses should be viewed as partners rather than subordinates. Nurse managers should see the needs of the employees (nurses) as no different from their own needs.

Caring should be grounded in humanistic values such as kindness, empathy, concern and love for others and altruistic values that bring meaning to one's life through relationships with other people (Watson, 1985).

Factor 2 *The instilling of faith and hope.*

The emphasis on faith and hope in the human resource management process should be a natural development from the humanistic-altruistic system of values. The instilling of faith and hope should ensure a professional and positive environment in nursing management and is never a completed process. The nurse manager should instil faith and hope in each one of her/his nursing personnel. The instilling of faith and hope would contribute to the most important caring task in human resource management, which is to encourage nurses to believe in their own potential to care for patients and their families. *The instilling of faith and hope in patients is basic to the healing process and helps to determine the outcome of disease. A person's mind and soul should be inspired before the illness can be treated* (Watson, 1985, p. 13-16).

Factor 3 *The cultivation of sensitivity to oneself and to others.*

Sensitivity to oneself and to others is grounded on the formation of a humanistic-altruistic system of values with the aim of satisfaction, comfort, and a high level of health (in nursing management this means low stress levels and no burnout of

nurses). Burnout results when the individual is not allowed to develop, and when the individual works in an organization that is only bottomline driven. Without the cultivation of sensitivity to oneself and to others, nursing care would fail, because nurses need to be sensitive towards their own needs and to the needs of others to develop the ability to learn about another person's view of the world (Watson, 1985).

The nurse manager should try to help nurses to develop a sensitivity towards their own feelings. People who are not sensitive towards their own feelings, might find it difficult to be sensitive and responsive to feelings of others. If nurses fail to be human in sensitive situations, then they fail in their nursing task, to nurse and care for the patient (Watson, 1985).

In a management environment sensitivity provides a climate for understanding and acceptance of nurses as individuals with individual needs. Moving towards higher levels of maturity and self-actualization is only possible when nurses are accepted and understood by nurse managers. Watson (1985) believes that the more self-actualized a person is, the higher is his/her quality of living. Self actualization is the need to maximize one's potential. Nurse managers have a major role to play in helping nurses towards self actualisation. Management performance is an opportunity for managers where, nurses could be encouraged towards further development of potential. Individual needs could be identified and career goals could be set, and planning towards career goals could be facilitated.

Competence is a major desire of human beings. In human resource management of nurses, insistence on competence is of special importance, since patients expect high levels of competence from nurses. Nurse managers could help to improve the competence of nurses by providing means for professional growth and development.

Factor 4 *The development of a helping-trusting relationship between the care-receiver and the caregiver to ensure a relationship of quality.*

A helping-trusting relationship evolves from a certain quality of congruence, empathy, warmth and communication and listening. Patients and others that feel another person really cares about them are more likely to establish a trusting relationship with that person. The first three factors namely, the formation of a humanistic-altruistic system of values, the instilling of faith and hope, and the cultivation of sensitivity to oneself and to others, determine the quality of the relationship. The nurse who experiences caring in the human resource management situation will be more willing to discuss sensitive information concerning herself and her problems and needs with the nurse manager, with the possibility that nurses could become more sensitive to the needs of patients under her/his care. Watson (1985) states that patients showed signs of receiving high quality care when they experienced good interpersonal relations with nurses. A basic element of quality care is the development of a helping-trusting

relationship. Knowledge of the other person is of utmost importance. For the helping-trusting relationship certain attitudinal processes, for example, sensitivity to self, openness and altruism, are prerequisites. Other processes that are interrelated to the helping-trusting relationship are as follows:

Congruence is a critical element in the helping-trusting relationship and is tied to sensitivity to self and others that includes an openness towards feelings. Guidelines for congruence in nursing management are honesty at all times, and genuineness and openness on the side of the nurse manager. Honesty must be shown in identifying problems in the health services and a readiness to communicate with nurses.

Empathy is a basic element essential for the development of a helping-trusting relationship. Empathy refers to the ability to experience the other person's personal world and feelings. It includes the ability to communicate understanding to the other person. According to Watson (1985) the working conditions of nurses could change positively for nurses with the understanding and acceptance of nurses in the human resource management environment. Nurse managers should show appreciation and understanding of the work that nurses do.

Warmth refers to the degree to which the nurse manager communicates caring to others. Warmth could be communicated to others in a variety of ways, for example, gestures, posture, tone of voice, touch and facial expressions. These aspects are important aids that could be used by the nurse manager in handling difficult human resource management aspects such as dealing with discipline and handling of grievances. Chappel, (cited in Kerfoot, 1997) notes that people from happy, loving families will do anything for each other as will people who work for happy loving companies.

Communication with effective feedback to nurses will ensure the development of effective helping-trusting relationships. *Open communication helps to facilitate a trusting relationship in nursing between nurse manager and nurses* (Watson, 1985, p. 23). The nurse manager should maintain open communication channels with staff. The majority of grievances in nursing are the direct result of management failing to listen to their staff (Potgieter & Muller, 1992). Effective listening skills should be developed by nurse managers to ensure a helping-trusting relationship in the human resource management environment of nurses.

Nurse managers should concentrate on maintaining relationships and avoiding thoughtless things that might damage the relationship between management and nurses. Nurse managers should concentrate on setting the right example to staff, the caring role model, and being consistent in temperament so that nurses know how to read the nurse manager. The nurse manager must always try to be fair, impartial, and consistent regarding staffing matters, for example, applying the rules, executing discipline procedures and rewarding nurses. A sincere personal interest in nursing staff as individuals, and counselling staff on matters that affect their jobs are important caring strategies in nursing management.

Factor 5 *The promotion and acceptance of the expression of positive and negative feelings.*

This factor forms an inherent part of the helping-trusting relationship and encourages a move to a deeper and more honest level of the relationship between nurse management and nurses. This factor seems to be so basic that it could easily be taken for granted. In reality this factor is often not recognized or used in the most effective way. It includes aspects such as communication and interaction between people. This factor is important for the nurse manager in the human resource management position because communication and interaction form part of the functions of nurse managers (Watson, 1985).

Factor 6 The systematic use of the scientific problem-solving method for decision-making.

A creative problem-solving approach is the basis of a science of caring in patient care. The emphasis is on the art and science of caring in nursing. The use of the scientific problem-solving decision-making method is as important as the human caring approach in nursing. According to Watson (1985), a student in nursing needs additional knowledge and understanding for the application of the scientific problem-solving decision-making method in nursing. Firstly nurses must have the conceptual and theoretical understanding of a phenomenon or a problem, and theoretical background to solve the problem. Nurse managers could set the example for scientific problem-solving in nursing by using this method when solving patient care problems.

The scientific problem-solving decision-making process tries to solve problems or answer questions and was introduced as a method of nursing that considers an individual's physical, social, psychological reactions to disease, the individual as a member of society with his own stresses which may affect her/his reaction to disease. Nursing, as a science of caring, becomes a more complete science and profession as it incorporates systematic use of the scientific problem solving method (Watson 1985).

The scientific process of nursing includes the following processes:

Assessment Observing, distinguishing relevant from irrelevant data, distinguishing important from unimportant data, validating data, organizing data and categorizing data;

Analysis/diagnosis Finding patterns and relationships, making inferences, stating the problem and suspending judgment;

Planning Generalizing, transferring knowledge from one situation to another, developing evaluative criteria and hypothesizing;

Implementation Applying knowledge and testing hypotheses;

Evaluation Deciding whether hypotheses are correct, making criterion-based evaluations and judgments (Watson, 1985).

Factor 7 The promotion of interpersonal teaching and learning.

Learning is more than receiving information, as it also depends on the nurse's ability accurately to scan, assess, formulate, appraise, plan, implement, evaluate and to make a decision. Nurse managers have a major task to ensure that all nurses are sufficiently skilled and knowledgeable to cope with modern demands. The factor of interpersonal teaching and learning is part of nearly all nursing interventions with nurses. Watson (1985) identifies seven clinical care phases for problem-solving in the interpersonal teaching-learning process:

Scanning Identify the major problems and goals that are important to the specific person. Discover potential as well as actual problems within the other person's framework according to his/her own perceptions. The nurse manager could use scanning to help with identification of staff problems in time, and to be able to plan interventions;

Formulating This includes exploring the issue of concern and examining the significance of the problem together with the nurse;

Appraising A joint decision about the problem is taken, with willingness to solve it on both sides, including nurse managers and nurses;

Problem solving This phase involves the willingness to solve the problem, to take action and to learn from the experience. The helping-trusting relationship and interpersonal processes become critical elements at this stage. The nurse manager and nurses should display honesty, empathy, warmth and a commitment towards learning and problem-solving in the nursing management environment;

Planning Includes joint decision-making by nurse managers and nurses and the identification of ways in which to solve the problem. Active participation on both sides to generate alternatives is of critical importance.

Implementing This stage includes traditional learning such as cognitive information. The nurse manager with her/his higher level of experiences should take the lead and teach the nurses how to implement decisions;

Evaluation At this stage whether or not the learning did in fact takes place is investigated (Watson, 1985).

Factor 8 *The provision of a supportive, protective, and (or) corrective mental, physical, socio-cultural, and spiritual environment.*

The goal of this carative factor is to strengthen the self-concept and self-worth of nurses through a holistic approach to the health environment. This carative factor emphasizes the lower needs of Maslow. The nurse manager could support the nurses towards motivation and success by acknowledgment of their achievements. The implementation of management by objectives and the provision of guidelines to attain the objectives could motivate the nurses. The following are important for the provision of a supportive, protective, and (or) corrective mental, physical, socio-cultural, and spiritual environment:

Comfort The nurse manager could control stress and provide comfortable working conditions by ensuring that nurses are well equipped for the task ahead and that enough competent nurses are employed with enough equipment and resources to care for the patients.

Privacy This is a major factor in caring in the sense that the privacy of an individual must always be respected. Depersonalisation that sometimes occurs during hospitalisation contributes to the factor of privacy in nursing. Privacy is often linked to health and well being. Maslow's early findings showed that healthy people have a strong liking for privacy or even a need for it. Privacy maintains the nurse's human dignity and integrity. A violation of privacy could mean a violation of a nurse's dignity. All personal information should be treated as confidential by the nurse manager and the nurses.

Safety This is a basic human need, a basic function of the nurse manager and the nurse is to ensure the safety of all individuals working or users of the service, and a critical consideration in the health of patients. The nurse manager and the nurses must be constantly on the alert to safety factors in health services for both the patients and nurses.

Environment This factor includes more than safety and comfort. It is the provision of support, protection and correction of the environment. Cleanliness is closely linked with quality care. (Watson, 1985). Nurse managers should visit the units in the hospitals and acquaint themselves with the conditions under which nurses have to work. Nurse managers should ensure that the environment in the hospital is conducive to health and safety of all concerned.

Factor 9 *Assistance with the gratification of human needs.*

It is important to the nurse managers and the nurse's role to help others in their daily activities as well as facilitating growth and development of patients towards health. Watson (1985) classified Maslow's needs as follows, for the purpose of nursing:

1 Lower order needs (survival needs) that include food and water, elimination and ventilation and the functional needs that include activity and rest;

2 Higher order needs (integrated needs) that include aspects such as success and affiliation and the growth-seeking needs that include needs of self- actualisation.

This order of needs could be useful to the nurse manager to assess the individual needs of nurses. It is important for nurse managers to assess the needs of nurses towards self-actualisation as well to provide opportunities for fulfilment of these needs. The most important aspect for nurse managers is to mend broken spirits and to develop a supportive work atmosphere that encourages worker involvement and fosters employee growth (Watson, 1985).

The goal of nurse managers is to create an environment in which nurses may live up to their potential or at the highest level of need attainment. Nurse managers should care about what nurses think, feel and believe. Nurse managers, who still believe in old outdated approaches, like using threats and intimidation to get

results, need to rethink their position. Caring is the chief building block upon which new business and professional relationships should be built (Bickham, 1996).

Factor 10 The allowance for existential-phenomenological forces.

This factor emphasizes understanding of people from their frame of reference in order to help the person to find his or her own meaning and solution to problems. The understanding of people from their frame of reference is an ideal, and different situations will allow different levels of caring in the health services (Watson, 1985). Nurse managers should try to understand the nurses from their (the nurses) frame of reference for better identification of the individual needs and problems of nurses. Watson (1985) (cited in Boykin and Schoenhofer, 1990) provides insight as to what it entails when a nurse is caring for a patient. Watson mentions that caring is expressed through commitment, compassion, confidence, conscience and competence. These caring concepts are of considerable importance in human resource management in nursing. Health services should provide a human environment for nurses to practise nursing with the enactment of values such as commitment, support and the development of human resources, sensitivity to the needs of nurses, helping and trusting relationships with nurses and the provision of a safe and protective environment.

Leininger (1984) (cited in Wesorick, 1991) said: The concepts, principles, and practices related to human care have not been institutionalised as a nominative expectation of nursing, and so the chance of care being a major part of nursing education and nursing services cannot be ensured. Leininger (1984) defines care/caring as assisting, supportive or facilitative interventions that focus on the needs of individuals or groups, to improve the human condition. Leininger, (cited in Kyle, 1995) believes further that caring for patients requires nurses to acquire culturally-based knowledge and skills. The implication for nurse managers is to ensure that nurses have relevant knowledge regarding the cultures of their patients and nurse managers also need knowledge regarding the different cultures of the nurses in their services. It is not the scope of this research specifically to explore the cultural differences in nursing services but it might identify the need for cultural sensitivity in human resource nursing management.

Nyberg (1989) made an important contribution to the literature on caring with the emphasis on caring in nursing administration. Nyberg (1989) asks the question whether caring could make a difference in the daily activities of nurses and nurse managers in nursing. Nyberg sees caring as a burden because of the many areas that need care, a responsibility towards others and lastly as a feeling towards some one else (Nyberg, 1989). Caring means to be committed and involved. Nyberg (1989) identified five caring attributes for nurse managers that could facilitate caring behaviour in nursing. By developing these attributes as

indicated in Table 2.3, the nurse manager could be a role model who exemplifies caring to nurses.

TABLE 2.3 THE FIVE CARING ATTRIBUTES OF NYBERG (1989)

1. *Commitment to a continuing relationship*
2. *Self-worth to achieve feelings of self-worth*
3. *Ability to prioritise that enables one to be caring.*
4. *Openness develops into trust and growth in the relationship*
5. *Ability to bring out the potential of others*

1 *Commitment* must be made to a continuing relationship that consists of interest in someone and knowledge through learning about the person that leads to understanding and a desire to get more personally involved.

2 *Self-worth* is important to achieve feelings of self-worth, self-understanding, and self-confidence. The concept of caring requires that the caring person has developed a strong sense of self-worth and feel cared for in her/his own life.

3 *Ability to prioritise* enables one to be caring. Nurse managers feel uncared for and pass this feeling on to their staff. *Ability to prioritise* enables the ordering of activities to allows time for caring practices and to reflect a caring approach. Nurse managers need to plan to have time for their own needs and for the needs of their staff.

4 *Openness* encourages trust and growth in the relationship. It means being willing to disclose your own humanity for other people to see the "real person". It includes listening, soliciting comments, and taking note of non-verbal communication cues, asking the right questions and waiting patiently for answers.

5 *Ability to bring out the potential* of others by acting on the belief that other people have abilities and talents and motivating them towards achievement is important. Recognizing the opportunities for growth requires a deep appreciation for the potential of others. Nurse managers can only motivate their nurses if they know them well enough to identify their potential, provide opportunities for their potential to be realized and give meaningful praise and rewards for jobs well done (Nyberg 1989).

It was emphasized by Farley and Nyberg (1990) emphasized that an environment within which nurses can grow and thrive professionally will positively impact on the quality of patient care in the hospitals.

Morse, Bottroff, Neander, Solberg and Johnson (1991) reviewed nursing articles and described the concept of care or caring where the term caring or care was used as a focus of a research project. Morse et al. (1990) identified the five conceptualisations of caring as listed in Table 2.4:

TABLE 2.4 THE FIVE CONCEPTUALIZATIONS OF CARING BY MORSE, BOTTROFF, NEANDER, SOLBERG AND JOHNSON (1991)

1	*Caring as a human trait or as the "human mode of being".*
2	*Caring as a moral imperative and describe caring as a "fundamental value" or moral ideal in nursing.*
3	*Caring as an affect extends from emotional involvement*
4	*Caring as an interpersonal interaction*
5	*Caring as a therapeutic intervention with caring actions*

1. *Caring as a human trait* or as the ' human mode of being ' (Morse et al. 1991, p. 4). Roach (1987) (cited in Morse et al. 1991, p. 4) said ... *one's own experience in being cared for and expressing caring, influences one's ability to care.*" The authors stated that the nurse's experiences of caring during her/his period of nurse training influences the nurse's caring skills.

2. *Caring as a moral imperative* is described by Morse et al. (1991) as a "*fundamental value"* or moral ideal in nursing). Watson and Gadow (cited in Morse et al. 1991) see caring as a basis for the preservation of dignity of patients and a commitment to maintaining the individual's dignity or integrity. This implies that the environment in which nurses work must facilitate and support caring.

3. *Caring as an affect* extends from emotional involvement. McFarlane, (cited in Morse et al. 1991), states that caring signifies a feeling of concern and

interest and protection for the patient. It is a response of increased intimacy between the nurse and the patient and where mutual self-actualisation is successful progresses through the stages of attachment, persistence, intimacy and confirmation towards caring.

4. *Caring as an interpersonal interaction* should be represented in the nurse manager-nurse interpersonal relationship as the essence of caring.

5. *Caring as a therapeutic intervention* involves caring actions such as attentive listening, teaching, advocacy, touch, being there and technical competence with adequate knowledge and skill as the basis for caring Morse et al. (1991).

Kyle (1995) stated that when caring has these above characteristics it could serve as a standard for nursing practice. It is not enough for nurses to be caring and to identify the characteristics, but the way in which these activities are carried out must be stressed. A number of research studies were conducted by nurse researchers internationally on the way in which caring was performed in nursing practices.

2.3 INTERNATIONAL RESEARCH STUDIES ON CARING IN NURSING PRACTICE

Larson (1981) was one of the earlier researchers to investigate caring in nursing practice, focusing on patients with cancer. Larson developed the (CARE-Q) instrument as a means to determine important nurse caring behaviours. The perceptions of caring of nurses working in oncology departments showed that *listening to the patient* was ranked as the most important item from the nurses' perspective. The patients' perception differed from that of the nurses and the most important caring aspect identified by patients was *to monitor and follow through*. The research showed that the large majority of nurses were in agreement on the important caring concepts. This research of Larson indicated differences in the perceptions of caring from the patients' and the nurses' viewpoints, but there was agreement amongst nurses on caring.

Wolf (1986) developed the Caring Behaviour Inventory (CBI) instrument by selecting phrases from the literature that represented caring. Registered nurses ranked *attentive listening* as the most important concept in nursing: It is comparable with the findings of Larson (1981), Kyle (1995) and Watson (1985). Attentive listening as part of the communication process is one of the main responsibilities of the nurse manager as the human resource manager. These views on caring as interactional behaviour are shared by Benner (1984), (cited in Kyle 1995).

Mayeroff (1971) described caring as a process of relating between individuals where growth and self-actualisation occur. The work of Mayeroff (1971) is important in human resource management of nurses where the main priority in human resource management should be the growth and development of nurses. Mayeroff (1971) identified **eight** key concepts of caring as listed in Table 2.5.

TABLE 2.5 THE EIGHT KEY CARING CONCEPTS OF MAYEROFF (1971)

1.	*Knowing*
2.	*Previous and current experiences of caring must be explored to planned the nursing care intervention or the relationship in the nursing management environment.*
3.	*Patience on the side of the caregiver during the caring process*
4.	*Being honest with oneself in order to see the other person as he/she really is,*
5	*Trusting in one self that you could care*
6	*Acknowledgment of the uniqueness of other people*
7	*Hope and trust*
8	*Courage to be a caring person.*

1 *Knowing* - gaining knowledge about the other person before one can render any care or manage any person or group of persons.

2 *Previous and current experiences* of caring must be explored to plan the nursing care intervention or the relationship in the nursing management environment.

3 *Patience on the side of the caregiver* is important during the caring process, as is patience with nurses in the management of health services.

4 *Being honest with oneself* in order to see the other person as he/she really is, is a prerequisite for caring to take place.

5 *Trusting in oneself* that the care given to a nurse will enhance the self concept of the caring nurse.

6 *Acknowledgment of the uniqueness of other people* is important to plan individualized nursing care for each patient and to treat nurses by taking into consideration their individual needs during the human resource management process.

7 *Hope and trust* are cornerstones in the caring relationship between patient and nurse or between nurse manager and the nurse.

8 *Courage to be a caring person* is necessary to ensure quality-nursing care at all times (Mayeroff,1971).

The major premise of Mayeroff's (1971) concept of caring is that growth will occur. Mayeroff believes that self-actualisation of both the caregiver and the care receiver is possible.

Valentine (1989) underlines the fact that caring in nursing is more than kindness. Caring has been found to be a complex set of affective and cognitive elements in the interaction with patients or individuals with the purpose of promoting health, learning and/or physical comfort (Valentine, 1989). The implications of these findings for the nurse manager may be related to the need for the nurse manager to take the patient's vision of caring into consideration when taking decisions that concern staffing. An example would be the practice of so-called floating nurses who do not know the area in which they work.

Ray (1989) uses the organizational structure in which caring takes place to define caring. Ray (1989) developed a formal theory of caring, called bureaucratic caring. According to this theory caring seems not only to be differentiated according to the roles and positions of people within the organization, but also within specific clinical units. Ray (1989) is in agreement with Mayeroff (1971) in that growth and development are important caring concepts in nursing practice.

In the changing health care environment it is important that nurse managers review their role and tasks as managers of human resources. The theory of

Watson (1985) formed the basis for the study on the exploration of the presence and enactment of caring in the human resource management of nurses. The framework could be used for future development of a caring human resource management environment in nursing in which both nurses and patients could experience caring.

2.4 HUMAN RESOURCE MANAGEMENT

The task of management is mainly to combine, allocate, co-ordinate and deploy resources or inputs in such a way that the organization's goals are achieved as productively as possible (Covey, 1996). The management process is use to accomplish and execute all the above functions on time. The management process entails four fundamental functions namely, planning, organizing, leading and controlling. Human resource management has a dual responsibility, to improve the economic well being and quality of life of all stakeholders. Economic well-being includes the fact that jobs should produce things that people can use and consume in their daily living and they hope to earn enough money to feed clothe and educate themselves and their families. Quality of life includes dimensions such as acceptance and love, challenge and growth, purpose and meaning, faimess and opportunity and life balance. Human resource management defines people as assets, and people as intrinsically valuable, and not just an asset to the company.

Different models of management have been proposed to achieve these goals. The management process and the four functions of the process are encountered at all levels and in all departments of an organization. In an organization there are different management areas. The management areas described by Smit & Cronjè (1997) are marketing, finance, operations, human resources, administration and others. The purpose of the present study is to explore the presence and enactment of caring only in the human resource management process. The human resource functions as described by Smit & Cronjè (1997) are in agreement with other authors and entail the following main areas:

- Appointment of staff including the selection of the right people;
- Development and in-service education for staff with the right training in order to make the best use of them;
- The maintenance of the human resources of the organisation.

Carrel, Elbert, Hatfield, Grobler, Marx, and van der Schyf (1998) explain the human resource process in more detail and state that the emerging trend in human resource management is towards the adoption of the human resource approach, through which organizations benefit in two ways, namely:

1. An increase in organizational effectiveness;
2. The satisfaction of each employee's needs.

The human resource approach holds that organizational goals and human needs are mutual and compatible. The term, human resource management, became popular during the 1970's when research showed that viewing people as

resources rather than factors of production brought real benefit to both the organization and the employee. It is still hard to define human resource with clarity and the views of authors differ regarding certain terminology. The following principles, as set out by Carrell et al. (1998) are common in the literature and are in agreement with the views of Swanepoel, Erasmus, van Wyk, and Schenk (1998) which provide the basis for this study on caring in the human resource management of nurses:

1. Employees are investments that will, if effectively managed and developed, provide long-term rewards to the organization in the form of greater productivity;
2. Policies, programmes and practices must be created that satisfy both the economic and emotional needs of employees.;
3. The workplace environment must be created in which employees are encouraged to develop and utilise their skills to their fullest potential;
4. Human resource management practices must be aimed at balancing the needs of both the individual and the organization (Carrell et al. 1998).

Carrell et al. (1998) identify the following functions or activities of human resource management:

1. Job analysis and design for every employee to perform at a satisfactory level and to meet the job requirements. A mismatch could result in poor performance, staff turn over and problems;
2. Recruitment, selection, induction and internal staffing form part of the effectiveness or non-effectiveness of an organization.;

3. Appraisal, training, development and career management are linked to the growth of both the employee and the organization. Carrell et al. (1998) point out that an important development function is performance appraisals of employees. Career management is a relatively new concept to the personnel field;
4. Compensation and health have posed problems all along. The question is posed: *are salaries competitive and fair and what is the possibility of an incentive compensation system tied to performance?* The health and safety of employees is an area of concern to the employee and employer;
5. Labour relations exert a powerful influence on employers and could help to shape labour relation policies;
6. Research and problem solving of issues such as absenteeism, turnover, job dissatisfaction, and unfair labour practices should be addressed by human resource managers to combat costs and low productivity.

Plunkett & Attner (1992) describe a model for the staffing process, (human resource management process) that is in consensus with the human resource management processes of Carrell et al. (1998) and Swanepoel Ed. (1998). Their formulation includes the following functions:

1. The legal environment for the staffing function that includes equal opportunities and affirmative action;

2. Human resource planning that includes forecasting, human resource inventory, and comparison. This step is to ensure that the personnel needs of the organization will be met;
3. Recruitment of sources of applicants for the job. This step is done after the needs of the organization have been identified;
4. Selection and the selection process may include the evaluating of candidates and choosing the one whose credentials match the job requirements;
5. Induction and training of personnel;
6. Performance appraisal that includes successful appraisals, appraisal systems and methods;
7. Implementing of personnel decisions, for example promotions, transfers and demotions of staff;
8. Compensation and the influences of compensation and types of compensation (Plunkett & Attner, 1992).

Plunkett & Attner (1992) view the human resource process as a series of steps that managers perform to provide the organization with the right people in the right positions. Compensation of staff is not viewed as a step, but rather as an ongoing process.

The measurement of human resource management is a continual process of measuring products, practices and services against one's toughest competitors, or against companies acknowledged as leaders in other business sectors. All the

dimensions of human resource management need to be evaluated or measured (Scott, 1996). According to Scott (1996) the dimensions of human resource management are organising and employment (planning dimension), recruitment and placement (resource dimension), motivation and communication (leadership dimension) and monitoring and training (performance dimension). The dimensions, functions, processes, or structures described by the various authors are to a great extent in agreement, although different authors named the activities differently.

It is clear that the above authors, together with Bratton (1999) agree that the human resource process covers the following five functional areas:

1. *Staffing:* Including practices such as resource planning, job analysis, recruitment and selection;
2. *Rewards:* Such as job evaluation, performance appraisal, and benefits;
3. *Employee development:* Including the training needs to ensure the necessary knowledge and skills to perform in their jobs;
4. *Employee maintenance:* The administration and monitoring of the workplace, safety and welfare policies to ensure competent staff members;
5. *Employee relations:* It includes union participation and negotiations and employee contracts.

The human resource management model of Swanepoel Ed. (1998) is used as the framework for this study because of its clarity and comprehensive structure of the human resource processes. It is important to note that the human resource processes cannot stand alone. The processes are interdependent and closely linked to each other and overlapping of aspects in the various processes is possible. The framework of Swanepoel Ed. (1998) includes the following:

1. *Formulating strategies* (organising) is an important aspect to investigate the human resource management of nurses, and it is not clearly identified in the views of the other authors, as described above;
2. *Structuring the work* (organising), workforce planning (employment);
3. *Workforce planning* (job descriptions and specifications);
4. *Staffing* (human resources);
5. *Utilising and maintaining human resources* (leadership) and human relations dimensions.

Swanepoel Ed. (1998) described human resource management as an intervening process which establishes continuously an optimal fit between people and the employing organization. This model provided a structure where the human being as an employee and the organization as employing entity could be explored in a systematic way. The spectrum of human resource management functions in the framework of Swanepoel Ed. (1998) served as a guideline for the exploration of the presence and enactment of caring in human resource management of nurses in hospitals.

2.4.1 Formulating strategies

The formulating strategies includes the mission statement, goals and objectives and the philosophy of service. The mission statement is the highest priority in the planning process. For health care services it means the provision of health care to maintain health, cure and to allay pain and suffering. A mission statement allows the nursing department to be managed for performance. The mission statement should include definitions of nursing as described by professional nurses for example Henderson, Orem, King or other nursing theorists. The mission should be known and understood by nurses, health care practitioners, by patients and the community (Swansburg, 1993).

A philosophy of nursing is a guide or framework for action. It identifies what are believed to be the basic phenomena of the discipline, which is the most crucial step in the development of a philosophy (Salsberry, 1994). It is a set of values or beliefs and is developed from the purpose (mission). The mission statement and the philosophy can only be helpful if they direct nursing care. Each nursing unit should use the organisation's philosophy to develop its own unit philosophy. Each professional nurse should have a personal nursing philosophy corresponding with the organisational philosophy (Marquis & Huston, 1994).

All philosophies must be translated into specific goals and objectives to result in action. A goal can be defined as the aim of a philosophy. Objectives are more specific than goals and describe how the goal is to be accomplished. Usually more than one objective is necessary to meet a goal. *Process objectives* are most common in nursing and are written in terms of the method to be used while *result-focused objectives* describe the outcome.

Objectives, as the mission statements and the philosophy, must be functional and useful. Objectives should be used to evaluate nursing care and the performance of nurses, to plan education programs, to do the estimation of staffing requirements and to order equipment and supplies. Objectives are the standards against which the performance of the health service can be measured. Objectives are the basis for work and task assignment in nursing. Objectives make nursing tasks clear and unambiguous with measurable results (Swansburg, 1993).

Any successful organisation usually strives to attain congruency between the philosophy of the individual employees and that of the organisation as a whole. Policies and procedures will guide the nurses further towards attaining the goals of the organisation (Marguis & Huston, 1994).

2.4.2 Structuring the work

Organisation design indicates a structure that is appropriate for strategy implementation and mission accomplishment for an organisation. It is the formal system of working relationships that separates and integrates tasks. The framework allocates responsibility, authority, accountability and delegation to various posts. It is also concerned about workflow, work organisation, workforce planning, and matching supply to demand. Four elements of organisational structure are as follows:

1 Specialization occurs where specialized tasks are identified in an organisation for specific groups or individuals and this process is then called departmentalisation. Skill specialization, expert development, career development, high quality technical problem solving is promoted (Roos, 1996);

2 Standardization ensures that staff perform their duties in a uniform and consistent manner. Standardization of procedures includes the availability of procedure and policy manuals in nursing units;

3 Co-ordination is the process of integration of all the activities of the staff and departments. Key elements of co-ordination are as follows:

- Understanding the problems and needs of different people and departments;
- Integration of functions within departments;
- Respect for the role and functions of the staff;
- Effective communication channels;

- Consultation and co-ordination of efforts of all staff towards quality patient care.

4 Authority is power given to make decisions and to take actions. Decisions are mainly taken by management. Decentralized and participative decision-making should be implemented in health services to enhance a caring environment.

2.4.3 Workforce planning

Job analysis according to Swanepoel Ed. (1998) is a technical procedure that explores the activities of a particular job with the end results of generating job descriptions and job specifications.

1. *Job descriptions* define the nature of the job content, the environment and its conditions and include aspects such as, job title, purpose of the job, responsible to and for, main duties and subordinates;
2. *Job specifications* stipulate the acceptable characteristics a jobholder must possess as requirements for a specific job, including such aspects as, education, experience, aptitude, disposition and skills.

2.4.4 The staffing processes

The staffing function of some large organizations such as hospitals is currently done by a human resource department (personnel department). Such personnel

departments were not included in this study because the human resource management functions of nurse managers were the focus of this research study. The nurse manager is responsible for technical staffing matters regarding nurses. For part of these functions the nurse manager and the human resource management department need to work together very closely such as the application for annual leave and the monthly payment of salaries. These aspects were not included in the research study. Staffing, according to Swanepoel Ed. (1998) could be viewed as a series of steps that managers perform to provide the organisation with the right people. Towards the end of the eighties recruitment and selection were seen as the two key issues in the staffing process. The decline in the number of young people with relevant skills forced the process of recruitment to move to the one of the top priorities of the personnel functions in organisations (Gold, 1999). This decade is seen as *the era of the recruiter* where the recruiting and retaining of staff are the main concerns in human resource management. On the other hand, employees would also be selecting an organisation and work on offer as much as employers would select the candidates. Failure to appreciate the importance of forming expectations during recruitment and selection may result in the loss of high-quality applicants (Gold, 1999). For the purpose of this study, the steps as identified by Swanepoel Ed. (1998) were investigated. The process of staffing starts with human resource planning and includes the following:

- Recruitment attempts to identify and attract candidates to meet the requirements of certain positions in the organisation. Job descriptions and job specifications are used during this step (Plunkett & Attner, 1992);
- Selection of staff is the process by which the organisation decides which candidate has the abilities, skills and characteristics that most closely match the job requirements (Plunkett & Attner, 1992). Organisations have become increasingly aware of making good selection decisions. Selection of staff involves costs such as the selection process itself, the use of various instruments, the induction and training of new staff and the turnover of staff (Gold, 1999);
- The level and content of induction training and orientation are aimed to bring the employee into the mainstream of the organisation as quickly as possible;
- Training and development programmes are aimed at supplying the staff with skills, knowledge, and competencies to improve their abilities to perform at high levels in their present jobs. Development of staff means preparing the employees for the future. Development of staff exposes people to skills, knowledge and attitudes that will be helpful to them in higher positions (Plunkett & Attner, 1992);
- Socializing new employees starts as soon as the selection process has been completed. It is a welcoming process and introduces and supplies the newly appointed employee with the necessary information and

networks inside the organisation. It encourages the employee to feel at ease and reduces anxiety (Swanepoel 1998).

Staffing of organisations is to a large extent, *to put the right person in the right job*.

2.4.5 Utilizing and maintaining human resources

Utilizing and maintaining human resources includes the following:

- **Performance management** could be defined as a formal and systematic process by means of which the job-related strengths and weaknesses of the staff are identified, observed, measured, recorded and developed (Bratton, 1999). The appraisal of the staff can only be effected if employees receive feedback on their performance. The appraisal system serves as a career development tool and for personal remedial interventions, diagnosis of training and developmental needs and promotes effective communication;
- **Knowledge about leadership styles** of managers enhance the level of guidance to nursing staff by identifying the four distinct leadership styles used by leaders (Swanepoel, 1998).

1 *Directive leadership* where the staff is told what is expected of them and leadership provides special guidance, standards, and schedules of work;

2 *Supportive leadership* where subordinates are treated as equals and the leader shows concern for the well-being and personal needs of staff and the development of pleasant interpersonal relationships among all the staff;

3 *Achievement - orientated leadership* where challenging goals are set for the staff, and staff are expected to perform at their highest level with continual improvement of performance;

4 *Participative leadership* where the suggestions and ideas of staff are important in the decision making process (Swanepoel, 1998).

- **Induction, orientation and in-service training** of staff is the education of an employee while he/she is doing his/her job. Induction training is regarded as the first part of the orientation process and includes aspects such as the physical and geographical layout of the institution, conditions of service, recreational activities, work schedules, grievance procedures, the philosophy, mission, goals, communication process and safety measures (Booyens, 1998). Orientation is training towards the specific job and in-service training is a continuous process of training and development of the employees.
  - **Development of career paths** for nurses consists of two components namely:
    1. *Career planning*. This includes self-appraisal, identification of opportunities, setting of goals, planning and implementation of plans;
    2. *Career management*. This includes steps such as human resource planning, designing career paths, disseminating of career information, publication of job openings and assessment of staff.

- **Employee well-being** includes consideration of work, human behaviour as well as occupational mental health and the rewarding system in terms of praise for work well done.
- **Labour relations** are the relations between management and their employees, and relations between employees themselves and the maintainment of a standard of work conducive to sound labour relations and a generally more successful organisation. Labour relations include communication with employees. Communication can generally be viewed as the process of conveying and sharing information between staff. It is a process of information exchange between receivers and senders. Proper communication is a two-way process. Different methods to communicate with staff includes formal letters or memoranda, notice boards, in-house journals, special publications or reports, electronic mail, briefing groups, committees, different face-to-face methods, and written communication (Swanepoel, 1998).
- **Grievance handling** procedure for nurses refers to the process whereby management formally deals with officially presented complaints. The grievance procedure normally manifests itself in a document which spells out the stages or steps to be followed when employees have grievances (Swanepoel, 1998).
- **Discipline procedures** are intended to ensure that all staff conform to the performance and behavioural standards for successful operation of the organisation. Discipline has the individual's needs and the improvement and

development of nurses in mind. A disciplinary code is a guideline and assists management and staff in the identification of offences warranting formal disciplinary measures and helps to ensure consistency in disciplinary matters.

