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A contemporary work performance management framework for the Assistant Nurse Manager in the provincial health-care setting

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DECLARATION

I, Beryldene Swartz declare that this research study titled '*A contemporary work performance management framework for the Assistant Nurse Manager in the provincial health-care setting'* is my own original work. It has not been submitted before for any degree or examination at any university and all the sources that I have used or quoted are indicated and acknowledged as complete references.

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Date : November, 2017.

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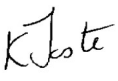
Signature : 

Date : November, 2017.

DEDICATION

I dedicate this work to nursing, the profession.

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The road to completing a doctoral study in hospital Nursing Management has been a long yet very meaningful journey that commenced at the time I first entered an in-patient ward as a student nurse at a large tertiary hospital in Cape Town some years ago. All along this road there have been people and support, and learning, incidental and formal, easy and difficult, and resources. My gratitude goes to all those people, with special thanks to the participants, the Assistant and Deputy Managers: Nursing, in the General Specialist and Emergency Medical Services Directorate in the Western Cape.

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To my special family I say *'Thank You so much'* for having spurred me on the way you had. To my husband Malcolm Swartz for the many other roles and tasks you've undertaken for me on this journey, and for your patience, I remain deeply grateful.

ABSTRACT

Performance management (PM) in a work setting is seen as process within the broader human resource management (HRM) system that involves people in the attempt to secure the best work performance from the individuals, the working groups and that of the entire work society. Various factors play a role in the performance of nurse managers in South Africa. Since the determination and the simultaneous implementation in 2007 of the occupational specific dispensation (OSD) job descriptions for nurses working in the government setting in South Africa, the understanding of what the required work performance for the Assistant Nurse Manager (ANM) was, remained unclear, as there was no PM framework that directed the work performance of the ANM in the Western Cape Province (WCP).

This study adopted a constructivist meta-theoretical approach with an underlying philosophy of Appreciative Inquiry (AI), to understand the work performance of the ANM. The overall question posed, that was to be answered was:

- *"What is the understanding of the ANM and the Head of Nursing (HON) with regard to the key performance management areas of the ANM?"*

The aim of this study was to develop a contemporary work PM framework for ANMs in the provincial health-care setting. To develop this framework the following objectives were needed to be obtained:

- Explore the understanding of the ANMs and the HONs with regard to the key performance management areas of the ANM in the workplace.
- Explore the ANMs and the HONs experiences of the ANM's best work performances in their work situation.
- Describe the best work performance experiences regarding the ANM to improve best work performance practices.
- Explore the ideas of the ANMs and the HONs on the ideal work performance opportunities of the ANM for the future.
- Describe how the ANMs and HONs view the commitment of the ANM to deliver actions towards work performance in their workplace.

This qualitative study was exploratory, contextual and descriptive in nature. It took place at nine of the ten government General Specialist Hospitals of the Department of Health, Western Cape, Provincial Government (WCPG), situated in the geographical area of the WCP of South Africa. Two population groups from the ten General Specialist Hospitals in the Western Cape were accessible for this study. They were: (i) the population of the ANMs (N=48) and (ii) the population of the HONs (N=10) who worked at the General Specialist Hospitals in the Western

Cape. Purposive sampling was applied. Twenty-eight semi-structured individual interviews with ANMs and two focus group discussions with HONs were conducted. The interviews were conducted in offices and rooms away from the clinical setting by the researcher and the assistant, with the use of an audio recorder. Field notes were taken. The interviews did not take longer than 60 minutes. Data was collated until data saturation occurred and the researcher no longer found any new information. The data of all the interviews was analysed collectively along with the field notes, leading to data triangulation. Constant comparative analysis was applied. The major themes identified were within the AI framework and related to the Logic Model (1970s). These were:

- Understanding the key performance management areas
- Best work performance experiences of the ANM (*Input*)
- Best work performances experience that could improve best work performance practice and ideas on ideal work performance opportunities for the future (*Output*)
- Commitment to deliver actions towards work performance in work performance (*Outcome*)

Four main categories supported by sub-categories emerged namely: (1) strategic planning, and quality assurance and nursing care, (2) human resources (HRs), (3) the Business Unit and managing finances and (4) the support function. The ANMs discovered that their best work performance experience in strategic planning, quality assurance and nursing care related to passion for nursing care and leadership. They dreamt and designed a future where there would be improved communication between themselves and the ONMs, and where change will be driven. They committed to deliver in managing and communication processes. The ANMs discovered that their best work performance experience in human resources (HRs) was in relationship building and motivation. They dreamt and designed a future where there would be staff involvement and enhanced interpersonal relationships and unity between shifts. They committed to deliver in increasing managerial involvement and support, and in relation to the need for enough staff/ adequate staffing resources. The ANMs discovered that their best work performance experience in the Business Unit (Functional Business Unit/ FBU) and in managing finances, was in staff well-being and staff posts, and in problem solving and conflict management skills. They dreamt and designed a future where there would be better/ increased resources and working together towards this future. They committed to deliver in managing absenteeism. The ANMs discovered that their best work performance experience in the support function was their communication and interpersonal skills. They dreamt and designed a future where there would be staff orientation and training, workshops for nurses and appreciation of staff by means of incentives and motivation. They committed to deliver in own training.

Trustworthiness was ensured by the application of credibility, transferability, dependability and confirmability. The integrity of this research and its processes were upheld and maintained by having obtained consent, ensuring right to privacy, confidentiality, anonymity and autonomy. Participants were protected from discomfort and harm, and were treated fairly and with honesty.

Academically, the study produced an original contemporary framework within the philosophy of AI and an adapted Logic Model theoretical approach and described work performances of ANMs using the survey list of the Practice Orientated Theory of Dickoff, James and Wiedenbach (1968). The context for the implementation of the contemporary performance management framework for the ANMs is the nursing managerial environment, in the General Specialist Hospitals of the WCP. The primary agent was identified as the HON. The secondary agents were the Chief Executive Officers (CEOs), Heads of the FBUs, Head Specialists in the FBUs, other Heads of Departments, and the multidisciplinary teams (MDTs). The agent's characteristics related to being a strategic planner, communicator, innovator, coach, training facilitator and mentor. The recipient was identified as the ANM. The characteristics of the recipient related to being a senior hospital nurse in the profession, a strategic member/ partner, leader, relationship builder, team member, cost center manager, innovator, learner and coach. The energy source in the performance management framework was identified as staff development. The guiding procedures in the framework was identified according to an adapted Logic Model of input, output and outcome referring to strategic planning, and quality assurance and nursing care, HRs, the Business Unit and managing finances and the support function. The terminus was the contemporary performance management framework for ANMs in the provincial health-care setting.

The framework will be used by the primary agent, the HON, to manage the performance of the ANMs, and also as a guide by the recipient, the ANM, in work performance. Staff development, identified as the dynamic in this study, will be used as the means to facilitate best and desired work performance, work performance initiatives and commitment. The contribution of the framework allows for a contemporary approach to ANM work performance that emphasises the importance of training programmes for ANM Nurse Managers and other agents. The framework is recommended for use in the yearly performance management of ANMs, for promotion to nurse manager posts, to identify performers for opportunities to serve on national committees, to train new nurse managers to be part of the leadership succession planning programme, and to prepare upcoming leaders and for career planning.

LIST OF ABBREVIATIONS

AI	Appreciative Inquiry
AOP	Annual Operational Plan
ANM	Assistant Nurse Manager or *'Assistant Manager'*
C^2AIR^2	Care, Competence, Accountability, Integrity, Responsiveness, Respect
DOH	Department of Health
EAP	Employee Assistance Programme
FBU	Functional Business Unit or *'Business Unit'*
HEI	Higher Education Institution
HON	Head of Nursing
HR	Human Resource
HRH	Human Resources for Health (South Africa)
HRM	Human Resource Management
MDT	Multi-disciplinary team
ONM	Operational Nurse Manager or *'Operational Manager'* or *'Unit Manager'*
OSD	Occupational Specific Dispensation
PM	Performance Management
PMF	Performance Management Framework
PFMA	Public Finance Management Act
QNC	Quality Nursing Care
SPMS	Staff Performance Management System
WCP	Western Cape Province
WCPG	Western Cape Provincial Government
SANC	South African Nursing Council

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CHAPTER 1
ORIENTATION TO THE STUDY

1.1 INTRODUCTION

In South Africa where this study was conducted, political influences and managerial change have vehemently dominated all spheres of management. This in turn has impacted on work performance generally yet more so for managers in the government health sector, where staff work performance is directly related to the sustainability and quality of life for hospital health-care users. McCarthy and Fitzpatrick (2009, p. 347) refer to the notion of 'competence' as a job performance indicator which was to be stipulated in a performance plan. This implied that an employer could determine with pre-employment testing, the degree or ability or non-ability of a prospective employee to deliver the required standard of the work performance plan. The concept of performance management (PM) emerged late in the 1980s' as a means to assess work that had already been completed by individual workers (Hellqvist, 2011, p. 927). The mark of the successful implementation of a PM system is evident by way of transformation and accountability (Kgomotso, 2011, p. 3-4). Arising from public management, PM has become an important organisational process characteristic, which influences performance (Walker, Damanpour & Devece, 2011, p. 367). Required competence in work performance is still being referred to today, and described as the required knowledge, behaviours and skills to perform specific tasks or responsibility (Salleh & Sulaiman, 2015, p. 77). PM is the managing of work performance in a work setting where performance is regarded as the prospective and promising execution of deeds which will lead to the achievement of the desired 'objectives' and 'targets' of the job (Dransfield, 2000, p. 69; Walker, 2007, p. 55). In a work setting, PM is seen as a process within the broader human resource management (HRM) system. It involves the attempt to secure the best work performance from the individuals, the working groups and that of the entire work society (Dransfield, 2000, p. 69).

A clear PM framework did not exist for Assitant Nurse Managers (ANMs) in the Western Cape Province. A framework is a supporting structure of principles and ideas (Macmillan Dictionary, 2015, online). The inferred meaning of 'framework' for PM applied in this study, is that of a supporting structure adapted to the reality of the work performance practices of the ANM, using the adapted Logic Model processes of input, output and outcome (Turabi, Hallworth, Ling & Grant, 2011, p. 3). Atkinson (2012, p. 48) points out that the preliminary step in the development of a PM framework is the endeavour to define 'PM' from a corporate perspective. Franco-Santos, Kennerley, Micheli, Martinez, Mason, Marr, Gray and Neely (2007, p. 785) emphasise the multiplicity of the matter leading to agreement on PM that is still undefined. Performance

nonetheless is a construct created by a formal administrative system and is to be ensured by managers and supervisors.

1.2 AN OVERVIEW OF PERFORMANCE MANAGEMENT

PM is recognised as a global issue within a context where the workplace has been revolutionised by the demand for accountability for sound performance practices (Forni, Tijerina, Hunter & Davenport, 2009, p. 39). It is crucial to have a PM system to ensure that performance plans are implemented, that the desired effect is achieved and that there is effective use of resources (Overstrand Municipality, 2008). Tense competition and pressure on staff to perform is rife in large organisations. New processes to improve PM are essential and multifaceted and innovative approaches to measure work performance should be implemented (Davenport, 2013, p. 1). A similar situation exists in South Africa. It is for this reason that emphasis in the workplace has to be placed on efficiency and effectiveness of performances (within a performance framework), to understand the realities and dimensions of jobs. Organisations are investing huge amounts of time and effort to enhance their outputs, competencies and proficiency (Jehanzeb & Ahmed Bashir, 2013, p. 244).

PM consists of different components. Aguinis (2009, p. 5, 6 & 30) indicates that PM is a continuous process that involves 'identifying', 'measuring' and 'developing' the work performance of persons and groups by having connected the work performance with the overall business goals. Khan and Ukpere (2014, p. 662) state that performance feedback is an important aspect of an effective PM system, if given promptly. Hellqvist (2011, p. 929) points out that the fundamentals of PM are setting of goals, determination of work performance standards, measuring against the standard set, feedback and monitoring, and links to training and development planning. In the context of this study, PM is defined as a methodically structured practice, which details the work procedures with its required outcomes. It is the constant examination of work performance, the growth of competence standards with respect to the execution of the work, the evaluating and scoring of work performance for set periods in a review-like manner and the incentivising of higher-quality work performance (Western Cape Provincial Administration, Department of Health, (DOH), 2002, p. 1). The structured system approach of PM entails planning, monitoring, developing and appraising.

Input is given through planning. Input is the outset step where the finer stages and goals are determined. At the input stage, criteria are discussed and determined, and basic details are outlined and communicated to relevant stakeholders (Western Cape Provincial Administration, DOH, 2002, p. 5). A PM system has a feedback mechanism that informs the management division, if identified objectives have been reached by the people working for the organisation (University of Minnesota, 2017, online). However, Armstrong (2009, p. 246) believes that PM

should not be seen as an aid to HRM. In the *monitoring* phase, *output* through the execution of work is observed, overseen and critiqued. Supervisor scrutiny occurs in this phase with guidance, and advice that is provided (Western Cape Provincial Administration, DOH, 2002, p. 5). Also, *the outcomes and results* of progress are evaluated. In the *developing phase*, substandard performance is dealt with, whilst work of a high-quality is recognised, sustained and further improved. Today the assessment or evaluation, of work known as performance appraisal, makes up part of the ongoing process of PM (Claus & Briscoe, 2009, p. 176; Hellqvist, 2011, p. 929). During the *appraisal phase*, work is reviewed in the attempt to establish if the determined goal has been achieved. The *outcome* is scored in quantifiable terms and agreement is reached with regard to the former by both the supervisor and the supervisee (Western Cape Provincial Administration, DOH, 2002, p. 5).

A corporate view of PM refers to the critical people management process that allows for consistent delivery of better results: *"PM is the systematic process by which you, as the business owner, involve employees in improving their effectiveness so that the company can achieve its goals and objective…"* (Standard Bank Ltd, 2015, online). Standard Bank stipulates that PM is the process whereby people are directed to work according to a prescript; the job description and a performance plan being the pivotal tools to this process. Frameworks for performance have been spoken about in various contexts. PM frameworks are used to enhance organisational effectiveness. A framework could also be developed and applied to autonomously assure aspects of safety, quality and availability of services (Atkinson, 2012, p. 47). Yiannis, Ioannis and Nikolaos (2009a, p. 909) claim that a tactical yet a comprehensive way to bring continued accomplishment to organisations, is by enhancing the performance of the employees, and by improving group capacity, whilst people should also be rewarded. PM could be pivotal in the overall reward system as reward elements could be clustered together, and be regarded as a collective reward system. Rewarding work has always been a contentious issue as monetary, non-monetary, and intrinsic and extrinsic issues are debated (Yiannis *et al*., 2009a, p. 910).

1.3 BACKGROUND TO THE STUDY

Various factors influence the performance of nurse managers in South Africa.

The **first factor** is the occupational specific dispensation (OSD) of 2007, implemented for nurses in South Africa. The OSD eliminates identified non-nursing tasks and offers more lucrative benefits to nurses associated with their core competence i.e. caring and working directly with patients. In realigning nurses to tasks that related to direct patient care, the OSD has changed the structure of nursing management from its conventional pyramidal shape, to a flatter managerial structure. As a result, a significant quantum of clinically trained nurses at hospitals, many though highly skilled in the rendering of direct patient care but less experienced in management of

services, evolved to newly created managerial posts. The implementation of the OSD thus saw the evolution of professional nurses of various categories, translating to newer managerial posts. In almost all cases this occurred without any accompanying formal guidance or training. It is therefore apparent that nurse manager performance has taken on an evolved and new momentum.

This study is specifically around the nurse manager and PM. The backdrop of this managerial research is the work setting of the occupational class of the Assistant Manager: Nursing, forthwith termed Assistant Nurse Manager (ANM). They constitute the target population of this study in General Specialist Hospitals in the Western Cape Province (WCP), South Africa with specific reference to the 2007 nationally prescribed OSD job description for this rank. Those in ANM positions have officially been appointed to these posts, at the designated hospitals, and report directly to the Head of Nursing (HON) and more recently also account to the service Head. More recently they are also expected to account to the Head of the Functional Business Unit (FBU) in which they work. These post holders usually manage a number of homogenous units. The ANM, also known as the Area Manager, is a Professional Nurse registered at the South African Nursing Council (SANC). It is a senior position both in the nursing hierarchy (Table 1.1) and that of the hospital.

Table 1.1: Nursing hierarchical structure (Department of Public Service and Administration, 2007)

REGISTERED (PROFESSIONAL) NURSE CATEGORIES in the health-care setting		
Rank/ Official designation	**Position held**	**Nursing stream/ level**
Deputy Manager: Nursing (DNM)	HON	Senior level hospital management
Assistant Manager: Nursing (ANM)	HON at a smaller health-care setting/ hospital, or a senior in nursing management, responsible for a number of units/ wards	Middle-level hospital management
Operational Manager: Nursing (ONM)	Head of one or two unit/ ward	Middle-level hospital management
Professional Nurse (Specialty)	A shift and/ or programme leader in a unit/ ward	Ward managerial level
Professional Nurse (General)	Likely to be a shift leader in one unit/ ward	Ward managerial level

The second factor influencing the performance of nurse managers in South Africa, is the National 10-Point Plan for Health. The 10-Point Plan, a quality service improvement initiative for health delivery, was announced by the National Health Minister (National Department of Health, 2009). The current job expectations (performance) for nurse managers in South Africa are directly influenced by three of the imperatives, namely No's. i, iv and v of the 10-Point Plan which confirm the necessity of adequate management of nursing services that substantiates the need for clear PM for nurse managers. The purpose of a PM framework should address three imperatives of the 10-Point plan for Health in South Africa, as provided below:

Imperative No. i: 'Provision of strategic leadership and creation of a social compact for better health outcomes'. The former part of this statement namely the 'provision of strategic leadership' could be achieved through the development of a PM framework for ANMs who are the more senior cadre in the nursing, as well as in the services hierarchy, and who are required to apply calculated direction.

Imperative No. iv: 'Overhauling the health-care system and improving its management'. A PM framework for ANMs will contribute to managerial improvement in that performance activities will be stipulated for which there has to be accountability.

Imperative No. v: 'Improving human resources management, planning and development are essential'. A PM framework for ANMs is a HRM tool for staff development. The use of PM improves performance driven behaviour, and consequently the results of an organisation (de Waal, 2013, pp. 10, 115, 140 & 243). Lin, Wu, Huang, Tseng and Lawler (2007, p. 157) indicate that management development is a 'highly necessary pursuit' for managers to address the challenges in their positions.

The third factor of importance is the *Annual Operational Plan* (AOP) of the DOH, Western Cape Provincial Government. The AOP of the DOH, Western Cape Provincial Government relates to three main objectives namely: (1) Service Delivery and Transformation, (2) Clinical Governance and Quality Assurance (QA) and (3) Corporate Governance (Department of Health, Provincial Government of the Western Cape *Annual Operational Plan,* 2014/2015; Department of Health, Provincial Government of the Western Cape *Annual Operational Plan,* 2015/2016; Department of Health, Provincial Government of the Western Cape *Annual Operational Plan,* 2016/2017). In order for the ANM to meet the imperatives of the plan, it is essential that actual performance be linked to identified goals and objectives.

Fourthly, service delivery and transformation plays a role in PM (Department of Health, Provincial Government of the Western Cape *Annual Operational Plan,* 2013/2014; Department of Health, Provincial Government of the Western Cape *Annual Operational Plan,* 2014/2015; Department of Health, Provincial Government of the Western Cape *Annual Operational Plan,*

2015/2016). Indicators of service delivery at the health-care settings/ hospitals of the Department of Health, despite its monitoring being regulated, reveal that the standard of health-care is poor overall with the hospitals being overpopulated whilst the realisation of treatment and care predominately still conforms to a tertiary approach. The AOP requires of hospitals to manage the burden of disease in South Africa. It has become imperative for ANMs to play a fundamental role, to stay ahead of developments in areas of accountability and to be part of PM.

The fifth factor playing a role in PM, is clinical governance and QA (Department of Health, Provincial Government of the Western Cape *Annual Operational Plan,* 2013/2014; Department of Health, Provincial Government of the Western Cape *Annual Operational Plan,* 2014/2015; Department of Health, Provincial Government of the Western Cape *Annual Operational Plan,* 2015/2016). The quality of delivery of services by state hospitals is poor and has now become an open contentious political and economic public discussion (National Department of Health, 2009) receiving lots of negative media publicity. When baseline audits were conducted at hospitals in South Africa in September 2011, it became clear there was a distinct link between the standard of care required and the PM of the ANM.

Corporate Governance is the **sixth factor** to take into consideration in PM (Department of Health, Provincial Government of the Western Cape Annual Operational Plan, 2013/2014; Department of Health, Provincial Government of the Western Cape Annual Operational Plan, 2014/2015; Department of Health, Provincial Government of the Western Cape Annual Operational Plan, 2015/2016). Today, PM systems can be found in almost all organisations (Lawler III, 2003, p. 396), both private and public. Public organisations and institutions such as state hospitals in particular, must demonstrate sound hospital management practices. Lin *et al.* (2007, p. 157) and Chase (2010, p. 1), concur that nurse managers play a pivotal role in hospitals and other organisations. PM itself is therefore a priority responsibility of a nurse manager hence the need to embrace the PM systems and to develop a clear and more specific performance framework.

In 2002, the Western Cape Provincial Government (WCPG) initiated a PM system formally known as the staff performance management system (SPMS) (Western Cape Provincial Administration, DOH, 2002, p. 3). The guideline document in this regard asserts that it is an acceptable practice for performance agreements/ individual PM plans, to be negotiated between an overseer and an individual member of staff, as the two main role-players in the process (Western Cape Provincial Administration, DOH, 2002, p. 8). With regard to the broader goals of a department, it is the explicit purpose of the Provincial Government of the Western Cape to link the performance of individuals, groups and institutions, who are employees and/ or vested

partners or stakeholders, to the desired goals and that of a related higher governing institution/s (direct researcher observation and understanding). More recent arrangements with regard to PM resulted in the pre-alignment of the components of the PM plan of those heading institutions. These are the CEOs, the Head/s of Nursing Departments (HON/s), other nurse managers and other Departmental Heads at health-care institutions within the Provincial DOH. Written prescripts supporting the SPMS, have been implemented, that allow employees to work according to determined work outputs in achieving the goals of the organisation and the WCP as set out in the respective AOPs (Department of Health, Provincial Government of the Western Cape *Annual Operational Plan,* 2013/2014; Department of Health, Provincial Government of the Western Cape *Annual Operational Plan,* 2014/2015; Department of Health, Provincial Government of the Western Cape *Annual Operational Plan,* 2015/2016). Fulfilling the review and evaluation requirements of the SPMS ought to occur by means of formal interviews at regular intervals that vigilantly examine performance. The dialogue serves as a means to ascertain if the organisation, business or hospital is using its full potential to render the required services and achieve quality outcomes. It has been emphasised that time and effort invested in improving organisational PM strategies becomes futile if the monitoring and reviewing are absent (Jehanzeb & Ahmed Bashir, 2013, p. 248).

1.4 PROBLEM STATEMENT

It is a well-known fact that managers in the South African context generally need to improve on performance (Ronnie, 2009, p. 13). Since the determination of the 2007, OSD and the simultaneous implementation of the OSD job descriptions for nurses working in the government setting in South Africa, the understanding of what the required work performance is for an ANM remained unclear as there is no PM framework which directs the work performance of the ANM. The ANMs work in a managerial environment without a PM framework though they occupy senior nursing posts and have to manage a number of wards/ an entire service. This means that different work performance standards are applied when work performance are determined and measured, and this has created a PM system that is inconsistent in its application where managers could be accused of not being clear and steadfast in performance.

ANMs and their supervisors, the HONs at the General Specialist Hospitals, have since autonomously and/ or independently interpreted the prescripts of the job description. This has resulted in inconsistencies in the understanding of the required (expected) work performance and to the ineffective fulfillment of the key management performance areas of the job description of the OSD as it was intended. Currently, nurse manager work performance experiences, are therefore still not acknowledged, as the PM system fails to recognise and re-affirm work performance carried out well. Furthermore, work that is planned and performed is to be linked in a logical way to its effect/s on the service, i.e. practices. This notion was supported by the W. K.

Kellogg Foundation (2004, p. III) that indicates that there has to be a clear connection of deeds along the performance pathway and its likely outcome advocating the need to illustrate logical progression of thinking, planning, interaction; from aims to actual attainment. Consequently the prevailing work PM system created uncertainty for those in ANM positions, with regard to what the performance requirements were and hence how their performance was to be measured. This had also led to unhappiness in the workplace for the ANM, and the negative PM climate was spoken about openly. Taking cognisance of this fact, the underlying philosophy of Appreciative Inquiry (AI) was selected to understand the 'social world' of the work setting of the ANM, and also to give recognition to the 'performance story'. The first question posed was:

- *"What is the understanding of the ANMs and the HONs with regard to the key performance management areas of the ANM?"*

From this question the following research sub-questions within AI were posed:

- *"What are the ANM's best work performances in the work situation?"*
- *"How do the best work performances of the ANM improve work performance practices?"*
- *"What are the ANMs and the HONs ideas of the ideal work performance opportunities of the ANM, for the future?"*
- *"How do ANMs and HONs view the commitment of the ANM to delivering of actions towards work performance in their workplace?"*

1.5 AIM OF THE STUDY

The aim of the study was to develop a contemporary work PM framework for ANMs in the provincial health-care setting.

1.6 OBJECTIVES OF THE STUDY

The objectives of this study therefore were to:

- Explore the understanding of the ANMs and HONs with regard to key performance management areas of the ANM in the workplace.
- Explore the ANMs and the HONs experiences of the ANM's best work performances in the work situation.
- Describe the best work performances regarding the ANM, to improve work performance practices.
- Explore the ideas of the ANMs and the HONs on the ideal work performance opportunities of the ANM for the future.
- Describe how the ANMs and the HONs view the commitment of the ANM to deliver actions towards work performance in the workplace.

1.7 PARADIGMATIC AND THEORETICAL ASSUMPTIONS ON WHICH THIS RESEARCH REST

Plowright (2011, p. 177) refers to a paradigm as 'an arrangement of thoughts or main conjectural beliefs'. A paradigm regulates the approach a discipline takes when concerns are to be addressed. Therefore a paradigm also guides the philosophical understanding of a discipline when research is undertaken. Paradigms differ from each other based on truths more fundamental than the setting where the research occurs, the design of the report, or the nature of the methods applied. Paradigms are *'axiomatic systems'* branded by the various sets of assumptions of the phenomenon they intend to research. The values and beliefs of a paradigm have not necessarily been proven as definitive facts, but a cluster of fundamental viewpoints forming part of the paradigm, is embraced based on good-faith (Guba & Lincoln, 1985, p. 233). The approach of a 'qualitative research paradigm' used in this study refers to the general communal approach taken in social research on which research assumption is based (Babbie & Mouton, 2011, p. 270).

1.7.1 Appreciative Inquiry as a philosophical paradigm

The AI paradigm was applied as the underlying philosophical approach in this study. AI does not fit into any particular ideology but is known for its inspirational approach (Reed, 2007, pp. 45-46). With AI, the focus is placed on what people perceive as their valuable contribution in their labour, the attempt by those in authority to recognise and validate the contribution and to further enhance the contributory effort. This is a positive approach where the customary stage of problem identification is not concentrated on. The AI approach emphasises the importance of focusing on the workplace setting and understanding its context; an approach described as far-reaching. It forces those in management to alter the conventional philosophy on how people go about their work practices, and how the principle/s guiding the conceptual understanding of work practices, can change. In the attempt to get an understanding of the experiences of others, the questions were directed at asking the ANMs what they have attained or accomplished. When nurse managers were asked what has gone well, the inquiry was expected to be positively received, appreciated and ANMs would feel validated (Reed, 2007, p. 2). The basic assumptions of the meta-paradigm of AI adopted for this study were based on that of Jan Reed, however there are many other scholars in this area. Reed (2007, pp. 27-28) has identified the following assumptions which are applied to this study as provided below.

"In every society, organisation, or group, something works": It was believed that the ANMs work well especially within the multi-disciplinary team (MDT); they know when to be assertive and how to negotiate that MDT relationship.

"What we focus on becomes our reality": It was anticipated that ANM and HON awareness of what best ANM work experiences are, would lead to deliberate practices of best work performance.

"Reality is created in the moment, and there are multiple realities": It was believed that the ANM responses on their work performance related to best experience, best possible opportunities, initiatives for the future and commitment to deliver put forward at the interviews, were their reality of the many realities of work performance they had experienced.

"The act of asking questions of an organisation or group influences the group in some way": It was assumed that the research questions based on the positive AI approach put to the ANMs, would improve, innovation and commitment individually and as a collective.

"The person has more confidence and comfort to journey to the future (the unknown) when they carry parts of the past (the known)": It was believed that the ANMs would be inspired and feel appreciated if work performance done in the past was recognised as they go forward.

"If we carry parts of the past forward, they should be what are best about the past": It was accepted that the knowledge of past best work performance practices of ANMs discussed in the interviews would allow the ANMs forthwith to feel more self-assured to follow and build on these best practices and experiences even further.

"It is important to value differences": It was assumed that valuing the differences of ANM performance promoted openness, respect and inclusivity and therefore upheld AI. This is opposed to the traditional ways of finding a common way for all to follow.

"The language we use creates our reality": It was accepted that language (verbal and body) is the tool used by ANMs to perform in work, and therefore also their reality.

1.7.2 Meta-theoretical assumptions

This study adopted a constructivist meta-theoretical approach. Constructivists focus on one or more constructs. As opposed to positivists who set out knowing what the unknown is, constructivists set out without knowing what the unknown is and redefine and redesign as a study unfolds (Babbie & Mouton, 2011, p. 275). Constructivists researchers address the '*process*' of interaction between individuals and in the particular context in which people live or work, seeking understanding (Creswell, 2014, p. 8). This study set out to inductively investigate the unknown constructs of nurse manager understanding and interpretation of their work, and was therefore aligned to constructivism. The social constructionist outlook of the world is that realism exists which is created by the people in the world and their experiences. This view rejects the theory that charts social interactions and discussions as fixed manifestations or phenomena (Gergen, 1985, pp. 266-267). AI therefore embraces the social constructivist orientation (Mishra & Bhatnagar, 2012, p. 545).

1.7.3 Theoretical assumptions

1.7.3.1 The Logic Model

The Logic Model is premised mainly on the distinguished Systems Theory that was created initially by Joseph Wholey in the 1970s, a period when the merits of a framework for programme

evaluation and development surged (Dillon, Barga & Janiszewski Goodin, 2012, p. 37). The Logic Model allows for the systematisation of data collection and evaluation processes of a programme/ framework throughout (Dillon *et al.,* 2012, p. 37). In this study it was assumed that:

- The experiences of the work performances of the ANMs would inform the development of a PM framework, requiring a logical progression of inquiry that include the understanding of the known key performance management areas, to identify best work experience *(input)*, to explore best possible performance opportunities and performance initiatives for the future (output), and commitment to deliver work performance *(outcome)* (see the research questions of this study in Section 1.4 and Table 1.3).
- The use of the adapted Logic Model as an organised and diagrammatic method, allowed for presentation and sharing the understanding of concepts and resources that drive the framework. The adapted Logic Model would assist in including planned activities needed in the workplace (W. K. Kellogg Foundation, 2004, p. 1).
- The adapted Logic Model was theoretically deliberately applied in this study as it was expected to conceptually be included in the framework, as the purpose/ outcome of this study (Dillon *et al.*, 2012, p. 37).
- The adapted Logic Model furthermore allowed for the story around the work performances to be told (Newcomer, Hatry & Wholey, 2015, p. 64). AI further assisted in uncovering the work performances and experiences 'story' that complemented the authenticity of the research on nurse managers. AI has allowed for the richness of the experience to be revealed (Reed, 2007, p. 29; Mackoff & Triolo, 2008, p. 123).

Some similarities further exist between the Logic Model structure (Dillon *et al*., 2012, p. 37) and the systematic process of the SPMS format (Western Cape Provincial Administration, DOH, 2002, pp. 4-5).

Input: Input in the context of the Logic Model means all types of resources used in a setting. These could include human and material resources. It could also include partnerships and service contracts (Choi & Kim, 2016, p. 6680). Hellqvist (2011, p. 930) refers to input as encompassing the values that an employee brings to the job, or the competencies or behaviours that individuals are able to demonstrate.

Output: Outputs are the direct consequences of activities. Outputs can usually be described in terms of dimension and/ or scope; products and services delivered or produced (W. K. Kellogg Foundation, 2004, p. 8).

Outcome: An outcome is a *goal* or *result* or an *end.* These could be actions/ work deeds in performance that is required to be displayed or executed whilst specific work performance goal/s commonly refers to the behaviour inclusive of the required knowledge, abilities and talents for a particular position (Walker, 2007, pp. 54-55).

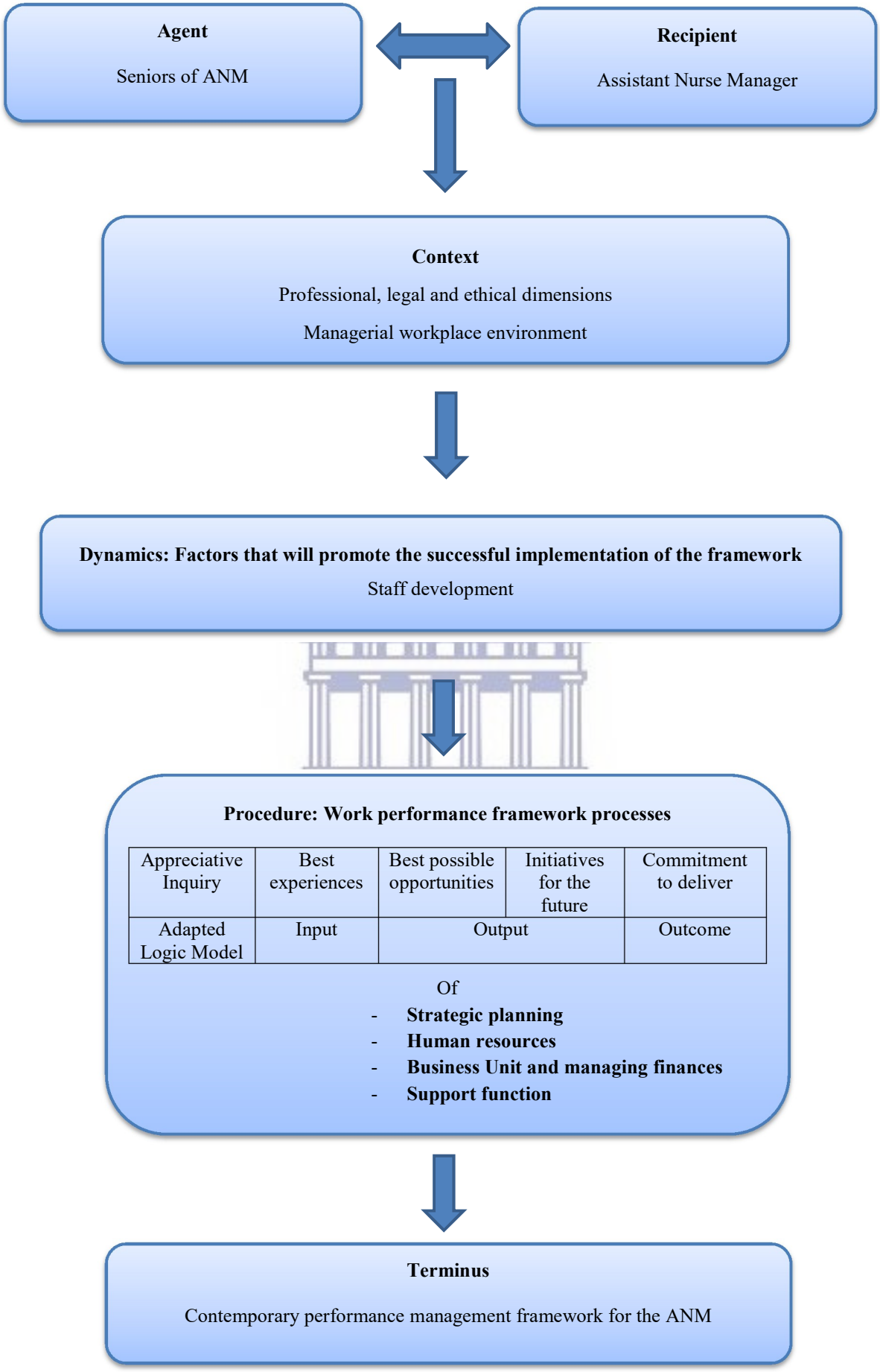

Figure 1.1: Survey list of the Practice Orientated Theory

1.7.3.2 The Practice Orientated Theory

The survey list of the Practice Orientated Theory of Dickoff, James and Wiedenbach (1968, p. 425) was used to guide the reasoning for development of the framework (Figure 1.1). The survey list set out to provide answers to six key questions.

According to the framework as set out by the survey list of the Practice Orientated Theory of Dickoff *et al*. (1968, p. 425), the questions were:

1. In what context is the activity performed (i.e. the framework)?
2. Who or what performs the activity (i.e. the agent)?
3. Who or what is the recipient of the activity (i.e. the recipient)?
4. What is the energy source for the activity (i.e. the dynamic/s)?
5. What is the guiding procedure of the activity (i.e. the procedure)?
6. What is the end point of the activity (i.e. the terminus)?

In this study the questions were asked with a focus on a contemporary framework on PM related to ANMs who worked in provincial health-care settings.

1.7.3.3 Other definitions

Health-care setting:

The term health-care setting in this study is used interchangeably with hospital. A hospital is an institution that has organised medical, and other professional and allied staffing, that delivers a wide range of services for 24 hours a day for seven days a week (World Health Organization, 2017, online). In South Africa a health-care setting could include a primary health-care service, a district, provincial tertiary, regional, specialised or tertiary hospital (Department: Health Province of Kwazulu-Natal, 2017, online). In this study health-care setting refers to the 10 General Specialist Hospitals in the Western Cape.

Assistant Nurse Manager (ANM):

The ANM (official rank is Assistant Manager: Nursing) is used synonymously with 'Nurse Manager' and 'Assistant' or 'Area Manager'. The ANM is a Professional Nurse registered at the SANC and is regarded as holding a senior position both in the nursing and in the hospital.

Staff:

In this study the term staff refers to nursing staff of all categories registered with the SANC.

Functional Business Unit/ Business Unit (FBU):

In the context of this study the FBU comprises a cluster of wards that offer a service. The FBU is headed by a health-care practitioner and operates on business and economic principles of which the management of an allocated budget is an important function.

[NB: In this dissertation use is made of 'her' and 'she' in the generic sense when either gender could apply].

1.8 RESEARCH SETTING

The research setting of this study was the ten government General Specialist Hospitals of the Western Cape Health Department situated in the geographical area of the WCP of South Africa, in both urban and rural localities (Table 1.2) in relation to the nursing hierarchical structure comprising of 48 ANMs and ten HONs (only nine were eligible), at the ten government hospital echelon (distribution depicted in Table 1.2). These hospitals were selected as the research setting as the need to identify what the ANM KPAs were, was talked about here. It also provided service and geographical diversity. The total accessible ANMs and HONs from the ten General Specialist Hospitals comprised 28 and six respectively.

Table 1.2: Distribution of ANMs at the ten General Specialist Hospitals in the Provincial Government of the Western Cape

	Hospital type	Urban area (Numbering per Figure 1.2)	Rural area	Number of ANM posts	Number of HON posts
1	General	6. Somerset Hospital		4	1
2		5. Paarl Hospital		3	1
3			10. Worcester Hospital	4	1
4			2. George Hospital	3	1
5	Psychiatric	8. Valkenberg Hospital		6	1
6		7. Stikland Hospital		6	1
7		1. Alexandra Hospital		5	1
8		3. Lentegeur Hospital		9 (8 at end of study)	1
9	Maternity	4. Mowbray Maternity Hospital		4	1
10	Rehabilitation	9. Western Cape Rehabilitation Centre		4	1
	Total			**48 (47 at end of study)**	**10**

1.8.1 Research design

The research design is a plan that plots the research study course. The research design assists a researcher with planning and operationalising the research in such a manner that the aim and objectives of the research is likely to be achieved (Babbie & Mouton, 2011, p. 72). A generic qualitative, exploratory, contextual and descriptive design was followed, as the questions were flexible and open-ended and concentrated on work experiences (King & Horrocks, 2010, p. 3).

This *qualitative study* is distinguished by characteristics of qualitative research namely that: (a) the researcher is the key research mechanism, (b) the study attempts to make sense of occurrences in the PM context, (c) the research process is inductive, and the focus is the acquisition of in-depth data (Babbie & Mouton, 2011, p. 270). The qualitative design of this research therefore complemented the objectives of this study that explored and set out to describe best experiences of the work performances of the ANMs. Semi-structured individual interviews and focus group discussions were used. It was anticipated that the qualitative nature would further allow the research to evolve and adapt dynamically as the picture of the work performance of the ANM was being listened to and heard (Rubin & Rubin, 2012, p. xv).

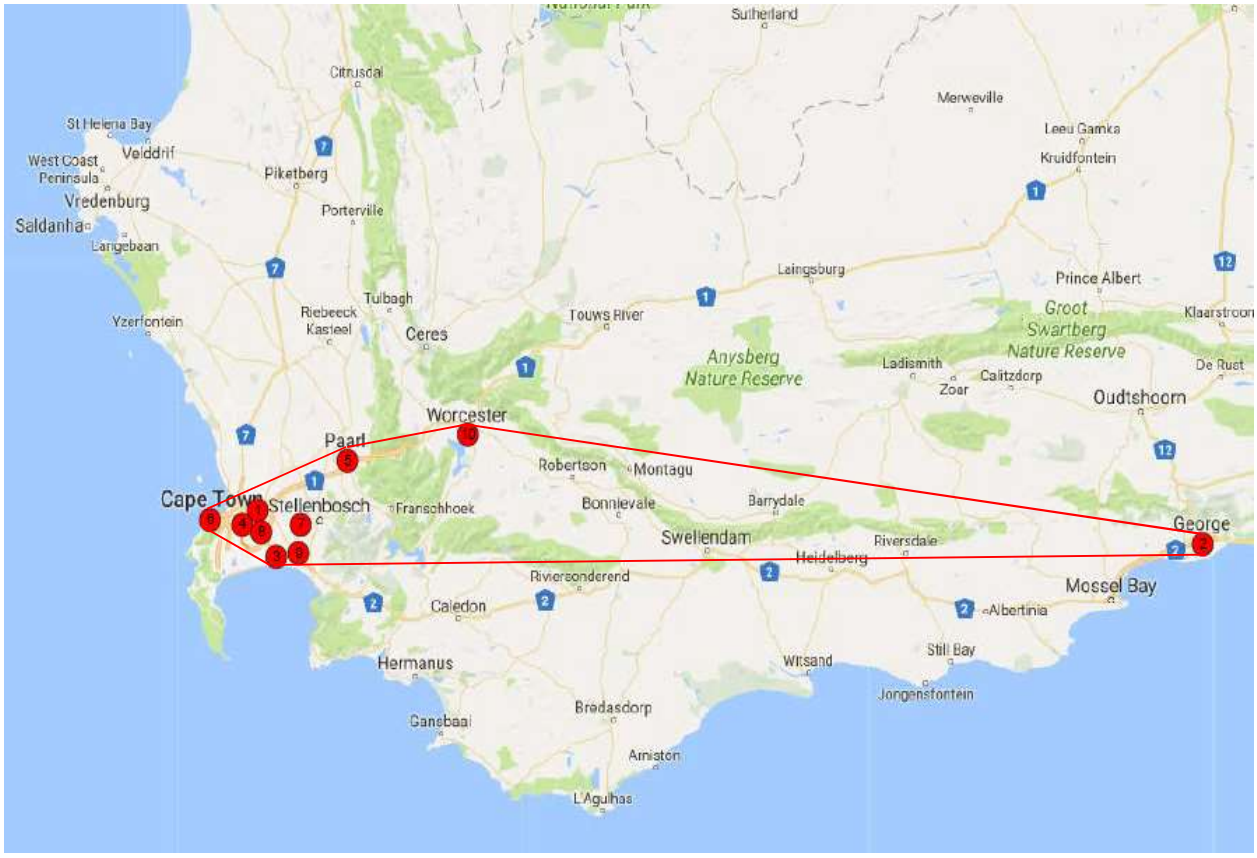

Figure 1.2: Government General Specialist Hospitals Western Cape

1 - Alexandra Hospital, 2 - George Hospital, 3 - Lentegeur Hospital, 4 - Mowbray Maternity Hospital, 5 - Paarl Hospital; 6 - Somerset Hospital, 7 - Stikland Hospital, 8 - Valkenberg Hospital, 9 - Western Cape Rehabilitation Centre, and 10 - Worcester Hospital (www.wikimapia.org).

The study design was *exploratory* as it investigated the ANM's understanding of best work performance experience and opportunities in practice. Qualitative research methods focuses on exploring and describing views or experiences of research participants with the aim of comprehending the meaning research participants place on their reality (Harwell, 2011, p. 148).

The *contextual* study design in qualitative research relates to how research participants understand their world and make sense of it; what therefore was the ANMs' understanding of the stipulated key performance management areas (Babbie & Mouton, 2011, p. 272). According to Brink, van der Walt and van Rensburg (2012, p. 112), *descriptive* studies are conducted to provide an accurate impression of the phenomenon which in this case was the work performance experience of the ANM.

1.8.2 Population

The population in this study was all the ANMs who worked at the ten General Specialist Hospitals in the Western Cape; the target population being those who met the sampling criteria as stipulated in Section 1.8.3. The sample to be studied was selected from that portion of the population to which the researcher had reasonable access (Grove & Cipher, 2016, p. 25). Two target population groups from the ten General Specialist Hospitals in the Western Cape were incorporated into this study. They were: (i) the population of ANMs (N=48) and (ii) the population of the HONs (N=9).

1.8.3 Sample

A sample is a selected number of units comprising a subgroup of the bigger research population (Brink *et al*., 2012, p. 131). Purposive sampling is the deliberate selection of participants by the researcher, from a population to find information richness (Etikan, Musa & Alkassim, 2016, p. 2; Wright, O'Brien & Nimmon, 2016, p. 98). The sample was purposively drawn from the population of ANMs and HONs who met the eligibility criteria. All participants needed to be full-time and permanently appointed, or in an acting position, for a minimum of 2 years and directly involved in nursing management. Data was collected from the samples of participants until the researcher no longer found any new information (Babbie & Mouton, 2011, p. 288).

1.8.4 Data gathering

The process of data collection is the gathering of 'actual' information in line with the pre-established research plan; the collection method varying according to the research design (Brink, *et al*., 2012, p. 57). Data was collected by means of: (i) 28 semi-structured individual interviews with ANMs conducted by the researcher and (ii) two focus group discussions with six HONs conducted by a research assistant, who received training from the researcher beforehand on interviewing. All the interviews were conducted away from the clinical setting. Semi-structured interviews and focus group discussions were intentionally chosen as data gathering methods, as they allowed the interviewers to pose specific questions, predominantly open-ended. They even allowed for probing beyond the specificity of the intended questions, in an atmosphere that was slightly more natural but that would still yield thick data (Brink *et al*., 2012, p. 158). Use was made of interview guides (Annexures R & S) drawn up for the interviews. Data was also gathered using voice recording that supported the field notes taken. This enabled data

triangulation (Tobin & Begley, 2004, p. 393; Flick, 2007, p. 51). Two individual interviews and one focus group discussion served as pilot interviews to investigate if the research question would elicit the needed data. Once it was established that the research questions would indeed yield the needed data, the data was therefore part of the collated data. The same questions put to the ANMs in the semi-structured interviews were put to the HONs in the focus group discussions. The interviews and the discussions did not take longer than 60 minutes. The benefit of the collective nature of the focus group allowed for interaction and sharing of directed thoughts with each of the participants in the group. Focus groups stimulate the generation of new and diverse views and facilitate elaboration, analyses and justification on the directed issues (Brink *et al*., 2012, p. 158; Plummer-D'Amato, 2008, p. 70). Kvale and Brinkman's (2009, p. 97) stages of completing the interviewing process, were adopted as a guide for doing the actual interviews. The stages are schematising, designing, interviewing, transcribing, analysing, verifying and reporting. The researcher remained cognisant of the intended application of AI throughout the research methodological processes.

1.8.5 Data analysis

The analysis of data in the research process is a search for meaning and is regarded as one of the most important steps in qualitative research (Leech & Onwuegbuzie, 2007, p. 557; Onwuegbuzie, Leech & Slate, Stark, Sharma, Frels, Harris & Combs, 2012b, p. 24). The data of all the interviews was analysed collectively with the field notes. This enabled data triangulation, which is when data from audio recorders are used to corroborate data from field notes (Tobin & Begley, 2004, p. 393; Flick, 2007, p. 51). For this study qualitative comparative analysis was used. In this regard the following steps were followed: (1) reading of data (main and/ or subsets), (2) clustering data together in smaller meaningful divisions, (3) labeling (coding) divisions descriptively, (4) contracting new divisions with existing ones so that labeling standard is consistent, (5) grouping similar labeled divisions together to form themes according to which documentation can occur (Onwuegbuzie, Leech & Collins, 2012a, p. 13).

The conventional notion of thoroughness in research is obtained through the processes of assuring its objectivity. In this study after initial data analysis by the researcher, an independent coder assisted further in the data analysis process that was concluded with a consensus meeting between the coder and the researcher.

1.9 DEVELOPMENT OF THE FRAMEWORK

As outlined in the theoretical assumptions, the adapted Logic Model (Table 1.3) and the Appreciative Inquiry approach as well as the survey list of the Practice Orientated Theory (Dickoff *et al*., 1968) informed the development of the PM framework. A scientific

contemporary PM framework based on having explored and described the best work performance experiences of the ANMs was derived.

Table 1.3: Overall plan: Research rationale, questions and objectives

Rationale	Research questions	Objectives	Adapted Logic Model
Develop a contemporary work PM framework for ANMs' in the provincial health-care setting	*"What is the understanding of the ANMs and the HONs with regard to the key performance management areas of the ANM?"*	-Explore the understanding of the ANMs and HONs with regard to key performance management areas of the ANM in the workplace	**Input**
	"What are the ANM's best work performances in the work situation?"	-Explore the ANMs and the HONs experiences of the ANM's best work performances in the work situation	
	"How do the best work performances of the ANM improve work performance practices?"	-Describe the best work performances regarding the ANM, to improve work performance practices	**Output**
	"What are the ANMs and the HONs ideas of the ideal work performance opportunities of the ANM for the future?"	-Explore the ideas of the ANMs and the HONs on the ideal work performance opportunities of the ANM for the future	
	"How do ANMs and HONs view the commitment of the ANM to delivering of actions towards work performance in their workplace?"	-Describe how the ANMs and the HONs view the commitment of the ANM to deliver actions towards work performance in the workplace	**Out-come**

1.10 TRUSTWORTHINESS

Validation: The process of validating qualitative research is done by means of assuring trustworthiness i.e. credibility, transferability, dependability and confirmability (Babbie & Mouton, 2011, pp. 276-278). Criteria for evaluation of nursing models suggested by Pearson, Vaughan and FitzGerald (2005, p. 226) were used to validate the framework. The validation process is described more comprehensively under Section 3.3.8.

Credibility: In this study the researcher regarded it feasible to be attentive to presenting data that could have had different meanings or be interpreted differently (persistent observation). The researcher also extracted a range of data constructs from various viewpoints pertinent to the study (triangulation). Relevant documentation were sought (referential adequacy) and its data sources confirmed findings, and interpretation for intention (member checking). Other credibility assurances applied were peer debriefing and prolonged engagement (Babbie & Mouton, 2011, p. 277).