- **The process of implementation of changes** in the health services includes aspects such as education and communication, participation and involvement, facilitation and support for those caught up in change, negotiation and agreement on potential resistance to change, manipulation and co-option away from resistance to change, explicit and implicit coercion as a way of forcing people to go along with change (Swanepoel, 1998).
- **Decision-making and problem solving methods** that are used by nursing managers.
- **Elements of organizational culture** such as beliefs, values, assumptions, expectations, norms, sentiments, symbols, rituals and so forth must be considered.
- **The distribution of power** and the understanding thereof by staff within the health services.

2.5 CONCLUSION

From this literature survey it is clear that caring in connection with patients is relatively well defined and described but the literature clearly indicates limitations regarding research on caring in connection with the caregiver. There is greater emphasis on caring for the patients with little emphasis on caring in human

resource management in nursing (Grigsby and Megel, 1995). Limited emphasis is placed on the implementation of caring concepts in human resource management in nursing (Shriber and Larson, 1991). Most literature concentrates on patient expectations of caring with no or very little descriptions of the expectations on caring by nurses from nurse managers (Nyberg, 1993 and Boykin and Schoenhofer, 1990). There is not enough emphasis on describing the meaning of caring in human resource management from the nursing management and nurse's point of view (Shriber and Larson, 1991).

It is clear that top management is part of the human resource management process on the strategic planning level. The rigid labour practices of the past have been changed, and replaced by a more people-orientated approach where training and development of staff are important aspects of management. People are no longer interested in one blanket package for all. Staff members want to be treated as individuals and as part of the organisation and therefore certain aspects such as performance management should be aimed at the developmental and training needs of each employee as well as in terms of profit factors such as absenteeism and proper maintenance of equipment (Burger, 1997).

In the next chapter the methodology of the study is described, with regard to the exploration of the presence and enactment of caring in human resource management in nursing. The research methods in the different phases of this

study are described with the emphasis on phenomenology and descriptive research.

CHAPTER 3

METHODOLOGY

3.1 INTRODUCTION

This study aimed to explore the presence and enactment of caring in human resource management in nursing. A combination of the qualitative and quantitative research approach was used to study caring in the human resource management of nurses. The phenomenological approach was utilized during the qualitative research to explore the meaning and expectations of nurse managers and nurses and their lived experiences of being cared for as a nurse within the context of human resource management (Riemen, 1986). The survey method was used during the quantitative research phase to study the experiences and the presence of caring in the human resource management of nurses. The research was conducted in multiple phases, combining the collection of both qualitative and quantitative data.

3.2 TARGET POPULATION AND SAMPLING

The target population included hospitals with a history of caring practices and with a reputation for caring in KwaZulu-Natal. Purposive sampling applied where the hospitals were selected according to the judgement of the researcher about

the most representative hospitals on caring practices and also to include hospitals with different financial and service systems to ensure the inclusion of a broad spectrum of health care that are offered to general patients in KwaZulu-Natal (Polit and Hungler, 1993). Three hospitals were included in the study and the sample consisted of a general provincial hospital, a private hospital and a mission hospital in KwaZulu-Natal. The hospitals were identified from the list in The Hospital Yearbook for South Africa (1997). Rational purposive sampling with the following guidelines applied:

1. A medium size non-government hospital with a reputation for caring in nursing care and in the city was included. (Hospital 1);
2. A medium size private mission hospital with a reputation for caring was included. (Hospital 2);
3. A medium sized general provincial hospital that was known for quality patient care and with a reputation for caring in a more rural area of the region was included. (Hospital 3).

The purpose and importance of the study was explained to the chief nursing service manager, of each hospital to assess their interest and willingness to participate in the study.

3.3 RESEARCH METHODOLOGY

The research was conducted in multiple phases combining the collection of both qualitative and quantitative data. During phase one, (objectives one and two), the meaning and expectations of nurses regarding caring in human resource management and caring practices of nurse managers were researched. Phase two, (objective three and four), studied the experiences and the presence and enactment of caring in the human resource management of nurses. The final phase, phase three, explored the presence of caring concepts in the structure standards involved in the human resource management process in nursing.

3.3.1 **Phase one The meaning and expectations of nurse managers and nurses regarding caring in the human resource management process**(Objectives one and two)

The principles of phenomenological research were applied to describe the lived experiences of nurse managers regarding caring in human resource management. The participants included all nursing service managers in charge of the hospitals, nurse managers in middle management positions and professional nurses in first level management positions in the units that were available and willing to participate in the research, in the selected hospitals. The participants were informed that their experiences should focus on their current positions. Each participant was assigned a code number according to the

hospital as an assurance of confidentiality, for example (1.1). The participants were asked to identify a suitable venue, date and time for the interviews. Nurse managers, middle managers and professional nurses were interviewed (20-80 min) and the data were audio taped, with consent from the participants. Twelve participants were included in phase one of the study. The participants included in the study were ten nurse managers; three participants were nursing service managers in charge of the hospitals, seven participants were at middle management level and two participants were professional nurses at first level management. (See Table 4.1 for the sample of phase one). The data collection was terminated as soon as the data was saturated.

A data collection protocol was used with caring concepts as a guide for the interviews (see Annexure 8). An introduction to each participant was done and the following information was communicated to them:

> *Thank you for your time. I am doing research on caring in the human resource management of nurses. The focus is not on the human resource department, but on the human resource management functions of nurse managers. You need to tell me the meaning of 'caring in human resource management' and I want to learn more from your experiences on 'caring' to nurses in this hospital only. I am not interested in experiences other than in this hospital.*

The data was collected in a contextually informed way by capturing not just the words but also the differences in pitch, gestures, body language, silences and

simultaneous speech. A copy of the transcript was returned to each participant for review and for additions or corrections if needed.

3.3.1.1 *Treatment of data*

The raw data, as recorded, was transcribed for each participant. Before working on the data, the researcher needed to identify her own preconceptions on the phenomenon of caring. The researcher's own preconceptions needed to be set aside (the process of bracketing) (see Annexure 2). That enabled the researcher to be more open and to validate her own beliefs and concerns. Biases cannot be controlled fully.

The data was analysed qualitatively with the help of the computer software program for qualitative data analysis called NUD*IST 4. NUD*IST was used in this qualitative research to explore the meaning of lived experiences of nurse managers and nurses. The interviews and the observations during the interviews were made in natural settings. The steps to be followed were:

Step 1 Familiarising and immersion

The data came in the form of audio taped interviews with participants together with field notes of the researcher. The audio tapes were transcribed and typed into a word processing computer programme on the computer. The typed data

was then selected in Microsoft Word, imported and pasted in the qualitative data analysis programme NUD*IST. In NUD*IST a project was created and all the documents were selected, imported and pasted into the project under the code name of each participating Hospitals. The data was read over and over and after careful thought *free nodes* were created with a description where applicable. By the time of data analysis a preliminary understanding of the meaning of caring from the perspective of the nurse managers and nurses was formed. The data was worked through many times, over and over, and notes and diagrams were made until the data was known well enough to know more or less what kind of information could be found, where and what interpretations were most likely to be supported by the data (Terre Blanche and Durrheim, 1999). The issue of HIV/AIDS emerged from the first interviews and it was clear that nurse managers spend much of their time dealing with it.

The data was studied to identify material related to the phenomenon of caring. The data was then searched for deeper regularities and irregularities and for differences and similarities. Units with the same meaning or idea were identified.

Step 2 Coding

Coding meant breaking the data down in analytically relevant ways (meaningful pieces) (Terre Blanche and Durrheim, 1999). The cut and paste method and the computer software programme NUD*IST were used to assist in this step of data

analysis. Open coding, by studying the data and focusing on meaningful moments or segments in the data documents, enabled the researcher to identify specific ideas, pieces of information or moments. Meanings were interpreted by using the wise men, (who, what why, when, where) to identify key events, people and important processes and issues on caring in human resource management. A conceptual label was given to each of the interpreted meanings (coding). Sensitivity towards recurring regularities and repetitions was applied during the analysis of the data.

The data was coded into free nodes from the interviews. No new free nodes emerged after interview eight, which indicated that the sample was adequate but the research at that stage only included two of the hospitals, and therefore the interviews proceeded to included the third hospital as well. The second last interview, interview number eleven, added seventeen new free nodes to the study. The researcher then decided to interview another candidate to ensure that the sample was indeed adequate. No more free nodes emerged after interview eleven. The fact that interview eleven added so many new nodes could be the result of the person's own interest in caring in nursing. (See the Node list Annexure 3)

Step 3 Inducing themes

The bottom-up approach as described by Terre Blanche and Durrheim (1999) was used to organize the data that naturally underlay the material. The content was not being merely summarized but the caring processes and concepts were being kept in mind when organising the data into themes.

After the data was coded sixty three free nodes emerged from the data. Merging the codes was a tedious process via the computer. The nodes were studied to identify relationships between the nodes. The free nodes were merged by hand and grouped into codes. The major codes from the data were *humanity, problems, needs, HIV/AIDS, illness, funeral support, education, social problems, communication, counselling*. In Table 3.1, the major codes, definitions and examples, the node addresses and researcher's comments were displayed. These major nodes were used as a guide for the categorisation of all the nodes. Humanity, and the nodes that were related with similar patterns to humanity, were categorised and transformed into a meaningful theme together with general aspects of the human environment into **The general aspects of human environment theme.** The next theme with communication and interpersonal aspects were grouped into **The interpersonal theme**. Problem-solving and the nodes concerning problems were categorised into **The problem-solving theme**. Education and all the nodes on development of nurses were categorised into **The development and growth theme**. Needs, illness, social problems and the nodes

on all the different aspects of the needs of nurses were categorised into **The needs theme**. HIV/AIDS, counselling, dying of AIDS and funerals were categorised into **HIV and AIDS theme**.

The data and main categories from the data were then compared and reviewed. Transferability was established by the fact that the interviews towards the end of the study did not produce any new free nodes. Dependability was ensured by the fact that the interviews were audio taped, transcribed and the transcriptions were checked by the participants and verified by them as a true reflection of the interview. The HIV and AIDS category emerged as a new category in caring human resource management of nurses in health services.

The categories were as follows:

1. **General aspects of human environment**
2. **Interpersonal aspects**
3. **Problem solving.**
4. **Development and growth.**
5. **Needs.**
6. **HIV and AIDS.**

TABLE 3.1 MAJOR CODES, DEFINITIONS AND EXAMPLES

MAJOR CODE OR THEME	EXAMPLES FROM THE DATA	NODE ADDRESS	RESEARCHER'S COMMENTS
Humanity	If there is a problem you can trust them and confide in them. They have been extremely understanding and helpful. You come and you find that someone has done work that should have been done by yourself, because I knew that you are not feeling well.	Free node F112 Text unit 214-217 Hospital 2 Free node F112 Text unit 407 Hospital 2	Trust, understanding and helpfulness were seen as humanity. Helping each other was seen as humanity.
Problems	We sit down as matrons and what ever difficulties or problems we encountered, we have to sit down and discuss it and we advise one another.	Free node F36 Text units 629-631: Hospital 1	Problems and problem-solving form an important part of human resource management in nursing.
Needs	That means caring is to be there for the staff when she is in need and supportive and understanding of problems.	Free node F51 Text units 14-15 Hospital 3	Needs in the major pattern were large and describe a variety of needs of the nurses.
HIV/AIDS	And that is about sickness. And then I want to quote an incident where a member of staff with a needle stick injury, in the hospital and she got HIV and she and then went through the incident and she was sick. Yes, nursing is down because the nurses themselves are sick, they are sick, with HIV. So we felt we should try and include this in our teaching especially how to handle a dying patient to our staff, how do they handle those HIV cases.	Free node F31 Text units32-33 Hospital 3 Free node F31 Text units33-36 Hospital 2 Free node F31 Text units306 Hospital 1	HIV/AIDS emerges as a major pattern from the interviews. At all the hospitals the participants elaborated on various aspect of HIV/AIDS.
Illness	Number one for example if a staff member is sick, she is admitted in our institution	Free node F23 Text units 24 Hospital 3	Respondents refer to caring for staff and when they receive caring as to treatment during illness.
Funeral support	No, no. But even with her, because I attended the funeral, I supported her.	Free node F34 Text units 60 Hospital 3	All three hospitals indicated attending funerals as caring.
Education	We apply the organisational policy, and staff apply for studying either with Universities, technicons or other training institutions.	Free node F11 Text units 68 Hospital 3	Education in nursing was identified by participants as caring.
Social problems	She will come up with some of the problems like I have a sick mother at home, I have to wake up at 4 am. I have to prepare breakfast before coming to work so sometimes I come late	Free node F36 Text units 718-719 Hospital 1	Social problems of staff seem to form a great part of problems that nurse managers need to deal with every day.
Communication	I think what they (nurses) want from management is communication,	Free node F15 Text units 95 Hospital 3	The nurse managers indicate communication as caring to nurses.
Counselling	Hmm, hmm, I can go into lots of caring we do AIDS counselling. I myself am an AIDS counsellor.	Free node F32 Text units207 Hospital 3	A lot of emphasis was placed on counselling.

TABLE 3.2 PATTERNS (NODES) AND THE MAIN CATEGORIES

MAIN CATEGORIES	PATTERNS (NODES)
General aspects in the human environment	love consideration understanding hope individual treatment sensitivity friendliness
Interpersonal	interaction leading by example communication knowledge of staff openness helpfulness happiness listening interest in staff empathy availability relationships trust advocacy
Problem solving	problem solving
Development and growth	comfort education spiritual needs support/supportive participative management growth and development welfare of nurses feedback mentoring enough equipment safety
Needs	holism needs identification flexibility/flexible accommodating teamwork/team spirit lower needs social needs commitment sensitivity to needs self-actualising
HIV and AIDS	HIV/AIDS family support HIV/AIDS care counselling care to dying staff

Step 4 Interpretation and checking

This step included the written version of the phenomenon of caring human resource management of nurses. The interpretation of the phenomenon under study was studied carefully to identify weak points and contradictions in the interpretations. The objectiveness of the researcher was of utmost importance during this step (Terre Blanche and Durrheim, 1999).

3.3.1.2 Ethical considerations

The process of human interaction has certain risks of interaction and it applied to this research as well. Aspects such as embarrassment, anger, violation of privacy, misunderstanding and conflicts in opinion and values might arise during the study (Morse, 1989). The researcher tried to avoid or to minimize the above aspects during the data collection and analysis by the following measures:

- The persons were not forced to answer embarrassing questions. Questions were phrased with great concern to avoid any embarrassment, anger or violation of privacy. Validating the information with the participants minimized misunderstandings. The well-being of the individual was always handled as a priority by the researcher.
- Permission with informed consent from the health services, nurse managers and nurses was a priority and the fact that persons were free to withdraw at any stage was emphasized throughout the study.

- Great care was taken to ensure anonymity and confidentiality because of the sensitivity of the information, specifically the non-caring interactions of nurses.
- Entry into the various departments to interview nurses was carefully planned and discussed with the parties concerned to prevent disappointment and stress to the nurses.
- The researcher tried to protect participants by the following:
  - Describing experiences faithfully as expressed by the participants;
  - Explaining that precise quotations could be used but anonymity was guaranteed;
  - Informing participants that all data formed part of the study;
  - Explaining the risks involved to the participants and warning them that the conversation might trigger emotional responses.

3.3.2 Phase two The determination of the experiences of professional nurses regarding caring and the exploration of the presence and enactment of caring concepts and practices, in the human resource management process in nursing.

(objectives 3 and 4)

This phase took the format of a descriptive survey to explore the experiences of professional nurses regarding caring as well as the presence of caring within human resource management in nursing. The health services that were included in phase one were included in phases two. All registered nurses who did not participate in phase one and all the enrolled nurses in the participating hospitals that were available and willing to take part in the research were included in phase two. This ensured the inclusion of different perspectives of caring within the human resource management structures in nursing.

3.3.2.1 Contents of the questionnaire

The questionnaire was divided into two sections, Section A comprised demographic information and section B was divided into six sections.

Section A This section collected the biographical data from the participants. Biographical data was important for analysis of data for the gross tabulation of items in section B with items in section A. An example of the cross tabulation was a certain caring concept with the different hospitals. A specific caring concept

was cross tabulated with the different positions of nurses in the hospitals to explore the different views within the different ranks of nurses. (Example Items 1 and 3 were cross tabulated)

Section B The questionnaire consisted of Likert type questions, open-ended questions and yes/no questions. The questionnaire was designed to assess the presence of the ten carative factors of Watson (1985) in the human resource management structures as identified by Swanepoel Ed. (1998).

Each of the divisions included questions on the ten carative factors of Watson (1985) (see Table 3.6 p. 91) and were constructed as follows:

Division1: (Items 4-22) These items covered caring in the *formulating strategies*, regarding the mission statement, goals and objectives and the philosophy of the service;

Division 2: (Items 23-34) These items covered caring in *structuring the work* in the job analysis, job design, organisational structures;

Division 3: (Items 35-48) These items covered caring in *workforce planning*, matching supply to demand and organisational design;

Division 4: (Items 49-66) These items covered caring in the *staffing process;* recruitment methods, the process of selection of staff, induction training, socializing and team concept the nursing unit;

Division 5: (Items 67-87) These items covered caring in the *utilising and maintaining human resources:* performance management, leadership styles of managers and level of guidance to nursing staff, in-service training, development of career paths for nurses, grievance procedures for nurses, discipline code, communication, decision-making;

Division 6: (Item 88) This item was an open-ended question on a caring experience with a nursing colleague.

3.3.2.2 *Validity of the questionnaire*

The validity of the instrument was ensured for content validity by using the theoretical framework from the literature on caring and human resource management to construct the instrument. (See Table 3.6 p. 91) The ten carative factors listed by Watson (1985) were used as a guideline in the construction of each of the human resource processes described by Swanepoel Ed. (1998).

Content validity was further ensured by asking professional nurses with expertise on caring, research and nursing practise to evaluate the questionnaire, and to

ensure that it included the best items on caring in human resource management in nursing (Terre Blanche & Durrheim, 1999).

Professional nurses with expertise in the nursing field were seen as follows:

- Nursing researchers with knowledge of instrument construction in the academic field;
- Professional nurses with a post- basic qualification in nursing management;
- Professional nurses with special writing skills;
- Practising professional nurses who were engaged in further studies in nursing at post basic level at academic institutions;
- Associates at the University of Natal.

The comments of the experts were generally positive and indicated that the questionnaire was clear and easy to understand. There were a number of changes that were suggested by the experts and the following changes to the questionnaire were made:

1. Demographic data: The instrument consisted of three nurse-manager levels and it was suggested that only one level of nurse-managers need to be identified.
2. Likert scale: The Likert scale was a four point scale and it was suggested that another category namely '*uncertain*' should be added to make it a five point scale.

3. Items 20 - 23 were on a yes/no scale and it was suggested that these should be changed to a three- point scale to include the "uncertain" option.
4. It was suggested that all the items that refer to patients and nurses were changed to refer only to nurses, as caring in the management of nurses was the focus of the study.
5. It was suggested that Item 26 was given an option (item 27) to explain in cases where the respondent answered *no* to question 26, and this was implemented.
6. Item 88 was changed to narrow the description down to a description of a caring experience with a nursing colleague only instead of the wider choice that could cause confusion for the respondents.
7. All spelling and grammar mistakes were rectified.
8. Difficult concepts that could contribute to confusion in the context were removed and described by simple and clear terms to reduce any uncertainty, for example, *holism, adaptiveness,* and *stable.*
9. The items that had two ideas or aspects in one, were separated into two questions to reduce confusion.

The questionnaire was finalised and edited by an editor to ensure that it was grammatically correct. An expert on statistical data analysis reviewed the questionnaire and recommend that information on the position of the researcher should be included to ensure that respondents knew that the research was not being carried out by the management of their health services. The respondents

might have given biased responses if they thought management was collecting the data. The relevant information on the researcher was included in the questionnaire. The aspect of the value of the research to the participants was included in the questionnaire to motivate the participants to complete the questionnaire. Items 25, 33 and 34 were reviewed and the language was simplified to ensure a better understanding of the questions. The items in the questionnaire were validated with the data collected in phase one (qualitative interviews with the nurse managers).

3.3.2.3 *Reliability of the questionnaire*

Reliability refers to the dependability of an instrument to yield the same results repeatedly. Cronbach's coefficient alpha was used to establish the internal consistency. Reliability Coefficient for the questionnaire in the whole was calculated with the computer program, Statistical Programs for Social Sciences (SPSS) with a Cronbach's alpha value of: Alpha = .9538. This value indicates a high reliability coefficient. The reliability coefficient was an important indicator of the quality of the instrument and was a sophisticated and accurate method of computing internal consistency and range in value between .00 and 1.00 (Polit and Hungler, 1991). The Cronbach's alpha value was calculated for items that belonged together and tested the same caring concept in the questionnaire. Items in each division of the questionnaire that belonged together were identified by the researcher and the Cronbach's alpha value was calculated by using SPSS

(see Table 3.3). The Cronbach's alpha value for specific items, ranged between .2397 and .7725 in the questionnaire.

TABLE 3.3 RELIABILITY MEASUREMENT FOR SELECTED ITEMS IN THE QUESTIONNAIRE ON CARING IN HUMAN RESOURCE MANAGEMENT OF NURSES ACCORDING TO THE DIVISIONS IN THE QUESTIONNAIRE (n=188)

Item	Reliability coefficient Cronbach's alpha
DIVISION 1 5 Love for others is visible in your hospital 6 Respect for human dignity of nursing staff is always considered.	.6205
4 Kindness to people (patients and staff) is emphasised in the philosophy of your hospital. 21 In your hospital you are experiencing commitment from management towards two-way communication. 22. Nursing managers trust the nurses.	.4637
10 You are acquainted with the philosophy of the hospital. 11 The philosophy of the hospital guides my actions during the execution of my job. 17 You are familiar with the values and beliefs of your hospital.	.4616
7 In your hospital there is a commitment to ensure the comfort and wellness of nursing staff. 12 The environment in which I am working facilitates support and caring to nurses.	.2397
DIVISION 2 24. There are enough nursing staff members to render quality nursing care in your hospital. 28. The workload is distributed in such a way that the dignity of the staff and patients are preserved.	.4160
33. The achievement of high levels of production and efficiency are accomplished through extensive use of rules and procedures. 34. High levels of flexibility with limited use of rules are a good description of the nursing management of your hospital.	.4873
DIVISION 3 39. The nursing managers and the hospital as a whole can be described as a warm, caring community. 40. Your hospital is a place where nurses can work, live and grow.	.7725
38. Teamwork in nursing is of utmost importance in your hospital. 42. There is a feeling of interdependence among nurses in your hospital. 43. In your hospital the nursing staff experience a great deal of unity. 44. The nursing staff help each other to succeed in their daily nursing activities.	.7230
DIVISION 4 51. The dignity of staff during the interview and the selection process is respected at all times. 52. Selection interviews are conducted in a friendly and kind manner.	.7621
DIVISION 5 71. Coaching and teaching in your job are a continuous process in your health service. 77. Your superiors are supplying you with feedback on your performance.	.4370

3.3.2.4 *The pilot study*

The pilot study (as described below) was done and twelve respondents completed the questionnaire. Twenty respondents, a ten percent sample of the respondents which were selected for the study, were asked to complete the questionnaire. The sample included ten registered nurses and ten enrolled nurses. The respondents for the pilot study were selected to include those respondents on leave during the time of the data collection. Sample realization were as follows:

- Seven registered nurses completed the questionnaire
- Five enrolled nurses completed the questionnaire

A variance or no response on items could be an indication that the item was unclear or insensitive (Polit & Hungler, 1991).

Problems and changes were identified and rectified before the actual data collection phase of the research. The actual questionnaire was administrated and the data were analysed for inconsistencies, gaps, repetitions or flaws in the data collection instrument. The language was checked for clarity and the clarity of instructions was checked. The time allocation of 15 minutes to complete the questionnaire was checked and respondents indicated that 30 minutes were actually needed for completion of the instrument.

The coding of the questionnaire did not indicate any problems. The data was entered into the statistical programme SPSS. The data analysis indicated the following aspects:

1. The pilot study helped to identify the fact that the respondents did not identify their unit of placement (item 4). The identification of the unit was important to the research in the sense that caring could be at a high level in one unit and low in another unit in the same health service. This could also impair the feedback to the units, if the unit was not identified. Statistical analysis would be difficult if units could not be compared with one another. The units were then pre-coded on the questionnaire, before it was handed to the different units.
2. The *yes /no* questions were supplied with another alternative, *uncertain*. The pilot study indicated that such an alternative was indeed necessary.
3. Item 28 revealed that when nurses were not happy in their job, the reasons for the unhappiness were the lower needs as identified by Maslow's hierarchy. This item was post-coded.
4. Two items were added to section 2 (items 33 and 34), (structuring of the work), to explore the organisational structure of the hospitals.
5. Item 88, the description of a caring experience with a nursing colleague identified rich descriptions on caring and it was post-coded for the purpose of the pilot study. The researcher decided to use the qualitative programme NUD*IST 4 for the data analysis of this item in the research

study to ensure that all the caring concepts as identified by the participants were identified.

6. The statistician at the University of Natal was consulted again after the results of the pilot study and the following aspects were discussed:
    - The variables and possible relationships among the items;
    - The sample size and statistical calculations and appropriate data analysis for the study;
    - The processes of coding, entering and cleaning of the data and missing values were discussed.

3.3.2.5 Ethical considerations

The following ethical considerations applied:

- Permission was asked from the hospitals that were selected;
- Informed consent was sought and appropriate documentation was kept;
- Health services were not identified in the research report;
- Questionnaires were coded to guarantee anonymity. No names of the hospitals or respondents were revealed at any time during the research or in the subsequent thesis;
- Respondents were selected by their willingness to participate without any discrimination and no risks to the respondents could be identified at any stage of the research;

- Subjects could withdraw at any stage from the research;
- The researcher honoured all agreements;
- Debriefing to divulge information was done;
- Respect and courteous treatment applied throughout the research process (Polit & Hungler , 1991).

3.3.2.6 *Data collection and* analysis

After permission from the different hospitals was obtained, appointments with the nursing service managers were made. During the meetings with the nurse-managers the research purpose, the importance and the process of the research were discussed and explained. During the meetings, the participants for phase one (1), the respondents for phase two (2), and the structures for phase three (3) were identified. The research project was welcomed and the nurse-managers of all three hospitals asked for feedback on the research. The in-service educators of all three hospitals made appointments for follow up discussions on the research. The Ethical committee of one hospital was very interested in and concerned about the research project. The inputs of the Ethical committee were regarded seriously by the researcher and the items on performance management were changed accordingly and verified by the literature. The return date for the questionnaires was finalised and the respondents were given two to three weeks to complete the questionnaires.

The questionnaires were distributed during September 2000 at all three participating hospitals. At two hospitals the questionnaires were handed out to the respondents by the researcher. The respondents asked questions and discussed their concerns about caring. The researcher spent more time at these two hospitals than at the third hospital where the chief professional nurses distribute the questionnaires. It was interesting that the return rate of the questionnaires at hospital one was only 26%. The nurse-managers said that the hospital was very short staffed as many nurses were on sick leave during September 2000. The second hospital's return rate was 59% as indicated in Table 3.4. The hospital in which the chief professional nurses handled the questionnaires, the return rate was a satisfactory 57%. The return rate on all the questionnaires for the three hospitals was 47%. as indicated in Table 3.4.

TABLE 3.4 FEEDBACK ON QUESTIONNAIRES

HOSPITAL	NUMBER OF QUESTIONNAIRES OUT	NUMBER OF QUESTIONNAIRES BACK N	PERCENTAGE QUESTIONNAIRES BACK
1	130	34	26%
2	130	74	57%
3	136	80	59%
TOTAL	396	188	47%

From Table 3.5 it was clear that hospital 1 provides 18% of the sample, hospital 2, 39% and hospital 3, 43%.

TABLE 3.5 SAMPLE REALIZATION FOR EACH PARTICIPATING HOSPITAL (n= 188)

HOSPITAL	FREQUENCY	PERCENT	VALID PERCENT	CUMULATIVE PERCENT
Hospital 1	34	18.1	18.1	18.1
Hospital 2	74	39.4	39.4	57.4
Hospital 3	80	42.6	42.6	100.0
Total	188	100.0	100.0	

The SPSS software computer programme was used to analyse the data statistically. Data was coded and entered into the computer. After coding and entering of data, cleaning of data took place to ensure that errors were identified and corrected. The checking of data was done by random sampling of 10% of the cases. The data was re-coded and re-entered and any mistakes were rectified.

Comparison of biographical data and, for example, the data on the experiences of nurses on caring in human resource management was made. Cross tabulation of biographical data (Section A) and data from section B was done. Opinions of nurses on caring in human resource management in the different hospitals were compared and cross tabulations were done for identification of relationships between opinions on caring in the different nurse categories. The descriptive analysis aimed to describe the data by exploring the distribution of scores on each variable. Frequency distributions were presented in graphical format in the next chapter (Terre Blanche & Durrheim, 1999). The narrative at the end of the questionnaire was analysed with the aim of identifying common themes. The approach was to seek understanding, to reveal meanings of caring, and to

identify the experiences of nurses during an experience with a colleague in the hospitals. The computer programme NUD*IST was utilised to assist with the analysis of the narrative (item 88) and this analysis was described with phase one in chapter four.

TABLE 3.6 CONTENT ANALYSIS OF THE CARING FACTORS OF WATSON (1985) AND THE HUMAN RESOURCE MANAGEMENT PROCESS OF SWANEPOEL (1998) IN SECTION B OF THE QUESTIONNAIRE

CARING FACTORS OF WATSON	ITEMS IN THE FORMULATING STRATEGIES 1	ITEMS IN THE STRUCTURING OF THE WORK 2	ITEMS IN THE WORKFORCE PLANNING 3	ITEMS IN THE STAFFING PROCESS 4	ITEMS IN THE UTILISING AND MAINTAINING OF HUMAN RESOURCES 5
Factor 1 The formation of a humanistic-altruistic system of values.	4,5,6,11,14,15	24		51,52	69,71,81,83,85 86
Factor 2 The installation of faith and hope.		34	35		67,68,76
Factor 3 The cultivation of sensitivity to one's self and to others.		23,25, 29,31	41		74,78
Factor 4 The development of a Helping-trust relationship between care-receiver and caregiver to ensure a relationship of quality	13,16,21,22		39,40,48	53, 54,64,66	87
Factor 5 The promotion and acceptance of the expression of positive and negative feelings	20				77,84
Factor 6 The systematic use of the scientific problem-solving method for decision-making.				49,50	72,79,82
Factor 7 The promotion of interpersonal teaching and learning.	10,17,18	30,32,33	36	55,56,57,58	70,73
Factor 8 The provision of a supportive, protective, and (or)corrective mental, physical, socio-cultural , and spiritual environment.	7,12	26,27	47	61,62	80
Factor 9 Assistance with the gratification of human needs	9	28	37,38,42,45, 46	59,63,65	87
Factor 10 The allowance for existential-phenomenological forces	8,19		43,44	60	75

3.3.3 Phase 3 The exploration of the presence or absence of caring concepts in the structure standards involved in the human resource management process of nurses. (objective five)

This phase dealt with the analysis of the documentation in human resource management of the health services. Permission was asked to investigate the human resource management documents from each participating health service. A guide according to Watson's ten caring factors was drawn up to facilitate the analysis of the documents (see Annexure 9).

The induction and in-service training documents were examined with the in-service education nursing officer of each health service to clarify certain caring concepts in the education of nurses. It was not enough to identify the presence of caring concepts in the in-service education programme for nurses, but necessary to explore the teaching of *what the contents of teaching entail* regarding caring.

The documents under investigation comprised the following:

- Mission statements
- Goals and objectives
- Philosophy of the services
- Job descriptions

- Performance management tools, for example career development sessions with staff, individual goal setting together with the staff and goal achievement measurement.
- Induction and in-service training programmes
- Grievance and disciplinary procedures.

3.4 CONCLUSION

The findings from all the above phases were investigated and patterns of convergence were found which helped to confirm findings inferred from other data, literature and the caring theory of Watson (1985). Divergence of data with the literature helped to build a case against a finding. Congruence between the responses of nurse manager, nurse and the analysis of the structures in human resource management was investigated and described in Chapter four. In annexure two the researcher described her own experiences regarding caring (bracketing) and perceptions of caring during different development phases through her life as well as her nursing career.

In chapter four the description of the data follows, with reflection on participants and the interviews as well as the data analysis from the questionnaires. The analysis of the documentation in the human resource management of nurses was described and referred to.

CHAPTER 4

RESULTS OF THE FINDINGS ON THE PRESENCE AND ENACTMENT OF CARING IN THE HUMAN RESOURCE MANAGEMENT PROCESS OF NURSES

4.1 INTRODUCTION

The aim of this chapter is to describe the results of the study. During the first phase, the qualitative research analysis computer package namely NUD*IST, was used to analyse twelve interviews with nurse managers and professional nurses on the meaning and expectations regarding caring in human resource management in nursing in the three hospitals included in the research. The sample is reflected in Table 4. 1 on page 96.

The second phase included the results of the experiences, the presence and enactment of caring in the human resource management of nurses in the health services in KwaZulu-Natal. Professional nurses and enrolled nurses were included in this phase and the total respondents who participated were one hundred and eighty eight (188) with the percentages of respondents for each hospital in the study reflected in Diagram 4.1, on page 135. This phase included quantitative and qualitative data analysis. Items (Items 1-87) in the questionnaire were analysed by using the Statistical Programs for Social Sciences (SPSS). The last item (Item 88) on the questionnaire, was a narrative of a caring experience with a nursing colleague, and it was analysed

qualitatively by using the computer program, NUD*IST. The data was described with the data of phase one, as it reflected the nurses' descriptions of caring incidents. The data reflected actual caring experiences or examples rather than descriptions of what caring should be.

Phase three of the research entailed a description of the presence of caring in the human resource management documents in the nursing department.

4.2 THE MEANING AND EXPECTATIONS OF CARING IN THE HUMAN RESOURCE MANAGEMENT PROCESS OF NURSES (Phase one, objectives 1 and 2)

4.2.1 The participants in their settings in the health services

A sample of twelve (12) nurse managers and professional nurses was sought from the three participative hospitals in KwaZulu-Natal. Nursing service managers were approached and nurse managers and nurses were asked to volunteer to take part in the study. The nursing service managers of all three hospitals were accommodating and the nurse managers and professional nurses were asked to participate in the interviews. The interviews took place over a period of four months. The participants at each hospital were selected on the basis of their willingness to participate. The number of nurse managers and nurses available for the interviews were indicated in Table 4.1. It seemed to be a problem to interview the nurses in the wards because of the shortage of staff in the hospitals at that period of time. Two of the participants were professional

nurses, one participant was in a dual position as a nurse educator and nurse manager, and nine of the participants were nursing service managers.

TABLE 4.1 SAMPLE OF NURSE MANAGERS AND NURSES INTERVIEWED DURING PHASE ONE IN THE THREE HOSPITALS

Hospital	Frequency	Percent
1	6	50
2	4	33
3	2	17
Total	12	100.0

4.2.2 The results of the investigation into the meaning of caring and the expectations of professional nurses regarding caring practices in the human resource management of nurses

The results were discussed under the headings of the categories that emerged from the data. Direct quotes from the interviews are typed in italics and are indented in the text. The reference to a specific quote indicates the hospital and the transcript line number, for example (1,102). The text bracketed in italics was added by the researcher for better understanding, for example ... (*love is visible*)... In some cases to clarify meaning, a word or words may have been altered and this is indicated by square brackets around the alteration, [relieved].

Actual caring interventions or descriptions were used for the study rather than descriptions of what should be (the ideal). Caring experiences with a nursing colleague (Phase two, Item 88 of the Questionnaire) were described by respondents. The data was analysed in the computer programme NUD*IST and coded into free nodes. The

free nodes were categorised and transformed into the themes that emerged from phase one and the information was integrated in the discussions below.