Transferability: Transferability can be equated to external validity or generalisability in quantitative research (Sinkovics, Penz & Ghauri, 2008, p. 699). 'Thick descriptions' and 'purposive sampling' were generated to facilitate transferability of the findings of this study to

that potentially in another milieu or to other individuals or groups (Babbie & Mouton, 2011, p. 277).

Dependability can be likened to reliability and focuses on ongoing stability of results (Sinkovics *et al*., 2008, p. 689). The researcher kept independent anecdotal notes throughout the study along with crucial notes on the interviews so that dependability could be tested retrospectively (Babbie & Mouton, 2011, p. 278).

Confirmability in a qualitative study such as this one is equated to objectivity in a quantitative study (Sinkovics *et al*., 2008, p. 689). Draft outlines of field notes, personal notes, process notes, 'write-ups' of results, arrangements, discussions to illustrate that the information had been obtained and the deductions made were logically concluded and objectively extrapolated in a rational manner (Babbie & Mouton, 2011, p. 278).

1.11 CONTRIBUTION OF THE STUDY

Academically, this study produced an original framework combining the philosophy of AI, the adapted Logic Model theoretical approach and the survey list of a Practice Orientated Theory. In practice, scientific contemporary views serve as powerful organisational change agents worldwide. This study suggests that a contemporary PM framework for those in ANM positions is needed. A contemporary PM framework allows for a clearer common understanding of the performance prescripts (key performance management areas), elicits best work performance experiences and illustrates how best work performance experience can improve best work practices in this nurse manager category. An authoritative definition of the term 'contemporary' in the practice of HRM is said to be contentious and influenced by various factors within and external to an organisation, that is further subjected to changes over time. Other factors such as age and priority shifts are said to be some of the major change stimuli in this regard. Aptly therefore, for the purposes of this study which focused on aspects of best ANM performance and the development of a PM framework, the application of the term contemporary is in accordance with the objective of developing a modern and applicable PM framework. The development of a PM framework for the ANM that is related to best ANM practice is thus considered to be contemporary. This study also sets out a logical pathway from performance input (key performance area) to performance outcome (practice) with the adapted Logic Model.

Frameworks and programmes that follow the Logic Model maintain a fair vision of the bigger system and simultaneously keep abreast with the requirements of focal areas (W. K. Kellogg Foundation, 2004, p. III). Such programmes and frameworks can be set out in a documented plan that ultimately evaluates performance; that which has been set to be achieved. A Logic Model portrays the flow of processes to produce desired organisational or programme results, illustrates the visual connection between inputs, activities, outputs, and outcomes and gives guidance in the

development of a system such as for performance management (Wong, Yin, Bhattacharyya, Wang, Liu & Chen, 2010, online; Dillon *et al*., 2012, p. 37).

1.12 CONCLUSION

Chapter 1 presented the rationale and the overview of this research study. The scope of the research was encapsulated by the articulation of the research questions and objectives. The overview of the concept PM, the context (methodological) of the research study that served as a guide for the identification of the research method for this study, was identified. The context was discussed to clarify aspects of work performance of the ANM at the provincial health-care setting in order to develop a contemporary work PM framework.

The research study's point of departure and assumptions for the conceptual framework was based on the meta-theoretical, theoretical and methodological dimensions and assumptions of the AI approach and the adapted Logic Model. The researcher reflected on the chapter including the theoretical approach of the use of the adapted Logic Model proposed to be used for the development of the conceptual framework. The researcher deemed it vital to outline the assumptions early in this nursing management study as it was believed that they would resonate throughout the study and be reflected as important principles. Assumptions facilitate the approach to and the research purpose of a study (Knight & Cross, 2012, p. 39). The use of a qualitative, exploratory, contextual and descriptive design has aligned this research to the constructivist paradigm. The researcher also showed consideration for the importance of timely formal acknowledgement of what the strategies would be to ensure trustworthiness of the findings as well as the ethical considerations. In the writing up of this chapter the researcher furthermore reflected on the importance of the findings, and its original contribution to the body of knowledge in the field, with compelling consideration to the background of the study. In Chapter 2 an overview of the phenomenon performance management will be described.

CHAPTER 2
AN OVERVIEW OF PERFORMANCE MANAGEMENT

2.1 INTRODUCTION

This chapter focuses on an overview of PM in management and health services. It elaborates on the need for an overview of the literature, outlines the organisational culture and context of PM, the role players in PM, the different concepts of performance and management, PM approaches in various countries, and PM evaluation. It also looks at the types of systems that are found in other countries and reflect on PM in the South African context. The primary objective of the literature is to identify and integrate what is the most known and relevant about a particular research topic (Gray, Grove & Sutherland, 2017, p. 120), such as PM. Atkinson (2012, p. 48) has though warned of the challenges of trying to delineate PM within clear boundaries. Additionally, management research has shown that even the dividing line between PM and performance measurement is unclear with some writers at times using these concepts interchangeably. The need for an overview of the literature is also pointed out by Mokoena (2012, p. 20), who states that the literature review in qualitative research is still an area of much discussion, as various researchers have different opinions with regard to when the literature review is to be undertaken. Polit and Beck (2014, p. 117) state that views on the literature reviews in qualitative research vary. Holloway and Wheeler (2010, pp. 37, 42) indicate that when qualitative research is undertaken, a literature review conducted at the beginning of a study can merely be an overview of the knowledge depth in the particular field. According to Hesse-Biber and Leavy (2011, p. 336), qualitative research attempts to uncover theory iteratively and therefore the literature review may be conducted at various stages of the process as compared to quantitative research that requires the literature study at the initial stages of the research in order to test the hypothesis. Literature was sourced mostly using key words. The incorporation of the literature within the findings of the research strengthens trustworthiness (Campbell & Corpus, 2015, p. 4). The purpose of consulting the literature in a qualitative study is to establish what is known about the topic and to put this knowledge forward (Grove, Burns & Gray, 2013, p. 265). The findings of this research study were corroborated, and confirmed, integrating literature to produce a robust discussion in Chapter 4 and Chapter 5.

2.2 THE ORGANISATIONAL CULTURE AND CONTEXT OF PERFORMANCE MANAGEMENT

Vance and Paik (2015, p. 48) define organisational culture as a set of values, beliefs, priorities and assumptions held by an organisation that direct individual and collective behaviour; that which can be shaped naturally by the members of the organisation but can also be formed and molded through systematic programmes and by managers of corporations. Today, PM has become a global issue where the workplace has been revolutionised by the demand for

accountability for sound performance practices (Forni *et al*., 2009, p. 39; Saravanja, 2010, p. 34). PM comprises features associated with a host of other disciplines and relates to organisational capacity. These include HRM, strategy management and project management at three levels; strategic, operational and individual (Brudan, 2010, pp. 111-112) PM is scripted by the Western Cape Provincial Administration, DOH, 2002, p. 3) as: *"In its widest definition, PM refers to all the processes and systems designed to manage and develop performance at the levels of the public service, specific organisations, components, teams and individuals. In its most narrow definition, it is used to refer to specific systems for managing and developing individual performance, especially performance appraisal systems."*

2.3 ROLE PLAYERS IN PERFORMANCE MANAGEMENT

The role players of PM include the person whose performance is being managed, the manager and other levels of management deciding on performance policies and procedures. Traditionally managers and employees in the public service have often felt threatened by performance measures; the latter's perceptions that the system is forcefully imposing more expectations and attempting to increase the work pressure for harder work and added output (Sole, 2009, p. 7). Line managers are the actual custodians and drivers of the HR practices and hence PM processes, but the risk exists that even well-designed HR practices might be implemented incoherently and below the required standard (Sikora & Ferris, 2014, p. 271). A paper by Brudan (2010, p. 109) who intended to explore PM as a discipline, found that it was relevant to both the academic field and to health-care practitioners.

2.4 THE DIFFERENT CONCEPTS OF PERFORMANCE AND MANAGEMENT

The mission to improve performance in public organisations such as health-care settings and hospitals has seen the introduction of concepts such as efficiency, accountability and strategic planning, alongside new formats for performance indicators and quality management systems (Peregrina, 2009, p. 18). According to Ferreira and Otley (2009, p. 264), influential work has been done by Robert Anthony (1965), under the banner of management control systems (MCS), that was adopted from the generic terminology of PM systems.

2.4.1 The historical emergence of the concept Performance Management

The conceptualisation of scientific management by Frederick Taylor, very early *in the twentieth century,* advocates the analysis of existing work methods and performance by observation and measurement (Kanigel, 1996, p. 44; Brudan, 2010, p. 113; Radnor & Barnes, 2007, p. 386). This was followed by Frank and Lilian Gilbreth and others, that believed that every movement of workers should be measured in the course of their work performed (Radnor & Barnes, 2007, p. 386). *Early in the 1950s,* the Japanese quality management ideas emerged on which many of the current PM theories and policies are based (Busi & Bititci, 2006, p. 13). Another *early postulation* on PM is that performance development is enhanced best, by means of the practical

challenges of on-the-job exposure and mentoring, which include commentary from supervisors (Armstrong, 2009, p. 21). The history of management studies reveals that PM was first spoken of as work output, which later became known as 'productivity' and is now referred to as 'performance' (Hellqvist, 2011, p. 929).

In the United States of America *in the nineteen seventies,* and in Great Britain *in the eighties and nineties*, legislation introduced the upholding of rights such as equal work opportunities and performance management systems (PMSs) became commanding tools for public sector, to redress with regard to culture and ethos (Furnham, 2004, p. 84). The concept 'PM' then emerged late in the 1980s, as a means to assess the work completed by individual workers (Hellqvist, 2011, p. 927).

Therefore since the *early nineties*, PM has gained global momentum as a result of global public sector reforms (Manyaka & Sebola, 2012, p. 300). The period of *the nineties,* witnessed two major influences that reformed individual PM. The first was the growing attractiveness of self-assessment of performance which at times would be the precursor to line manager feedback. The second was the trend to assimilate strategic management and individual performance, a current day PM requirement (Department of Health, Provincial Government of the Western Cape *Annual Operational Plan* 2014/2015; Department of Health, Provincial Government of the Western Cape *Annual Operational Plan* 2015/2016; Department of Health, Provincial Government of the Western Cape *Annual Operational Plan* 2016/2017). The use of the Balanced Scorecard was then incorporated as a measuring instrument (Brudan, 2010, p. 112). The development of PM along with HRM was also a response to the political, legal, economic and social changes throughout the 1980s and 1990s, and the question around the HRM discipline (Thorpe & Holloway, 2008, p. 88). Prior to the beginning of the new millennium, there was a strong emphasis on goal setting and an increase in conventional evaluation in PM (Tahvanainen, 2000, pp. 267-268). PM now integrates the management of employer and organisational performance (Mlambo, 2010, pp. 12, 14, 15 & 102).

PM management serves as a communication tool in regard to what a good job means and entails (Mahapa, Dzimbiri & Maphosa, 2015, p. 19; Armstrong & Taylor, 2014, p. 336). In line with this notion, the provincial government setting in which this study was conducted has also advocated that PM serves this strategic purpose (Western Cape Provincial Administration, DOH, 2002, pp. 4, 8 & 10). Managers and employees should reach consensus on the work that is required and the work progress, in the attempt to reach the set goals, followed by an assessment/ feedback on whether the goals are reached.

2.4.2 The concept performance

There has been a challenge over the years in identifying very specifically what *performance* comprises of, the various forms it takes and therefore how it is to be appraised (Shane, 2010, p. 12). Performance is not easy to define (Brudan, 2010, p. 110). Work performance could be

viewed as multidimensional (Fitriati & Rahayu, 2013, p. 7; Seemela, 2005, p. 46). Managerially, two major and inseparable processes stem from performance, namely PM and performance measurement (Brudan, 2010, 111). However, Smith (2009, p. 512) cautions that performance measurement and PM are interrelated but not interchangeable, performance measurement being a needed proviso for PM. Performance measures are also referred to as performance indicators. A performance measure is a gauge that is used to provide objective evidence of the extent to which a performance result is occurring over time (Kasunic, 2014, p. 63).

Performance is related to *behaviour*, *processes* and *results* comparable to the linearity of the Logic Model of *inputs*, *outputs* and *outcomes*. The Logic Model process focuses on effected changes caused by one work deed on the next as activities, tasks, programmes and outputs occurring in a linear fashion, lead to outcomes (Mucha, 2012, p. 44). Shields, Brown, Kaine, Dolle-Samuel, North-Samardzic, McLean, Johns, Robinson, O'Leary and Plimmer (2016, p. 2) conceptualise work performance as a linear system comprising of three main facets, namely: (1) *inputs* which are abilities and attitudes, (2) human resource (HR) *throughputs* which refer to actions that transform inputs to outcomes and (3) *outputs* which are deemed to be outcomes from work performed/ behaviour. Performance may be an individual or a group effort, and can be seen as the provision of work outputs in the form of worker knowledge, skills and abilities. It should be applied through effort and other related forms of work behaviour, to produce a certain quality of services, within a defined period of time.

In the management arena, the expressive term 'performance' may be applied in various ways, and personal, team and/ or organisational performance could be pertinent. *Performance* is that which an organisation employs one to do, and the expectation that it (performance) has to be done well (Cascio, 2012, p. 183). Generically, the term performance could be used to demonstrate an achievement, whilst performance could also be used to illustrate a benchmark (Franco-Santos *et al.*, 2007, p. 798; Brudan, 2010, p, 110). Borman and Motowidlo (2014, p. 75) state that performance has been placed into two expansive performance aspects, task performance and contextual performance. Task performance is distinguished further into direct core work deeds and non-core work activities. Contextual performance does not support work directly through the organisations' core technical work performance, but supports the broader organisational, social and psychological milieu in which the technical core operates (Borman & Motowidlo, 2014, p. 75). Miah and Hossan (2012, p. 13) as well as Armstrong and Taylor (2014, p. 331) assert that work performance is about both the actual work that is done, as well as how it is done. Similarly Armstrong and Taylor (2014, p. 334) also view performance as both behaviour and results. PM facilitates the performance process in an evolutionary manner, starting initially abstractly with the performer, and then translated into deeds. Defined as a process, PM has been

created to promote and strengthen the 'organisational', 'team' and 'individual' performance', *"…owned and driven by managers"* (Armstrong, 2009, p. 9). PM is a constant procedure that involves 'identifying', 'measuring' and 'developing' the work performance of persons and groups by connecting the work performance with the overall business goals (Aguinis, 2009, pp. 5, 6 & 30).

In line with a systems thinking view, Brudan (2010, p. 110) calls this the 'journey taken' from thought to deed in realising the set outcomes and concedes that the most commonly used term in daily life that mirrors this journey's progress is 'performance'. The view in systems thinking is that each system must fulfill a purpose. In attaining its purpose, it would be considered having 'performed' as intended. Mlambo (2010, p. 28) alludes to the notion that there are countless intellectual and physical processes preceding the end stage of reaching a work performance outcome, processes that could be evaluated separately from the outcome. In South Africa, the Department: Public Service and Administration (2007, p. 7) classifies a PM system as *"an authoritative framework for planning, managing and measuring performance of both the organisation and the employees"*.

2.4.3 Understanding of the concept performance management in various contexts

Armstrong (2014, p. 56) describes PM as *"A strategic and integrated approach to delivering sustained success to organisations that focuses on performance improvement and employee development"*. A fundamental purpose of PM is to establish systems and methods that translate the strategic goals of an organisation into terms that describe individual performance criteria. It also serves to improve performance in important areas by creating accountability to goals and objectives, and hold the institution accountable for resources used. PM is an agent; through improved economy, efficiency and effectiveness in service delivery, PM can also be used to promote institutional services (Mlambo, 2010, p. 1; Hellqvist, 2011, p. 929). Likewise, Maley (2011, p. 32) argues that the purpose of PM, apart from having to control people and maximise the company's financial performance, is to develop and to make allowances for subordinates to express themselves in a milieu of trust. PM forms part of the broader HRM system having its focus on achieving the best performance outcomes, from individuals and teams, in an organisation whilst it is also directed at the organisation as an entity (Dransfield, 2000, p. 69). Assessment or evaluation, also known as performance appraisal is part of the ongoing process of the larger systemic process of linking individual PM and development to organisational goals (Aguinis, 2009, p. 5, 6 & 30). Performance appraisal is the episodic formal assessment of an employee's performance. However, Armstrong and Taylor (2014, p. 334) recommend that the term 'performance review' be used instead, as it denotes a combined event of dialogue and agreement. PM being an engaging process cannot be conducted in remoteness, but measures effectiveness of strategic business processes as well as the operational aspects (Corcoran, 2006,

p. 43). A pronouncement by Standard Bank Ltd (2015, online) claims that PM was regarded as a crucial people management process that facilitated the steady delivery of superior outcomes. The implementation of an inclusive PM system is said to be a timely process (Diamond, 2005, p. 19) but it does lead to change, as opposed to being a static activity (Hellqvist, 2011, p. 930).

Saravanja (2010, p. 105) and Hellqvist (2011, p. 929) have drawn attention to the complex PM realm that exists. For PM to be effective, people who work in the organisation have to be informed about, and have to grasp what the organisational goals are (Dransfield, 2000, p. 69). According to Cascio (2012, p. 186), three fundamentals distinguish PM, namely '*goals*', '*measures*' and '*assessment*', with feedback inclusive of consequences, being given to everyone in an organisation who performs work (Hellqvist, 2011, p. 929). Hellqvist (2011, p. 929) rephrases these fundamentals, and has advocated the setting of goals, the determination of work performance standards and the measuring of performance against the standard set. Yiannis, Ioannis and Nikolaos (2009b, p. 913), and Dowling, Festing and Engle (2008, p. 156) have shared the view that key rationales of PM include advancing worker skills and ability to perform work more efficiently, using feedback. Rao (2016, p. 114) also states that the PMS is effective if the feedback is well timed. PM should occur naturally and not be seen as an aid to HRM (Armstrong, 2009, p. 246). PM is regarded as a decisive process of managing human capital that allows for consistent delivery of better results (Standard Bank Ltd, 2015, online). PM is tactical yet comprehensive in bringing about continued accomplishment of organisations, by enhancing the performance of the employees, and by improving group capacity. The common understanding of the notion of PM is based on a conjecture, that when success is achieved with having improved the performance of workers (also known as personnel) in an organisation, that the entire organisation benefit from the improved organisational performance, by learning from the daily successes and challenges (Pillai, 2012, p. 7).

2.5 PERFORMANCE MANAGEMENT APPROACHES

PM in health-care facilities/ hospitals depicted as organisations, institutions or companies. PM can be outlined according to three main categories namely: (1) strategic, (2) operational and (3) individual approaches. PM models and/ or frameworks in America, Europe, Asia and Africa are addressed.

2.5.1 Strategic performance management level

Orientation to strategic performance management and global examples are illustrated as follows:
The strategic level of PM is said to be the highest and absolute level of usage of PM principles in organisations (Brudan, 2010, p. 114; Sole, 2009, p. 5). PM at this level has to do with the achievement of organisational objectives which is often referred to by practitioners as corporate, business or enterprise. Major processes that deal with strategic PM systems are: (1) strategy

formulation and (2) execution identified as strategic management subsets. In this regard some of the most well-liked performance measuring instruments include the Balanced Score Card (BSC) and the Performance Prism (Brudan, 2010, p. 114). Bourne (2014, p. 1) indicates that a set of academic disciplines contributes to the sphere of PM and measurement. Significantly it is the practice and the engagement of lead practitioners that contribute to this field.

2.5.1.1 Frameworks and/ or models of strategic performance management in the British Isles and Europe

- **Britain and Northern Ireland: A health and social services collaboration**

Atkinson (2012, p. 47) reflects on a PM framework that was developed in Northern Ireland between Britain and Northern Ireland. The regulatory organisation collaborated with legislative health and social regimes throughout Northern Ireland to facilitate high service quality governance standards. In this context, the development and utilisation of a PM framework was explored and initiated of which the first step was to characterise 'corporate PM'. It was recognised that a collective description of PM was critically needed (Atkinson, 2012, p. 48). Liaison with stakeholders revealed that when performance was to be managed, that plain and clear language should be used, that the characterisation of PM should to be aligned to that which was required to be achieved, and that there had to be a clear understanding of the distinction between 'PM' and 'performance measurement'. The philosophy of this PM framework was continuous learning and improvement. Essentially the framework responded to the performance intelligence gathered and decided on how real service delivery improvements ought to occur.

- **United Kingdom: The Balanced Scorecard**

The introduction and restructuring of the Balanced Score Card (BSC) by its pioneers Kaplan and Norton, are said to have initiated a '*PM revolution*' in the mid-1990s (Kennerley & Neely, 2003, p. 214; Brudan, 2010, p. 115; Bourne, Franco & Wilkes, 2003, p. 15). Kaplan and Norton first presented the BSC as a performance measuring tool which apart from the financial activities, would measure and report on an organisation's or business' intangible qualities. In 1993, a year after this initiation of the BSC, pioneers Kaplan and Norton allude to the correlation between performance metrics and strategy, and by 1996 the BSC was known as a strategic PM system premised on a 'comprehensive' framework for "*strategic processes, resources allocation, budgeting and planning, goal setting and employee learning*". It went on to be utilised in broader managerial spheres that were used to guide strategic planning, operational implementation, feedback and learning (Kaplan & Norton, 1992a, pp. 76-78). In a period of 16 years, the BSC transformed from a measurement apparatus to a managing tool, and continued to develop into a system and subsequently to an instrument within a system. The BSC has largely become the most popular stratagem and viewed as the icon of strategic PM (Brudan, 2010, p. 115). The application of the Balanced Score Card PM model is said to have both benefits and limitations.

The use of the BSC is now viewed as one of the most well-liked management tools that are being used to improve organisational performance in both the private and public sector (Chu, Wang & Dai, 2009, p. 401; Saravanja, 2010, p. 98). The BSC model established fresh performance measuring perspectives which were more relevant and comprehensive and related to elements of financial performance such as internal industry processes, innovation and learning, and to the perception of key customers/ stakeholders. Each element asks specific delving questions which are designed to yield improvement of quality. It requires managers to act proactively and strategically by paying attention to those factors which will accomplish longer term sustainable success, link stakeholders to identified key organisational success factors to do with finance, quality and learning as opposed to meeting short-term end-result financial compliance and deadlines only (Saravanja, 2010, p. 98).

- **Greece: The strategy-target-assessment-implementation-results (STAIR) performance framework**

Another example of strategic PM, is the national governmental structure of the strategy-target-assessment-implementation-results performance framework, known as the STAIR model. It has proven to be a wide-ranging tool designed for the purpose of improving the Greek government's performance to change to an ostensible '*strategy focused*' organisation. Being *strategy focused,* could transform an organisation from underperformance to a leader in the industry (Kaplan & Norton, 2000b, p. 29). It serves to answer some of the crucial organisational management questions geared at its mission, strategic goals and how these were to be achieved. It measures organisational performance, the performance gap and the utilisation of performance output that effected improvement. The STAIR model is recognised as holistic and cognisant of the threats, strengths and weaknesses of the environment both internal and external. Significantly the STAIR model is found to be compatible with the matrix of how the sub-structures in the Greek Government are interlinked in its course of converting input and processes into prolific output and outcomes (results) (Zeppou & Sotirakou, 2003, p. 323). The STAIR model is said to be enabling in that it assisted organisations to prioritise and understand what was needed for success. It was formulated on the premise that strategy and the development of a performance measurement system reflected performance despite organisational intricacies. The STAIR model portrays a systems approach that combined a number of change techniques, e.g. SWOT, TQM, BPR and benchmarking with the cognisance that a solitary approach to performance would not be able to inspire important organisational change (Zeppou & Sotirakou, 2003, p. 323). STAIR, promotes lasting change and organisational success on an on-going basis (Zeppou & Sotirakou, 2003, p. 324). The organisational culture that comes about when the STAIR model is applied is one that underpinned employee dedication, proficiency and results orientated entrepreneurial behaviour. This milieu assists the human potential in organisations to self-actualisation and to

build a natural global thinking public administration that could demonstrate the ability to apply innovation locally (Zeppou & Sotirakou, 2003, p. 325).

2.5.1.2 Frameworks and/ or models of strategic performance management in Asia

Following the 1997 Asian financial catastrophe, new public management means that would improve public accountability and assist countries in coping with the global economy, was welcomed by Asian political leaders. However the various Asian countries introduced various PM systems (Koike, 2013, p. 347).

- **Malaysia: An integrated results-based management (IRBM)**

The framework in Malaysia links the elements of 'budget performance', 'resources usage' and 'policy implementation'. In 1990 the Malaysian government initially introduced a modified Results-Based Management system (Thomas, 2007, p. 96). Recognising that this was inadequate, the Integrated Results-Based Management (IRBM) system came about in 1999 (Thomas 2007, p. 97). The Integrated Results-Based Management system comprises of the Integrated PM framework (IPMF) that endeavours to merge the results-base budgeting system and the personnel performance system. The overall goal is to integrate all systems of government in Malaysia in an effort to establish a government-wide results-based management system. The stages of the system allow for problem analyses of programme implementation, resource deployment (inputs), execution of deeds, output accomplishment and realisation of outcome/ impact (end result).

- **Indonesia: A Government agency performance accountability system (SAKIP)**

In 1996 in Indonesia a study on PM was conducted that later realised the development and initiation of a PM model for the public sector namely the 'Government Agency Performance Accountability System (SAKIP)'. This model was motivated largely by the financial and monetary crisis and other governance issues of the late 1990's (Koike, 2013, p. 349). In 1999, in accordance with Indonesian legislation, Presidential Instruction No. 7 relating to government agency performance accountability was issued, that directed good governance of the state in Indonesia directly (Koike, 2013, p. 349). The components of SAKIP are: (a) a five-year strategic/ performance plan, and a (b) performance measurement. The strategic plan comprises of the performance vision, mission, five-year strategic goals, annual strategic objectives and programmes, where after the annual performance plan takes effect. Performance measurement occurs by comparing the performance indicator attainments with those identified targets planned to have been achieved. Comparison is also made with the performance achieved for the preceding years (Koike, 2013, p. 350). In Indonesia, as from budget year 2005, a written contract labeled 'annual performance agreement' was instituted between the parties comprising of the line functionary and the supervisor that clarifies the work performance agreement. It also has a

summary of the annual performance plan that stipulates the main projects to be accomplished and work performance indicators (outputs and or outcomes) inclusive of the budget allocation. The latter was an attempt to create a performance-based budgeting system (Blöndal, Hawkesworth & Choi, 2009, p. 19).

The Indonesian PM experience, according to Koike (2013, p. 350), was that there were major impediments in trying to development and implement SAKIP. Four factors played a role. Firstly, the commitment of government officials to employ SAKIP, played a major role in endeavours at improving methods of management and performance, as reflected in a report on accountability. Secondly, the customary perceptions held by public officials that they are to serve the government as opposed to the public were another hindrance. This notion also reinforced the perception held by public officials that the positions held in government related to patronage rather than by virtue of professional competence. Thirdly, even though performance indicators are regarded as important features to measure work performance, determination of what the correct indicators are continues to be problematic. Fourthly, variations in the definition of work performance still exist (Koike, 2013, p. 350). In this regard performance has been defined by the Government Agency Performance Accountability System, SAKIP in Indonesia as the "*results in terms of output and/ or outcomes*" (Koike, 2013, p. 350).

- **Japan: Policy evaluation performance evaluation**

In reforming policy in Japan by means of the introduction of a policy evaluation system in 2001, in ministries and agencies), national hospitals and universities could also be scrutinised. Policy evaluation in Japan is decentralised. Individual ministries may plan and implement their own evaluation whilst the verification responsibility of the self-evaluation and of having to conduct the broader overall assessment of transversal issues resides with a ministerial department (Koike, 2013, pp. 351-352). The Ministry is responsible to publish a condensed report on the evaluation that reflects how results are illustrated in policy and other organisational matters. Legislation in Japan identifies: (a) project assessment, (b) performance evaluation and (c) comprehensive evaluation as the standard methods of evaluation. The evaluators are provided with performance evaluation guidelines from the ministry (Koike, 2013, p. 351).

In 2005, it was evident that interest in the constructive use of performance and comprehensive appraisal that aids improvement in the quality of public policies and programmes had increased. On the other hand, it has found that ministries submitted evaluation results in the interest of self-preservation of own policies and programme. It was also found that the intended means to formulate the budget in accordance with performance evaluation results and policy evaluation was not accomplished (Koike, Hori & Kabashima, 2007, p. 5). A revision of the National Public Service Act of 2009 in Japan, announced a new personnel evaluation system which proposed that

staff appraisal be linked to remuneration increases, bonuses and promotion criteria. In this way the Japanese government aimed to transform the customary *'career system'* determined by seniority rule to a system that upheld and appraised worker capacity and work performance (Koike, 2013, p. 351). The Act stipulates that if a good performance record was not achieved by individual workers, they will suffer a reduction in pay to a lower remunerative scale (Koike, 2013, p. 351).

The outcome then, of the new performance evaluation system in Japan, however seemed inadequate. Those at management level were inclined to offer small pay incentives to those who acquired some results whilst the personnel evaluation system produced a small number of downgraded cases suggestive of the difficulty to change the 'culture of seniority' in Japan. The new Democratic Party of Japan, in an attempt to promote civil service reform, has only just established a personnel agency and put forward a restructured package that would manage higher-ranking executives in an included way and engage with civil servants and enter into collective labour. The restructured model is yet to be implemented, according to Koike (2013, p. 351).

2.5.2 Operational performance management level

The operational level of PM is associated with management of operations where the focus is more on the functional level (Sole, 2009, p. 5; Brudan, 2010, p. 113). In the sphere of HRM, the use of tools that measure performance is well-known. Examples of such tools are scorecards and dashboards; the latter used more so to analyse management indicators that direct management decisions. Supplier scorecards, portfolio dashboards and marketing scorecards are further examples of comparable tools used in other functional areas (Brudan, 2010, p. 113). Attention has been drawn to the specific use of the '*tableau de bord'*, a dashboard popularly used by managers in France since its introduction in the 1930s to monitor the operational performance of their organisations (Bessire & Baker, 2005, p. 647). According to Sharif (2002, p. 63), a combined framework allows for flexible management scoring and reporting on strategic and operational issues.

2.5.2.1 Frameworks and/ or models of operational performance management in Asia

- **Thailand: Results based management in the public sector in Asia**

A results-based management means was introduced in Thailand in 2003 to gauge and give impetus to the work 'performance of ministries, departments and all provisional administrations'. In 2004, the Thai Cabinet ordered that all government agencies compile performance agreements and make use of key performance indicators to reach work performance targets (Koike 2013, p. 355). Based on the identified needs of having to measure success of the execution of the strategic plan, the worth of public sector work performance, distinction in service delivery and organisational development, the Public Sector Development Commission (OPSDC) of the Thai

Government introduced the Balance Scorecard model. By 2007, three hundred and ten public sector organisations had implemented performance agreements. The organisations which included provincial authorities, universities and government departments, were required to develop performance indicators within the domains of the *'effectiveness of strategy implementation'*, *'quality of service delivery'*, *'efficacy of work performance'* and *'organisational development*". The departments were also required to develop scoring criteria that would be applied (Koike, 2013, p. 355). Thailand was rated as having been successful on the whole with the implementation of the results-based management system in its early stages according to the World Bank report (World Bank, 2006, p. 15).

- **Philippines: Office Performance Evaluation Systems**

A Civil Service Commission (CSC) initiative in the Philippines in 2007 brought about a reassessment of the existing Performance Evaluation System (PES) and led to the implementation of a newer system namely the PM System-Office Performance Evaluation System (PMS-OPES). This system was to institute a high-performance culture within government synchronising individual objectives with organisational objectives (Koike & Hiromi, 2008, online; Valeriano, undated, online).

- **Taiwan: Combining the Balance Score Card with an incentive plan: A hospital case study**

At a Taiwanese hospital, an empirical study was undertaken combining the Balanced Scorecard (BSC) with an incentive plan which was geared at improving hospital performance (Chu *et al*., 2009, p. 401), based on the premise that although some data showed a steady increase in the use of BSC by organisations, little was known about implementing the BSC in combination with an incentive plan (Chu *et al.*, 2009, p. 402). Before the implementation of the 'BSC-based incentive plan', nurses were paid according to a scale which differentiated in terms of seniority and rank. Only supervisors and directors received additional pay. Performance assessments were based on the subjective system of supervisor rating according to which bonuses were paid out (Chu *et al.*, 2009, p. 402). The new plan proposes incentives by which nurses continued to receive a basic salary with an additional share of collective bonus based on scores from group performance, according to a specific formula (Chu *et al.*, 2009, pp. 402-403). This was intended to persuade nurses to improve their work performance through teamwork that would reflect and be calculated by the scorecard (Chu *et al.*, 2009, p. 403).

2.5.3 Individual performance management level

The performance dimensions of an organisation are the productivity and effectiveness of the individual or the team (Sole, 2009, p. 6). Individual PM possibly has the longest evolutionary history and is the most traditionally used method at organisations (Brudan, 2010, p. 112).

Effective individual PM emulates the level of organisational maturity (Brudan, 2010, p. 112). Management of the organisations' performance is based on the performance of the work deeds of the individual as part of a work setting cluster. During the 1990s, organisational performance goals and measures were reproduced in individual performance goals and measures, in an attempt to increase the accountability of all employees in organisations so that the organisational strategy could be achieved (Brudan, 2010, p. 112).

2.5.3.1 Frameworks and/ or models of individual performance management in Europe

- **Slovenia: Middle-manager capacity**

Most of the hospitals in Slovenia are in the public sector (Savič & Robida, 2013, p. 13). A study investigating middle-manager capacity for people working in hospitals or health-care organisations in Slovenia, found that leaders like those in middle-management were not chosen for their managerial skills. Selection and appointment of persons to the managerial posts in the Slovenian hospitals and health-care organisations were based on their clinical proficiency (Savič & Robida, 2013, p. 12). According to Sole (2009, p. 8) there is a number of factors that influence a PM culture. The factors are listed as internal and external. The internal factors are: (1) leadership and internal management commitment, (2) internal resources, (3) performance-orientated culture, (4) employee engagement, and (5) the maturity of the PMS. The external factors are listed as: (1) society and elected officials and (2) the legal requirements. It appears the anomalies with the Slovenian situation have subsequently been corrected as there are subsequent reports of change in the situation. This change has been attributed to team work and the successful application of 'change-implementation' in the Slovenian hospitals, a case that was however not supported nor promoted by the established hierarchical organisational culture (Savič & Robida, 2013, p. 2). It was advocated that hospitals attempt to acquire accreditation for quality post graduate programmes in the field of health-care management equivalent to that offered in fellow European countries (Savič & Robida, 2013, p. 13).

- **Italy: The performance management model (tool)**

For managers in the public service, Sole (2009, p. 6) proposes a six stage PM model to effectively measure work performance. The stages focus on: (1) creation of organisational transparency, (2) assurance of effective internal communication, (3) development of systemic procedures, (4) review and update requiring the appraisal and update of the performance measurement system at all levels of the organisation, (5) reconcile performance measure alignment, and (6) managers' verification and assurance of positioning and constancy between defined strategic, operational and HRM threads at all organisational levels (Sole, 2009, pp. 6-7).

2.5.3.2 Frameworks and/ or models of individual Performance Management in the USA

- **State of California: A PM appraisal system making use of core competencies**

In California, the City of American Canyon, a manager's tool, was provided for the purpose of addressing performance appraisal. The tool assisted managers to improve in the area of written reporting and enhanced auditing of performance reviews (City of American Canyon, 2012, p. 53). Fundamental goals and principles were developed and provided to steer the appraisal process. The City of American Canyon intentionally set out to improve the work performance of the staff in order to achieve its work intentions and goals, identify achievements and contributions, support desired staff development and support on-going learning and reinforce managerial accountability (City of American Canyon, 2012, p. 53).

- **North America: The ABC Performance Model**

The ABC PM model was purported to be a forerunner to talent management whilst it facilitated the recruitment and retention process, and succession planning (Walker, 2007, p. 55). The ABC performance model recognises employee differences in employee characteristics such as persona, talent, capacity, interest, motivation and engagement, and therefore believes that the approach to managing individual performance is to be individualised. The adoption and implementation of this model mean that the manager must have knowledge of employee behaviour and of the individual's personality (Walker, 2007, p. 54). Walker (2007, pp. 54-55) in embracing the ABC model, distinguishes between employee (also referred to as a 'player') characteristics according to three performance types, namely the A player, B player and C player. When the principles of the ABC PM model are applied, there is an accompanying expectation that the potential of the A employees who were said to be the high performers, must be unleashed. The B employees are expected to be moulded into high performers. The C employees whose performance is poor/ unsatisfactory should be reprimanded as their performance was seen to have a grave effect on various aspects of staffing such as employee confidence, commitment, loyalty, and on staffing exits (Walker, 2007, p. 55). Walker states that the model propels the organisations' performance efficiency, team contentment and client service to a higher level.

- **The McKinsey Sevens Framework in the management industry**

The McKinsey Sevens Framework (in the 1980s) is an illustration of an approach to improve the efficacy of a company, enabling a strategic vision for business groups and units. This model adopts a systems approach to an organisation, asserting that the following interrelated elements constitute an organisation: (1) strategy, (2) structure, (3) systems, (4) shared values, (5) style, (6) staff and (7) skills. In this framework, strategy, structure and systems make up the 'hard' elements. This management model, which has often been used for analysis of an organisation to

monitor and review its internal situation, emphasises the 'soft' elements as they appear to be otherwise overlooked in organisational performance improvement initiatives. These are shared values, style, staff and skills (Saravanja, 2010, p. 102; Singh, 2013, pp. 39-40).

2.5.3.3 Frameworks and/ or models of individual performance management in Asia

- **South Korea: Performance-based budgeting**

Following the Asian financial crisis of 1997 South Korea has adopted a progressive stance in promoting PM change. The change revolves around three key elements, namely 'performance agreement', the 'annual policy evaluation system' and 'performance based budgeting'. In the 'performance agreement' realm, managers (administrators) and supervisors (overseers) consult on work performance targets yearly. In this regard, the signing of performance contracts occur in sequential rank order in that a minister in government signs a performance contract with a Deputy Minister. The latter in turn contracts with a government department (bureau or agency) Director and Associate Director. This would continue down the ranking order. In South African where this study was conducted, Section 92(1) of the Constitution compels an individual Minister to be accountable both to the State President and to Parliament for the administration of the portfolio entrusted to them (Citation of Constitutional Laws, 2005 [Republic of South Africa: Constitution, 1996, pp. 56-57]). Performance agreements are required to incorporate a stratagem or plan, goals, monitoring and appraisals. The PM process typically links the achievement or work performance targets to performance-based pay. Promotion in the career orientated system is also based on realising performance targets (Lee & Moon, 2010, p. 436; Koike, 2013, p. 354).

In South Korea, policies would be appraised by a policy evaluation committee, established by the office of the Prime Minister, the year following its execution. Once work performance goals and dimensions are set for policy by the ministries, key indicators are developed (Koike, 2013, p. 354). Ministerial evaluation criteria categories are stipulated in relation to policy performance with an incremental range of low, medium and high where incentives are awarded accordingly. Ministers who achieve high scores are frequently rewarded with inducements or esteemed ministerial projects by the President. Those who achieve lower scores face the possibility of being dismissed (Lee & Moon, 2010, p. 439; Koike, 2013, p. 354).

Korea however has a customised performance-based budgeting system based on the USA blueprint of GPRA and the Programme Assessment Rating Tool (PART) (Kim & Park, 2007, p. 2; Koike, 2013, p. 354). Annual performance plans, inclusive of their work performance targets, are submitted by ministries and agencies to the Minister of Planning and Budget (MPB). These are accompanied by the annual budgetary projections as an indication of their requests. Once ministries/ departments have completed preliminary self-assessments of their work performance, the MPB ratifies the results in a concluding step (Koike, 2013, p. 354). South Korea is nonetheless still in its infancy stage of establishing a PM system and has to overcome a number

of difficulties (Kim & Park, 2007, p. 1). Korean workers in the public sector in Korea have become more amendable to a work setting that is 'results-orientated PM'. The reality is that PM transformation is changing the managerial culture in Korea (Kim & Park, 2007, p. 9).

2.5.3.4 Frameworks and/ or models of individual performance management in Africa

- **Performance management in some government departments in South Africa**

In South Africa the Public Service Regulations (PSR) (2001), Part VIII, introduces the SPMS for the Public Service as a model comprising a performance prescript and a developmental facet for each individual staff member (Western Cape Provincial Administration, DOH, 2002, p. 6). The aim of the public PM system is similar to that of most other PM system in that it is to manage work performance in a participatory and fair manner. This will improve organisational efficiency and effectiveness while applying the required financial accountability in realising public service objectives (Mlambo, 2010, p. iv). The formalising of this process is a necessary event so that the developmental part of the individual's SPMS is linked to the organisations overall objectives (Western Cape Provincial Administration, DOH, 2002, p. 1).

- **Performance management in a South African provincial Premier's Office**

Mlambo (2010, p. 82) also investigated awareness and perceptions of PM system in the office of the Premier in the North-West Province of South Africa and also asked what the best practices in relation to performance or PM were. Based on shared trust, the SPMS system in Limpopo is purported to be pragmatic and cost-efficient and is set up in such a manner that it allows for mutual joint duty and answerability. While balancing the needs of the organisation and the rights of an employee, the SPMS incorporates a contractual agreement on performance, agreed upon quantifiable standards and provision for improvements in service quality (Mlambo, 2010, p. 78). The underlying principles, on which the implemented SPMS are based in the Limpopo Office of the Premier, follow provincial and departmental prescripts. The system is designed, uniformly applied, and equitably and fairly in all departments involving all employees, and implemented in a way that allows for participation. Individual performance instruments are in line with the organisation's strategic objectives, as set out in the overall plan. It is expected that individual performances be communicated in a counselling manner between the two parties namely supervisor and supervisee. The principle, that there is a clear association between work, and 'recognition of work systems', is also regarded as pertinent (Mlambo, 2010, p. 78). Along with systems growth and sustenance, three distinct phases of performance management exist in the Limpopo Province, i.e. planning and contracting, monitoring and evaluating. Mlambo (2010, p. 59) points out that certain measures are vital components to the PMS; these include 'indicators', 'targets', 'standards', 'results'.

- **Performance management in the Department of Health in the Western Cape (South Africa)**

In 2000, a Public Service Coordinating Bargaining Council resolution, determined that the rank and leg promotion system used at that stage, be terminated earlier or by 1 July 2001 if a new pay progression system had successfully been negotiated by then (Mlambo, 2010, p. 59). The health facilities/ hospitals in the Western Cape where this study was conducted are all governed by the Provincial Government of the Western Cape (PGWC) (Table 1.2). In 2002, the PGWC implemented the PMS formally known as the SPMS. In accordance with the prescripts of the system, the (PGWC) adopted the work PM practice where performance agreements would be negotiated between an overseer (manager or supervisor) and an individual member of staff as the two main role-players in the process (Western Cape Provincial Administration, DOH, 2002, p. 8). The PGWC also seeks to ensure that there is an alignment between the work performance of individuals, groups and institutions to its broader departmental/ provincial objectives (direct research observation and understanding). Fulfilling the review and evaluation requirements of the SPMS ought to occur by means of formal interviews at regular intervals that vigilantly examine performance. The dialogue serves as a means to ascertain if the organisation, business or hospital is using its full potential to render the required services and achieve quality outcomes. In the context of current labour practice and the labour agreement within the formal employment sector, the arrangement where a pre-determined payment is received for a specified quantum of work done, is viewed to be fair. In this regard the principle of 'equal work for equal pay' is applied (Western Cape Provincial Administration, DOH, 2002, p. 4). In the public sector in the Western Cape, PM is the process whereby people are directed to work according to a prescript, the performance plan being the pivotal tool to this process. This prescript also makes provision for collective key performance areas/ objectives for employee clusters where jobs are alike (Western Province Provincial Administration, 2002, p. 13).

The fundamental principle of adopting a non-punitive approach when the SPMS is embarked on, is reiterated in the Limpopo Province and the Western Cape (Mlambo, 2010, p. 78). Broad prescripts that stipulate the expectation of improved performance in government in the Western Cape, are the Premiers game-changer outline (2016) and the leadership development strategy launched August and September in 2016 (Western Cape Provincial Legislature, 2016).

Provincial prescripts include the Provincial Annual Performance Plan, the Provincial AOP and the institutional AOP. Specific to the employees work performance are the job descriptions and the individual performance plans. Entrenched, in these plans, are having to improve the health status of patients, being patient-centered, maintaining a population perspective on maternal, neonatal and child, HIV and TB, and non-communicable disease outcomes. There is also a focus on the behavioural values of care, competence, accountability, integrity, respect, responsiveness

and innovation (Department of Health, Provincial Government of the Western Cape *Annual Operational Plan* 2014/2015; Department of Health, Provincial Government of the Western Cape *Annual Operational Plan* 2015/2016; Department of Health, Provincial Government of the Western Cape *Annual Operational Plan* 2016/2017; Western Cape Provincial Government (Budget Speech), 2012, online).

- **Public Service performance management and the Balanced Score Card**

The ease of the application and attention placed on key performance drivers such as finance, efficiency, learning and clients of the BSC are said to be appropriate for use in the South African public service setting, as it allows for a more focused approach on a small amount of selected (explicit, quantifiable, attainable, rational) key performance goals. Additionally, the requisite time frames linked to desired performance goals with the BSC are seen as useful in the SA public sector context (Saravanja, 2010, p. 101). The noted shortcomings of the BSC model within the SA public service are that too much emphasis is placed on financial performance (Saravanja, 2010, p. 101). Saravanja (2010, p. 101) furthermore asserts that the use of the BSC requires having to develop performance indicators to measure efficiency, learning, and customer satisfaction.

- **Performance management in the an executive provincial government office**

A South African study conducted by Mlambo (2010, p. 74), explored the level of awareness, the perception of and the extent the Office of the Premier of the Limpopo Province of South Africa complied with the theoretical and statutory requirements of their PMS. The PMS system in the Province of Limpopo was influenced at the time, by directives and training prescripts of the Department of Public Service Administration (DPSA) and the former South African Management Academy, PALAMA. Another potential influencer might have been the external consultancy group who was specifically tasked to assist with revising the PMS in this province in 2000 (Mlambo, 2010, p. 75). The PMS developed for Limpopo was a progression from a similar experience in the Eastern Cape Province of South Africa, who themselves had evolved from a systems-based PM approach that utilised the Balanced Scorecard (Mlambo, 2010, p. 75). A view held by these developers was that PM is a process of harnessing all accessible resources within an organization, and ensuring that they perform maximally so that desired results are achieved. Culture and relationships, building processes and systems that aid an organisation in achieving its objectives, are also seen as part of PM. In compliance with Chapter 1, Part VIII of the Public Service Regulations of 2001, the Office of the Premier of Limpopo established a system of PM and development for its employees, in all ranks other than Senior Management Services (Mlambo, 2010, p. 75). The Department of Public Service in South Africa was also seen to

support the application of a PM system based on the Balanced Scorecard (Saravanja, 2010, p. 51).

The Limpopo Province embraced the need for staff members to have clarity on the significance of the roles they play in the organisation and acquiring organisational goals (Limpopo Provincial Government, 2004, p. 10). The Limpopo Province stipulated that the PM system for an individual staff member must make provision for insight into and acknowledgement of performance levels. It should also make provision for the alignment of responsibilities of the individual to the team, department and the overall strategic goals (supported by Saravanja, 2010, p. 105), definitive areas of responsibility with indicators for measuring performance, and the two-way flow of feedback on performance (Mlambo, 2010, p. 76). The PMS stipulations collectively for team, departmental and provincial performance, required the alignment of goals, an appreciation of good quality performance and correction of poor performance. This meant that the PM system set out to achieve the goals of the WCP. The system further allowed for the recognition of superior performance and ensured that sub-performance would be attended to (Mlambo, 2010, p. 77).

The established Limpopo Province PMS was designed to offer a systematic framework that allowed for performance that incorporates: (1) planning, (2) monitoring and review and (3) assessment. Additionally, it strives to inculcate in staff a collective sense of responsibility to reach strategic aim/s and purposes. Following on this, managers are persuaded to create work conditions for optimal performance of tasks and give added attention deliberately to training and development; development being regarded as a fundamental principle requirement (Limpopo Provincial Government, 2004, pp. 12-13).

2.6 PERFORMANCE MANAGEMENT EVALUATION

Performance measures are inherent in and applied through performance management systems, and aid decision making and accountability of an organisations (Sole, 2009, p. 4).

2.6.1 Performance measurement, appraisal and/ or evaluation

An important regard for the measuring of performance exists. The proclamation made by Lord Kelvin that measurement precedes improvement, supports the notion that performance must be measured: "*If you can't measure it, you can't improve it*" (Thomson, 2008, online). Saravanja (2010, p. 63) points to the saying that if something can't be measured it cannot be managed. Employee performance measurement systems have traditionally kept an eye on work in the broader realm of managerial control at organisations (Hellqvist, 2011, p. 929), notwithstanding the fact that measurement is multifaceted and demanding (Sink, 1991, p. 23). Lately, appraisal is re-emphasised as part of the continuous PM process (Claus & Briscoe, 2009, p. 176). The system

of performance measurement is regarded as critical as it serves as the information system to PM and its processes such as quality assurance and monitoring efficiency (Budimir, Lutilsky & Letinić, 2016, p. 49).

The Western Cape Provincial Administration, DOH (2002, p. 2) asserts that performance appraisal is frequently referred to as the yearly performance assessment discussion at the end of the performance cycle, assessment though forming part of the bigger, systemic process of aligning individual PM and development to organisational goals. The assessment is merely one aspect of managing and developing the performance of individuals. It is cyclical and repetitive and is predominantly aimed at performance improvement through ongoing learning and growth. Assessment thus should primarily not facilitate a final rating in the performance appraisal. Overall, a close relationship between performance and quality exists. In order to measure performance, related standards have to be in place. In the international arena, without losing the focus of a company, performance management systems also serve the purpose of having to successfully translate and integrate dormant or latent talent of employees into required company outcomes (Hellqvist, 2011, p. 940). The absence of a suitable performance appraisal and measurement system could pose as a hindrance to progression and transformation as they have traditionally been developed and used for monitoring and maintaining organisational control (Hellqvist, 2011, pp. 929-930). PM could be pivotal in the overall reward system as they could be clustered together and be regarded as a collective reward system. Rewarding work has always been a contentious issue as monetary, non-monetary and intrinsic and extrinsic issues are debated (Yiannis *et al*., 2009a, p. 909).

According to Yiannis *et al*. (2009a, p. 909), PM is a tactical yet comprehensive way to bring continued accomplishment to organisations by enhancing the performance of the employees and by improving group capacity but believed that people should also be rewarded. Even though it has been said that most health workers draw satisfaction from performing better than what the expected standard requires, more concrete inducements have been given by employers. These include high rated quality rewards, certificates of endorsement and money (Shaw, 2006, p. 110). In other instances, other non-financial incentives were seen to have been applied to alter clinician behaviour in particular ways (Iversen & Luras, 2000, p. 208; Shaw, 2006, p. 110). The non-financial rewards relate to aspects such as the importance of having job satisfaction. People want acknowledgement and admiration from peers and managers for their effort in performance (Shaw, 2006, pp. 109-110). Whilst inducements (and resources) play a role in PM, it also serves a pertinent role in change management (Shaw, 2006, p. 108 & 110).

2.6.1.1 Performance Management by means of remuneration

The remuneration-driven PM is seen as both: (1) reward-driven integration, and (2) reward-based systems (Mlambo, 2010, p. 48). Based on short-term targets, remuneration-driven PM systems are reward-driven in that performance is related to pay and often referred to as 'performance-related-pay' which resultantly underrates other activities of a human resources nature. Performance-related pay affected task performances, where the rewards were secret in nursing practice (Price, 2011, p. 230); though being paid for performance is regarded as encouragement for small portions of good performers and risks the majority being de-motivated. As stated by the participants in this study, Price (2011, p. 241) indicates that this practice reduces more and strengthens the perceptions of unfairness. Even though cash rewards may stimulate enhanced performance, they aren't viewed as fundamental to PM. Martínez and Martineau (2001, pp. 3-4) have previously warned of the strong likelihood of the influence on the organisational culture that facilitates the drive for a cash reward system. Cash rewards are not appreciated by all staff members due to rewards being given to individuals for what is perceived to be group work reward. Rynes, Gerhart and Minette (2004, p. 389) also found that despite pay being a potentially powerful motivator to get people to work, its actual motivational value is dependent on how it is administered in practice as well as other individual and situational factors. Grindle and Hildebrand (1995) in Shaw (2006, p. 109) state that; *"... the pay packet is not the only motivator, even in low income countries".*

The notion put forward is also that performance management systems that are reward-driven might be restrictive. In this vein some performance management systems that promote discussion, have common visions, and agreement sustains organisational effectiveness as compared to rating employees for pay rewards (Odhiambo, 2013, p. 5). Short of being fired, automatic pay rises in historical reward systems, have become an expectation that is almost always fulfilled. In cases where these kinds of systems are still applied, the reward system does not improve work performance (Mlambo, 2010, p. 48). McNeese-Smith (2001, p. 174) states that, work performance is rewarding when it becomes an extension of the individuals' self-image, and inherent principles.

2.7 CONCLUSION

This chapter provides an overview of some of the relevant PM theories, models, and frameworks in management and health services. It elaborates on the types of systems that are found in other countries and reflects on PM in the South African context. However, no clear framework for performance management of the ANM in the health-care setting has been found in the literature with regard to scope and relevance that could be used as a template for this study. Additionally, the notion of contemporary is indicative of modern or new (Merriam-Webster Dictionary, 2016, online). A high level of reliance has therefore been placed on the empirical evidence sought for in this study. The researcher regards the discussion in this chapter as important for the

understanding and the positive AI inquiry forthwith of nursing management in this study as opposed to a problem-solving approach where the problems are firstly identified and a solution is sought, whilst a number of ANMs and HONs had stated that there is a need for a research investigation such as this. Hence it became clear that the need for the study could be justified. The reader will recognise though that there are some methodological approaches in the literature on the phenomenon in this chapter pertaining to qualitative research. Chapter 3 will outline the methodology followed in this study.

CHAPTER 3
RESEARCH METHODOLOGY

3.1 INTRODUCTION

This chapter deals with the research methodology of this study. The methodology is a systematic sequence of procedural steps that allow for audit tracking illustrating how data was collected and then managed with regard to the analysis. It is also referred to as the procedural framework (Wilson & Sharples, 2015, p. 123). Research methodology involves the orderly and coherent approaches to conducting a research study. The research methodology is vital as it focuses the study and gives it direction (Jonker & Pennink, 2010, p. 33). The terms 'research methodology' and 'research design' are at times used interchangeably, however, methodology refers to the principles, procedures, and practices that oversee research. It guides the researcher in collecting, analysing and interpreting observed phenomena in line with the research design, population and sample, data collection and data analysis (Marczyk, DeMatteo & Festinger, 2005, p. 22; Okiro & Ndungu, 2013, p. 153). The main purpose of this chapter is to describe the research design and methods from the information acquired in the study. This study sets out to develop a contemporary work PM framework for ANMs in the provincial health-care setting of the Western Cape with reference to the job description of this nurse manager grouping by applying the research objectives. The research methodology assures that the research data remains valid to the intended research plan, (Knight & Cross, 2012, p. 48).

3.2 RESEARCH DESIGN

The research design details the description of the research. It is described as the architectural backbone of a study (Polit & Beck, 2013, p. 51; LoBiondo-Wood, 2014, p. 233). Creswell (2013, p. 5) notes the research process as a whole that commences with problem formulation, followed by writing of the research questions, collection of data, data analysis, and interpretation and writing of the report as the research design. Yin (2014, p. 29) states that the research design is the logical succession of events in the research process that links the empirical facts to the study's initial research question/s, and in due course to its conclusive ending. The steps of the research process followed in this study, in pursuance of the research aim, commenced with the drawing up of a research proposal. This was followed by data collection, data analysis processes, writing up of findings and the development of a PM framework. The research design was therefore an integrated framework or a blue print for conducting the study as it served to outline the overall research plan or strategy of the study as the researcher chose, in a logical and coherent manner that ensured that the research problem is effectively addressed (Sinha, 2015, p. 227). Research can be categorised as having either a qualitative, quantitative or mixed methods

approach (Babbie & Mouton, 2011, p. 272; Becker, 2010, p. 139; Olaogun & Fatoki, 2009, p. 14).

3.2.1 Qualitative design

This research study is qualitative with an explorative, contextual and descriptive approach. A number of scholars have given various definitions of qualitative research (Mokoena, 2012, p. 39; Olaogun & Fatoki, 2009, p. 13). Qualitative research is an inductive way of collecting data (Brink *et al*., 2012, p. 5) during which findings are arrived at other than by statistical means or other processes using quantification (Babbie & Mouton, 2011, p. 272; Becker, 2010, p. 139; Olaogun & Fatoki, 2009, p. 14). As with all other research customs, qualitative research aims at acquiring knowledge and understanding (Walker, Cooke & McAllister, 2008, p. 82).

Qualitative and quantitative research distinguish themselves from each other in studies based on their respective theoretical suppositions, the means of acquiring data, their research approaches, and the exclusive research methods used (Wisdom, Cavaleri, Onwuegbuzie & Green, 2012, p. 723). In keeping with the characteristics of qualitative research as described by Babbie and Mouton (2011, p. 270), this study distinguished itself by its qualitative research characteristics where: (a) the researcher was the key research instrument, (b) the study attempts to make sense of deeds and occurrences in the context of the research, (c) the research process is inductive and subjective, and thereby is expected to lead to the formulation of new theory, and (d) the goal is the acquisition of in-depth data. Qualitative research features include the correct choice of suitable methods and theories, the acknowledgement and analysis of different perspectives, researcher reflection on their research as contributors to knowledge production and the assortment of research approaches and methods (Flick, 2009, p. 14).

According to Thorne (2000, p. 70), Morse's abridged cognitive processes of qualitative analysis have led to an improved understanding of the interface between the cognitive processes of the researcher and qualitative data which is aimed at attaining outcomes as well as the generation of original knowledge. Morse's (1994) summary of cognitive processes in qualitative analysis, irrespective of any specific approach followed, includes comprehension, synthesis, theorisation and re-contextualisation (Thorne, 2000, p. 70). Comprehension is related to having the understanding alluded to earlier, of the phenomena at hand. The process of synthesising involved the creation of a bigger picture of the phenomena that described aspects in the framework. The survey list of the Practice Orientated Theory with the components of agent, recipient, context, endpoint, guiding procedure, and the energy source of Dickoff *et al*. (1968, p. 423), was used as the foundation of the reasoning map for the development of the framework. Newly generated

knowledge about the phenomena was placed into context (Thorne, 2000, p. 70; Walker *et al.*, 2008, pp. 85-87) by literature, in the developed framework in this study.

Qualitative studies are seen as naturalist research by some as they require the researcher to go to the natural setting where the phenomenon is being studied (Guba & Lincoln, 1985, p. 39; Babbie & Mouton, 2011, p. 270). The natural setting in this study can be seen as the nursing managerial field at the provincial health-care settings where the work performance experiences of participants occurred. The study participants were the ANMs and the HONs.

Quantitative research on the other hand, could be viewed as a natural sciences approach; the type of research that is devised from a positivistic world-view (Lepine, 2011, p. 2). Quantitative research collects quantitative data in a manipulation of observations, and numerically depicts these so that the phenomena can be described and explained (Sukamolson, 2010, online). The approach in quantitative research is deductive while qualitative research is inductive. Quantitative researchers attempt to illustrate different aspects of social life by means of variables that can be collected and accurately measured in number format (Lepine, 2011, p. 3) and is amenable to being analysed mathematically (Hartas, 2015, p. 66; Sukamolson, 2010, online). Quantitative research is also known to be objective and hypothesis-driven. The quantitative research approach allows for causal relationships to be discovered (Hartas, 2015, p. 66).

As the health services research arena persisted in its evolution, so too have its research methods (Wisdom *et al.,* 2012, p. 722). Today there is a departure from the differentiated research approaches of the qualitative and quantitative methods seen to be applied effectively, and known as the mixed methods, that can enhance the understanding of health services in a composite manner, than either method independently (Brannen, 2005, p. 173; Wisdom *et al.,* 2012, p. 721; Shdaimah & Stahl, 2011, p. 12). Mixed methods research makes the most of the strengths of the two mentioned methodologies. It combines them in a single research study to enhance the vigor and the extent of understanding and corroboration (Wisdom *et al.,* 2012, p. 721).

This study followed the qualitative research approach in anticipation of the yielding of rich, descriptive data (Frankson, 2009, p. 6). The application of qualitative research in this study has assisted the researcher in obtaining a detailed understanding of the work performances of the ANMs. It allowed the researcher to gain rich insights into the experiences of the ANMs and their meaning leading to understanding of the phenomenon, also because of the abundant interconnectedness of the detail (Stake, 2010, p. 49). In this study meaning was fundamentally generated by using the social means, inductively, where meaning is shaped from collected field data (Creswell, 2014, p. 8). The qualitative design also complemented the research. The use of

the semi-structured interviews and the focus group discussions played a role in allowing the research to evolve (Babbie & Mouton, 2011, p. 272).

3.2.2 Exploratory design

The intricacies of a research design, in cases where exploration is used, are inclined to be more open and flexible. The use of an exploratory research design is frequently recommended as the research strategy, where some groundwork has been conducted with provisional results at hand, and where the problem still needs to be clarified (Oivo, Kuvaja, Pulli & Similä, 2004, p. 306). Exploratory research is largely used in social research (Babbie & Mouton, 2011, p. 79; Oivo *et al.,* 2004, p. 306). Frequently, the exploratory research design means are used as orientation to a new study focus or when a new interest is to be explored (Babbie & Mouton, 2011, p. 79), such as the PM of the ANM. This study was undertaken to: (i) explain the central ideas and constructs of a study, (ii) enhance the understanding of the phenomenon (Polit & Beck, 2014, p. 10; Babbie & Mouton, 2011, p. 80), and to (iii) gain new insights (Oivo *et al.,* 2004, p. 306). Exploration is an essential attribute for understanding phenomenon in qualitative research (Polit & Beck, 2014, pp. 12).

3.2.3 Contextual design

The quest for understanding occurrences, acts and deeds, and processes within their context is preferred by a qualitative researcher. Some scholars have labeled this research approach as contextualist or holistic (Babbie & Mouton, 2011, p. 272). Researchers in the qualitative realm accept that reality is socially constructed and context-dependent. Further it is believed that even when two people have shared a similar experience that has common threads, the experiences will be different (LoBiondo-Wood, 2014, p. 97). This has to do with the use of contextual research which relates to how research participants understand their world and make sense of it. Qualitative researchers collect 'close-up' information by means of direct interaction with the study participants to see how they behave and engage within their context (Babbie & Mouton, 2011, p. 272; Creswell, 2013, p. 45). Guba and Lincoln (1985, p. 233), and reiterated by Terre Blanche, Durrheim and Painter (2006, p. 287), state that the natural setting of people is where the mind-set and conduct is best understood. This study is therefore contextual as an understanding was sought on how the research participants understood the ANMs key performance management areas, their best work performance experience, their desire of what work performance experience could be improved, and their future work performance initiatives and commitments.

3.2.4 Descriptive design

Babbie and Mouton (2011, p. 272) state that descriptive studies are embarked on to explore and describe real-life phenomenon. According to Grove *et al*. (2013, p. 215) descriptive designs are valuable in establishing practices. Babbie and Mouton (2011, p. 273) point out that descriptive

research allows the researcher to narrate intricate phenomena. In this way the researcher stays true to the participants involved in the research study and authenticity is retained (Holloway & Wheeler, 2010, p. 304). In this study, the ANMs' understanding of their key performance management areas (KPAs) was considered to be a job domain or job function, decisive to making effective contributions to the achievement of organisational goals. The quest to ascertain this understanding was to have the ANMs and the HONs relay, within the context of their work, the work performance experiences of the ANMs. Streubert and Carpenter (2011, p. 23) note that descriptive studies are useful for documenting a phenomenon of interest in its actual setting. In relation to the work performed by the ANMs, this study attempts to represent that reality. The researcher has therefore applied the descriptive design to gather rich data from interviews, discussions and observation regarding the work performance experiences of the ANMs working in provincial health-care settings.

3.3 STUDY SETTING

- **Location**

The ten General Specialist (government) Hospitals of the DOH, Western Cape Provincial Government, South Africa, who participated in this study (Table 3.1) were geographically located in the WCP of South Africa, in both the metropolitan hub and in the bigger outlying towns. The three furthest hospitals from Cape Town where the researcher worked were located in the towns of George, Worcester and Paarl, which were respectively 420, 104 and 54 km away from Cape Town.

Table 3.1: Location of study hospitals

Hospital type	Urban area	Rural area
General	Somerset Hospital	
	Paarl Hospital	
		Worcester Hospital
		George Hospital
Psychiatric	Valkenberg Hospital	
	Stikland Hospital	
	Alexander Hospital	
	Lentegeur Hospital	
Maternity	Mowbray Maternity Hospital	
Rehabilitation	Western Cape Rehabilitation Centre	
Total	**8**	**2**

These hospitals (Table 3.1) together with the forensic pathological services and the emergency medical services are collective known as a Directorate. A Chief Director heads the Directorate. Services delivered at the research hospitals vary. These services are regarded as secondary level health-care services or general specialist services that offer general specialist care, whilst a

tertiary level service offers tertiary and super specialist management and care. Formal referral is required between services. The general specialist services offered at the study hospitals were of a medical, surgical, maternity, obstetrics, psychiatric and rehabilitative nature within which nursing managers supervised and managed the health and nursing care. All those in nurse manager positions such as HONs, ANMs and ONMs were in the employment of the health-care setting in the post of Professional Nurse. Collectively they managed a 3227-bed (3209-bed later in the study period) health-care service (Table 3.2).

The physical appearances and layouts of the hospitals where the participants worked were:

- Old-styled provincial facilities and historically-styled psychiatric facilities with some having recently new age built wards
- Revitalised, modernised hospitals
- Super-modernised (disabled person friendly)

Both rural hospitals had a contemporary appearance after having undergone modernisation (repair and renovations or rebuilt) in accordance with the hospital revitalisation programme that modernised their appearance. The researcher perceived one of the rural hospitals in particular to be 'beautiful', embellished by striking mountain scenery as a background.

Table 3.2: Number of hospital beds

Health setting	Number of beds	Type of Service	Location
Health-care setting 1	334	General Specialist	Cape Town
Health-care setting 2	256	General Specialist	George
Health-care setting 3	277	General Specialist	Worcester
Health-care setting 4	301	General Specialist	Paarl
Health-care setting 5	340	General Specialist: Psychiatric	Cape Town
Health-care setting 6	318	General Specialist: Psychiatric	Cape Town
Health-care setting 7	740 reduced to 722	General Specialist: Psychiatric and Intellectual Disability	Cape Town
Health-care setting 8	300	General Specialist: Intellectual Disability	Cape Town
Health-care setting 9	205	General Specialist: Maternity and Neonatal	Cape Town
Health-care setting 10	156	General Specialist: Rehabilitation	Cape Town
TOTAL	3227 reduced to 3209		

3.3.1 Population

Polit and Beck (2014, p. 51) regard a research population as the entire grouping of individuals or objects with universally defining features as required by the research study. Grove *et al*. (2013, p. 351) state that a particular group of people on which a research study focuses, is a population. The target population is therefore the entire set of individuals or elements who meet the sample criteria (Grove, Burns & Gray, 2014, p. 250). All the ANMs and HONs in the identified study setting were regarded as the research or study populations (Table 3.3). The two target population groupings were selected for this study at the General Specialist Hospitals. These were: (i) ANMs (N=48) and (ii) HONs (N=10). None of the participants in this study were paid.

Table 3.3: Distribution of participating ANMs and HONs

[D= day duty; N= night duty]

Hospital type		Urban area	Rural area	No. of funded ANM posts	No. of funded ANM posts	Study sample of ANMs	Study sample of HONs
General Specialist (Level 2)	1	Health-care setting		4 (2D, 2N)	1	1D, 2N	1
	2	Health-care setting		3 (1D, 2N)	1	0D, 2N	
	3		Health-care setting	4 (2D, 2N)	1	2D, 2N	1
	4		Health-care setting	3 (1D, 2N)	1	1D, 2N	
General Specialist Psychiatric services	5	Health-care setting		6 (4D, 2N)	1	4D, 1N	1
	6	Health-care setting		6 (4D, 2N)	1	4D, 2N	1
	7	Health-care setting		5 (3D, 2N)	1	0D, 1N	
	8	Health-care setting		9 (7D, 2N)	1	0D, 0N	1
General Specialist Maternity services	9	Health-care setting		4 (2D, 2N)	1	0D, 0N	1
General Specialist Rehabilita-tion services	10	Health-care setting		4 (2D, 2N)	1	2D, 2N	
Total	10			48	10	28 (day and night)	6

3.3.2 Sampling

Sampling refers to the process the researcher embarks on, to choose a study sample, a representative group from a population, so that information regarding a phenomenon to be studied can be acquired in a way that represents the index population. A sample is a selected number of units comprising a subgroup of the bigger research population (Brink *et al*., 2012, pp. 131-132). Sampling means choosing a sample of people or elements for a study where, because

of the size of the population, it cannot be used in its entirety. In probability sampling, all the elements of the population have an equal chance of being part of the sample (Polit & Beck, 2014, p. 180). On the other hand, if non-probability sampling is used such as in qualitative research, generalisations cannot be made from the findings and a measure of subjectivity exists. Non-probability sampling selects participants from the population non-randomly. This occurs when the goal of the research study is to obtain insights into a phenomenon, individuals, or experiences, and not to generalise to a population, the researcher purposefully chooses individuals, groups, and settings that maximises understanding of the fundamental phenomenon (Onwuegbuzie & Collins, 2007, p. 287).

Purposive sampling, a form of non-probability sampling, which is also referred to as 'judgmental' sampling (Mokoena, 2012, p. 13; Babbie & Mouton, 2011, p. 644; Grove *et al.,* 2013, p. 705), was considered the most appropriate sampling technique to be used in this study. The method of purposive sampling is typified by its 'selection of key informants' (Lyon & Hardesty, 2005, p. 288). In this study the researcher decided what was needed to be known and then embarked on finding the sample, the people, based on their knowledge and experience (Brink *et al*., 2012, p. 141), in nursing management, and who were willing to supply the information needed. The sample of ANMs and HONs who met the eligibility criteria were:

ANM population:

- In the permanent post of an ANM
- In the position for at least two years

HON population:

- Occupy the position full-time or could be in an acting position for at least two years

On the other hand, exclusion criteria are characteristics that disqualify a person or an element from being included in a study (Grove *et al.,* 2013, p. 353). Any potential participant who did not meet the inclusion criteria was excluded from the study. The recruitment process involved having to obtain permission from the Health Department followed by the individual hospital. Thereafter ANMs and HODs were communicated with, and invited to participate by a formal invitation letter.

Twenty-eight ANMs (fourteen from the day shift and fourteen from the night shift) met the accessible ANM population criteria. They agreed to take part in the individual interviews. Six HONs met the accessible HON population criteria. They agreed to take part in the focus groups (Table 3.3). Data is saturated when the researcher no longer find any new information, no new categories or new inputs in new categories from the interviews and/ or discussions (Babbie & Mouton, 2011, p. 288; Glaser & Strauss, 2012, p. 61). Data saturation was obtained at the 27th

individual interview with ANMs; however another interview was conducted (thus 28 interviews). Already with the 2nd focus group discussion with HONs, data saturation was obtained. Three individual interviews and one focus group discussion served as the pilot interview/ discussion.

3.3.2.1 Sample size

Selecting and achieving an appropriate sample size is a challenge that any researcher has to confront. Factors influencing the sample size include the nature of the sample, the study purpose and the study design (Brink *et al*., 2012, p. 143). Ordinarily sample sizes in qualitative research are small to allow for sufficient in-depth inquiry. Qualitative interviews allow for face-to-face engagement of the researcher with a group of participants of six to eight (Creswell, 2014, p. 190). However, Krueger and Casey (2014, online) state that the general rule is that the group could be small to allow everyone to contribute their insights though big enough to acquire an array of information. According to Langer (2006, p. 35) one focus group should comprise six to ten participants. The use of very small focus groups is referred to as "mini-focus groups" that include three or four participants (Onwuegbuzie, Dickinson, Leech & Zoran, 2009, p. 3). In this study the focus groups were comprised of three participants each. Small numbers of participants in the focus groups were used because the researcher believed that more in-depth information could be obtained from the participants about the phenomenon (Onwuegbuzie *et al*., 2010, p. 711), related to PM. The HONs were all from different health-care settings each with its own speciality. The focus group discussions in this study were reported to be intimate and each one shared their heartfelt experiences (Stewart & Shamdasani, 2015, p. 89; Morgan & Scannell, 2014, pp. 73-74).

3.4 RESEARCH METHOD

3.4.1 Preparation for the study

Once all the clearance for the empirical part of this research investigation was in hand, an information sheet containing the research objectives, purpose and the proposed methodology was sent to all prospective participants, to explain and seek their participation. The researcher set up independent appointments with the ANMs and HONs who were willing to participate, for a time that did not encroach on the service operations, and that was convenient for their day or night working schedule. Interviews were scheduled for random times on random days in agreement with the participants and with due consideration to the 24-hour 7-day a week operational times, and functions of the health-care setting. All the health-care settings and the prospective participants welcomed the opportunity to be involved in the study however some of the challenges in this regard included: (1) no further response being received from one hospital after an engagement indicating that the research request would be presented at their internal research committee; (2) difficulty in contacting one hospital at night, and hence the night ANM, because

of the redirected telephone system at night; (3) no ANM email accounts and hence no direct electronic communication with night ANMs (at the time); and (4) the day to night handover time proving to be particularly busy for the service. Interviews that were conducted during the night with the night managers, had some interferences as night ANMs needed to attend to the nursing staff, support personnel such as drivers, security persons and clerks, and other stakeholders such as the South African Police Service that required prompt attention.

The researcher who was based in Cape Town, travelled to the various hospitals within the region, and further afield to the George, Worcester and Paarl Hospitals at different times, to meet with both the day and the night ANMs at these hospitals, to conduct the semi-structured individual interviews. At the health-care settings, the individual interviews were conducted in either the office space the ANMs used as their work space or a general office space. The venues used for the all interviews varied in size and milieu even when they were conducted at the same hospital. Permission for the venues for the two focus group discussions was separately acquired from two other independent government institutions, specifically for geographical convenience for the HONs who agreed to participate. One was conducted at a nursing college and the other at a hospital in Cape Town. Overall the individual interviews were free of major distractions and conducive to conducting discussion/s. Most of the rooms available for interviews were comfortable. Before each of the individual semi-structured interviews and the focus group discussions commenced, the researcher ensured that two voice recorders were sufficiently functional and that extra batteries were available.

3.4.2 Pilot interviews

In preparation for this study, three pilot individual semi-structured interviews and one focus group discussion were conducted. Prior to the commencement of the pilot and main interviews/ discussion, written consent was acquired from the prospective interviewees. A pilot venture allowed the researcher to timely assess the feasibility of the structure and practical aspects of conducting the interview. Pilot interviews alert the researcher to elements that support or detract from the research objectives. It therefore serves the purpose of detecting and correcting any interview process error likely to occur (Hennink, Hutter & Bailey, 2011, p. 120). In this study the pilot interviews/ discussion were conducted to assess whether the planned questions were clear and well understood. It also served to ensure that the questions that were being asked would elicit the data/ information required. The pilot interviews/ discussion confirmed that the questions were indeed clear, well understood and that it could be expected to generate the desired data/ information hence no changes were required to the research questions. The data formed part of the main studies.

3.4.3 Research questions

The overall question for the quest of the study was, "What comprises a contemporary work performance management framework?" During individual interviews and the focus group discussion the first overall question was:

> *"What is the understanding of the ANMs and the HONs with regard to the key performance management areas of the ANM?"*

From this question the following research open-ended sub-questions were posed:

> *"What are the ANM's best work performances in the work situation?"*
> *"How do the best work performances of the ANM improve work performance practices?"*
> *"What are the ANMs and the HONs ideas of the ideal work performance opportunities of the ANM for the future?"*
> *"How do ANMs and HONs view the commitment of the ANM to delivering of actions towards work performance in the workplace?"*

The above questions were put to both the ANMs and the HONs partaking in the study. Hudelson (1994, p. 51) states that once the research questions are specified, the appropriate data collection method that facilitate the answering of the questions, is to be selected. Grove, Gray and Burns (2015, p. 502) concur that for the relevant purpose of the research, the questions or hypotheses direct the data collection. Since no changes were required to the questions or data gathering process, the data from the pilot interviews were incorporated into the main study.

3.4.4 Data collection

The process of data collection is the gathering of 'actual' information in line with the pre-established research plan; the collection method varying according to the research design (Brink *et al*., 2012, p. 57). In this study, data collection was preceded by the important step of knowing what the research questions were (Hudelson, 1994, p. 51). The questions used in the semi-structured individual interviews and focus group discussions were similar, and deemed to be appropriate to use, as they allowed the participants to share their experiences within the confines of the topic that the researcher was truly interested in, which was the performance experience of the ANMs (Mitchell, 2015, p. 45). The understanding of the ANMs' key performance management areas was posed (Section 3.3.3) in the first question in, to understand the meaning of the phenomenon, with sub-questions within the AI philosophy, with regard to the phases of Discover, Dream, Design and Deliver. The related areas of inquiry put to the ANMs and the HONs in the sub-questions focused on the ANM and their:

- Best work performances : Discovery phase
- Envisioned improved work performances in practice : Dreaming phase

- Ideal work performance opportunities for the future : Designing phase
- Commitment to deliver processes, tasks and actions that ought to be in place for delivery of work performance : Delivery phase

Once the data was collected from the accessible participants, it was examined for completeness and accuracy in preparation of data analysis or processing as Brink *et al.* (2012, p. 57) recommends. All the interviews were neatly typed out into a document comprising 584 pages.

3.4.4.1 The interviewing/ discussion process

Semi-structured individual interviews and focus group discussions were selected for use. Data was collected using these means between November 2013 and March 2014 (Table 3.4).

Table 3.4: Interview schedule, interviewer allocation and venues used

Period	No of interviews/ discussions	Participants	Interviewer	Venue
November 2013 to January 2014	**28** semi-structured individual interviews	28 ANMs	Researcher	Nurse manager office or general nursing management office usually used by the day and night shifts at ANM employer hospital site
March 2014	**2** focus group discussions	6 HONs	Independent experienced researcher	Private lounge in Nurses Home at Nursing College; tea-room at a hospital

The researcher conducted the individual interviews. Two research assistants were trained beforehand in the process, and assisted the researcher with the focus groups. One posed the research questions, and probed, while the other one acted as the scribe. Both observed and reflected on the focus groups afterwards. The questions were open-ended and sought to obtain authentic insight into the participants work performance experiences in relation to the ANM. During the interviews, there was active engagement between the interviewer(s) and the participants as the interviewer(s) sought to understand and interpret the explanations of the performance actions and experiences that were being provided by the participants (Mitchell, 2015, pp. 44, 46 & 48). The interviews/ discussions did not take longer than 60 minutes. This study adopted AI as an underlying philosophical approach. As a result, the questioning and guiding process during the interviews/ discussions were aligned to the underlying AI philosophy throughout. The study participants conversed in the English and Afrikaans languages which are two of the three official languages of the WCP, and dominant amongst the nurse manager cohort from the study hospitals (own experience). The participants were all thanked for their willingness to participate in the interviews.

3.4.4.2 Semi-structured individual interviews

According to Al-Busaidi (2008, p. 14), semi-structured interviews are more commonly used in health-care related qualitative research. Semi-structured interviews make provision for a conversation to evolve in the areas of interest. Rabbani, Lalji, Abbas, Jafri, Razzak, Nabi, Jahan, Ajmal, Petzold, Brommels and Tomson (2011, p. 5) attest to the distinction, that the semi-structured interview reflects ways of thinking, that in turn influences behaviour as well as the views people have of certain issues or subject matter. The semi-structured interviews were conducted on a one-to-one basis where the researcher asked the open-ended questions, probed and encouraged the participant to talk about matters pertinent to the research questions. The interviewer where needed, rephrases, rearranges or clarifies the questions to further explore aspects introduced by the participant (Tong, Sainsbury & Craig, 2007, p. 351). Typically, a flexible interview guide is used for the questioning which is relatively loosely structured in order to explore participant experiences. In this regard, interview guides (Annexures R & S) were used. The guide is a written list of questions and prompts that are covered during the interview, (Hudelson, 1994, p. 12). The flexibility of the semi-structured interview also made allowance for new probing questions to be entered into that added to the richness of the data (Al-Busaidi, 2008, p. 14; Jarbandhan & Schutte, 2006, p. 678). Jarbandhan and Schutte (2006, p. 678) indicate that the use of the semi-structured interview instrument is fitting in cases where the researcher is certain what needs to be known but still wants to explore as the interview proceeds. Open-ended questions as advocated by Tong *et al*. (2007, p. 351) and again suggested by Creswell (2014, p. 8), were thus followed in the research context as they explore the specific areas of a phenomenon such as PM of an ANM in this study. This required the researcher to carefully apply interviewing skills so that what the people described they experienced in their settings, were heard.

3.4.4.3 Focus group discussions

Qualitative research makes use of qualitative observation, qualitative interviews, qualitative documents and qualitative audio and visual materials. As a method of gathering qualitative data, the focus group in health and social sciences spheres has gained considerable popularity (Rabiee, 2004, p. 655). Focus groups complement qualitative research well (Arthur, Waring, Coe & Hedges, 2012, p. 187). A focus group is described as a special type of gathering where a group comprising of people with various backgrounds and/ or experiences, gather to discuss an explicit topic of interest (Krueger & Casey, 2014, online). Hennink *et al*. (2011, p. 136) add that a focus group discussion is an interactive discussion between a selected number of pre-selected candidates, led by the researcher or trained interviewer where a specific set of issues are comfortably focused on. The aim is attaining a broad range of views on the research topic in a time period of 60 to 90 minutes. The discussions are usually directed by open-ended questions (Creswell, 2014, p. 190), as in this study (Annexure S).

Ogunbameru (2003, p. 2) ascribes the success of focus groups to the fact that it relates to human tendencies; attitudes and perceptions internalised partly by interaction with other people. It has been shown that people are influenced by the comments of others in the course of a discussion. Ogunbameru (2003, p. 2) asserts that the permissive and non-judgmental group environment of focus groups also give individuals permission to divulge emotions, that other forms of questioning might not be able to elicit. Focus groups stimulate new and diverse views to be generated and facilitate elaboration, analyses and justification on the directed issues (Brink *et al*., 2012, p. 158; Plummer-D'Amato, 2008, p. 70).

In this study the benefit of the collective nature of the focus group allowed for interaction and for sharing of thoughts (Plummer-D'Amato, 2008, p. 70). The focus group was used to obtain the experiences of HONs using the same questions as those put to the ANMs in the individual semi-structured interviews. Two focus group discussions were conducted separately, with the first one serving as the pilot. The researcher made use of an independent experienced researcher and an independent scribe (two research assistants) to assist with conducting the two focus group discussions and taking the field notes respectively (Annexure T). The reason for this was that the researcher is a HON herself and was known to some participants.

3.4.4.4 Field notes

Taking field notes is a data gathering technique used to complement the customary data gathering methods such as journalising, observation, or interviews, by extracting data and giving it meaning (Wang, 2015, p. 365). Field notes are observational records (Polit & Beck, 2008, p. 405), that are written down or mechanically recorded from a period of observation in the research process, and which from raw data eventually develop and become study findings. They are analogous to the interview script (Merriam, 2014, p. 128). Field notes are also detailed notes done by hand (Merriam, 2014, p. 128) which make them pertinently support the data analysis. Field notes entail a much broader, more analytical, more interpretive representation than a single listing of occurrences. Field notes demonstrate participant-observer effects in a record format that also facilitates synthesises and understanding of data (Polit & Beck, 2008, p. 405). They offer a narrative of what had happened 'in the field' (Polit & Beck, 2008, p. 406). Merriam (2014, p. 129) points out that field note writing takes longer than observing. Polit and Beck (2008, p. 406) alert researchers to the labour and length of time field note writing can take to prepare, noting that it needs discipline to achieve the wealth of detail which field notes can produce; thick descriptions being the goal for observing participation.

Field notes contained the highlights or synopsis of the engagement and conversations between the researcher(s) and the study participants during the interview process. Field notes were held for purposes of describing (descriptive) and reflecting (reflective). Descriptive field notes are

also termed observational notes. Field notes of a descriptive nature are depictions of observed events (occurrences) and dialogue (conversations). Information encompassed in field notes is comprehensive reporting about actions, conversations and context as the process permits (Polit & Beck, 2008, p. 406). Fransworth, Baldwin and Bezanson (2014, p. 13) argue that while field notes need to reflect accuracy in its documentation of the natural world, there is a place for expression of the heart. Merriam (2014, p. 130) suggests that field notes could aid the chronological order of data and demographic characteristics of participants, as in this study. As in this study, the reflective component (Merriam, 2014, p. 131) of field notes included the researcher's feelings, reactions, premonitions or instincts, initial interpretations, and speculations. Detailed field notes typically include notes on various elements such as the place and the people (Hennink *et al*., 2011, p. 155).

In this study, field notes of individuals and groups were made at the time of conducting the interviews. The researcher's observations focused on the participants as well as their settings in lieu of their participation, their personal and professional manner of engagement with the interviewer, the ease with which they spoke about nursing management, and their working environments. This included their verbal and non-verbal gestures such as tone of voice, facial expressions, body stance and degree of eye contact. The researcher also noted the locations, dates and times when the observations were made. At the time of the individual interviews and focus group discussions, field notes were made by the interviewers. After each session, the researcher compiled more comprehensive notes. Personal experiences, thoughts, feelings and reflections about the study were also recorded by both the researcher and the research assistants.

3.4.5 Communication skills used in data collection

During the process of data collection the researcher made use of various communication techniques and skills. The researcher also trained the research assistant who was the second interviewer, to do the same.

3.4.5.1 Minimal, unobtrusive verbal responses and non-reflective listening

During an interview process participants can be encouraged by the use of non-reflective listening by the interviewer. In this way minimal interviewer responses occur as the interview seeks to gather data from the participants (King & Horrocks, 2010, p. 72). An interviewer may use head nodding and 'mm-hmm-s'. Minimal encouragers were thus used to allow the participants to talk. These included a nod of the head, positive facial expressions and responses such as 'hmm' and 'uh-huh' by the interviewers (Davies & Jones, 2016, p. 6). This is further described in Section 3.3.5.4 under the heading 'probing'. In this study the researcher made deliberate effort to facilitate and ensure that participant-participation dominated the interviews and discussions.

Participants had sufficient time to respond to the questions posed in the interviews and the interviewers steered clear of interrupting them when they responded.

3.4.5.2 Active listening

Listening is said to be the most important skill used when interviewing. Seidman (2013, p. 81) points out that listening occur on three levels namely: (i) listening by concentrating on the substance; (ii) listening to the inner voice; and (iii) listening actively to both the substance and the process. The natural instinct of the researcher to talk is quashed by the *"listen more, talk less"* prescription (Seidman, 2013, p. 81). Non-verbal responses were used to avoid distracting and interrupting the interviewee giving the participant the space to tell 'her' story 'her' way (Robertson, 2005, p. 1054). The expression 'active listening' requires that the listener really attempts to understand the experience being shared without listener intrusion or listener interpretation (Weger, Castle & Emmett, 2010, p. 35). Kvale (2007, pp. 63-64) argues that active listening facilitates recall in areas such as bodily presence and social atmosphere, when the exact wording is forgotten. The interviewers maintained eye contact with the participants throughout the discussions. The interviewers would also nod their heads occasionally to acknowledge what was being said.

3.4.5.3 Clarifying

Clarifying occurs when an interviewer or even a listener asks questions that gently tests or challenges a participant's version without being confrontational. Clarifying can serve to encourage participants to elaborate even more. The interviewers in this study sought clarity from the participants in instances where the information volunteered by the participants was unclear or vague. The aim was that the ideas, thoughts and feelings exhibited or expressed by the participants are accurately interpreted and reflected in the study (King & Horrock, 2010, pp. 72 & 185).

3.4.5.4 Probing

Probing is a technique used by interviewers to acquire more information in a specific area (Grove *et al*., 2013, p. 705). When participants supply incomplete or irrelevant answers to answer questions, it necessitates further inquiry by an interviewer with the aim of obtaining a more complete or specific answer to the given question (Roe, 2008). In some cases the questions being asked, need to be repeated (Grove *et al*., 2013, p. 424). It could sometimes mean that the researcher should push the participant for a response during the interview. It could also mean that the question being asked needs to be expanded on, or that the participant needs to be asked to elaborate on comments or statements already made (Grove *et al*., 2013, p. 424). The use of non-threatening but challenging questions could often be viewed as probing (Grove *et al*., 2013, p. 424). In this study, the interviewers used probing techniques such as 'uhm?', 'um?', and 'm?', and other similar utterances to encourage and stimulate the participants to continue speaking.

Furthermore, explanatory probing statements such as 'could you elaborate on that …' or 'tell me more …' were used.

3.4.5.5 Silence

When engaging participants in interviews, the use of silence is a compelling enticement that allows the participant to demonstrate deeper emotions and thoughts (Grove *et al*., 2013, pp. 272-273) and also lures a response (King & Horrocks, 2010, p. 59). Grove *et al*. (2013, p. 272) recommend that the interviewer remains quiet when a participant is not talking but appears to be thinking or pondering on the topic. Using silence strategically and appropriately can be very effective to get participants to consider their responses, speak more and elaborate on the issue under discussion (Gill, Stewart, Treasure & Chadwick, 2008, pp. 292-293). The interviewers in this study used the technique of silence when they thought it appropriate during the interactions with the participants but were conscious of doing it in a manner that did not cause alienation (Grove *et al.,* 2013, p. 272). The interviewers also ensured that they were not interrupted during the interviews. In this regard they turned their cell phones off at the beginning of the interviews. Some ANM interviewees, whose offices were used for conducting the individual interviews, were able to re-direct their in-coming calls to avoid being disturbed.

3.4.5.6 Paraphrasing

Paraphrasing is at times referred to as reflection of content. Paraphrasing is a deliberate technique in interviewing that feeds back to the participants, the crunch of what they have just said (Ivey, Ivey & Zalaquett, 2013, p. 151). In other words, paraphrasing occurs when the researcher makes use of another format or different words to restate what a participant has already said without losing the meaning (Hennink *et al*., 2011, p. 130). Paraphrasing is useful as it demonstrates to participants that they have actually been heard and offers them the opportunity to explain and expand on their story (De Jong & Berg, 2012, p. 32). In this study the interviewers used the paraphrasing technique by differently stating what the participants' own words were when clarity from the participants was sought.

3.4.5.7 Summarising

Summarising is periodically repeating the thoughts, actions, and feelings to the speaker (story teller) after a detailed description of a part of the story being told has been listened to with the judicious use of open questions and echoes (De Jong & Berg, 2012, p. 30). Careful listening is a pre-requisite for successful summarising (De Jong & Berg, 2012, p. 32) as it is inclined to remove heightened emotions from the discussion or conversation by bringing rationality and understanding where participants differ. In this study the interviewers summarised key concepts and dimensions put forward by the participants at strategic points and intervals to emphasise the important issues raised during the interview as accurately as possible. This allowed the

participants the opportunity to reflect on the key issues and to verify whether the interviewers correctly understood and interpreted the information they (participants) had provided.

3.4.5.8 Appreciation

The principles of AI were used in this study as an underpinning guide or philosophy.

3.4.5.9 The use of Appreciative Inquiry in this study

AI is the highly engaging, shared, systems approach to searching, classifying and enhancing the inherent 'life-giving' energy that is present within any human, economic and organisational organ that is performing well (Watkins, Mohr & Kelly, 2011, p. 22). AI is a journey that is able to illicit reflective and insightful knowledge of the human system at its finest, and can be utilised to co-construct the 'best and highest future' of the respective system (Watkins *et al*., 2011, p. 22; Schooley, 2013, p. 30). Cockell and McArthur-Blair (2012, online) state that gentle nonetheless insightful transformation has occurred in a number of social sciences fields with regard to how people are thought about, where this approach has been applied. One of the outcomes is illustrated in the development of the positive psychological approach where AI is a transformative force that generates hopefulness and engenders strength-based ways of doing, leading, and learning. The word 'appreciative' stresses the notion that there is an increase in value; the finest or best in individuals or in the world one is immersed in. It therefore appreciates. An 'inquiry' is the act of asking questions, exploring and discovering in order to acquire understanding (Watkins *et al*., 2011, p. 23). AI is the specific inquiry process that seeks out that which engenders growth and upliftment. It is also referred to as life-giving (Cooperrider & Whitney, 2005, online; Watkins *et al*., 2011, p. 23). AI is a journey along which reflective and insightful knowledge of the human system at its best, is revealed and is utilised to co-construct the 'best and highest future' of the respective system (Watkins, Mohr & Kelly, 2011, p. 23). AI is the highly engaging, shared, systems approach to searching, classifying and enhancing the inherent wholesome energy that is present within any human, economic and organisational organ that is performing well.

When AI is used, the focus is placed on what people perceive as their valuable contribution. In this study, the research question explored what the valuable contribution of the work performance of the ANM is. AI is known for its refreshing approach as it does not fit into a particular ideology (Reed, 2007, pp. 45-46). The AI approach emphasises the importance of focusing on the workplace setting and understanding its context; an approach described as far-reaching as it forces those in management to alter the conventional philosophy on how people go about their work practices and how the principles guiding the conceptual understanding of work practices can change.

With the application of AI the focus was placed on what people perceive as the worthwhile contribution of their labour. It is the attempt by those in authority to recognise and validate this and to further enhance the contributory effort. AI is a positive approach where the customary stage of problem identification is not concentrated on. In the attempt to get an understanding of the best work experiences of the ANMs, the inquiry interrogated the understanding of both the ANMs and their supervisers, the HODs, their positive experiences (what worked well), their hopes (what could be improved) and their potential positive contributions (their constructive recommendations). When nurse managers are asked what has gone well, the inquiry is positively received and appreciated. The philosophical view of AI is that people appreciate being asked what has gone well and feel validated (Reed, 2007, p. 2), lending itself to a qualitative paradigm. The AI approach was seen as a practical approach and therefore was pertinently applied during the interviewing/ discussion processes in this study. Later in this chapter the AI approach is elaborated upon in relation to the research questions posed in the interviews process (Table 3.5). The researcher was mindful throughout this study, of the assumptions of AI as stated in Chapter 1.

Table 3.5: The 4-dimensional Appreciative Inquiry approach to questioning

AI dimension	Sub-question/s posed: "Relating to your work performance:
Discovering	…what do you do well?" …what have you been successful in/ made a positive impact in?" …what has been a highlight?" …what are you passionate about?"
Dreaming	…what can be done better?"
Designing	…what would you like to see in the future?"
Delivery	…what are the tasks or the processes or actions or commitments required?"

Certain principles underlie AI: *The poetic principle* is described by Mishra and Bhatnagar (2012, p. 545) that a poetic version is given by an individual and it is that version which could make a difference. This notion is important for this study as the criticism against AI is that it only takes into consideration or looks into the best experience. It is thus an illustration that the individual outlook, even though he/ she belongs to a bigger union such as an organisation, will constantly structure the perspective of their world based on the aspects of their own vested accounts and on that which they will still wish to endeavour (Mishra & Bhatnagar, 2012, p. 545). The anticipatory principle according to Mishra and Bhatnagar (2012, p. 545) indicate that the demonstrated behaviour of an individual member is illustrative of their perception of what the future would hold for the particular organisation they are a part of. The principle of simultaneity contends that the 'act of inquiry', is an active intervention that facilitates the thinking processes of people, allowing for different inventive ideas to be brought to the fore (Mishra & Bhatnagar,

2012, p. 545). The 4-dimensional model of AI was embedded in the sub-questions posed during the interviews/ discussions.

3.4.6 Data analysis

Analysis is defined as the '*detailed study or examination of something in order to understand more about it; the result of the study'* (English Oxford Living Dictionaries, 2016, online). The initial step of the data analysis in qualitative research begins with the data gathering stage (Brink *et al.,* 2012, p. 193). The analysis of data in the research process is a search for meaning and is regarded as one of the most important steps in qualitative research (Leech & Onwuegbuzie, 2007, p. 557; Onwuegbuzie *et al*., 2012a, p. 24). In this regard, it requires the researcher to methodically organise and synthesise the collected research data. The data set was examined for recurrent kinds of instances which in this case were the utterances of the participants, and was systematically identified and clustered together in units of analysis to develop a categorisation system (Silverman, 2016, p. 85), in order to produce structure and formulate meaning (Brink *et al*., 2012, p. 193).

3.4.6.1 Transcribing

Transcriptions are interpretive constructions that serve useful purposes. Transcriptions are extrapolation; decontextualised conversations like topographical maps taken from a landscape (Kvale, 2007, p. 98). Interviews were firstly to be recorded and be audible enough to be transcribed before actual transcribing could occur. This phase of this study involved that all the interviews were transcribed and re-checked and corroborated with the recorded interviews (Brink *et al*., 2012, p. 193). In this study data was gathered through voice recording supported by the taking of field notes. When data from audio recorders are used to corroborate data from field notes in this way, data triangulation was enabled (Tobin & Begley, 2004, p. 393). Self-transcription allowed the researcher to maintain closeness to the data (Mitchell, 2015, p. 48). In transcribing the researcher listened and re-listened to the recorded interviews several times in conjunction with reading the field notes also a number of times, in preparation for the data analyses. There are a number of technical and interpretational nuances involved in the transcribing procedure from audio recorder to text and the application of some standard choices that researchers are to be aware of (Kvale, 2007, p. 95). In this study the transcriptions were done word for word. All 'mh'-s and 'uhm'-s, emphases in intonation and emotional expressions were included in the transcriptions. However, the transcriptions of the quotes into this thesis followed a more formal style. Afrikaans responses were translated into English by the researcher and quality checked by the research supervisor. The researcher when transcribing was mindful throughout of the difference discourse of oral and written texts, and their divergences as Kvale (2007, p. 100) cautioned. The data was transcribed according to the actual questions posed to the participants.

3.4.6.2 Steps of data analysis

In qualitative research, data analysis is the continuous course of action involving processing, comparing and assessing, that starts when a particular topic is being explored by means of a literature study or when empirical evidence is being gathered in the field, and could even continue into the phase of writing up of the research (Cloete, 2007, p. 513). Babbie and Mouton (2011, p. 490) describe qualitative data analysis as *"...all forms of analysis of data that was gathered using qualitative techniques, regardless of the paradigm used to govern the research*".

The data collected from the individual semi-structured interviews and focus groups discussions was analysed jointly with the field notes. The researcher analysed the data first after which an independent professional coder was consulted to further assist with the analysis followed by a consensus meeting held between the researcher and the coder. Thereafter the researcher assisted by the researcher's supervisor, considered the coder's findings and further refined the analysis in order to gain in-depth understanding of the phenomenon under study. Constant comparative analysis was used. The underlying assumptions of the AI framework were taken into consideration during at this stage while the data was also aligned to the adapted Logic Model (see Chapter 4). The analyses process occurred as follows:

a) Reading of data: The researcher read through all the data to determine exactly what has been expressed.
b) Clustering: The data was clustered into small meaningful divisions. This step involved independent and thorough examination of the data elicited from the AI approach
c) Labeling (coding): The researcher labeled each division descriptively by using an adequate code
d) Contrasting: Different parts of the interview/ s were compared meticulously; new emerging parts to existing ones, so that the labeling standard was consistent.
e) Grouping: Similar labeled divisions were grouped together. In this way, themes, categories and sub-categories were identified and named (Onwuegbuzie *et al*., 2012a, p. 72; Leech & Onwuegbuzie, 2007, p. 565). Critical interrogation of the themes, categories and sub-categories (Table 4.3) took place. The concepts were integrated into the adapted Logic Model using the steps of input, output and outcome (Table 4.3). Four main work performance categories of the ANM were established. These four main categories were the four overall key performance areas of the ANM that entailed: (i) strategic planning, and QA and nursing care, (ii) HRs, (iii) the Business Unit and managing finances, and (iv) support function. The themes, categories and sub-categories are discussed in Chapter 4.

3.4.6.3 Use of 'thick descriptions'

Key to working data appropriately is the notion of thick description, as it illustrates various factors and complex facets of particular phenomena; thick description analyses produce deeper

meaning (Holliday, 2007, pp. 74 & 75). As compared to 'thin description', thick description provides the context of the experience, positions the intentions, and meanings that envelop the experience, and announces the experience as a course that is unfolding (Holliday, 2007, p. 75). This is different from triangulation where the aim is to acquire an amount of different viewpoints of the same experience using various means. Thick description is the way different aspects of the prevailing social conditions or e.g. organisational culture, within which it is found, is examined. It therefore helps to develop a good analysis (Holliday, 2007, p. 76). Thick description emanated from the information the participants provided in the context of which this study was done.

3.4.7 Development of the contemporary performance management framework for Assistant Nurse Managers in the provincial health-care setting

This part of the study focused on the development of a contemporary PM framework for ANMs in the provincial health-care setting. The survey list of the Practice Orientated Theory of Dickoff *et al*. (1968, p. 434) provided the reasoning (thinking map) illustrated further in Table 3.6, for describing the contemporary framework by posing the following questions:

a) Who or what performs the activity (agent)?
b) Who or what is the recipient of the activity (recipient)?
c) In what context is the activity performed (framework)?
d) What is the endpoint of the activity (terminus)?
e) What is the guiding procedure, technique or protocol (procedure)?
f) What is the energy source for the activity (dynamic/s)? (Dickoff *et al*., 1968, p. 423)

Synthesis took place to describe the framework in order to offer a comprehensive understanding of the phenomena.

Table 3.6: The thinking map adopted in this study

Concept	Meaning of concept in this study
Agents	Hospital management/ senior hospital figures, HONs, Hospital CEOs, heads of FBUs, Head Specialists, Departmental Heads, MDTs; They were responsible for performing the activity of performance managing the ANMs
Recipients	ANMs who perform work in the General Specialist Hospitals in the Western Cape
Context	The context within which the activity of work performance occurred is the nursing and hospital managerial and supervisory environment at the General Specialist Hospitals in the WCP of South Africa
Dynamic/s	The subtleties or forces that serve as motivating factors in ANM work performance
Procedure	Guiding policies, procedures/ strategies related to ANM work performance at the General Specialist Hospitals in the Western Cape
Terminus	The terminus was the contemporary work performance framework for performance managing ANMs at General Specialist Hospitals in the WCP, South Africa

3.4.8 Validation of the contemporary performance management framework

Validation is providing the participants and other relevant stakeholders in the field of study with an account of the findings for an assessment, and for commentary to be made on the validity of the research outcomes (Bryman, 2012, p. 715). The research findings of this research were presented to fourteen ANMs and three HONs, who had participated in the study earlier, and three other newly appointed HONs and one ANM from the General Specialist Hospitals. The validation established credibility of findings that ensured that the canon of good practice and the submission of research findings to those members of the social world who were studied, were correctly understood (Bryman, 2012, p. 390). The developed contemporary PM framework was therefore validated by some participants present in October 2016, which added to the thoroughness of the analysis of the study. Their comments were incorporated (Chapter 5) in the final framework. The criteria used to evaluate the findings were based on Pearson *et al*. (2005, p. 226). The validation outcome is reported on in Section 5.4.