4.2.2.1 Caring to nurses in terms of general attributes of the environment

Caring to nurses was described in practical terms by respondents. One respondent, described caring practically by the following example:

> *(Caring is like) a sewing machine. See, you must look after it, service it and then it will perform well. That is what I do to the staff, doctors and all. You got to care (1, 61-63).*

Caring in nursing management differs from caring in the patient care environment and it seemed to be a problem for some nurse managers to apply the caring concepts in nursing management and for nurses to perceive it as caring. It was illustrated by the following:

> *I think hmm, the first thing that comes to my mind is that it is ever so much more difficult than in the nursing context. We have been taught to be nurturers and to be carers and to be people who are hands on in the sense that if someone is uncomfortable I relieve their pain. If somebody is untidy, I will clean them up. If someone is bleeding I will stop the bleeding and my interpretation of care is with my hands. Now suddenly in a managerial position, hmm, I am trying to care*

without that direct contact, physical contact. I really think that we do not prepare our nurse managers [for] how difficult that is. In my experience here, I found that when I am expressing caring by attitude or by words, I am often a little bit disappointed, that the person has not interpreted it as such. So, when I think I am being compassionate, or sympathetic, the person in their wounded state is unable to see the depths of my compassion. I had to learn to readjust my concepts of whether I am effectively caring for a nurse or not. I am going to relate that again to the physical care. Once the patient is comfortable they will say, " oh this feels better". Whereas if interacting with nurses, who are wounded or stressed again, they are not able to respond, because they are already in a cycle of burnout. So perhaps one of the things that is difficult as a nurse manager, is when you are in a caring mode and attempting to care, and then you are accused of being uncaring. I think I had to learn to not wait for the response and not adjust my actions of caring, based on reciprocal response, with other words, I just have to keep on trying to show people that I do care even if I know sometimes that they are not able to process that (2, 316-337).

Another expression of caring and helping each other in the human resource management of nurses was:

They are always eager to help on their own. If my problem is that someone falls sick and I am short [staffed], they come and present themselves and take over (1, 86-87).

A more personal and practical experience of helping was described as follows:

> *The subtle caring is very evident. You know that what I appreciate very much for instance is, at the moment all of us are going through flu, and we all are feeling very miserable. You come and you find that someone has done work that should have been done by yourself, because (they would say) "I knew that you are not feeling well", that kind of "listen I can come on, on Saturday, because I know you have a funeral or what ever," this kind of voluntary assistance to each other, I think it is very prevalent amongst us, and I appreciate that, I interpreted as if someone is saying: "I care about you." I do not think we do enough of it* (2, 405-413).

Love for each other was evident in all the interviews. Love is fundamental to good leadership because leadership is all about caring (Kerfoot, 1997). It seemed that the participants realized that successful leaders made their organisations places where their passion became the organising force. The informants were smiling when they described the level of love for their jobs and their colleagues. Nurses managers love their work and their nursing colleagues. One respondent even told the nurses that she loved them, as was expressed by the following:

As the leader I always make sure that they know work comes first. I tell them that I love them, but I do not love them more than my work. [Love is visible] by the little things that we do for each other. [For] example if they go for maternity leave then we give them a shower (presents for the baby). If someone is going away or getting married we give them a present and we are concerned. We congratulate them on their birthdays and share gifts at Christmas times. Caring means love to a certain extent (1, 101-127).

Concern for nurses came out as an important caring concept in human resource management of nurses during the interviews. It was emphasised by nurse managers that concern must be shown when the nurses needed it. The nurse manager should listen to the problems of nurses and the concerned nurse manager engaged the nurse with concern, giving attention to the particular situation not only because he or she was a professional person but also because of her/his understanding and appreciation of the situation. Nurse managers know that caring includes affection and regard. Caring involves feeling with the other and it was well described during the interviews, receiving the other unto oneself. Sensing with understanding was described as follows:

You got to care about them. See before they got problems anticipate that problem, show them [how] to solve it and (emphasised) show concern (1, 64-65). *Nurses expect, when a nurse comes into my office, I lend a listening ear* (1, 647 -649).

Welfare of nurses was described in terms of bereavement of staff. Welfare of the nurses seemed to focus on the needs of staff in case of family losses. An example is as follows:

> *One thing we do have a matron who is actually a welfare matron. This means when they start presenting with problems outside their working environment, they have to come to her, like somebody loses a family member, somebody is pregnant, she wants to plan her maternity leave, somebody is studying, she wants to plan the study leave, they always come to that welfare matron to report and then she would advise (1, 736-741).*

Humanity, dignity, friendly, smiling, concern and kindness were mainly described in the narrative in relation with illness and during the orientation phase in a new hospital by respondents in phase two of the study as follows:

> *When I first came to the hospital I was shy and often worked by myself. A colleague, I can't remember her name, saw that I was feeling out of place and did everything in her power to make me feel welcome (2, 359-362).*

> *I got sick last year for 3 months. My colleagues were so concerned about my condition, they phoned and visited now and again while I was admitted at McCords Hospital. Some of them they even brought me flowers and sympathetic cards (3, 167-171).*

Understanding and empathy included the ability to perceive as well. It seemed that nurse managers try their best to understand the nurses, but nurses sometimes have difficulty in perceiving the actions of nurse managers as caring and understanding. Nurse managers should also care for their institutions and sometimes the weight of the institution is more than the needs of the individual nurse. Understanding was described with reference to situations where nurse managers and nurses could not understand each other's needs. The needs of nurse managers seemed to be institutional needs, and nurses had personal and social needs that could not be met or seemingly not understood by nurse managers and higher management levels of health services in general. Empathy in regard to perceiving what the other felt was well referred to and nurse managers knew that communication is not possible without a significant degree of sensing and understanding of the nurse. Nurse managers referred to empathy as sympathy:

> *We sit with them, we hold hands, and pray with them, so that they are released from the pressure* (1, 608-609).

> *A known diabetic staff nurse lost her only son. I with my nurses on night duty kept in touch reassuring, counselling and demonstrating empathy and reassuring her* (3, 281-285).

The following was an example of the needs of nurses that seemed to be in conflict with the needs of the organisation:

> *Nurses want nurse managers to be there for the nurse, they feel that if a nurse has got a problem, the matron must be understanding of that problem. I just give you an example, when a nurse has a death in the family they want ten days off, (we give them five days of leave). The nurse expects five days before the funeral and five days after the funeral, especially with the African nurses, it is in their culture. If you say no, then you are really uncaring to them, which is difficult, because you have got to think of the service as well* (3, 95-102).

Holism, needs identification, sensitivity to needs and accommodation of needs were well described by the participants and a lot of emphasis was put on the needs of the staff. The majority referred to caring in terms of working conditions, salary, wages, medical and insurance benefits, job security, fringe benefits, retirement plans and survival needs. Physiological needs such as, food, shelter and clothing that are usually associated in our society with money were referred to in terms of low salaries, lack of housing and car benefits. Safety needs, such as the desire to remain free from hazards of life, including ventilation and activity needs, were referred to as well. Spiritual needs were emphasised by some of the participants as an important aspect of caring. Sensitivity came to the fore as sensitivity to individual needs of nurses. The aspect of needs fulfilment is discussed under the needs theme. Sensitivity to individual needs was well described by one respondent as:

I am very happy when I see that the personality (of the neophyte manager) is beginning to bend and (she/he) is beginning to understand that the staff do have other needs and other problems than nursing matters that sometimes need to be considered in light of not an excuse, or pull on the heart string for something, and you soon get to know the ones who do it professionally and the ones who have a real problem (2, 433-437).

Holism was referred to as the consideration of all the needs of the nurses to put them in a position to render quality care. The nurses were seen as human beings who had family commitments as well, and not only as working units or *a pair of hands*.

As I see it I think caring means to me to be supportive. When the staff member is in need it does not end with the staff member herself. It also extends to the family of that staff member because she is not just on her own she also has a family. So caring means that I must not just look at her within the hospital setting I must also try and see if she has any family problems that might be actually affecting her performance. (3, 9-14).

The participant has a few hesitations before explaining how the needs of the staff were met in the specific hospital:

You should look at the nurse in totality not only as the nurse but as one person for example if the nurse is not happy at home, if something is disturbing her she will not be able to perform effectively at work (1, 12-14).

Everything is done here by the hospital, the security and everything here by the hospital. They are really very caring. Spiritually as well. This hospital is unique, it does not care for us only physically, but also professionally and spiritually, they make sure that we are well looked after spiritually. There are services in the hospital, for us and the patients. There are services on Sundays as well (1, 549-553).

Sensitive to the identification of needs was referred to as being sensitive to family problems and illnesses of staff members. One of the participants indicated that the needs of nurses were not asked about as such. Very few comments were made on real working issues (job related needs) or working conditions needs. Examples were as follows:

If you go on the ward rounds sometimes you can see that the nurse is not well, they expect you to ask them, if they are well, not just to ignore it. If they are not well, they expect you to send them home (3, 102-104).

Trying to be sensitive to what people want is also part of that development of personality, they just flower, all of a sudden you see an energy in the person that was not there before. That is great (2, 393-396).

It means being aware of the needs of the nurses working with you. It means observing for e.g. if she has any problems that you can pick up by means of observations. It means getting interested and [obtaining] knowledge about her social background so that you appreciate her social problems if they arise (1, 705-709).

Needs accommodating was described as learning the developmental needs of nurses and being a flexible nurse manager in trying to accommodate the nurses if possible. It was described in terms of accommodating illnesses and personal problems of nurses as follows:

Hmm, hmm, to be a flexible somebody means quite a lot. I will speak on off duties only. I can speak of changing of the work schedule. If you come on duty and you are suppose to do orthopaedics that is a rigorous discipline and you have a personal problem then I got to be flexible and take somebody else to do your duties and you look after the patients in recovery room for that day (1, 29-35).

In comparison with the work of Watson (1985) the descriptions as given by the participants in the main theme, general attributes of caring in the human environment such as kindness, concern and love, were caring concepts grounded in humanistic values and bring meaning to one's life through other people according to factor three of Watson (1985). The instilling of faith and hope (factor two of Watson, 1985) was not evident in the interviews. Watson (1985) described the instilling of faith and hope as the inspiration of the mind and soul and illness of a patient could then be treated. Faith and hope could be instilled as a caring attribute in the nursing management environment as an inspiration of nurses towards growth and development. Understanding and acceptance of the nurse as an individual, (factor three of Watson, 1985) were clearly described by the participants.

4.2.2.2 Caring to nurses in terms of interpersonal relationships.

Caring in terms of interpersonal relationships with other people was described by the participants in various ways and by using different expressions. This main theme included affiliation needs of individuals in relation to other people in interpersonal relationships. The management of nurses is an interactive process and therefore emphasis was placed on relationships and interaction. The interest in, and openness to nurses and the availability of nurse managers to assist nurses in the nursing situation that were described by the participants were indications of how important nurse managers rate these aspects in their management functions in the health services.

Communication and listening were clearly defined from the nurse manager's point of view and nurse managers indicated aspects related to communication and pointed out the aspects they (nurses managers) thought nurses expected from them:

> *There is no doctor that I can say I cannot sit and talk to, because I am scared of him/her. I know in other theatres there are a lot of noise and the matron make the biggest noise in the department, but I am not that type of matron. I sit down and talk to the staff, and talk to the doctors and talk to everyone and my patients as well (1, 71-75).*

> *I feel part of the team and I want them to know that I am there for them, should they encounter problems. We have meetings, every month with my staff where we look at patient management, human relationships, and the medical staff also join us in meetings. So we generally discuss problems and solutions and we look at solutions and we plan together. We schedule our meetings once a week so that we meet with everybody (1,671-673).*

One participant reflected on the importance of written communication and described the value of a communication book as follows:

> *We have a communication book for every department, so that communication is both ways (2, 211-212).*

On the other hand, the lack of communication, or failing to perceive it, was referred to by a respondent and it illustrated the frustrations that nurse managers sometimes have in communication with nurses.

> *I just have to keep on trying to show people that I do care even if I know sometimes that they are not able to process that. I relate it to communication, you talk to people twenty times, you put up notices, you send out a newsletter, you put it on the grapevine and you will always hear the nurses say, "They tell us nothing, they tell us nothing". So it is sometimes the inability to perceive it at that time (2,337-340).*

Listening to nurses was an important caring aspect to nurse managers and participants commented on listening as follows:

> *Hmm, when I visit them in the wards, I listen to problems that they have,(silence) usually staff, hmm, hmm staff shortages, staff needs (1, 229-230).*

Interest in staff including knowledge was a very important caring concept, and the need to have an interest in somebody to start off the relationship before one could get engaged in a caring relationship with others was recognised. Nurse managers described their interest in, and knowledge of their staff, as human beings, by the following comments:

This is a smallish hospital and I think we know the individuals, their likes and dislikes and we also know them more than you would know them in a big institution. We have also better private discussions with staff on ward rounds when we go around, I often chat about their families and where they like working and I also ask them [about] their studies, what they would hope to achieve in their nursing career (3, 175-181).

If you know your staff you know by facial expression that there is a problem (1, 78-79).

To know them by their name, that is caring. So when you go to a ward and you say nurse so and so and call her by her name and you greet her also, that is caring, she then feels good when she comes to work and [is] called by her name (1, 455-457).

Openness and availability, helping and support in the human resource management environment in nursing were considered important aspects of caring by the participants. Openness as described by Nyberg (1989) based on the views of Watson (1985), sets the stage for trust and growth in interpersonal relationships. Being open is much more difficult than it sounds. It entails the disclosure of your own humanity for others to see you, the nurse manager, more as a *real person*. They can then reveal themselves with some sense of safety. Openness and availability were described as follows:

Personally I think my colleagues, (matrons), when I do not feel well, most of the time we are open to each other and there are no barrier line where you say you cannot discuss it, we are flexible in this office (1, 641-642).

What I am personally doing is an open door policy. Although I have stipulated times for matron's office, I can accommodate anybody who wants to come and see me at any time. I am always available for the nurses. I never turn them down (3, 112-114).

Helping each other, trust, and warmth were described in the narratives by respondents during phase two by using examples of supporting each other in the nursing situation or help with personal problems. The respondents describe interpersonal relations as:

A colleague came on duty very depressed and sad. When I asked her why she was so sad, she explained that there were 3 deaths in her family. We sat down and spoke about it. She cried and I listened, empathized and reassured her. Later she felt much better. I asked if she would like to go home, she refused as she did not want to be alone. She preferred the company of her colleagues at work (3, 49-55).

I lost my boyfriend and my colleagues comforted me. My sister in charge organized a special leave for me so as to grieve and attend the funeral.

Counselling was done for me and I was able to cope with the situation (3, 156-160).

About 8 months ago, I was on duty at ± 10h00, and I received a call from my Dad, informing me that my mother had not woken as yet, and he thought she was just tired, but on checking, he thought that she was dead. I promised to go to him immediately, threw the phone down, shouted to my colleagues what I was doing and ran out of the hospital. Five minutes after [I arrived] at my Dad's (and confirming my mothers death – a coronary) one of my colleagues arrived at the house. She is an old friend and followed me to my Dad's home in her car. She was a pillar of strength for me as I had to phone my sisters, brothers etc, while my Dad was in shock. 3 hours later (lunchtime) the rest of my departmental staff arrived to sympathise. She had returned to the hospital and brought them back with her. She helped with the tea making and those "small" errands that came with a sudden death. She has been my closest friend for 17 years (we've done all our training together) and she really showed how good a friend she is when I needed her the most (1, 121-128).

Happiness was described extensively by participants and it seemed to be a very important caring concept in the hospitals. Tom Campbell (1993) (cited in Kerfoot, 1997) notes that people from happy, loving families will do anything for each other as will people who work for happy, loving companies. The participants commented as follows:

I am very happy in my workplace and I feel that if a person is happy they try and extend it right throughout the hospital (3, 246-248).

We spend most of our time in the ward situation, so this is the place that we must be happy and free. If you are not happy you can not render quality care. We need not quantity, we need quality (2, 102-104).

In comparison with Watson (1985) the categories for behaviour and relationships between human beings, were in line with the nursing management situation in health services. The five categories of behaviour are according to Watson (1985) living with another, co-operation with others, establishing a healthy emotional and physical environment, establishing a bond and nurturing and accepting others. Aspects of the categories that were included were communication and listening to the other, and interest in the other person and knowledge of him/her. The openness to each other to establish a bond and availability to assist the other were emphasised and referred to by the participants in this study.

4.2.2.3 *Caring to nurses in terms of problem solving*.

Problem solving and identification of problems seemed to form a major part of the job of a nurse manager. An interesting fact that came to the fore was that problems seemed to be more social problems of staff than patient care problems, as would be expected. The participants indicated that problems were shared and means to solve the problems

were in place such as discussing the problem and referrals were done if necessary for example:

> *You counsel her, and look at options like for instance if she persistently comes late on duty and when she tell you about this problem, then you talk with her and perhaps suggest, how about taking her (mother that she is looking after) to a home, inviting a relative to assist her, and look after [her] mother and give [her] a break so that [she can] actually concentrate on [her] work. So you plan together with her but she takes the leading part (1, 725-730).*

Problem solving was an important part of caring in the sense that nurses, particularly the nursing students, needed knowledge and understanding for the application of the problem-solving and decision-making process in nursing. The components, such as assessment, analysis and diagnosis, planning, implementation and evaluation of the problem-solving process, did not figure clearly from the discussions with the participants. The counselling of nurses was indicated by the participants as an important aspect of problem-solving.

4.2.2.4. Caring to nurses in terms of development and growth.

Growth and development of staff was identified as a major theme in caring and for the purpose of this research it was categorised as a major theme. Growth and development, participative management and feedback formed a major part of the theme

on growth and development. Caring was understood as helping the other to grow, and therefore mentoring and leading by example formed important aspects of the growth process, which was described in detail and many examples were given as to how the development of nurses were being dealt with, for example:

> *About developing them, I do not like the idea of keeping a staff member in one department for a long time so I keep the staff member in one department if they request so, but in most cases I put them for three months in one area and then I change them to another area. And with specific departments like theatre, I also develop them so that I have more nurses who are experienced in theatre, so I put them for four months in theatre and then all the categories are to rotate in theatre [including] those who do not have theatre technique as well. With matron's office I take the CPN's (chief professional nurses) to [the] matron's office to gain more experience. So they are developed in [the] matron's office on management skills. (3,126-137).*

> *I want to tell you how I cared once [for] a newly appointed nurse. It is all about identifying the developmental needs of nurses in this hospital. It was reported that the new nurse made a mistake in the ward. There was no injury to the patient, but it was a serious mistake. (She did not indicated what the mistake entailed.) The nurse was asked to see me (the matron) in the matron's office. I interviewed her, I then got up from my chair, stepped around the table and gave the nurse a hug. I assured the nurse that the patient did not get hurt and no patient died as a result of her mistake, but she must go back and sort out the*

mistake herself. The nurse could not believe that she was not disciplined or dismissed. The nurse thanked me and promised to solve the problem herself. She was so grateful (1, 570-581).

We have an in-service education department running smoothly. Beside the in-service on ward level, each ward is supposed to have its own in-service. We do send people away to attend workshops, seminars out of the hospital. People pay for it and we allow time to attend it. People are actually encouraged to study on their own and there are a lot of them who are actually involved in their own studies, developing themselves. (long silence) Even the very junior categories, like the nursing assistants, they are upgraded to do the two-year course, and the staff nurses are encouraged and are given opportunity to do the bridging course so that they qualify as registered nurses and on completion of the bridging course they are automatically offered [a opportunity] to do midwifery (1, 746-755).

Personally my greatest joy is watching people grow and take off. I really love it when you have worked yourself out of a job and somebody else takes off with it, and they even stop talking about you having been associated with it and now talk about that person running it (2, 389-392).

But from looking, [it is possible to set] *on fire that something from inside the person that changes them from being a routine worker and a routine thinker, to*

being someone who is taking responsibility for themselves, their own learning, and taking responsibility for a team, beginning to see themselves as being pivotal to a team of caring, and recognising it with better knowledge and skills they are able to care in a better way (2, 451-465).

Caring in terms of development and growth was described by respondents in the narrative during phase two in terms of educating, support and assistance, to uplift the level of training. Continuous training was described extensively and nurses described their satisfaction with the in-service education and training at unit level. Nurses commented as follows:

When a member gives you warm welcome you feel welcomed. On arrival they can give you orientation because you are not familiar with their trade names of medicines (2, 95-99).

As a newly qualified nurse I received great orientation and a warm welcome even in the ward situation, as some procedures are done in a different manner so they helped me to feel accepted and to be efficient enough and [have] confidence in my work (2, 539-543).

My nursing colleague is very particular about our well-being. She always makes a record of your improvement and records it on daily basis (1, 169-174).

Participative management was described by participants from all three hospitals and received a lot of emphasis. The following were examples given by participants in their description of participative management strategies:

> *We tried to implement it (participative management) last year, when we formulated our policies for accreditation. We used all the categories in our policy formulation and also there is an ethics committee before you take a decision, so it was easy for them to understand the policies, because they have been part, part of it. It is a continuous process, but now they know that you can not make a policy alone you must have input (1, 412-417).*

> *We are working hand in hand sharing ideas and knowledge (2, 7).*

> *We have been teaching each other and doing demonstrations (2, 8-9).*

Feedback to nurses on their progress is important in growth and development of nurses. One participant comment as follows:

> *At these meetings, we discuss improvements that they feel they want to introduce in the ward routine. We really and truly take note of it, and if it is a good idea, we try and encourage it. And also a very important aspect is to give them positive feedback and reward in the sense that the work has improved or is at a satisfactory standard. I think that is very important (3, 236-237).*

Leading by example was very prominent in one hospital only. The synonym for leading by example, such as role modelling was also mentioned by the other hospitals. At the one hospital, however, one participant described leadership and development. It seemed that the participant who commented on this aspect believed strongly in leading by example and role modelling. It was expressed as something one should do and no examples were given of how actually to lead by example:

> *They got to see you doing it and once they see you are doing that most of the time they will copy it besides you teaching it (1, 49-50).*

> *Well, I think we should set an example as leaders. We should be exemplary because you cannot expect the subordinate to be caring if you do not have that attitude (1, 408-410).*

Education was described in depth and the participants seemed to think it was very important in the human resource management of nurses. Caring is based on an attitude of nurturing and helping one another to grow. It was described as follows:

> *We try to put them in the correct department and we should try and promote that aspect and provide study leave for a particular person, sort of updating the staff. Study leave is granted depending on the needs, because now for that person to have study leave she must actually work in that particular department. For*

instance paediatrics, if she wants to do paediatrics, she is placed in that ward (1,352-359).

In the comparison with the theory of Watson (1985) development and growth of nurses is described as the teaching-learning process in nursing as it engaged both the nurse and the other person. It includes the issues of imparting of information as well as consideration of the nature of learning and what interpersonal processes facilitate learning. Nursing educators always maintain that health teaching is one of the main functions of a nurse. According to Watson (1985, p. 79) "*The science of caring concerns itself theoretically and practically with all the aspects of interpersonal teaching-learning...*" A supportive and corrective environment provides for a person's mental, spiritual and socio-cultural harmony and well-being. Nyberg (1993, p. 13) makes it clear that "*...caring requires us to recognize the potential of people we care for, by empowering them and not by having power over them.*" Caring makes the nurse manager different from other managers in that caring defines the behaviour and attitude of the nurse manager in a more relational and growth-orientated way. It also asks openness, listening to and valuing of the other while the goals of the organisation stay important. The duties do not change in caring management but the manner in which one goes about executing it. The use of power changes to empowerment and growth and development and this is a constant challenge for nurse managers.

4.2.2.5 *Caring to nurses in terms of needs.*

The identification of needs were categorised according to Maslow (cited in Booyens 1998) in the lower, social and higher categories of needs.

Lower order needs that include the physiological and security needs, such as comfort, spiritual needs, welfare of nurses, enough equipment and safety, were aspects that were identified by the participants. These identified needs could contribute to an environment that is conducive for nurses to render quality patient care in the hospitals. Basic to the environment created for the nurses is enough equipment at the disposal of nurses in the health services. This need was emphasised by participants as follows:

> *I make sure that nurses, so called understaffed or stressed, have got everything they need in order to function. Now I put a lot of energy into that. You know making sure that every single one of my nurses has got everything that she needs. I have learned to turn that into my concept of caring, if I can make sure of that, and know that the nurses in my area have got absolutely everything to achieve patient care, I see that as part of my caring role (2, 363-368).*

> *We need more resources, linen, syringes, drugs, gauze, and more material so that there is enough material so that we are able to render proper care (2, 108-110).*

Safety of staff was referred to in terms of safety of nurses when they are leaving the premises and in relation to needle stick injuries, with the following example:

> *We have an Occupational Health Sister who has just started, and she works hand in hand with the Occupational Health Officer. We encourage our staff to use identification badges, so that if they come to the security at the gate they know that this is a member of staff. We have policies that cover the staff, like needle stick procedures injury on duty (2, 269-273).*

The lack of fulfilment on the lower order needs was expressed by professional nurses as follows:

> *Crèche facilities for staff and after school care, transport and the money (salaries) are less than Government with no benefits (2, 161-162).*

> *There are not enough benefits in this hospital. No house subsidy, no car subsidy, no crèche facilities [although] we tried so much to motivate for crèche facilities (1, 137-138).*

After thinking seriously the participant commented as follows on the lower order needs:

Should I say that they are trying to fulfil the lower order needs but as I said they are not able to satisfy us because of those needs, the essential needs that we lack and the needs that [have] made people leave the place (1, 186-188).

Lower order needs of staff, such as the survival needs were identified. The participants made it clear that the nurse managers do not have a lot of control over the fulfilment of the lower needs of nurses, such as salary increases, housing and car allowances, medical aid assistance and the granting of sick leave:

When a nurse is not feeling well, we have our doctor that is responsible for the staff, and if she decides that the person is not well, the person is booked off, and there is a sick leave form that should be submitted it to the superintendent (2, 232-234).

Free health [care is available] for the staff and for the health for their families only 50% of the normal fees are applicable. And when they retire, the staff became free members of our sick parade, free medical aid to the family, the children, the husband, but here they get everything free. If it is something that you can not look after (care for as a nurse manager), medical problem, then there is a solution, they go to other institutions similar to us and we take it to ourselves, if we can not do it here, we transfer and we pay (1, 507-514).

Social needs are, according to Maslow (cited in Booyens, 1998), the needs of employees to take part in social activities in the hospitals. After the satisfaction of the physiological and safety needs, social needs (belonging needs) become predominant. Social needs were described as teamwork and team spirit and were referred to very briefly, although they are very important in nursing and the care of patients. It seemed as though the participants saw themselves separately from the nurses in the wards in some of the hospitals. This perception should be investigated further to establish the reasons for it. The comments on teamwork were as follows:

> *Everybody, doctors and all, everybody is like a good family (1, 92-93).*
>
> *So as matrons we all stand together (1, 369-369).*

Social needs, the affiliation needs of nurses, were seen to and examples of socialisation within the hospitals are:

> *[There is] a netball club in the hospital. The nurses organise it in their own time in lunch times. And when they have to go to tournaments I make arrangements for them to go by asking others to relieve them. With music as well, we have a hospital choir that practises during their lunch time and a football club for the males that helps with teambuilding (3, 143-147).*
>
> *I think we need to be more happy, get to know each other, know we are just concentrating on the patient mostly. Perhaps it could be more exciting if we had*

more activities here. I think we would be able to keep staff if we had more activities (1, 248-250).

We provided for our matrons, a special Matron Parlour, to make them feel free and comfortable and at home and come and share with their colleagues and also join them. Occasionally, we do have special treats, like, birthdays. We just come together and give them a surprise. If we have no present we sing happy birthday to her, to cheer her up (2, 275-279).

The higher needs or self-actualisation needs were dealt with to a great extent under the growth and development theme and should be seen as part of this need as well (see 4.2.2.4 of this chapter). Self-actualisation was explained in terms of:

I think, you see, caring within the Christian ethos, is a very important part of my lifestyle. And caring without making dependence, you know. I think hundred years ago, the concept of Christian evangelisation was very dependence producing, in the sense that all the churches that evangelised in the area, the people became very dependent. Now it is totally different, and nursing and Christian compassion in care are so much part of what we are trying to achieve in the Hospital, you cannot really separate one from another. That is why strongly we have been vigorously trying to maintain our autonomy in this Hospital as an institution. And not move over to Government, because Government is trying to achieve many of the aims that we are, but we would like to think that we are

expressing the Christian compassion of Jesus. As He healed, He did not change the world, but He put His hand on each person that was there, just that touch, the ability to touch. We would like to see our institution reflecting that to some extent. I think, you see, caring within the Christian ethos is a very important part of my lifestyle. And caring without making dependence, you know (2, 467-480).

In comparison with Watson (1985), nurse managers addressed the needs of nurses to a certain extent by putting the emphasis on personal problems of nurses due to illness and family problems. The classification of needs as set out by Watson (1985), could serve as a guideline to nurse managers to identify other needs of nurses as well. The need classification is as follows according to Watson (1985):

- Lower order needs, the survival needs, that include food and water, elimination and ventilation and the functional needs that include activity and rest.
- Higher order needs, the integrated needs, that include aspects such as success and affiliation and the growth-seeking needs, that include needs of self-actualisation.

4.2.2.6 Caring to nurses in terms of HIV and AIDS.

HIV/AIDS was identified as a major theme in caring in human resource management. For the purpose of this research it was categorised as a major theme because of the emphasis placed on it by nurse managers. HIV/AIDS and the problems associated with it seemed to take up a lot of the time of nurse managers. It also seemed important to

look at the competencies needed by nurse managers to deal with the complex problems and the demands that this killer disease put on nursing resources.

HIV/AIDS and support to the families of nurses with the disease seemed to be a major issue because of the influence of it on health services and the nurses themselves. Nurse managers see caring for nurses to a great extent as dealing with the disease and support to the families of nurses. Nurse managers see their caring task as supporting the staff members to deal with the disease and organising the funerals of staff members dying of AIDS. Support to nurses was described from the context of illness or HIV/AIDS and not in the context of true caring to help the nurses to grow and develop in their professional lives. The following were examples described by the nurse managers:

> *When she was sick at home I did not want her family to bring her here. I always communicated with her family. If they needed a vehicle they must not hire one or go to the problems to bring her to hospital, I used to go and fetch her myself or send a driver. If the driver was not available I would go there myself or (the other matron) (3, 39-43).*

> *We nursed her here and when she died I communicated with her mother, because she was a breadwinner, and I asked her mother if there was a sister who was actually big enough to get employment at the hospital, then I discussed it with the management, and we all agreed that we should offer this family assistance, because it was a very, very poor family. So what I did I asked the*

mother to bring the sister here, I interviewed the sister and I employed her as a general assistant. She was qualified and did a secretary course after standard ten. But she accepted the post as an assistant. I did not have a post for a secretary with the hope when there is a post in admin, then she can apply for it, she was employed here. Unfortunately she also contracted HIV/AIDS and she died, she died two months ago (3,47-58).

But even with her, I supported her throughout when she started with the TB, I supported her, I made sure that the supervisor did the same. I arranged breakfast for her, and when she died, I attended the funeral together with her supervisor and the medical superintendent and the deputy as well (3, 60-64).

Caring to nurses was mainly referred to in terms of AIDS counselling and support as follows:

Hmm, hmm I can go into lots of caring. We do AIDS counselling. I myself am an AIDS counsellor. I do know some of the staff are HIV positive and in the allocation list, (I do the allocation), I try to place them in suitable departments. For a lot of them, I have torn up the HIV results and keep it confidential. I think also in the office here, confidentiality plays a very important role (3, 207-212).

Nursing is down because the nurses themselves are sick, they are sick with HIV and in all these wards the patients (twelve a day die), gone dead, they are

dying, that is so demoralising and they even said you know they are going to die and even themselves (the nurses) they die by HIV/AIDS (1, 33-36).

With the few resources they always have a complaint, we are overworked, because they (the nurses) are sick. They don't come on duty, they stay off sick, put in leave again and again because their immune system has gone down. Flu, so many [of the nurses] have flu they stay away with flu for two months. No doctor's certificate is presented, that is a problem (1,43-48).

Spiritual needs of staff were described in terms of their needs when they lost family members, with one example as follows:

You know especially with our students, when they received a report from the college that they lost a father, then they are referred to their spiritual leader so before I can make any arrangement about the funerals I used to close the door and pray for those nurses together, to try to comfort them (1, 290-295).

Counselling was described in terms of counselling HIV/AIDS nurses. The nurse managers see the counselling of nurses as a major part of their management functions. In some of the hospitals the need for a person to counsel the staff on the HIV/AIDS issue was so great that a nurse counsellor was appointed. It was described as follows:

Because when the elderly person die it is much better, but with the young ones dying now, you can see it is so difficult, almost every day, they die and we liase with our counselling department. We have a counselling department here (1, 310-311)..

We have a pastoral counselling service who is caring for the nurses. We got a senior counsellor, one of the senior professional nurse is the counsellor. She visit them in the wards, she talks to them spiritually (2, 39-41).

Also at the same time, we have got a counsellor for HIV/AIDS. At present we are looking for someone for counselling the staff. She comes from the first of October. She will look at counselling the AIDS stricken staff members. The staff actually have family members that are HIV/AIDS positive. They themselves might also not be feeling well, and then somebody, not the matron or a colleague, (need to be available to them) to open up to, someone who is neutral, so provision is being made for this (2, 254-260).

Care to dying staff was very prominent at the hospitals and it was expressed as follows:

They want the matron to visit them at the hospital and they want the management to be there at the nurse's funeral and to take a lead in organising the nurse's funeral, especially the African nurses. The other races are not a

problem, but the African nurses, want the management to get involved in organising the funerals for a nurse who dies, and the management to be there at the funerals (3, 105-110).

Employees who have HIV/AIDS, were managed well by nurse managers in the health services. Employees living with HIV/AIDS will be productive for a long period if they receive the medical, social and psychological support they need. It is important to develop guidelines and policies for managers to assess and manage the situation (Davies, Schneider, Rapholo and Everatt, 1997).

HIV/AIDS is never far from the headlines and the scenario that was created at the Nursing 2000 Conference in Midrand during the first week in September 2000 indicated that twenty percent of the South African nursing population could theoretically be HIV positive. That means that of the 174 000 nurses available for duty in South Africa, 34 000 nurses could be HIV positive and one student nurse would die of AIDS every month, (Geyer, 2000). The Gauteng Department of Health indicated that there is no proof of these statistics and it is not clear how these figures were leaked and questions are being raised about their accuracy.

The fact that nurse managers spend a lot of their time on HIV/AIDS related aspects, could be an indication of the seriousness of the infection rate and the effect of the disease on the health services. Nurse managers indicated that they are spending a

great deal of their time on counselling nurses with HIV/AIDS, care of the ill nurses, and organising funerals of nurses who have died of AIDS and related diseases.

4.2.2.7 *Non-caring in nursing management*

Non-caring was mentioned by a few respondents and was described as stress, selflessness, no participative needs identification, carelessness, de-motivation and dismissal of nurses, and examples were as follows:

Stress can be the opposite of caring (1, 112-112).

We must care for our patients, our visitors, in fact to an extent that we even forget about ourselves that we also need to be cared for (1,169-171).

We asked for computer skills to be developed, we are the seniors, but nothing is done so far about it (1, 202-204)

Nurses demand now, they know their rights, they are not like us (the matrons). They say now I got so many days I want to be off I want to go, I got days which I would like to take off. They (the nurses) have no concern about the wards (2, 26-30).

Nurses play hide and seek so much. Things are changing. We, the matrons, really care to try to meet the staff's problems, and general complaints of nurses. Higher management does not meet the needs of staff. The staff is going (leaving) (2, 141-143).

De-motivation of nurses cut off the service. There is no future in this hospital. The focus is on money, how best to be economically viable (2, 146-147).

Caring has changed now. Complaints from nurses are for example, not meeting the needs, the gates are open (nurses feel that they are not cared for, and therefore they are free to leave the hospital), discipline and dismissals and final written warning are given (too often and not fair), unpaid leave for absenteeism, no value is placed on the staff for long time service, we, the nurses are very bitter, we saved lives and made the walls stand, ... (2, 150-153).

The participants were in agreement with other authors on non-caring in their description on non-caring in nursing management. Macdonald (1993) describe non-caring as *not interested and feeling drained, not keen to get involved.* Personal dislikes and illness of the carer herself/himself could contribute to non-caring as well. It seemed that theorists are not willing to describe non-caring in nursing, but it is present in human resource management of nurse, as illustrated in this study during phase two. It seemed to be important to investigate why

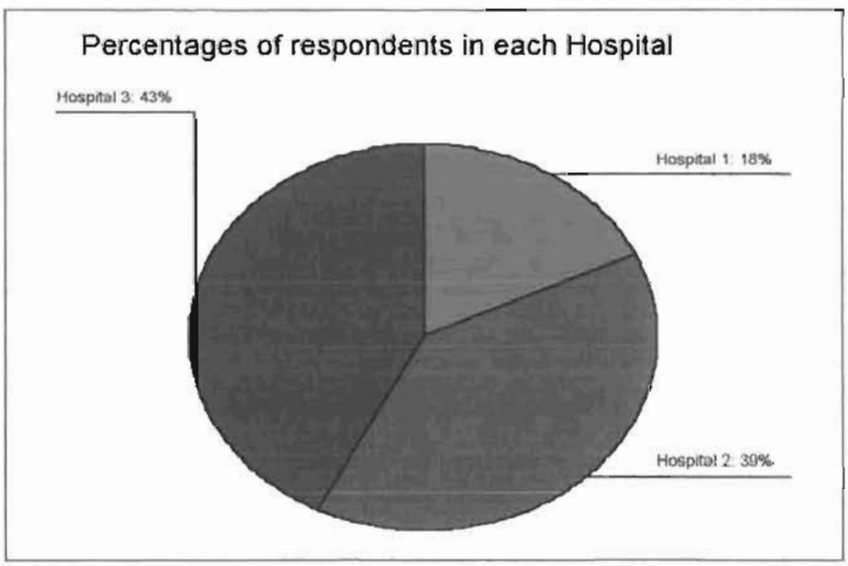
humans are non-caring at certain stages in their relationships with others, to ensure a better understanding of their feelings.