3.5 REASONING STRATEGIES

Reasoning is described by Grove *et al.* (2013, p. 706) as processing and arranging ideas in order to arrive at conclusions. Various kinds of reasoning spans exist; and the reasoning strategies used in this study were inductive reasoning, deductive reasoning, synthesis and bracketing.

3.5.1 Inductive reasoning

Babbie and Mouton (2011, p. 272) state that inductive reasoning is the reasoning pathway that emanates from the specific leading to the general. The reasoning pathway in qualitative research starts by talking with or observing people who are sufficiently experienced with the study phenomenon. These discussions are loosely structured so that participants can express their beliefs, feelings, and behaviours, whilst the data collection and analysis and interpretation are continuous. When this data is analysed, related types of narrative information are clustered together into a coherent scheme such as e.g. a framework, through a process of inductive reasoning. Researchers identify themes and categories which then contribute to building a rich description of the phenomenon (Wildemuth, 2017, p. 319). Following the research investigative processes of data collection through semi-structured interviews and focus group discussions, observations and field notes on the phenomenon of the study, the work performance experiences of the ANMs, conclusions were drawn. This information was conceptualised in the framework and complemented with literature.

3.5.2 Deductive reasoning

Polit and Beck (2014, p. 42) state that researchers often start with a theory, and then make use of deductive reasoning by forecasting on how phenomena would behave in the real world, assuming that the theory were true. Polit and Beck (2014, p. 49) also indicate that the need for deductive reasoning presents itself in the early stages in studies when creative skills and a

foundation in existing research evidence on the topic of interest is typically required. In this study literature only confirmed the findings, and was integrated into the framework.

3.5.3 Synthesis

Synthesising is a research analytic skill that allows for deeper insights into participants' accounts of their experience (Richie & Lewis, 2003, p. 21). Synthesis is the process and outcome of systematically reviewing, and formally grouping and interrelating ideas from various sources to form a whole or new, complete picture (Grove *et al*., 2014, p. 23). Synthesis was applied in this study to develop an original and contemporary PM framework for ANMs in provincial health-care settings.

3.5.4 Bracketing

Bracketing in qualitative research is a research technique where a researcher sets aside what is known about the research phenomenon as well as own beliefs (Grove *et al*., 2014, p. 501). Bracketing requires a researcher to identify own expectations of a study and then to deliberately become devoid of those ideas in order to be open to consider other perspectives (Brink *et al*., 2012, p. 122). In this study the researcher employed the bracketing technique by identifying and writing down what her experiences were about the study phenomenon, her personal beliefs, assumptions and preconceptions, before commencing with the collection of data. The intention of bracketing was to contain any personal bias the researcher might have had, which in turn could have misrepresented the interpretation of the experiences of the participants. Since the researcher is a HON herself and met with the other HONs intermittently, she used the research assistants to conduct the group discussions with them. Supervisory sessions with the researcher supervisor specifically also dealt with the importance of bracketing.

3.5.5 Reflexivity

Reflexivity is the ability of a researcher to apply self-awareness and critically examine the data in qualitative studies whilst data collection and analysis are underway. Such consciousness is likely to stimulate the introspection of the researcher with regard to own feelings and experiences related to the study phenomenon, including the researcher's responses to a particular participant and interpretation of data (Grove *et al*., 2014, pp. 268 & 707). In this study the researcher persistently and consciously applied reflexivity by considering any background and personal values that might have had an influence on the research processes, specifically data collection, interpretation and presentation.

3.6 TRUSTWORTHINESS

The process of validating qualitative research is done by means of ensuring trustworthiness in terms of four measures of criteria of credibility, transferability, dependability and confirmability (Babbie & Mouton, 2011, pp. 276-278). Authenticity in the broader sense is recognized as a fifth

criterion (Lincoln, 1986, pp. 4 & 6; Elo, Kääriäien, Kanste, Pölkki, Utriainen & Kyngäs, 2014, p. 2).

3.6.1 Credibility

Credibility is the means by which a researcher ascertains confidence in the truth of the collected data and its interpretations (Elo *et al*., 2014, p. 3). Credibility has to do with the selection of the appropriate data collection method, as it has a bearing on the analysis (Elo *et al*., 2014, p. 3). In this study the researcher regarded it feasible to be attentive to presenting data that could extract a range of data constructs from various viewpoints pertinent to the study (triangulation), seek relevant literature confirmation (referential adequacy) and verify source data and interpretation for intention (member checking). Triangulation was undertaken when data from audio recorders was used to corroborate data from field notes (Tobin & Begley, 2004, p. 393), in this study, lending itself to credibility. Another credibility assurance was prolonged engagement with the participants according to the premise of Babbie and Mouton (2011, p. 277). For this reason the data analysis steps included the services of a scribe in the group discussions and an independent coder with whom a concluding consensus meeting was held. A coder certificate authenticated this stage (Annexure V). Researcher experience, training and qualifications also lend credence to the research credibility and data, as do researcher reflexivity (Polit & Beck, 2008, p. 550). In this regard the researcher is a Professional Nurse and Midwife, and a nursing management service veteran. The researcher was supervised by another Professional Nurse and Nurse Educator, who is an accomplished researcher of professorial status. The independent coder, also a Professional Nurse holds a doctorate degree and is experienced in qualitative research and data analyses. The South African Nursing Council, the professional nursing regulator in South Africa where the study was conducted, registers all professional nurses and controls their professional practice.

3.6.1.1 Triangulation

The term triangulation in qualitative research refers to the use of various methods or data sources (Carter, Bryant-Lukosius, DiCenso, Blythe & Alan, 2014, p. 545). Atkinson and Delamont, (2011, p. 60) assert that a ‘triangulation frame of mind’ ought to pervade when the empirical data is managed by the researcher which allows for the identification of weaknesses. It also aids researcher confidence for imparting research findings. The term *triangulation* involves the use of a number of methods and measures to collect data on the same topic. In this way triangulation allows for the data to be cross-validated but more importantly for different dimensions of the phenomenon to be captured (Carter *et al*., 2014, p. 545). Triangulation is distinguished as: (i) data triangulation, (ii) investigator triangulation, (iii) methodological triangulation, and (iv) theory triangulation (Cox & Hassard, 2005, p. 110).

Methodological triangulation occurs where quantitative researchers incorporate two or more research methods with one investigation (Streubert & Carpenter, 2011, p. 353). In this study the 'within-method triangulation', a subsidiary of method triangulation, was applied as focus group discussions, semi-structured individual interviews and field notes were used. The within-method triangulation engages two or more similar data collection approaches in one study to measure the same variable (Streubert & Carpenter, 2011, pp. 353-354). Triangulation of data sources involved collecting data from different types of people/ people forums which includes collection of data from individuals and groups to gain different perspectives (Carter *et al*., 2014, p. 545). Theoretical triangulation was obtained by the integration of all the theoretical assumptions as pointed out in Chapter 1, in the research report and framework. Triangulation therefore allows for completeness to understanding a research phenomenon (Carter *et al*., 2014, p. 545).

3.6.2 Transferability

The aptness of being able to transfer the findings of one study to the context of another or to other participants is referred to as transferability (Brink *et al*., 2012, p. 173). Qualitative research primarily characterises observations within a specific context as opposed to primarily making generalisations from study findings (Brink *et al*., 2012, p. 173). Transferability can though be equated to external validity or generalisability in quantitative research (Sinkovics *et al*., 2008, p. 699). The generation of 'thick description' and 'purposive sampling' could facilitate transferability of the findings of this study to that in another milieu or to other individuals or groups (Guba & Lincoln, 1985, p. 241; Babbie & Mouton, 2011, p. 277). The findings of this study however cannot be generalisable to all provincial health-care settings as generalisability is to be evaluated for adaption (Barnes, Conrad, Demont-Heinrich, Graziano, Kowalski, Neufeld, Zamora & Palmquist, 1994-2012, p. 4). Brink *et al*. (2012, p. 173) indicate that in qualitative research the onus is on those who want to demonstrate transferability, to do so.

3.6.3 Dependability

Dependability is another criterion which establishes trustworthiness of a study (Lincoln & Guba, 1985, p. 189). Dependability refers to the provision of evidence so that should another study be done using the same or a similar context, and the same or similar participants, the findings would be similar (Brink *et al*., 2012, p. 172). In essence it means that the conclusions of a study are transferable to that of another study even over time. Brink *et al*. (2012, p. 127) note that an inquiry audit is required for demonstrating dependability, by tracking procedures and the processes used by the researcher of a study, to show that those used in the study, were acceptable (Brink *et al*., 2012, p. 127). The keeping of independent anecdotal notes throughout the study along with crucial notes on the interviews by the researcher, was a means of dependability in this study (Babbie & Mouton, 2011, p. 278). Credibility is reliant on dependability (Brink *et al*., 2012, p. 173). In this study dependability was enhanced by the detailed description of the study's

methodology. Credibility as a dependability enhancer was also addressed as the scribe in the focus groups was included in the analysis process that ensured that the non-verbal context of the statements made, were considered (Toye, Matthews, Hill & Maher, 2014, p. 203). Preliminary coding was done by the researcher and then by the independent coder. The researcher engaged with the independent professional coder a few times to clarify understanding and interpretation of the data and the outcome of the analyses up to the point of having a consensus meeting. Excerpts from the interviews are included in this study (Chapter 4) to explain how the concepts and categorisations were reached. The inclusion of some of the participants, other ANMs and HONs at the point of validating the developed contemporary PM framework, further enhanced the credibility (Campbell & Corpus, 2015, p. 4), and therefore the dependability of the findings.

3.6.4 Confirmability

According to Brink *et al*. (2012, p. 173), confirmability is the study's potential to produce congruency of data with regard to accuracy, relevance or meaning. Confirmability concerns itself with establishing whether the data gathered is represented in the information and that there is accuracy in the interpretation of the data. In this study, the voice of the participants was reflected and not that of the researcher, which could have been bias. Confirmability in a qualitative study such as this is equated to objectivity in a quantitative study (Sinkovics *et al*., 2008, p. 689). This study kept draft outlines of field notes, personal notes, process notes, write-ups of results, terminations and concluding reports, timetables, annotations (including observations), and notes on arrangements and discussions to illustrate that the information obtained and the deductions made were logically concluded and objectively extrapolated from the data in a rational manner (Babbie & Mouton, 2011, p. 278).

3.6.5 Authenticity

Authenticity entails an assessment of the meaningfulness and usefulness of interactive inquiry processes and the resultant social change. It is argued that authenticity is a critical element of qualitative inquiry (Shannon & Hambacher, 2014, p. 1) in order to ensure that research findings are credible. This means that the findings are not only derived from the participants experiences but also hold regard for the ultimate research outcome. Authenticity is demonstrated when a researcher has shown a number of different perspectives on a matter, and the levels of understanding that represent such perspectives (Shannon & Hambacher, 2014, p. 2). In this study the researcher enhanced authenticity by using AI (Reed, 2007, p. 29). Authenticity was further enhanced by the researcher by accurately relaying the milieus found and the tone of the feelings expressed by the paricipants. A summary of the strategies used in ensuring trustworthiness is depicted in Table 3.7.

Table 3.7: Summary of the strategies used in ensuring trustworthiness

Strategy	Criteria	Applicability
Credibility	**Triangulation**	**Theory triangulation** The theoretical assumptions were adopted using the AI dimensions (Watkins *et al*., 2011, p. 84). The theoretical framework (Dillon *et al*., 2012, p. 37) of the linear Logic Model was used at the point of analysis. The contemporary PM framework was developed adapting the Logic Model (Dillon *et al*., 2012, p. 38). Semi-structured individual and focus group discussions were conducted to investigate if the research question would elicit the needed data (Kvale, 2007, p. 88). A literature review was carried out once the data was collected to confirm the findings (Holloway & Wheeler, 2010, pp. 37 & 42). **Data triangulation** The use of data from more than one source -HONs & ANMs (Streubert & Carpenter, 2011, p. 354). **Methodological triangulation** The use of different methods for collecting data: focus groups, individual semi-structured interviews and field notes (Streubert & Carpenter, 2011, p. 353; Campbell and Corpus, 2015, p. 4).
	Reflexivity	The research reflected on her perceptions about the study throughout, in order to remove any personal bias and prejudices and to remain objective (Polit & Beck, 2014, p. 271). The researcher also made use of bracketing.
	Member checking	Member checking was carried out to validate the understanding if what the participant had volunteered (Babbie & Mouton, 2011, p. 277).
	Peer debriefing	The researcher debriefed by engaging with her research supervisor, after having conducted initial interviews (Babbie & Mouton, 2011, p. 277).
	Authority of the researcher	The researcher is a Professional Nurse and Midwife with a Master's Degree in Nursing and has 23 years of Nursing Management experience. The research supervisor holds a doctorate degree and professorship; she held the position of Director at the School of Nursing at the university at the time the study was underway. The independent coder is a Professional Nurse and also holds a doctorate degree and is experienced in qualitative research and data analyses.
Transferability	**In-depth description**	The use of thick and rich description/s of the research participants, the research context/ setting and the research findings of this study allowed for the possibility of application or transferability to another study setting or to participants with similar characteristics (Holliday, 2007, p. 74; Babbie & Mouton, 2011, p. 277).

Strategy	Criteria	Applicability
Dependability	**Thick description of research methodology**	A thorough account of the research methodology used in conducting this study is presented in Section 3.5.3.
	Code-recode	The researcher and an independent coder analysed the data that was collected; a consensus discussion was held that lead to the required inter-coder agreement.
	Audit trail	The researcher secured all the voice-recording, the field notes and the transcriptions of the individual and focus group discussions.
Confirmability	**Reflexivity**	The researcher applied bracketing and reflexivity so that the study would not be influenced by personal bias or prejudice (Polit & Beck, 2014, p. 271).
	Neutrality	The exact words of the participants were used at times as quotations in the discussion of the research findings (Chapter 4).
Authenticity	**Fairness**	The researcher considered all the viewpoints of the participants and attempted to represent them in a fair manner, and the compatibility between the constructed and attributed realities (Shannon & Hambacher, 2014, p. 2; Babbie & Mouton, 2011, p. 277).

3.7 ETHICAL CONSIDERATIONS

The term 'ethics' in research according to Holloway and Wheeler (2010, p. 54) is derived from the word 'ethos', a Greek word that implies character, and points to the credibility of the speaker or writer. The word *'ethical'* is defined in the Oxford Dictionaries, Language matters (2016, online) as "*relating to moral principles or the branch of knowledge dealing with these…; morally good and correct*". The ethical conduct of this study commenced with the researcher registering as a bona-fide student at the HEI, and maintaining this status throughout the study. The ethical conduct of research commenced with the identification of the study topic and will be maintained throughout publication stage, as quality research evidence in relation to this study, is desired for practice (Grove *et al*., 2013, p. 191). In South Africa the National Health Act No. 61 of 2003 ethically regulates health research (Government Gazette No. 26595, 2004).

At the time of the interviews, the participants were made aware that they did not have to answer any questions if they felt uncomfortable or that their rights were being compromised. The researcher remained conscious of the potential power relationship between herself and the participants in the individual interviews as she holds the position of HON at one of the General Specialist Hospitals. An independent research assistant and scribe were therefore used to conduct the focus group discussions with the HONs whom she worked with from time to time. The

participants were informed that field notes would be taken during the interviews. Participants were also informed that a dicta-phone apparatus would be used during the interviews and that the recordings would be made available to the researcher, supervisor and the independent data analyser only. Grove *et al*. (2013, p. 191) state that, in order to conduct research ethically, protection of human rights of subjects (participants) is required that relates to: (i) self-determination; (ii) privacy; (iii) anonymity and confidentiality; (iv) fair treatment; and (v) protection from discomfort and harm.

3.7.1 Consent

The ethical processes of this study began with consent first being sought by means of presenting the full study proposal to an open panel comprised of academics and postgraduate students at the School of Nursing, at a University in the Western Cape where the researcher was registered. Permission to proceed with the study was obtained from the Higher Degree Committee of the Faculty of Community and Health Sciences and the Senate Research Committee of the university. The registered ethical clearance number allocate to this study is 13/6/16 (Annexure A). Once approval was obtained from these bodies, application was made (Annexures B & C) as per prescript to the Directorate: Health Impact Assessment (DOH) who coordinates and considers research applications for approval. This process was over the period 30 July 2013 to 15 November 2013; permission was received in two parts (Annexures D & E). Thereafter the 10 target General Specialist Hospitals in the Western Cape of South Africa were individually contacted seeking permission to conduct the empirical work of the study (Annexure F (sample)) as set out in the proposal. These health-care settings independently considered the researcher's application for this research study. Responses were received from eight of the ten health-care settings (Annexures H - O).

Informed consent requires the researcher to disclose all relevant information pertaining to the prospective research, to the participants. The potential participants of this study were informed in a letter of the proposed study, and invited to participate. The letter was an explanation of the study aims, objectives, methodology and benefits of the study. It also served to assure the potential participants of their anonymity and confidentiality and of the option to withdraw from the study at any stage without fear of prejudice (Annexure G). The researcher obtained written consent from the respective study participants (Annexures P & Q). Participation was thus free and voluntary. The participants were also informed that if they had any additional questions about the study that they could at any time ask the researcher or the research supervisor. There was no pressure from the researcher whether implicit or explicit, nor any inducement for participants to partake in the research (Holloway & Wheeler, 2010, p. 59).

3.7.2 Right to privacy

Privacy is the liberty people have to decide if and when they want to share or withhold information and to what extent (Grove *et al*., 2015, p. 105). Privacy is viewed as a part of the principle of respect for autonomy therefore researchers must respect research participants' right to privacy (Holloway & Wheeler, 2010, p. 55). Privacy is the freedom an individual has to settle on time, extent and general circumstances under which private information will be divulged or withheld from others (Grove *et al*., 2013, p. 705). Frequently social research requires that participants reveal information about themselves. In such cases it is imperative that their privacy is respected and that they are not coerced or forced to participate in a research study (Babbie & Mouton, 2011, p. 521). Participant privacy was seen to be protected when they have been given information about the study and voluntarily give their consent to take part in a study in which they share information with the researcher and accept that the data is kept confidential (Grove *et al*., 2015, 171-173). The physical areas where the interviews were conducted ensured privacy and disturbances were avoided, as interviews were held as away from the clinical wards. Interviews were held at time periods that were convenient to the nurse managers and the hospital, in order to minimise disruption of activities and not to intrude in the flow of activities of the participants (Creswell, 2013, pp. 57 & 165; Rowley, 2012, p. 264).

3.7.3 Confidentiality and anonymity

Qualitative health-care research is likely to have more of an intrusive nature than quantitative research. A researcher therefore is required to apply sensitivity especially with regard to the identity of research participants and thus to pledge anonymity (Holloway & Wheeler, 2010, p. 60). According to Babbie and Mouton (2011, p. 523), confidentiality is assured when a researcher can identify a particular participant's response but chooses not to publicise it. Participants were also informed that the study involved no procedure that would be potentially harmful. The names of the participants in the focus group and individual semi-structured interviews that were voice-recorded were not written into the coding, transcripts or the field notes. Subsequent to the data collection, use was made of numerical coding on the transcripts, understood only by the researcher as advocated by Babbie and Mouton (2011, p. 523). Participants in the focus group were requested to keep the information shared in the group confidential. The data was also not disclosed to any person other than the researcher, the research supervisor and the independent coder. A confidentiality agreement was signed (Annexure W) by the independent coder for this study which bound her from disclosing any information about this research. The researcher, research supervisor and independent coder all made use of password-protected electronic facilities that ensured the safekeeping and confidentiality of the electronic data of this study. The data gathered will be kept for a further five years and secured in this manner after the publication of the results of this study, after which it will be destroyed by the researcher.

3.7.4 Autonomy

Interviews were conducted at times that proved convenient to hospital staff to minimise disruption of activities so that work flow was not impeded and when it best suited the nurse managers (Creswell, 2014, pp. 97 & 98). Participants were informed of the nature and intention of the study before the commencement of the data gathering. Prior to the interviews and discussions the participants were further informed that it should not take longer than 60 minutes. The participants were informed of their right to withdraw from the process at any stage of the research study.

3.7.5 Right to protect from discomfort or harm

The principles of *beneficence* (to do good) and *non-maleficence* (to do no harm) set up by the World Medical Association strongly require that research study benefits outweigh its risks for the individual and the broader society (Holloway & Wheeler, 2010, p. 55). Social research should never injure or cause damage to those being studied regardless of whether they volunteered to participate in the study or not (Babbie & Mouton, 2011, p. 522; Grove *et al*., 2013, p. 705). In this study it was ensured that the participants were not subjected to injury, stress or discomfort.

3.7.6 Right to fair treatment

Fair treatment is a human right that is to be protected. In research human rights, that is, claims and demands justified according to the perception of an individual or by consensus of a collective in relation to a participant's right to protection from discomfort and harm, and fair treatment, must be protected. Research that is conducted ethically requires this protection and is based on the ethical principle of justice. This principle therefore requires research participants to be treated fairly in that there is a fair distribution of e.g. benefits (Grove *et al*., 2013, p. 191; Holloway & Wheeler, 2010, p. 55). The study participants in this study were selected fairly as a purposive sample was used. The method of purposive sampling is typified by its 'selection of key informants' characteristic in Lyon and Hardesty (2005, p. 288). The participants were all treated with the utmost dignity and respect. The findings of the study would be made known to the participants.

3.8 CONCLUSION

This chapter describes the research methodology of this study. Before having rationally selected the methodological approach, it was presented and described systematically. The selection of a qualitative approach using an exploratory, contextual and descriptive design was deliberate and appropriate as it was congruent with the objectives and the research questions of the study. Furthermore, it was also logical for the worldview of the researcher which is based on the constructivist paradigm. This study selected theoretical frameworks in respect of guiding the

study on the phenomenon. The grounding of the research study field, the semi-structured interviews and focus group discussions (including the pilots) and procedures used for data collection, the phases of the study and the field notes all gave rich descriptions, in line with appropriate theoretical and methodological sources. The researcher endeavoured to unambiguously reflect on and describe the study setting, research population, sampling technique and sample used, to convey the 'performance story' of the ANMs with all the characteristics of the research context, as succinctly as possible. The data collection procedure is also described. The analysis of Onwuegbuzie *et al.* (2012, p. 13) facilitated the qualitative nature of the data collected. Strategies for securing trustworthiness were applied and aptly described in this chapter according to the conventional measures appropriate to qualitative research. The researcher furthermore described the reasoning strategies that were applied in processing and organising the concepts and in drawing conclusions. Lastly, the researcher comprehensibly articulates the ethical standards applied in this study to ensure ethical integrity.

CHAPTER 4

FINDINGS AND DISCUSSION

4.1 INTRODUCTION

In the previous chapter, the research design and methodology were discussed. Consistent with the focus of this study, this chapter presents the experiences of participants on the ANM's work performances. Themes, categories and sub-categories emerged and were presented in an adapted Logic Model format and the underlying AI philosophical approach. This chapter commences with the description of the biographic and demographic profiles of the ANMs (Table 4.1) who participated in the semi-structured interviews and the HONs (Table 4.2) who participated in the focus group discussions.

4.2 BIOGRAPHIC AND DEMOGRAPHIC COMPOSITION OF THE RESEARCH SAMPLE

As set out in Tables 4.1 and 4.2, the sample comprised of two groups of nurse managers namely ANMs and HONs.

Table 4.1: Composition of the ANM participants (n=28)

							TOTAL
Years of experience as an ANM	Did not indicate **n = 17**	< 2 years	2-5 years **n = 4**	6-10 years **n = 7**	11-15 years	> 15 years	**n = 28**
Total years of health-care experience	**n = 13**	< 6 years	6-10 years	11-15 years	16-20 years	> 20 years **n = 15**	**n = 28**
Age	**n = 9**	Younger than 30 years	30-39 years	40-49 years **n = 7**	50-59 years **n = 10**	60 years and older **n = 2**	**n = 28**

Table 4.2: Composition of the HON participants (n=6)

						TOTAL
Total years of health-care experience	< 6 years	6-10 years	11-15 years	16-20 years	> 20 years **n = 6**	**n = 6**
Years of experience in the post as a HON	< 2 years	2-5 years **n = 2**	6-10 years **n = 2**	11-15 years	> 15 years **n = 2**	**n = 6**
Age	Younger than 30 years	30-39 years	40-49 years **n = 1**	50-59 years **n = 4**	60 years and older **n = 1**	**n = 6**

Five male and 23 female ANMs participated in the study (n=28). Of these participants, one was African, sixteen were Coloured and eleven were White. One male and five female HONs took part in the study (n=6). Of these participants, one was White and five were Coloured. All the ANMs were older than 40 years. All the HONs were older than 50 years. In relation to the

question of the number of years of experience as an ANM, eleven responded. Five were in their posts for two to five years, while seven were in their posts for six to ten years. In relation to the same question of the number of years of experience as a HON, five responded. One was in the post for two to five years, two were in their posts for six to ten years, and two were in their posts for more than fifteen years. In regard to the number of years' experience in health-care, the fifteen ANMs and six HONs who responded to this question were all working in provincial health-care settings for more than 20 years.

4.3 DESCRIPTION OF DATA FINDINGS

4.3.1 Themes, categories and sub-categories

The study findings were initially categorised according to the questions within an AI philosophy (Table 4.3). These questions were called the themes.

Table 4.3: Themes, categories and sub-categories

Themes according to the adapted Logic Model, outlining the link with AI	**Categories**	**Sub-categories**
1. Understanding the KPA	1.1 AMs relate their KPAs to specific areas - Strategic planning, quality nursing care, QA and nursing care, audits - HRs - FBU and financial management - Support function	
2. Discovery - Best work performance experience - AMs' take pride in their communication and interpersonal skills, HRM and administrative strengths	2.1 AMs feel positive in the way that they utilise communication and interpersonal skills.	
	2.2 AMs relate success with regards to HRM	Problem solving and conflict management skills Staff well-being and staff posts Motivation and support
	2.3 Leadership	
	2.4 Building relationship	
	2.5 Passion about nursing caring	
3. Dream - Best possible opportunities - AMs envision that there are things that can be done better	3.1 AMs identified best possible opportunities to flourish in their work	Training and workshop for nurses Communication between OMs and AMs Staff involvement
	3.2 AMs own need for training	
	3.3 Desire for enhanced interpersonal relationships and unity between shifts	
	3.4 A need for enough staff	
4. Design - Initiatives for the future	4.1 AMs best initiative/ ideal expectations for the future	Aware of the need to drive change Working together towards a better future/care Training and appreciation of staff
5. Deliver - Commitment to deliver work performance	5.1 AMs made recommendations to commit to better work performance	Increased managerial involvement and support Suggestions to work towards: o Better resources o Staff incentives and motivation o Working together o Training Managing absenteeism Managing processes

The categories of Theme 1 indicated the overall performance areas of the ANM. They were further restructured into four new main categories (Table 4.4):

Table 4.4 Restructured four new main categories

Restructured four new main categories from Theme 1
1) **Strategic planning, and quality assurance and nursing care** comprising two sub-components: o Strategic planning o Quality assurance and nursing care
2) **Human resources** comprising two components comprising of two sub-components: o Human resources management o Human resources development
3) **The Business Unit** and managing **finances**
4) **Support function**

The identification of four main categories, served as the four overall key performance areas of the ANM entailing: (i) strategic planning, and QA and nursing care; (ii) HRs; (iii) the Business Unit and managing finances; and (iv) support function. This confirmed the AI assumption in Chapter 1, that reality is created in the moment, and that there are multiple realities. These four categories in Theme 1 also corresponded with the more detailed content in Themes 2 - 5 due to the semi-structured questions posed, indicated in Table 4.5 as the sub-categories (colour coded Table 4.5).

Table 4.5: Themes with four categories (KPAs) and 21 sub-categories

Themes	Categories	Sub-categories
Theme 1: Understanding of key performance management areas: ANMs relate their key performance areas as involving the following: →	Strategic planning; quality assurance and nursing care	
	HR comprising HRM and HRD	
	The Business Unit, managing finances	
	Support function	
Theme 2: Discovery: Best work performance experience ANMs take pride in their communication and interpersonal skills, HRM and administrative strengths **(Input)**	Strategic planning; quality assurance and nursing care	Passion about nursing caring
		Leadership
	HRs	(Success in) building relationship
		Motivation
	The Business Unit and managing finances	Staff well-being and staff posts
		Problem solving and conflict management skills
	Support function	Communication and interpersonal skills
Theme 3: Dreaming: Best possible work performance opportunities ANMs envision that there are things that can be done better **(Output)**	Strategic planning; quality assurance and nursing care	Communication between ONMs and ANMs
	HRs	Staff involvement
		Desire for enhanced interpersonal relationships and unity between shifts
	The Business Unit and managing finances	Better/ increased resources
	Support function	Staff orientation and training/ workshops
Theme 4: Designing: Initiatives for the future **(Output)**	Strategic planning; quality assurance and nursing care	Need to drive change
	HRs	(Success in) team work
	The Business Unit, managing finances	Working together toward better future care
		Appreciation of staff, staff incentives and motivation
Theme 5: Delivery: Commitment to deliver work performance **(Outcome)**	Strategic planning; quality assurance and nursing care	Managing processes
	HRs	Increased managerial involvement and support
		Adequate staffing resources
	The Business Unit and managing finances	Managing absenteeism
	Support function	ANMs' own need for training

The identified themes were aligned to the adapted Logic Model in relation to the work performance of input, output and outcome of the ANMs work performance management (Table 4.6).

Table 4.6 Alignment of themes to adapted Logic Model

Input into understanding the KPAs; that which is 'discovered'
Input into best work performance experience; that which is 'discovered'
Output of best work performance opportunities; that which is 'dreamt'
Output on work performance initiatives for the future: that which can be 'designed'
Outcome on commitment to work performance; that which will be 'delivered'

The themes, categories and sub-categories are portrayed, discussed and supported by direct quotes of participants in the narrative using an *italicised* format, and are further substantiated and confirmed by literature in order to illustrate its importance (Bazeley, 2009, pp. 6-14). The responses of the participants are indicated by using denotations in the discussion of the findings, such as II (Individual interview), FG (Focus group) and P (Participant). An underlying dynamic that emerged from the analyses of the data indicated that a contemporary performance management framework for the ANMs in the provincial health-care settings needed a staff development and training approach. The findings are therefore discussed as outlined in Table 4.7.

Table 4.7: Themes, categories (KPAs) and sub-categories according to the adapted Logic Model alignment

Theme 1 Understanding the KPAs:	Theme 2 Discovery	Theme 3 Dreaming	Theme 4 Designing	Theme 5 Delivering
Category 1 Understanding the KPA: *Strategic planning, and Quality Assurance and Nursing Care*	**INPUT**	**OUTPUT/ PROCESS**		**OUTCOME/ RESULT**
	Best work performance experience	Best possible work performance opportunities	Initiatives for the future	Commitment to deliver work performance
	a) *Passion about nursing caring* b) *Leadership*	*Communication between ONMs and ANMs*	*Need to drive change*	*Managing processes* *Communication between ANMs and management* *Communication between Management and the broader staffing corps*
Category 2 Understanding the KPA: *Human Resources*	Best work performance experience	Best possible work performance opportunities	Initiatives for the future	Commitment to deliver work performance
	a) *Building relationship* b) *Motivation*	a) *Staff involvement* b) *Desire for enhanced interpersonal relationships and unity between shifts*	*Team work*	*Increased managerial involvement and support* *Adequate staffing resources/ need for enough staff*
Category 3 Understanding the KPA: *The Business Unit and managing finances*	Best work performance experience	Best possible work performance opportunities	Initiatives for the future	Commitment to deliver work performance
	Staff well-being and Staff posts *Problem solving and conflict management skills*	*Better/ increased resources*	*Working together toward a better future/ better care*	*Managing absenteeism*
Category 4 Understanding the KPA: *Support function*	Best work performance experience	Best possible work performance opportunities	Initiatives for the future	Commitment to deliver work performance
	Communication and interpersonal skills	*Staff orientation, training, workshops for nurses*	*Appreciation of staff, incentives and motivation*	*ANMs' need for own training*

4.4 KPA 1: STRATEGIC PLANNING, AND QUALITY ASSURANCE AND NURSING CARE

4.4.1 KPA 1: Understanding the KPA strategic planning, and quality assurance and nursing care

This section involves a discussion of the findings of the category understanding in terms of the individual but interlinked sub-categories of: (1) strategic planning, and (2) QA and nursing care.

4.4.1.1 Strategic planning care in relation to the KPA strategic planning, and quality assurance and nursing care

The ANMs in the provincial health-care settings understood strategic planning to be a key management area of work performance in conjunction with quality nursing care (QNC) and QA, and nursing care. James (2006, p. ii) states that strategic importance could be given to any aspect of performance. Ferreira and Otley (2009, p. 264) have nonetheless separated the sphere of management control into strategic planning, management control and operational control, where management control is defined as *"the process by which managers assure that resources are obtained and used effectively and efficiently in the accomplishment of the organisation's objectives"*. The fallout of this separation has resulted in a number of disadvantages including 'strategic planning' being isolated from the other two processes of management control and operational control (Langfield-Smith, 2007, p. 754). James (2006, p. ii) has also made reference to those managing HRs who often find themselves unable to give strategic importance to the role of HRs in an organisation because of being engrossed in daily administrative duties. The ANMs claimed that they do have a part in strategic planning:

"We are really involved in our budget, strategic planning …" (II P2). *" … Strategic and management of FBU and nursing … and strategic we must 'in any case' plan … we have an AOP"* (II P13).

The ANMs understood that there was a need for the overall service objective to resonate at the ward unit level to allow a performance thread to be drawn from the top (provincial level) to the bottom (ward level) as a whole:

Part of the key performance area is 'as a matter of fact' now your strategic planning and things like that, so you must have a plan in place for your unit to manage your unit as a whole" (II P16).

Planning staff development was also regarded as strategic planning by ANMs. In one instance where an ANM indicated awareness and confidence to perform strategically, the focus was on

the skills development plan for her ward units. The following statement illustrated her performance areas involving strategic planning:

"Your KPA three: I've got a very definite plan that I work according to. I say to the staff, you know it's simple -your KPA is as simple as ensuring that all the developmental needs of each and every staff member passing through your unit… and add it to your existing individual skills development plan for your unit, which would be evaluated at the end of April on the developmental needs of your staff as per their SPMS document …" (II P9).

Selectively the ANMs also perceived that they were being coached in strategic planning as they (ANMs) needed at times to stand in for their HONs in all management aspects:

"If she's (HON) *not here, most of the time she has asked me to stand in for her, so I've gained a lot of experience in that, and I've learned a lot …"* (II P11). *"I'm an Assistant Manager but I must think of when HON Solomon (fictitious name) is not here, I have to act most of the time"* (FG2 P3).

A HON was of the view that the ANMs still found it a challenge to think ahead and to plan strategically:

"You know, nobody's (referring to her ANM supervisees) *shown yet the willingness, and say I will take the lead in this also…. So for me, they are still very much on a learning curve. Today things like seeing that the staffing is there, and reallocating and so on that is fine, but seeing a bit further and looking further uh strategically, I think people* (ANMs being supervised by this HON participant) *have a long way to go"* (FG1 P3).

The uncertainty of the ANMs not knowing how to fulfill the strategic role could be deduced from the need expressed for *'a lot of'* assistance. In this regard another HON explained what her perceived ANM shortcoming is with regard to strategic management:

"… I'm saying there's the lack of attention to detail -and finishing tasks correctly, and a lot of the quality in there is lost" (FG1 P3).

The findings indicated the need for competencies in strategic planning. There was apparent doubt among HONs with regard to the ability of ANMs to think strategically and therefore to plan:

"I find the two on day duty who are reluctant to make decisions especially when it comes to HR issues --those kind of things despite the fact that I've said …you look at things and what effect it's going to have on the service, how's it going to affect the service, how's it going to affect the staff? And then we make a decision irrespective of whether I'm here or … but that is what you base your things on" (FG1 P3).

A HON indicated that she needed to also orientate the Medical Superintendent (title at the time) of the hospital on the need for the ANMs to develop in order to think more strategically. She relayed what she had said at the time:

"Doctor, these people are very good people. There is no doubt about that, but they need to be helped to get to a certain level" (FG2 P1).

Ferreira and Otley (2009, p. 270) refer to the notion of managements' perceived actions needed for success in the development of the organisation. When the organisations' goals are known, these are often expressed in the vision and mission statement. Whilst key success factors are

often identified by organisations, it is commonly known that strategic planning is only successful where the required actions to achieve the goals are stipulated. A night ANM at one of the provincial health-care settings was specifically asked by her Head of Institution/ hospital (HOI) to contribute to a process of reviewing and renewing their vision and mission:

"… and Mrs. HON Hospital No. 9 phoned me that time and said … I am so glad I got you here…. Mrs. CEO Hospital No. 9 wanted to speak to me because we had this guy here. He's reviewing and renewing our vision and our mission statement uhm …" (II P17).

Considerations for strategic planning should invariably involve how strategies and plans would be produced and communicated to managers and other employees. The approach could either be by conventional means, where senior managers undertake the tactical thinking, decision making, planning and subsequent communication to the broader group of employees, or an inclusive process - of involving all levels of management, respectively also referred to as the top-down or bottom-up approach (Ferreira & Otley, 2009, p. 270). The ANMs as a practice, could plan and make decisions, and follow through on the plan and/ or decision:

"...we have an AOP, for each I mean... (referring to each of her earlier stated KPAs namely 'operational, strategic and management of FBU and nursing,' … 'management of HRs,' … 'budget', 'management of QA' … and 'management of support to the nursing care'...) *the Department of Health, Hospital and I have for each of my wards, devised a plan from these"* (II P13).

Ferreira and Otley (2009, p. 270) point out a paradoxical phenomenon where organisations might be reluctant to rigidly follow a detailed planning process and could prefer to adopt a more flexible, receptive approach to respond to environmental eventualities and uncertainties. The notion in this regard is that forecasting emanating from strategic planning might be unreliable and that it is better to ensure capacity to be able to react to events as they occur. Ferreira and Otley (2009, p. 270) also indicate that within the contemporary competitive and changing nature of the environment, the significance of planning might have dissipated. A more flexible adaptive approach to response to events as they unfold might also be adequate. An ANM indicated that she could not pre-plan her day as each day brought its own challenges and took her away from the planned events (field notes - II P10). Strategic planning can be a spontaneous event at times which makes the term misleading (Tenblad, 2012, p. 40). From the findings of the component understanding of strategic planning, and QA and nursing care, concluding statements were made (Annexure X) in relation to *strategic planning*.

4.4.1.2 Quality assurance and nursing care in relation to the KPA strategic planning, and quality assurance and nursing care

Economic restrictions worldwide have placed health-care systems under pressure. Contributing factors are the aging population, the mounting burden of debilitating disease, the growing user demand for access to available quality care and relevant health services. As health services have evolved in the attempt to meet the patient demand, and brunt, 'quality and safety' has taken on

new meanings of significance (Peregrina, 2009, p. 2). QNC/ QA and nursing care were understood by the ANMs in provincial health-care settings to be a key aspect of work performance in conjunction with strategic planning. An ANM described QNC/ QA and nursing care:

"... it is to provide for the patient needs, the immediate needs of the patient, to involve the family and, and to give feedback (referring to the patients' family - field notes) *and to absolutely address problems and complaints of the family and to resolve the problems and then even just to ensure that everything the patient requires is done as such"* (II P23).

Another's interpretation of a key performance area in regard to quality was:

"Management and implementation of and support for the QNC ..." (II P18).

In accordance with the general view that nursing is an inherently caring profession (Marinus, 2014), this study has identified quality assurance and nursing care as part of the main key performance areas of the ANM; the ANMs desired quality of nursing care. They deemed it as important:

"The most important functions for me in that key performance area is to ensure that my patients receive quality care" (II P10).

At the provincial health-care settings of this study, the responsibility of quality nursing care is directly that of the ONM at the forefront, who is supervised and managed by the ANM. The ANMs in turn therefore also assumed a shared custodianship of ensuring accountability in the clinical nursing care role of delivering quality in care. In this regard, an ANM stated:

"... if their (referring to her supervisees, the ONMs) *first key performance area is to provide holistic specialised nursing care then I need to be part of that ..."* (II P9).

Zori and Morrison (2009, p. 75) point out that the role of nurse managers on the forefront of operations is crucial in achieving organisational goals of service delivery of a high standard that satisfied patients. Armstrong, Rispel and Penn-Kekana (2015, p. 1) recognise that the coordination of patient activities embarked on by the frontline (unit) nursing managers, is crucial to the proposed South African quality health-care reforms. First-line nurse managers must be provided with the required resources that assure quality patient care, thereby enabling them to spend more time managing (Loo & Thorpe, 2004, p. 88). The ANMs also shared the responsibility of delivering holistic quality patient care with the multidisciplinary team.

An 'improvement' consciousness prevailed amongst the ANMs interviewed, to ensure safety in care which is illustrated by the following statements:

"I am busy with quality improvement plans for each of my wards ..." (II P13). And: *"... as an area manager* (ANM) *for me that is my responsibility and accountability to ensure that the patients are nursed in a safe and secure environment and that they receive quality care to the best of our ability at all times"* (II P10). And: *"... look at the Health-care 2030, which is the* (stated optimistically and anticipatory - field notes) *thing towards which you must work as part of your plan to see that those are those goals* (objectives) *that is indicated therein that you are to reach those at the old end of the day so as I always say...we have these things ...it's just that they don't reflect in all these different words being used for the same thing"* (II P16).

Chin and Kramer (2015, p. 242) have asserted that features of perceived measurable quality of care could include satisfaction, benefits and even dissatisfaction of care. It is however the premise that underlies a care outcome. Nurses who are satisfied with their work circumstances will provide quality in care. In this study it is assumed that the endeavours put forward by the ANMs to provide quality assured nursing care, show their satisfaction as they continued to describe their passion to meet patient needs, and their strength to keep supporting the rendering of specialised (quality) nursing care:

"We now have six people who are ICU trained (i.e. qualified)*... and so… especially with the students who are now here, there's good support now and on each shift we now have someone* (who is a trained ICU Professional Nurse). *The students* (i.e. the ICU nursing students) *get good learning opportunities within the hospital. Our staff nurses and nursing helps and so on -so we try to in a small way. So we've got the support from the specialised people* (referred to the post-basic trained nursing staff - field notes) *so we can move forward*" (II P25).

As the assurance of quality care was assessed on the night rounds, the ANMs related the following:

"... and I take her (i.e. a ward nurse on the particular night shift - field notes) *round and she must tell me about every patient"* (II P1). *"We must look at our QNC that we are required to do'* (II P12). *"You must listen to the bells ringing! The patients are calling!"* (II P1). *"I speak to them a lot about their attitude 'how to treat people', 'how to receive people', and you know and 'be honest with people' and about the confidentiality… You have to always tell the people… if they phone...', .telephone etiquette, because that's part of service, that's your quality"* (II P1).

The ANMs related how their passion for rendering quality nursing is sustained even when there was a shortfall in staffing. An ANM with extensive experience stated:

"I've also learnt that we need to work - find the best pathways with the limited resources that we've got. And I think -I feel good in the fact that because of my EAP (Employee Assistance Programme) *experience way back"* (II P9).

This confirmed that the AI assumption in Chapter 1 that the best parts of the past should be what is carried forward. In this regard the ANM kept encouraging the staff positively despite the limited resources. ANMs spoke of their determination to allow the required standard of quality to be rendered in nursing. A night ANM who was responsible for the entire intellectual disability health-care setting described her passion to continue to provide a service in the face of a staffing shortfall said:

"And if there's for example a shortage in a ward where there's only one nurse with 30 patients, I don't have a problem going and doing physical work" (II P22).

Various experiences of having assured 'good' nursing care practices were narrated. The night ANMs in particular proudly explained the operationalisation of quality nursing. In an apparent demonstration of her customer-focused disposition, an ANM described the following scenario which she wanted to rectify:

"... like last night patients came late from the hospital (i.e. a general hospital at another site) *you know then I 'in fact' call HON Hospital No. 9 them and say 'No, this is poor* (service) *because*

our patient left this morning 7 o'clock, 8 o'clock'. No, if the patient is not here by 4 (pm)*... No!* (expressed the words emphatically - field notes). *If you* (referring to the health-care setting) *can have your own transport service like we used to have, then we can fetch the patient ourselves* (uttered almost abruptly - field notes) *because Network* (fictitious name for the authorised patient transport system) *would take long"* (II P1).

Customer/ patient-centeredness is experienced when the delivery of patient care is focused around the patients' requirements, first choices, conditions and welfare (Cosgrove, Fisher, Gabow, Gottlieb, Halvorson, James, Kaplan, Perlin, Petzel, Steele & Toussaint, 2013, p. 321). Yoder-Wise (2015, p. 416) duly points out that there is economic value in improving the patients experience. In this study, the proximity of the night ANMs to patients often enabled them to perform clinical roles directly and personally, making use of their level of quality oversight. Some of the operational tasks the night shift ANMs embarked on at the provincial health-care settings included three aspects:

(1) Pain management -*"He* (patient) *was lying there, had an abdominal operation but he an occlusion of both his legs when I got to him. And that's where he had pain!"* (II P26).
(2) Flow management: The physical movement (transfer) of patients from the emergency room to the in-patient wards - *"I just take a patient to the ward* (from the Casualty Department)*, a patient that sits from what time! I don't mind"* (II 28).
(3) Administration of medication and patient education at the psychiatric hospitals - *"... something that I do that doesn't appear at all on the job description is that we administer medication on night duty, so you take responsibility for the medication -administer and do health education with the patient in this regard, because these are long-term patients to whom we administer medication as well as those in the Alcohol Rehabilitation Unit and even there as well, the patient must be given health education regarding medication, and motivate them and say 'Are you feeling alright?' That 'it's comfortable to be here but the moment you are discharged…' to make them aware of all the pitfalls that they could fall in"* (II P18).

These work deeds were carried out largely on the ANMs' own accord and judgment of the service needs. To this extent an ANM said:

"To care for patients -which means I must be sure that the patient is holistically nursed… I am also very patient-oriented… even if I am in a manager post, I still have 'that'… that I want to care for a patient" (II P28).

An ANM related her satisfaction in the improvements she had made in the practical quality of the provincial health-care settings since her appointment to the position, in terms of aesthetics and infrastructure that enhanced quality in care. Her ability to source beds of the appropriate height from another health-care setting, had ergonomically improved working conditions with bed-bound patients, and therefore improved nursing service delivery at the rehabilitative health-care setting where she was employed:

"The standard was already too low, so I started there; you know I changed all those beds! I had the ward painted. I had the ward painted. I had curtains made (stated with much passion - field notes) … *really those were my best years because I could see the improvement, I could see this nursing* (emphasised the words - field notes) *care, the standards you know - quality"* (II P1)!

The improvement/initiative was not only confined to the bedside. At the same hospital there were no managerial rounds taking place. The ANM initiated such rounds which she referred to as walkabouts:

"I did quality (stressed the point - field notes) *walkabouts because that was never there! I formed a quality committee. We walked about once a month, myself, the Infection Control Sister, laundry, cleaning, everybody, and then anything that I see, we make a note and then we go to the CEO and then improvement must come from there"* (II P1).

Based on the evidence that eleven ANMs were in their posts for four to ten years, and fifteen of them were working in health-care for more than 20 years, the above initiatives of improving the bed heights, having curtains made and initiating managerial quality walkabouts, confirmed the AI assumption in Chapter 1 that best parts of past experience is carried forward. The night ANM also carried out 'self-initiated' quality rounds and quality checks:

"I make sure that I go during the nurses work time - so that the lights are still on and I can still converse with patients et cetera" (II P19). "*I started at 8 o'clock* (20h00) *and then I go to Casualty, and then I go to ICU, then I start in the wards with the Sister on rounds from bed to bed and I greet each one* (i.e. each patient) *and then I look as I'm doing these rounds, I look to see if everything is in place… and I hear if there are any complaints or problems* (i.e. from the patients)' (II P23). "*You must see to the safety of your patients. So if you go on the rounds i.e.* (ward rounds)*, you must check -maybe patients who have convulsions, they must have their cot sides up - you must be alert all the time wherever you go with your patients, you must be alert so you must see the patient holistically. If the patient comes for gynae* (referring to gynaecology)*, it's not only the baby inside the mum but you must have a look that the mother as well"* (II P27).

Walkabouts carried out by the executive team members in a NHS organisation in the UK was shown to have created opportunity for seniors (executives/ leaders/ managers) to demonstrate the kind of leadership behaviour that values the quality in patient experience. The seniors were able to listen to frontline staff, whilst the frontline staff in turn, were able to speak directly to seniors/ management. Walkabouts also provide authentic opportunity for management to recognise and comprehend problems and mark examples of good care (West, Eckert, Steward & Pasmore, 2014, pp. 13 & 15). Without exception, the night ANMs who participated in this study embraced the nature of this role as it pertained to the quality of nursing care. In all of the tasks they executed, the researcher observed that job fulfillment prevailed. They conveyed a confidence and a desire to ensure quality (field notes). A specific goal-profiling study concerning the goals of first-line nurse managers in a work setting caring for older persons identified that they (nurse managers) had no control over certain goals that were determined by the job description such as administrative and leadership goals. It was however found that there was exceptional control, acceptance and fulfillment of goals personally chosen and self-regulated (Johansson, Pörn, Theorell & Gustafsson, 2007, p. 149). It was the researchers' perception that the jobs embarked on by the ANMs on their own accord that could be self-regulated, as those listed to facilitate the rendering of quality care, were experienced as fulfilling. The expression below from one of the participants aptly captures that passion:

"And that is what I live for …" (II P28).

Two participating ANMs working on the day shift at psychiatric provincial health-care settings each attested to their initial intention to gain a short spell of experience at the time of their appointed as entry level professional nurses to the setting. They revealed that they however found such fulfillment in the job that they each remained in that service 24 years on. Elsewhere, with regard to the view where the nurse manager applied HR practices fairly (highly regarded as procedural justice), older nurses were found to be more satisfied and likely to remain in the service (Armstrong-Stassen, Freeman, Cameron & Rajacic, 2015, p. 55). The ANMs in this study were gratified with the positive outcomes from their interventions. One ANM who worked the night shift said:

"…that is what it's been about all the years in nursing. It's nice for me to see that people are happy in the work …" (II P23).

One of the two nurses mentioned above who had continued to work for 24 years in spite of the initial intention to merely gain a short period of work experience, pointed to the belief she had in the leadership and her love for caring for the mentally ill that was instilled by the leaders. She indicated that she had another career plan which was to follow the ICU path. She stated that she often pondered on what her life would have been, had she followed her former planned career. She claimed that her path was destined by God, she was not regretful of her situation, and merely speaking about her work was fulfilling for her (field notes – II P10). There seemed to be a deeper sense of reward for the night ANMs in cases where they would observe patients responding with gratitude:

"... as my work is, I do rounds each night by each patient at this hospital and it's for me the most wonderful thing with the patients and for the little things they (the patients) *are so grateful for. Little little things, for instance when I say 'sleep well' then you can see some of them …, it means so much to them …"* (II P23).

Referring to some of the very ill general hospital in-patients, a night ANM expressed her caring and empathic demeanour during her observation of how the patients would maintain a positive demeanour in accepting their situation:

"… and they never complain, some of the patients they are soo (accentuated the disposition with tone of voice - field notes) *satisfied with a little, they are just always happy …"* (II P23). *"I have to see that patient care is delivered and that they are satisfied with treatment"* (II P8).

The ANM demeanour described above was also in sync with the prescribed 'care' values of the WCP where the study was conducted. These values are 'innovation', 'care', 'competence', 'accountability', 'integrity', 'responsiveness' and 'respect' (I-C^2AIR^2) (Western Cape Provincial Government (Budget Speech), 2012, online; Western Cape Government: Department of Health (2015). An exploration of the interrelationships of service quality between three areas namely physician satisfaction, employee satisfaction and patient satisfaction in health-care delivery, organisations reveal that the promotion of patient-centeredness, developing medical personnel

relationships and the enhancement of staff satisfaction and loyalty, were not independent entities competing for hospital resources and management consideration. The results indicated that numerous service quality improvement activities are indeed interrelated and result in a simultaneous positive outcome (Clark, Wolosin & Gavran, 2006, pp. 79 & 96).

Night ANMs in particular needed to at times, diffuse tension between patients and/ or relatives, and nurses and/ or other caregivers. The night ANMs stated that some night shift nurses lacked the needed positive understanding of complaints and found that they would respond defensively when a complaint was lodged. They (the nurses) therefore failed to see the 'complaining individuals' as relatives at a bedside of their very ill hospitalised loved ones. The perception held at times by a few night nurses of those who complained according to the night ANM, was that people *"just wanted to complain"* (II P26). This therefore meant that they failed to realise that resolving complaints would help to improve quality. The ANM also said:

"But they (the nurses) *only heard the man* (patient) *who moaned, and the wife who was moaning all the time of her husband having too much pain -nothing further …"* (II P26)!

ANMs who worked the night shift described the 'customary' role that they were called upon to fulfill from time to time; that is, to attend to telephonic calls from dissatisfied irate members of the public and the quality responses that they were required to enact to safeguard and maintain the professional image both the health-care setting and the health system. The following statement characterised such a situation:

"Ja, a lot of people phone here... public, complaining, and then you must be calm, you must try to diffuse the situation and said 'Ok, I'm sorry. The patient was not turned. I will s...' Staff have an arrogant attitude 'I'm sorry for that, I will deal with it now' and I call them back and say 'the situation has been solved'" (II P20).

From the findings of the sub-category on strategic planning, and QA and nursing care, concluding statements were made in relation to *QA and nursing care* (Annexure X).

4.4.1.3 Audits in relation to the KPA strategic planning, and quality assurance and nursing care

The involvement of audits was understood by the ANMs in provincial health-care settings to be a key aspect of work performance in conjunction with strategic planning, and QA and nursing care. The researcher also understood the ANMs' perception of auditing of the nursing process, to be an important inherent part of nursing practice. One response which illustrated this was:

"…the first key performance area as per my jd (job description) *is patient care. So as an Area Manager* (ANM) *for me, that is my responsibility and accountability to ensure that the patients are nursed in a safe and secure environment, and that they receive quality care to the best of our ability at all times… to ensure that there is control measures in place like the audits"* (II P10).

In this study, the ANMs indicated that they give a lot of attention to conducting audits in the key performance area of QNC/ QA and nursing care with specific attention to nursing

documentation. A number of ANMs from both the day and the night shift indicated that audits were indeed being done:

"For me auditing (i.e. of nursing documentation) *is important …"* (II P1). *"They had to audit at least 10 files and I want to see the evidence at random"* (II P1). *"We do the audits, the nursing process audits. Uuh, we keep regular meetings with them* (the nurses)*, include them* (the nurses) *in discussions"* (II P2). *"Our patient records get audited"* (II P13). *"Then I am also responsible for audits. I must go into the wards and go and have a look at the different folders, whether it is being done correctly! That this now audits on the whole --of the wards performance"* (II P24).

Audits in this regard concentrated on the written nursing notes, which consisted of nursing documentation on patient care, and suggested that it referred to the documentation of nursing care already rendered.

"… We do the audits, the nursing process audits" (II P2).

According to Salmela (2013, p. 58), the term 'documentation' is usually used in the context of discussing nursing work. Nursing documentation is inclusive of the development of nursing care plans which might be perceived as a secondary role in documentation. Salmela points out that it is conversely the care plan that guides documentation. The implementation and maintenance of a live care plan throughout the care period of a patient, constitutes nursing decision making as opposed to log entering (Salmela, 2013, p. 58). A HON in this regard passionately supported by another stated the following:

"Sometimes I've also tell them that please you must, you must must, you must work something out to compare the admin (administrative or managerial) *with the clinical and to do your audits and your patient records... in that wards...your nursing process… do these type of things"* (ardent cries, supported by 'umns' and 'mms' from the other HONs in the focus group - field notes) (FG2 P2).

An ANM reported that she was obligated by her HON to conduct each visit to a ward (matrons' round) in a structured quality-orientated manner, so that nursing care objectives could be measured daily and thus needed an audit checklist for this purpose. The required structured visit was well accepted by the ANM who viewed the auditing initiative positively and constructively and stated that it was 'right' (field notes):

"I did some audits because my manager (HON Hospital No. 2) *said she don't want me to go like just go to the wards since I'm now the Clinical Manager… I must go with an objective. I must go with a objective to see if things are being done the correct way and if people are being looked after in the correct way and stuff… actually the audit is very good"* (II P4).

Nursing documentation constitutes a vital component of the daily routines of nursing work with thorough nursing documentation being an essential section of multi-professional care. Nursing documentation therefore is a means of communicating patient care. Hence, the delivery of good quality care including patient safety is dependent on the quality of information available and the effectiveness of the communication process amongst all members of the health-care team (Mykkänen, Saranto & Miettinen, 2012, online; Saranto, Kinnunen, Kivekäs, Lappalainen, Liljamo, Rajalahti & Hyppönen, 2014, pp. 629-630; Instefjord, Aasekjær, Espehaug &

Graverholt, 2014, p. 1). In this regard, nursing documentation in the form of nursing care plans is highlighted as an important aspect of all of such information (Mykkänen *et al*., 2012, online). The aspects of safety were additional focal areas for conducting audits in key performance areas with regard to staffing expertise/ knowledge, staffing norms and hygiene/ cleanliness:

"… and part of that would be to ensure that there is safe staffing norms, uhm to make sure that the environment is clean and safe for them to be nursed in, uhm that the staff that treat them are knowledgeable, to ensure that there is control measures in place like the audits that we do for various systems, to make sure that you know that the outcome for the patient is quality, 100% quality care ja" (II P10). *"… And then all of that Infection, and Waste Management, that type of things and the Audits and the 'SEAT' audit tool and all that type of things in order to look at those things as such. I mean we do those inspections monthly -inspections, the usual ward inspections and nursing process audits, exactly to look at certain things, and the complaints and compliments and things"* (II P16).

There was a general awareness amongst the ANMs that compliance with the National Core Standards for Health Establishments in South Africa (forthwith will be referred to as National Core Standards (NCS) audit requirements were to be met. After having embarked on a preparatory audit process in the ward, the ANM reacted as follows:

"… And I gave them feedback, and now they can go back to the wards and look at the shortcomings and correct that before we do audit. So every nurse manager was given an audit to do, to be done, like 'office management'" (II P4).

Björvell, Thorell-Ekstrand and Wredling's (2000, p. 6) point out that concurrent ongoing auditing of patient records followed by discussions on upgrading, improves quality of records and allows for change in the behaviour of health-care professionals that in turn has a direct influence on patient care. At Jamaican hospitals increased training and ongoing monitoring and even research of nursing documentation was identified to address the nursing documentation gaps, especially in the light of the changed disease burden (Lindo, Stennett, Stephenson-Wilson, Barret, Bunnaman, Anderson-Johnson, Waugh-Brown & Wint, 2016, p. 508). In line with these sentiments, a resounding view of an ANM was that the key performance area of the job addressed the quality of the care rendered to patients and that audits assured this. This view was expressed by:

"…we have lots of quality things in place like audits and all those things, do you understand? It is being done, but I think the point that I want to also tell you is when I receive an audit back from my wards, because in my three wards they go and audit different people, you know, it isn't the ward who audit themselves and I audit, then when I receive it back, then I go back to the people and I discussed it …" (II P13).

This was the practice and commitments of an ANM. The audit results taken back to the ward, would then be considered in an evaluative ward discussion. The ANM viewed this follow-up as her quality improvement plan. This further confirmed the AI assumption in Chapter 1 that having learnt from the audit outcome (the past), improvements can (the future) be implemented.

Good quality documentation is also considered to improve quality of care and presents a reliable tool in nursing management for the assessment and expansion of care. Internationally it has been

shown that nursing documentation is being done poorly. Its content is incomplete (Salmela, 2013, p. 64). In this study the quality contribution audits made, as well as the accountability role the National Core Standards audit played was recognised and accepted as important:

"…we are going to have our all National Core Standards audited again… so we now busy with the planning… I did the medication audit now in the ward" (II P4).

Accurate, comprehensive and systematic documentation is a catalyst for improved continuity and safety of care. It further facilitates real seamless care chains whilst it further makes allowances for the patients' independent needs and experience to be considered. In the nursing managerial field, sound documentation is the dependable means for assessing and developing nursing care (Salmela, 2013, p. 64). The experience of a night ANM participant was that the nursing process audits were being neglected during the day:

"...and what is lacking a lot, is auditing of files. These people don't audit any longer… you know peer group auditing then I do your ward and you come and do my ward and there I picked up a lot of problems at Hospital No. 12 (her previous employer) *with the auditing"* (II P1).

An assessment of quality in psychiatric nursing documentation by Instefjord *et al*. (2014, p. 1) found a shortfall in the required references and legal prescripts in the way nurses at a psychiatric hospital department documented patient care. The availability and application of a validated nursing documentation audit tool that can evaluate the quality of local nursing documentation content, is vital. The study also established that the shortcomings identified in nursing documentation in clinical disciplines other than the psychiatric field, could indeed be applied to the psychiatric field.

Based on how the ANMs intertwined their responses in relation to nursing documentation, audits and quality of care, it was the opinion of the researcher that the ANMs applied aspects of strategic planning, along with the rendering of QNC, and does conducted audits, in an interrelated fashion. From the findings of the sub-category on the understanding of strategic planning, and QA and nursing care, concluding statements were made in relation to *audits* (Annexure X).

4.4.2 KPA 1: Discover

INPUT: Best work performance experience in the KPA strategic planning, and quality assurance and nursing care

Best work performance experience in relation to the KPA strategic planning, and quality assurance and nursing care, involves: (1) passion about nursing caring and (2) leadership.

4.4.2.1 Sub-category 1.1: Passion about nursing caring in relation to strategic planning, and quality assurance and nursing care

A question in the context of establishing their 'best work performance experience' put to the ANMs was: "*What are you passionate about*?" Simultaneously the question "*When we look at ANM performance, what do they do, well*?" was put to their supervisors, the HONs.

A participating ANM in this study expressed his passion in relation to his commitment to nursing and caring as follows:

"I used to wake up early in the morning in the rainy days and go and open (the Clinic) *for them* (the patients he served) *and give them their ARV's outside, located outside the Clinic, so in rainy days, because I was staying around... ja And then I wake up about 5 o'clock, … So I got that kind of relationship with the patient. Yes. I feel good about it. When I go home, my patients are happy, ja"* (II P5). The same participant stated: *"I'j, I love nursing. Ja ja, I love people and that is the way I am …"* (II P5).

Nurses on the frontline described several common characteristic behaviours of nurse leaders who by example demonstrate certain virtues. These behaviours include having a passion for nursing, demonstrating a sense of hopefulness, having the ability to form personal networks with their staff, the show of outstanding role modeling and mentorship, and the ability to manage crisis while still upholding moral principles (Anonson, Walker, Arries, Maposa, Telford & Berry, 2014, p. 127). The participating ANMs in this study highlighted their zeal for people, in the context of:

"My personnel" (II P12); *"My people"* (FG2 P2); *"My people"* (II P14) (said repeatedly by this participant - field notes); *"My people"* (II P15); *"My people"* (II P16); *"My passion is people and 'things'"* (II P23), *"My people"* (II P25); *"My people"* (II P27). Another similar sentiment stated was: *"People, people, patients and my personnel. I am a very very people's person so I am serious about people"* (II P23).

The researcher's interpretation of this utterance spoken passionately, (and stated almost emotionally - field notes) was that the ANM signaled a sense of 'belonging to the people and hypothetically perceived the people/ staff belonging to her; a 'togetherness/ oneness with the people' and a 'protector of the people'. The '*people*' referred to included patients, however to a lesser degree. The staff were identified as key:

"I think my passion is really the personnel. Just to deal with them, just to show them that I know where he is coming from because I was there and that is -this is what I like my managers to do and then performance will be better" (II P7).

Engaging with the people in the ward was regarded as an endearing activity for one ANM:

"… The only thing I am passionate about is my staff … I am passionate about my staff … and I'm passionate about my patients. I love going to the wards" (II P15).

Another night ANM, in response to the question of what she did well, what successes she had in work performance and what it was that made a positive impact, emphasised:

"People skills; what I think is my people skills that is the most important…, because to me, I mean everything involves people" (II P17).

The ANMs took pride in how they managed people apart from the HRM prescripts. A night ANM in particular also felt very passionate in this regard and said that he demonstrates a humane approach when he needs to correct staff behaviour. He would call the nurse aside and give the required guidance (field notes - II P6). Another night ANM indicated her passion regarding the nurses in training on the night shift:

"But you know (spoke excitedly, loudly, assertively and passionately - field notes) *those nurses* (i.e. the pupil nurses placed at the health-care setting via the SETA), *when they finish, they are out of work, they not from Hospital No. 5* (i.e. the hospital where the participant was employed)*, we just provide the training. So they are the ones* (conveyed passionately and softly, almost whispering - field notes) *that is so enthusiastic, they got the ooooooooooooee smart, they so smart really really* (demonstrated exuberance about the ability of the pupil nurses - field notes)*. You'd love to have them in permanent post*(s)*"* (participant spoke with elation and passion, first loudly then softly - field notes) (II P28).

The participating ANMs listed certain aspects of their job that they felt passionate about. Some of them passionately embraced caring in nursing as a whole:

"Uhm ja ... this is what I always say to my friends --I never thought that I will be a nurse, but I have been socialised in a profession and I became ja ja -- sometimes this is what I say to some people when they're talking, being rude to the patients and then I say '... these people, they depend on us' and ja ja, so I develop that kind of passion ja with ja my work" (II P5).

The fervour of the ANMs for the job was duly observed by the researcher as they related their experiences about their job performance and the service in which they worked (participants conveyed passion; their body language conveyed eagerness and a willingness to help - field notes). An ANM who had previously worked the night shift described the passion others recognised in her:

"It was a couple, he (patient) *was in a cardiac ward and I was talking to him (and his wife) and then I left him, and then they call me back because I was busy with other patients and then they called me back and they asked me 'Are you a Christian?' And then I thought I wonder why they asking and… 'Oh now we can see* (reportedly couple's response)' *... they said 'I, we can see you're a Christian' so I thought 'that is what I want to do'. I want people to see* (participant openly revealing of self, emphasising the words - field notes) *where I am at and where I'm coming from. So that is my passion"* (participant laughed loudly, seemed proud and confident - field notes) (II P3).

In the study settings where persons/ patients with intellectual disability were cared for, both the staff and the patients passionately referred to the night ANM, using an 'endearing' name (participant had been working with these patients for many years; they could not pronounce her lengthy and possibly intricate name, hence her 'unofficial name of 'Beanie' (fictitious) stayed (field notes).

A psychiatric professor, Phil Barker in his first column for the Mental Health Practice in 2000, made reference to passion as the 'oddly unscientific concept' as he reflected on a number of renowned scholars who appealed, inspired, advised … that nurses become more passionate and

treat less. He further described his own overwhelming feeling of passion, experienced at a conference in Ireland; a feeling of raw emotion he had never felt before as people in the psychiatric context bore testimony to the need to rediscover the power of human caring (Barker, 2002, p. 39). Some other ANM participants gave credit to colleagues for the passion shown in aspects of management. With specific reference to her opposite night shift partner's expertise, one ANM stated:

"P17 -very good colleague, she is in fact long on night shift" (II P1).

A number of ANMs vehemently pointed out their nostalgia for the focus on basic nursing. (prior to participant's response, a serious persona prevails along with a short wait; she seemed to be thinking deeply - field notes):

"… I feel if I can get the nurses to go back to 'back-to-basics', then it will mean so much to me. When I can see that what I say to them tonight is tomorrow night being done the way I had said (implemented). *It is now about as I said really 'back-to-basics' because that for me is absolutely important. The fact that you have to look after your patient (because the paperwork infuriates me), because there is no more time for nursing, and I feel good when those* (emphasised the words - field notes), *things are again starting to be in place, yes, but that's how I've been reared man"* (II P26) (stated cheerfully and passionately - field notes); *"I am more concerned about the quantity of care, of nursing care of what the patients are getting and about if I just want to use a simple example … basic nursing care, like brushing a patient's hair - yes we do mouth care - but even those who do need assistance… take the dentures of the people that cannot walk and do this kind of thing… -they are working very hard"* (II P19).

A number of them revered the importance of the prevention of infection and their quality control measures they professed to have in place. They also aspired to high quality standards.

"*The only thing that we can do for 'Best Care' practice is CAUTI"* (A quality programme to prevent a hospitalised patient with an indwelling urinary catheter from acquiring a urinary tract infection; a recent provincially adopted practice), *we call it the CAUTI -for urinary tract infection …"* (II P3).

Another participant stated:

"And then there's still infection control as well (participant was bubbly, wordy, interjecting - field notes), *we have an Infection Control Sister but many times when she's not here, then I do her stats, already this is her file lying here, she isn't here this week, so the stats reflects the EPI* (referring to the expanded Programme on Immunization -South Africa – field note) *and the measles and those things that goes in on a Monday. So then I do that for her and then off course we must ensure that in the ward, that all the personnel receive their training regarding Infection Control"* (II P24).

This confirmed the AI assumption in Chapter 1, that reality is created in the moment, and that there are multiple realities as the ANM in this regard was able to take on the role of the Infection Control Sister. The researcher observed that all the ANMs who participated in the interviews demonstrated support for the research and an eagerness to be interviewed on what they did well and were passionate about. A number of ANM participants presented themselves superbly neat and extremely well attired professionally for the planned interview. The researcher interpreted

this display as a positive sign of respect for others and hence attributed it to their passion for nursing and caring. Two of the night ANMs who participated, did so in their off-duty time. One of them expressed how invigorated she felt when she spoke about the cohort of 320 patients at the hospital where she works. At the end of her response to the questions, she excitedly stated:
"... And that was interesting! I'm then now feeling passionate" (demonstrated passion and interest by means of her body language, conversed loudly - smiling and laughing; researcher told the participant that her face had lit up when she was communicating, - the mood was positive and excited; researcher reflected after the interview that she reciprocated the passion, smiled and laughed, in response to the exuberance the participant displayed - field notes) (II P27).

Some participants also shared the passion they had at their previous workplaces prior to their appointment to the position of ANM. They loved and remained willing to still plow their toil into those areas when there was a service need more so, even though the post of ANM was deemed to be 'middle-management' (Table 1.1):

"Before I was a ANM here, I was a Trauma Trained sister so I was just in the Trauma Unit and then I became a ONM and now I'm an ANM but if I must have a choice (emphasised the utterances - field notes). *I would go back being a ONM because for me a ANM is too all over the place. It's too all over the place. Um I'm that... for me maybe somebody else likes it...right! But for me I like to... if I've got the task that I want to do, I want to do it to the best of my ability and even MORE"* (II P21)!; *"I started initially at Casualty and my passion is still there, the way things happens fast"* (II P27); *"I don't want to sit long in meetings. I want to be in the wards. I am an ICU sister, understand"* (II P25)!

The assistance required of an ANM also includes directing, in relation to the internalisation and demonstration of the core values the employing department fundamentally ascribes to, which are caring, competence, accountability, integrity, respect and responsiveness, and striving toward ensuring that patient-centered quality of care is rendered (Western Cape Government: Health, 2014; Western Cape Government: Department of Health, 2011). An ANM at a psychiatric health-care setting stated:

"... I am passionate about my patients... I like to see that there is more patient interaction, patient to nurse, patients are able to approach nurses and be treated with dignity and respect" (II P10).

A passionate desire expressed by an ANM at another psychiatric hospital was stated as follows:

"My passion is to see that my patients (referring to a psychiatric patient) *go out into the community... and they get through the system, once they go out into the community. I would love to see those patients being understood and not the stigma that is still here..., because we say that we've moved* (interpreted as away from stigma)*"* (II P9).

At the psychiatric hospitals and the center for persons with intellectual disability, the ward units are individual (independent) house-type structures physically separated from each other. Some of the night ANMs here described their passion, as their ability and zest for taking up the challenges this shift presented in the open hospital grounds whilst having to do night rounds. Despite having to traverse the dark uneven hospital terrains, which was said to be a haven for wanderers and

vagrants, and even ex-patients at times, doing the required rounds was done with a passion; it was the caring part of the job:

"It was only about two months ago that the lights (outside on the hospital grounds) *were actually put up for us. So* (pleased, laughing - field notes) *before hand* (stretching out her hand in front of her – field notes), *t'was dark and we knew exactly where every hole was and where every step is and ran from the clinic to ward without stepping in one hole. We actually manage to run from this side to that side without stepping in one hole or falling over anything"* (II P22)!

The passion and opportunity to assist hands-on were more evident with those who worked the night shift as the role of the night ANM shifted between that of being operational and strategic, according to the demands of the service need. Nonetheless whenever such an eventuality did occur, although reactive, the willingness of the ANM to help out operationally, as well as their experience, assured service delivery:

"We ourselves have to help out in Casualty" (II P27); *"...just because you're in the office, say, you can't get out, you cannot be rigid... you can't ask me* (an illustration of the wrong attitude - field notes). *We go out, we help each other; we try. Sometimes it is difficult especially when one sometimes have four or five people absent simultaneously"* (II P27); *"And if there's for example a shortage in a ward where there's only one nurse with 30 patients, I don't have a problem going and doing physical work"* (participant was on the night shift - field notes) (II P22).

This confirmed the AI assumption in Chapter 1, that the night ANM was influenced by the possibility that she could be asked to 'help out' in a patient area, and would inherently fulfill the expectation; her response being indicative of the potential influence of the question. In this regard passion towards the patients was also seen as important. The ANMs said that they derived satisfaction from their close involvement with the patients.

"And I'm passionate about my patients. I love going to the wards. I go to Ward B two, three times a week and I go and I go sit there with the patients and chat to them. I got three patients there that I spoil every week because I've got no family. I spoil them every week. I bring them fruit and sweets, so every week when I come there, they want to know (displayed enjoyment and laughed - field notes) *when's the next sweet's coming. So I'I go and sit there and I chat to the patients"* (II P15).

Those at the busier hospitals expressed the plight of the patients more ardently and expressed their determination to improve service delivery:

"*I am very satisfied ... and so I want it must always be for the other people whom l work with ...*" (II P23); "*Uhm at the end of a shift I feel when I hand over in the morning, I feel real good. There was not a single night, or morning that I will say I want to get away* (emphasised words - field notes) *from this place* (interpreted as 'from the work situation') *as soon as possible"* (II P28).

In the focus groups the HONs were observed to respond passionately to what the other had said, which showed their mutual support. ANMs also spoke passionately and with appreciation about still having a job, and that provided fulfillment:

"*My work for me is still nice*" (II P26); "*The fact that I have work* (am employed)… *that's what I am passionate about. It's not everyone ... everyone isn't happy to be in the position that we are in, do you understand? And you want to actually be grateful that you still have a work to which*

you can come to. And whatever problems there may be in your way, you must make it interesting for yourself and you must make it nice for yourself" (II P27).

According to Wood (2014, p. 528) it is a fact that nursing training has schooled nurses in the medical model. It was assumed that caring related aspects of work performance of a nurse was innate or would have been learned in the service practice. The ANMs in this study verbalised, namely:

"*We must now start moving away from diagnosis's and actually start teaching the staff how to manage stress, how to manage certain things that is not only work related*" (II P22).

A number of nurse leaders had also publically pledged their passion for nursing as an innate response to the profession. Jennifer Trueland the then newly appointed Chief Nurse in Scotland in 2010, pledged compassion as her motivation for nursing (Trueland, 2010, p. 13). The Nursing Standard headlines stated *"My focus will be the patient's experience of nursing care"* (Trueland, 2010, p. 13). Potential nurses must also be caring. In an attempt to get caring people into the nursing profession, student nurses being recruited to a UK university according to the Francis Report, were required to inherently be beneficent, intelligent and caring. Values that supported nursing such as the well-being of others were sought. The critical list of skills and talents people needed was the promise of elevated quality of service and positive caring to patients and families (Wood, 2014, p. 528).

Apart from having applied an underlying philosophical approach of AI in this study, the ANMs illustrated a passion for nursing and caring overall (spoke with passion - field notes). ANMs in this study reiterated this notion as:

"… but as I say, you must have a passion… you must also have a passion …" (II P27).

From the findings of the sub-category on *passion about nursing caring* in relation to the KPA strategic planning, QA, concluding statements were made (Annexure X).

4.4.2.2 Sub-category 1.2: Leadership in relation to strategic planning, and quality assurance and nursing care

The perception and belief the HON has of an ANM are that they are leaders:

" … That you are actually a leader" (FG2 P2).

The ANMs were also proud of their (own) leadership. The path of a nurse leader could start by firstly being a supervisee who at a very early stage evaluates desired role model behaviour in the supervision received (Bond & Holland, 2011, p. 291). The responses verbalised by the ANMs in this study described leadership as being indicative of managing people well and rendering support. One of the ANM participants indicated her pride in managing her staff well. She described her management style as that of firmly applying the managerial principle of control while she also allowed her staff space to function and act autonomously:

"Okay I think I manage my staff well. I give my Operational Managers quite a lot of lee-way to make decisions. I'm a bit of a control freak, I am, but I allow them to make decisions …" (II P15).

An ANM inherently takes on a headship role that requires expert liaison responsibility. The managerial competencies that are to be internalised and executed by the ANM are the facilitation of managerial and managerial related tasks and the coordination of hospital service areas. The support function in the leadership role was stated with conviction and confidence by the ANMs. This confirmed that the AI assumption in Chapter 1 that the ANMs has more confidence and is more comfortable journeying forward (the unknown) as they carry parts of the past (the known). In this regard, the night ANM has mastered the central liaison and support role on the shift, gaining confidence:

"*You are the one that must do the liaison with the other disciplines, with the consultants as it becomes necessary. My support function is the other one that comes out strongly"* (II P18).

In the leadership role, the presence and active participation of nurse managers in hospitals can be described as the most essential component in hospitals functional systems today. Nurse managers fulfill a fundamental role in hospitals and other provincial health-care settings and should command respect. One of the HON participants stated:

"*But I'm thinking if you have an Assistant Manager who's got a good understanding of budgets, finances… so I see a person who's got a good grasp of that. I don't say they must be accountants or whatever but must just have a good understanding of that kind of thing -good leadership* (said with conviction - field notes) *and mustn't be leadership out of a book -not just theory -you must really show in the way you interact with people and you know that when you come into the room you can just feel that aura -here is somebody whose whole persona demands that respect*" (FG2 P1).

In this regard, a similar sentiment was related, that without nurse managers, hospitals will demise (Lin *et al.*, 2007, p. 157). The ANMs in this study also fulfill a clinical leadership role. Clinical leadership attributes are to both lead and inspire, requiring the managers to have attributes of fervour, openness, flexibility, talent for reflection and transformation, and the ability to orchestrate a set of actions that will improve delivery of patient care such as ability to prioritise, focus, and enact values and ethical care, and be able to converse. An individual's choice on how work is to be performed even when there is no choice about the actual work that is required is a challenge in a demanding clinical situation (Stapleton, Henderson, Creedy, Cooke, Patterson, Alexander, Haywood & Dalton, 2007, p. 814). Nurse leaders in an organisation can be taught to positively influence the mood by means of their individual and group interactions. In regard to fervour, a passionate and trusting working relationship was described by an ANM (II P27) which she stated 'might not sound real' but that it indeed was there (initially used a soft and thereafter an exhilarated tone of voice and facial expression - field notes). Her description included her availability to and love for talking to her staff and (said passionately almost emotionally - field notes) for their sake, improving their work performance. Barr and Dowding (2015, p. 42) also

reflected on the differences in leadership style that can be influenced by gender differences. This confirmed the AI assumption in Chapter 1, that it is important to value differences.

In regard to reflecting as a leader a participant mentioned:

"... you keep on getting busy, you keep busy whereas at night you have a time to, you know reflect on what you've done and, how you can do it. There's lots of reflecting time and that because you know it's quiet during the night but at day is no time for day dreaming" (II P4) (participant laughed loudly, yet showed intent - field notes).

In regard to prioritising as having a focus on end results it was uttered:

"*…but when I'm finished with my ward-rounds* (night rounds), *and I've seen the patients has been sorted out there -there's enough staff, then I focus on the Emergency Unit*" (II P28).

In regard to being focused on creativity and innovation it was mentioned:

"*It's organising well uhm coming up with new ideas even on night duty which benefits the functioning of this service you know... the other one ... he dwells on the right and wrongness of the staff behaviour and so we sit with a lot of disciplinary issues and so on. But the focus is on a good service and getting it done*" (FG1 P3).

It appears as if ANMs, because of their experience and willingness and not only because of position, assume other leadership roles in the hospitals/ provincial health-care settings. The coordination of a component of a psychiatric service was one such function, a response conveyed with confidence and pride. This confirmed the AI assumption in Chapter 1, that the person has more confidence and comfort to journey to the future (the unknown) when they carry parts of the past (the known). In this regard the ANM, who would ordinarily have managed a nursing corps, is able to additionally incorporate the managerial co-ordination of an aspect of the MDT, confidently and comfortably. She stated:

"*... and it's for the past year I've been chairing our work male acute services admin meeting on a Friday morning, which is very helpful in keeping my tasks… In those areas where we need to get more multidisciplinary input, I've got all the role-players together in the one room*" (II P9).

The HONs also indicated that the ANMs displayed goal-directedness in their work performance when they (HONs) were away from the hospital. During such absences, selected designated ANMs were placed in charge of the Nursing Department and were found to manage the department well. The following was verbalised in this regard:

"*Assistant Managers…, they are reliable, responsible and yes, I can go on holiday and one of them can act in my place and things are going on …*" (FG2 P2).

The focus of the preparation of the new nurse leader for the 21st century has to be on values like Ubuntu (Downing & Hastings-Tolswa, 2016, p. 214), characterised by respect, professional maturity, cultural kindliness, cohesion, compassion and caring for others. In order to gain a competitive space and advantage, Western and Eastern techniques could be adopted but along with ethical standards. The nurse leader must be realistic, visionary and technically knowledgeable (Dolamo, 2015, pp. 490-491).

The HONs indicated their contentment with the sense of responsibility shown by the ANMs. They (ANMs) internalised (understood) what was required and endeavoured to do the specific work performance required of them. In this regard, the ANMs were described as also being goal-directed:

"You don't have to stand behind them and say- 'You know this area didn't receive attention! What about that area?' So okay, they might not do everything well in the tasks but overall in their responsibilities. I think they're very responsible people" (FG2 P1).

The researcher observed that some of the ANMs were particularly well dressed attired and professionally. According to Musker (2004, p. 45), complemented by Cherry and Jacob (2015, pp. 33- 34), the image of the nurse manager as a leader can have a major effect on others. Musker (2004, p. 45) note that the aspects of personal grooming that are considered to project an effective nurse manager image as a role model does include appearance and attire. A professional appearance does matter as it has an impact on patient perception in relation to confidence, caring, professionalism, reliability, cooperation and empathy (Porr, Dawe, Lewis, Meadus, Snow & Didham, 2014, p. 154).

The research conducted by Scoble and Russel (2003, p. 325) indicate that the profile of the future nurse leader, a 2020 vision, places the emphasis on *"highly competent and effective leadership"*. Nursing leadership is required to uphold a distinctive cluster of performances and talent in the organization, at all levels of the management spheres. In the attempt to ascertain the future needs of nurse managers, an analysis of the existing study programme and literature was undertaken by Scoble and Russel (2003, p. 324), together with other surveys to establish the educational preparation, skills and knowledge considered significant for both future nursing managerial and leadership positions. In this regard, leaders in hospital such as nurse managers are faced primarily with the increasing demand for accountability for quality care and its sustained improvement, budgetary responsibility and positive patient experiences, and are required to integrate best practices and interdisciplinary patient management and care (Soklaridis, 2014, p. 830). As a nurse manager hospital leader, one ANM stated:

"*I think I'm quite a good leader né, I'm very supportive… firstly I'm very task orientated, get the task DONE* (stressed with passion and conviction - field notes)*... I believe in transformational leadership …"* (II P21).

McGuire and Kennerly (2006, p. 179) found that transformational leaders used their talent to influence attitudes and moved beyond the management of business, to motivate followers to exceed the standard expected of them. Traits and performance of followers described by Bass in 1985 in the context of the transformational leadership style, was said to transcend individual needs and increase productivity in the broader interest of the group or organisation (Patton, 2013, online), a leadership feature still noted today. At one of the psychiatric hospitals in this study, an ANM who had been at post for twenty-four years since her Psychiatric Nursing Science training attributed her motivation to exceed her initial intention to work for only two years after training

to the attractiveness of the leadership shown her (II P10). Staff nurses/ professional nurses ascribed their decision to remain in their positions to the pivotal quality of the relationship with their nurse manager (Warshawsky & Havens, 2014, p. 32).

A nursing management study that explored the impact of transformational leadership on nurse innovation behaviour and the mediating role of organisational change by Weng, Huang, Chen and Chang (2013, p. 427) suggest that hospitals should robustly promote transformational leadership as it improves patient outcomes. It seems that leadership training programmes are to be developed and a transformational culture be established. Nurse managers are persuaded to embrace nursing innovation through improvements in the organisational climate. Colbert, Kristof-Brown, Bradley and Barrick (2008, p. 83) has concluded that transformational leaders who inspire individuals and groups within an organisation, increases efficiency, job contentment, and organisational performance. The ANM participants have both a managerial leadership and clinical responsibility. They recognised that a more contemporary managerial approach is required that embraces appreciation and culture. Effective leaders capitalise on knowing each individual member of staff, whilst they (i.e. the leaders) are also aware of the significance of exploring each one's skills, interest and talents. Such entrepreneurism in the work setting gives the transformational nurse leaders the apparatus to link with each one (Olson, 2006, p. 14). In this regard, the following was stated by an ANM:

"The answers must come from them, not from me. I will say… 'now listen…' and then they say… then I say … 'no … ok ...let's get the pros and let's get the cons, and then we weigh it up'" (II P21)!

Dever (2010, p. 7) highlights primary leadership functions as the setting out and taking ownership of the vision, together with developing one's staff. Another response indicative of transformational leadership was:

"… but I'm not going to force it upon them. Subtly I'm going to move them into what I'm thinking because I gave this thing whatever I'm doing a lot a thought. But I'm not going to force it upon them. I'm gonna phase it in easily with them" (II P21).

Nurse managers can learn transformational leadership skills that include setting out required unambiguous expectations, the creation of a shared vision and resultantly rousing a strong organisational commitment (McGuire & Kennerly, 2006, p. 179). With reference to improving the quality and efficiency of health-care, McAlearney (2008, p. 329) asserts, that leadership growth programmes positively enhance workforce quality, effectiveness and staffing turnover. Such programmes also allow leaders to focus on strategic concerns. From the findings of the sub-category on *leadership* in relation to the KPA strategic planning, and QA and nursing care, concluding statements were made (Annexure X).

4.4.3 KPA 1: Dream

OUTPUT: Best possible work performance opportunities in the KPA strategic planning, and quality assurance and nursing care

Best possible work performance opportunities in relation to strategic planning, and QA and nursing care, involve communication between ONMs and ANMs.

4.4.3.1 Sub-category 1.3: Communication between ONMs and ANMs in relation to strategic planning, and quality assurance and nursing care

The ANMs identified communication between ONMs and ANMs to be one of the best possible opportunities to flourish in their work performance. They envisioned that communication and culture related aspects between ONMs and ANMs could be better. The communication matrix in the nursing management setting includes communication between nursing levels, and day and night shifts. The ANMs verbalised areas related to communication between day and night nursing staff and nurse managers:

"… really a dream is open communication… at the moment there's massive breakdown between day and night… I think that if my communication is more free-flowing in both directions, a lot of difficulties will also be changed" (II P22); *"There's still a lack in communication from day to night, you see, that is where we need to work on…, because we never meet"* (II P3); *"So I think there is still the lack with us -communication with the night duty, so if we have a meeting, it should actually be with them"* (II P3).

Nursing has the vital role of communicating information not only to the family of the patient, but to staff so that all the team members can make the appropriate decisions about imperative patient care. Communication between ONMs and ANMs in relation to strategic planning, and quality assurance and nursing care, has to be timely, accurate and relevant (Motacki & Burke, 2017, p. 99).

In communication, there has been a focus on rational coordination of services, an area in which communication between ONMs and ANMs is integrally involved in; rational coordination focusing on the value of high-quality relationships. This is typified by shared objectives, shared information and reciprocated respect, as well as superior communication that are timely, recurrent, precise and problem-solving. A growing body of research conducted on the impact of rational communication on health-care outcomes is showing a positive relationship. A consistent relationship has been observed between such coordination and nursing reports on quality. Furthermore, as rational coordination among providers increased, key negative incidences decreased (Havens, Vasey, Gittell & Lin, 2010, pp. 926 & 928). The ANMs expressed their premise that communication both between their managers and them, as well as between them

and their subordinates is to be aimed at facilitating participation. It is to be two-way communicative:

"... so I think communication stays number one for me and participatory management ...get your people - allow them to give input and do not just force things down on them" (II P22).

The ANMs pointed out the gap that existed in the communication from the wards to them which they felt the wards were still having difficulty in effecting:

" ... but I don't have all that time to go to the wards so much, but then I need them to understand that also, and I need feedback from them" (II P3).

Whilst an envisioned improvement is sought regarding better communication between ANMs and ONMs, the night ANMs report on the tension that exists between them, relating to their practice when managing the entire health-care setting as required, and the microcosm ward unit on the night shift, as determined by the ONM who is the day ward unit manager. The ANMs proposed that there be a cross-pollination of communication:

"We trying to get QNC so if we have problems now, we need to discuss and then you go and say 'listen this is what happens'. Now we get an OM telling the Area Manager uh 'your nurses is not working right', but it shouldn't come from them (i.e. ONMs)*"* (II P3).

A performance management system also relates to learning and culture. Indications are that it is important for an organisation to understand the learning cycle of their performance management system, so that evolution and growth in this regard is embraced and established as part of the organisational culture (Martinez, Kennerley, Harpley, Wakelen, Hart & Webb, 2008, p. 24). An ANM also indicated that culture plays a role in the workplace performance and may affect communication. The following was emphasised:

"Improve on communication… I think the culture we must also take into account. I started already to uhm explore, help to understand different cultures better, to better the communication" (II P8).

The recognition and acceptance of generational diversity in the workplace allow the nurse manager to apply approaches that harness communication leading to staff cohesion (Hendricks & Cope, 2012, p. 717). ONMs who fulfill front-line nursing managerial positions are generally younger than ANMs and HONs, who are their seniors, based on the researcher's assumption that the years of experience required to be appointed to the position of an ANM exceeds that required to be an ONM. Generational differences in nursing has also been shown to present challenges to a contemporary approach in nursing management in a provincial health-care setting that is multifaceted and vibrant as the generations think and behave differently due to the incongruence in core personal and generational principles, namely communication, commitment and compensation (Hendricks & Cope, 2012, p. 717). When these factors are considered, it clarifies how some of the differences in communication between ONMs and ANMs can be overcome, that could result in the best possible work performance opportunities for the ANMs to flourish. This also confirmed the AI assumption in Chapter 1 that it is important to value differences.

Nursing management cohorts are deemed to be health-care providers. A shortcoming in communication between health-care providers has been seen to be associated with mistakes and adverse episodes of care (Instefjord *et al*., 2014, p. 1). Globally, the nursing corps comprises four generations of nurses each with their associated attitude, beliefs, work habits and expectations relating to the role of the nurses in the provision of service and care, as well as the manner in which they set out and embark on their daily activities (Hendricks & Cope, 2012, p. 717). Suhonen and Paasivaara (2011, p. 1029) state that the emotional intelligence of the nurse manager relates to the success of projects because the nurse manager who has emotional intelligence would focus on open communication and understanding of strategic outlook and insight. From the findings of the sub-category on *communication between ONMs and ANMs* in relation to strategic planning, and QA and nursing care, conclusions were made (Annexure X).

4.4.4 KPA 1: Design

OUTPUT: Initiatives for the future in the KPA strategic planning, and quality assurance and nursing care

Initiatives or best/ ideal expectations for the future in relation to strategic planning, and QA and nursing care, involve the need to drive change.

4.4.4.1 Sub-category 1.4: The need to drive change in relation to strategic planning, and quality assurance and nursing care

Patients have become more knowledgeable. The disease profile has mutated and become more complex. Therefore, the demands of patients together with the emergence of new disease profiles have led to a quickening pace of change in health-care delivery (Brand, 2013, p. 1). Brand (2013, p. 54) asserts that the aspiration to change is indicative of the motivation and eventual choice to uphold and participate in change. One notion expressed by the ANM participants regarding the ideal expectations for the future and the need to drive change was that when the initiator of the change embarks on the change process within the hospital or nursing management structures, that the initiator also keeps up the change momentum, to see the project through until the end. In this regard, an ANM verbalised:

"…if you implemented a certain thing you must also drive it" (II P4).

The ANMs also viewed themselves as instrumental in stimulating others to drive change. An ANM said the following:

"I might be able to… empower somebody else to be that drive" (II P8).

Strategic planning has to do with change. Within the provincial health-care system where the study was conducted, a number of rapid changes driven by forces stimulating change had already

occurred (Western Cape Provincial Government, 2016). This confirmed the AI assumption in Chapter 1, that reality is created in the moment, and that there are multiple realities, as the ANMs needed to adapt to these changes.

The focus of health-care today is on the process of managing change and of getting individuals and groups encouraged. In turn the awareness of the health-care system is directed at establishing how individuals are to be moulded to respond to health-care needs with changes occurring rapidly in health-care itself, that are not always predictable, and in technology (National Department of Health, 2011a, p. 74). Strategic planning in health-care requires dedicated time (Laker, Callard, Flach, Williams, Sayer & Wykes, 2014, p. 2). Marquis and Huston (2009, p. 168) assert that change is concerned with strategies that will overcome resistance to change and has consultative processes, with sustained support, delineating the roles of management and the influence of the organisational milieu. There would also be the existing arrangement in place that facilitates and manages change. In relation to her current activities at work, another ANM expressed the need to drive change:

"... if one also doesn't drive a process then nothing comes from it at the old end of the day. You know I am in any event a slave-driver" (II P16).

The identification of the need to drive change by the ANMs included having identified the need for the use of technology:

"*I don't have internet access"* (II P20).

However, Brand (2013, p. 2) reports that despite the potential improvement to patient care, the burden on health-care providers and the management of the health-care setting, nurses and other health-care providers disliked the use of technology and other changes. New technology can be introduced by managers though cannot be forced upon employees, as employee support and participation are necessary for change. The desire to support and participate in change may be influenced by the kind of change and whether change is perceived as a prospect or a threat, the organisational milieu and the compensation that change will carry, the record of previous efforts made to change as well as the inherent or individual motivation (Brand, 2013, pp. 54-55). Leadership effectiveness suggests that there are a number of interconnected facets to reflect on in relation to developing nurse leader effectiveness that includes the development of clinical innovation and change (Willcocks, 2012, p. 8). In the post-1997 era in the NHS, quality reforms also drew attention to the worth of leadership in enhancing modernisation nationally and locally. Nurse leaders were then regarded as significant change agents who would be able to contribute to implement change (Willcocks, 2012, p. 10). Driving change in order to affect improved clinical care, clinical leadership and the nurse's role in teams can be strengthened. With a lesser impetus from the top, such change is therefore driven by the influence process shared by all nurses irrespective of their position in the hierarchy. In this way frontline people potentially

influence quality of care directly and the effective working of partners such as that between ANMs and ONMs and the clinical team (Willcocks, 2012, p. 15).

The ANM participants recognised that having to save money in their work performance in the provincial health-care settings had changed and had taken on new importance, and that there was a need to drive cost-effectiveness in relation to the KPA that incorporated planning and quality care:

"And I think they are trying to save costs" (II P20). *"I was working towards saving, saving, saving, saving all the time"* (II P17); *"... and I encourage savings"* (II P18).

Similarly, a change of focus has come about in the UK financial management sector with the focus being placed on leadership and support, in relation to leadership effectiveness. Internationally as well, the current financial climate of recessions have become a variable to contend with as policy makers have asserted that leadership should support changes within clinical practice aimed at cost savings (Willcocks, 2012, p. 11).

"*I must first do my job right and then the OB's* (OMNs) *must ensure that they do the job right and so it must cascade down"* (II P26).

Change is pioneered by compelling leaders who are visionary (Daft, Kendrick & Vershinina, 2010, p. 582). Driving change therefore was seen to have relevance on nurses, in regard to the international approach of effectiveness in clinical leadership as listed by Willcocks (2012, p. 13), change being is seen as the process of engaging with followers. The leader motivates and inspires (change). A framework consisting of elements that involved the management of processes is the McKinsey Sevens framework model where processes are linked to systems within the broader sphere of work performance of an organisation. It could be used to analyse the processes and facilitate change. The processes that comprise the Mckinsey Sevens systems are both internal and external, and practices that facilitate effective communication (Singh, 2013, p. 43).

In this study, ANMs wanted to be forewarned about changes that were to be implemented such as the aspects of the newly operationalised implemented service model of the FBU/ s and the newly established roles required to be performed by the various role-players at the health-care setting. They also emphasised that such communication in regard to change needed to be clearly disseminated:

"I think change with regard to procedures such as the FBUs that is being implemented… I think communication in regards to changes especially procedurally, it goes to everybody" (II P18).

This point was well illustrated by one of the ANMs at the time of the interview that the research questions might have been better received and potentially better responded to had she been previously informed about details of the interview:

"*... the thing is, you didn't have a chance to think about these questions nê you're asking for you know right now and you have time to ...just to bring your mind together because we were busy the whole day with a lot of things uhm but I will say when I started in this office*" (II P4).

An ANM revealed that in her experience, knowing what her forthcoming 6-month continuous shift duties were, prepared her for the work performance required:

"*In the previous hospital where I had worked, myself and the other sister worked for six months without a day off opposite each other doing 12-hour shifts -for six months long and that didn't bother me... because I knew I had to do it*" (II P26).

Change can be emergent whilst it can also be planned. When change is deliberate and there is mindful reasoning with action, change can then be regarded as planned change. When change on the other hand unfolds in a seemingly spontaneous unintended manner, it can be regarded as emergent (van der Voet, 2013, p. 380). Dever (2010, p. 6) states that initiating change constitute one of the top ten categories that leadership and management is said to have in common. From the findings of the sub-category on the *need to drive change* in relation to strategic planning, and QA and nursing care, concluding statements were made (Annexure X).

4.4.5 KPA 1: Deliver

OUTCOME: Commitment to deliver work performance in the KPA strategic planning, and quality assurance and nursing care

Commitment to deliver work performance in relation to the KPA strategic planning, and QA and nursing care, involves: (a) managing processes, (b) communication between the ANM and management and (c) communication between management and the broader staff component.

4.4.5.1 Managing processes in relation to strategic planning, and quality assurance and nursing care

The processes needing to be managed were identified as that of a: (i) HR, (ii) quality patient care, and (iii) supply chain nature.

i. Managing processes related to human resources

The movement of documents: Based on the manner in which the ANMs and the HONs in this study responded to the questions and the manner in which they engaged with the interviewers, it could be deduced that they aspired to applying work performance administrative processes soundly, thereby committing to work performance. In relation to managing processes of a HRs nature, the ANM verbalised:

"And I came here and they asked me for that uh criminal check record because they had lost my things then HR said that I must go again to the police; I had to go three times…!! So there's a lack of … you know …by die HR Department… They ask you for unnecessary things and you know you wait long for your things and …" (II P1).

With regard to the administrative processes, the ANM expressed that if these are not done well, it might influence commitment to service delivery and asserted that if the HR educated staff

(users and HR staff) more about personnel matters, HR efficiencies could be gained in work performance:

"These people do not know about... (annoyed, using incomplete sentences - field notes) *about capped leave. They do not know that when you resign, that you will not receive a payout* (i.e. leave payout)*, then you don't get capped leave because it falls away -you know such things -the HR Department -I'm not sure whether on day* (duty) *…"* (II P1)?

The very structured administrative processes of recruitment and selection were well accepted by the ANMs:

"*…like us as the manager, and you try to recruit people right… your processes must be in place. Everything must be in place because …*" (II P21).

ii. *Managing processes related to quality of patient care*

In relation to managing processes related to quality of patient care, the nursing process is probably the most common process form. The nursing process model and classifications according to Saranto *et al.* (2014, p. 629) are used world-wide as 'nursing data structures' in care plans and nursing records. The utilisation of standard nursing language within the framework of the nursing data structures was believed to have positively impacted workflow processes daily, which in turn enhanced the safety of patients. Other processes supported by nursing data structures are auditing, nursing practice, the care continuum, team care, and reuse of information. Saranto reaffirms that nurses require more schooling and support from managers to gain maximum benefit from standard nursing language (Saranto *et al.*, 2014, p. 629).

In relation to managing processes and quality, the conducting of audits on the nursing process documentation to evaluate nursing care was recommended by the ANMs as another area of work delivery that could be improved. They therefore believed that their recommendation of managing the nursing documentation auditing process by implementation is a commitment to deliver and better work performance. An ANM verbalised:

"We do the audits, the nursing process audits. Uuh, we keep regular meetings with them (i.e. the staff), *include them in discussions"* (II P2).

Quality has become a major performance indicator at all levels - individual, team, departmental and organisational. The performance of public service organisations in particular is ultimately critiqued by the quality of their output with regard to service delivery and other relevant outcomes. In order to sustain or better the work performance of organisations to meet the required quality standards, systems and processes are needed (Saravanja, 2010, p. 88). The process of documenting in nursing, by the professional cadre, is a vital function to nursing practice (Okaisu, Kalikwani, Wanyana & Coetzee, 2014, p. 1). When the saying *'only that which is measurable can be improved*' (Thomson, 2008, online) is applied to work performance in nursing, only that which is measurable can be acted on and improved. In this light, the WHO recognises the wide use of the nursing documentation process model (Saranto *et al*., 2014, p. 641). The initial paper-based and later the electronic form of the nursing process have enhanced

patient care planning, delivery, monitoring and assessment. The nursing process phases of assessment, analysis, goal setting, planning, intervention and outcome assessment recognised by the WHO, which has been applied over the years, is still deemed to be the basic format to record patient care in various health settings (Saranto *et al*., 2014, p. 641). The ANMs in this study indicated that nursing documentation and auditing of nursing documentation is a commitment to better work performance.

iii. Managing processes related to supply chain

The ANMs committed to managing processes to deliver in their work performance of which the processes of supply chain were identified. In relation to managing processes of a supply chain nature, the ANMs said:

"But now if you procure, if something is procured again…, you need to see that they follow the correct processes like going through what is being condemned and replacing that with something else and …" (II P3).

The above illustrates that the ANMs had knowledge about the importance of compliance to the correctly sequenced procurement process but also how important required supplies in hand were in the context of nursing management. The ANMs need thus to commit to better work performance, was to have an understanding of the logical flow of the supply chain process firstly as an orientation to what the required work performance was/ is, and secondly to embark on the process meaningfully. However, the ANMs asserted that they require coaching and/ or mentorship in regard to assimilating the essential micro supply chain processes, that such service learning also be attained timely. They added that opportunities to gain insight into the workings of other positions such as that of a CEO, places the supply chain processes they are committed to, into perspective:

"If she explained me the processes (relating to the quotations/ vetting processes used at the hospitals), *how it works…, it's not just you go and sign your cheque and what what, but if she explained me this is how it works, … go through this process, this is what Supply Chain is doing, then it comes to vetting, this is what the CEO is doing, this is his role, that is my role, that is your role, that is that one's role …"* (II P4).