4.3 THE EXPERIENCES AND THE PRESENCE AND ENACTMENT OF CARING CONCEPTS AND PRACTICES IN THE HUMAN RESOURCE MANAGEMENT PROCESS OF NURSES (phase 2, objectives 3 and 4)

4.3.1 Sample realization

This phase includes the data that was collected by using the questionnaire on caring in the human resource management of nurses in the health services in KwaZulu-Natal. Professional nurses and enrolled nurses from the participating hospitals were included in this phase and the total number of respondents who participated was one hundred and eighty eight (188).

DIAGRAM 4.1 SAMPLE REALIZATION FOR THE PARTICIPATING HOSPITALS (n= 188)



From Diagram 4.1 it is clear that Hospital one had the lowest number of participants namely 18%, Hospital two 39%, participants and Hospital three had 43% participants.

The questionnaire was divided into the following sections:

Section A: Demographic data of respondents

Section B Likert type of 88 questions.

4.3.2 Demographic background of the participants in their settings in the health services (Section A of the questionnaire)

Section A of the questionnaire established the demographic information on the respondents. The demographic data was used to determine whether the position, unit, age and experiences of respondents played a role in their experiences of caring in the human resource management of nurses.

- *The clinical units of the respondents*

The respondents were selected from a wide range of clinical units is illustrated in Table 4.2. Nurses from the clinics were the highest number of respondents with 21%. Nurses from the intensive care units (ICU) were lowest (1%).

4.3.2.1 The position of the respondents (Item 1). (n= 188)

In Diagram 4.2, the professional nurses were the highest number of the respondents at 48%, with enrolled nurses at 31% and nurse managers at 19%, including the chief professional nurses and nurses in administrative positions.

TABLE 4.2 CLINICAL UNIT OF THE RESPONDENTS (n= 188)

Clinical unit	Frequency	Percent	Valid Percent
Surgical	16	8.5	8.6
Medical	13	6.9	7.0
Pediatric	23	12.2	12.3
Operation theatre	13	6.9	7.0
Clinics	40	21.3	21.4
ICU	2	1.1	1.1
Gynaecology	26	13.8	13.9
Education	27	14.4	14.4
Night Duty	18	9.6	9.6
Nurse in administrative positions	9	4.8	4.8
Total	187	99.5	100.0*
Missing	1	.5	
Total	188	100.0	

* Indicates percentages that do not add up to 100%
Missing values indicated the number of respondents without a response to the item on the questionnaire.

4.3.2.3 *The experiences of respondents in nursing in years (Item 3)*

Table 4.4 shows the experience in the hospitals of the respondents. Thirty four (34%) of nurses have 1-5 years of experience and 24% from 6-10 years experience in the hospitals. This correlates to the ages given in Table 4.3.

TABLE 4.4 EXPERIENCE IN YEARS OF RESPONDENTS IN THE NURSING PROFESSION (n= 188)

Years of experience	Frequency	Percent	Valid Percent
1-5 years	63	33.5	34.2
6-10 years	45	23.9	24.5
11-20 years	43	22.8	23.3
21 years and over	32	17.1	17.4
Total	183	97.3	100.0*
Missing	5	2.6	
Total	188	100.0*	

* Indicates percentages that do not add up to 100%
Missing values indicated the number of respondents without a response to the item on the questionnaire.

4.3.3 The results of the experiences of caring and the presence and enactment of caring practices in the human resource management of nurses (Section B of the questionnaire).

4.3.3.1 *Introduction*

The aim of this description was to explain the presence and enactment of caring in the human resource management processes in nursing environments. According to the figures in Chart 4.1 caring was not present at high levels, nor

experienced at satisfactory levels in the human resource management processes of nurses. Percentages of forty four (44%) to sixty three (63%) positive responses on caring were a significant indication that there is a lack of caring in the human resource management of nurses.

Caring was not present at high levels in the formulating strategies (the mission, goals and objectives and philosophy of the service). These received 55% positive responses. The nurses indicated that caring was present in the workforce planning (demand and supply and organisational design) with 53% of positive responses. Staffing, (recruitment methods, the process of selection of staff, hiring of staff, level and contents of induction training and socialising of nurses) received 55% of positive responses, which indicates that caring was present, but at low levels in the above processes.

Caring was reflected most strongly in the structuring of work, aspects regarding the job of the nurse, with an average of 63% positive responses on the questionnaire. The caring issues that were addressed in this section of the questionnaire focused on job descriptions and tasks allocated according to knowledge and abilities of nurses, staff shortages, happiness in the job, distribution of the workload and flexibility in nursing.

Caring in the utilising and maintaining process (performance management, leadership styles, in-service education, employee well-being, grievance and

disciplinary procedures) in nursing management received 44% of positive responses. The process of utilising and maintenance included management aspects that aimed at the development and growth of nurses and the general welfare of nurses at the work place. It was clear that although nurse managers and nurses have the knowledge and structure for the implementation of caring in the hospitals, the everyday practical application of caring in nursing management needed attention. The highest negative response, 28%, was also to this section of the questionnaire. The staffing process received the lowest negative response of 19% (see Chart 4.1).

For the purpose of this study a reflection of seventy percent (70%) and higher was rated as a high level of caring in the human resource management of nurses. A reflection of sixty to sixty nine percent was rated as a moderate level of caring, with a fifty to fifty nine percent reflection of caring as a low level of caring and anything below fifty percent as a reflection of an alarming low level of caring in the human resource management process in nursing.

The Questionnaire

The items in section B of the questionnaire addressed the human resource management aspects in nursing. Each section of the questionnaire represented certain functions in the human resource process of nurses.

The questionnaire was divided into six sections and the description of the data in this chapter followed the format of the questionnaire as follows:

Section1: (Items 4-22) Caring in the *formulating strategies*

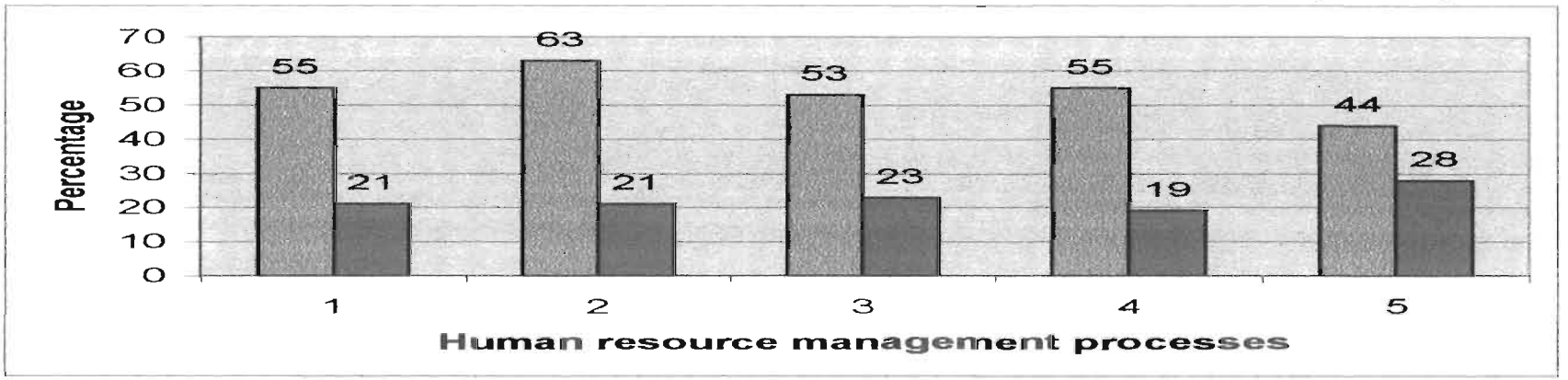
Section 2: (Items 23-34) Caring in the *structuring of the work*

Section 3: (Items 35-48) Caring in *workforce planning*

Section 4: (Items 49-66) Caring in the *staffing process*

Section 5: (Items 67-87) Caring in the *utilising and maintaining of human resources*

CHART 4.1 THE AVERAGE POSITIVE AND NEGATIVE PERCENTAGES ON EACH OF THE HUMAN RESOURCE PROCESSES ACCORDING TO THE DIFFERENT SECTIONS OF THE QUESTIONNAIRE REGARDING CARING (n= 188)



Key:
Negative responses
Positive responses
* Uncertain responses were omitted

1 Caring in the formulating strategies regarding the mission, goals and objectives and philosophy of the Service.
2 Caring in structuring the work in the job analysis, job design and organisational strategies.
3 Caring, in workforce planning , matching demand and supply and organisational design.
4 Caring in the staffing process including recruitment methods, the process of selection of staff, hiring of staff, level and contents of induction training, socialising of nurses.
5 Caring in the utilising and maintaining of human resources, including performance management, leadership styles, in-service education, employee well-being, grievance and disciplinary procedures.

Section 6: (Item 88) One open-ended question on a caring experience with a nursing colleague. This was described with phase one of the study

See Annexure 10 for the description of the coding and re-coding of the Likert scale in questionnaire.

In addition, Chi-squared (χ^2) tests were calculated and a nonparametric test was used to measure the hypothesis in which the row and column variables in the cross tabulation were independent. A low significance value (typically below 0.05) indicates that there may be some relationship between the two variables. The items were selected in the questionnaire with the statistical computer programme SPSS that showed a relationship between the independent variable and the dependant variable, and SPSS was used to calculate the Chi-squared (χ^2) test between variables. The Chi-squared (χ^2) test for the specific items was discussed at the relevant discussion of each item.

4.3.3.2 Caring in the formulating strategies, regarding the mission statement, goals and objectives and the philosophy of the service (Items 4-22) Table 4.6

Caring concepts, such as kindness, love, respect, commitment and trust were included in the exploration of the philosophy, goals and objectives and standards of the hospitals.

- *The presence of universal human values, such as kindness, and love, concern and respect. (Items 4, 5, 6, 11, 14 and 15, Table 4.6)*

The human values, such as kindness, and love, concern and respect for self and others start usually in early life but could also be learned through role modelling. The findings indicated that these guiding values that affect one's caring behaviour were present in the formulating strategies of the hospitals under study. The respondents indicated that *kindness to people in the philosophy* (Item 4) of the hospitals was present with a percentage of 86% of respondents in agreement and *love for others* (Item 5) with 68.3% agreement amongst nurses.

An interesting finding was that nurses were in disagreement (33.0%) with the fact that *respect for the dignity of nurses* (Item 6) was considered in the hospitals. (Items 4, 5, 6 &11, Table 4.6). *The addressing of the concerns of nurses by nurse managers* (Item 14) was characterized by an uncertainty among nurses with 35% responding yes, 32.4% no and 31.4% uncertain. It seemed that nurses do not know if their concerns are noted and addressed by management in the hospitals. The fact that nurses did not indicate a positive yes, with only 45% of respondents who indicated that *their personal values matched the hospital's values* (Item 15), could be that nurses did not know the values of the hospital where they were working at present (Items 14 &15, Table 4.6).

- *The level of enriching experiences of nurses in the hospitals. (Item 20, Table 4.6)*

Forty seven (47%) of the respondents were uncertain if they could *describe their experiences in the hospital as enriching*, (Item 20) whereas only 36.4% of the nurses could agree on the fact. Only a few nurses, 4,5% in Hospital 1; 13% each in Hospital 2; and 3, disagreed that their experiences in the hospitals at present were enriching experiences (Chart 4.2). It is clear from Chart 4.2 that the nurses in Hospital 3 experienced their jobs as enriching. Caring in the management environment is at the heart of development and growth of nurses and this issue should be investigated further. The need for development of nurses was a major theme that came from the data and was emphasized by nurse managers during phase 1 of this study. There could be several reasons for the fact that nurses did not find their jobs an enriching experience. One reason could be the devastating effects of HIV/AIDS in the health services (Item 20, Table 4.6).

- *Knowledge of the philosophy and values. (Items 10, 17 and 18, Table 4.6)*

Most of the nurses were *acquainted with the philosophy, the values and beliefs of their hospitals* (Item 10) as only seven to ten percent of the nurses indicated that they did not know it. Nurses were not involved to a great extent in *the reviewing of the philosophies of the hospitals*, (Item 18) as only 42% were involved (Items 10,17 and 18, Table 4.6).

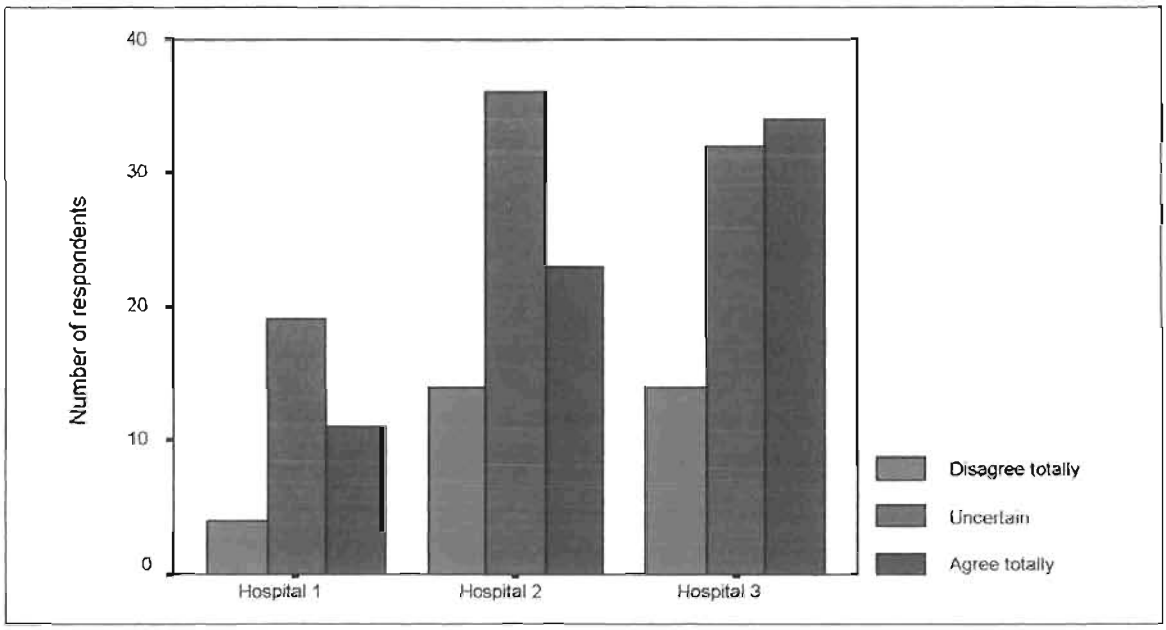
TABLE 4.6 CARING IN THE FORMULATING STRATEGIES IN THE HUMAN RESOURCE MANAGEMENT IN NURSING (n = 188)

Percentage of responses

Item	Disagree totally/ Disagree 1	Uncertain 2	Agree/Agree totally 3	Total Percentage %
4 Kindness to people (patients and staff) is emphasised in the philosophy of your hospital.	5.9	7.4	85.6	100.0*
5 Love for others is visible in your hospital	12.4	19.4	68.3	100.0*
6 Respect for human dignity of nursing staff is always considered.	33.0	21.4	45.6	100.0*
7 In your hospital there is a commitment to ensure the comfort and wellness of nursing staff.	46.5	28.1	25.4	100.0*
8 A culturally sensitive approach towards the nursing staff is followed in your hospital.	33.3	34.4	32.2	100.0*
9 The satisfaction of the patient is always a major concern to all nursing staff at your hospital.	7.6	10.8	81.6	100.0*
Item	NO 0	Uncertain 2	YES 1	Total Percentage %
10 I am acquainted with the philosophy of the hospital	4.9	11.9	83.2	100.0*
11 The philosophy of the hospital guides my actions during the execution of my job.	4.3	11.3	84.4	100.0*
12 The environment in which I am working facilitates support and caring to nurses.	26.7	30.5	42.8	100.0*
13 The philosophy of the hospital is to be honest in all circumstances and with all people.	6.5	13.0	80.5	100.0*
14 Nursing managers address the concerns of the nursing staff.	32.4	31.4	34.6	100.0*
15 Your personal values match those of the hospital where you work.	22.8	32.6	44.6	100.0*
16 Ethical issues in the hospital are discussed and clarified at meetings, workshops, and in informal ways.	17.6	23.0	59.4	100.0*
17 You are familiar with the values and beliefs of your hospital.	6.4	15.5	78.1	100.0*
18 Nurses at all levels are involved in reviewing the philosophy of the hospital.	36.4	21.9	41.7	100.0*
Item	Disagree totally/ Disagree 1	Uncertain 2	Agree/Agree totally 3	Total Percentage %
19 You feel valued by the nursing managers.	29.4	33.7	36.9	100.0*
20 Nurses in your hospital would be able to describe their experiences with the hospital as enriching experiences.	17.1	46.5	36.4	100.0*
21 In your hospital you are experiencing commitment from management towards two-way communication.	24.6	35.5	39.9	100.0*
22. Nursing managers trust the nurses.	23.0	40.0	36.9	100.0*

* Indicates percentages that do not add up to 100%.

CHART 4.2 THE EXPERIENCES OF NURSES AS INDICATED IN THE DIFFERENT HOSPITALS REGARDING THEIR JOB IN THE HOSPITAL AS AN ENRICHING EXPERIENCE IN COUNTS (n =188)



- *The provision of a comfortable and caring working environment in nursing. (Items 7 and 12,Table 4.6)*

There was total disagreement with the fact that *the hospitals are committed to ensure the comfort and wellness of nursing staff,* (Item7). Forty seven (47%) of the nurses said that they disagreed that the hospital was committed to ensure the wellness and comfort of nurses. When the nurses had to indicate the reasons for being unhappy in their jobs, the reasons amongst others were shortage of staff and the aspects grouped into the lower level needs of people according to Maslow (1954) (cited in Swanepoel Ed. 1998) (Item 7, Table 4.6). In agreement with this finding, the nurses indicated that *the environment in which they are*

working does not facilitates support and caring to nurses, (Item 12). Forty three (43%) of nurses indicated that they worked in an environment of support and caring, whereas 31% were uncertain and 27% said they were not working in a supportive and caring environment (Item 12, Table 4.6).

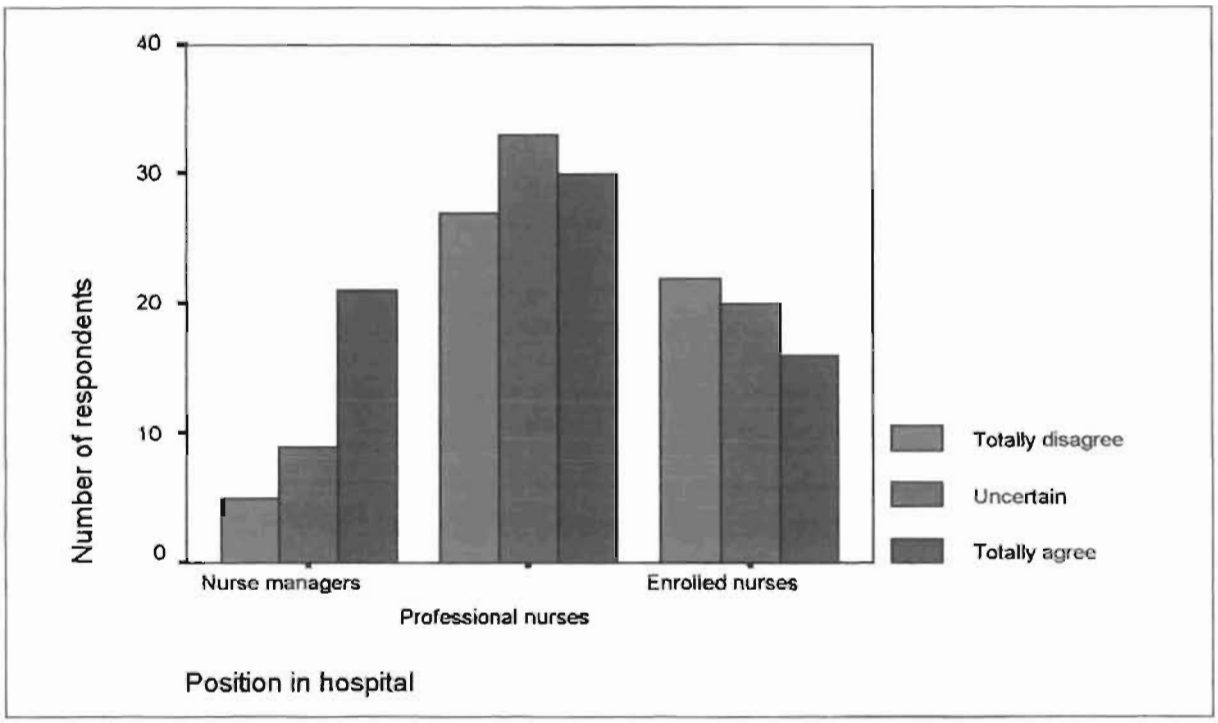
- *The satisfaction of patients. (Item 9, Table 4.6)*

It was positive that nurses agreed totally, (82% of the respondents), *that the satisfaction of the patient is always a major concern to all nursing staff* (Item 9, Table 4.6).

- *Cultural sensitivity towards nurses and the extend that nurse feel valued in nursing. (Item 8 and 19, Table 4.6*)

Disagreement 33% or a high level of uncertainty with (34%) was expressed with the fact that *a culturally sensitive approach towards nurses was followed in their hospitals* (Item 8). Only 37% of nurses felt that *they are valued by the nursing managers* (Items 8 and 19, and Table 4.6). It was remarkable that nurses in different categories felt differently about the aspect of feeling valued by the nurse managers. The nurse managers were the only group to feel valued by management, and the majority of enrolled nurses indicated total disagreement on this issue. The professional nurses were uncertain but indicated that they felt valued to a certain extent (Chart 4.3)

CHART 4.3 THE EXPERIENCES OF NURSES AS INDICATED IN THE DIFFERENT POSITIONS REGARDING THE FACT THAT THEY FELT VALUED BY NURSE MANAGERS IN COUNTS (n =188)



Items 4, 21,22, are requirements for a healthy environment in any relationship and the Cronbach's alpha value of .4637 indicated them as such. The fact that items 10,11, 17 presented with a Cronbach's alpha .4616 was significant because it indicated that if nurses are acquainted with the philosophy and the values of the hospital, their actions were guided during patient care interventions. Items 7,12 presented with a Cronbach's alpha of.2397 and this indicated that if nurses felt that there was no commitment to ensure their wellness and comfort, (Item 7) then they also experienced a lack of support in their environment (Item 12, Table 4.6).

4.3.3.3 *Caring in structuring the work in the job analysis, job design, organisational structures (Items 23-34) in Table 4. 7*

Caring concepts in the job descriptions, goals and objectives, the workload and the knowledge and skills of nurses to do the job were included in the structuring of the work in Items 23-34. Item 27 was an open ended question and answered only if the answer was no, to question 26 *(Are you happy in your job?)*.

- *Sufficient nursing staff available in the hospitals (Item 24, Table 4.7)*

Seventy-nine (79%) of nurses indicated that there were *not enough nurses in the hospitals to render quality nursing care* (Item 24) (Table 4.7). Shortage of nurses was mentioned as well by nurse managers in phase one of the study. The fact that there were not enough nurses to render quality care could be the reason for nurses to feel that they were not valued by nurse managers.

A significant relationship between item 24, querying whether there were enough nursing staff members to render quality nursing care in the hospitals and item 28, about whether the workload distribution was done in such a way that the dignity of the staff and patients was preserved resulted in a Chi-square of (χ^2) .004. This was an indication that the dignity of staff and patients were not respected in hospitals which experienced staff shortages.

- *The level of flexibility in the management of nurses. (Item 34, table 4.7)*

Most of the nurses disagreed, 40% of the respondents were uncertain and 28% indicated that it was totally untrue (item 34) (Table 4.7) that *high levels of flexibility and limited use of rules were being used by nurse managers in the hospitals.* This finding was an indication that nurse managers should be aware of the fact that humans cannot always be controlled by rules and regulations. One of the participants in phase one illustrated the situation by stating that a nurse manager could sometimes overrule the regulations to accommodate a nurse, and stand up for that nurse, and that gave the nurse manager great joy, because the nurse manager then showed a great deal of maturity in management functions.

- *The job related issues. (Item 23, 25, 29 and 31, Table 4.7)*

A positive fact was that nurses indicated overwhelming agreement 96% that *they have job descriptions* (Item 23) and 84% of nurses agreed that *the patient goals are important and all nursing care is aimed at meeting the goals* (Item 25). The *jobs are designed according to the knowledge and abilities of nurses* (Item 29) was endorsed by 82% of the nurses. Ninety-six (96%) agreed that the *main goal of their jobs is aimed at the welfare of patients* (Item 31) and this fact was illustrated in the Chi square of (χ^2) .002 between item 9 and 31. It was significant and positive that the satisfaction of the patient was always a major concern to all nursing staff at the hospitals, with the main goal of the jobs of nurses being aimed at the welfare of patients (item 9 and 31, in table 4.7).

TABLE 4.7 CARING IN THE STRUCTURING OF WORK IN THE HUMAN RESOURCE MANAGEMENT IN NURSING (n = 188)

Percentage of responses

Item	NO 0	Uncertain 2	YES 1	Total Percentage %
23. You have a job description.	3.2	.5	96.2	100.0*
24. There are enough nursing staff members to render quality nursing care in your hospital.	79.3	14.4	5.3	100.0*
25. The patient's goals are important and all nursing care is aimed at meeting the goals.	4.3	10.8	84.4	100.0*
26. You are happy in your job.	35.5	20.2	44.3	100.0
Item	**Totally untrue/ Not true 1**	**Uncertain 2**	**True/ totally true 3**	**Total Percentage %**
28. The workload is distributed in such a way that the dignity of the staff and patients are preserved.	40.4	29 5	30 1	100.0
29. Your current job is designed according to your knowledge and abilities	12.6	5.5	82.0	100.0*
30. You could describe your job as meaningful and it contributes towards your career development.	6.5	9.1	84.4	100.0
31. The main goal of your job is aimed at the welfare of patients.	2.7	1.6	95.7	100.0
32. You are mostly performing the tasks for which you are responsible according to your job description.	15.1	9.7	75.3	100.0*
33. The achievement of high levels of production and efficiency is accomplished through extensive use of rules and procedures.	7.6	27.6	64.9	100.0*
34. High levels of flexibility with limited use of rules is a good description of the nursing management of your hospital.	27.6	40.0	32.4	100.0

* Indicates percentage that do not add up to 100%

- *The job was considered as meaningful. (Item 30, 32 and 33, Table 4.7)*

The majority of nurses (84% of respondents) described their *job as meaningful towards career development* (Item 30) and most of *the tasks were according to the job description* (Item 32) according to 75% of the nurses. Sixty-five (65%) of respondents said that it was totally true that *high levels of efficiency are accomplished through extensive use of rules and procedures* (Item 33) in the hospitals (items 30, 32 and 33, Table 4.7).

Items 33 and 34, with a Cronbach's alpha .4873, indicated that high levels of efficiency were accomplished through extensive rules and regulations without flexibility (Table 4.7).

- *The level of happiness of nurses in their jobs. (Item 26 and 27, Table 4.7)*

Only 44% of nurses agreed that they *are happy in their jobs* (item 26). The nurses were asked to identify reasons for their answer to question 26 if they indicated "No" to the question. The reasons were categorised according to Maslow's (1954) (cited in Watson, 1985) theory into lower, social, higher order needs and staff shortages and HIV/AIDS problems. The latter category was formed after the results of phase one, but did not seem to be a reason for unhappiness amongst nurses as only two of the respondents identified HIV/AIDS as a reason.

Reasons identified by nurses that answered "No" on question 26 for their unhappiness in their jobs were as follows:

1 Shortage of staff was identified by 25% of the nurses;
2 Lower order needs were identified by 23% of nurses, including issues such as safety at the workplace, salaries, crèche facilities for their children, low salaries and no benefits such as housing and travel subsidies;
3 Social needs and the lack thereof were only identified by 10% of the nurses as an issue that made them unhappy;
4 The higher order needs were identified by 14% of the nurses as a reason for unhappiness in their jobs.

It is significant, as is indicated by a Chi-square of (χ^2) .025, that if *nurses felt happy in their jobs they felt valued by the nursing managers* (Items 19 and 26).

- *Workload distribution in nursing. (Item 28,)*

Forty (40%) of the nurses disagreed totally that *dignity of the staff and patients are preserved* (Item 28). The nurses were divided in their answers on this item, 30% said that they were uncertain and 30% indicated that it was true that the dignity of the staff and patients was preserved.

Items 24, 28 showed by a Cronbach's alpha of .4160 that if there were not enough staff then the nurses felt that the workload was not distributed in such a way that the dignity of staff and patients could be respected (see Table 4.7).

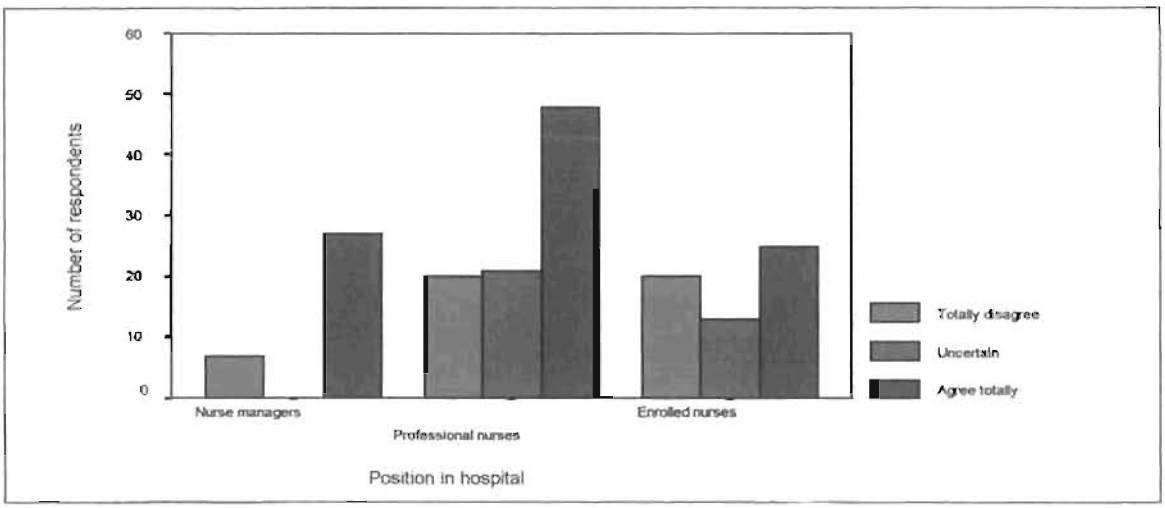
4.3.3.4 *Caring, in workforce planning, matching supply to demand and organisational design (Items 35-48) in Table 4.8*

Organisational design, individual needs of nurses, the level of control over the work, growth and emotional security were included in the exploration of the planning of the nursing workforce in hospitals by items 35 to 48.

- *The level of control over the work. (Item 35, Table 4.8)*

The majority of nurses (56%), indicated that they *have control over their jobs in the hospitals* (Item 35). Twenty five percent (25%) said that they disagreed totally with the above premise. Chart 4.4 indicated that nurse managers said either they had control over their work or they did not have control over their work. Professional nurses said positively they did have control over their work, and the enrolled nurses were very much divided in their answer (Chart 4.4), (Item 35, Table 4.8). The Chi-square (χ^2) .006 was significant for the relationship between position in the hospital and item 35, indicating the control that nurses have over their jobs. The higher up in the management levels the nurses were positioned, the higher the control over the job.

CHART 4.4 THE NUMBER OF RESPONDENTS IN THE DIFFERENT NURSING CATEGORIES REGARDING CONTROL OVER THEIR WORK IN COUNTS (n =188)



- *Emotional security of nurses. (Item 41Table 4.8)*

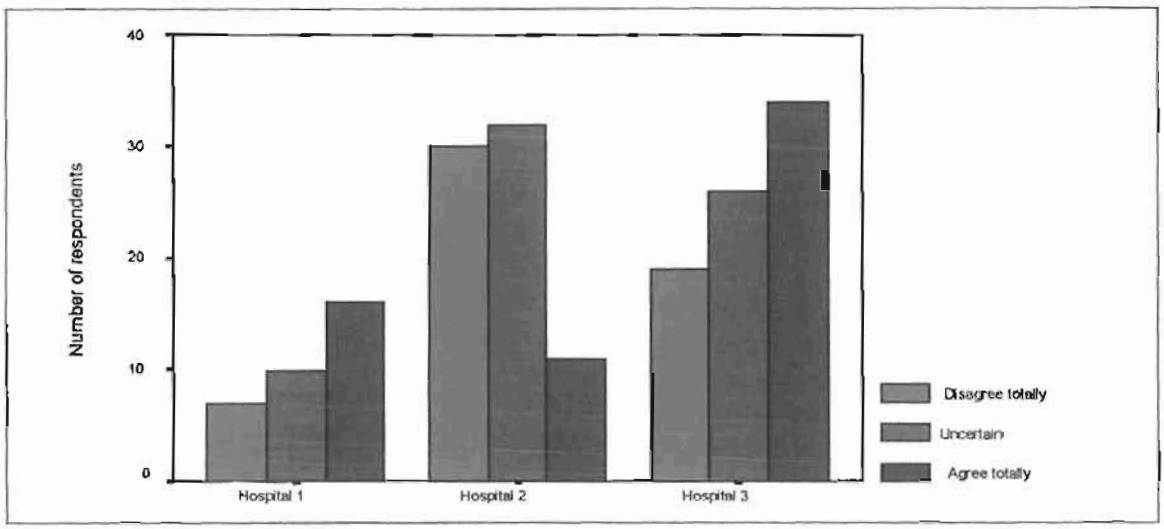
The nurses were very much divided on the question of whether *the hospitals are places where they experience emotional security*. (Item 41). Thirty (30%) of respondents disagreed totally on this aspect and 37% were uncertain, while 33% agreed that hospitals were places where emotional security could be experienced (Item 41, Table 4.8). Chart 4.5 indicated that the nurses in Hospital one and three did experience emotional security in their workplace, but in Hospital two the nurses indicated that they were uncertain and did not experience emotional security in their workplace.

TABLE 4. 8 CARING, IN WORKFORCE PLANNING IN HUMAN RESOURCE MANAGEMENT IN NURSING (n = 188)

Item	Percentage of responses: Disagree totally/ Disagree 1	Uncertain 2	Agree/Agree totally 3	Total Percentage %
35. In your current job you have control over your own work to a great extent.	25.4	18.4	56.2	100.0
36. The organisational design enables nurses to achieve high levels of production.	17.4	34.8	47.8	100.0
37. The organisation allows for accommodation of needs of nurses.	35.5	33.3	31.1	100.0*
38. Teamwork in nursing is of utmost importance in your hospital.	9.1	10.2	80.6	100.0*
39. The nursing managers and the hospital as a whole can be described as a warm, caring community.	32.9	27.0	40.5	100.0*
40. Your hospital is a place where nurses can work, live and grow.	25.9	26.5	47.6	100.0
41. Your hospital is a place where you are experiencing emotional security.	30.3	36.8	33.0	100.0*
42. There is a feeling of interdependence among nurses in your hospital.	11.4	26.5	62.2	100.0*
43. In your hospital the nursing staff experience a great deal of unity.	18.3	24.2	57.5	100.0
44 The nursing staff help each other to succeed in their daily nursing activities.	9.7	10.8	79.5	100.0
45. The maintenance of the health of the nurses is always a priority for nurse managers.	46.2	24.7	29.0	100.0*
46. Nurses are seen as individuals in spite of the level of departmentalisation of your hospital.	24.9	37.8	37.3	100.0
47. When tasks are delegated to nurses, the scope of practice, level of knowledge and competence of the individual nurse is considered.	12.9	9.7	77.4	100.0
48. Work relationships in the hospital are marked by trust.	15.8	26.6	57.6	100.0

* Indicates percentages that do not add up to 100%

CHART 4.5 THE NUMBER OF RESPONDENTS IN THE DIFFERENT HOSPITALS INDICATING THAT THEY EXPERIENCED EMOTIONAL SECURITY IN THE HOSPITAL IN COUNTS (n =188)



- *The hospital as a caring place (Item 39, 40 and 48, Table 4.8)*

On the issue of whether the hospital is a *warm, caring community*, (Item 39) the nurses were also divided in their answers. Forty one percent of the nurses indicated that they could describe their hospital as such, with 27% uncertain and 33% of the nurses indicating that they could not describe their hospital as a warm and caring community. Twenty-six 26% of respondents disagree that the *hospitals were places where they could live and grow* (Item 40), and 58% of nurses said that *work relationships in the hospitals are marked by trust*, (Item 48) (Items 39, 40 and 48, Table 4.8). Nurses also indicated (see Item 22, Table 4.6) that they are uncertain and in disagreement on the issue that *nurse managers trust nurses* .

- *Organisational design and production of nurses. (Item 36 Table 4.8)*

Only 48% of nurses agreed totally that *the organisation design enabled them to achieve high levels of production.* (Item 36)

- *Delegation of tasks to nurses. (Item 47 Table 4.8)*

The nurses indicated that *their level of knowledge and competence were considered when tasks were delegated to them.* (Item 47) Seventy-seven (77%) of nurses totally agreed on this aspect.

- *The accommodation of the belonging needs of nurses in the hospitals. (Item 37, 38, 42, 45 and 46, Table 4.8)*

Thirty six (36%) of nurses disagreed totally with the fact that *hospitals allow for the accommodation of the needs of nurses* (Item 37) and this is in line with the reasons for the unhappiness of nurses currently in the hospitals. Nurses generally agreed (81%) that *teamwork is of utmost importance in the hospitals* (Item 38). Sixty-two (62%) of nurses agreed that there is *a feeling of interdependence among nurses* (Item 42) in the hospitals. The maintenance of *the health of nurses is not a priority in the hospitals* (Item 45) according to the 46% of nurses that indicated it as such. Nurses were divided on the aspect of whether *nurses are seen as individuals in spite of departmentalisation of the*

hospital, (Item 46). Twenty five (25%) of respondents disagreed totally, 38% were uncertain and 37% agreed totally on this issue (Items 37, 38, 42, 45 and 46, Table 4.8).

- *The level of unity amongst nursing staff in the hospitals (Item 43 and 44 Table 4.8)*

Fifty eight 58% nurses agreed that they were *experiencing a great deal of unity* (Item 43) and 80% of nurses agreed that *nursing staff help each other in their daily activities* (Item 44). Helping each other to succeed is very important in nursing and the fact that there was a high level of agreement on this aspect was positive for caring in nursing (Items 43, 44, Table 4.8).

The high Cronbach's alpha .7725 for items (39, 40) indicated that if nurses felt that the hospital was a warm and caring community, then they felt they could live and grow in that hospital. Items (38, 42, 43, 44) addressed the issues on teamwork and unity of staff with a high Cronbach's alpha .7230 (see Table 4.8).

4.3.3.5 *Caring in the staffing process; recruitment methods, the process of selection of staff, hiring methods, the level and contents of induction training, socializing and team concept within the nursing unit (Items 49-66) in Table 4.9.*

Items 49 to 66 explored the caring concepts in the staffing processes such as recruitment, interviewing, selection of staff, induction and orientation of nurses in the hospitals.

- *The presence of caring during the selection and interviewing process in nursing. (Items 51 and 52 Table 4.9)*

Nurses agreed 59% on the aspects that *the dignity of staff during the selection interviews are respected* (Item 51) and 67% agreed that *interviews are conducted in a friendly and kind manner* (Item 52) (Item 51, 52, Table 4.9).

- *Keeping of promises and the level of loyalty and trust between nurses in the hospitals. (Items 53, 54, 64 and 66, Table 4.9)*

A positive fact was that 78% of nurses indicated that it was totally true that their *anxiety was reduced during the first few days after appointment* (Item 53) at the hospitals. Seventy-five (75%) nurses said that *induction training and job orientation were done soon after appointments* (Item 54). On the aspect of

nurse managers keep their promises (Item 64) the nurses were again divided in their answers. Thirty-one (31%) said it was totally untrue that nurse managers kept their promises, 44% of nurses were uncertain and only 25% of nurses said it was totally true that nurse managers kept their promises. Chart 4.6 indicated that the nurses said that it is totally untrue that nurse managers in Hospital 1 and 2 kept their promises, but in Hospital 3 the nurses were either uncertain or said that it was true that nurse managers kept their promises. Fifty-four (54%) of respondents indicated that *they experienced a climate of loyalty in the hospitals* (Item 66) (Items 53, 54, 64 and 66, Table 4.9).

CHART 4.6 THE NUMBER OF RESPONDENTS IN THE DIFFERENT HOSPITALS INDICATING THAT NURSE MANAGERS KEEP THEIR PROMISES IN THE HOSPITALS IN COUNTS (n =188)

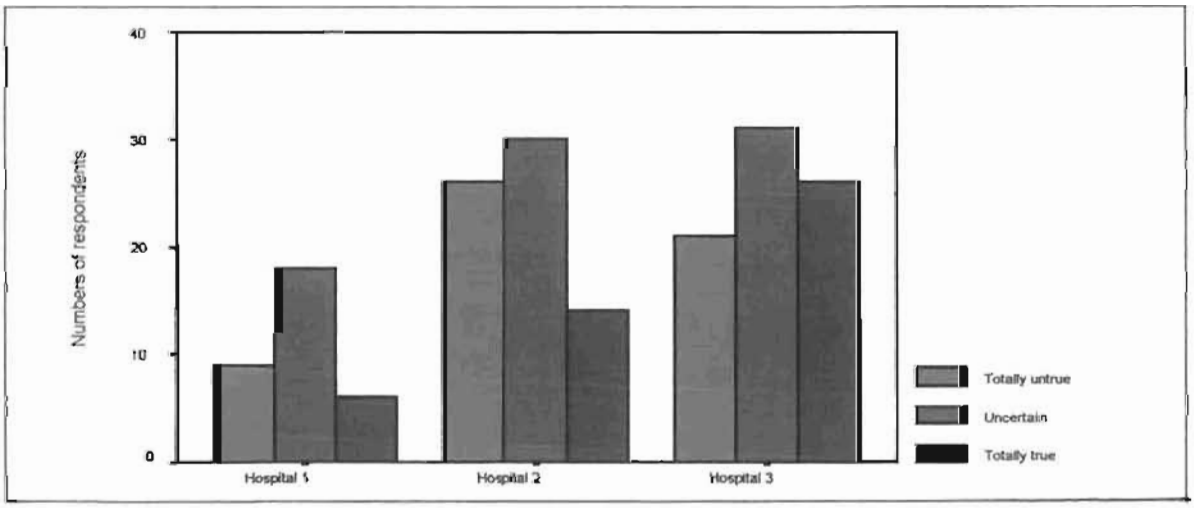


TABLE 4. 9 CARING IN THE STAFFING PROCESS OF HUMAN RESOURCE MANAGEMENT IN NURSING (n = 188)

Item	Percentage of responses on 1-5 scale: Totally untrue/ not true 1	Uncertain 2	True/totally true 3	Total Percentage %
49. Recruitment of staff is done in a fair and non-discriminatory manner.	26.1	36.4	37.5	100.0
50. Staff is selected according to a scientific approach.	14.4	45.6	40.0	100.0
51. The dignity of staff during the interview and the selection process is respected at all times.	6.6	35.0	58.5	100.0*
52. Selection interviews are conducted in a friendly and kind manner.	5.4	27.2	67.4	100.0
53. During the first few days at this hospital, the other staff members try to reduce your anxiety as a new staff member.	12.6	9.3	78.1	100.0
54. Induction training and job orientation was done soon after your appointment at your hospital.	20.4	5.0	74.6	100.0
55. During induction the beliefs, values, norms, and symbols of the organisation were explained to you	22.0	14.3	63.7	100.0
56. During induction training, the general communication channels were explained	16.6	8.3	75.1	100.0
57. Employee health policy was explained during orientation.	23.2	20.4	56.4	100.0
58. Training and self-development strategies are in place at the hospital.	18.9	23.9	57.2	100.0
59. Attention is given to the individual needs and concerns of new staff members.	17.1	35.9	47.0	100.0
60. An understanding relationship between nursing management and the newly appointed nurse is established during induction.	10.9	32.2	56.8	100.0*
61. You felt confident about doing the job after the orientation period.	12.7	16.6	70.7	100.0
62. The nurse manager/s are present in the clinical areas in a reassuring manner.	25.3	31.3	43.4	100.0
63. New nursing staff are introduced to the social activities of your hospital.	22.3	28.5	49.2	100.0
64. The nurse manager keeps promises.	30.9	43.6	25.4	100.0*
65. Equal opportunities exist for each nurse to reach her/his potential and to develop further.	34.8	34.8	30.4	100.0
66. You are experiencing a climate of loyalty towards nurses in general in your hospital.	20.2	24.8	53.6	100.0*

* Indicates percentages that do not add up to 100%

- *Recruitment of nurses. (Items 49 and 50 Table 4.9)*

Thirty-eight (38%) of nurses were uncertain whether *recruitment was done in a non-discriminatory manner* (Item 49) and 36% indicated that they were uncertain of the facts. Nurses did not *know if the staff selection is done by using a scientific approach* (Item 50) or not and 46% of the nurses indicated uncertainty on this question (Items 49, 50, Table 4.9).

- *Induction training and orientation of newly appointed nurses. (Items 55, 56, 57* and 58 Table 4.9)

Most of the nurses, 64% said that it was totally true that *the beliefs, values, symbols and norms were explained to them* (Item 55) with 75% of nurses indicating that the *communication channels were explained to them* (Item 56) and 56% said that the *health policy were explained during induction training.(*Item 57*)* Fifty-seven (57%) of nurses indicated that it was totally true that *training and self development strategies were in place (*Item 58*)* (Items 55,56,57,and 58, Table 4.9).

- *Orientation and support from nurse managers (Items* 61 and 62, Table 4.9)

Seventy-one (71%) of nurses *felt confident in doing the job after the orientation period,* (Item 61) but nurses did not *experience the presence of nurse managers in a reassuring manner (*Item 62*)* to a great extent in the clinical areas of the

hospitals. Forty-three (43%) of the nurses said that it was totally true that nurse managers were present in a reassuring manner, 31% of nurse were uncertain and 25% said it was totally untrue that nurse managers were present in the clinical areas in a reassuring manner (Items 61, 62, Table 4.9).

- *The individual needs, socialisation of nurses and equality. (Items 59, 63 and 65 Table 4.9)*

Forty-seven (47%) of the nurses indicated that *attention is given to the individual needs and concerns of new staff members*, (Item 59) 36% of nurses were uncertain if that was the case. Nearly half, 49%, of the nurses indicated that *the new staff members are introduced to social activities in the hospitals* (Item 63) but only 30% of nurses said it was totally true *that equal opportunities exist for each nurse* (Item 65) (Items 59, 63 and 65, Table 4.9).

- *The level of understanding (Item 60, Table 4.9)*

It was positive to see that 57% of nurses indicated that it was totally true *that an understanding relationship between nursing management and nurses was established during induction training period* (Item 60, Table 4.9). The high Cronbach's alpha .7621 for items 51, 52 in Table 3.3 page 84, indicated that selection interviews that were done with dignity included friendliness and kindness (see Table 4.9).

4.3.3.6 *Caring in the utilising and maintaining of human resources (Items 67-87) in Table 4.10.*

This section included aspects such as performance management; leadership styles of managers and level of guidance to nursing staff; in-service training; development of career paths for nurses; employee well-being including work and human behaviour; the individual needs of staff and the improvement and development of nurses; communication methods and channels; as well as decision-making used by nursing managers (Items 67-87).

- *Human rights and humanity. (Items 69, 70, 81, 83, 84, 85 and 86,Table 4.10)*

Forty-two (42%) of the nurses reported there was no *performance appraisal system in hospital in place for nurses*, (item 69). Thirty-two (32%) of the nurses said there was a performance appraisal system for nurses and 26% were uncertain. Forty-five (45%) of nurses did not believe that *their growth and development is the main goal of performance appraisals in hospitals* (Item 70). Thirty-one (31%) of nurses were unsure of this fact. This negative response could be caused by the restructuring of the performance management process in the hospitals.

TABLE 4.10 CARING IN THE UTILIZING AND MAINTAINING OF HUMAN RESOURCE MANAGEMENT IN NURSING (n = 188)

Item	Percentages of responses: NO 0	Uncertain 2	YES 1-	Total Percentage %
67. The culture in your hospital is one of caring in which people are inspired to work.	19.7	34.3	45.5	100.0*
68. A nurse colleague reference group is available and supports a caring environment for nurses.	41.7	29.1	29.1	100.0*
69. A performance appraisal system for nurses is in place in your hospital.	41.8	26.0	32.2	100.0
70. Your development and growth is the main goal of performance development in your hospital.	45.2	31.1	23.7	100.0
Item	**Totally untrue/not true 1**	**Uncertain 2**	**True/totally true 3**	**Total Percentage %**
71. Coaching and teaching in your job are a continuous process in your health service.	8.3	8.3	83.4	100.0
72. Specific goals and objectives for your job are set by yourself in participation with your supervisor.	16.8	20.1	63.1	100.0
73. You and your supervisor have regular meetings to discuss ways and means to improve your job performance.	23.1	18.7	58.2	100.0
74. You feel that your work-related needs are respected by the nurse manager.	18.8	35.9	45.3	100.0
75. Your talents, potential and abilities are appreciated by your superiors.	24.9	29.3	45.9	100.0
76. The nurse manager encourages you towards self-growth in your career.	30.3	22.5	47.2	100.0
77. Your superiors are supplying you with feedback on your performance.	36.9	19.6	43.6	100.0*
78. Your hopes and dreams for the future are identified and opportunities are in place to meet them.	35.0	38.3	26.7	100.0
79. In your job you are assisted by your supervisor with your career planning decisions.	41.4	18.2	40.3	100.0*
80. The leadership style of nurse managers in your hospital is characterised by participative leadership principles.	28.1	36.5	35.4	100.0
81. The human rights of nurses are protected in your hospital's Labour Relations policy.	25.1	32.4	42.5	100.0
82. You are allowed to see the whole task (case assignment) rather than bits and pieces (as experienced in functional nursing) in your tasks.	25.7	48.0	26.3	100.0
83. You are acquainted with the grievance procedure of your hospital.	19.2	22.5	58.2	100.0*
84. The nurse manager takes notice of your grievances.	32.2	31.1	36.6	100.0*
85. You are acquainted with the disciplinary code of your hospital.	11.5	20.8	67.8	100.0*
86. Discipline is executed fairly and humanely.	32.1	40.2	27.7	100.0
87. Your health, safety and welfare at work are ensured by the hospital.	29.5	26.2	44.3	100.0

* Indicates percentages that do not add up to 100%

It was important to notice the fact according to Gold (1999) (cited in Bratton and Gold, 1999) that appraisal as we know it, is outdated and a new approach should be adapted by managers. Performance control approach is more feasible where the work is defined, measurable targets are set, and the performance is assessed against targets. The incomplete implementation of this approach as yet in the hospitals could be the reason for the uncertainty and absence of performance appraisals in the hospitals at present.

Nurses were divided in their answers to the item on whether *human rights of nurses are being protected in their hospital's Labour Relations policy* (Item 81). Forty-three (43%) of the nurses indicated that it was totally true, 32% were uncertain and 25% indicated that it was totally untrue that human rights were protected in the policy. Fifty-eight (58%) of *nurses are acquainted with the grievance procedure* (Item 83) and 68% of nurses are *acquainted with the disciplinary code of their hospital.* (Item 85). On the aspect of *whether the execution of discipline is fair and human,* (Item 86) nurses were divided in their answers. Thirty-two (32%) indicated it was totally untrue that discipline was executed fairly and humanely, 40% were uncertain and 28% said it was totally true. Chart 4.7 indicated that in Hospital 2 the nurses indicated that discipline was not executed in a fair and humane manner. Nurses were very unsure of whether *nurse managers took notice of their grievances in the hospitals* (Item 84). Chart 4.8 makes it clear that the uncertainty was shown mainly in Hospital 2, regarding

the fact that the nurse manager took note of grievances (Items 69, 70, 83, 84, 85 and 86, Table 4.10).

CHART 4.7 THE NUMBER OF RESPONDENTS IN THE DIFFERENT HOSPITALS REGARDING THE FAIR AND HUMANE EXECUTION OF DISCIPLINE IN COUNTS (n =188)

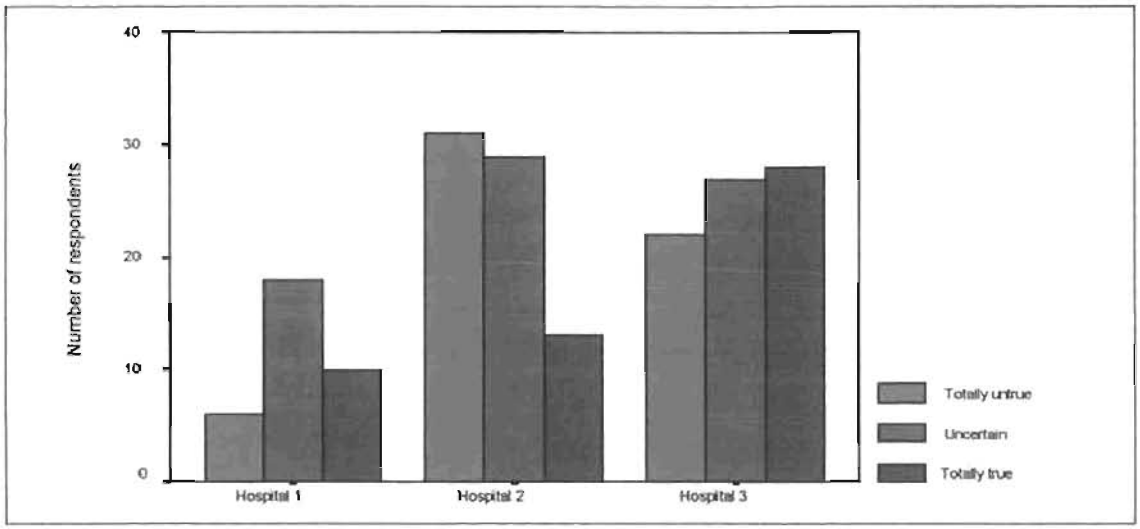
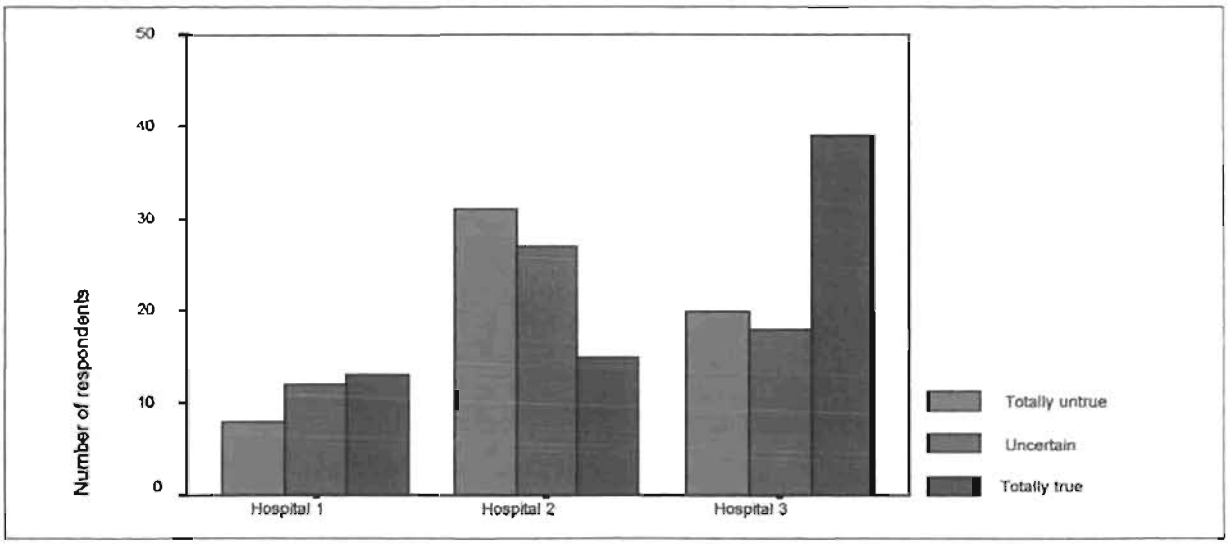


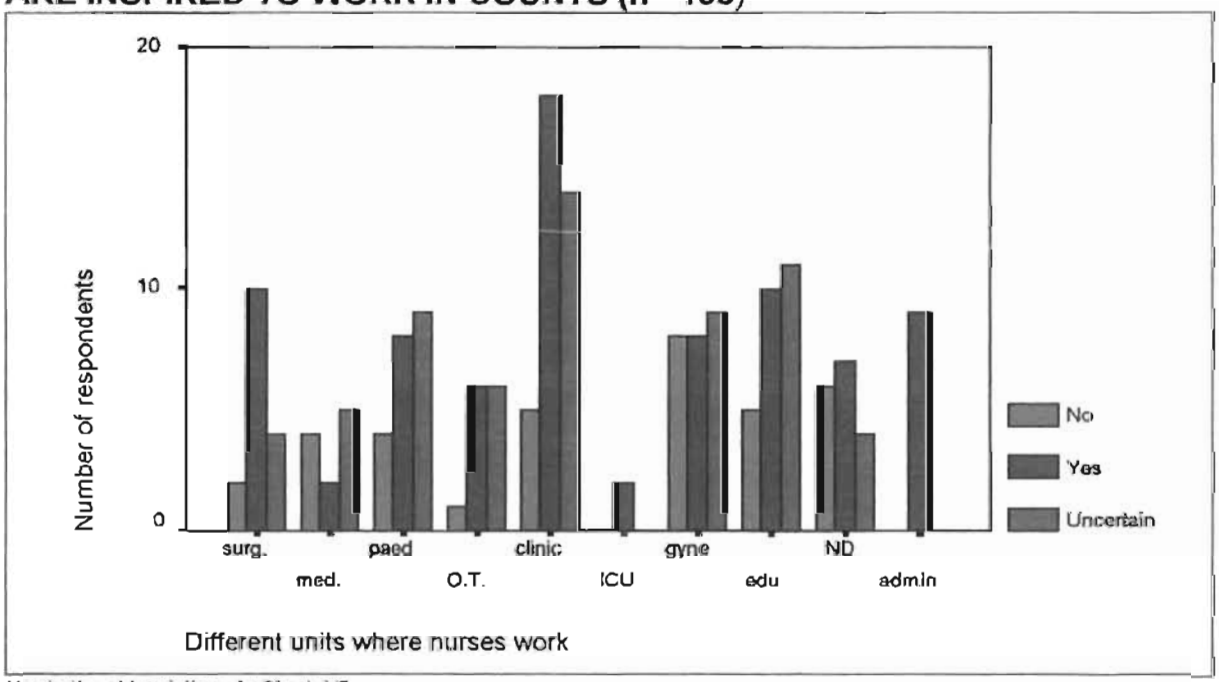
CHART 4.8 THE NUMBER OF RESPONDENTS IN THE DIFFERENT HOSPITALS REGARDING THE NURSE MANAGER TAKING NOTE OF THE GRIEVANCES OF NURSES IN COUNTS (n =188)



- *The growth and development of nurses in the hospitals (Items 67, 68, 71, 73, 74, 76, 77, Table 4.10)*

Forty six (46%) of nurses indicated that *the culture in their hospitals is one of caring in which people are inspired to work* (Item 67). Thirty-four (34%) of nurses were uncertain if that was indeed the case. In Chart 4.9 (Item 67) it was remarkable that nurses in the intensive care units (ICU) and the nurses in administrative positions indicated unanimously that their hospital's cultures were caring and inspiring people to work.

CHART 4.9 THE NUMBER OF RESPONDENTS IN THE DIFFERENT NURSING UNITS REGARDING THE CARING CULTURE WHERE PEOPLE ARE INSPIRED TO WORK IN COUNTS (n =188)



Key to the abbreviations in Chart 4.5

Surg. = Surgical unit
Med. = Medical unit
Paed. = Paediatric unit
O.T. = Operation Theatre
Clinic = Clinics and Casualty
ICU = Intensive care units
Gyne = Gynaecology and obstetrics
Edu = Education department and nursing Colleges
ND = Night Duty
Manage = Nurses in administrative positions

The results on item 71 in Table 4.10, could help to explain the lack of performance appraisal systems, as 83% nurses indicated *that coaching and teaching in their jobs is a continuous process in the hospitals* and this is in line with the latest thoughts on performance management. Nurses were divided in their answers to whether a *colleague reference group was present to support a caring environment for nurses* (Item 68) with 42% indicating that such a reference group was not present. Forty-seven (47%) of nurses said that it was totally true that *nurse managers encourage nurses towards self-growth in their careers* (Item 76).

The Chi-square (χ^2) of .003 between item 71, *coaching and teaching in your job are a continuous process in the health service* and item 40, *your hospital is a place where nurses can work, live and grow,* was significant and an indication that if teaching and coaching were not continuous processes in health services, then nurses did not experience the hospital as a place where they could live and grow.

Most nurses felt that their *work related needs are being respected by the nurse managers* (Item 74) with 45% of nurses reporting this was totally true (Item 74). Forty-four (44%) of respondents said that they were *supplied with feedback on their performance* (Item 77) whereas 37% said this was totally untrue. Most of the

nurses (58%) said that *they have discussions with their supervisors on improving job performance* (Item 73) (Items 67,68, 71, 73, 74, 76, 77 and 78, Table 4.10). Items (71 and 77) with Cronbach's alpha .4370 indicated that feedback on job performance and coaching and teaching in the job are related issues in nursing management (see Table 4.10).

- *Career development of nurses (Items 72, 78, 79 and 82, Table 4.10)*

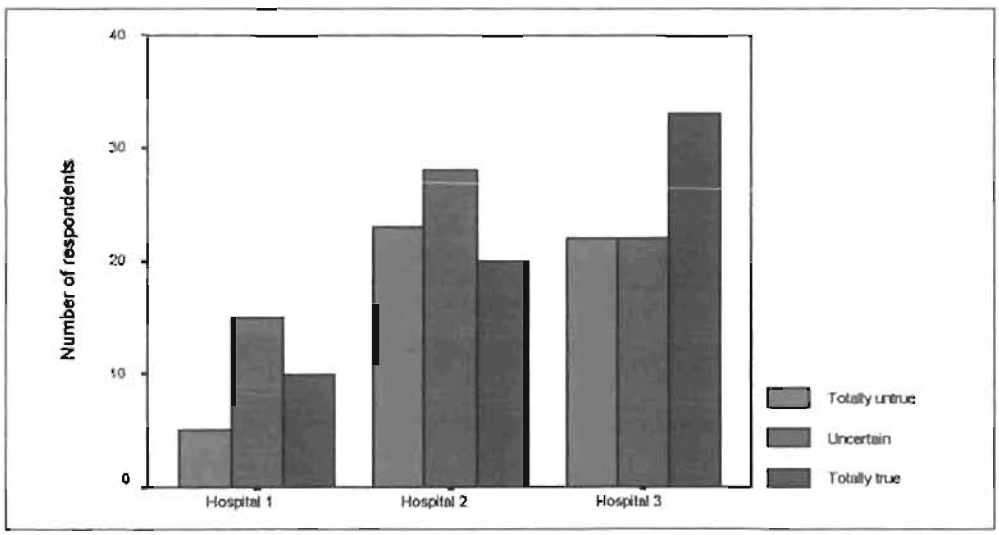
Specific goals and objectives for the jobs of nurses were set in participation with the supervisor (Item 72) according to 63% of the nurses. Forty-one (41%) of nurses said it was totally untrue that supervisors *assisted them with career planning decisions* (Item 79) and 48% of nurses were unsure of *whether they were allowed to see the whole task rather than bits and pieces as in functional nursing* (item 82) (Items 72, 79, 82, Table 4.10).

Nurses did not indicate that *their hopes and dreams for the future were identified and opportunities to meet them were in place* (Item 78). Only 27% of nurses said that this item was totally true and 38% were uncertain, with 35% of nurses indicating that it was totally untrue (Item 78, Table 4.10). It was a significant Chi-square (χ^2) of .003 that the *age of the respondents and their hopes and dreams* were related. The older the respondents, the higher the number was of nurses who reported that their hopes and dreams for the future were identified and opportunities were in place to meet them (age and item 78).

- *Participative leadership in the hospitals (Item 80, Table 4.10)*

The nurses in Hospitals 1 and 2 were not certain whether *the leadership styles of the nurse managers are characterised by participative leadership* (Item 80) (Chart 4.10). Most nurses in Hospital 3 indicated that it was totally true that the leadership styles of the nurse managers were characterised by participative leadership (Table 4.10)

CHART 4.10 THE NUMBER OF RESPONDENTS IN THE DIFFERENT HOSPITALS REGARDING LEADERSHIP STYLES OF THE NURSE MANAGER REGARDING PARTICIPATIVE LEADERSHIP IN COUNTS (*n* =188)



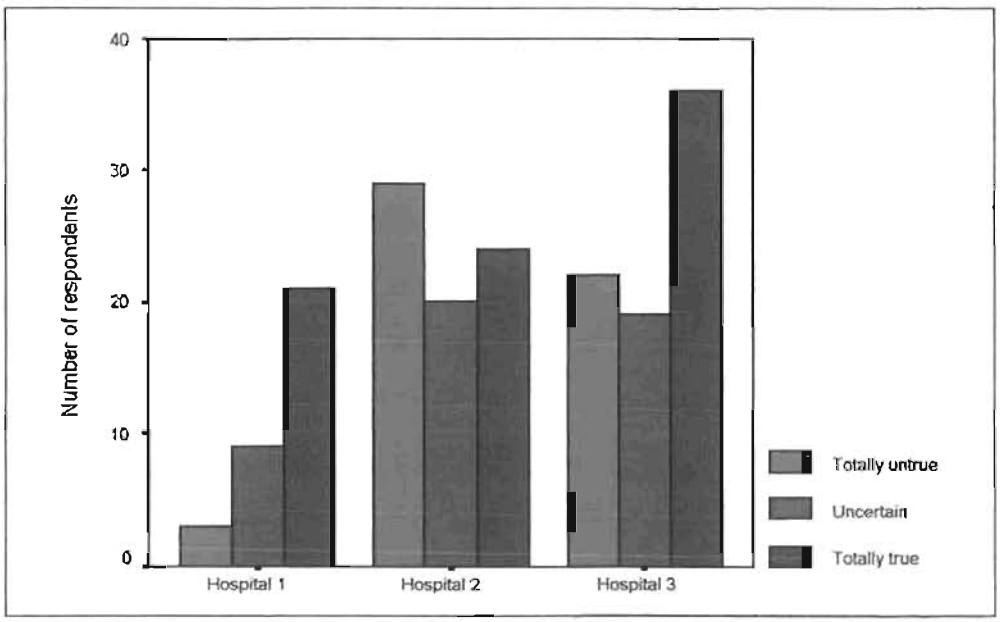
- *The safety and welfare of the nurses in the hospitals (Item 87, Table 4.10)*

Forty-four (44%) of the respondents said that it was totally true that *their health, safety and welfare at work were ensured by the hospital*, (Item 87) while 30% of

nurses indicated that it was totally untrue (Items 87, Table 4.10). According to Chart 4.11 the nurses in Hospital 1 and 3 indicated that their health, safety and welfare at work were ensured but the nurses in Hospital 2 indicated that it was totally untrue that their health, safety and welfare were being taken care of at work. Further investigations should be done to identify the needs of nurse in this regard (Item 87, Table 4.10) .

The significant relationship, Chi-square (χ^2) of .004 between item 5, *love for others is visible in your hospital,* and item 87, *your health, safety and welfare at work were ensured by the hospital,* was an indication that in hospitals in which nurses experienced love they felt secured in their safety as well.

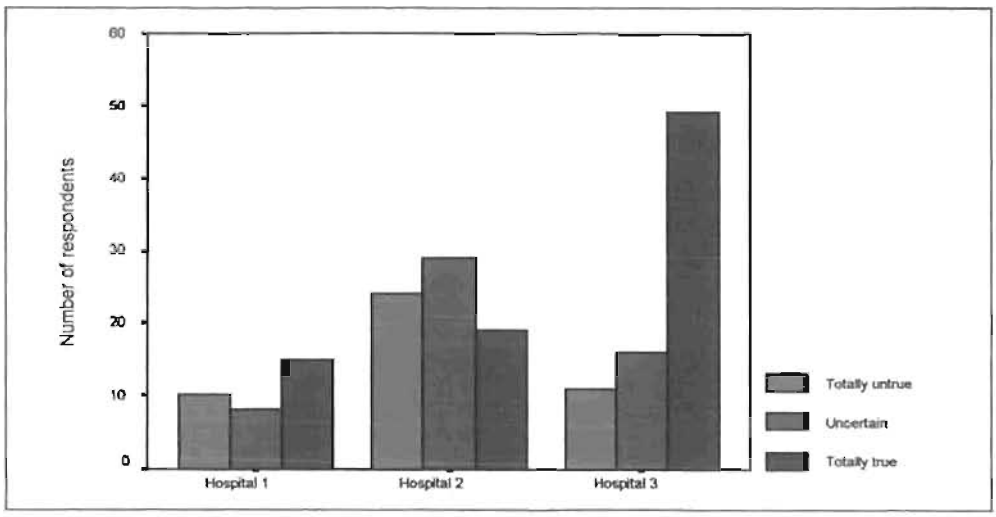
CHART 4.11 THE NUMBER OF RESPONDENTS IN THE DIFFERENT HOSPITALS REGARDING THEIR HEALTH AND SAFETY IN COUNTS (n =188)



- *Appreciation for the talents, potential and abilities of nurses (Item 75, Table 4.10)*

Forty-six (46%) of the nurses indicated that it was totally true that *their talents, potential and abilities were appreciated by their supervisors* (Item 75). Twenty five (25%) of nurses said that it was totally untrue and 29% were uncertain. Chart 4.12 shows that in Hospital 2 the nurses indicated that it was totally untrue that their talents, potential and abilities were being appreciated by their supervisors. The nurses in Hospital 1 and 3 indicated that it was totally true (Item 75, Table 4.10). The Chi-square (χ^2) .003 was significant for the hospitals and item 75 and the relationship indicated that in certain hospitals the nurses felt that their talents and potential were appreciated by nurse managers.

CHART 4.12 THE NUMBER OF RESPONDENTS IN THE DIFFERENT HOSPITALS REGARDING THE APPRECIATION BY SUPERVISORS OF THE TALENTS, POTENTIALS AND ABILITIES OF NURSES IN COUNTS (n =188)



4.4 THE PRESENCE AND/OR ABSENCE OF CARING CONCEPTS IN THE STRUCTURE STANDARDS OF HUMAN RESOURCE MANAGEMENT PROCESS OF NURSES (phase 3, objective 5)

The documents under investigation were collected from each hospital and studied for the presence of caring concepts. The hospitals seemed to be very much aware of the mission statements as it was displayed in the hospitals and the nurse managers were able to produce copies immediately.

4.4.1 Mission statements

The mission statements were well presented and most of the caring concepts of Watson (1985) could be found in them. Factor 5 of Watson's (1985) theory, *The freedom for expression of positive and negative feelings* could not be found in the mission statements of the hospitals. One of the hospitals addressed the fact of assistance with the gratification of needs of the community. The fact that the needs concept did not figure strongly in the Mission statements of the hospitals could add to the problem identified by nurses that their needs were not addressed by nurse managers, as identified in Items 27 and 37 (Table 4.9) of the questionnaire.

Two of the hospitals addressed Christian values in their mission statements and an example is as follows:

Our mission is dedicated and compassionate service in imitation of Christ, who provided healing for all.

Another mission statement was:

..to share the love of Jesus Christ ...

4.4.2 Philosophy of the services and the goals and objectives

The philosophies of the hospitals were in the form of goals and objectives and core values. Again it was the experience that nurse managers knew their philosophies and referred to them during phase one of this study. It was common that nurse managers used the philosophies as a guide in their actions and referred to them quite often during the interviews. Factor 2, *The installation of faith and hope* and 5, *The freedom for expression of positive and negative feelings* of Watson's (1985) caring theory were not addressed in the philosophies of the hospitals.

Christian and caring values such as *commitment, dignity, development of people, fairness and the spirit of Jesus Christ* were emphasized in the philosophies of the hospitals. *Protection of human rights, participation and community partnership, development and learning, professional excellence, scientific nursing process,*

safe environments, patient well-being, respect for life, and in one of the philosophies *financial discipline* and *development of equitable protocols for education and care of people who are HIV positive and or living with AIDS* were identified objectives, in the philosophies of the hospitals.

One of the hospitals provided goals and objectives of the nursing sector together with the goals and objectives of the organisation. Caring concepts that were identified in this document were amongst others, *improved communication, establishing and maintaining spiritual care for all, counselling services and participative management, financial control and effective utilisation of staff according to their skills and knowledge, and level of training and quality improvement strategies.*

4.4.3 Job descriptions and Performance management tools, for example, career development sessions with staff, individual goal setting together with the staff and goal achievement measurement.