Saravanja (2010, p. 106) points out that empowerment of individual team members by means of continuous learning and development as part of the PM process is necessary for optimum team performance. In line with the overall focus of this study which relates to the management of work performance processes, Corcoran (2006, p. 43) cautions that PM being an engaging process, cannot be conducted in remoteness but needs to measure effectiveness of strategic business processes as well as the operational aspects. Every ANM should have a skills development plan that clearly outlines their strategic direction of professional and personal development inclusive of work processes. From the findings of the sub-category on *managing processes* in relation to strategic planning, and QA and nursing care, concluding statements were made (Annexure X) relating to HRs, quality of nursing care and supply chain processes.

4.4.5.2 Communication between ANMs and management in relation to strategic planning, and quality assurance and nursing care

The desire to enhance interpersonal relationships and unity between ANMs and management was identified by the ANMs in this study as another envisioned dream of something that can be done better to acquire the best possible work opportunities. A view expressed by some ANMs and HONs in this study was that if ANMs served on the executive management committee of the hospital as they had in the past, continuity in many aspects of nursing management would prevail.

"I mean sometimes the communication between us (nurse managers) *and the office of the CEO is also not always..! That's why I say... things are said at the Executive meeting, then it is carried over to us and at that point it already is something else, and then how do we carry it over? And then something else ...?"* (II P13)

"With our previous CEO, Dr CEO Hospital No. 10, all of us nurses were in the management meetings, so we knew what was going on, everything you know. We were the 'Management of the Hospital'. But now with the new CEO it's only Mrs. HON Hospital No. 10 that's allowed in the meeting. And I think that is actually cutting the two of us (day ANMs) *--- our throats because stuff gets handed over, but still you know there's lots of other stuff that needs to be discussed or what is discussed, but it's not handed over, and that I almost want to say it hamper, that for me it feels, it hampers me because if Mrs. HON Hospital No. 10 isn't here, then I must step in. If she's on leave, I must be at the next meeting ...but I don't know what happened ..."* (II P25).

The above reveals that continuity in management is dependent on communication. Angst, Devaraj and D'Arcy (2012, p. 257) suggest that more research needs to be conducted on the role that information technology plays in enhancing the efficiency and effectiveness of communications considering that a large number of adverse hospital incidences originate from communication failures:

"...over the past few years -two years, say a year and a half, our Management Team changed, and what happened previously with my previous supervisor, she empowered the Assistant Managers so much that whenever I go to a meeting, especially in the hospital, if there's a meeting a Top Management meeting, they (ANMs) *will form part of Top Management. Now at the moment we have a new Head of Establishment and she only wants me there in the meetings so that is a link that I must ensure that everything that I learnt or get information from in the management meeting, the top management meeting or the Exco* (Executive Management)*... I must give through to the Assistant Managers"* (FG1 P1).

From the findings of the sub-category on *communication between ANMs and management* in relation to the KPA strategic planning, and QA and nursing care, concluding statements were made (Annexure X).

4.4.5.3 Sub-category 1.5: Communication between management and the broader staffing community in relation to strategic planning, and quality assurance and nursing care

The ANMs dreamt of how good it would be if management also engages directly with the people (staff). The ANMs verbalised:

"… communication still down to lower levels I feel… remains a problem because they say… we hear from management, management never comes to explain to us" (II P18).

They envisage a situation where the CEO would speak directly to the people 'from the horse's mouth' as it was referred to, a situation that then excludes 'hear-say' and distortion no matter how minute, in the communication chain. They stated the following:

"… There's a distance between your personnel and your management, as management is communicating something different, as compared to what message the people have received on the ground. Otherwise those on the ground actually don't even receive all the things! So I think communication is really one of the points that I feel it must be a priority in a hospital...even from the direction of the CEO …" (II P13).

Case studies conducted by Angst *et al*. (2012, pp. 273 & 277) geared at the most successful programme for the introduction and development of multi-skilled generic hotel services support workers at a designated National Health System Trust, found that the lack of support and communication from management was experienced as a strong demotivator. Suggestions to improve in this regard were either not attended to, or not sought. On the contrary, the study showed that where managers addressed serious concerns, success was possible. Angst *et al*. (2012, p. 257) indicate that even though about ninety percent of the information transactions in hospitals are that between patients, doctors, nurses and others, there is a modest amount of research about the role that information technology plays in enhancing the efficiency and effectiveness of communications-based transactions. The attempt therefore to deal with this research shortfall is deemed important considering that a large number of adverse hospital incidences originate from communication failures.

Whilst being escorted to the front entrance after the individual semi-structured interview had been conducted with a participating night ANM at one of the hospitals, the researcher witnessed how well the night ANM engaged with the night staff, as they walked through various passages. He spoke to the staff in isiXhosa. He also referred to the older cleaning female staff we encountered, in an honoured way. There was mutual respect shown. From the findings of the sub-category on *communication between management and the broader staffing community*, in relation to strategic planning, and QA and nursing care, concluding statements were made (Annexure X).

4.5 KPA 2: HUMAN RESOURCES

4.5.1 KPA 2: Understanding the KPA human resources

A crisis exists in HRs in the health-care sector. The WHO acknowledges a global shortage of close to 4.3 million doctors, midwives, nurses and other health professionals (Aluttis, Bishaw & Frank, 2014, online). The knowledge that the supply of the nursing workforce will not be able to meet the nursing demand is however not a new phenomenon (Redknap, Twigg & Towell, 2015, p. 263). In the South African health sector, priority has been given to the issue of management and leadership for all levels of the health system in relation to a planning strategy for 'human resources for health' (National Department of Health, 2011a, p. 57). In this study the ANMs in provincial health-care settings understood their key performance management areas to involve human resources. The analyses of their involvement of HRs, point to managing HRs in two spheres distinguished as: (a) managing (or administration of) HRs/ human resources management (HRM) and (b) developing HRs/ human resources development (HRD). The findings of understanding the KPA HRs are discussed in these two components.

a) Human resources management

The ANMs in this study pointed out that having to manage HRs is 'people management' linked with varied administrative tasks illustrative in the following expression:

"…pure personnel functions and then finance... But now with staffing shortage, that would be to ensure that you have safe staffing norms..., to make sure that their (the staff) *leave is allocated to them as per their right, that they get the lunch and their tea-times and to make sure that your staffing is you know broken down… compensate* (them) *for the hours that they work over and above their 40 hours… to ensure that there is a plan in place for say leave"* (II P10).

In this study the ANMs listed the components of managing HRs as comprising corporate governance, service delivery and administration. They perceived their experience to be schooling that had prepared them for these tasks. The following statements are illustrative of this matrix.

"You play a role in Corporate Governance, you play a role in Service Delivery like the province prescribed for us, and you plough all of that. All your KPAs are attached to that but because of your years of experience, your evolvement, your development over the years and …" (II P25); *"Administration, managing of staff that is now including sick leave, PILIR* (referring to the policy and procedure on incapacity leave and ill-health retirement), *all those things …"* (II P22).

It was however not only the schooling experience. The ANMs also believed that it was their qualifications and training as well as their approach to work performance that allowed them to manage HRs as well as they did. In this regard the following was stated:

"I am very enthusiastic. You know I come with a good disposition to work. I like the work. I am actually spinal trained and you know I actually look forward to come and work. Just so, so… I am indeed motivated" (loudly and assertively - field notes) (II P1).

According to Armstrong and Taylor (2014, p. 5), HRM includes the strategic actions such as having to manage human capital, knowledge management, corporate social responsibility, organisational growth, resourcing (planning, recruitment and selection and talent management of staff), training, development and empowerment, PM, reward and incentive management, worker relations and welfare and having to provide services to staff. The understanding of managing HRs by the ANMs, interpreted by some as 'staffing matters' were to be attended to. An ANM who reiterated the view of Armstrong and Taylor (2014) said the following:

"You must manage your people so it includes everything from absenteeism, disciplining, recruiting, appointing (referring to the appointment of people to posts)… *all those things"* (II P18).

Another particular entity listed as important by the ANMs in the domain of HRs was managing the sick leave of the nursing group. One ANM stated that her coordinating responsibility in this regard involved all the nurses at the health-care setting where she worked. She stated:

"… part of the HR… is the long sick leaves. I manage the long sick leaves whether it comes from any other ward. If I see somebody's booked off sick for some time, it doesn't matter where the person is working, whether it's Night Duty or Day Duty, I would follow that up. I would make sure that all the documents are here in time" (II P11).

Armstrong (2014, p. 4) supports the understanding that HRM comprehensively deals with all the employment (work) features of people (employees) and how people (employees) are managed at the institution. HRM is understood to be an all-encompassing expression that depicts several unique means to managing people (Price, 2011, pp. xv & 3). In managing HRs the ANMs referred to the importance of people management in their work input. They regard having to guarantee that their staff (nurses and others) are afforded the contractual benefits as set out in their employment conditions of the provincial health-care settings as important, and to be within the ambit of managing HRs. An ANM vehemently stated:

"...the HR function…, to ensure that staff receive all the… I would say conditions of service that is placed by the Department" (II P10).

Various ANM responses placed staff development and the need for continuous assessment within the ambit of HRs. Monitoring and managing staff performance in a time effective manner was also found to be a key personnel (staffing) performance function, related to the HR performance domain of the ANM.

"The SPMS system… (staff PM system), *there must be a system that there is a continuous assessment, to make sure that the reviews* (assessment of performance) *are done on the time"* (II P10).

In relation to managing staff performance, an ANM asserted that once a certain performance standard had been mastered by her supervisee the ONM, she expects there to be a determination to attain a higher performance standard. In this regard the following was verbalised:

"Then the people must start thinking … I'm always there (apex of performance) *then … next quarter they must look for something else because I've mastered that"* (II P21).

A night ANM who had the experience of having 22 people absent simultaneously on one of the night shifts stated:

"Where you have to…you know where you tell the people 'I know I understand tonight that you might be feeling…' this or 'you have covered there last night but I'm really in need…' that kind of relationship with people. People need to understand and I say people understand better if you actually give them all the information" (II P19).

A publicised position in relation to HRs was that the component of HRs within an organisation has to be more profound. The use of modern technology however is recognised as an aid to this position as it has been shown to have created some ease for HRs managers in having to manage HRs situations (James, 2006, p. ii). In this regard the management of human resources along with information management is now also recognised as distinctive skills in management (Dever, 2010, pp. 6-7).

The focus should be on employee service before customer service. An organisation is to invest in the recruited staff by paying attention to them, training them, grooming them, and considering their career growth. Such interventions help to retrain staff and ultimately customers/ patients will be treated well (Taylor & Stern, 2009, p. 79). Night ANMs in particular illustrated such values. One of them illustrated her tolerance in relation to treating staff well. She said:

"They send the problem cases to night (referring to night shift). *They actually ask me if they can send someone* (who was challenging to manage) *to night duty and I said 'Okay, I'll try; I'll see what I can do!' And most of the people tend to stay* (thereafter on the night shift)*, so it works out because for me I can really say if you do treat people well, then they do* (work)*... because I've seen how some people get treated ... and I mean you wouldn't know if you don't treat them right, if they can be better"* (II P17).

The management of human resources requires a humane approach. Another ANM expressed her humaneness in working with the staff by the following:

"It showed that they do appreciate to work with me, because I treat them with respect ja" (II P5).

Seethalakshmi (2012, p. 247) found that in relation to the overall implementation of HRs practices in specialised hospitals, the majority of employees – respondents have a positive opinion that enriches motivation and job satisfaction among the employees. One night ANM explained that when he needed to quickly reassign a nursing staff member elsewhere for the night shift because of the service needs, he would later as the shift progressed into the night,

make a deliberate attempt to go back to the individual nurse to find out how she was doing, and even discuss the matter with her in more detail (II P6) (did not want to be recorded - field notes).

Kumi-Kyereme and Boachie-Mensah (2012, p. 1) have asserted that the wealth of an organisation is not dependent on its financial and material reserves, but rather on the human capital and their contribution of work deeds in the setting. Another ANM pointed out that managing HRs have evolved and expressed her interpretation thereof as follows:

"However things have changed. So the type of management you know, it has changed. It's more as I'd say it's give-and-take… it's pulling on all those different management styles. You have to have authority you know -autocratic sometimes, but most of the time is actually democratic leadership" (II P19).

According to Kumi-Kyereme and Boachie-Mensah (2012, p. 1) the HR is seen as the most adaptable, resourceful and prolific of all resources. The ANMs also attached special value to the management of HRs and people as a KPA in that they advocate not just managing people but getting to know them. Illustrations of such management engagements/ conversations were:

"… but it's nice for me to work with all of the people, that you get to know all the people" (passionately and sincerely - field notes) (II P18).

This approach correlated well with the AI philosophy that interrupts the cycle of depersonalisation and presented the night ANM a chance to truly know those she worked with as unique individuals and as part of a matrix of relationships (Cooperrider & Whitney, 2005, online).

Other illustrations verbalized by the ANMs in this regard were:

"'I cannot report for duty tomorrow …' and that staff member comes in the following day and you as the manager don't even take the time out to ask that staff member 'how is your child that you were sitting with …?'" (II P9); "*I've learnt over the years that I ask you how you are and if you tell me about your child… in a week I will ask 'How is he doing? How is his school doing? How is his health?' So by showing interest, I acknowledge them as a human, as a person … I think it's real interest* (implying manager interest). *It's not that I pretend. It's a real interest. I can remember all the staff's children's names. I can remember in which grade they are* (emphasised this point - field notes)*"* (II P22); *"… and that is for me the most important, my passion is people and things... my personnel, but I love people"* (II P23).

A night ANM (II P6) highlighted having to manage HRs with special reference to the principled framework in which HR takes place. He described her necessary professional intervention with a Professional Nurse who, on his shift, had allowed photos to be taken of a patient. He explained how he had called the Professional Nurse aside to point out the violation. He emphasised that in managing HRs, corrective action is to be conducted in a humane manner when needed. The dynamism of the night shift in relation to managing HRs is an important aspect to be considered. The ANMs recognised that the management of HRs vary and is not predictable. Working the night shift especially seemed to excite ANMs as they never knew what the shift held in store for them. In this regard the night ANM said:

"But as I say, it's a different situation every night with regards to type of people; how they respond …" (II P19).

Concluding statements in relation to HRM are in Annexure X.

b) Human resources development

Managing HRs effectively in health-care institutions is essential as it allows for the delivery of health-care services of a quality standard whilst it improves the performance of hospital personnel and leads to patient satisfaction (Elarabi & Johari, 2014, p. 13). Both ANMs and HONs showed a positive regard for and embraced staff development. This was evident from the following statements regarding staff development stressed by the participants:

"And that's why we are here to develop them (referring to nursing staff) *and equip them to perform better"* (II P2). *"They would at the most need different courses ... especially the middle-management and the people management kind of courses… -but then also the strategic thinking and planning I think is what you need to look at …"* (FG2 P1); *"…You* (meaning the self, the ANM) *facilitate most of the training and development …"* (II P10); *"The provision, and ensuring that the staff are educated …"* (II P9).

A focus on developing both ANMs and ONMs has taken on new significance. The HONs believed that their ongoing supervisory contact with their supervisees, the ANMs was educative:

"We take some days discussions with them only -I have a meeting twice a week with my ADs and my OMs and … I think we've already done so much… we have to give guidance to them, we've train them" (FG2 P2).

Intertwined in the leadership role in human resources development (HRD) is the crucial need for ANM coaching-supervisory role, for ONM learning, as ANMs supervise them directly; illustrated by the following participating ANM's statement:

"…your effective utilisation of resources and here specifically I'm referring to the management of the human resources, because a lot of them (i.e. ONMs) *are still struggling, especially …"* (II P9).

The ANMs who participated in this study also perceived their leadership and guidance to involve developing less experienced nurse managers. They deemed their leadership to be supportive and motivational in contributing to career building in nursing. The following was stated:

"…provide guidance, support to the nursing staff… motivates them to achieve their goals career-wise and to develop them" (II P8).

The ANMs perceived the need for training of staff as well as their own training:

"Development of staff and myself" (II P22).

The preparation of a workforce for the future is also important. In the WCP where this study was conducted, work is also being done to introduce resilience into HRs planning in order to prepare a workforce to meet the service delivery needs of the future (Western Cape Health, Directorate Nursing Services, 2015). A consideration that has to be borne in mind involving HRs and staff development is that career desires for nurses differ. This notion was expressed by a HON in the following statement:

"… because not every nurse wants to be a manager, so at which point will we help people? How will they be kept career pathed, to know these are the people that must be helped to gain that kind of knowledge? So I don't want to be unrealistic, because if you start out as a nurse, you want to be a nurse" (FG2 P1).

Career management has however been seen to become an integral part of HRM practices in organisations (Martin, 2010, p. 41). There is *need to focus on night shift training and development*. Some of the ANM participants stated that they also had a responsibility to ensure that nursing staff who were working the night shift were also developed. A reminding statement from one of the night ANMs was:

"You must give your personnel the in-service training required… they must grow professionally whether it is in-service training formally -you must nominate them… because some people on night have been there for long, so you can't allow your personnel to stagnate on the night shift" (II P27).

Night ANMs indeed showed how proactive they were with training. One night ANM described his enjoyment with conducting in-service training using the means available to him:

"The other thing that I also like to do is the in-service trainings on night duty, of the staff … six months ago I called all the nurses to the office, and on the computer … there was that educative videos, health videos, conditions and all that procedures, and I then pick and choose topics and they attend it and then they ask questions… they were really appreciative and … they look forward to this in-service training; and the nurses lack so much knowledge… lots of things they didn't know" (II P20).

Another ANM conducted nursing curriculum tuition for nurses, who were currently studying, from 18h00 to 19h00, that is, prior to the commencement of the night shift that started at 19h00. Another ANM used adverse incidents to rebuild capacity particularly, after something had gone wrong:

"If there's shortcoming, send them for special courses in line with their functioning at work level" (II P8).

A major United Kingdom acute hospitals study on people management and organisational performance reported by West, Borril, Dawson, Scully, Carter, Anelay, Patterson and Waring (2002, p. 1309) found a strong link between the degree of excellence in the management of HRs and patient mortality. Negative or adverse incidences occurring within nursing or the provincial health-care settings can therefore be used to facilitate new or re-learning. The quality of training policies and team working was further strongly associated with managerial effectiveness (West *et al*., 2002, p. 1305). The following was verbalised by an ANM participant:

"… And through my incident reports I deduct that this is the in-service training that will be held. And we've got a structured format, every month, every week we will have …" (II P22).

Conclusions on the above findings on HRD are seen in Annexure X.

[Note: The management of HRs in the WCP where the study was conducted has subsequently started to use the term 'People Management' since 2017].

4.5.2 KPA 2 Discover

INPUT: Best work performance experience in the KPA human resources

Best work performance experiences in relation to the KPA HRs, involve: (1) building relationship, and (2) motivation in relation to HRs.

4.5.2.1 Sub-category 2.1: Building relationship in relation to human resources

Jooste (2003, p. 22) elaborates on the attributes needed by the most important leadership categories in nursing. The attributes include good interpersonal relationships with fellow and lower levels of staff and patients, a feature that should be endorsed by a nurse manager (Jooste, 2003, p. 19). In South Africa, the activity of relationship building has now also been included into a model put forward for use by nurse managers in a mentoring programme for newly appointed nurse educators within the mentor-mentee process (Soekoe, 2014, pp. 1, 3 & 6). The ANMs in this study indicated their success in building relationship, which they viewed as consulting staff and securing staff confidence in operational matters; a practice likely to carry on. This therefore confirmed the AI assumption in Chapter 1 that a person has more confidence and comfort to journey to the future (the unknown) when they carry parts of the past (the known). The ANMs believed that such managerial practice was important as they found that it led to successful implementation or execution of work performance. They related that in work practice it was imperative to ensure that implementation occurred after decisions had been made. The ANMs in this study were proud of efforts they made to involve the lower levels of the nursing categories in some of the decision making processes. They viewed such involvement as engendering the feeling of ownership and esteem in those who were consulted, which in turn assured the ANMs that implementation of work tasks/ deeds (performance) would follow. An ANM at one of the provincial health-care settings stated:

"For me it's important to go to grassroot level … did the people at the lower level you know, give input because once they give input, they feel they are part of it. So the buy-in for the end goal is more successful for me (emphasised these sentiments - field notes) *than me saying - speaking downwards to them to say … this is what we going to implement, that* is *what we going to implement … no…"* (conveyed with sincerity and authenticity - field notes) (II P21)!

Stapleton *et al*. (2007, p. 811) assert that consultation with staff and building staff self-esteem supports a sense of fulfillment and of being inspired in the workplace which are seen as vital components that improve work performance (work place efficiency) and work productivity, leading to a happy motivated workforce. This assertion by Stapleton *et al*. (2007, p. 811) was

based on the intricacies of work relationships that nurses faced daily in the clinical areas. In building relations, the ANMs indicated their high regard for maintaining professionalism at work whilst still building relationship. They conveyed the notion that such relationship building required them to be able to adapt their supervision and instill learning and growth:

"We are more at work than what we are at home… so one has to make it nice for each other (referring to the work performance environment). *I'm not saying that we must be overfriendly mates! We must be strict, and we must work accordingly, we must work as we should work but it should be nice for others to work with me, and I adapt very easily. I can work with anyone, …but I feel from my side it should also be nice for them to work with me … the first night we sit with the people when they start to work* (the night shift), *it's then feel feel* (interpreted as adapting to) *each other"* (II P23).

A view elicited from the study of Jooste (2003, p. 23) also found that the nurse manager can be seen to be a good organiser involved in developing and preserving an environment in which subordinates can be productive and efficient. In this study a night ANM reflected on the slow but definite 'warming-up' response she experienced from a young nurse who was new to the night shift. She described this as a best work performance experience:

"… but as the month ticks on, -for example this one specific person, *shame she's so in a world of her own, she just does her own thing, and she's starting to open up towards me, and the two of us... and that is for me the most important, my passion is people and things… my personnel, but I love people and that is what it's been about all the years in nursing …"* (II P23).

Managers, whose work performance has been rated as the highest, have also been found to exude warmth and affection compared to their weaker performing counterparts (Stapleton *et al*., 2007, p. 814).

In building relationship, a night ANM indicated that she had been instrumental in having encouraged nurse managers at the hospital where she worked, to study further. Subsequently these nurse managers had indeed successfully pursued courses such as Nursing Management, Nursing Education and the Bachelor Curationus (nursing degree qualification). She further indicated that she had continued to encourage and motivate, and had thus garnered relationship building in this way (field notes). One ANM on the day shift with its associated complexity believed that trying to build relationships, positive and constructive involvement on the day shift was potentially more challenging as compared to the night shift because more people worked the day shift. She stated:

"…but obviously ther's far more activity and things like that (on the day shift) *Uhm and the multidisciplinary members are far more in areas and you have to deal -I think you have a lot more interpersonal relationships during the day than at a weekend and at night"* (II P25).

Nurse managers hold unique positions because of their daily close proximity to personnel on unit level and can advance relationships with the staff. However, helping professions need to acquire skills such as leading, coaching and inspiring (Stapleton *et al*., 2007, p. 814). Work performance experience that also demonstrated the building of positive and constructive relationships was illustrated by a night ANM at a busy General Specialist Hospital. Even though she had not been

working for long at the site where she held the night position (participant still met the criteria of two years in the post for this study as she had been working elsewhere previously in the same post ranking), she had started carving out a relationship with the night nurses which led to securing continued service delivery, especially when faced with staffing shortages. She described the relationship as an 'involvement' with the nurses:

"I have sort of built a relationship already, so there was that kind of you know…, because you need to ask, you need to be involved with people so you need to be able to ask them to cover although they cannot really refuse …" (II P19).

Similarly, another night ANM indicated that a trust relationship with the staff was her first priority when she took up her position. Her experience informed this study that meetings with the nursing staff also facilitated relationships:

"…what I find out works for me is when I have meetings with the staff, they really need input and they really need to trust me. And that was my first focus to build a trustworthy relationship with them …" (II P17).

Yet another night ANM described the various tasks and acts he had embarked on and pledged to continue with, to maintain relationship with all the hospital staff. The researcher observed his manner; a natural sincere engagement with the staff, with mutual respect, as the researcher walked with him through the areas of the hospital to front door and into the parking lot of the hospital. He spoke to all in their mother tongue using one of the three official languages of the WCP in which the study was conducted, researcher being able to understand two. This confirmed the AI assumption in Chapter 1, that language people use, becomes their reality. Although she did not want to be recorded, she spoke with great passion and pride as she revealed that she would pray with staff, and would visit some who were bereaved, at their homes. Stapleton *et al*. (2007, p. 814) indicate that nurse leaders might need to be taught to construct such relationships to positively influence the disposition of individual and group engagement at a psychological and physical level. The belief expressed by an ANM in this study was that the adoption of a positive attitude was the underlying overarching need to many areas in managing:

"I would really like to see that I successfully…, that all the personnel under me, that they are motivated and 'how shall I say' committed with a positive attitude, and I feel I can contribute much, to realise this and if that can happen then the work will also improve. Service delivery would improve; quality care will improve, if everyone has a positive attitude …" (II P24).

In preparing for the role of manager, the understanding of internal and external motivation, nurturing internal motivation amongst the nursing corps and investing in relationships are pragmatic concepts that could be implemented in the clinical setting (Stapleton *et al*., 2007, p. 811). Another night ANM added that definitive steps must be taken to build relationship in order to influence the happiness and motivation of the nursing staff. In this regard an ANM said:

"*I did a situational analysis and I went to Mr. HON No. 12, I wrote a report on my findings and what can we do to sort-of give it a therapeutic environment; make the nurses happy in their job"* (II P1).

Stapleton *et al*. (2007, p. 811) argue that a gauge of sound leadership and managerial distinctiveness is the dexterity a nurse manager possesses to arouse morale.

"I'm just so passionate about my whole work that it doesn't sound real but you know what, I love to speak to my staff. I want them to trust me, if they got a problem, I go with them. I want to be there for my staff ... That's why I told you I'm here past six in the morning because I love my work. I really like my work but I want to be there for my staff when they need me" (II P2).

Stapleton *et al*. (2007, p. 814) found that relationship building, compassion, realness and respect are very useful attributes for the supervision of nurses, respect also being one of the adopted values of the health department where this study was conducted (Western Cape Government: Department of Health, 2015). A decisive work performance feature for the CEO and similar positions in large organisations is communication that in turn lends itself to relationships with subordinates and enhances their job satisfaction (Stapleton *et al*., 2007, p. 814). In response to the question on best work performance experience, the values of openness and honesty in the relationship with the HON were advocated by the ANMs in this study, as a managerial practice, and in staff engagements:

"… I say always and that's one thing that I've learnt 'be honest'. They (staff including her) *must learn that open communication. And so that if you're at home, you're not afraid ...maybe they will find out what you did not tell them from another angle or… be honest and open all the time because ..."* (II P4).

Mackoff (2015, p. 24) describe work engagement comprising the attributes of love for the job, the colleagues and the patients, a devotion and a 'calling to work', for a nurse manager; *"It is who I am"*. Nurse managers are driven by ardor (excitement, warmth, animation). The importance of building relationship in nursing management has been illustrated well by Ros Moore, Scotland's Chief Nursing Officer when taking up office in 2010 as she sets out to re-focus on the 'minutiae of nursing'. Her top priority in particular is stated as 'relationship-based care', that is, the relationships between professionals and patients and between members of the team providing the health-care (Trueland, 2010, p. 13). From the findings of the sub-category on best work performance opportunities involved *building relationship* in relation to the KPA HRs, concluding statements were made (Annexure X).

4.5.2.2 Sub-category 2.2: Motivation in relation to human resources

A study conducted by Keys (2014, p. 100), indicates that professional success is subjectively experienced when managers/ supervisors believe that they positively impact the staff. The researcher observed that a positive managerial work performance attitude towards having to motivate and support staff seems to exude almost naturally from the ANMs. The ANMs in turn claimed that they were very good with motivating staff when the work situation became critical as verbalised by:

"I find myself spending a lot'a of time supporting staff…, to go in and to say to the staff 'Guys, I see how very hard you work …'" (II P9).

Even when the work situation was not critical, best work performance experience included awareness for the need to recognise staff and taking deliberate steps to allow them to develop, respectively illustrated by:

"In nursing, I acknowledge them …" (II P22); *"Most of your staff goes on skills* (i.e. training); *you make time for them to go"* (II P17).

The act of showing appreciation and thanking staff serves as a motivator and demonstrates support. This revelation was attested to by an ANM who claimed that her own 'learning to motivate' was a result of work performance experience. She displayed appreciation for what she had internalised during the work opportunity especially in cases of staffing shortages. For instance, the ward had only one nurse to look after 30 patients:

"And what I've learnt over the last… -I've been on night duty for seven, eight years where there is the simple word of 'Thank you'" (II P22).

Supporting and motivating staff by saying '*thank you*' was practiced by Smit (2005, p. 26) as nurses felt that a *'thank you'* from management for the hard work done made them feel acknowledged and inspired. MacKusic and Minick (2010, p. 338) refer to an investigation on why clinical nurses were demotivated to the point of leaving the profession. Three causes were identified namely, the hostile place of work, the emotional strain associated to the delivery of patient care, and the tiredness and exhaustion. Further in this regard, the inhospitable workplace related to regular lack of support from other RNs, reports of a sexual harassment nature and verbal (belittlement) or physical abuse by fellow staff members, managers or doctors, were cited. One nurse 'victim' claimed that the manager were aware of the situation and chose to ignore it. In this study the principle of fairness and consistency was indeed considered as best work performance experience motivator. One ANM verbalised (stated vehemently - field notes):

"I want to be consequent and I strive to be consequent. I mean sometimes, you not always consequent because of these human things that come in..., and I tell my staff as well. You know what the staff are like. They would always say to you 'but why do you say this now to me... you hadn't done so with that (other) *one...!' And so I try, and prevent that, they ever able to say that to me"* (II P15).

Two ANMs in this study who were previously involved with the formal EAP at their workplace health settings indicated their best work performance experience involved successful intervention when faced with challenges. The following statements were made in this regard:

" … and when they are in a crisis, it is my ability because of my years that I spent in EAP to actually go in and say 'What is it that you want?' but also to ensure that we don't minimise the result of the trauma that happened …" (II P9); *"I mean, you can, for instance, if you now have to give someone an audi* (disciplinary related letter) *because they'r coming late or whatever and you know* (emphasised this point word - field notes) *that they been beaten up at home"* (II P15); *"... and try and find ways around"* (II P9).

From the findings of the sub-category on best work performance experience in *motivation*, concluding statements were made (Annexure X).

4.5.3 KPA 2: Dream

OUTPUT: Best possible work performance opportunities in the KPA human resources

This study found that best possible work performance opportunities for ANMs to flourish in work relate to: (1) staff involvement and (2) the desire for enhanced interpersonal relationships between shifts, in relation to the KPA HRs.

4.5.3.1 Sub-category 2.3: Staff involvement in relation to human resources

The participants in this study dreamt of things being better and described the area of staff involvement to be one of the best possible opportunities for this purpose, and in which to flourish. The ANMs related to the ability to attract staff to attend hospital functions such as Madiba Days (a South African celebration of the late President Nelson Mandela on the date of his birth). ANMs want nurses to be able and willing to participate in such transversal hospital celebrations far more than the current work system allows them to. In response to asking the ANM participants to deliberately dream about betterment, the following was stated:

"And this is like really a dream because I know it is not possible, but to get my staff more involved with certain things. Just to give you an example -a Christmas party is held and everybody at Admin closes their office and they go and sit there for the whole day. My poor staff have to run in quickly for half an hour and gobble down their food and go back to work so so.... So my dream would be that there would be some or other way... I don't know how, that they will also be fully involved. I mean Sports Day everybody goes except the nurses…and Madiba Days ...!" (II P15).

ANMs also indicated that they could do better in involving nursing staff working the night shift in hospital functions. They foresaw such involvement to have a beneficial effect on the staff. In this regard it was also dream to have both day and night nursing staff more participative. She stated the following:

"Because I mean it's also the Night Staff, and they not involved and how do you involve these people? Ja! For me it's an absolute dream to get everybody involved because I mean if you talk about motivating staff and getting them to partake ..." (II P15).

Conversely the ANMs felt that it would be better if they could be part of the top hospital management team to get information first hand as opposed to having to wait for feedback via their HON Nursing. The sentiments expressed in this regard were:

"With our previous CEO, Dr. CEO Hospital No. 10, all of us nurses were in the management meetings, so we knew what was going on, everything you know, we were the 'Management of the Hospital'" (II P25).

Srsic-Stoehr *et al*. (2004, p. 38) assert that *"a nurse manager does not have to feel alone in addressing all problems or developing all solutions. One of the best approaches is to get staff buy-in or achieve the synergy of multiple ideas through staff involvement. Guiding and coaching*

becomes the nurse manager's focus", when the role of the nurse manager in relation to nurse manager success skills was described. An aspect of such a role is to develop teams, and involves staff appropriately in addressing problems or developing solutions. In this study an ANM believed that nursing staff can be stimulated more positively in order to get them involved:

"Then strange enough the other day when I was with the staff, we had our end of the year function, and I said 'people you must go (to the location of the event)' *and they said 'no, we're not going...', and I said 'now… what are the reasons - tell me what the reason that you don't want to go?' … And you know I spoke to them and in the old end all went. So I think that it is also how you as manager can convince your people to change. It is now a very simple and straightforward example, and also to bring in diversity; we sat and spoke …"* (II P13).

In line with the AI step of dreaming of best possible opportunities of things that could be done better in their work, the ANMs identified the necessity for and will to practice participative management. Relating to both nursing operational and strategic management, the ANMs emphasised the attempt they made in facilitating part-partners with the staff/ subordinates. An ANM said:

"Then also not just tell them what to do but make them part of decision making" (II P8).

The ANM of a night shift who was conducting health education for patients ensured that all staff shared the responsibility. He made the following statement:

"I try to involve everybody (all those on the shift), *there's not only one person who is gonna give something about diabetes or something about how to do a blood pressure whatever …"* (II P7).

In this regard the night ANM further encouraged nurses on the night shift, to be conscious (involved) in their own health. The health education talks on conditions of life style as part of patient management that were being conducted on the shift was a good opportunity, if not the best, for the night ANM and the staff to also derive the benefits, thereby improving their own health and life style. They all subsequently reverted to having healthier snacks and food at their night staff meetings (field notes). A manager who facilitates a supportive environment in the work situation, and who consults with her staff, is perceived to be effective, and thereby increases job gratification and fulfillment in quality nursing (Duffield, Roche, Blay & Stasa, 2010, p. 23).

An ANM indicated that her involvement along with other staff members in a transversal hospital project had led to success. She stated the following:

"I am sort-of the driver for OPD. So I am the boss of OPD that can make any decision. I have thus already said that they must remember that OPD is not just 'nursing'. OPD comprises finances, OPD has the reception part, OPD has the archives part, so I mean that is clearly not my domain there. But at the old end of the day, I am the key person over them and have received the jurisdiction from Mr. CEO Hospital (fictitious name) to say what needs to be said, and the authority to give them instructions do you understand! But quality (referring to the Quality Manager) *has together with me spoken about the reception manual. So I mean, I hadn't done this alone"* (II P16).

At the study hospitals, it appeared as if nurse managers were involved in active team leadership roles on a small scale. For maximum team success it is important that members of the multidisciplinary team other than nursing are also involved (Potter *et al*., 1994, pp. 16 & 17). An action research project on continuous improvement in an acute hospital recognised that medical staff underestimated the significant influence of their leadership role. This consequently led to the sense of 'leaderlessness', frustration and even skepticism being experienced and displayed by the other staff. There was an apprehension by nurse managers of not wanting to upset the medical staff but to rather achieve a few successes first with the hope that medical staff will buy in later. On the contrary other staff were afraid that if the medical staff were involved, that they would dominate affairs (Potter, Morgan & Thompson, 1994, pp. 16 & 17).

With regard to being involved in finances, nurse manager participants in this study stated that sometimes only those in management positions knew how finances worked but that the less senior people did not always understand. A few of the ANMs interviewed nonetheless verbalised that financial management was a participatory process requiring collective decision making:

"… and how to initiate a request and to know how the 'financial prescripts' and things work and the people lower down don't necessarily always understand this… And that's why I try to keep them informed of all the workings so that they don't lose faith" (II P16).

Staff involvement was advocated as being one of the best strategies to garner staff support and secure the benefit of facilitated combined nurse manager efforts of multiple coaching ideas and guidance (Srsic-Stoehr, Rogers, Wolgast, Chapman & Douglas, 2004, p. 38). Participants in this study also identified work related relationships between them and their subordinates, the ONMs (supervisor-supervisee relationship) as important and as the best possible opportunities for ANMs to flourish. The rationale adopted seems to assert that neither of the nurse manager groups should work in isolation of the other but rather be engaging and involved. One ANM with confidence advocated how she had recently asked her ONMs to ensure that work engagements between them were reciprocal in relation to involvement and to do better in work performance:

"I think that is one of the things I do well, but that is the idea that I've got, to get them (ONMs) *more involved and to get them to involve me more"* (II P15).

There is agreement today about the need for new nursing managerial learning more, as opposed to clinical learning. This means that managerial training as it had been conducted in the past is no longer adequate (Johansson *et al*., 2007, p. 150). In this regard nurse managers require people and leadership skills. However, the need for effective communication skills is highest as these skills stimulate staff involvement and motivation (Johansson *et al.,* 2007, p. 150). The notion that nurse managers are to be re-taught to involve staff was evident throughout in the engagement with the participants. Staff involvement can be facilitated by showing the way, ensuring that there is an effective communication flow and involving staff in decision-making (shared decision-making), all of which are deemed to be critical to cultivating a philosophy of

empowerment (O'Brien, 2011, pp. 14, 20, 22 & 189); Redknap *et al*. (2015, p. 266) attest to this belief. Stimulation, engagement, multi-tasking and involvement are wanted by Generation Y (the millennials) (Mokoka, 2015, p. 45).

Staff involvement also builds relationship. An important relationship identified by the ANM participants was that between the day shift and the night shift ANMs, as night ANMs were seen to be isolated from their day shift counterparts. A notion thus put forward was to have the two staffing groups more involved with each other by creating opportunities to work together better as a team that leads to prosperity in management. In regard to nursing managerial operations and with reference to the two ANMs shifts, an ANM on the day shift stated the following:

"I think from our side we can involve them (referring to the night ANMs) *more in our management team. Although they're part of the team, they're working night shift …"* (II P25).

From the findings of the sub-category of *staff involvement* in relation to the KPA HRs, concluding statements were made (Annexure X).

4.5.3.2 Sub-category 2.4: The desire for enhanced interpersonal relationships and unity between shifts in relation to human resources

The desire to enhance interpersonal relationships and unity between shifts was identified by the ANMs in this study as an envisioned dream of something that can be done better to acquire the best possible work opportunities. Work performance in nursing management is inherently embedded in the interpersonal realm hence the need to focus on interpersonal relationships and unity between shifts seemed to be naturally recognised by the ANMs. ANMs desired that there be enhanced interpersonal relationships and unity between various shifts as part of best possible opportunities for improvement. The shifts identified were those between day and night, and the various day shifts.

- *Strengthening of relations between day and night shifts*

The issues of the work performance sphere that were volunteered by the participants and supported by the literature on this point drew attention to the relationship between the day and the night shifts, and the disconnection that existed between these two shifts. In line with what can be improved, a strong intention was expressed by one ANM participant who worked the night shift was to progressively eradicate a perception held by her day shift counterparts that night nurses slept on duty and were dishonest. She verbalised the following:

"…still a battle to fight with them because they (day shift) *still think '… ag, you night people… you just come to sleep…' and if anything happened they'll just say 'no, it's night Duty! Night Duty! It happened on the night shift, it will just happen on night'* (reflecting on them being judged; meaning that it is bound to happen on the night shift). *If there's something missing from an area, then they say '…that must be in the night*, *that could just have happen during the night'"* (II P28).

Doing rounds at unscheduled times and enlightening night nurses to maintain the best ethical practice was identified by the night ANM to ensure that they (night nurses) were not sleeping as believed, and to report on this finding. The attempt to have this perception changed and thus improve the relationship as a best possible opportunity in relation to work was expressed:

"So, I'll try. I try even to explain to the staff also '... please, we must get away from that (perception that night nurses sleep on duty and loose ward assets)' *-it is an old tradition but we must prove the opposite. So that is still a big struggle for us. It's a challenge for me, that's why I don't do rounds at specific times. I go anytime into the wards and go see with what are they busy with, who's where and what is going on. So when the day managers bring up something, then I can explain and say 'oh no, that time was when I got in that ward that time, this and this was in place' and all that. But it will still take time to get the… out of that uhm what do they call it? What would one term it as…?* (participant attempted to recall an apt name - field notes), '*the ooold'"* (II P28).

The prevalence of misconceptions of night staff exists (Powell, 2013, p. 2181). Some of the misconceptions held of night staff are that the night shift is easier to work, that patients sleep along with nurses through the shift and that night staff are less intelligent or career orientated or committed compared to day staff. A night ANM also identified that inconsistencies in day and night ANM communication was an area that could be improved:

"…that we as night and day managers work more closely … we must speak out of one mouth" (II P12).

Contrary to the strong and unified relationship that should preferably exist between the night ANMs and the day ANMs, as well as other managers, some night ANMs also experienced a sense of being undervalued as there seemed to be little understanding of what was involved on the night shift duty. One satirical view expressed by an ANM who worked the night shift at a health-care setting for intellectually disabled individuals, was that day staff held a perception that the patients were 'absent' at night:

"We isolated yes. I like to use the metaphor of at 7 o'clock (19h00, i.e. at the start of the night shift) *we close the hospital and we as night staff take the patients to a total different hospital and tomorrow morning at 7 o'clock* (07h00, i.e. at the end of the night shift) *we quickly bring them back because we are not part of the group"* (II P22).

A view of being undervalued is cruel and damaging to the functioning and self-worth of night nurses and could affect patient care (Powell, 2013, p. 2180). Other night ANMs from the various different services spoke about the limited resources left out for them. One of them indicated how she facilitated complementary supplies for one department by obtaining additional supplies from another during the night. In this regard the following was expressed by the night ANMs:

"Uuumm there is a bit of problems on night where the access to some of the things is problematic for me. I'm struggling with it but I'm speaking with the day staff because I think on Night I felt now a bit like I'm on my own island" (II P7); *"The problem that we sometimes encounter uhm is that the day people leave us out an amount of stock whilst the other stock is locked up ne and they go home with the key"* (II P27); *"a lot of the stock gets locked away so we don't have access to dressing packs or access to that kind of stuff"* (II P22).

The limited resources particularly available for the night shift was acknowledged by both day and night staff, with the day ANMs illustrating the enormous challenges they have with the support services from which they acquired the stock items. A night ANM suggested (vehement - field notes) that a clerk is needed to assist with the required clerical work on the night shift which could in turn facilitate improved working relationships. According to De Cordova, Phibbs and Stone (2013, p. 286) health-care providers and clerks were less available during the night. Self-reliance and the ability to perform work as a team was found to be one of the dominant self-perceptions the night nurses held in this regard, yet those who are working the night shift have a need for more support. De Cordova *et al*. (2013, p. 290) assert that it is key to combine less experienced staff with those who are more experienced when after-hour and night shifts are planned. Nurse managers ought to engage night nurses and promote open communication between day and night shifts. When situational differences between day and night shifts are acknowledged, and importance is allotted to night nurses by nurse managers, feelings of disconnection from day operations, the managerial arena and day shift counter-parts are decreased, and a sense of appreciation is felt (De Corvoda *et al*., 2013, pp. 290-291); confirmation of the AI assumption in Chapter 1 that it is important to value differences. Powell (2013, p. 2179) agreed that the sense of disengagement experienced by night shift nurses could be as a result of the poor attempt by organisations to involve night nurses or because this group has consciously chosen not to be involved. Engaging night nurses both on ward units and within the health-care setting (De Cordova *et al*., 2013, p. 291) is a means that will facilitate communication between day and night staff and involvement of night nurses in decision making. However, the apathy night nurses demonstrate toward governance could be attributed either to uncertainty or already being engrossed in departmental matters (Powell, 2013, p. 2179). Further persuasion was in this regard ought to be ensuring that meetings and programmes are held at times convenient for night nurses to attend (Stewart, Snyder & Sullivan, 2010, p. 305; De Cordova *et al*., 2013, p. 291).

- *Strengthening of relations between day shift ANMs*

The ANMs in regard to the desire to enhance interpersonal relationships and unity, advocated that the characteristic of friendliness be adopted. The following was stated:

"... and friendliness because interpersonal is very important especially seeing that we working with human beings" (II P8).

A night ANM emphasised the fact that a working environment is to be an environment that is friendly. She pointed out that *"... there are no toilets"* (also known as rest or cloak rooms) (II P6). The researcher observed that the night office (interview room) was small and cramped. There researcher sat on the one chair that was available behind a small desk near the telephone however the telephone rang intermittently and needed to be answered by the participant. The ANM pointed out that there was no privacy in the night office and illustrated the fact by pointing

to the small pile of what she referred to as confidential (personnel) documents on the desk. She stated that these were to be better managed by keeping it in a file cover to maintain a degree of confidentiality, respect and administrative order. She said it was disturbing to the spirit. In describing the term psychological climate, Armstrong (2006, pp. 244-245) indicates that people's perceptions of a situation give it psychological significance and meaning, and suggested that friendliness amongst others could be a key environmental variable that influences the psychological climate.

This study also identified the need for information disseminated by ANMs at the provincial health-care settings to occur in a manner that demonstrates consistency so that they all 'speak with one voice'. The application of disciplinary steps was also listed as being inconsistent, an area where things can be done better. The participants who raised these matters felt that if this expectation was achievable, ANMs would be a bigger stronger team which in turn would be beneficial to other aspects of the work such as staffing and ratios. The consistency they desired also related to all shifts having the need for parity and equity in relation to nursing numbers. The following in this regard was said:

"… so I dream of one each day that we speak out of one mouth, all of us do the same thing, and no one you know… that there be some people favoured whilst others just get into trouble …and then that we can become one even bigger team, and a stronger team, and that really that they will look after us in the sense of personnel: patient ratio, the amount, the ratio because this is real" (II P23).

From the findings of the sub-category regarding the desire for *enhanced interpersonal relationships and unity between shifts*, concluding statements were made (Annexure X).

4.5.4 KPA 2: Design

OUTPUT: Initiatives for the future in the KPA human resources

This study found that, initiatives or best/ ideal expectations for the future in relation to the KPA HRs, involve team work.

4.5.4.1 Sub-category 2.5: Team work in relation to human resources

AI, the underlying philosophy of this research study upholds team work. Grandy and Holton (2010, p. 178) who made use of AI in their research, that was aimed at initiating change in a business school, found that the experimental nature of AI promoted a collective group vision. The use of AI was also found to have assisted with the exploration and discourse amongst the participants of their study, whilst it encouraged cooperation within and strengthened team work

(Grandy & Holton, 2010, p. 178). The ANMs in this study indicated that nursing staff held the belief that team work required more staff. An ANM in this regard verbalised:

"…what we hear all the time from the staff. If only we had more staff! And I keep saying to the staff 'What if we don't get more staff and the situation is getting worse! How can we actually try and make the best use… find the best possible pathway to deliver the best possible care with the limited resources that we've got?' … and I think it's going to take a mind-shift …" (II P9).

Night ANMs working opposite each other at the same institutions had a special affinity for each other. Each had often made reference to the opposite night shift partners. The night ANMs perceived themselves and their opposite night shift ANM partner as a team, working together in managing HRs. One ANM asserted that team work personifies their working relationship. Despite the virtual contact the sets of night ANMs had with each other, the collegial relationship that existed between them because of their common night shift platform was their reality. This confirmed the AI assumption in Chapter 1, that what people focused on became their reality. Another set of night ANMs independently shed light on how they would help each other out and expressed their commitment to being partners to, or part of various other management teams. In this regard, the following was said:

"Yes, once a week we work together, né and phone each other, we actually work nice, it's nice working with her …" (II P1).

The night ANMs in the general hospitals of this study cluster of provincial health-care settings viewed themselves and acted as team players when the work demands in the hospitals' trauma department required 'extra hands'. The following was said by a night ANM:

"I'll see how many people must still go through the Triage? Is there enough staff there? I myself sometimes land up there also where the need is. So even if I'm in a Manager post, I still have that, that I want to care for a patient, so I will... I don't mind -finish the patient off (do that which is necessary)*, give his medication, put up a drip and take him to the ward …"* (II P28).

Another experience shared with regard to the night ANM management of HRs shortage was verbalised as follows:

"We go out, we help each other, we try.... Sometimes it is difficult especially when one... sometimes we had four or five people absent simultaneously, so you really have to cut. You must cut, you must look how many patients are there (referring to one area) *tonight, looking at your main areas like for instance your labour ward that you must cover, your casualty area which is you busy areas. Uhm -your theatre cases, because we have a night theatre so you must ensure that the cases and stuff are done by the night theatre. So that is really how we accommodate each other"* (II P27).

The ANMs also had an appreciation for operational team work and workload and believed that the importance of team work can be demonstrated:

"Now I still find it very difficult to keep my distance from nursing as 'nursing care' but it's a fulfillment for me so I go down to the Casualty, I evaluate -I see how many people are waiting for doctor, I go check how many doctors, I ask the doctors also … 'who's the casualty officers on tonight…?', then I'll rearrange …" (II P28).

Feather, Ebright and Bakas (2014, p. 131) in a study on professional nurse satisfaction and nurse manager behaviours, identified the importance of the visibility of a manager in the unit, showing an interest in others' needs, having an awareness of their workload and the willingness to help in any way possible. The ANM on the night shift articulated how she often provided assistance for staff:

"But when I'm finished with my ward-rounds (night rounds), *and I've seen the patients has been sorted out there, there's enough staff, then I focus on the emergency unit"* (II P28).

This statement also confirms the AI assumption in Chapter 1, that what is focused on, becomes reality. According to Dever (2010, pp. 102, 118 & 137-138), the importance of nurse manager visibility as repetitively stated in her study, was effectively a function of the nurse managers' ability to coordinate all nursing unit activities, and be attentive to the patient and staffing needs at any point in time. Official documentation from the study province supports this (Department of Health, Provincial Government of the Western Cape, internal memorandum, ref. 16/4, 2016a). A cross-sectional study that investigated perceived nursing leadership practices stated that nurse managers who worked closer to the staff were rated more positively as opposed to nursing directors who did not (Eneh & Vehviläinen-Julkunen, 2012, p. 166).

This attitude was in line with the C^2AIR^2 values of the Provincial Department where the study was conducted. Each worker is required to demonstrate care, competence, accountability, integrity, respect and responsiveness (Western Cape Government: Department of Health, 2011; Western Cape Provincial Government (Budget Speech), 2012, online; Western Cape Government: Department of Health, 2015). The following single statement of an ANM encapsulates these values:

"…you see, and I have to leave everything and I do, go whenever there's an emergency …" (II P17).

In a study using 1,432 patient discharges, the relationship of collaboration and teamwork between Intensive Care Unit doctors and nurses, and patient outcomes found that improved patient outcomes were associated with nurse-reported greater collaboration between medical and nursing teams (Coombs, 2004, p. 17). No association of collaboration with doctor-reported echelons was reported. These findings of key health-care studies on collaboration identified how differently doctors and nurses interpreted collaboration as well as the lack of interest in collaboration by the medical fraternity (Coombs, 2004, pp. 17-18). Contemporary health-care has come to depend increasingly on teamwork by means of developing inter-professional teams. A health-care philosophy grounded on such interdependence and mutual respect might prove challenging in practice (Coombs, 2004, p. 18).