Job descriptions of professional and enrolled nurses were studied for caring concepts of Watson's (1985) theory. Factors 1 and 3 were not present in the job descriptions of nurses in two hospitals, but were in the other hospital's job descriptions. The caring concepts were mainly focused on the care of patients by the nurse. Factor 2, *The installation of faith and hope* and Factor 10, *The*

allowance for existential-phenomenological forces were not present in any of the job descriptions. An example of factor 1 in the job descriptions was as follows: *Personal competencies: flexibility, compassion, firmness and caring.* Factor 3 was expressed as *ensuring ongoing self- development and updating.*

The performance management documents were not available and it seemed that the services were working on it. One hospital presented a performance appraisal document that seemed to be under construction and was very vague.

4.4.4 Induction and in-service training programmes

The in-service education departments for nurses of the hospitals were well established and co-operated well in trying to identify caring concepts. All identified the need and willingness to work with the researcher towards further improvements regarding caring. The hospitals provided in-service training to nurses on a needs basis. Most of the topics were identified by the nurses in the wards on meetings or informally during visits to the wards. Training needs were identified by using complaints of patients and by identification of medical legal risks and safety needs, for example, infection control measures in the hospitals. PHC (Primary Health Care) courses were identified as a need in the hospitals. The educators believed that caring concepts should be emphasized in their education of nurses.

4.4.5 Grievance and disciplinary procedures

The grievance and disciplinary procedures were present and clearly described. It was not clear from the documents whether discipline was executed in a caring way. According to the results gathered from phase two, nurses indicated that discipline was not executed in a fair and humane way (Item 86, Table 4.10). This should be investigated further.

The grievance documents were available and were clearly described, and it was clear from the documents that it was the intention of management that nurses should be treated in a humane way when grievances needed to be reported. During phase 2, nurses said that nurse managers did not take notice of the grievances of nurses (Item 84, Table 4.10).

4.5 CONCLUSION

Although the caring concepts were reflected in documents and nurse managers saw themselves as caring, nurses did not always experience high levels of caring in the nursing management environment. The factors that were identified by nurses that made them unhappy in their jobs could contribute to the level of *"un-caring"* in the hospitals. The effects of staff shortages and the effect of HIV/AIDS on the hospitals and nurses should be taken into account when the findings are being studied.

Recommendations, conclusions and limitations of the study in caring human resource management for nurses for the future are discussed in Chapter 5.

CHAPTER 5

DISCUSSION, CONCLUSIONS, RECOMMENDATIONS AND LIMITATION OF THE STUDY ON THE PRESENCE AND ENACTMENT OF CARING IN THE HUMAN RESOURCE MANAGEMENT PROCESS OF NURSES

5.1 INTRODUCTION

The aim of the study was to explore the practice of caring in human resource management of nurses. Both the qualitative and quantitative research approaches were used to ensure the inclusion of the richness of the complexities of caring in the study. During the qualitative phase the phenomenological approach was used to *study and to paint a picture* of the lived experiences regarding the meaning and expectations of nurse managers and nurses in the hospitals (Morse, 1989). This interpretative part of the study aimed to understand, or to try to understand, the complexity of the phenomenon of caring in human resource management though the meanings that nurse managers and nurses assigned to this concept (Oiler, 1986).

The quantitative phase of the study comprised a survey method and it was utilised to explore the presence and experiences of nurses in the human resource management in the hospitals. The quantitative phase of the study on its

own, where measurement, prediction and causal inference were made, would not be fit to measure the values, feelings, perceptions and lived experiences of caring that were attempted to be measured in this study. Therefore a combination of qualitative and qualitative methods were utilised for the study for the enabling of more comprehensive and reliable findings. This chapter discusses the findings, the conclusions and recommendations for each phase of the study, with an indication of the limitations of the study at the end of the chapter.

5.2 DISCUSSION ON THE MEANING OF CARING PRACTICES AND THE EXPECTATIONS OF NURSE MANAGERS AND PROFESSIONAL NURSES REGARDING CARING PRACTICES IN THE HUMAN RESOURCE MANAGEMENT OF NURSES (Phase one, objectives one and two)

The general aspects of the human environment was described with an explanatory comparison of caring in nursing management by a participant, in terms of the maintenance of a sewing machine. The example implied that if you look after the nursing staff and you keep them up to date and supply the nurses with well functioning equipment, they will perform well and give high quality nursing care. This view of the nurse managers was in agreement with the view of Kurtz (1991) and Wang (1991) (cited in Barker, Renolds and Ward, 1995) that for

nurses to be caring with their patients, they must experience and feel cared for by nurse managers.

Concern was expressed by a participant that nurses were taught to nurture and care for patients with their hands but when a nurse became a manager then the nurse must care and be caring in another dimension, without direct and physical contact with the person. Nurse managers should be prepared to make the shift from direct care to a more indirect type of care when they become nurse managers. Nyberg (1993) holds the view that the duties of the nurse manager do not change, but how one goes about those duties differs. The management functions need to be more flexible, and interactive decision-making should be the norm in the health services of today.

Love for the nurses was evident in the interviews and according to Kerfoot (1997, p. 50) ...*love is fundamental to good leadership because leadership is all about caring*. It was emphasised that concern should be shown to nurses and nurses should be seen as holistic human beings with other needs than only work related needs. The needs of staff do not end with the staff member herself but extend to the family of the staff member. Nurses were seen as holistic human beings and the participants referred to caring as the needs of nurses mostly in relation to family demands, illness and sick leave. This fact is described and is emphasised that:

"*people are the greatest asset of a organisation and that caring affirms the uniqueness, importance and potential of every individual*"

(Kerfoot (1997, p. 50).

Caring in terms of interpersonal relations and interaction was described as communication and listening and this was emphasised as very important in human resource management of nurses. Two-way communication seemed to be a problem in nursing in the sense that the message from the top did not always reach the bottom. Nurse managers expressed their concern with the fact that nurses were unable to perceive the message at some stages. Knowledge of nurses as persons was important and openness was described as an open door policy and not as a trusting relationship between nurse manager and nurses. Helping was expressed in terms of helping in times of illness and when nurses experienced death in their families, and not as helping nurses with their patient care and nursing tasks. Watson (1985) said that knowledge of a person is of utmost importance for the caring relationship to develop. Certain attitudes for the process of helping are necessary, for example openness, altruism and a readiness to communicate with nurses. Open communication channels help to facilitate relationships in nursing and effective listening ensures caring in the helping-trusting relationship between nurse manager and nurse.

Happiness was referred to as important because of the fact that nurses spent most of their time in the workplace, and it is noted by Chappell (1993) (cited in Kerfoot, 1997) that people from happy, loving families will do anything for each

other as will people who work for happy, loving companies. This is in contrast with the findings in phase two of the study where 44% of nurses indicated their unhappiness at work, citing some of the reasons for their unhappiness (Item 26, 27, Table 4.7).

Problem-solving received less attention from nurse managers and it was referred to as the solving of social problems of nurses and not problems related to patient care as had been expected. Nurse managers emphasised the fact that a lot of time was allocated to solving problems related to family matters. The question of whether nurse managers were fulfilling their management functions regarding problem-solving of nursing problems immediately came to mind when the results of phase two of the study were examined. Seventy nine (79%) nurses indicated that there were not enough nursing staff members to render quality care in their hospitals (Item 24) and 25% nurses indicated that the shortage of staff was the reason for their unhappiness in their work (Item 27). Problem-solving, however, is described by Watson (1985) in terms of scientific problem solving regarding nursing issues. The importance of problem-solving in the nursing management environment is to teach nurses to solve their problems according to certain guidelines such as assessment and observing, analysis and diagnosis, planning, implementation and evaluation of a problem, patient or phenomenon in nursing.

The focus of caring for nurses in terms of development and growth was well described by nurse managers by providing opportunities to nurses and allowing

nurses to improve their skills and rectify mistakes. A lot of time and effort was spent on in-service education to meet the needs of the health services, and not so much to meet the needs of the nurse herself in her own professional development. Caring in relation to the growth and development of nurses includes the professional needs of the individual nurse as well as the needs of the organisation. Caring, according to Nyberg (1993), means the encouragement of innovation and creativity as part of the growth and development process of nurses. Nyberg (1989) claimed that the person who would care for another must be able to search for the abilities of a person and provide for the development of skills and encourage the other to strive toward self-growth.

Participative management and feedback to nurses were described as caring in the human resource management of nurses. This is explained by the following:

> *...nurses become empowered when leaders use genuine other-regarding caring evidenced through sharing authority and providing access to information, resources and opportunities for advancement.*
>
> Brandt (1994, p. 72)

In contrast with the above, only 35% of nurses during phase two of the research indicated that participative leadership principles were evident in the leadership styles of nurse managers and 37% nurses indicated that it was totally untrue that they received feedback on their performance by their superiors. Nurse managers were aware of the importance of role modelling and leading by example. One

participant explained this function as being example to nurses by sharing a caring attitude and then expecting the same from nurses when they rendered patient care.

Caring in terms of needs fulfilment focused mainly on the welfare, illness and family needs of nurses outside the work place, (the lower level needs of Maslow). The need for enough resources (nurses and equipment) was expressed by nurse managers but it seemed to be an unresolved problem for nurse managers to ensure that nurses have all they need to render quality patient care in the current health services. The lack of fulfilment of the lower level needs of nurses was expressed by nurses in terms of the lack of crèche facilities and subsidies for housing and a car. The need for more social gatherings for nurses was mentioned and the higher level needs such as growth and development of nurses was clearly described as caring for nurses.

Nurse managers saw their caring role for nurses with HIV/AIDS mainly as supportive, being involved in family problems and counselling and guiding nurses living with HIV/AIDS. Nurse managers were involved in planning and organising the funerals of nurses who died from HIV/AIDS. The nurse managers seemed to play a major role in counselling the nurses suffering from HIV/AIDS in the health services. Nurses needed counselling not only because they contracted the disease, but also to help them to cope with the changing demands of the high

number of patients who no longer recover from their illnesses, but die as a result of AIDS.

If the scenario is true that was painted during the Nursing 2000 Conference in Midrand (Geyer, 2000) where the indication was that 20% of the nursing population may be HIV/AIDS positive, with an estimation of 34,000 nurses HIV/AIDS positive in South Africa, then the emphasis that was put on this issue by the nurse managers in this study, should be seriously considered in the training and development of nurse managers currently and for the future.

Non-caring was also described by the nurses. They referred to it as stress, carelessness, de-motivation, dismissal of nurses, the inability of general management to identify the needs of nurses and the expectation that nurses should be selfless in the execution of their patient care duties. Llewelyn (1994) (cited in Webb, 1996) described non-caring as burnout. Nodding (1984) (cited in Webb, 1996) defined caring in terms of the engrossment of the carer in the caring role. When nursing tasks were done in a perfunctory or grudging way, it could not be called care (caring) and burnout of the nurse could be the result. Harrison (1990) was concerned that resource constraints might lead to burnout when nurses were not able to give care in the way they wished and therefore could not receive the emotional rewards that are part of the reciprocity and mutuality of the caring relationship. Non-caring may then replace caring in nursing.

5.2.1 Conclusions for phase one

On the whole the reflections on the meaning of caring in the human resource management of nurses were interesting and surprising. Caring in human resource management of nurses was seen as keeping the nurses in a good physical condition to enable nurses to do the job. Physical well-being of nurses was seen as very important by nurse managers. Love for their work and colleagues were clearly described and the importance of supporting of, and helping the nurses in times of crisis were emphasised by the respondents.

Two-way communication was seen as an important aspect of caring in the human resource management of nurses and nurse managers made it clear that communication with nurses was open at all times. Nurse managers were aware of the fact that communication in the hospitals was a problem at certain stages and that communication could be distorted and blocked at times.

Problem-solving did not receive much attention from nurse managers and problem-solving were aimed at solving the social problems of nurses. Patient care problems and support in solving professional problems in nursing did not receive any attention from the participants.

Nurses were seen as holistic human beings with family commitments and nurse managers tried to fulfil the needs of nurses and accommodating their needs

outside the working place. Attention to and knowledge of the personal and social needs of nurses was seen as very important for caring. Support was given to nurses in times of illnesses and the assurance of the availability of applicable medical care for the nurses. Sick leave was granted and nurses were referred to the correct medical care in case of illness. Support was given to nurses with family commitments and demands, to enable the nurse to function as a caregiver in the health services.

Growth and development with feedback to nurses on their progress, leading by example, granting nurses study leave and various actions to help nurses towards self-actualisation in their professional careers received the attention of nurse managers. The nurses were helped to further their education with consideration of the needs of the hospital.

Dealing with the illnesses of nurses and HIV/AIDS related factors received much of the attention of nurse manager in this study. Nurse managers saw their caring role as support, guidance and counselling of nurses living with HIV/AIDS. Nurses dying from AIDS were cared for and support and inputs in organising the funerals of nurses were provided by nurse managers.

5.3 DISCUSSION ON THE FINDINGS ON THE PRESENCE AND ENACTMENT OF CARING CONCEPTS AND PRACTICES IN THE HUMAN RESOURCE MANAGEMENT PROCESS OF NURSES (Phase two, objectives three and four)

Caring was explored in terms of the human resource management process. It included caring in formulating strategies, structuring the work, workforce planning, staffing process and in the utilising and maintaining of human resources. On the whole, nurses expressed their dissatisfaction with caring in the human resource process in the hospitals. The highest score of sixty three percent (63%) of positive responses for the presence of caring in the structuring of the work, (the job related issues) in the hospitals indicated that caring was not present at a high level in the human resource management of nurses in the hospitals. The fact that the remaining 37% indicated either an uncertainty or that it was totally untrue that caring was present, indicated that caring was not present at satisfactory levels in the human resource management environment, nor was caring experienced at high levels by nurses in the hospitals (Chart 4.1).

5.3.1 Caring in the formulating strategies

This study showed an average of only 55% of positive responses on caring in the formulating strategies, with 45% of either uncertain or negative responses was an indication that caring was not practiced in the working environment in the

hospitals (Chart 4.1). This was in contrast with phase one, in which nurse managers described the meaning of caring in human resource management and phase three, where the mission, philosophy and goals and objectives were studied and in which caring concepts were well established. Reflection can help nurse managers and nurses to pull theory, as described in the mission, philosophy and goals and objectives of the health services and practice together in a way that makes theory relevant to the real world of nursing and human resource management of nurses. Reflection provides access to interpretations of the meaning of caring in practice which could enable nurses to make caring visible in their everyday nursing care practice (Garbett, 1996).

Caring concepts with which nurses expressed dissatisfaction were as follows:

- **Respect for human dignity** (Item 6) where 46% of respondents agreed but 54% of respondents were either uncertain or disagreed that respect for human dignity of nurses was always a consideration. According to Gaut (1983) respect for the other person is of the utmost importance as it determined the attitude towards the other. **Commitment to ensure comfort and wellness of nurses** (Item 7) received 25% of positive responses with 75% of respondents indicating that they were either uncertain or in disagreement with the fact that their comfort and wellness were ensured by the nursing management of the hospital. The low percentage of positive responses was a reason for concern. According to Nyberg (1993), the goal of nurses is related to caring patient care. Nurses

expect a high standard to apply to patient care and if the standard slips, the morale of nurses slips with it. If nurses are not able to nurse the patients for reasons of shortages of human resources and equipment, then nurses who believe in the caring ethic, feel violated and guilty and often seek a better environment in which to practice. **A culturally sensitive approach towards nurses** (Item 8) in the hospitals received only 32% of positive responses. To understand and manage people from their frame of reference, identifying individual needs is important in nursing for the accommodation of all the different cultures. Leininger (cited in Boykin and Schoenhofer, 1990) described caring within nursing as actions which addressed the specific obligation to be competent in transcultural knowledge.

- **Support and caring to nurses** (Item 12) received only 43% of positive responses as did **the addressing of the concerns of nurses** (item 14) which received only 35%, of positive responses. Holden (1991) found after interviews were done at a large hospital in London in a study on the analysis of caring, participants indicated the lack of caring support and reassurance could be particularly painful for nurses who should also deliver care and caring to patients themselves. This indicated that if nurses do not receive caring then it became difficult for nurses to render quality patient care. Only 45% of nurses felt that **their personal values matched those of the hospital** (Item 15). This finding is in contrast with the view of Gruber (1991) who said that when an organisation and its staff

share the same goals and values, the staff know what the organisation stands for, and staff performance and behaviour supports those values. Only 42% of the respondents indicated that they were **involved in reviewing the philosophy of the hospital** (Item 18). To ensure quality patient care there must be provision for a supportive, protective and corrective environment in nursing, according to Watson (1985). In an environment in which the concerns of people are not addressed, nurses will not be able to feel valuable and this will result in a high level of dissatisfaction among nurses (Watson, 1985). The formation of an altruistic value system grounded in human values such as kindness, concern and love is the most basic factor for a science of caring in nursing (Watson, 1985).

- Only 37% of respondents indicated that they **felt valued by the nurse managers** (Item 19), with 36% of positive responses of nurses who described their **experiences with the hospital as enriching** (Item 20). Forty percent (40%) of respondents **experienced two-way communication** (Item 21) which indicated that open communication in the hospitals was at low levels and was also alarming when the view of Blattner (cited in Macdonald 1993, p. 26), on caring is taken into consideration in the human resource management of nurses. Blattner stated that caring is an interactive process by which nurses could help each other to grow, actualise, and transform professionally, towards higher levels of well being. This was in contrast with the findings in phase

one where nurse managers indicated the importance of two-way communication and the importance of meetings with the staff. Only 37 % of respondents indicated that **nurse managers trust the nurses** (Item 22) (Table 4.6). It is not always easy to trust the other person, as described by Mayeroff (1971) because trusting the other involves letting go, it includes an element of risk and the process of leaping into the unknown, and it takes courage from the nurse manager to take the risk. In the situation which is currently the case in the hospitals, where staff shortages and minimum resources are present, it could be the reason for nurses to have feelings of not being valued by their institutions and therefore they would describe their experience in the hospitals as not enriching. Without the support of resources and trust that are basic requirements for caring according to Watson (1985), quality patient care is also not possible and this could contribute to the fact that nurses felt that their experiences in the hospitals were not enriching. Basic altruistic values such as concern for the individual nurse, respect, love, kindness and empathy must be present before the development of trust could occur in the human resource management of nurses.

5.3.2 Caring in the structuring the work

The study showed an average of 63% of positive responses on caring in the structuring of the work and 37% of either uncertain or negative responses. This

was an indication that caring was present to a certain level, in the job related aspects such as job analysis and organisational design in the hospitals, but not at a satisfactory level (Chart 4.1).

Caring concepts with which nurses expressed dissatisfaction were as follows:

- **Enough nursing staff members** (Item 24) received 79% of negative responses which was an indication of a very negative situation currently in the health services. It is clear that reasons for nurses leaving their jobs are not only related to the job and its characteristics, but also due to the work environment of the nurses. General factors according to Booyens (1998) are important to keep nurses in their jobs and these include the perception of the nurse regarding the overall environment of the hospital and role clarity, whether the nurse knows what the supervisor (nurse manager) expects of nurses, frequent feedback on their job performance, the type of interaction that the nurse and the supervisor have, the number of nurses available, the motivation and feelings of other workers about their work, opportunities to learn new things, and independent decision making at all levels.
- Of all the respondents, only 44% felt that **they were happy in their jobs** (Item 26). The reasons for the unhappiness of nurses were, amongst others, shortage of nurses in the hospitals (25% of the nurses), the lower order needs (23% of nurses) and factors such as safety at the work place, salaries, crèche facilities for children of nurses and housing benefits were

named. Only 10% of the nurses indicated that the lack of social activities made them unhappy and 14% described the lack of self-actualisation factors as reasons for their unhappiness. Twenty eight (28%) of respondents did not give a reason for their unhappiness.

According to Bernhardt (1994) these reasons are in agreement with reasons given by nurses internationally for being unhappy or quitting their jobs. Scarcity of nursing leaders who are knowledgeable about governance, low salaries and little reward, low prestige, much responsibility and little recognition, inflexible hours and schedules, excessive overtime, anger of physicians towards nurses and poor physician-nurse relationships, the gap between education and practice, lack of autonomy, too much work, quantity of assignments interferes with quality, frequent reassignments to unfamiliar units with lack of skills, incompetent and unsupportive supervisors, lack of opportunity for advancement, lack of administrative support and communication, were reasons identified by nurses internationally.

Factors that contribute to retention of nurses as identified by Hinshaw (cited by Farley and Nyberg, 1990), seemed to be related to the reasons identified by Boooyens (1998), such as the control of schedules, group cohesion, control over practice, promotional opportunities and clinical ladders, participative decision making and communication, appropriate staff utilisation and support and supportive staff, career counselling and frequent meetings between supervisors

and staff. Lack of individual recognition and respect, inadequate educational opportunities and lack of opportunity to communicate problems to the nurse managers, were identified as factors influencing nursing turnover.

During 1989 and 1990 the South African Nursing Association filed a report on various investigations into the crisis in the nursing profession. The investigation by Pim Goldby Management Consultants (1990) (cited in Muller & Coetzee, 1990) identified five major reasons why nurses had left the public sector. The reasons given were in agreement with the reasons given by nurses in this study for their unhappiness in the hospitals. The reasons given by nurses during the 1990 investigations were: poor remuneration, inflexible work schedules, household duties, excessive workload, inadequate conditions of service, for example maternity leave and crèche facilities. The conclusions for the 1990 investigations were, amongst others, that workload and pressure constitute the single major source of dissatisfaction among members of the nursing profession. The fact that nurses had to perform tasks for which they were not qualified or paid or which fell outside their scope of practice was also a source of dissatisfaction among nurses. Recommendations by Muller & Coetzee (1990, p. 44) were in agreement with the recommendation for this study and were as follows:

1. *That a nursing management model be introduced which makes provision for the involvement of nursing personnel on every level of management in the organisation;*

2. *A managerial value system for health services;*
3. *The application of situational leadership with preference for participative management;*
4. *Communication network;*
5. *Quality control;*
6. *Leadership training and development in nursing.*

Given that these recommendations were published in 1990, it is surprising to see that they have not been implemented and that these problems are still not resolved in nursing.

- **The fair distribution of the workload** (Item 28) was rated positively by only 30% of respondents, and only 32% of respondents felt that **high levels of flexibility were present in the hospital** (Item 34). The issues of sufficient nursing staff, work distribution, flexibility and happiness in the workplace have already been referred to above. For the facilitation of caring in nursing it is important to note that the factor for the unhappiness of nurses should be addressed first, before trying to implement caring concepts. The human environment must provide enough nurses and other resources for example, equipment and supplies (Watson, 1985).

5.3.3 Caring in workforce planning

This study showed an average of 53% of positive responses on caring in the workforce planning process and 47% of either uncertain or negative responses was an indication that caring was not present at satisfactory levels in the job descriptions, specifications and planning for staff in the hospitals (Chart 4.1).

Caring concepts with which nurses expressed dissatisfaction were as follows:

- **The organisational design enables nurses to achieve high levels of production** (Item 36), received only 48% of positive responses and there seemed to be little **accommodation of needs of nurses in the hospitals** with only 31% of positive responses (Item 37). It was disappointing that the hospitals were not caring institutions according to 60% of the respondents who disagreed or were uncertain as to whether the hospitals could be described as **warm and caring communities** (Item 39). The fact that 52% of the respondents did not see the hospital as **a place where nurses can work, live and grow,** or were uncertain about this, also indicated that caring was not present to satisfactory levels in the human resource management of nurses (Item 40). In caring, according to Mayeroff (1971) the experience should be that the person cared for is an extension of oneself and at the same time as separate from oneself and is to be respected in his/her own right.

- The majority of respondents, 66% of nurses did not agree, or were uncertain about the fact, that their **hospitals were places where emotional security existed** (Item 42). According to Kerfoot (1997) successful leaders realise that caring is the basis for community and that the best gift a leader can give is a community of caring. *In warm caring communities our souls can find a home* (Kerfoot 1997, p. 1).
- It was significant that **the maintenance of the health of the nurses is always a priority for nurse managers** (Item 45), received only 29% of positive responses, in contrast with the emphasis that was given to the health and illness issues of nurses during phase one of this study. Nurses were not seen as **individuals in the hospital** (Item 46) according to the 63% of negative and uncertain responses of nurses (Table 4.8), in contrast with phase one as well. According to Watson the cultivation of sensitivity to the recognition of feelings, painful as well as happy ones, is cultivated by firstly looking into oneself and a willingness to explore one's own feelings. People who are not sensitive to their own feelings may be unable to allow others to express and explore their feelings. Nurses who recognise and use their sensitivity promote self-development and are able to encourage the same growth in others.

5.3.4 Caring in the staffing process

The study showed that an average of 55% of positive responses on caring in the staffing process while there were 45% of either uncertain and negative responses. This was an indication that caring was not present at satisfactory levels in the recruitment, selecting, appointment and socialising processes of the hospitals (Chart 4.1).

Caring concepts with which nurses expressed dissatisfaction were as follows:

- Nurses (63%) expressed their dissatisfaction by indicating it was untrue or that they were uncertain about the fact that **recruitment of staff was done in a fair and non-discriminatory manner** (Item 49) in the hospitals. This aspect needs further attention as to the reasons for nurses to perceive the recruitment as not fair. Only 40% of respondents felt that **staff was selected according to a scientific approach** (Item 50).
- Fifty-three (53%) of the respondents felt that their **needs and concerns were not addressed when they were appointed** at the hospitals (Item 59), as discussed above. The majority of respondents (57%) were uncertain and felt that **nurse manager/s were not present in the clinical areas in a reassuring manner** (Item 62), in contrast with the comments of nurse managers who claimed to be in the clinical units most of the time. Watson (cited in Kyle, 1995) claimed that *caring can be practised only interpersonally* and nurse managers can only facilitate caring when they

are present in the clinical units or when the nurse is visiting the nurse manager in the office.

- It was interesting but alarming that only 25% of the respondents agreed that **nurse managers kept their promises**. This implied that nurses could not trust or expect honesty from nurse managers in the human resource environment (Item 64). Honesty, according to Mayeroff (1971), is also present in caring in different ways. The first important requirement for caring is that the carer must be genuine in caring for the other person. It must *"ring true"* (Mayeroff 1971, p.14). There should not be a gap between how you act and what you really feel. There must be openness;
- Only a few nurses (30%) said it was true that **equal opportunities exist for each nurse to reach her/his potential and to develop further** (Item 65) (Table 4.9). Watson (1985) described honesty and openness with others as basic to the helping-trusting relationship. This indicated that nurses felt that there are no equal opportunities for development in the hospitals and the reason should be investigated, before the trusting relationship could be developed in the human resource management of nurses.

5.3.5 Caring in the utilising and maintaining human resources

An average of 44% of positive responses on caring in the utilising and maintaining of human resources and 56% of either uncertain or negative

responses was an indication that caring was not present nor practised in the performance management, leading and guiding, training and labour relations aspects in the hospitals (Chart 4.1). It was interesting to note that nurse managers were aware of caring practices as indicated in phase one, but that caring was not practised in the utilisation and maintenance of nurses in the hospitals.

Caring concepts with which nurses expressed dissatisfaction were as follows:

- Forty six percent (46%) of the respondents indicated the **culture in their hospitals was one of caring in which people are inspired to work** (Item 67) as discussed under the caring community in nursing and in contrast with Nyberg (1990) where nursing management is defined as an arena of work where nurses and nurse managers have the responsibility of providing inspiration, work structures, and support to facilitate the provision of specific professional services. As human beings we all long for an experience at work that we can feel that "**Wow**" experience that inspire humans, according to Tom Peters (1994) (cited in Kerfoot, 1997). Hospitals should be places that provide environments for nurses to be inspired towards growth and develop in their profession. Only 29% of respondents indicated that **a nurse colleague reference group was available and supported a caring environment for nurses** (Item 68). Professional relationships are of the utmost importance in nursing. Curtin (1996) described this relationship as enabling the other to be a

professional person through identification with others and through recognition of the dilemmas of others within oneself. Such relationships between nurses teach nurses *how to be* and this means that each nurse recognises herself in others and sees the characteristics of others in herself. Curtin (1996) goes further and advises that nurses must recognise their duty to nurture, support, guide and correct one another. Cooperation and mutual growth should be the norm in the profession instead of competition and the acquisition of power. In the practice of nursing, it is true that one's own success depends largely on the knowledge and skill of one's colleagues as well as the willingness to share information and insights and to engage in constructive criticism with one's peers. Without strong intra-professional relationships, nurses will be unable to fulfil their commitments to patients and to achieve their professional goals.

- A high percentage of nurses, 68% were uncertain or said that there was no **performance appraisal system for nurses in place in the hospitals.** (Item 69). A very low percentage as expected because of being the construction of the performance management process in the hospitals at present. Only 24% of respondents said that their **development and growth was the main goal of performance development in the hospitals** (Item 70). Forty five (45%) percent of respondents indicated that their **work-related needs were respected by the nurse manager** (Item 74), in contrast with the investigation in phase one, in which nurse managers indicated the importance of the identification of needs of the

nurses. The assistance with the gratification of human needs is important to the nursing role of helping the other person to grow and develop (Watson, 1985). Mayeroff (1971) said to care for someone, you must know many things, for example, who the other person is, what his powers and limitations are, what his needs are, and what is conducive to his growth. Fifty-five (55%) of the respondents, did not feel that their **talents, potential and abilities were appreciated by their superiors** (Item 75). The low percentage could be an indication that nurse managers did not know the work-related needs of nurses. It was also not true that **nurse managers encouraged nurses towards self-growth in their careers,** as was discussed above and only 47% of respondents said that **they were encouraged** by nurse managers (Item 76). Nursing supervisors did not **supply nurses with feedback on their performance** according to the 57% negative response on Item 77. In the light that caring is an interpersonal process, the above results could be expected if nurse managers were not in the clinical units, communicating and interacting with the nurses. The supplying of feedback to nurses is also part of the growth and development process of nurses according to Nyberg (1989). Motivation of others by providing opportunities for their potential to be realised and giving meaningful praise and feedback for the completion of a task, is part of the nurse manager's tasks, to convey faith in the nurse's potential, and it is a strong message of caring. In contrast with these findings, nurse managers indicated during phase one of the study that

they knew that feedback to nurses was an important aspect of caring in human resource management of nurses. The **hopes and dreams for the future were not identified and opportunities were not in place to meet them** according to the 73% negative response on Item 78. Only 40% of the nurses agreed that they were **assisted by their supervisor with career planning decisions** (Item 79). This low response could be the result of the performance management process that was under construction at the time of the research. Sixty five percent (65%) of respondents did not experience **the leadership style of nurse managers in their hospitals as participative leadership** (Item 80), in contrast with phase one, in which the participation of nurses was well described and frequently referred to by nurse managers. According to Watson (1985) it is important to assess the self-actualisation needs of nurses and to supply opportunities for nurses to grow and develop in a caring environment in nursing. Participative management is such an opportunity in which nurses could learn and participate in management and other issues for the purpose, amongst others of empowerment of nurses. Empowerment is not only delegated decision making but also giving every one an opportunity to give inputs into decision making and for the distribution of responsibility through the whole organisation. The enabling of participative management is to provide a climate for nurses to make mistakes (not life threatening to the patients), participative decision making, delegation of power, constructive conflict management, team spirit and problem solving at the

lowest level of service (Jooste, 1998). Only 43% of respondents experienced **the protection of human rights of nurses in their hospital's Labour Relations Policy** (Item 81). Nurses felt that they were not able to see the whole task with a negative response of 74% for item 82. It was significant in the light of the descriptions of caring in phase one that only 37% of respondents said that **the nurse manager took notice of their grievances.** Taking note and handling of grievances together with an understanding of the task of nurses and their responsibilities and personal needs is referred to as caring in the human resource management of nurses (Potgieter & Muller, 1998) (Item 84). A few nurses, (28%) felt that **discipline was executed fairly and humanely** (Item 86).

Only 44% of respondents indicated that their **health, safety and welfare at work were ensured by the hospital** (Item 87). This result is in contrast to the efforts of nurse managers as described during phase one of the study. A fair amount of time and effort were put into the health and wellness of nurses, especially those that were ill or HIV/AIDS positive. The health, welfare and safety of people are basic needs according to Maslow, (cited in Watson, 1985). These basic needs must be satisfied before a person can move towards the higher level needs of self-actualisation. Christensen (1988) described strategies for promoting the welfare of nurses in which nurses could grow towards self actualisation in their jobs, that could be useful in the hospitals. The enhancement of autonomy of

nursing practice by developing a perspective of well being of all concerned. A professional nursing system that adheres to a set of standards for quality, an environment for ethical reasoning that involves thinking about ethical issues and being aware of how one's own values fit into nursing. Policies regarding the staff should include principles of respect for the individual, beneficence and justice for all with the principle of a management style (participative management) that incorporates empowerment of nurses.

5.3.6. Conclusions for phase two

In this research study it was found that caring was not present to satisfactory levels in the human resource management process of nurses. Caring in the formulating strategies showed that nurse managers failed to show respect for human dignity, concerns and the cultural needs of nurses. Although nurse managers said they cared a lot about the wellness of the nurses during phase one of the study, it seemed that nurses do not experience that the nurse managers were caring regarding their comfort and wellness during the every day nursing activities in the hospitals.

The majority of nurses did not receive enough support and caring in the human resource process from their nurse managers and the personal values of nurses did not match those of the hospitals. Most of the nurses did not experience that

they were valued by the nurse managers or that their nursing work in the hospitals was an enriching experience. The absence of two-way communication remained a problem in the hospitals and nurses did not experience that nurse managers trusted them.

It was found that caring was not prevalent in the structuring of the work in the human resource management of nurses. There were not enough nurses in the hospitals to do the nursing tasks and this shortage contributed to the fact that nurses were unhappy in their jobs. The shortage of staff was the main reason for the unhappiness of nurses in their jobs. Other reasons were the lack of safe working conditions at work, low salaries without housing subsidies and the absence of crèche facilities for the children of the staff.

The workload was not distributed equally and fair and the nurses experienced the management styles as rigid, without participative management principles. This response was in contrast with phase one where nurse managers indicated the importance of the happiness of their staff in the hospitals.

Caring in the workforce planning indicated that the individuality of nurses had not been accommodated in the hospitals and the majority of nurses felt that the hospitals were currently not caring and warm communities where nurses could grow and develop professionally. The hospitals seemed to be places where

nurses could not experience emotional security and where their health could not be maintained.

Caring in the staffing process revealed that recruitment and selection of nursing staff were not transparent processes according to the nurses, and not enough attention was given to newly appointed staff members. Nurse managers were not visible enough in the clinical areas in the hospitals according to the nurses. This was in contrast with phase one where nurse managers indicated that they spent most of their time in the wards. Nurse managers did not keep their promises to nurses. No equal opportunities existed for nurses to develop themselves in the nursing profession.

Caring in the utilising and maintaining of human resources received the lowest positive percentage and the highest negative percentage in the study. The conclusion was that nurses did not experience caring in their everyday working environments from nursing management in the hospitals.

The nurses did not experience the hospitals as inspiring places to work in, and the work-related needs of nurses were not respected nor were their talents, potential and abilities appreciated. There was no colleague reference group to support nurses although performance management processes were under construction in all the hospitals included in the research. There were no systems in place to accommodate the hopes and dreams of nurses for the future and

career planning was not done to accommodate these needs of the nurses, nor were nurses able to see their work as a whole and not as bits and pieces as in the functional method of nursing. The majority of respondents indicated that they did not experienced participative management in the hospitals. This was in contrast with phase one where nurse managers described the involvement of nurses in policy-making and decision-making.

Nurses indicated that their human rights were not respected in the human resource management processes of the hospitals and their grievances were not noticed by nurse managers and disciplinary procedures were not executed fairly and humanely in nursing.

A report by Hudson (1991) (cited in Potgieter & Muller, 1998) indicated that the health services in South Africa were in a crisis already at that stage and the Nursing Council expressed their concern about the decline in services. Many nurses resigned because of the tremendous work load, emotional demands and unrealistic salaries. A study done by Kaplan (1996) (cited in Potgieter & Muller, 1998) found that nurses had high job involvement but low job satisfaction. It has been clear for a long time that if nurses are happy it leads to higher job satisfaction, improved physical and psychological health, low staff turnover and a positive attitude. Strong interpersonal relations also seemed to be a job satisfier. From the study of Potgieter & Muller (1998) it is clear that the main factors that contribute to stress and burnout in nursing are organisational factors.

5.4 DISCUSSION ON THE PRESENCE AND/OR ABSENCE OF CARING CONCEPTS IN THE STRUCTURE STANDARDS OF HUMAN RESOURCE MANAGEMENT PROCESS OF NURSES

(Phase three, objective 5)

The mission statements, philosophies and the goals and objectives were present in the hospitals and caring concepts were clearly described in the documents. All the hospitals used job descriptions for the different categories of nurses. The job descriptions focused on patient care with reference to self-development and up dating of knowledge of nurses. The performance management process was under construction and documents were not available during the time of the study. The hospitals have developed in-service education departments and training needs were identified. Lectures, demonstrations and workshops were organised to meet the needs of the services. The grievances and disciplinary procedures were clearly described with guidelines to handle the grievances and disciplinary procedures. The documents showed that it is the intention of nursing management to treat nurses in a humane and fair way.

Shriber and Larson (1991, p. 65) claimed;

...that nurses could no longer be held accountable for ensuring a caring relationship in the absence of educational, organisational and professional structures that create a milieu in which caring is possible.

The policies and procedures should reflect adequate flexibility to meet individual staff needs, for example, salaries, child care arrangements, working hours and individual professional development as well as adequate resources and the allocation thereof.

5.4.1 Conclusions for Phase three

Caring concepts as well as Christian principles were present and clearly described in the mission statements, philosophies and goals and objectives of the hospitals. The job descriptions included some of the caring concepts related to patient care and development of nurses. The well developed in-service education departments of the hospitals concentrated mainly on the needs of the services and patient care aspects. The performance management processes were under construction and the grievances and disciplinary documents were all inclusive and well described.

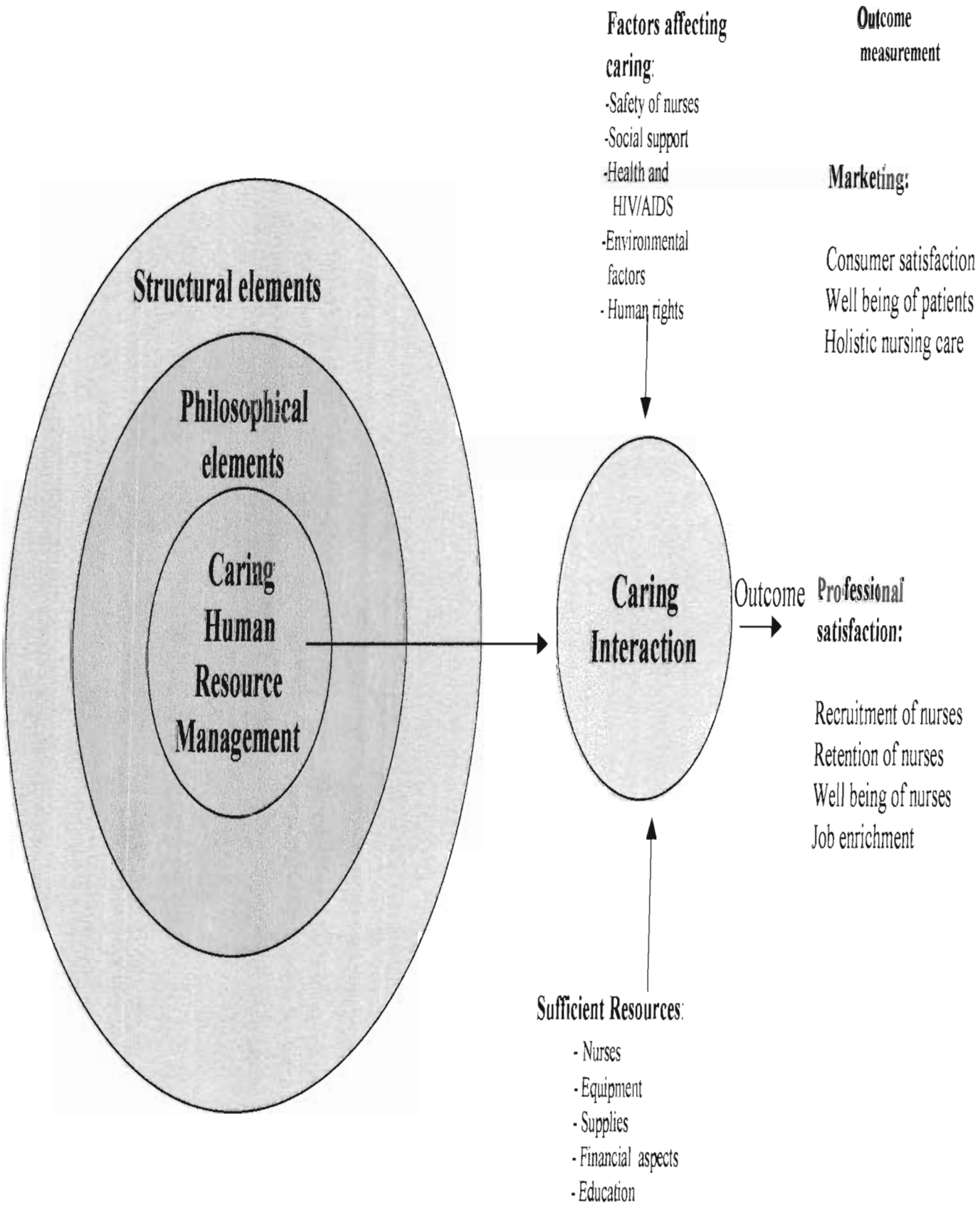
5.5 INTEGRATED MODEL OF CARING IN THE HUMAN RESOURCE MANAGEMENT OF NURSES

The model, adapted from Valentine (1989) (Figure 5.1) shows the core concepts of caring in human resource management of nurses. Caring Human Resource Management involves the caring concepts in the different human resource management process of nurses which could be put into action in the interactional

process between nurse manager and nurses. These core caring concepts influence each and every process of nursing management although the further one moves from the centre, through the processes of philosophical aspects such as the mission, philosophy, goals and objectives, and all the structural processes such as the staffing process in nursing, the leadership styles, safe-, supportive-, corrective-, and protective environment and the well-being of nurses, the less the influence of the caring concepts becomes. Caring, however, is portrayed in the interaction circle in which caring is active between individuals in the human resource management of nurses and includes caring concepts such as communication, feedback and listening, growth and development and teaching, trusting, helping, inspiring and career planning. The nature of caring is affected by other factors, namely the social support in the hospitals, health and HIV/AIDS, environmental factors, and human rights. Resources, for example the number and adequacy of nurses, equipment, supplies, financial aspects and education, influence the caring interaction process between nurse manager and nurses. Nurses and the patients who experience caring interaction with results such as high quality patient care, patient satisfaction and for the nurses, job satisfaction, retention of staff and high productivity levels, have certain implication for marketing and professional satisfaction of nurses.

Figure 5.1 INTEGRATED MODEL OF CARING IN THE HUMAN RESOURCE MANAGEMENT OF NURSES

(Adapted from Valentine, 1989)



5.6 RECOMMENDATIONS FOR THE STUDY

Nurse managers must be made aware that caring in human resource management includes not only illness and HIV/AIDS issues, but many other caring concepts and aspects as well. The caring task of nurse managers is aimed at all the staff, including the wellness of nurses as a whole. Nurse managers and nurses should receive information on the caring theory of Watson (1985) and the practical application of it in the management of nurses. Clearly caregivers can no longer define quality by their standards (structural processes) only. The standards should be the foundation for services and for continuous improvement of caring in the human resources of nurses. Furthermore the following recommendations were made for the study:

5.6.1 Recommendations for caring in human resource management regarding research

- A survey to assess the current situation regarding HIV/AIDS amongst nurses, to enable appropriate planning.
- The effect of HIV/AIDS on the health delivery system should be researched further to establish the needs of nurse managers regarding support, guidance, counselling and care to dying nurses.

- The influence of HIV/AIDS positive nurses on the management of the hospitals should be estimated and additional support systems should be put into place.
- Nurse managers should do a survey in their hospitals to establish the presence and enactment of caring by using the instrument that was developed for this study to identify the specific caring needs for their services, because this study indicated differences in caring between hospitals.

5.6.2 Recommendations for caring in human resource management regarding nursing services

- The ability of nurses living with HIV/AIDS should be established and their capabilities to render nursing care should be investigated to enable nurse managers to supply enough nurses to do the job.
- Sufficient additional support and guidance to nurse managers and nurses should be provided to cope with the demands of HIV/AIDS positive nurses so that nurse managers are clear on the following criteria:

1 Dealing with absenteeism of staff suffering from HIV/AIDS.;

2 Sick leave and the number of days on sick leave without a medical certificate;

3 Transfer of staff to lighter duties due to their inability to do strenuous work;

4 Ill-health of staff due to prevailing minor illness as a result of low resistance to diseases;

5 An understanding of AIDS-related illnesses and their treatment;

6 More days off work to recover from exhausting and minor illness;

7 Time off during the day to lie down and rest before duties could be taken up by the AIDS sufferer.

- Criteria should be established for the following aspects in the hospitals:

1 Determining when nurses are too sick to work;

2 Supporting and educating other nurses and employees who refuse to work with colleagues with HIV/AIDS;

3 HIV testing of nurses and employees in the workplace;

4 Early retirement for nurses suffering from AIDS;

5 The need of the nurses with HIV/AIDS for counselling services and other medical care (Davis, Schneider, Rapholo, and Everatt, 1997).

- A SWOT analysis to identify the strengths, weaknesses, opportunities and threats of each hospital should be done for each hospital as part of a strategic planning process after the above mentioned survey has been done, to plan the implementation and maintenance of caring in the human resource process of nurses effectively;
- The permeation of caring should be assured at all levels and aspects in the hospitals by using the Integrated model of caring for human resource management of nurses (Figure 5.1);

- A workshop for nurse managers and nurses to clarify and to deal ethically with the problems of the lack of caring in human resource management of nurses and unhappiness of nurses as identified in the study;
- The introduction of a nurse advocacy role whose time will be dedicated to nurse well-being only. This appointment might improve the morale, increase the retention of nurses and enhance the atmosphere of optimism amongst nurses in the hospitals in general (Loomer, Jacoby and Schader, 1993).

5.6.3 Recommendations for caring in human resource management regarding nursing education

- The nurse managers should attend workshops and discussion groups on caring in human resource management of nurses. In these workshops, caring in human resource management strategies should be planned strategically. The integrated model for human resource management as adapted from the model of Valentine (1988) could be used for planning and implementation of caring in human resource management of nurses;
- Caring in human resource management should be emphasised in the curriculum of all the nursing courses for registration as a professional nurse. For the course leading to registration for nursing administration the following the guidelines and principles and learning activities as described

by van der Wal (1999, p. 70) should be included in the curriculum and human resource management programmes:

- *Be knowledgeable and skilful in the working environment;*
- *Value the other person as a human being;*
- *Be accountable for one's own actions;*
- *Be open and creative to new ideas, human being are creative beings;*
- *Connect with other persons, and get involved in their lives;*
- *Take pride in oneself. This implies self-awareness, dedication and being at ease with oneself;*
- *Love for the job and find meaning in what one does;*
- *Enjoy the job within the struggle of living;*
- *Recognise your own limitations and do your best;*
- *Rest and start afresh.*

5.7 LIMITATIONS OF THE STUDY

On the whole the interviews reflect the ideal caring environment in the human resource management process in nursing, but in the practical situation caring was not present at satisfactory levels. The nurse managers showed however during the interviews that they knew the meaning of caring, but in the second phase it was clear that nurse managers needed more guidance as how to apply caring concepts in their management functions. A limitation of the study was that the nurse managers and nurses were not interviewed on the problematic issues

that came to the fore during the second phase of the study. A further limitation was that the relationships could not be clarified between caring and uncaring in human resource management of nurses between nurse managers and nurses.

5.8 CONCLUSION

The fact that nurse managers are not solely responsible for the experiences of nurses and the way nurses expressed themselves on the caring issues in human resource management in the study should be emphasised. Organisational factors such as salaries and benefits of nurses, shortage of nurses at national and international levels, organisational structures and other financial constrains in hospitals contribute to the experiences of nurses in this study. Health service administrators, nurse managers and nurses should all take the responsibility to find means to improve and instil caring in hospitals.

Nurse managers need basic traditional management skills together with caring attributes in the human resource management of nurses in health services of today. Furthermore nurse managers need specialized skills, in dealing with the impact of HIV/AIDS on nurses and health services. The organisation-wide caring philosophy could be enhanced by enlisting the nursing staff in the whole process, discussion and reviewing the concepts identified as problematic in this study and relating them to nursing practice and care to the caregivers. The next step should be the formulation of caring standards and behavioural criteria and development

and implementation of an educational and marketing plan. It came to the fore that management skills were needed but these are not enough to survive in the current health services. Therefore the decision to train nurse managers and to upgrade the management knowledge and the implementation of the practice of caring concepts in nursing management with relevant care and support to HIV/AIDS nurses, is of the utmost importance to equip nurse managers to survive in these demanding circumstances.

The first step in the beginning of the caring process, the philosophical structures, such as the mission statements, philosophies and goals and objectives were in place regarding caring concepts in the hospitals. The task is now to ensure that the other processes such as the structural elements which included the staffing process, leadership styles, and a safe-, supportive-, corrective- and protective work environment, nurse well-being as well as caring interaction between nurse manager and nurses, (coloured blue in Figure 5.1) are in place in the hospitals to ensure the practice of caring in the hospitals and quality of work life for nurses with the result of quality patient care.

REFERENCES

Barker,P.J., Reynolds,W. and Ward, T. (1995). The proper focus of nursing: A critique of the caring ideology. International Journal of Nursing studies, 32 (4), 386-797.

Benner, P. & Wrubel, J. (1989). The primacy of caring and coping in health and illness. Menlo Park:Addison-Wesley.

Bernhard, J. A. (1994). Mobilising existing resources. Simms, L.M., Price, S.A., Ervin, N.E. Eds. The professional practice of nursing administration, (pp279-294). New York: Delmar publishers.

Bickham, W. (1996). Liberating the human spirit in the workplace. Professional Publishing: Chicago.

Booyens, S.W. (1998), Turnover. Booyens, S.W. Ed. Dimensions of Nursing Management, (pp369-379). Cape Town: Juta.

Boykin, A. and Schoenhoffer, S. (1990). Caring in nursing: Analysis of extant theory. Nursing Science Quarterly, 3 (4), 149-155.

Brandt, M.A. (1994). Caring leadership: Secret and path to success. Nursing Management, 25 (8), 68-72.

Bratton, J. (1999). The human resource management phenomenon. In Bratton, J. and Gold, J. (Ed.), Human Resource management: Theory and practice. (pp3-35). Houndmills: Macmillan.

Burger, T. (1997). Human resource management: from backroom to boardroom. Human Resource Management Yearbook. 12 (10), 39-41.

Carrel, M.R., Elbert, N.F., Hatfield, R.D., Grobler, P.A., Marx, M. & van der Schyf, S. (1998). Human resource management in South Africa. South Africa: Prentice Hall.

Christensen, P.J. (1988). An ethical framework for nursing service administration. Advances in Nursing Science, 10 (3), 46-55.

Chipman, Y. (1991). Caring: Its meaning and place in the practice of nursing. Journal of Nursing Education, 30 (4), 171-175.

Concise Oxford Dictionary. (1988). J.B. Sykes. Oxford:Oxford University Press.

Covey, S. (1996). Universal mission statement. Human Resource Management. 12 (8), 4-9.

Curtin, L.L. (1996). Collegial ethics of a caring profession. Nursing management, 25 (8), 28-32.

Davis, S. Schneider, M. Rapholo, G. Everatt, D. (1997). Guidelines for developing a workplace policy and programme on HIV/AIDS and STDs. Department of Health: Pretoria.

Erasmus, B.J. (1998). Nursing professional's views on the workplace. Curationis, 21(4), 50-57.

Farley, M.J. & Nyberg, J. (1990). Environment as a major element in nursing administration practice theory development. Nursing & Health Care, 11 (10), 532-535.

Garbett, R. (1996). Second sight. Nursing Times, (92), 42-43.

Gaut, D. A. (1983). Development of a Theoretically Adequate Description of Caring. Western Journal of Nursing Research, 5 (4), 313-324.

Geyer, N. (2000, October). AIDS statistics in perspective. Nursing Update, p 1 (col. 2).

Gilbey, C. (2000). Nurses under fire. Femina, *November* 2000:114-122.

Gold, J. 1999. Recruitment and Selection. In Bratton, J. and Gold, J. (Ed.), Human Resource management Theory and practice. (pp189-208). Houndmills: Macmillan.

Gormley, K.J. (1996). Altruism: a framework for caring and providing care. International Journal Nursing Studies, 33 (6), 581-588.

Grigsby, K.A. and Megel, M.E. (1995). Caring experiences of nurse educators. Journal of Nursing Education, 34 (9), 411-418.

Gruber, E.P. (1991), Building staff commitment: The role of caring values. Caring magazine, 10 (10),12-18.

Halldorsdottir, S. (1991). Five basic modes of being with another. In D.A. Gaut and M.M. Leininger (Ed.), Caring: The compassionate Healer. (pp 37-49). New York: National League for Nursing Press.

Harrison, L.L. (1990). Maintaining the ethic of caring in nursing. Journal of Advanced Nursing, 15, 125-127.

Holden, R.J. (1991), An analysis of caring: attributions, contributions and resolutions. Journal of Advanced Nursing, 16 (8), 893-898.

Hospital and Nursing Year Book of Southern Africa. 1997.

Jooste, K. (1998). Work Motivation, Booyens, S.W. Ed. Dimensions of Nursing Management, (pp 451-478). Cape Town: Juta.

Jooste, K. (1999), Bemagtiging van verpleegkundiges – 'n konseptuele raamwerk. Curationis, 22 (4), 54-62.

Kerfoot, K. (1997). Leadership - The courage to care. Nursing Economics, 15 (1), 50-51.

Kurtz, R.J. (1991). The caring ethic: More than kindness, the core of nursing science. Nursing Forum. 26 (1), 4-8.

Kyle, V.K. (1995). The concept of caring: a review of the literature. Journal of Advanced Nursing, 21, 506-514.

Larson, P.J. (1981). Oncology patients' and professional nurses' perception of important nurse caring behaviours. San Francisco: University of California.

Leininger, M.M. (1984). Southern rural black and white American lifeways with focus on care and health phenomena, In M.M. Leininger (Ed), Care. The essence of nursing and health, (pp133-160). Detroit: Wayne State University Press.

Loomer, A.H. Jacoby, J. Schader, J. A. (1993). The nurse advocate and care for the caregivers. Nursing management, 24 (2), 64-65.

Macdonald, J. (1993). The caring imperative: A must? Australian Journal of Advanced Nursing, 11 (10), 26-30.

Marquis,B.L. Huston, C.J, (1994). Management decision-making for nurses. Philadelphia: Lippincott.

Matthews, A . & Whelan, J. (1993). In charge of the ward. (3rd ed.). London: Blackwell.

Mayeroff, M. (1971). On caring. New York: Harper & Row.

McNally, J.M. (1977). The nurse leader- A caring administrator. Supervisor Nurse. December 1977 47-49.

Miller, K.L. (1995). Keeping the care in nursing care. Journal of Nursing Administration, 25 (11), 29-32.

Minnaar, A. (1994). Die aard van sorg aan verpleegpersoneel - 'n Verpleegbestuursperspektief.– Unpublished MA (Cur) dissertation. Pretoria: Unisa.

Molzahn, A.E. (1997). Creating caring organization cultures in dialysis units. ANNA Journal, 24 (2), 247-253.

Morath, J. & Manthey, M. (1993). An environment for care and service leadership: The nurse administrator's impact. Nursing Administration Quarterly, 17 (2), 75-80.

Morse, J. M. (1989). Qualitative Nursing Research: A Contemporary Dialogue. Rockville: Aspen Publications.

Morse, J.M., Bottroff,J., Neander,W. , Solberg, S. and Johnson, J.L. (1990). Concepts of caring and caring as a concept. Advances in Nursing Science, 13 (1), 1-14.

Morse, J.M., Bottroff, J., Neander, W. and Solberg, S. (1991). Comparative analysis of conceptualizations and theories of caring. Image Journal of Nursing Scholarship, 23 (2), 110-126.

Muller, M.E. Coetzee, L. (1990). Report on the Inquiry into the Nursing Profession 1990. Pretoria: South African Nursing Association.

Nyberg, J. (1989). The element of caring in nursing administration. Nursing Administration Quarterly, 13 (3), 9-16.

Nyberg, J. (1990). The effects of care and economics on nursing practice. Journal of Nursing Administration, 20 (5),13-17.

Nyberg, J. (1990). Theoretical explorations of human care and economics: Foundations of nursing administration. Advanced Nursing Science, 13 (1),74-84.

Nyberg, J. (1993). Teaching caring to the nurse administrator. Journal of Nursing Administration, 23 (1),11-17.

Nzimande, P. (1995). Who cares? South African Nursing Times, January, 18-19.

Oiler, C.J. (1986). Phenomenology: The method. In P. Munhall and C.J. Oiler (Ed.), Nursing research: A Qualitative Perspective (pp 69-84). Norwalk: Appleton-Century-Crofts.

Plunkett, W.R. & Attner, R.F. (1992). Introduction to management. Boston: PWS-Kent publishing company.

Polit, P.F. & Hungler, B.P. (1991). Nursing Research: Principles and Methods. 4th edition. Philadelphia:Lippencott.

Potgieter, S. and Muller, M. (1998). Griewe in Suid-Afrikaanse hospitale: 'n geskiedkundige-verpleegkundige perspektief. Curationis, 21 (4), 14-23.

Radsma, J. (1994). Caring and nursing: a dilemma. Journal of Advanced Nursing, 20, 444-440.

Ray, M.R. (1989). The theory of bureaucratic caring for nursing practice in the organizational culture. Nursing Administration Quarterly, 13 (2), 31-42.

Riemen, D. J. (1986). The essential structure of caring interaction: Doing phenomenology: In P. Munhall and C.J. Oiler (Ed.), Nursing research: A Qualitative Perspective (pp 85-108). Norwalk: Appleton-Century-Crofts.

Roos, J. (1996). Organization in health services. Ed. Booyens, S.W. Introduction to health services management. (pp. 132-154). Cape Town: Juta.

Rodgers. D.L. (1994). Conceptions of caring in a Fourth-grade Classroom. Ed. Prillaman, A. R. and Eaker, D.J. The tapestry of caring: Education as nurturance. (pp 33-47). New Jersey: Ablex.

Salsberry, P.J. (1994). A philosophy of nursing: What is it? What is it not? Ed. Kikuchi, J.F. Simmons, H. Developing a philosophy of nursing. (pp 1-20). London: Sage Publications.

Scott, J. (1996). Benchmarking the human side of management. Human Resource Management, 12 (2), 30-31.

Sherriffs, P. (1995). Nursing in South Africa -Mercy and compassion... Femina, August 1995:68-72.

Shiber, S. & Larson, E. (1991). Evaluating the quality of caring: Structure, process, and outcome. Holistic Nursing Practice, 5 (3), 57-66.

Smit, P.J. & Cronjè, G.J. de J. (1997). Management principles. Cape Town: Juta.

South Africa. (1978). The Nursing Act, no. 50, 1978 (as amended). Pretoria: Government Printer.

South Africa. (1980). Government Notice R157. Pretoria: Government Printer.

Swanepoel, B., Erasmus, B. , van Wyk, M. and Schenk. H. (1998). Human Resource Management Theory and Practice. Cape Town: Juta.

Swansburg, R.C. (1993). Introductory management and leadership for clinical nurses. Boston: Jones & Bartlett.

Terre Blanche, M. & Durrheim, K. (1999). Research in Practice Applied methods for the social sciences. Cape Town: UCT Press.

Valentine, K.L. (1989). The Value of Caring Nurses. Ph.D. Dissertation, Graduate School of Cornell University.

Valentine, K.L. (1989). Caring is more than kindness: Modelling its complexities. Journal of Nursing Administration, 19 (11), 28-35.

Van der Wal, D. M. (1999). Furthering caring through nursing education. Curationis, 22 (2), 62-70.

Watson, J. (1985). Nursing, Human Science and Human Care: A Theory of Nursing. Norwalk:CT Appleton.

Webb, C. (1996). Caring, curing, coping: towards an integrated model. Journal of Advanced Nursing, (23), 960-968.

Wesorick, B. (1991). Creating an environment in the hospital setting that supports caring via a clinical practice model CCPM: In D.A. Guat and M.M. Leininger (Ed); Caring: The compassionate healer. (pp 135-160). New York: National League for Nursing Press.

Wolf, Z.R. (1986). The caring concept and nurse identified caring behaviours. Topics in Clinical Nursing, 8 (2), 84-93.

ANNEXURES

Annexure 1

TABLE A.1 TO ILLUSTRATE THE ANALYSIS OF THE QUESTIONNAIRE IN TERMS OF THE CARING FACTOR OF WATSON (1985)

HUMAN RESOURCE PROCESS	HUMAN CARING FACTOR	ITEMS
1 Formulating strategies, 2 Structuring the work, 3 Workforce planning, 4 Staffing 5 Utilising and maintaining human resources	*Factor 1 The formation of a humanistic-altruistic system of values.*	1) 4, 5,6,,11,14,15, 2) 24 3) 4) 51,52, 5) 69,71,81,83,85,86
1 Formulating strategies, 2 Structuring the work, 3 Workforce planning, 4 Staffing 5 Utilising and maintaining human resources	*Factor 2 The installation of faith and hope.*	1) 2) 34 3) 35 4) 5) 67,68,76
1 Formulating strategies, 2 Structuring the work, 3 Workforce planning, 4 Staffing 5 Utilising and maintaining human resources	*Factor 3 The cultivation of sensitivity to one's self and to others.*	1) 2) 23,25, 29,31 3) 41 4) 5) 74,78
1 Formulating strategies, 2 Structuring the work, 3 Workforce planning, 4 Staffing 5 Utilising and maintaining human resources	*Factor 4 The development of a helping-trust relationship between the care-receiver and the caregiver to ensure a relationship of quality.*	1) 13,16,21,22, 2) 3) 39,40, 48 4) 53,54,64,66 5)
1 Formulating strategies, 2 Structuring the work, 3 Workforce planning, 4 Staffing 5 Utilising and maintaining human resources	*Factor 5 The promotion and acceptance of the expression of positive and negative feelings.*	1) 20 2) 3) 4) 5) 77,84
1 Formulating strategies, 2 Structuring the work, 3 Workforce planning, 4 Staffing 5 Utilising and maintaining human resources	*Factor 6 The systematic use of the scientific problem-solving method for decision-making.*	1) 2) 3) 4) 49, 50 5) 72,79,82
1 Formulating strategies, 2 Structuring the work, 3 Workforce planning, 4 Staffing 5 Utilising and maintaining human resources	*Factor 7 The promotion of interpersonal teaching and learning.*	1) 10,17, 18 2) 30,32,33 3) 36 4) 55,56,57,58 5) 70, 73
1 Formulating strategies, 2 Structuring the work, 3 Workforce planning, 4 Staffing 5 Utilising and maintaining human resources	*Factor 8 The provision of a supportive, protective, and (or)corrective mental, physical, socio-cultural , and spiritual environment.*	1) 7,12 2) 26, 27 3) 47 4) 61,62 5) 72,79, 80,
1 Formulating strategies, 2 Structuring the work, 3 Workforce planning, 4 Staffing 5 Utilising and maintaining human resources	*Factor 9 Assistance with the gratification of human needs.*	1) 9 2) 28, 3) 37,38,42,45,46 4) 59,63,65 5) 87
1 Formulating strategies 2 Structuring the work, 3 Workforce planning, 4 Staffing 5 Utilising and maintaining human resources	*Factor 10 The allowance for existential-phenomenological forces*	1) 8,19, 2) 3) 43,44 4) 60 5) 75

*Item 27 is included for the reason if a no, was given to question 26, respondents should give a reason.

Annexure 2

THE RESEARCHER'S EXPERIENCES REGARDING CARING

1 INTRODUCTION

Before the researcher started with the data collection and analysis, the researcher's own preconceptions regarding caring as a phenomenon needed to be set aside to enable a more open approach and to validate the researcher's own beliefs and concerns. I decided to write stories on encounters with caring and with a few remarks on uncaring people. The stories started during early childhood to primary school years, student nursing years, clinical professional nursing years, nursing management of critical care units and finally the period of teaching nursing management at tertiary level.

2 IDEAS ON CARING

I grew up in a middle class family in the Pretoria area with my father, mother, grandmother, sisters and brother. I recall my grandmother who was the first example of a caring person that I could remember. Roach (1984) in Halldorsdottir (1991) pointed out that we live in a violent society, where atrocities are committed against individuals everywhere. The result of this is that modes of being with another involve both caring and uncaring dimensions. The continuum

of caring and uncaring varies between life giving (enhances growth, restores, reforms and potentiates learning and healing) and life destroying (causes distress and despair, hurts and deforms the other) (Halldorsdottir 1991).

During my childhood and developmental years I experienced many examples of life-destroying as well as life-giving events. I grew up realising that adults could sometimes treat children as human beings, with respect and softness and on the other hand adults could treat children in the most inhumane, harming or deforming ways. This study explores the presence and enactment of caring practices in human resource management of nurses in the health services therefore the emphasis is on caring descriptions and caring people.

3 CARING DURING EARLY CHILDHOOD YEARS

My grandmother stayed with us in our house as part of our family. My grandmother was **good, goodness** was one of her strongest characteristics that I recall, and I remember her as the stabilising factor in our household. She was always **calm and collected** in her approach to problems. If I need to describe her in one word it would be **listening. Listening** was one of the skills that she mastered like no one else. I recall her as a sensitive person that could listen to your story until you have finished, without interrupting. It was important to her to get the other side of the story as well. Grandma would talk things over with the children and negotiate solutions to the problems. I could not recall that she ever

involved herself in gossiping or listened to any gossip. She always maintained that if you could not say anything good of a person, then rather say nothing.

Grandma could spot your needs one hundred percent correctly. She knew when you just needed a sweet or rather a more demonstrative hug or just an assurance from her. She was **sensitive** to the needs of others and could influenced you to see the viewpoint of the other person, although you did not want to. She knew when to withdraw to her room when things were out of hand and when to re-appear to pick up the pieces and to do the patchwork in her **comforting** way. Grandma could calm down a tornado. Sometimes I believe that she was the only one that kept us going. She was a master at **keeping people together** as a unit.

She taught us the value of giving without expecting something back. She was a Christian and I believe that she was practising what God asked us to do here on earth and that is to **love** Him and to love one another as He loves us. She taught us to **love** each other, no matter what. One of her friends had written the following of her (1907): "**To know her was to love her.**'

4 CARING DURING STUDENT NURSING YEARS

Caring was not experienced during my nursing education years from educators or nurse managers in the nineteen seventy's in a Gauteng Hospital. It was the years of bureaucratic administration and autocratic leadership in nursing. Seniority was treated with the utmost respect and a strong system of discipline and obedience to higher authority were regarded as effective. Nursing was characterised by giving orders and the leaders made the decisions alone with the coercion of exercising of power. I experienced the nurse managers of health services as the type X supervisors as described by McGregor in Booyens (1998). During those days it appeared that nurse managers and senior nurses assumed that people hated work and that they had to be coerced to get something done with strict control. Senior nursing students were sometimes supportive but most of the time they were also displaying autocratic leadership styles. However, one senior student nurse seemed to be empathetic and understanding. I remember her **interest** towards us, the new student nurses very well. She was the first caring person that I met in my nursing career. She did not care about all of us, but selected three student nurses and make an effort to get involved with us. She was **concerned** about our **well-being** and the progress in our nursing studies. She **explained** difficult nursing and anatomy concepts to us, though it was not her duty to do so. She went the extra mile to make our lives a little better in pointing out the positive aspects. She was a very special person in the sense that she could identify a problem by just looking at you. She would then invite you into

her room, enquire about your well being, **listen** to you, (most of the time this action of listening was enough), and then she would **advise, help or support** you. She always greeted us with a **smile** and tried to put us at ease when problems arose. She truly tried to keep up with our progress in our nursing careers. This senior student nurse did more to retain young nurses than any nursing tutor or nurse manager did during that time of my career.

This period of my nursing career would be incomplete without mentioning a senior professional nurse in charge of the midwifery unit. This special person came from England and worked in a small hospital in the rural area of the Northern Province of South Africa. Her **attitude** towards student nurses was quite different from the previous experiences I encountered at the Gauteng Hospital. I often wonder why she was the only one that **treated us as human beings with human needs**. I do not have the answer, but it was an **enriching experience to work with her** during my midwifery training. I learned that you can be the senior and still **be human and friendly** and still render **high quality of nursing care**. In this unit no one ever considered giving less than their best for the patients and for the nursing service. I cannot recall any unrest, gossiping or low morale in that unit. We had to work longer hours for the reason of staff shortage without extra payment and everyone did it including her without complaining. This was a very good learning experience for me in my further nursing career. She managed to **get the best out of every single person** in that unit without being rude or using an authoritarian leadership style. The quality of

care was very high without incidents of complaints from patients and medical legal hazards. She built a strong health care team and expected the best from everyone. She ensured that the students got the best training and she checked our records with us in a **guiding and supportive** way. She **respected** every one in her unit.

5 CARING DURING CLINICAL PROFESSIONAL NURSING AS A PROFESSIONAL NURSE

As a neophyte professional nurse in the surgical unit in a Gauteng hospital I met a senior professional nurse who was different from the professional nurses that I worked with during my training. She took me by the hand and taught me management skills that were needed in a nursing unit. The management principles that I learned there are still applicable in nursing management. She taught me to handle difficult situations with medical staff members in a **humane** way. She was always in **control of herself** and the situation. She was **competent and extremely skilled** in all clinical skills. She was **assertive,** but never rude in dealing with difficult clients and other health workers. The most amazing thing to me was the fact that she always managed to get things her way. I then realised that you could get what ever you want, if you stay in control of yourself and the situation. If I need to describe her, I think **competence** is a good word.

6 CARING DURING THE PERIOD OF NURSING MANAGEMENT IN A PRIVATE HOSPITAL

In the private health care situation I experienced a good deal of caring as well as un-caring practices. The un-caring practices were always connected to money and costs. It seemed to me that costs and cost effectiveness formed the opposite of caring in nursing. During my orientation period at the hospital I was told that it is cost effective for the hospital when the wounds of patients became infected. The high costs of the medication and high care services that the patient could be charged, made it cost effective for the health service. This philosophy changed after a while to a more quality service approach. A few years later I learned that to be truly caring in nursing one should be cost conscious as well.

The high level of technological advances contributed to the un-caring attitude during that phase. The bad name that the hospital inherited as a result forced the hospital management to change towards a more caring, but still cost conscious attitude. Support services and education of staff and patients were then a priority. The health service changes slowly and other new private hospitals forced the changes to happen for reasons of survival of the service. With the more user-friendly service, patients and nursing staff approached the hospital again. Patients left the service **happy** and **satisfied** with no or very few complaints. Staff turnover rates dropped and **nurses were retained** that contributed to cost savings. Infection control measures were installed and infection rates dropped.

7 CARING DURING THE PERIOD OF TEACHING NURSING SCIENCES AT TERTIARY LEVEL.

During my early teaching years at a South African University I met a caring professor with whom I worked with for nearly ten years. She was firstly my teacher and later she became a dear colleague of mine. The words that I could use to describe her are, **inspiration, hope, motivation** and **love.** She always found **the time for her staff**. She had the ability to see one as an **individual human being, each with different needs**. She always tried to provide for the needs of her staff and colleagues. I can not describe her in any better way than the testimony described by Rogers (1994).

A testimonial of a student to a caring teacher (Rogers 1994, p.42)

"It's going to be very hard to leave you! I have a **great time** with you. Thanks for all you've done to help me. I'm really going to miss you. You **taught** me the two most valuable lessons of all:

- to be myself and to **give** my all to all I do,
- to try my hardest, and to do my **best**.

You have been my **best teacher** and my best **friend.** You have kept me at the top because you care for me. I want to tell you thanks for everything you've given me, for caring for me, and for being yourself. No one can ever take the place of you."

She **believed** in her staff and always told them that she knew that they would be able to cope. She always **let you believe that you could do it**. She was truly

interested in and **supportive** of her staff and their families. She **accepted only your best** efforts and expected **dedication and commitment to excellence**. Only the **best quality work** was good enough. She was truly a **role model** in every sense of the word. She **loved** her work and her staff. Her knowledge on nursing aspects was always **up to date** and she **shared** it with her staff. She was a good **listener** and **communicator.**

She practised **caring leadership** by **motivation and inspired** her staff to use their talents **towards goal attainment.** She was a strong believer of **empowerment** of her staff by **sharing** authority and **providing** access to information and resources, and opportunities.