The HONs and ANMs believed that ANMs ought to be included in the meetings of the hospitals' top management team. The American Association of Critical-Care Nurses states that the voice of every team member is important in acquiring the common goals in health-care. When team

members are heard, others are empowered and respect is conveyed. In this way individual differences can be integrated and competing interests resolved. When member voices are heard, it safeguards their crucial essential contribution to achieving optimal outcomes (Vollers, Hill, Roberts, Dambaugh & Brenner, 2009, p. 23). The Clinical Nurse Advancement System, an institution that holds nurses accountable to a standard applicable to all clinical practice, points out that true collaboration as an unconditional component is required for health-care teams to be enfranchised holistically and for its independent members to achieve 'working together as partners' (Vollers *et al*., 2009, p. 23). The ANMs derived pleasure from team work:

"I really enjoy my work… and here we work together. We work in a multidisciplinary team. We work with all the other teams. We attend their meetings; when they need us, we there. We've got committees that we work with" (II P2); *"I am very happy and… it is an enjoyment for me to come and work. No this is really as I say 'such an enjoyment' for me. It is what makes it a pleasure for me is that I am in such close contact with the patients"* (II P23).

The success of an organisation is based on the motivation and professionalism of the staff. Professionalism and motivation is maintained when staff enjoy their work, and feel that they are important team member and for the organisation (Partanan, 2014, p. 4). The ability of the ANMs to work well in a team with the other disciplines whilst they could still execute their own required work performance was commended by the HONs. In this regard the ANMs expressed a sense of ownership for being regarded as co-clinical partners leading to success and assurance in quality of clinical care because of the inclusiveness maintained by the hospital clinical teams:

"Oh, the QA -every quarter actually, she is keeping M and M meeting that we go -all our operational managers (ONMs) *are going to that. Actually the whole team, the doctor, and everything and what we do there -she discuss patients… from patients that died… that is a whole list that she goes through* (i.e. QA checklist), *its quality issues that we discuss. We put strategies in progress and then we evaluate the strategies"* (II P2).

The ANMs also believed that their positive team spirit and attitude led to success and to team relations to the extent that the staff would freely call on them when in need in the working situation. The following as verbalised illustrated the approachability of the manager and the willingness to assist with team work:

"I mean, you then build up a relationship with your people and they know at any time they can say Mrs. ANM here is a crisis here now… we go out, we help each other, we try …" (II P27).

A night ANM related success to working so directly with and forming close working relationships with the Head of the Institution, and the Heads of Medicine or medical sub-specialties as well, during the after-hour and night shifts despite the anomalies. The following was said:

"Ja, it's sometimes a bit tricky. Some decisions you are allowed to do, others you must first take to the CEO. Well these days it's not her, but it's the people who are standing in for her as 'SUP' (referring to the term 'Medical Superintendent')*, the doctors are also to be consulted …but in general, we have a very good relationship with each other …"* (II P26).

Team work is said to be beneficial when there is a change from 'management' to 'leadership' as team members distinguish and prosper in the scope and supportive atmosphere that is afforded them (Baker, Peacock, Cozzolino, Norton, Joyce, Chapman & Dawson, 2009, p. 286). In nursing HRs management, the coexistence of authentic leadership and a successful nurse advancement system has a beneficial affiliation and lends itself to teamwork (Vollers *et al*., 2009, p. 25). An aspect advocated in such an affiliation is the psychological engagement of employees by 'authentic' leaders, said to lead to a healthy work environment. On the night shift all the staff would take direction from or account to the ANM (the matron) including the doctors, making the engagement and the commitment a team or co-partner decision. A small sample study at UK hospitals that looked at the relationship between HRM practices and organisational performance that included quality of care in health-care settings found that a strong relationship existed between HRM practices and mortality. It was however teamwork and the superiority of training strategies that related to patient morality (Shaw, 2006, p. 2). A night ANM indicated her success to a team work and hence team spirit at night, even though the nurses worked in various departments in the hospitals. The researcher observed the collegial manner in which she spoke to the staff and endearingly referred to them in the Afrikaans term as *'volk'* (folk). One participant stated:

"The volk work as a team, and not as a department. Because we are on the night shift, it works like this: we have three -there are only three people in a department … I am referring to a ward with 28, 30 patients… then there's only three…-the sister, the staff nurse and the nurse or a student or a nurse aid. And they know -each individual knows what is expected of him and each one does (emphasised - field notes) *his part …"* (II P23).

Despite the night nursing staffing pressure, the ANMs were proud of the positive team efforts and outcomes:

"There is lots of positive feedback -sometimes complaints still come. There are still complaints, but they aren't major complaints, things that we cannot resolve. So - the team is oiled well. The machine is rolling very well. So that is for me so much so that there are only few where there now really are problems, such that requires reverting to disciplinary action and such things. So that is one thing about these guys, when they work, we really work well as a team" (II P23).

In a nursing managerial situation at one health-care setting where the team consisted of the HON and two day shift ANMs, they said that a particularly close working relationship prevailed:

"…the communication between Mrs. HON Hospital No. 10 and Mrs. P24 (the other day ANM) and myself, you know -the team is quite solid because if the one isn't here then the other one can run with whatever there is …and we know what everybody is doing, each other are doing, so you know …" (II P25).

On the night shift, relationship with colleagues is more co-operative, intimate and profound on the night shift. Difficulties, concerns and fears are shared (Zannini, Gritti, Martin, Palese & Saiani, 2015, p. 261).

Another night shift ANM described the sentiments of the conversation she would have with a nurse on the first night of the shift:

"And adaption is always required, but we - it is going well. When we get to our change-list for the month, then the first night we sit with the people when they start to work (the night shift)*, it's then that 'jy voel voel makaar'* (referring to a human means of adapting to each other by almost putting out feelers, one for the other) *but as the month ticks on …"* (II P23).

An appreciative outlook, personal understanding and an engaging manner also facilitates change and allows growth of a greater force (Baker *et al*., 2009, p. 285). The AI dialogue opposes obsessing about rift-causing problems that needs to be followed with a remedial plan. Team building is enhanced by the AI conversation. This conversation builds on positive ground work that inquires about what is working well, and what the desire is for things to be better. Such exploration allows for the growth of greater energy. This is pursued by the exploration of how things could be better and what actions could be taken to realise what is desired (Baker *et al*., 2009, p. 285). The competencies of working well in a team and communicating have also been identified as essential for nursing recruits (Wood, 2014, p. 529). Whilst having to be the night shift leader, a night ANM made purposeful effort to have her shift-mate, a staff nurse, skilled. She stated the following:

"Me and her work in the clinic and we have decided to empower her so much that she actually do the hospital's medication with me so that if I should be called away on an emergency, the service doesn't die down, she can still give the medication... and she's quite competent, when I'm with the medication, she manages the emergencies… so it's not only me that gets called, the staff has now learnt that they can call her -they trust both of us and they can -if there's an emergency, either one of us can go" (II P22).

Shared decision making processes in the sphere of team work, have been advocated to involve nurses and nurse leaders on the management of nursing workloads for healthy work environments. In regard to workloads, a night ANM stated:

"What else is there that happen in the night? (conveyed excitement; rhetorical question - field notes). *There's sometimes such a lot of things. And sometimes it's not so...serious things but it do happen that it can lead to a serious thing … not every night the same* (using a high tone of voice, with conviction - field notes) … *and it's not quiet at all, always things happening, challenges, doctors that need help …"* (II P28).

Shared team decision making allows for a greater sense of pride and fervour, and an increased perception of professional autonomy and independence (Macphee, Wardrop & Campbell, 2010, p. 1018). In this study team working relationships that had consolidated over time such as that of ANMs-HONs, were described with a sense of pride and satisfaction. Macphee *et al*. (2010, p. 1018) note that through shared decision making there was an agreement on using constructive communication to resolve issues as the regard for teamwork was paramount. The significance of each member to team work was reinforced. A hindrance to the significance of such desired team work was linked to individualism amongst ANMs:

"We are working for the State; we work together, even though we are in different …" (II P13).

The night ANMs pointed out that the crucial working bond was needed between the position of night team ANM and the day team ONM, because of the direct working relationship required for

purposes of communication and having to work well together to deliver work performance. The ANMs were generally pleased with the structured interaction they had with the ONMs, the operational leaders in service delivery. From the findings of the sub-category of success in *team work* in relation to the KPA HRs, concluding statements were made (Annexure X).

4.5.5 KPA 2: Deliver

OUTCOME: Commitment to deliver work performance in the KPA human resources

Commitment to deliver work performance in relation to the KPA human resources, involves: (1) increased managerial involvement and support and (2) adequate staffing resources/ need for enough staff.

4.5.5.1 Sub-category 2.6: Increased managerial involvement and support, in relation to human resources

Involvement of the executive and lead or higher-ranking managers must be clear and noticeable (Sole, 2009, p. 7). In the context of this study, ANMs are also seen as high-ranking managers. Most have however as indicated earlier, taken up managerial post without formal training. As a consequence, HONs noticed that ANMs needed a lot of support and training after having assumed these positions:

"They would at the most need different courses" (FG1 P3).

Elsewhere it was also found that a number of nurse managers with minimal managerial expertise and leadership talent took up their positions based on their clinical expertise experience (Zori & Morrison, 2009, p. 76; McCallin & Frankson, 2010, p. 319). The HONs stated they therefore needed to take on the work of the ANMs and were required to offer a lot of support, teaching and training. For sound organisational performance it is therefore imperative to appoint the right person to the position of a nurse manager and also to retain good quality nurse managers. This cadre of nurses is regarded as indispensable to aiding excellence in nursing practice, staff nurse engagement and patient satisfaction. They are also responsible for building and supporting an environment that develops staff nurses into leaders (Espinoza, Lopez-Saldana & Stonestreet, 2009, p. 327; Thompson, 2009, p. 50).

The ANMs stated that they were committed to paying greater attention to the ward situation. They expressed the desire to have fewer distractions in the work setting so that they could give more support in the ward in the form of time and the ability to assist with the work. A belief also existed that if the need to attend meetings were fewer, that they could indeed fulfill their required ward support role. They also expressed their need for support to in turn be supported. The ANMs said:

"I would think that there should be other support so that I as an Assistant Manager can give more attention and have more time to be in the wards" (II P14); *"... To be more hands-on around here as opposed to be managing only from this side ..."* (II P16).

The HONs though, recognised that it might be that ANMs were too overwhelmed with everything they were expected to do in fulfillment of their KPAs. This included the assistance needed to be given to the ONMs and therefore they (ANMs) could not give sufficient attention to the more strategic work performance issues. Sherman and Bishop (2007, p. 295) state that, too frequently, nurse leaders have '*fallen into'* their posts rather than having chosen to take on the nurse leadership career.

As the ANMs related their perceived need to support and motivate, they also made reference to having to remain positive despite the service pressures. An ANM revealed that she regularly needed to go into the wards to contain and appease the nursing staff, who were dealing daily with aggressive and violent psychotic patients in overfull wards said:

"... and all I can do from my side is to say..., is to try and stay positive against all the odds..., is to support the Nursing staff..., is to try and manage the absenteeism by supporting them (i.e. the staff) *..."* (II P9).

The uncertainty in the work PM system in which the ANM worked and which had led to unhappiness is also pointed out in the background to this study. McGuire and Kennerly (2006, p. 179) stated that the onus is on a nurse manager to be involved and transformational, a leader who is able to craft a positive work environment that lends itself to a happy workforce. A night ANM described his involvement in coaching nurses who were doing the bridging courses, for an hour before his night shift starts. He would bring his own books and innovatively allowed for sought-after learning that in turn allowed the health-care setting to be seen as a learning organisation (did not want to be recorded - field notes). Although learning organisations may present differently depending on their context, a common thread shared by all learning organisations is that they demonstrate their potential that enables innovation in hospitals (Soklaridis, 2014, p. 831).

The role of the nurse manager is an exciting one. If the process for changing the first line nurse managers' role is not sufficiently prepared for and supported, the lack of clarity will continue to persist and will result in an inability to develop this challenging role (Johansson *et al*., 2007, p. 50). Therefore, ongoing support from more experienced managers is also needed in the development of such a role. The HONs in this study added that the expression of managerial involvement and support ability of an ANM is someone who can support others. There was a commitment from the ANMs in this study to support. The following statement was verbalised:

"...continuous support and guidance but as I say, they need that buddy" (II P19).

Some HONs especially from smaller hospitals, where there were two or less ANMs on the day shift, supported a peer perception at their hospital that this cadre ought to serve on the executive management of the hospital, as support to them. The HONs expressed commitment to support

initiatives that might have been delegated to the ANMs by the Head Specialists or the FBUs where the former had accepted the task/s. There was acknowledgement for the extent to which ANMs have grown in understanding their 'support to the HON' role. Such managerial involvement from a HON stimulates employee motivation, accountability, learning and problem solving and contributes to a culture of PM (Sole, 2009, p. 8). An ANM on the night shift at a rural hospital, explained how as a means of support he would facilitate a short prayer session in the mornings at 05h00, especially at the time when school examinations were being written, to pray for the success of their children collectively who were writing exams. He reported that this initiative was most welcomed by the staff and resulted in nourishment of workplace spirituality, which he perceived to be part of a nurse managers' duty. In relation to managerial involvement and support, Rego, Cunda and Souto (2007, p. 163) considered that: (1) people want to reach their potential fully as complete human beings, irrespective of whether its related to the job or not; (2) people desire to perform meaningfully at work; (3) making money is not the most important aim for most people at work even though it is regarded as important; and (4) organisations that are seen to be more spiritual, are also perceived to be more profitable. An ANM in this study reported that he felt connected to his people (staff), and offered managerial and spiritual support to staff who, lives in his home vicinity, and have lost a family member/ experienced death in the family, by going to their homes to sympathise and leave them with a spiritual message of hope. He considered these as his abilities to render these services as a human resources management skill. According to Chase (2010, p. 51), human management skills of a manager is an important area of competence. The success of health-care projects is not only enhanced by the education and training a manager undergoes but that nurse managers' high emotional intelligence and understanding of spirituality in the workplace is significant (Suhonen & Paasivaara, 2011, p. 1029). Managerial involvement and support, a priority practice for all managers inclusive of nurse managers in the WCP, were requested to show *'visible leadership'* in the attempt to offer staff more support (Department of Health, Provincial Government of the Western Cape, internal memorandum, ref. 16/4, 2016a). From the findings of the sub-category on *increased managerial involvement and support* in relation to HRs, concluding statements were made (Annexure X).

4.5.5.2 Sub-category 2.7 Adequate staffing resources/ need for enough staff in relation to human resources

At hospitals and provincial health-care settings, personnel (health workers) are regarded as the main resource, having the most profound effect on overall performance (Henderson & Tulloch, 2008, p. 2). Staffing levels are also considered to be one of the most fundamental factors affecting the quality of nursing care, having a direct bearing on patient care. It was stated:

"Staffing…, it's the shortage of nursing staff. We know that it is a widespread problem. It's not only centered on Hospital No. 5… these CSPNs (referring to Community Service Professional Nurses)*, they fill such a huge gap… We are complaining about the sisters you know that they lack that certain responsibility or accountability"* (II P19).

The commitment of the ANMs, in search of service delivery, involves having identified the need for enough staff (staff ratios). An ANM verbalised the following:

"… ok, my very big dream for my wards is that they are staffed properly" (II P15).

Inadequacy of staff does not only hamper the rendering of planned care, it also allows for human error that could compromise patient safety (Numata, Schulzer, Van Der Wal, Globerman, Semeniuk, Balka & Fitzgerald, 2006, p. 436). Ridley (2007, p. 439), who linked nursing workload and quality of care in child and adolescent mental health in-patient services, concluded that the benchmark for nursing staffing should improve to ensure a therapeutic milieu and meaningful outcomes in quality of care. Staffing should be calculated per occupied bed for each shift. If the patient dependency was to have increased, whilst the number of nurses remained the same, the 'therapeutic milieu and quality of care' was likely to have been compromised. Peculiar to this situation where the number of nurses dropped to below eleven per day, the *"not enough staff issue"* would be raised, which identified 'a less than satisfactory therapeutic milieu and quality of care'. This implied that the adolescents did not get the quality standard of care to obtain a certain level of recovery and timely discharge. Significantly this resulted in the inability of other adolescents to access the treatment they needed (Ridley, 2007, p. 439). An ANM verbalised the nurse-patient situation as follows:

"…with more personnel…we really need more personnel. At the moment, okay, what we have currently --There's one adhoc nurse (a free nurse on orientation) *… in a ward of 33-36 patients that I could use in the case of needing to give specialised individual nursing care to any one patient …"* (II P27).

A night ANM from a general setting, almost repeated verbatim what her peer had stated (above) in regard to their need for more staff:

"So this is the big dream that there will one day be enough (raised her voice and emphasised this point - field notes) *nurses in each division* (department) *to ease the load just a little bit on everyone… we must just have more personnel on night shift"* (II P23).

Ridley (2007, p. 439) points out that burnout amongst nurses is a precursor to voluntary attrition, and results in valuable ward skills and expertise being lost. Invariably the 'therapeutic milieu and quality of care' become inefficient with a distortion in workload at times in relation to the number of nurses. In this regard, the participating HONs conceded that ANMs were required to do the work of the ONMs. They verbalised the following:

"But sometimes what happened now is that they (ANMs) *have got so many other tasks to do, that they because of the load, nurse-patient ratio and the OMs* (ONMs) *and the ADs* (ANMs) *didn't fulfill their tasks…. The HON has much more to do"* (FG2 P2).

Hence the assertion; *"Nurses play a vital role in health-care provision"* (Browne, 2012, p. 2). There was a plea that when staffing norms are decided on in the future, that scientifically determined appropriate staffing norms in the psychiatric field be sought/ applied:

"…because we have really… I've got a very big problem and I... my dream is … it is a dream because we've been asking it for years that in Psychiatry there must be a scientific way of putting out staff ratios …" (II P15).

Ridley (2007, p. 439) found that the practice of increasing the nursing numbers by hiring more nurses and depending on their good will to work more hours when the service needs increased was not sustainable for more than a few weeks. Based on the significant portion of nursing categories collectively comprising the staff component of the Health Safety Environment at the end of 2008, the WHO gave credence to the important and instrumental role nurses play in providing health-care in any country. This recognition by WHO drew attention to the fact that there has to be an investment in adequate nursing staff numbers and suitable HR policies and practices. The WHO reiterated the vital role needed to be played by HR managers who advocate and enforce sound HRs policy and practices at provincial health-care settings according to the Integrated Employee and Well-being Strategy 2009-2014 (Browne, 2012, p. 2). According to the study conducted by Browne (2012, p. 20), management found that when all leave demands are met, there is insufficient staff to deliver the basic services. Gopee (2003, p. 162) further found that when staff need to be released from duty to attend training as part of continuous professional development, the gap necessitated the workload to be shared by the remaining staff. The night staff indicated the need for such relief staff (complaining - field notes):

"They say I must identify whether there is a need (training need) *but now you have the need, you cannot accommodate the person in your working time who is coming to do the training, as the patient would then be waiting ---, and we must get to the patients... . So that more relief staff is given to the night shift, so that these people can receive in-service training more so on a continuous basis, in order for in-service training to happen as it is mostly the day people who receive in-service training because they are invariably more, they get the opportunity to receive in-service training"* (II P23).

An ANM on the night shift at a health-care setting for persons with intellectual and physical disability indicated that delivery in performance required the services of other members of the multidisciplinary team to be in support of the nurse-driven management of such a health-care setting at night. She advocated for the accessibility of the essential services of a doctor and social worker during the night shift period. In this regard, the following was vehemently stated:

"... 24 hour access to our hospital social workers, our hospital's doctor, *because at the moment until 8 o'clock* (20h00) *we have our doctor, and from 8* (20h00) *till 7* (07h00) *tomorrow morning we don't have a doctor, we've got to phone Hospital No. 8* (the bigger psychiatric hospital about 3 km away - field notes)*"* (II P22).

As part of ANM commitment to deliver in work performance they indicated that their added need and sought services was to assist nurses and other staff members when adversity was

experienced during the night shift. Even though they perceived their capacity in this regard to be limited, the ANMs described their own attempts to deal with situations of an emotional nature:

"We've got no emotional support for the staff if they get injured and … my knowledge is quite limited but I need to step in" (II P22).

Musker (2004, p. 84) notes that failure to provide emotional support was unhelpful clinical behaviour. Where inner aspects of the staff like emotional well-being are supported, a strong team sense of community will prevail. It is a sense of feeling respected and appreciated as valuable, intelligent, emotional and divine beings as opposed to leaving staff feeling like mere 'commodities' (Rego *et al*., 2007, p. 166). In the commitment to deliver work performance the ANMs also related to presenteeism as a resource and that attendance, absenteeism, punctuality, and productivity were seen as factors that could influence the resource availability. In this regard, late-coming was viewed as absenteeism (limiting resources) and thus a limitation to commitment to good work performance. One ANM stated:

"There was a staff member that came late - every night half past seven (19h30)*. I told him… 'You're not productive. You know late coming is part of absenteeism'"* (II P1).

The sentiments of Cowman and Keating (2013, p. 380) support this nursing managerial stance. They asserted that high incidences of sick leave absence at hospitals are resource burdens. Conversely therefore, the active management of absenteeism translates into better resource management (managing absenteeism is discussed in more detail in Section 4.6.5.1). Reporting on a paediatric intensive health-care setting, Foglia (2008, p. 201) indicates that the shortage of HRs had become a persistent problem that amplified staff turnover. In this regard HONs were committed to manage resources differently and be innovative in the future for service delivery. Such innovation includes the ANM being a potential teaching resource:

"And I'm also thinking if they can get to that point, they will be more of a resource … what kind of a resource shall I call it? Even a teaching resources at a slower pace and decide this is what I'm going to tackle for this period whether it's clinical, whether its administrative, whether it's about whatever …" (FG2 P1).

From the findings of the sub-category of *adequate staffing resources/ need for enough staff* in relation to the KPA HRs, concluding statements were made (Annexure X).

4.6 KPA 3:
THE BUSINESS UNIT AND MANAGING FINANCES

4.6.1 KPA 3:
Understanding the KPA the Business Unit and managing finances

The term Business Unit in this study is synonymous with the term the Functional Business Unit (FBU) model referred to by the nurse manager participants in this study. The understanding of the key performance management areas of ANMs relates to the Business Unit and financial management. It is within the Business Unit that they work with finances and manage the allocated budget. The world of economics is re-writing and re-designing health-care in order to gain efficiency and for rationalising services (Bergin, 2009, p. 59). Based on the literature, Russ, Jones and Jones (2007, p. 9) refer to four layers of strategy in organisational strategy levels, and distinguished them as: (1) Operational, (2) Functional, (3) Business Unit and (4) Corporate, the central point being the Business Strategy Unit. This research established that the FBU performance experience of the ANMs involved all of these levels to various degrees. This study also confirmed that the FBU comprises of a cluster of more or less homogenous wards at a hospital or health-care setting according to which administrative and clinical processes are conducted. The ONM who reports directly to the ANM is the lead nursing managerial of the ward (field notes and researcher experience). In this regard, the ANM understood the role with regard to FBU and financial management as overseer. The sentiments of one of the ANM follows but the sentiments of the others were similar:

"…our KPAs are operational and strategic management of the FBUs …" (II P18).

The FBU identified in this study could be seen as a microcosm of the bigger hospital where the systems of various hospitals are joined and economies of both scale and scope were achieved. In describing the moderating role of the hospital system membership in the context of systems affiliated hospitals, Chen, Preston and Xia (2013, p. 398) note an amalgamation, where independent hospitals were attracted to join their systems (Lovrien & Peterson, 2011, online). The multihospital system model featured two or more affiliated hospitals that could potentially be physically separate from each other, owned and managed independently, being linked (Chen *et al*., 2013, p. 398). This system varies in overall tactical management, promotional accent, ownership, span of work performance and size. Empirical studies however conducted more than two decades ago, had already indicated that the conventional belief was held that hospital membership affiliation to the multihospital system received considerable performance rewards as

compared to those hospitals that were not part of the affiliation, rewards perceived to have resulted from the 'economies of scale' (Chen *et al*., 2013, p. 398). In this manner, hospitals with matching systems would be strengthened by working together and attain cost savings, development of new services and in the provision of managerial input (Chen *et al*., 2013, p. 398). Such amalgamation facilitated 'economy of scope' because when merchandise or services produced by various business units which were sufficiently similar to each other integrated their expertise, more revenue was earned, prices would be set more effectively and access to capital markets improved. In this regard the application of economy of scope seemed apt in multihospital system as some hospitals offered general services whilst others may offer more specialised services (Chen *et al*., 2013, p. 398). The FBU identified in the context of this study consists of a number of individual homogenous wards having diverse service foci that were sometimes referred to as cost centers. One ONM would head one or two wards within the FBU (field notes). In the context of this study - the employer, the Western Cape Government DOH describes this system as a *'person-centered health system'* (Western Cape Government: Department of Health, 2015).

The implementation of the FBU model in hospitals and health-care settings in the WCP where the study was conducted was conceptualised and operationalised by the previous provincial Head of Health. The roll-out of this implementation had occurred in phases when over a period of time the bigger academic hospitals were first introduced to the BU model and much later followed by the psychiatric hospitals. An important aspect of this model is the information it accrues and the sets of data that can be accessed by the manager of the BU which is understood to aid clinical efficiency. The budget is however exclusive to the BU (Household, 2015; researcher own experience). The understanding of Peregrina (2009, p. 19) indicates that although countless responsibilities have now been included in the performance sphere of a Nurse Unit or ONM, the participants of this study stated that the focus of FBU management has shifted to finances. This was in keeping with the intended operationalisation of the FBU model conceptualised by Household (2015), which he said is driven by money. Managing the FBU in accordance with stringent financial measures had therefore become an imperative. In this regard the ANM has taken on a financial governance role within the FBU that confirms the AI assumption in Chapter 1. The focus the ANM had on managing finances in the FBU became their reality:

"I just have something to say, with Hospital No. 3, each Area Manager must control their (his/her) *own budget. It's allocated, you've got your overtime, agency -- your own recruitments, selection -you must do it yourself"* (FG2 P3).

A major more recent challenge for health-care staff is with having to manage the monetary control that has emerged along with good financial governance, yet as a consequence, it also rationalised services. The ANMs in this study worked in FBUs with its ring-fenced budget allocation:

"And of course it's now the FBUs. Each one has certain (amount of) *money. And all of them are trying to stay within the budget. All are trying to stay within their budget and so on, so doctor* (referring to the CEO of the hospital where she works) *cannot appoint more doctors then they'll say he's over his budget… and then he will also get the wind* (deterrence) *from up theeeerre from the Head Offices and so on …"* (II P27).

The financial accountability therefore did not only lie with the doctors. The ANMs took up financial responsibility within the FBU. Both the ANMs and the HONs spoke of the management (including negotiation and collaboration) of their FBU monetary allocation whilst still having to ensure optimal operational functioning of ward units and service areas. (ANMs described the financial management domain in a manner that almost ensured that it was not to be overlooked - field notes). Within the framework of the FBUs, the Nursing Departments at the various researched hospitals managed their budgets both centrally or de-centrally. The ANMs and HONs stated:

"Ours is still a central budget in the Nursing but we all sit together and say this is the overtime budget that we have. In terms of this budget, if we divided into quarters, how much would it be… and out of that, how many professionals on their salary can you call out per month, how many nursing assistants, how many this…, so we do it …" (FG2 P1);
"Ok, we at nursing we've got the own budget in the beginning of the year like in nursing we've got 7660 (rands)*, now then we come together and we discussed… the AMs, the Deputy Manager…. Now we look at the previous budget say for instance we take three years right, Area S – 'you used a lot of your budget, you running out of your budget last year' but there is reasons for that, so we divide the budget, 'Area S you've got more than the Area G'. We've got the G-type wards and three S-type wards. Right so you know the basic minimum and maximum levels in the ward …"* (II P2).

The use of the FBU is well-known in private sector and in many commercial enterprises for many years where the Medical Manager is accountable for the expenditure. This model can be likened to small semi-autonomous business entities. The FBU model is well-known for its means to de-compartmentalise its business activities from the higher centralised component in order to give ward units and/ or operational managers authority, although not autonomy entirely. This implies that there is a shared accountability for managing the results or outcomes of an FBU. The concept of the FBU is a business idea that promotes inclusivity. The FBU is a governance model for the doctors who propel and incur expenditure, in order to make business decisions, and then agree on the cost-related business output/s and also lead in this regard (getting everyone else to follow - field notes) (Household, 2015). The ANMs invariably work in the FBU structure within the health-care system where they are employed and illustrated their shared responsibility in this regard:

"Now with us the Assistant Managers is for the two FBUs, Clinical FBUs. They're the Deputy Chair persons of the two Clinical FBUs" (II P9); *"… because I am a sub-FBU Manager, so once a month I have a FBU management meeting with the entire team, from the cleaners to all the people"* (II P13).

The ANMs are simultaneously subjected to another chain of command and therefore allowed a different degree of autonomy within the FBU. Some of the HONs in this study described the matrix situations with regard to the FBUs, indicating that a good work relationship has developed between the ANMs and the doctor (referring to the Head of the FBU). Based on the well accepted premise that nurse managers (referring to the ANMs of this study population) account or report directly to executive nurse managers (referring to the HONs in this study), the ANMs in this study were found to be simultaneously subjected, since the inception of the FBU model, to another chain of command, namely to the Head of the FBU. The ANMs therefore had new-found autonomy and another route of accountability, one within the FBU (field notes). A HON in support of each other indicated:

"I find that they work very well with the other disciplines especially in my case the heads… like the Head Specialist doctors… ja, so they understand what is going on in that one's mind and where we moving towards …" (FG2 P1).

According to Household (2015), 'top' nursing managers at the time, in the WCP where the study was conducted, were uncomfortable with having to give up their authority in this regard. On the contrary, the HONs in this study who were not part of the 'top' Nursing Managers of the province did not seem averse to support the FBUs based on the relatively constructive way in which they engaged with the notion. They though perceived the night shift ANMs to lack knowledge on the FBUs and on other strategic nursing managerial aspects. This is because much attention and incidental learning on matters pertaining to the FBU occurs naturally during the day. Both the HONs and the night ANMs recognised that the night ANMs were far less involved in the budget as well as in matters pertaining to the FBU. From one of the focused groups, it was suggested that rotation of night shift ANMs from night to day shift might address their learning needs with regard to FBU matters.

A HON expressed the following:

"… no, no my Assistant Managers and I'm not too sure about yours, were specifically appointed and the posts were advertised as Night Duty posts. But I would have liked them to rotate on (to) *day duty, even just for a three months stint at a time. Just for them to get the exposure, and a feel of all the responsibilities on day duty, to get them exposed to the whole concept of FBUs …"* (FG1 P2).

A night ANM made the following assertion:

"… the 3rd one (referring to the key performance areas - field notes) *is management of budget and assets in the FBU …we* (night ANMs) *have very little to do with budget even though we still keep a look out for savings"* (II P18).

The ANMs were aware of both the broader national and the more localised provincial performance prescripts. They referred almost verbatim to the national generic OSD job description that required the ANM to take care of physical and financial resources (National Department of Public Service and Administration, 2007). The second reference was made to the broader provincial work performance domains for all health workers – financial management

pertaining to the recurring annual corporate governance domain (Department of Health, Provincial Government of the Western Cape *Annual Operational Plan* 2014/2015; Department of Health, Provincial Government of the Western Cape *Annual Operational Plan* 2015/2016; Department of Health, Provincial Government of the Western Cape *Annual Operational Plan* 2016/2017). In this regard the following was stated:

"…the Corporates which is the budget and all those things… but it's basically based on that …" (II P21).

Financial management was indeed located in the realm of corporate governance for most of the last decade as per the AOPs of the province where the study was conducted (researcher experience; Department of Health, Provincial Government of the Western Cape *Annual Operational Plan* 2013-14; Department of Health, Provincial Government of the Western Cape *Annual Operational Plan* 2014-15; Department of Health, Provincial Government of the Western Cape *Annual Operational Plan* 2015-16). For nurse managers, Peregrina (2009, p. 20) concurs that a prototype shift from clinical professional to having to manage the finances of a unit has come about. The role of the nurse manager further necessitates having to manage human and fiscal resources that would result in the most resourceful patient outcomes at hospitals/ provincial health-care settings. In this study financial management was also identified along with HR as being one of the two biggest key performance roles in the needed work performances of the ANMs. The ANMs indicated the following:

"My KPA is… It is more financial assistance. It is human resource and those type-a-things …" (II P11); *"… and then I have another KRA* (referring to the KPA) - *the management of human resource"* (II P2). *"Then of course there's the FBU which is a great big headache but anyway there's the FBU. You must see that they remain within their budget and if they go out* (meaning use more than their allocated amount), *do they have an explanation as to why they over expended …"* (II P3); *"… your QA and has an influence on your budget"* (II P3).

The ANM should be involved in all financial aspects of the FBU. The contemporary level of financial acumen required of the ANMs now further requires them to know the supply chain item classification system and how to share resources between where there is less and where there is more. The need to have knowledge about bed occupancy rate and its effect on the budget also featured as a financial imperative needing to be assimilated by a nurse manager. Another stated that her extended involvement with finances for the Nursing Department at the health-care setting she worked at was to have knowledge and manage compliance with the financial processes of hiring complementary staff which only she would sanction. She emphasised how effectively she executed this role:

"…so the human resource and the financial issues, I have a lot'ov input into that. Aah as I said, because my areas are not so patient related… 'to keep in the budget with the agency and the overtime …'" (II P11).

The shift undergone by an ONM from clinical authority to managerial supervisor has directly affected their required work performance and work performance accountability. The new

ONMs' work performance ranges from elementary management to successful leadership, complementing the FBU as it allows for devolved management and decentralised decision making, that facilitates and enhances health-care service delivery. Decentralisation and participative decision making generate a host of other novel work performance practices in contrast to traditional work practices where jobs are compartmentalised and have specific remunerative rates. Under those work performance circumstances, workers and supervisors were clearly distinguished from each other and decisions were made entirely by managers whilst communication followed the prescribed chain command (West, 2001, p. 46). The many and varied responsibilities of the Nursing Unit or ONM that was primarily geared toward having to ensure patient safety, monitoring provisions and goods, and working out duty rosters has changed to a more intricate role that includes being accountable and responsible for the type and quality of patients care (Peregrina, 2009, p. 19). An ANM working at a general (within the General Specialist) health-care setting verbalised his expectation of his supervisees -the ONMs, which was to swiftly internalise and lead the operationalisation of the FBU concept/ model and manage the budget. He stated the following:

"The other one (referring to the other KPA) *is the FBU because all the operational managers, FBU managers, so they must run with the FBU* (i.e. conceptually and operationally) *they must run within their budget, procurement of stuff, and that kind of thing"* (II P25).

There was a consciousness among the interviewees about the regulatory financial laws that prohibited and potentially criminalised wasteful expenditure. The overarching prescript within which all health-care managers are expected to function in South Africa is the national legislation of the amended Public Finance Management Act (PFMA) of 1999 (Government Gazette No. 33059, 2010, pp. 7, 37, 38, 41, 44, 48, 49, 52, 53, 61 & 64). In this regard, a number of ANMs stressed how necessary it was to work strictly:

"…according to the book" (II P4); *"okay now we divided that budget into four quarters, so you must see for the first quarter that you stay within that budget* (i.e. the allocated budget) *…"* (II P2).

Another re-emphasised:

"… so that we don't go over" (II P11).

The uppermost threshold of the allocated funding for these purposes was not to be exceeded. The ANMs seem to diligently strive to keep track of their expenditure for which they said they would be held accountable:

"And if you over that budget, you must come up and tell me (reportedly communicated to the ANM by the HON and supervisor to the ANMs), *what was the reason that you expend* (spend/ expenditure) *for instance did you increase in your acuity levels …"* (II P2).

An expectation a HON had of the level of financial acumen an ANM requires, was described as the ability to manage the 'nursing money' well ensuring that this money does not get 'lost'. The following was verbalised:

"… I'm thinking if you have an Assistant Manager who's got a good understanding of budgets, finances and that…, because that is where the crux ly. Now if you don't have that, all these other people --before you know they grab the money here and put it there and put it there …" (FG2 P1).

Peregrina (2009, p. 19) states that in keeping with developments in the health-care system over time, the role of the nursing unit manager likened to that of the Operational Nurse Manager (ONM) in this study has also changed. The role fulfilled by the ONM as depicted in this study, is comparable to the frontline management position described in Peregrina (2009, p. v). Generally in nursing, the hierarchical arrangement allows the lead nurse in the unit, the ONM to be in charge of the unit. The ONM is responsible for the administrative and operational unit management in addition to their established role of clinical management. The HONs in this study viewed the overseeing position of the ANMs, the target study population as having a crucial intermediary role between the HON and the FBU and operations. The establishment of the FBU model has though left some uncertainty with some of the ANMs. The following was verbalised by ANMs:

"I just wonder sometimes if there really is a place for an Assistant Manager because we now have Operational Managers in the ward! It feels to me as if I am just the medium between the Operational Manager, the ward and then HON. Because I mean the Operational Managers do everything. We only really have to do cooperation... the collaboration together …" (II P13); *"Yes, the Assistant Managers and the performance of Assistant Managers* - (there was a short period of silence and/ or thinking, then the ice is broken by someone saying something in jest; all group participants laughs - field notes). *You know what I think --I can't do without Assistant Managers. Me as Manager, as Nursing Manager, I can't do without Assistant Managers. They are a very vital link between the Operational* (i.e. the FBU level) *and the management team*" (FG1 P1) (others confirming, what fellow participant is saying by '*no's'* and *'mms'* - field notes).

ANMs are thus crucial to the workings of any health-care setting. They are the vital links between the management and the frontline staff in the FBUs. They influence the organisational environment by their throughput and output, and in turn the retention of nursing staff, all of which has been well documented (Keys, 2014, p. 97). Hospitals will not be able to operate if the roles of nurse managers are not played (Lin *et al*., 2007, p. 157). The position of an ANM is thus important. Concluding statements regarding understanding the *Business Unit and managing finance* (Annexure X).

4.6.2 KPA 3: Discover

INPUT: Best work performance experience in the KPA the Business Unit and managing finances

Best work performance experience in relation to the KPA the Business Unit and managing finances involves: (1) staff well-being and staff posts and (2) problem solving and conflict management skills.

4.6.2.1 Sub-category 3.1: Staff well-being in relation to the Business Unit and managing finances

A cross-sectional study in Shanghai related to nurse burnout and its association with occupational stress, found that most nurses showed a high level of emotional exhaustion, a moderate level of depersonalisation, and a low level of reduced personal accomplishment. It also revealed a higher burden of stress and burnout in nurses at younger ages, or on shift duties, or from higher grade health-care settings (Xie, Wang & Chen, 2011, p. 1537). In this study, the ANMs related success in HRM with regard to staff well-being. They described this as involving three areas namely: (i) prevention of burnout, (ii) EAP (nurse manager confidante and nurse manager crisis interventionist/ counsellor managerial supervision), and (iii) general support to staff well-being.

The Business Units at the psychiatric hospitals where some of the participating ANMs worked, offered acute psychiatric and longer term residential services, where in some instances in the latter, an aging population resided (Western Cape (Government) Health, Clinicom summary report, 2012; Western Cape (Government) Health, Clinicom summary report, 2013). In the male acute psychiatric ward units, the bed-occupancy exceeded 100% on an ongoing basis (Western Cape (Government) Health, Clinicom summary report, 2013; Western Cape (Government) Health, Clinicom summary report, 2014; Western Cape (Government) Health, Clinicom summary report, 2015). Patients who were aggressive, violent and psychotic were nursed both on conventional beds and on mattresses on the floor (Western Cape (Government) Health, Clinicom summary report, 2013; Western Cape (Government) Health, Clinicom summary report, 2014; Western Cape (Government) Health, Clinicom summary report, 2015). Elsewhere there were dilapidated work facilities where inadequate nursing staff had to also make do with inadequate medical equipment to treat patients who also suffered from AIDS. One situation led to the expectation that the nursing staff had to care for more patients than the hospital wards could accommodate and execute other tasks outside of their scope of practice such as floor cleaning and fetching linen (Smit, 2005, p. 26). The ANM participants in this study said they offered ongoing support to staff in the attempt to prevent or reduce burnout in staff because of the increased number of very volatile psychiatric patients and an increased workload so that staff well-being in the workplace was ensured. With conviction to staff well-being, an ANM from the psychiatric services stated the following:

"…Male Acute Section, because of our constant pressure, is constantly exposed to a lot of trauma… of things that might happen…, work-related. So it's the knowledge within myself that I know how to manage the trauma …" (II P9).

Another night ANM, in regard to securing staff well-being, said that she served as a confidante whilst also fulfilling the role of the supervisor. She stated:

"When they have problems, they speak directly to me. They ask me if I have any suggestions, how I can refer them. I would then refer them to ICAS" (the confidential independent counselling

and advisory service hired by government to do counselling and give advice with regard to personal, financial and legal matters) (II P12).

Smit (2005, p. 26) referenced earlier in regard to the deteriorated workplace, further indicated that the occupational stress of the staff working at the facility was exacerbated by the little or absence of support from the nurse managers and Hospital Administrators. On the other hand, the strategy embarked on by ANMs in this study, to be available to staff was proudly described as an aid to staff well-being. One said:

" ...and the more critical the situation become, the more alert I am to making myself visible at ground level ..." (II P9).

For ANMs who are also leaders, the ability to be responsive amongst other values, was regarded as vital (Kallas, 2011, p. 10). Responsiveness supports staff well-being (Western Cape Government: Department of Health, 2015). Kallas (2011, p. 10) reflects on the notion of the manager having a visible presence for the staff as a key factor to making a success in the nurse manager position. With reference to staff contact, the ANMs related that email as a means for communication was inadequate. Staff desired face-to-face contact. In a rehabilitative clinical situation, the night ANM depended largely on her own strengths and that of her immediate support personnel to aid staff well-being. The importance of being visible and responsive to staff well-being was illustrated by another night ANM who worked at a center for intellectually disabled persons. She related the following:

"A lot of our staff have been working years with me, so you start reading the body language, you come into the tea-room and the staff is busy on the cell phone and you ask '*Hi Hospital No. 1 Nurse, how you doing?' 'I'm fine* (described a blunted response - field notes)' *... and then you go through to the ward and you hear on his voice, he's a bit short tonight... voice is raised towards the patients* (voice of participant is raised as well…, seen as wanting to illustrate her point - field notes). *They don't feel like doing it really so they put the sheet half way* (on the bed) *and you know it's something at home that happened or they didn't sleep during the day ---you know it* (intuition - field notes) *like we picked up the patient's body language, we pick up the staff's body language"* (II P22).

The visibility venture noted by this night ANM in 2014 is congruent with an instruction issued by the Head of Hospitals in the study province in 2016 on required visible leadership. In regard to staff well-being, another night ANM proudly indicated that her best work experience included her ability to manage the entire health-care setting and support the staff at night when difficulties arose:

"Look that which we do on Night Duty ...with regard to everything that happens here is your responsibility. So if anything happens, you have your support in that regard ..." (II P17).

In a childbearing clinical situation the strategy of team huddles was implemented for 'multidisciplinary team debriefing', to support immediate review and evaluation of the post-partum hemorrhage occurrence and intervention. Following a standardised procedure, the huddle involves conversation that focuses on identification and feedback in relation to risk awareness, treatment and outcomes. The team participants identify what went well and what the

opportunities are. The debriefing outcomes indicate that potential solutions are frequently produced directly at the point of care. Using filled-out feedback scripts from the debrief, an analysis is carried out by the Clinical Nurse Specialist and the nurse manager within 24-48 hours in order to offer further evaluation, assess systems issues, and support quick improvement. The strengths and opportunities as a gauge of progress are tracked. Additionally, in an appreciative spirit, the process allows for a celebration of positive team response and growth (Hansell & Kirby, 2015, p. 46). An ANM, who participated in this study, was of the opinion that the nursing staff yearned for an increase in staffing numbers to mitigate risks, as they (ANMs) constantly heard:

"If only we had more…!" (II P9).

Factors in the study workplace setting that had led to stress in the nursing staff were identified as having to contend with staff shortages and other limited resources. An ANM indicated that her best judgment in work performance was to use reflection by asking the staff what the solutions are. This facilitated broader thinking and stimulated hopefulness which in turn aids staff well-being. The staff had also been often asked how they would manage if staffing numbers were not increased and the staffing situation worsened ostensibly to preempt the need for staff reassurance and well-being. An own response to this question was:

"*I'm so thankful for this flow management thing… 'think out of the box…'"* (II P9).

There was a proficiency and a calm resilience observed with which the ANM stated the above referring to their current nursing staffing composition for patient care, almost conveying the sentiments that all would be well both with staff and patients. The manager further stated:

"…and I can guilt-free say in these admin (administrative) *meetings that I am now chairing… because I don't see how we going to get more staff soon, we've got our APL* (approved posts list) *that we need to honour at all times, as long as we keep all the posts filled …"* (II P9).

Chana, Kennedy and Chessell (2015, pp. 2835-2836) conclude that it is particularly important that the emotional well-being of nursing staff is sustained both for the nurses and for patient care. Activities that contributed to staff support and a drive towards well-being included a night ANM offering tuition between 18h00 and 19h00 before his night shift started for nursing staff who were in training at his hospital and elsewhere as attendees drove to his workplace from outlying area. He assisted without payment. He reported to have contributing to a pass rate of 100 percent. He (P6) further demonstrated his zest for teaching and training by the use of his own textbooks.

Chana *et al*. (2015, p. 2836) also suggest that reviews are to be conducted on staffing and workload matters as a means to support nursing staff emotionally. Hodgkinson, Haesler, Nay, O'Donnell and McAuliffe (2011, p. 2), found that no decisive evidence exists to imply that any nursing or skills-mix staffing model would be useful for improving patient or staff well-being in a residential aged-care facility. At one of the hospitals in this study a practice was initiated to

interview all the staff and inquire about their state of health when they resumed duty from a bout of sick leave:

"They come from sick leave, and you must ask them certain questions, and ask them 'let me just ask you …?' How was their sick, are they feeling better now -that kind of thing that you never ask, sometimes how are they feeling... how they are -what do they think what was the impact of their illness on themselves, or on the work place and how can we help them to improve or is there anything they want us to do for them. That is for me nice and there was one person that I did this questionnaire with and since that time she's improved -her profile (attendance profile)*, because also there's somebody interested in my* (staffs') *well-being"* (II P4).

A cross-sectional longitudinal study by Nielsen, Yarker, Brenner, Randall and Borg (2008, p. 465) found a close relationship between a transformational leadership style and the environment in which the staff work. The environmental features identified were: (1) involvement, and (2) influence and meaningfulness. Involvement related to staff being content in the job whilst meaningfulness related to staff well-being. A direct link was found between staff well-being and leadership behaviour. Ensuring staff well-being was perceived to be a reciprocal process by a few of the ANMs, based on the following verbalised:

"If we look at the needs for the staff -look I bent over backwards you know, to try and accommodate, because I believe that if you look after the needs of your staff, you will get the best possible care for your patients from them. So I always say to them 'Guys look' I say to them 'Write your letter and if it's an emergency, I can understand that'. And I will personally step in …" (II P9).

Two ANM participants in this study had extensive previous experience in EAP that offered crisis counselling and management at the two independent psychiatric hospitals where they were employed. In their new positions as ANMs there were still being seen as part of the support system of the hospital and the staff trusted them. Even though the ANMs recognised that a more formal relationship was now needed to manage the staff, they described their ability to embrace staff by demonstrating the values of the Western Cape Provincial Government of care, commitment, integrity, respect and responsiveness. The two ANM participants independently related their current experiences of the staff still deliberately choosing to be supported by one of them in a situation of need, instead of the external employee assistance service provider specifically in place for this purpose.

In both cases the staff still addressed these ANMs informally using their first names, a situation the ANMs were comfortable with. They both indicated that being known to the staff by first name facilitated an ease with which they could relate to those they managed and allowed them to be more frank, a style that came naturally. There was agreement that their previous EAP involvement had cultivated a contemporary management style that was people-orientated:

"I like all my staff members to call me on my name. I like that, and it feels as if doing that I can be more straight forward with them, not be this Manager that's seen up there that is 'the be-all and the end-all' and that you have to bow down straight when that person comes into the ward.

That's just my management style. I like doing things more casually. And I think that comes a lot from me having done EAP" (II P15).

They agreed that there were some disadvantages to having this experience. It was thought that some of the disadvantages with the transition from EAP practitioner to ANM could be the risk subjectivity and inconsistency when dealing with the staff. There was a deliberate attempt by one of the participating ANM in this situation to have a conscious awareness of this likelihood. Both ANMs were from the psychiatric hospitals in this study. One of the best and enjoyable work experiences of an ANM is the relaxed atmosphere facilitated by her supervisor whilst she could still learn and managed to reach the job outcome:

"But the one thing that I enjoy is I work with a nurse manager, my DD, she is in a very relaxed atmosphere and not so tense that you feel stressed and you can do your work actually in a relaxed atmosphere. And you can learn from her. But what I enjoy is that you can actually get things done" (II P4).

It is well-known that when any major adverse incident such as a fire in a hospital had occurred, formal written reports are promptly required to be submitted by staff. A night ANM described her consciousness of and the attempt to sustain staff well-being at the time of experiencing such a crisis. With reference to the incident of a fire at a specific hospital, the ANM said:

"…they (i.e. the night staff) *were in shock, so I reassured them. I assisted them and supported with the writing of the statements"* (II P8).

The nature of a nursing service has always been that of caring for patients (and families) in crisis or when experiencing loss. At times nursing and medical emergencies require nurses to have to deal with emergencies that involve near death situations such as fires. Such critical events can leave nurses and other health-care staff feeling stressed and grief-stricken (Foreman, 2014, p. 61). In a particular perinatal health-care setting, after a markedly stressful period, the nurses identified a process in the form of a written plan to help them recover, and to give each other mutual support. This plan included the task of the charge nurse (sister in charge) having to find a suitable space away from the clinical or visitors area that could be used by the staff for a preliminary debriefing break. Other support steps in this process include having an assigned person to follow-up on the individual staff member/s after the shift to assess the situation and offer additional support if needed. Should this be found to be the case, the work schedule is then rearranged, and a rearrangement of the work schedule is done to make allowance for the staff member to have a period of rest (Foreman, 2014, p. 61).

The ANMs in this study described their support of staff well-being as being astutely aware of the stress the nursing staff were working under, asking them what they perceived their need for support to be, and then to attempt to put that which the staff had articulated, in place. One ANM stated that she sought the best pathways despite the limited resources. After a recent emergency situation in the perinatal service (referred to earlier), a Chaplain visited the work situation to establish how the staff were doing. Many of the nurses who had received support from the

chaplaincy reported that the interventive support was very useful. Based on this feedback, the support of the Chaplain was then again subsequently sought (Foreman, 2014, pp. 63-64). Responding to the question *"what are you passionate about?"* a night ANM said:

"People, people, patients and my personnel (exclaimed - field notes), *I am a very very people's person so I am serious about people, and that everyone should be happy. I have a saying that always says we are more at work than what we are at home. When we are at home, we still have to sleep as well and do all the other things so one has to make it nice for each other"* (II P23).

Anderson, Toles, Corazzini, McDaniel and Colón-Emeric (2014, p. 9), from a multiple case study in nursing homes, have asserted that certain work interactional strategies generate staff well-being. In this study, similar work interactional strategies were carried out by ANMs as work performance, which were related as success with regards to their HRM practices and therefore contributing to staff well-being. Table 4.8 comparatively depicts the performance behaviour from the multiple case studies with similar behaviour from this study.