8 CONCLUSION

In conclusion reflections on caring are described as experienced in my role as a mother. I think to describe the role of a mother with one word is to write **love** a thousand times. To be a mother, I learned, is to put **the needs of others first,** to **love unconditionally** and to have **endless patience,** to **give of yourself** and to never expect something back. To give of yourself is the greatest gift that you can give to someone. Motherhood teaches just that to me. The words of Ray (1988) are truly experienced by me as a mother. Caring is sharing the gifts that God has given to us. **Belief, hope and love.**

Annexure 3

THE FREE NODES LIST FOR THE INTERVIEWS

(F 1)	//Free Nodes/caring
(F 2)	//Free Nodes/care for
(F 9)	//Free Nodes/accommodating
(F 10)	//Free Nodes/leading by example
(F 11)	//Free Nodes/education
(F 12)	//Free Nodes/humanly
(F 14)	//Free Nodes/believe
(F 15)	//Free Nodes/communication
(F 16)	//Free Nodes/knowledge of staff
(F 17)	//Free Nodes/openness
(F 18)	//Free Nodes/helpfulness
(F 19)	//Free Nodes/team spirit
(F 20)	//Free Nodes/teamwork
(F 21)	//Free Nodes/love
(F 22)	//Free Nodes/non-caring
(F 23)	//Free Nodes/lover needs
(F 24)	//Free Nodes/social needs
(F 25)	//Free Nodes/knowledgeable
(F 26)	//Free Nodes/happiness
(F 27)	//Free Nodes/listening
(F 28)	//Free Nodes/consideration
(F 29)	//Free Nodes/understanding
(F 30)	//Free Nodes/spiritual needs
(F 31)	//Free Nodes/HIV/AIDS care
(F 32)	//Free Nodes/counselling
(F 33)	//Free Nodes/support
(F 34)	//Free Nodes/care to dying staff
(F 35)	//Free Nodes/hope
(F 36)	//Free Nodes/participative management
(F 37)	//Free Nodes/interest in staff
(F 38)	//Free Nodes/growth and development
(F 39)	//Free Nodes/individual treatment
(F 40)	//Free Nodes/care taking
(F 41)	//Free Nodes/welfare of nurses
(F 42)	//Free Nodes/empathy
(F 43)	//Free Nodes/availability
(F 44)	//Free Nodes/problem -solving
(F 45)	//Free Nodes/relationships
(F 46)	//Free Nodes/openness

(F 47) //Free Nodes/supportive
(F 48) //Free Nodes/flexible
(F 49) //Free Nodes/trust
(F 50) //Free Nodes/feedback
(F 51) //Free Nodes/uncaring
(F 52) //Free Nodes/sensitivity
(F 54) //Free Nodes/mentoring
(F 55) //Free Nodes/management caring
(F 56) //Free Nodes/commitment
(F 57) //Free Nodes/enough equipment
(F 58) //Free Nodes/sensitivity to needs
(F 59) //Free Nodes/friendliness
(F 60) //Free Nodes/advocacy
(F 61) //Free Nodes/self actualising
(F 62) //Free Nodes/making a change
(F 63) //Free Nodes/safety
(F 64) //Free Nodes/understanding from their frame of reference

Annexure 4

THE TREE-AND FREE NODES LIST FOR THE INTERVIEWS

(1)	**/human environment**
(1 12)	/human environment /humanely
(1 21)	/human environment /love
(1 28)	/human environment /consideration
(1 29)	/human environment /understanding
(1 29 64)	/human environment /understanding/understanding from their frame of reference
(1 35)	/human environment /hope
(1 39)	/human environment /individual treatment
(1 52)	/human environment /sensitivity
(1 59)	/human environment /friendliness
(2)	**/relationships**
(2 5)	/relationships/interaction
(2 10)	/relationships/leading by example
(2 15)	/relationships/communication
(2 16)	/relationships/knowledge of staff
(2 17)	/relationships/openness
(2 18)	/relationships/helpfulness
(2 26)	/relationships/happiness
(2 27)	/relationships/listening
(2 37)	/relationships/interest in staff
(2 42)	/relationships/empathy
(2 43)	/relationships/availability
(2 45)	/relationships/relationships
(2 49)	/relationships/trust
(2 60)	/relationships/advocacy
(3)	**/Scientific problem solving**
(3 6)	/Scientific problem solving/problem solving
(3 6 44)	/Scientific problem solving/problem solving-problem -solving

(4)	**/Development and growth**
(4 4)	/Development and growth/comfort
(4 11)	/Development and growth/education
(4 30)	/Development and growth/spiritual needs
(4 33)	/Development and growth/support
(4 33 47)	/Development and growth/support/supportive
(4 36)	/Development and growth/participative management
(4 38)	/Development and growth/growth and development
(4 41)	/Development and growth/welfare of nurses
(4 50)	/Development and growth/feedback
(4 54)	/Development and growth/mentoring
(4 57)	/Development and growth/enough equipment
(4 63)	/Development and growth/safety
(5)	**/Needs**
(5 3)	/Needs/holism
(5 7)	/Needs/needs identification
(5 8)	/Needs/flexibility
(5 8 48)	/Needs/flexibility/flexible
(5 9)	/Needs/accommodating
(5 20)	/Needs/teamwork
(5 20 19)	/Needs/teamwork/team spirit
(5 23)	/Needs/lower needs
(5 24)	/Needs/social needs
(5 56)	/Needs/commitment
(5 58)	/Needs/sensitivity to needs
(5 61)	/Needs/self-actualising
(6)	**/HIV and AIDS**
(6 3)	/HIV and AIDS/HIV/AIDS family support
(6 31)	/HIV and AIDS/HIV/AIDS care
(6 32)	/HIV and AIDS/counselling
(6 34)	/HIV and AIDS/care to dying staff
(F)	**//Free Nodes**
(F 1)	//Free Nodes/caring
(F 2)	//Free Nodes/care for
(F 22)	//Free Nodes/non-caring
(F 40)	//Free Nodes/care-taking
(F 55)	//Free Nodes/management caring
(F 62)	//Free Nodes/making a change

Annexure 5

THE TREE-AND FREE NODES LIST FOR THE NARRATIVES (QUESTION 88 ON QUESTIONNAIRE)

(1)	**/Human environment**
(1 10)	/Human environment/speedy and professional care
(1 11)	/Human environment/friendly
(1 13)	/Human environment/expertise
(1 24)	/Human environment/concern
(1 26)	/Human environment/kindness
(1 29)	/Human environment/dignity
(1 30)	/Human environment/humanity
(1 40)	/Human environment/smiling
(1 44)	/Human environment/understanding
(2)	**/Relationships**
(2 6)	/Relationships/help each other
(2 6 43)	/Relationships/help each other/helping
(2 17)	/Relationships/listening
(2 21)	/being there
(2 22)	/Relationships/relationship
(2 28)	/Relationships/trust
(2 31)	/Relationships/interaction
(2 35)	/Relationships/warmth
(2 37)	/Relationships/interested in
(2 38)	/Relationships/empathy
(2 46)	/Relationships/openness
(2 48)	/availability
(3)	**/Scientific problem solving**
(3 42)	/Scientific problem solving/problem-solving
(4)	**/Development and growth**
(4 4)	/Development and growth/support
(4 4 3)	/Development and growth/support/assistance
(4 7)	/Development and growth/uplift level of training
(4 8)	/Development and growth/continuous training
(4 12)	/Development and growth/follow-up
(4 14)	/Development and growth/efficiency
(4 23)	/Development and growth/educating
(4 25)	/Development and growth/recognise
(4 32)	/Development and growth/appraising
(4 36)	/Development and growth/reassuring

(4 45) /Development and growth/growth and development
(4 47) /Development and growth/cultural differences
(4 49) /Development and growth/encouragement

(5) /Needs
(5 16) /Needs/boosting of self-esteem
(5 27) /Needs/need identification
(5 33) /Needs/holistic
(5 39) /Needs/teamwork
(5 39 19) /Needs/teamwork/unity
(5 41) /Needs/fulfilment
(5 41 34) /Needs/fulfilment/self-care
(5 50) /Needs/commitment
(5 50 15) /Needs/commitment/dedication

(F) //Free Nodes
(F 1) //Free Nodes/calmed down
(F 2) //Free Nodes/brought light
(F 20) //Free Nodes/pillar of strength

Annexure 6
This interview is given as an example only and is presented as a verbatim transcription from the taped interview.

DOCUMENT : SR
* STATE: FIRST INTERVIEW
* OCTOBER 3 2000
* VENUE: HOSPITAL 2

- SR , THANK YOU FOR YOUR TIME. I AM DOING RESEARCH ON CARING IN THE HUMAN RESOURCE MANAGEMENT OF NURSES. THE FOCUS IS NOT ON THE HUMAN RESOURCE DEPARTMENT, BUT ON THE HUMAN RESOURCE FUNCTIONS OF NURSE MANAGERS. YOU NEED TO TELL ME THE MEANING OF CARING IN HUMAN RESOURCE MANAGEMENT AND I WANT TO LEARN MORE FROM YOUR EXPERIENCES ON CARING TO NURSES IN THIS SERVICE ONLY. I AM NOT INTERESTED IN CARING EXPERIENCES OTHER THAN IN THIS SERVICE.
-

* WHAT DOES CARING MEANS IN THE HUMAN RESOURCE MANAGEMENT CONTEXT?
* I think hmm, the first thing that come to my mind is that it is ever so much more difficult than in the nursing context. We have been taught to be nurturers and to be carers and to be people who are hands on in the sense that if someone is uncomfortable I relieve their pain. If somebody is untidy, I will clean them up. If someone is bleeding I will stop the bleeding and my interpretation of care is with my hands. Now suddenly in a managerial position, hmm, I am trying to care without that direct contact, physical contact. I really think that we do not prepare our nurse managers how difficult that is. In my experience here, I found that when I am expressing caring by attitude or by words, I am often a little bit disappointed, that the person has not interpreted it as such. So, when I think I am being compassionate, or sympathetic, the person in their wounded state is unable to see the depths of my compassion. I had to learn to readjust my concepts of whether I am effectively caring for a nurse or not. I am going to relate that again to the physical care. One the patient is comfortable they will say, " oh this feels better". Whereas if interacting with nurses, who are wounded or stressed again, they are not able to respond, because they are already in a cycle of burnout. So perhaps one of the things that is difficult as a nurse manager, is when you are in a caring mode and attempting to care, and then you are accused of being uncaring. I think I had to learn to not wait for the response and not adjust my

actions of caring, based on reciprocal response, with other words, I just have to keep on trying to show people that I do care even if I know sometimes that they are not able to process that. I relate it to communication, you talk to people twenty times, you put up notices, you send out a news letter, you put it on the grapevine and you will always hear the nurses say, "they tell us nothing, they tell us nothing". So it is sometimes the inability to perceive it at that time. The other thing in this particular hospital in the position that I held is also mentoring young nurse managers, trying to get them to understand that they have to make the move from hands-on-caring to management caring. Although they are often thrilled by a promotion and they think that is wonderful getting into nursing management, I am going to be where I aimed all my life, they also go through a period that they feel a bit depressed and frustrated, and "what am I doing here? I do not have any effect anymore on people's lives ". So I think in the nursing management context caring is double as difficult, it really is very difficult. And I was perhaps not prepared for how difficult that was going to be.

* WOULD YOU DESCRIBE YOUR HEALTH SERVICE AS A CARING SERVICE?

* Hmm, I would hesitate to say that. If I say caring, then it would mean that we really are managing it hundred percent. I would say we are committed to try to care. I think it is an underlying value that comes through all the time. And I wish I could say yes, that we are very successful, like that, I think we are trying. Just looking into that, with concepts of caring as well, and I am sorry, my mind is still back with the first question.

One of the things that is often misinterpreted by nurses or not realised by nurses, is that the nurse manager tries to care for staff by making it possible for them to work. And one of the things is like, and how difficult it is to get things out of administration, to get things like blood pressure machines, hmm, cardio topography, get things fixed, make sure there is linen for the patients, make sure that, that nurse, so called understaffed or stressed, has got everything she needs in order to function. Now I put a lot of energy into that. You know making sure that every single one of my nurses has got everything that she needs. I think also we, I have learned to turn that into my concept of caring, if I can make sure that, and know that the nurses in my area have got absolutely everything to achieve patient care, I see that as part of my role. We

also try to get our nurse managers to see to that as well. But it is not perceived by the staff as caring. We try the same thing by organising, spiritual retreats, having a library established, getting cassettes available. We even got one of our sisters who is trained in East Africa, in pastoral work, to be here, to be available for the staff, be a counsellor. We have a resource room, nurses do not use it.

* WHAT IS THE RESOURCE ROOM?

*A resource room where there are videos available, the library is available, they could go for small group work if they would like. So the things that we thought that would be evidence of caring and support have not necessarily fulfil the needs of the majority of the nurses. Some, yes. The thing that we found most helpful was when we took groups of about fifteen or twenty away on a retreat centre for a weekend and we have conferences and prayer together, everybody likes that. So again it is trial and error to see whether or not we are achieving the perceived needs of our staff.

* FROM THE LITERATURE YOU ARE CORRECT IN SAYING THAT YOU THOUGHT THE RESOURCE ROOM WITH THE LIBRARY WOULD HELP THE STAFF TO DEVELOPMENT AND GROWTH, AND THAT IT IS CARING. BUT NOW AS YOU SAY, THEY DO NOT ALWAYS SEE IT AS CARING OR USE IT AND MAYBE WE NEED TO WORK AROUND THAT TO MAKE IT CLEAR TO THEM THAT IT IS THERE TO HELP THEM.

* Personally my greatest joy is watching people grow and take off. I really love it when you worked yourself out of a job and somebody else take off with it, and they even stop talking about you having been associated with it and now talking about that person running it. That is what it is all about and I get a tremendous amount of fulfilment from that. In trying to be sensitive to what people want, is also part of that development of that personality, they just flower, all of a sudden you see an energy in the person that was not there before. That is great.

* DO YOU EXPERIENCE YOUR WORK SETTING AS A HUMANE (CARING) WORK ENVIRONMENT? DO YOU EXPERIENCE CARING?

* That is a very interesting question. I recently presented a paper in Johannesburg on caring for carers. In the paper, I elluded to the fact that nurse managers also need care. I had a nurse who came to me and asked me how I was, and I nearly dropped dead from shock. How often do you go to a nurse manager and say: And how are you? So I think it is an interesting question. If you are waiting for that kind of open caring response, you are not going to get it. But the subtle caring is very evident. You know that is what I

appreciate very much for instance at the moment all of us are going through flu, and we all are feeling very miserable. You come and you find that someone has done work that should have been done by yourself, because I knew that you are not feeling well, that kind of listen I can come on, on Saturday, because I know you have a funeral or what ever, this kind of voluntary assistance to each other, I think it is very prevalent amongst us, and I appreciate that, I interpreted it as someone is saying: "I care about you." I do not think nurse managers as a whole, I do not think we do enough of it.

* MAYBE IF YOU THINK OF YOUR FELLOW NURSE MANAGERS, ARE THEY CARING TOWARDS EACH OTHER IN THE GROUP?

* Definitely, there is no question.

* WHAT DO YOU EXPECT FROM CARING IN THE HRM PROCESS IN NURSING?

* Do you mean what do I expect to see in nurse manager?

* YES

* What I really expect to see is something beyond the mechanical, literal, legalistically fulfilment of her position. I like to see her break the rules on behalf of a staff member, that needs extra caring. I am actually very happy when a nurse manager comes, and a staff member has stepped out of line, or has been absent or an obvious problem, and she is standing for that staff member in a realistic way, not in a cover up way. Just simply saying lets have a look at this one she got a problem. You know you can actually see that she is engaged in a relationship which is beyond just that of being a matron. She has learned to understand her staff. I liked that very much.

* TELL ME MORE ABOUT THAT ENGAGEMENT IN THE RELATIONSHIP, THAT YOU REFER TO.

* For instance I have noticed that we have some nurse managers who tend to be autocratic women. They are strong woman, they come from a social background where they are expected to be matriarchal leaders, and therefore can be quite frightening. I am very happy when I see that personality beginning to bend and begin to understand the staff do have other needs and other problems that sometimes need to be considered in light of not an excuse, or pull on the heart string for something and you soon get to know the ones who do it professionally and the ones who have a real problem. So that leadership potential, the strong leadership potential which tends to be autocratic, begins getting tempered with compassion with staff. And also I am very happy when I see the nurse managers have solved the problems themselves and they are coming to us to talk

about it, not in the sense of wanting us to do anything at all, but just simply sharing the problem. That also shows the growth, their ability to deal with their staff members as well.

* YES A VERY IMPORTANT ASPECT OF CARING, THE PROBLEM SOLVING PROCESS. HOW DO YOU TRY TO CREATE A HUMANE (CARING) WORK SETTING IN YOUR SERVICE/UNIT.(EDUCATIONAL FRAME OF REFERENCE)

* Ok, hmm, I think one of the things that has always motivated me, in terms of education, is not necessarily capturing the subject matter and achieving a certain amount of knowledge and skills that made the person a better midwife. But from looking, setting on fire that something from inside the person that changes them from being a routine worker and a routine thinker, to being someone who is taking responsibility for themselves, their own learning and taking responsibility for a team, beginning to see themselves as being pivotal to a team of caring, and recognising it with better knowledge and skills they are able to care in a better way. Compassion and care is now intelligent, and releasing so many of the other staff members to do the same. I keep on saying to them if you walk into a unit, and not everyone can do exactly what you can do, you failed. The whole unit must move with you, so that everyone is as skilled as you, and you are a team that are just keeping the skills alive and moving. You can see it in a mature student, there is a time that their own staff members, the people with whom they worked begin to acknowledge them as a clinical consultant, even before they passed and with others it does not happen. So you can see the person's awareness of themselves, and every one around them begins to grow.

* THANK YOU FOR THAT, DO YOU HAVE ANYTHING MORE TO ADD?

* I think, you see caring within the Christian ethos, is a very important part of my lifestyle. And caring without making dependence, you know, I think hundred years ago, the concept of Christian evangelisation was very dependence producing, in the sense that all the churches that evangelised in the area, the people became very dependent. Now it is totally different, and nursing and Christian compassion in care are so much part of what we are trying to achieve in the Hospital, you can not really separate one from another. That is why strongly we have been vigorously trying to maintain our autonomy in this Hospital as an institution. And not move over to Government, because Government is trying to achieve many of the aims that we

are, but we would like to think that we are expressing the Christian compassion of Jesus as He healed, He did not change the world, but he put his hand on each person that was there, just that touch, the ability to touch and we would like our institution reflecting that to some extent.
* THANK YOU FOR THAT.

Annexure 7

PHASE 2
Only for office use

QUESTIONNAIRE:

CARING IN THE HUMAN RESOURCE MANAGEMENT OF NURSES IN HEALTH CARE SERVICES

Ansie Minnaar developed this questionnaire. (2000)

By completing the questionnaire, you will be helping me to identify *caring in human resource management*, in the health services in KwaZulu-Natal. You could benefit from this research by receiving feedback on caring practices in the management of nurses. The research could contribute to identify the importance of a caring culture in which both your own well being and that of the patient could be improved.

The objective of this questionnaire is to

1. Obtain your experience of caring in the Human Resource Management environment in your hospital.
2. Help me identify caring in Human Resource Management in Health Services.

UNDERTAKING

All information provided will be treated in confidence. You are not required to provide your name or any personal information in the questionnaire.

After you have completed the questionnaire, please seal the envelope provided and hand it over to the ward clerk. There will be no breach in confidentiality. I shall collect it personally.

September 2000

Dear Colleague,

COMPLETION OF QUESTIONNAIRE:

CARING IN THE HUMAN RESOURCE MANAGEMENT OF NURSES IN HEALTH CARE SERVICES

I would appreciate it if you would be so kind as to complete this questionnaire. I am a lecturer at the University of Natal doing research for the degree Doctor of Philosophy in Nursing. I am investigating Caring in Nursing Management (Caring to the Caregivers).

The questionnaire is divided into two sections.
Section A: Establishes demographic information and
Section B is divided into six (6) Sections with a total of 88 items. The questionnaire is designed to gather information on caring regarding the following:

1 *Formulating strategies*: mission statement, goals and objectives, philosophy.

2 *Structuring the work*: job analysis and job design.

3 *Organisational structures of health services:* workforce planning, matching supply to demand.

4 *Staffing processes:* recruitment methods, the process of selection of staff, hiring methods, the level and contents of induction training, socialising and team concept within the nursing units.

5 *Utilising and maintaining human resources:* performance management, leadership styles of managers, in-service training, development of career paths, employee well-being, labour relations and grievance procedures, discipline. communication, decision-making methods, organisational culture.

6 *A caring experience* with a colleague in nursing.

The following definitions apply:

Caring
Caring is described as an interest in someone, which expands through knowledge of that person with a feeling and a commitment to assist the person to exist and to grow.

Nurse manager
For the purpose of this study the nurse manager refers to the person in charge of the nursing care services of a hospital or health service.

Nurse
The nurse is a person who is registered or enrolled with the South African Nursing Council as a nurse according to article 16(1) and (2) of The Nursing Act, 1978 as amended.

Human resource management
Human resource management refers to the various processes and management structures which represent a very specific way or style of managing people at work.

All information will be treated in confidence.

Thank you for your participation in this study.

Sincerely,

AMinnaar

Ansie Minnaar

INSTRUCTIONS

1. Please answer all questions
2. Kindly fill in the information, using a " ✔ " in the appropriate column.
3. Please complete the questions as honestly, frankly and objectively as possible.
4. Please answer the questions as you experience the interpersonal environment in managing nurses in the health service (hospital) where you are working at present.
5. Use the opportunity at the end of the questionnaire to describe a caring encounter with a nursing colleague.
6. In all parts please express **your opinion** of the item statements.

Thank you for taking the time to complete the questionnaire.

SECTION A DEMOGRAPHIC INFORMATION

Kindly fill in the information, using a " ✔ " where appropriate.

1. ***Please indicate your present position in the hospital***

Nursing Service Manager	☐
Nurse Educator	☐
Chief Professional Nurse	☐
Senior Professional Nurse	☐
Professional nurse	☐
Enrolled nurse	☐

2. Indicate your age category

20-30 years	☐	31-40 years	☐
41-50 years	☐	51 years or older	☐

3. How many years have you been in nursing (exclude basic training)

1-5 years	☐	6-10 years	☐
11-15 years	☐	16-20 years	☐
21-25 years	☐	26-30 years	☐
Over 30 years	☐		

SECTION B

1 ***Instructions:*** *For each statement, mark " ✔ " in the appropriate column. To what extent* ***do you agree*** *with the following statements?*

ITEM	1= *Disagree totally*	2= *Disagree*	3= *Uncer-tain*	4= *Agree*	5= *Agree totally*
4. Kindness to people (patients and staff) is emphasised in the philosophy of your hospital.	1	2	3	4	5
5. Love for others is visible in your hospital.	1	2	3	4	5
6. Respect for human dignity of nursing staff is always considered.	1	2	3	4	5
7. In your hospital there is a commitment to ensure the comfort and wellness of nursing staff.	1	2	3	4	5
8. A culturally sensitive approach towards the nursing staff is followed in your hospital.	1	2	3	4	5
9. The satisfaction of the patient is always a major concern to all nursing staff at your hospital.	1	2	3	4	5

Instructions: *Is the following true in your hospital? Please answer* ***YES, NO, or Uncertain,*** *mark " ✔ " in the appropriate column.*

ITEM	*Yes*	*No*	*Uncertain*
10. You are acquainted with the philosophy of your hospital.	1	0	2
11. The philosophy of the hospital guides your actions during the execution of your job.	1	0	2
12. The environment in which I you are working facilitates support and caring to nurses.	1	0	2
13. The philosophy of the hospital is to be honest in all circumstances and with all people.	1	0	2
14. Nursing managers address the concerns of the nursing staff.	1	0	2
15. Your personal values match those of the hospital where you work.	1	0	2
16. Ethical issues in the hospital are discussed and clarified at meetings, workshops, and in informal ways.	1	0	2
17. You are familiar with the values and beliefs of your hospital.	1	0	2
18. Nurses at all levels are involved in reviewing the philosophy of the hospital.	1	0	2

Instructions: *For each statement, mark " ✔"in the appropriate column.*
To what extent ***do you agree*** *with the following statements?.*

ITEM	1= *Disagree totally*	2= *Disagree*	3= *Uncer-tain*	4= *Agree*	5= *Agree totally*
19. You feel valued by the nursing managers.	1	2	3	4	5
20. Nurses in your hospital would be able to describe their experiences with the hospital as enriching experiences.	1	2	3	4	5
21. In your hospital you are experiencing commitment from management towards two-way communication.	1	2	3	4	5
22. Nursing managers trust the nurses.	1	2	3	4	5

2 **Instructions:** *Is the following true of your job in your hospital? Please answer* ***YES, NO,*** *or* ***Uncertain,*** *mark " ✔ " in the appropriate column.*

ITEM	*Yes*	*No*	*Uncertain*
23. You have a job description.	1	0	2
24. There are enough nursing staff members to render quality nursing care in your hospital.	1	0	2
25. The patient's goals are important and all nursing care is aimed at meeting the goals.	1	0	2
26. You are happy in your job.	1	0	2

27If you answered **NO** for question 26 please give reasons for your answer

_____

_____

_____

_____

_____

_____

_____

Instructions: *For each statement, mark " ✔ " in the appropriate column.*
To what extent are the following statements ***currently true*** *in your hospital?*

ITEM	1= *Totally untrue*	2= *Not true*	3= *Uncer-tain*	4= *True*	5= *Totally true*
28. The workload is distributed in such a way that the dignity of the staff and patients are preserved.	1	2	3	4	5
29. Your current job is designed according to your knowledge and abilities.	1	2	3	4	5
30. You could describe your job as meaningful and it contributes towards your career development.	1	2	3	4	5
31. The main goal of your job is aimed at the welfare of patients.	1	2	3	4	5
32. You are mostly performing the tasks for which you are responsible for according to your job description.	1	2	3	4	5
33. The achievement of high levels of production and efficiency are accomplished through extensive use of rules and procedures.	1	2	3	4	5
34. High levels of flexibility with limited use of rules are a good description of the nursing management of your hospital.	1	2	3	4	5

3 **Instructions:** For each statement, mark "✔" *in the appropriate column.*
*To what extent **do you agree** with the following statements?.*

ITEM	1= *Disagree totally*	2= *Disagree*	3= *Uncer-tain*	4= *Agree*	5= *Agree totally*
35. In your current job you have control over your own work to a great extent.	1	2	3	4	5
36. The organisational design enables nurses to achieve high levels of production.	1	2	3	4	5
37. The organisation allows for accommodation of needs of nurses.	1	2	3	4	5
38. Teamwork in nursing is of utmost importance in your hospital.	1	2	3	4	5
39. The nursing managers and the hospital as a whole can be described as a warm, caring community.	1	2	3	4	5
40. Your hospital is a place where nurses can work, live and grow.	1	2	3	4	5
41. Your hospital is a place where you are experiencing emotional security.	1	2	3	4	5
42. There is a feeling of interdependence among nurses in your hospital.	1	2	3	4	5
43. In your hospital the nursing staff experience a great deal of unity.	1	2	3	4	5
44. The nursing staff help each other to succeed in their daily nursing activities.	1	2	3	4	5
45. The maintenance of the health of the nurses is always a priority for nurse managers.	1	2	3	4	5
46. Nurses are seen as individuals in spite of the level of departmentalisation of your hospital.	1	2	3	4	5
47. When tasks are delegated to nurses, the scope of practice, level of knowledge and competence of the individual nurse is considered.	1	2	3	4	5
48. Work relationships in the hospital are marked by trust.	1	2	3	4	5

4 **Instructions:** *For each statement, mark "✔"in the appropriate column.*
*To what extent are the following statements **currently true** in your hospital?*

ITEM	1= Totally untrue	2= Not true	3= Uncer-tain	4= True	5= Totally true
49. Recruitment of staff is done in a fair and non-discriminatory manner.	1	2	3	4	5
50. Staff is selected according to a scientific approach.	1	2	3	4	5
51. The dignity of staff during the interview and the selection process is respected at all times.	1	2	3	4	5
52. Selection interviews are conducted in a friendly and kind manner.	1	2	3	4	5
53. During the first few days at this hospital, the other staff members try to reduce your anxiety as a new staff member.	1	2	3	4	5
54. Induction training and job orientation was done soon after your appointment at your hospital.	1	2	3	4	5
55. During induction the beliefs, values, norms, and symbols of the organisation were explained to you	1	2	3	4	5
56. During induction training, the general communication channels were explained	1	2	3	4	5
57. Employee health policy was explained during orientation.	1	2	3	4	5
58. Training and self-development strategies are in place at the hospital.	1	2	3	4	5
59. Attention is given to the individual needs and concerns of new staff members.	1	2	3	4	5
60. An understanding relationship between nursing management and the newly appointed nurse is established during induction.	1	2	3	4	5
61. You felt confident about doing the job after the orientation period.	1	2	3	4	5
62. The nurse manager/s are present in the clinical areas in a reassuring manner.	1	2	3	4	5
63. New nursing staff are introduced to the social activities of your hospital.	1	2	3	4	5
64. The nurse manager keeps promises.	1	2	3	4	5
65. Equal opportunities exist for each nurse to reach her/his potential and to develop further.	1	2	3	4	5
66. You are experiencing a climate of loyalty towards nurses in general in your hospital.	1	2	3	4	5

5 Instructions: *Is the following true for your hospital? Please answer* ***YES, NO,*** *or* ***Uncertain,*** *mark " ✔" in the appropriate column*

ITEM	Yes	No	Uncertain
67. The culture in your hospital is one of caring in which people are inspired to work.	1	0	2
68. A nurse colleague reference group is available and supports a caring environment for nurses.	1	0	2
69. A performance appraisal system for nurses is in place in your hospital.		0	2
70. Your development and growth is the main goal of performance development in your hospital.	1	0	2

Instructions: *For each statement, mark " ✔" in the appropriate column.*
To what extent are the following statements ***currently true*** *in your hospital?*

ITEM	1= *Totally untrue*	2= *Not true*	3= *Uncer-tain*	4= *True*	5= *Totally true*
71. Coaching and teaching in your job are a continuous process in your health service.	1	2	3	4	5
72. Specific goals and objectives for your job are set by yourself in participation with your supervisor.	1	2	3	4	5
73. You and your supervisor have regular meetings to discuss ways and means to improve your job performance.	1	2	3	4	5
74. You feel that your work-related needs are respected by the nurse manager.	1	2	3	4	5
75. Your talents, potential and abilities are appreciated by your superiors.	1	2	3	4	5
76. The nurse manager encourages you towards self-growth in your career.	1	2	3	4	5
77. Your superiors are supplying you with feedback on your performance.	1	2	3	4	5
78. Your hopes and dreams for the future are identified and opportunities are in place to meet them.	1	2	3	4	5
79. In your job you are assisted by your supervisor with your career planning decisions.	1	2	3	4	5
80. The leadership style of nurse managers in your hospital is characterised by participative leadership principles.	1	2	3	4	5
81. The human rights of nurses are protected in your hospital's Labour Relations policy.	1	2	3	4	5
82. You are allowed to see the whole task (case assignment) rather than bits and pieces (as experienced in functional nursing) in your tasks.	1	2	3	4	5
83. You are acquainted with the grievance procedure of your hospital.	1	2	3	4	5

Instructions: *For each statement, mark "✓" in the appropriate column.*
To what extent are the following statements ***currently true*** *in your hospital?*

ITEM	1= *Totally untrue*	2= *Not true*	3= *Uncer-tain*	4= *True*	5= *Totally true*
84. The nurse manager takes notice of your grievances.	1	2	3	4	5
85. You are acquainted with the disciplinary code of your hospital.	1	2	3	4	5
86. Discipline is executed fairly and humanely.	1	2	3	4	5
87. Your health, safety and welfare at work are ensured by the hospital.	1	2	3	4	5

6 ***All respondents please answer the following question***

- **Question 88** Please describe a caring experience with a nursing colleague.

END

Thank you for your kind co-operation

After you have completed the questionnaire, please seal the envelope provided and hand it over to the ward clerk. There will be no breach in confidentiality. I shall collect it personally.

ANNEXURE 8

THIS IS THE RESEARCHER'S GUIDE **PHASE 1**

DATE———————— TIME————————

VENUE:————————————————————————————

NURSE MANAGER ☐

PROFESSIONAL NURSE ☐

INTERVIEW GUIDE FOR THE EXPLORATION OF CARING IN HEALTH SERVICES

Mrs-————————————————

Thank you for your time. I am doing research on caring in the human resource management of nurses. The focus in not on the human resource department, but on the human resource management functions of nurse managers. You need to tell me the meaning of caring in human resource management and I want to learn more from your **experiences on caring to nurses in this hospital only. I am not interested in experiences other than in this hospital.**

CONSENT TO AUDIO TAPE THE INTERVIEW:————————————

1. What does caring means in the human resource management context of nurses?
2. Would you describe your health service as a caring service?

2.1 If yes then : Describe the caring profile of your health service.

2.2 If no then: Why would you say that the service is un-caring?

3 Do you experience your work setting as a humane (caring) work environment? Elaborate...

4 What do you expect from caring in the HRM process in nursing?

5 How do you try to create a humane (caring) work setting in your service/unit. Correctional methods...

6 Anything more that you want to add?

ANNEXURE 9

THIS IS THE RESEARCHER'S GUIDE **PHASE 3**

CHECK LIST FOR THE ANALYSIS OF CARING IN THE MISSION STATEMENT, PHILOSOPHY, GOALS AND OBJECTIVES OF HEALTH SERVICES IN KWA-ZULUNATAL

DATE_____

Caring factor	yes	no
Factor 1 The formation of a humanistic-altruistic system of values. Friendliness Kindness Concern Love		
Factor 2 The installation of faith and hope. Believe in own potential		
Factor 3 The cultivation of sensitivity to one's self and to others. Satisfactory Comfort Sensitivity to needs Empathy Climate for understanding Development of potential		
Factor 4 The development of a Helping-trust relationship ***Between the care-receiver and the caregiver to ensure a*** *relationship of quality.* Empathy Warmth Communication Listening Trust Sensitivity to needs Congruence Openness Honesty Genuineness Responsiveness		
Factor 5 The promotion and Acceptance of the expression of positive and negative feelings. Interaction		
Factor 6 The systematic use of the scientific problem-solving method for decision-making.		

Assessment Analysis Diagnosis Planning Implementation Evaluation		
Factor 7 The promotion of interpersonal teaching and learning. Education Interpersonal teaching Growth and development Scanning Formulating Appraising Problem-solving		
Factor 8 The provision of a supportive, protective, and (or)corrective mental, physical, socio-cultural , and spiritual environment MBO Comfort Privacy Safety Clean aesthetic environment.		
Factor 9 Assistance with the gratification of human needs. Lower needs of Maslow Higher needs		
Factor 10 The allowance for existential-phenomenological *Forces* Understanding of people from their frame of reference Commitment Compassion Confidence Competence Support and development		

ANNEXURE 10

The Questionnaire consists of items either on a Likert scale of one to five or, a scale of null, one or two, (yes/no/uncertain). Respondents could choose as follows on the one to five scale:

1 Disagree totally
2 Disagree
3 Uncertain
4 Agree
5 Agree totally

The data was then re-coded into three categories as follows:

1 Disagree totally and disagree
2 Uncertain
3 Agree and agree totally

The original data was kept for references and for reasons of clarification. Certain Items were on a yes/no/uncertain scale of one, two and null and respondents could choose as follows:

1 Yes
2 Uncertain
0 No

Specific items were measured on a Likert of one to five scale where respondents could choose as follows to accommodate the type of questions:

1 Totally untrue
2 Not true
3 Uncertain
4 True
5 Totally true

The data was re-coded into the following categories:

1 Totally untrue and not true
2 Uncertain
3 True and totally true

The original data was kept for references and for reasons of clarification of aspects.

ANNEXURE 11

TABLE A 2 THE AVERAGE POSITIVE AND NEGATIVE PERCENTAGES ON EACH OF THE HUMAN RESOURCE PROCESSES ACCORDING TO THE DIFFERENT SECTIONS OF THE QUESTIONNAIRE REGARDING CARING (n= 188)

CARING IN THE HUMAN RESOURCE MANAGEMENT PROCESS	AVERAGE PERCENTAGE FOR THE POSITIVE RESPONSES ON CARING	AVERAGE PERCENTAGE FOR THE NEGATIVE RESPONSES ON CARING
SECTION 1 Caring in the formulating strategies, regarding the mission statement, goals and objectives and the philosophy of the service. (Items 4-22)	54.63684	20.56842
SECTION 2 Caring in structuring the work in the job analysis, job design, organisational structures. (Items 23-34)	63.18182	21.34545
SECTION 3 Caring, in workforce planning, matching supply to demand and organisational design. (Items 35-48)	52.66429	22.55
SECTION 4 Caring in the staffing process; recruitment methods, the process of selection of staff, hiring methods, the level and contents of induction training, socializing and team concept within the nursing unit. (Items 49-66)	54.72222	18.91111
SECTION 5 3 Caring in the utilising and maintaining of human resources in nursing. including performance management, leadership styles, in-service education, employee well-being, grievance and disciplinary procedures. (Items 67-87)	43.95238	27.96667