A night ANM at a general health-care setting emphasised the importance of handovers from the night shift to the day shift, in the mornings. Similarly as described by Eschenbruch (2007, pp. 37-38); and Mayor, Bangerter and Aribot (2011, p. 1), handovers occur at the beginning and end of every shift. It is a meeting that allows for a detailed discussion of the most important occurrences by those just finishing their shift, with the incoming shift workers. The night ANMs in particular indicated that handovers need to be conducted in a way that allows for a process that is non-emotional and one that secures the emotional well-being of night staff that allow them to leave the workplace in a good frame of mind; *not having been upset, at the hand-over to the day colleagues and having to leave 'heartsore'*) (II P6). In line with the former, another night ANM at a psychiatric health-care setting also made reference to the morning handover which would leave her subjectively feeling professionally shattered, a situation possibly exacerbated by unofficial miscommunication between the ANM group, the A-ONM group and the day-night nurse manager group. She stated the following:

"It feels as if one ...not that you can't function independently... this is now how I feel. If I now say (report) *something in the morning, then there's always someone that pulls to the other side* (differ) *that leaves me feeling that it isn't worth the effort, why have I raised it? But then there are persons that are with you. Speak out of one mouth, ...our people play us up against each other... it's really not a good thing, especially when somebody explodes and then you feel as if you the villain in the story, so if we could just speak out of one mouth, work together beautifully"* (II P12).

Table 4.8: Comparative depiction of performance behaviour between literature and this study

Literature	This study
(a) 'Pitching-in': the extension of oneself beyond normal duties to be of assistance to another (Anderson *et al*., pp. 9-11, 2014).	"*And if there's for example a shortage in a ward where there's only one nurse with 30 patients, I don't have a problem going and doing physical work*" (II P22).
(b) 'Reciprocating': the engagement with others in a manner that generated goodwill (Anderson *et al*., pp. 9-11, 2014).	End of the year incentives out of own pockets. His wife would bake muffins for this purpose. He would have a card for the staff. He also supplied the candles. He said that he had ability to liaise well with external stakeholders (field notes) (II P6).
(c) 'Showing appreciation': the expression of a positive opinion of other people's actions (Anderson *et al*., pp. 9-11, 2014).	"…*when I came there, most of the blacks, they couldn't do medicine* (rounds) *because people didn't trust them, and I took it on me and I said to them 'No, I will assist you. You come with me', and you could see the appreciation …and how glad that people felt afterwards so same here for the IT*" (II P17).
(c) 'Showing respect': letting others know that they are valued by you and that their opinion is valued (Anderson *et al*., pp. 9-11, 2014).	In trying to establish what the participant did well, the researcher witness him addressing staff and how they in turn revered him, regarding him in high standing. His exemplary spiritual demeanour was also witnessed by the researcher. He showed respect towards the staff and addressed a male staff member as 'pastor' that conveyed high regard and respect. He indicated that he was tired of the OMNs who at times show him or other ANMs disrespect by the manner in which they spoke. He himself did not allow it - field notes (II P6). *"…interpersonal is very important especially seeing that we working with uhm human beings*" (II P8). *"…It's not that I pretend. It's a real interest. I can remember all the staff's child's names. I can remember in which grade they are"* (II P22).
(e) 'Thanking': the expression of appreciation, delight and fulfillment (Anderson *et al*., pp. 9-11, 2014).	*"If they get the support from me as Assistant Area Manager, I've got the support of them. And what I've learnt over the last… I've been on night duty for 7, 8 years where there is the simple word of 'Thank you'"* (II P22).
(f) 'Praising': the expressions of letting others know that the work they did is admired (Anderson *et al*., pp. 9-11, 2014).	*"So for me I think positive -the support and the fact that I acknowledge them as 'not an equal' but in nursing I acknowledge them as an equal where knowledge is concerned …. So it's a give and take for me. And that for me is the most positive thing where I found that works on Night Duty for me"* (II P22).
(g) 'Receiving information': the acceptance of information graciously (Anderson *et al*., pp. 9-11, 2014).	*"…because I can draw from their knowledge"* (II P22).
(h) 'Explaining': the sharing of information that clarifies what was meant (Anderson *et al*.,	*"So staff nurse just* [he demonstrated how the staff nurse roughly pulled the dressing off the wound of the patient by ripping a piece

pp. 9-11, 2014).	of paper/ tearing sound is heard] *So I told her one night when she was here, not... That's not good. Really, you need to explain to the patient what you're doing"* (II P20). ("He said that if a Professional Nurse had incorrectly allowed photos to be taken of a patient or patients for instance, he would call her aside and point out the correct way": field notes -II P6). ("He makes comparison between the old Mental Health Act (9) relating to the commitment and treatment of a patient to a Psychiatric Institution and the current Mental Health-care Act (of 2002) and says that he would teach staff this" - field notes) *"I must explain to them that's how it works. We got a BMI* (Business Measurement Index -related to the finances of a post)*, you've got that and that and that, that…"* (FG2 P2).

Handovers serve a variety of purposes. Handovers provide an opportunity for the team to take stock of their resources (Mayor *et al*., 2011, p. 2), resolve problems and advance collaboration (Strople & Ottani, 2006, p. 197), and build cohesiveness (Strople & Ottani, 2006, p. 198), allow for clarity of information being shared and an opportunity to deal with concerns (Strople & Ottani, 2006, pp. 202-203). The creation of a culture of learning around hand-overs, promotes learning from experiences of the past to prevent a recurrence of disastrous mishandled handovers (Friesen, White & Byers, 2014, online). From the findings of the sub-category on success in the management of *staff well-being* in relation to the Business Unit and the management of finances, concluding statements were made according to three areas (Annexure X).

4.6.2.2 Sub-category 3.2: Staff posts in relation to the Business Unit and managing finances

In this study the ANMs related success with regard to HRM with staff posts. The ANMs indicated how efficient they were with recruitment and refilling a post in their areas, once it became vacant. They were proud of the way in which they would proactively manage the vacant staff posts, which they claimed left no wasted time between the posts being vacated until the time it was filled. In this regard an ANM verbalised the following:

"…the moment I become aware that there are people who intend leaving the service, I then put the process (administrative) *in motion immediately, in other words our nursing posts rate is very good… there is never actually a period where we do not have people in posts"* (II P13).

Africa's Public Service and Performance Review directs that the practice of public administration is HRM. Therefore, for services to be delivered by a department, the need exists for personnel to be employed and attached to specific posts within the organisational structure of a specific department (Mle, 2012, p. 22). According to Adhikari (2015, p. 289), it is imperative for all health-care systems to have enough duly trained health professionals including nurses at all levels of health services to deliver effective health-care. Recruitment is therefore one of the

most vital tasks that the nurse manager undertakes on behalf of a health-care service and, invariably, on behalf of the patients (Phillips, 2004, p. 164), and in the public personnel management arena (Philips, 2010, p. i). This study at the time of data collection revealed that filling of explicitly more senior nursing posts was seen to be challenging and therefore less expedient. The HONs who had vacant senior nursing ANM and ONM posts on their hospital nursing establishments expressed a yearning to see these posts filled; an illustration of an innate zest to optimise service delivery.

"... So I'm dreaming of the day when all those posts (ONM posts) *are filled"* (FG2 P2).

A high attrition rate has been noticed in key health professional groups (National Department of Health, 2011a, p. 20), and whilst the numbers of vacant posts in the public sector remain high, although the data might not have been reliable, the public sector is not in a position to fund and hence fill all 'unfilled' posts (National Department of Health, 2011a, p. 21). Duffield *et al*. (2011, p. 504) state that health services planners could reduce executive (equated to ANM posts) turnover by allowing for staff to grow by being challenged in their posts. Similarly, HONs felt that night ANMs needed to grow more into the ANM roles. In this regard, it was said:

"Because they (i.e. night shift ANMs)*... I don't think they realise when they're on night duty, all these effort that goes into managing the hospital. And they never part of the recruitment and selection process. Uhm -so I would love them to have that kind of exposure"* (FG1 P1).

At each of the research hospitals two ANM posts are specifically designated for the two night shift positions, working on opposite shifts, so that each night one or the other is on duty. This however means that they never see each other despite working at the same health-care setting on the night shift. One HON cautioned that having to ensure that ANM posts were filled with competent nurse managers who had developed was more than a mere swop of night and day ANMs. She stated the following:

"Uhm I don't think -if we switched -if the four switch -that the night Assistant Managers will continue as day duty the same as they do, so ja. I think they should also be more exposed to the FBUs and to the HR functions -the recruitment and selection" (FG1 P2).

In the light of administrative correctness in recruitment and selection, staff posts are important. The ANMs claimed that they completed documentation well in regard to staff posts (its precision) by soundly following the HR administrative tasks and processes required. These processes require that all the administrative steps are done in time and accordance with the required documentation prescript/s:

"…all the forms... your processes must be in place. Everything must be in place because if that person says I'm accepting that job..., then you must have a job description for that person. You must have your guidelines and your policies -all those things there… the nurse that comes in here must adopt that (job description) *because everything is there*, *alright!"* (II P21).

When the required processes of recruitment and selection are indeed followed, it facilitates the orientation process of the prospective employee into a post.

"…if those things are there, and the people go on orientation or induction or whatever, they know exactly what is expected of them. Therefore before you (i.e. the incumbent) *apply for a job, you* (the incumbent) *need to have an activity list* (performance plan)*, you need to have a job description'*; *so if that is in place, you know, then the service delivery will be effective. Because then that person knows from this part, this is the expectations"* (II P21).

When nurse managers are given direction by means of the job description, clarity is obtained regarding both the required performance and its post position on the staffing establishment. The following was stated in this regard:

"You need to know what the path of that person is going to be like, from an assistant nurse you indeed now can go to a staff nurse or a sister (Professional Nurse) *to an Operational Manager whatever …"* (II P21).

Staff posts after OSD, was mentioned as there was also awareness by the ANMs of having to recruit and select the 'right people' for the job. The following was stated:

"Say, like us as the manager, and you try to recruit people right …" (II P21).

A HON at one of the researched hospitals verified that they indeed had clarity with regard to job performance of the night ANMs as the appointments were made subsequent to the OSD translations and were detailed to the post:

"...were specifically appointed and the posts were advertised as night duty posts" (FG1 P2).

It is important to carefully plan recruitment and selection of employees so that only the right caliber of staff is employed in an organisation (Philips, 2010, online). A HON who had appointed ANMs to such vacant posts subsequent to the implementation of the mass OSD translations of 2007, referred to the variation in the understanding of the required work of ANMs, by the ANMs themselves. The HONs asserted that the distinction seemed to correlate with two bands of ANMs namely: (1) those that were translated into posts as part of the OSD process (also referred to as the 'Grandfather Clause' process) and (2) those that were appointed to these posts by means of a deliberate recruitment-and-selection process subsequent to the OSD process. They claimed that those ANMs who were duly appointed to these posts exhibited enhanced commitment. This was illustrated by:

"I think because all four of my people were appointed in their posts, and were not 'Grandfather Claused' (translated/ moved into newly created ANM post by the OSD) *into their posts, or OSD'd into their posts, the commitment is there"* (FG1 P2); *"And also they -because they applied for the post, they'e accepted the responsibility that came with it -ja, so I think that kind of commitment is there …"* (FG1 P2).

This was supported by another HON who verbalised the following:

"In my case it's the same. Uhm, the one Assistant Manager on Night Duty -I think when I came she was already there -the other three were (nurse) *managers in the hospital so they also applied for the posts and they went through the very same difficult interviews and stuff …"* (FG1 P1).

The rationale for wanting to develop a framework in this study thus has apt reference with regard to the latter.

Nursing ratios in relation to staff posts were also mentioned. In support of their success in HRs involving staff posts, the notion that more staff were needed, was put forward by the participants. They implied that both: (1) more posts were needed and that (2) all posts were to be filled. They said:

"…with more personnel… we really need more personnel.... At the moment, okay, what we have currently there's one adhoc nurse, so in a ward of 36 patients... 33 at one ward…, and if there are 'specials' (closer care) *then I can use this one nurse/ then I can call in this nurse - so that there's always one nurse, a loose nurse on orientation. So I would utilise maybe tonight at this one ward, and then at another ward"* (II P27).

The exploration of Weiner (2012, online) of the effects of mandated nurse-to-patient ratios and the reduction of preventable medical error and hospital costs, found that imposed mandatory nurse-to-patient ratios in hospitals showed a strong and consistent association, between staffing levels and patient outcomes. However, a challenge existed in determining which ratios would be effective and afford the best patient outcomes (Weiner, 2012, online). The HONs and the ANMs comprehended, and related their apprehension of the uncharacteristic competition in the work place environment in regard to the Business Unit and the management of finances. The need to reuse funds that became available from vacated nursing posts was now open for either nursing staffing posts or to expand staffing elsewhere in the hospital/ health-care setting. The HONs in one of the focus groups pointed out how nursing posts are taken away (scoffed and scorned at the HRs practice in regard to ensuring adequate nursing posts - field notes). They said:

"But in our hospital for example, if you hear, there's a new created clerk post who is a new …" (FG2 P2); *"What clerk …?"* (FG2 P1); *"Another ASD's, and AD something* (mockingly - field notes)*"* (FG2 P3); *"Understood"* (FG2 P2)!;*"And finance AO or what"* (FG2 P3)!; *"... so there's never in the forty years, yo nearly 40 years that I am in nursing, they didn't ever say…- I'm manager now 20, 30 years* (supported in unison by P3 with 'mm's' - field notes); *They didn't say 'here's a million rand* (R1m) *for an extra post or two for next year's budget' NEVER never in my whole life… . What they say is 'if YOU want more nurses, then you must save here or you must...!' Um ja and 'take that money to create a post'* (the participants expectation in the work place) *... yes we can still talk a lot about this* (sounded frustrated and angry - field notes)" (FG2 P2).

The creation of adjusted though needed nursing posts was financially limited, as funds from other actual nursing posts would need to be rechannelled to create these new posts. Based on the premise of the FBU, such re-design also required the permission of the FBU. The ANMs described the current system of having to first obtain approval to fill a nursing post as a frustration. In this regard, they said:

"... I don't think the situation is going to get any better with regards to the amount of patients that are flowing into the system. But if we can get the staff …" (II P9).

Suby (2009, p. 98) avidly refers to the posts on a nursing establishment as the result of a process of having intensely negotiated and securing them/ ratios, calling them '*hard-won nurse-patient ratios*'. Nursing ratios are said to have been implemented effortlessly in Australia because of the dedicated funding it received (Gordon & Buchanan, 2008, p. 211). Nursing ratios at hospitals in

Japan were also supported financially by the government and additionally incentivised if they met the ratio criteria of one nurse to seven patients. In both these instances support was received from their national health systems tax public funds. Although it was stated that funding for hospital nursing was not insurmountable, there was no national or state aided funds for such an objective in the United States. Many nurse executives and hospital managers in California argue that nursing ratios are an unfairly imposed burden because they embody an unfunded mandate (Gordon & Buchanan, 2008, p. 211). It was however the state of California that first outlined and implemented the mandatory minimum nurse-to-patient ratios, serving as a guide for other states. From the findings of the sub-category on *staff posts*, concluding statements were made (Annexure X) in relation to the Business Unit and managing finances.

4.6.2.3 Sub-category 3.3: Problem solving and conflict management skills in relation to the Business Unit and managing finances

Managing conflict and problem solving was not part of the formal training many professionals and managers had and in this regard is also one of the challenges of a nurse manager (Dever, 2010, p. 17). They acquired these skills by trial and error based on experience and maturity (Dever, 2010, 83). The ability to solve problems is said to be one of the higher level attributes a nurse manager can acquire, moving from the crude, practical approach to the innovative problem solving and integrative knowledge arena (Dever, 2010, p. 6). The ANMs accordingly related success in finding answers to problems and resolving conflict in the work setting. One ANM made use of participative management when problems needed to be solved. The following statement illustrates this:

"The answers must come from them, not from me. I will say ... now listen to what you are saying. Does it make sense...? And then they say '... Yes it makes sense!' Then I say 'ok ...' because now I know that mind-set is set but I need to change that mind-set you know. Then I say 'ok, I think of it in this way -let's get the pros and let's get the cons, and then we weigh it up'" (II P21).

Conversely, though the underlying AI philosophical focus of this study presupposes that the traditional problem solving approach that searches for what went wrong and sets out to rectify, consumes time and energy where the outcome may be potentially insignificant (Mishra & Bhatnagar, 2012, p. 543). The health-care setting where this study was conducted, involved a number of hospitals that were recently required to implement the FBU model as per provincial directive (Section 4.6 – see key performance domains). The ANMs are involved both formally and informally in the executive management of the FBUs. In this regard, they conduct meetings pertaining to the service the FBU delivers. ANMs share the leadership of the FBUs where they are required to manage problems and conflict related to the FBU and the multidisciplinary team membership whilst they confidently continue to manage their own span of nursing control. This was expressed vehemently by those working in the psychiatric hospitals illustrated by the following statement:

" ...because I am a sub-FBU Manager, so once a month I have a FBU management meeting with the entire team, from the cleaners to all the people" (II P13).

A HON independently stated the following:

"if I come back to the FBU -we implemented now in the Psychiatric Hospital, and they (ANMs) *are sub-FBU managers… but on the other hand it's very good that she's* (i.e. the ANM) *a sub-FBU manager because then she's in control… it's additional work... . They must have sub-FBU meetings every month, two weeks or what, if there's a problem, with the whole multidisciplinary team so it takes time of her… -take you away from the other tasks …"* (FG2 P2).

The night ANMs verbalised that they managed the entire hospital, a position of responsibility that becomes lonely at times, having to solve both strategic and operational problems:

"Look the day people, they have other day matrons, they can phone each other, yes, and say come over to my office, I struggle with this, but we alone!" (II P28); *"I am totally alone here. There isn't any other senior personnel on duty so for me it is a pretty responsible job, because when everyone sleep I am the one that has to see that things are running correctly… that the people can trust me that I can be here, and they can be resting, that if there is something that's not right, that I will report it immediately. So I think that is one of the most important things, and that the people know, even with the personnel they know they can depend on my cooperation, and my help and if there are problems, that we will sort out the problems, so that is for me the most important"* (II P23).

The requirement to work cost effectively and to make decisions after-hours/ at night that has cost implications was also part of the problem solving role the ANM needed to fulfill:

"There's a lot of workshop (mechanical/ engineering etc.) *things, then we must manage that. Then I must decide if that's now an emergency for the night? Do the person need to come in and come fix it now after-hours? I must look at the expenses of that if somebody from the company must come out especially from Cape Town …can it stay over till the next morning? So I have to make quick decisions"* (II P27).

The night ANMs stated that they managed conflict with relative ease and the required professionalism:

"You must be awake ... yes yes you must take responsibility and take initiative, must accept responsibility, I must uhm ...planning, I must plan fast …" (II P28); *"We have now developed such a relationship with outside people or with sisters, so if they* (the day staff) *couldn't find someone* (to work overtime because of the increase in patient acuity*), you always have your complementary staffing list* (known to her only - field notes), *someone who you can contact, and someone that would work for you ... and in the mornings they* (day managers) *are actually surprised and th'l say 'did you find someone?'"* (II P27)!

The ANMs would try and resolve problems once it reached their level, and would attempt to maintain the credibility of the health-care setting:

"...so I take it forward and I know how to handle situations like that and to tell you the truth, since uh .... So I've been about 15 years, where I was on night control …" (II P17); *"I always try to solve problems so I can restore the hospital's side that they* (patients and community) *don't feel so negative about the hospital"* (II P28).

Hospital management (agents) should be interested and committed to resolve conflicts and disputes by demonstrating the willingness to listen to all parties in order to find amicable

solutions (Manolitzas, Grigoroudis, Matsatsinis & Yannacopoulos, 2016, p. 215). It has become evident that the responsibility of problem solving and conflict management no longer rests with non-clinicians only. In the health-care setting the individual professional, an ONM and other designated structures may be delegated the responsibility of problem solving and conflict management. Amestoy, Backes, Thofehrn, Martini, Meirelles and Trindade (2014, online) assert that interpersonal conflict in hospitals predominantly involved the MDT, nurses and the nursing staff. In this regard a nurse must take a stance when she witnesses neglect and people being exposed to risks. Amestoy *et al*. (2014, online) resolve that participatory leadership based on communication is a coping aid for dealing with conflict in a hospital environment. In general a problem solving mind-set prevailed amongst the ANMs that avert potential staffing disarray. The HON revealed:

"…the managers, the ANMs and the ONMs… and because they're busy with the change-lists, had a problem staffing all the areas… they came to me with a solution. And I think that's the quality and the caliber of people that I have" (FG P2).

At one of the study settings, the nursing component numbers was about to be reduced as a new hospital opened and nurses were transferring out. The amount of nurses who needed to be transferred quantified to a workload of a twenty-bed (obstetric) ward. The resident HON, referring to the demonstrated understanding and insight of her supervisees, of the impending impoverished staffing situation, stated:

"…but that doesn't mean we're closing down wards …but they didn't come to me and say 'Mrs. HON Hospital (fictitious name), we got a problem staffing all the areas. What are <u>you</u> going to do?" (FG1 P2).

The nurse managers at this health-care setting preemptively revised their staffing structure more creatively in preparation for the imminent nursing staffing loss. The HON attributed the preemptive problem solving of the reduced number of nurses, to self-directedness in the work performance of ONMs and ANMs. In a study exploring temperament and character traits in nurses and nursing students in Australia, self-directedness was described as self-confidence, resourceful, responsible, reliable, and goal orientated (Eley, Eley, Young & Rogers-Clark, 2011, p. 564). In this study, these nurse managers applied one of four key sets of work organisational change namely the 'autonomy demand'. An examination of how work organisation changes occur reveal that change is linked to and motivated by the needs and demands of workers (Martin & Healy, 2009, p. 395).A notion suggests that competition and the need to improve efficiency has given rise to the autonomy (worker) demand as organisations are no longer able to provide the historical day to day managerial supervision and take on new methods of making sure that the required work performance occurs (Martin & Healy, 2009, p. 395). The autonomy demand relies on worker self-directedness and apt judgment progressively more and more whilst sight is kept of the optimal organisation work performance goal as shown by ANM and ONMs in this case. Organisations are encouraging such new employee autonomy initiatives as it develops

an organisational culture that workers embrace (Martin & Healy, 2009, p. 395). The ANMs and HONs were unreserved in portraying what the ANMs do well. The sentiments were reflected in the following:

"They (i.e. the ANMs)*'re very good at problem solving and not just problem-solving, but getting to the root-cause of the problem and taking it from there"* (FG1 P2).

In another study, a participating ANM described her experience at her previous employing health-care setting where she had identified problems and had found solutions to them as having been her best years:

Her array of problem solving successes is comprised in the following:

"I can tell you when I started at Hospital No. 12, that hospital looked like ... (named the big notorious prison of the region and raised her voice emphasising the point - field notes) *…I picked up you know a lot of problems like very low beds ... nurses were complaining about backache. They stayed out of work and you know the attendance patterns were poor …. I went to Hospital* (i.e. a big super specialist academic hospital in the province), *they had beds. I communicated with them and ask them whether you have extra beds that you don't want*? *The nurses ... their self-esteem was low… and ... there was no privacy…. So I started there. I did quality walkabouts because that was never there! I formed a quality you know a committee ...*" (II P1).

In the case of one of the night shift ANMs, the problem solving mode would commence prior to physically coming on duty as she would have made telephonic contract with the health-care setting by 18h00 (shift starts at 19h00 – field note) to ascertain what the potential staffing situation was for the night ahead and then already start putting steps in place in an attempt to avert a staffing shortfall should this be the case.

"So around 6 o'clock at night I would call in and ask whether there was pending absenteeism/ if someone was not going to be in for the night, just to make it easier for me in the evening when I come, has someone called in?, say…! Then I will with my own contacts that I have ...let's say it's a sister or they say it's a nurse… just to be able to give to the patients that effective care …" (II P27).

Suby (2009, p. 101) emphasises that managers are best suited with the indirect role of supporting, monitoring and ensuring that the system/s are well managed and when needed, that problems are solved, problem solving being seen as support. A night shift ANM participant confirmed their support role involvement and in this regard described it as:

"…taking steps or measures to sort out the problems that arise during the night and then obviously as a Professional Nurse yes still as I was talking about support and guidance to the nursing staff and not only nursing staff, doctors as well, they need that support and guidance with certain things …" (II P19); *"So that is why I… try to phone* (into work) *early so that I can just call* (those on her overtime list) *from home. I just call from home then, just until the hospital is sorted out* (staff coverage-wise)*"* (II P27).

Skjørshammer (2001, p. 156) found that in order to strengthen the conflict management skills of professionals and clinical managers in health-care, that creative problem solving techniques be encouraged and that negotiation and mediation skills be reinforced. At a psychiatric health-care

setting in the study cluster of hospitals, staffing problem solving and managing conflict was complemented by an out-sourced EAP. However, a participant in this study who was an EAP practitioner at her employing hospital prior to her position as an ANM indicated that the staff still chose her to intervene in a crisis situation, above the private out-sourced employee assistant company. She stated the following:

"So I found that over the years staff will say '... man call Taryn (fictitious name) *instead of ICAS' you know, that kind of thing"* (II P9).

A night ANM at another psychiatric health-care setting said:

"If it is now a very serious problem (that the staff has) *then it will be a formal referral with the person's consent. So they feel good to engage me, to speak to me about their circumstances and there are many people here on Night* (duty) *who have terrible circumstances that require referrals... and get them... so I feel my relationship with them is good"* (II P12).

In the health and social development sectors of the WCP where this study was conducted, a formal 'organisational rights agreement' exists, that sets out a process for constructive and proactive engagement relating to matters of conflict that could potentially arise between management and workers (Western Cape Health and Social Development Sectoral Bargaining Chamber, 2011). In terms of the broader health-care employee population, the public HR managers ought to be the custodians of ensuring the setting up of a wide spectrum of methods and strategies to assist and maintain sound employer-employee relationships such as change management, diversity management, conflict management, and to get managers skilled in negotiation and the ability to apply just labour practices (Saravanja, 2010, p. 86). The expectation to manage problems and conflict healthily and reach a constructive outcome is greater today than ever before (Western Cape Public Health and Social Development Sectoral Bargaining Chamber, 2011). Nurse leaders such as nurse managers are able to inspire staff into finding pioneering ways of solving problems to take on their goals and to do more than they are required to do (Peregrina, 2009, p. 6). Problem solving has to be sound as should conflict management. The public sector still spends a considerable amount of money, time and energy on having to manage conflict, in negotiating with formal labour structures and in legal disagreements (Saravanja, 2010, p. 182). From the findings of the sub-category of *problem solving and conflict management skills* in relation to the KPA HRs, concluding statements were made (Annexure X).

4.6.3 KPA 3: Dream

OUTPUT: Best possible work performance opportunities in the KPA the Business Unit and managing finances

Best possible work performance opportunities in relation to the KPA the Business Unit and managing finances, involve better/ increased resources.

4.6.3.1 Sub-category 3.4: Better/ increased resources in relation to the Business Unit and managing finances

First-line nurse managers must be provided with the required resources that assure quality patient care thereby enabling them to spend more time managing (Loo & Thorpe, 2004, p. 88). The night ANMs stood out in regard though to their expectation that more resources be supplied to them at their health-care settings for service delivery. The resources desired included human, financial and physical. In this regard to the commitment to deliver work performance, the following statements were examples of their cries (field notes):

"... a lot of the stock gets locked away so we don't have access to dressing packs or access to that kind of stuff so -if there's a emergency in one of the wards, we tend to scrounge (scavenge) *around to get stock ...!"* (II P22).

Monetary and physical resources are important in nursing management. In designing/ formulating best opportunities to flourish in work performance, the ANMs in this study expressed their need to be monetarily and physically better resourced. A number of ANMs who worked the night shift said that they were hampered by the limited stock they are able to access and suggested the need to be adequately resourced for better performance. The following was stated:

"So access to stock or own stock on night duty" (II P22).

The night staff stated how difficult it was working with no or little stock which was resolved by making the request to the ward's ONM (day duty) in order to be supplied for service delivery:

"And then you must check what stock is there -that it is sufficient. And there are times when the stock is problematic, then you must mention it -whoever is in charge of that ward, the operational manager, you must mention that so that the next night or when you come on duty again, the stuff is there" (II P27).

The lack of resources can affect staff negatively. People become worn out over time as their energy is depleted. Burnout is thus the culmination of continual exposure to chronic stress and can be defined as the intense demands and deficient resources linked to work and work circumstances. Where people are exposed in the aforementioned manner, the inevitable corroding of energy resources occurs over time that in turn increases health costs (Chênevert, Jourdain, Cole & Banville, 2013, p. 353). Another night ANM further stated:

"And then you must ensure that there is enough stock. The problem sometimes encountered is that the day people leave us out an amount of stock whilst the other stock is locked up ne and they go home with the key" (II P27).

The use of the words *"own"* in the expression above which links the essence of stock availability to work performance illustrates a sense of being intrinsically motivated and the desire to take ownership and full responsibility for the service they manage. Whilst the organisational climate of a hospital could affect resourcing, increased resourcing could play a positive role in designing/ working towards innovation in a health-care setting, the work sphere of nurse managers. The organisational climate influences employee innovative behaviour. A supportive organisational climate facilitates employee willingness to transform creative ideas into innovative production (Sarros, Cooper & Santora, 2008, p. 154; Weng *et al*., 2013, p. 428). Innovation has more recently been adopted as a value in the research province (Western Cape Provincial Government (Budget Speech), 2012, online; Western Cape Government: News (April, 2014). In desiring to be better resourced, the ANMs expressed the desire to improve the aesthetics of the wards which underscores the need for more money and/ or physical resources. In this regard the following was said:

"And I wish that there was money to make each ward pretty… with stock... and to make the ward pretty with flowers against the walls and so on …" (II P14).

The need for aesthetics has been described by Maslow as one of the higher growth needs. When this stage is reached by an individual, the basic needs have already been met and growth has occurred in regard to love and belonging, esteem, understanding and knowledge (Yahaya, 2014, online). On the other hand, the sentiment was expressed that the monetary allocation was sufficient but how it is used for best work performance opportunities was important:

"…so it's not as if we have shortage in terms of the budget, it is important that we look at the budget, but we're not 'tied' to it, we do our work and use that which we must use" (II P23).

In recent times, a number of Taiwanese hospitals have passionately encouraged their nurses to use innovation while supporting them with innovative training means and other support resources. Innovation was also rewarded (Weng *et al.,* 2013, p. 436). Being better resourced is therefore a means to perhaps change work performance behaviour from mediocre to innovative. During the 30th anniversary celebration of the Oncology Nursing Society in 2005, Roberta Strohl, past president of the Society said: *"If I have internet access, savvy, and understand the business environment... We have to be responsible for our budgets; we have to look at what kind of money we are spending …"* (Strohl, 2005, p. 5). This study showed that the ANMs today concur with this nurse manager veteran recognising the growing importance of finances in relation to the key performance areas of the nurse managers' job than in previous years (II P18). Both ANM and HON groups held the belief that they would have to be more astute with finances than before. The nurse managers expressed their need for improved judgment in financial and budgetary procedures:

"You have to be more astute with regard to finances than you have been before …" (II P18).

As opposed to requiring more nursing resources, a nursing managerial setting elsewhere found that cost could be saved on time and effort when working hours are interrogated, at a comprehensive health-care setting where rising costs, higher Professional Nurse vacancy rates and declining staff morale posed a major challenge. Its chief nursing officer introduced a 'Nursing Productivity Committee' (NPC) aimed at measuring and analysing nursing care hours per patient day (HPPD) by interrogating productive and non-productive hours in an attempt to improving staffing models and scheduling processes. As a credible alternative, the HPPD accepted as a credible alternative, the use of the acuity system to determine staffing, focused on re-establishing staffing plans and managing staff practically and the number of nursing care hours needed in relation to patient workload (McKenna, Clement, Thompson, Haas, Weber, Wallace, Stauffer, Frailey, Anderson, Deascenti, Hershiser & Roda, 2011, pp. 55-56). Despite workload intensity and expectations differing from one clinical area to another, direct care per patient day could be determined in monetary terms for clinical areas. Where reduced numbers of skilled nursing staff were experienced even nationally, existing resources continued to then meet the increased demand by adapting differently (Mckenna *et al*., 2011, pp. 55-56; Suby, 2009, p. 98). Taking into consideration the required skills mix and patient volumes, a cost reduction in the high cost driver of nursing hours was conceived by the introduction of more flexibility in nursing shifts. With the implementation of a more flexible system, the 'open shift' bidding management system electronically, nursing staff could view and request to work 4-hour or 8-hour shifts for which they were eligible inclusive of the on-call shift. This has resulted in genuine time saving and cost savings for personnel and managers who previously spent long hours securing shift coverage (Mckenna *et al.*, 2011, pp. 62-63). In this study setting, the reliance on costly complementary nursing staffing from an agency or even overtime shifts could be likened to this system implemented in the community health-care setting described above. A night ANM at a busy General Specialist Hospital indicated how much better it would be if he had access to the internet even though financial restrictions prohibited this facility:

"If I have internet access, it will help me but because …" (II P20).

In another survey of more than 300 health-care financial executives conducted by the Hospital Finance Management Association (HFMA), the working hours were classified into direct care and indirect care hours, although cost of care (whether direct or indirect) was not measured where complementary nursing staff were hired. This division included sub-categorisations based on presence, hours, productivity and remuneration (Suby, 2009, p. 99). Work rendered by all staff such as managers, ward/ unit clerks/ secretaries and ward tutoring staff even though not direct patient care, was included (Suby, 2009, p. 99). Although nursing hours were not measured in this way at the research hospitals of this study, the ANMs acknowledged firstly that fairness should prevail in relation to staffing conditions of service which are quantified in monetary

terms, and secondly that staff at times, work more than their roster'd time. One of the ANM's stated:

"I would say conditions of service that is put in place by the Department (of Health/ employer*), to make sure that their leave is allocated to them as per their right, that they get the lunch and their tea-times and to make sure that your staffing is, you know broken down* (analysed)*. If they* (the employer) *not able to, to in some way able to compensate for the hours that they* (the staff) *work over and above their 40 hours, to ensure that there is a plan in place for, say leave"* (II P10).

According to Suby (2009, p. 100) managers are to render, and are best at rendering indirect care by having a systems approach ensuring dedicated time to support staff, monitoring care and leading. When managers are depended upon to take on shift gaps to render direct care when staffing ratios become compromised, it converts the manager's role to that of having to solve urgent problems rather than dedicating time to solve the system issue underpinning the problem (Suby, 2009, pp. 100-101). In relation to resources and spending, the potential training of public servants in financial management is further viewed as a way to enhance professionalism and ethics in the public sector (Mle, 2012, p. 27). It is therefore imperative that managers in provincial health-care settings acquaint themselves with how to manage finances soundly. Poor financial management practices have become illegal (Government Gazette No. 33059, 2010, p. 7) and unethical (SANC, 2013, p. 5). Poor financial management occurs when inappropriate purchasing of resources occur. Poor financial management includes purchasing resources wastefully (Government Gazette No. 33059, 2010, p. 7). Mle (2012, p. 27) points out that one of the consequences of unethical and unprofessional behaviour will result in lack of investor confidence and could lead to poor economic growth. From the findings of the sub-category of *better/ increased resources* in relation to the Business Unit and managing finances, concluding statements were made (Annexure X).

4.6.4 KPA 3: Design

OUTPUT: Initiatives for the future in the KPA the Business Unit and managing finances

Initiatives/ ideal expectations for the future in relation to the KPA the Business Unit and managing finances, involve working together toward a better future/ better care.

4.6.4.1 Sub-category 3.5: Working together toward a better future/ better care in relation to the Business Unit and managing finance

Working together toward a better future/ better care requires a vision; a vision of understanding and engaging with the next cohort of nurse managers (Gaskin, Ockerby, Smith, Russell & O'Connell, 2012, pp. 625-626; Keys, 2014, pp. 97 & 98). The researcher observed that the night

ANMs at selected hospitals had a special partner-relationship. Individual ANMs (two opposite night shift partners), described their need to communicate with their partners. It was evident to the researcher that they listened to each other and each showed respect for the other's knowledge and contribution to work performance that ultimately translated into working well together even though they did not see each other due to working on opposite shifts. They trusted each other. The working environment of nurse manager may however also be affected by the organisational culture, usually the parent organisational culture *"Trust becomes reality through the nurse managers' clear communication and sensitivity in listening to others"* (Suhonen, 2011, p. 1029). One set of night partners described their work performance experience similarly in regard to working together:

"She takes my advice, you know, she has never said 'no'. Look she's coming in now (voluntarily at night)*.... We will have to work together"* (II P1 [Partner 1]). *"'...because Mrs. P1, she's here, she totally different than me, but you can learn SO* (participant emphasised this point - field notes) *much from her. Why are you so stupid not to take in what you can learn - what she can teach you?' That is the most important thing, I told them ..."* (II P17 [Partner 2]).

The partners also assisted each other with resolving staffing conflict:

"When Mrs. P3 started working here and Mrs. P1... so I told I told them (the night staff) *in front of her* (the partner, P1)*… I had the meeting; I came in also that night. I said 'just to think I was supposed to be with my family now, but I must come in now* (referred to being present at the meeting with the night staff with P1 - field notes) *and you're all adults', I said, 'but you're acting like children now ...'"* (II P17).

And with reference to the display of blatant rude behaviour by a male nurse to the partner:

"Because they were very rude to her, I said to her ... no! That is not on! ... because she phoned me and I said no ...I'm going to come in and we have to discipline him and I'll be there ..." (II P17).

Conflict can actually be avoided when the relationships are strong and relational (Schjoedt, Monsen, Pearson, Barnett & Chrisman, 2013, p. 9). The ANMs in this study indicated that nursing staff held the belief that working together towards a better future/ care required more staff. An ANM in this regard verbalised:

"...what we hear all the time from the staff. If only we had more staff" (II P9).

The divisive way in which some ANMs at times work, was criticised and rejected by other ANMs however initiatives for working together in the future based on these criticisms were also uttered:

"And the other thing that I also think that applies to us area managers that I feel can improve 'this is not my wards, this is not my area ...' and I brag about my area, your area... is bad! We are working for the State, we work together ..." (II P13).

Similarly another stated:

"Ok... I know that we function as my colleague does her part and I do my part" (II P3).

Research interest in emotional intelligence has increased over time. An important perspective thus in terms of the nurse managers' role is emotional intelligence; that is, the ability to be in touch with their own and the feelings of others and to be able to fare well with their emotions themselves and in their interactions with others (Suhonen & Paasivaara, 2011, p. 1029). Such advancement is important as it integrally relates to working along with others towards improvement. In the sphere of nursing management, the nurse manager′s emotional intelligence places high priority on open engagement and sensitivity often above strategic perspective and vision. They have the apt ability to produce delegating and proactive behaviour, which lends itself to constructive outcomes. Simultaneously nurse managers with high emotional intelligence are change agents as they are able to arouse team performance and innovation in the need for change (Suhonen & Paasivaara, 2011, p. 1029). At the study hospitals, where there was only two day ANMs, the need to work well together at ideal expectations for the future was overtly expressed (field notes):

"But we need to come together to meet somewhere and just discuss what we are, not you do your thing and I do my thing. We need to work together …but it's still she does her way in her wards (participant has one other colleague on the day shift her equivalent). *Okay that I know …we're not the same …but there are certain things like in your nursing care that you need to do a certain way so I need us to marry that, you see. I need to see the marrying part"* (II P3).

In line with the AI assumption in Chapter 1, it is asking questions of an organisation or group that influences them in some way. *"The human systems grow in the direction of what they persistently ask questions about, and this propensity is strongest and most sustainable when the means and ends of the inquiry are positively correlated. The single most important action a group can take to liberate the human spirit and consciously construct a better future is to make the positive core the common and explicit property of all"* (Cooperrider & Whitney, 2011, p11).

In South Africa where this study was conducted, the process of planning improvements in HRs for health is directed by the National DOH's 10-Point Plan which is alluded to along with strategic leadership and the creation of a social compact for better health outcomes (National Department of Health, 2009, online). The HRH strategy acknowledges the extensive work already done by the Provincial Departments of Health in having developed HR plans. The departments are nonetheless still encouraged to strengthen their HRM functions by embarking on various HR prerogatives inclusive of audits of the workforce. The audits will assess attitudes and perceptions in order to gain a better understanding of the workforce and to be able to contribute to future HRM strategy development (National Department of Health, 2011a, pp. 112-113). HR policies and procedures would also serve to further strengthen and enhance the HR functioning. The notion of 'future' in the question put to the participants in this study seems to conjure thoughts of age and time in relation to experience. The following was stated:

"I don't know how to put this… cause there's a lot of stuff that I cannot manage; I'm younger than three quarter of the staff who works with me" (II P22); *"If we can get back the skilled*

people into the wards away from meetings, I feel. Here are from the OBs (ONMs) *really 'they know their work'. If one can place them back in the wards, and ensure time for them to work with the younger people"* (II P28); *"I don't know about your area but the ANMs on this side* (psychiatric side of the psychiatric hospital where participant works), *they are forty five, fifty upwards… then they learn from you… all the new modern or effective leadership skills and how to manage that specific area"* (FG2 P3); "*…but there was a time that Coloured people did not get that kind of promotions. That's a fact - so whether you were good or no good, or excellent, you would not progress u u……, so most of us progressed almost in our 40, late 40s … ja ja it was out of reach and that's why many of us are much older than what maybe we would have been if our political situation was different in the country. So I think that plays a role in why we also have so many older Managers, and in my hospital for instance –I'm talking like I'm owning that, but in Hospital (fictitious) there are some of the managers that tell me they don't want to go and do the Advanced Psychiatry --- what are they going to do with it? They 57 years old, they'll spend one year at doing the Advanced Psychiatry* (course) *will come back and maybe work another three years and decide to go. … The youngest Assistant Manager I think is 52 …and the oldest one is I think the 57 so in that age group. So I mean for younger people to make comments like they must kind-of leave, I mean they told me"* (FG2 P1).

According to Patton (2013, online), the American Association of Critical Care Nurses, the American Organisation of Nurse Executives and the National League for Nursing were amongst the recognised organisations that had identified working together collaboratively as a required nursing leadership competency.

Working together and perseverance were highlighted in the study. An ANM stated that a goal needed to be achieved when she was met with strong resistance from an ONM when she (ANM) suggested that the appearance of a ward be improved by removing the 'jail-like' fence in front of the ward. In this instance the ANM perceived the ONM to be rallying for support against the proposed change from other influential members of the multi-disciplinary team. According to the participating ANM the goal of getting work performance cooperation in that situation required her persistence and positivity. She described the resistance experienced as similar to the group behaviour displayed in another situation when a hospital team building session was also not received well. However, she pursued in swaying a group's attitude toward a more positive perception. The ANM found that the resistive behaviour lessened and despite the attempt being long and tedious, working together did improve. The ANM has recommended a commitment to better work performance by working towards working together for one goal. This belief seemed achievable as it was stated that they were actually working well together. An ANM verbalised:

"…the Assistant Managers to get together with the Operational Manager(s). *We are actually a very good team …"* (II P25).

Therefore, while the ANMs recognised that their work situation demands change in the provincial health-care settings, in striving to work together they also expressed the desire for a shared ownership and understanding of the wards situations by peers. They verbalised the following:

"So 'change management' is a big thing… even though we are different …" (II 13).

Some of the night ANMs at the bigger provincial health-care settings in particular had instinctively integrated sound working together values in their work situation. They portrayed a working together demeanour. The researcher attributed this nursing managerial experience of needing to deal with a host of role-players especially at night at some hospitals. The two night ANMs who worked on opposite shifts had a special working bond and understanding. In another instance a night ANM who was on the night shift already for 22 years indicated how she and her opposite night shift partner had worked the rigid 12-hour per night shift for six continuous months without having taken a day/ night off outside of the shift off-nights. She attributed this to such a working bond and understanding when they had worked for

"… *Six months without a day off"* (II P26).

The commitment to deliver work performance stood out for night ANM participants in this study as they demonstrated working well with the staff they led. Their supervisory situations differed, from their day counterparts in that they had in all cases, far less staff and far more junior staff who comprised the night nursing team. The need to work better together with those who worked the night shift at the same health setting was also expressed by various day ANMs, who highlighted the fact that work performance rendered in various service areas differed, but that none were superior to the other. The night ANMs in particular were also astutely aware of the need to avoid conflict between themselves and their day counterparts that could be potentially caused by miscommunication or misunderstanding among staff in relation to staffing wants. Such conflicts could be averted if day and night ANMs worked well together. An ANM verbalised:

"I would like to see us work together… communication is at a level where we respect one another …" (II P10).

A close work relationship was reported to exist between the ANMs and the multi-disciplinary team at one of the smaller hospitals in the cluster of the 10 General Specialist Hospitals in the Western Cape of the study setting. This relationship could have come about as a result of the personal nature of their work performance which in this instance was rehabilitation and caring for people who have spinal cord injuries. The close working relationship at this health-care setting was attributed to a management style at the health-care setting exemplified in the expression of the ANMs' 'love' for their seniors which they said translated into the will to want to 'work with' their managers. The very close working relationship according to the researcher could also have been progressively established as a result of the entire team being relocated from a pristine metropolitan site to another on the outer over-inhabited flat lands.

The overall slogan for the government department where the study was conducted is, 'better-together' though none of the participants referred to it. The participants however mentioned that the social culture was diverse and that despite working together, there was still an ignorance of each other's need in relation to their background and experience of growing up. In the

commitment to deliver work performance, there was special recognition by an ANM, who tended psychiatrically-ill breastfeeding female patients, to work collaboratively with other outside support services, to serve the patients as best as she could, as a departmental objective. Future best work opportunity in work performance was to improve on the understanding of cultural diversity. The following statement was made:

"So these are the things (understanding the other ANM's background) *that we as a group can improve on …"* (II P13).

Stichler (2009, p. 177) asserts that skilled communication, real alliance amongst nurses themselves, and between nurses and other professional colleagues, authentic leadership organisational leadership, meaningful acknowledgement for the value of individual and group nursing efforts towards improved patient care and workplace excellence establishes and sustains healthy working environments. Collaborative decision making was also found to have improved work environments, in respect to job satisfaction of nurses, staffing morale as well as improved recruitment and retention (Stichler, 2009, p. 178). Evidence of collaborative working together translates into a sense of group or community, trust relationships, supportive headship and mutually respectful support (Shirey, 2006, p. 259). A case study by Rabie (2012, p. 207), investigating positive practice environments in community health settings, has found that instilling teamwork is seen as an important leadership characteristic of managers. In this study a HON visualised the ideal future ANM (design) as someone who would have a good understanding of finances whilst they are able to interact with and guide others (FG2 P1).

Based on the importance of the working relationship between doctors and nurses, and the rate of recurrence of conflict between them, findings of a descriptive study by Tabak and Kopak (2007, p. 329) on tactics of conflict management skills, used during nurse-doctor interactions, recommended that nurse managers give protégés opportunity to study conflict resolution, collaboration and cooperation and thereby act as constructively as possible for the best settlement. Patton (2013, online) as well as Porter-O'Grady and Malloch (2009, p. 246) identify innovative transformational leaders to be skilled in knowledge, work together and be able to visualise broader issues of the work environment including coaching and mentoring. Working well together has taken on a new impetus as it relates to developing new nurse leaders, the latter being seen as a needed pursuit (Sherman & Bishop, 2007, p. 295). Failure to take actual steps to build a culture where nurse manager engagement is facilitated could leave staff feeling that they are unsupported (Sherman & Pross, 2010, online). The ANMs indicated their challenge with having to be available for both their supervisees the ONMs and their manager the HON. The ANMs in particular verbalised that having to balance the many meetings was a challenge. Working well together could also be viewed as being accessible. When nurse managers are accessible, nurses are more supported in articulating the need to improve patient care environments (Sherman & Pross, 2010, online). The conceptualisation of managers and staff

working together is said to stimulate the creation of a profoundly fulfilling ward organisational culture where work performance takes place. In this manner staff members are also engaged in the development of shared work values (Sherman & Pross, 2010, online). From the findings of the sub-category *working together toward a better future/ better care* in relation to the Business Unit and managing finances, concluding statements were made (Annexure X).

4.6.5 KPA: Deliver

OUTCOME: Commitment to deliver work performance in the KPA the Business Unit and managing finances

This study found that commitment to deliver work performance in relation to the KPA the Business Unit and managing finances, involves managing absenteeism.

4.6.5.1 Sub-category 3.6: Managing absenteeism in relation to the Business Unit and managing finances

Absenteeism is seen as not coming to work when scheduled (Davey, Cummings, Newburn-Cook & Lo, 2009, p. 312). Irrespective of whether absenteeism is classified as authorised or unauthorised, intended or unintended, absenteeism is said to be *"the failure to report for scheduled work"* (Ramsay, 2006, p. 4). Attendance on the other hand is viewed as; *"Being present at work when scheduled"* (Davey *et al*., 2009, p. 320). The recommendations made by the ANM participants in this study who worked at provincial health-care settings in the Western Cape, were to commit to better work performance that also involved managing absenteeism.

Managing absenteeism in relation to service delivery: This study identified the management of absenteeism as an area of service delivery in which ANMs committed to improve work performance. Based on the response of the participating ANMs, the researcher perceived the operationalisation of the management of absenteeism as a HRs task that was being carried out robustly and with ease. They expressed their confidence that if the management of absenteeism and hence absenteeism improved, that patient outcomes would be enhanced. They said:

"…because if absenteeism has improved, then Service Delivery will… (spoken with conviction and determination - field notes)*"* (II P21).

In this regard the ANM participants also emphasised that nurse managers were to comply with the absenteeism management processes in its entirety to deem such management effective in the commitment to service delivery. This meant that absenteeism was to be investigated fully by using the administrative processes at hand. In relation to the latter they identified a need to improve compliance with what was described as the arduous administrative processes related to managing incapacity leave and ill-health retirement for staff members who were frequently and erratically absent from duty due to ill-health. They stated that fellow ANMs should speak out to

ensure the required processes are followed. The sentiments expressed also implied that the nurse manager should manage absenteeism in a manner that would steer the process to a remedial outcome after a period of absence, should it be required. One ANM participant stated the following:

"I would like to see that the managers manage the people… correct, have their interviews, have their… corrective counselling's" (II P4).

The ANMs voiced the struggle they experienced to deliver a service under a strain of absenteeism which they said nurse managers succumb to, nowadays. It appeared as if the viewpoint the ANMs held of the relationship between the efficient management of absenteeism and well delivered services was unwavering. The management of absenteeism in relation to ill health, the ANMs indicated that the strain of absenteeism on service delivery is not only because of the general incidence of poor attendance but also because nurses are sick and then are unable to come on duty and perform in service delivery:

"...nowadays we are struggling with absenteeism. People is sick, people is in poor health, and yet they come to work and they work a week or - the next week they off sick and more …that we can be aggressive towards handing those kinds of situations and to help them also and also for the service because they're not how can I say their performance is not good when they even here, so it's not good for the staff that they are working with, as well as for the units' performance and overall performance - caring of the patient …" (II P4).

In managing absenteeism, Browne (2012, p. 20) asserts that employee absenteeism and sick leave levels have shown decline and attendance increased when attention was paid to employee work-life balance. The incidence of turnover and absenteeism amongst health-care personnel having a considerable impact on the overall health-care system performance, was stressed by Daouk-Öyry, Anouze, Otaki, Dumit and Osman (2014, p. 93). Nurses are seen to be the key players at hospitals and health-care settings. Their attendance or presenteeism patterns; that is, their turnover and absenteeism is said to potentially incur severe negative consequences on health-care settings. Nurse absenteeism has been found to compromise quality of care and financial outcomes in health-care (Daouk-Öyry *et al*., 2014, p. 93). Additionally, economic situations globally and in specific countries may force nurses to hold multiple jobs leading to more stress, absences, and resignations. Strategies supporting sustainable health in the workplace can therefore be considered important for preventing high turnover and prolonged sick leaves among nurses (Josephson & Lindberg, 2008, p. 384).

An investigation by Van Rhenen, Schaufeli, Van Dijk and Blonk (2008, p. 461) into coping styles and sickness absence in a cohort of mainly male workers, found that employees with a problem-solving coping style were less inclined to be absent from work because of sickness. Schreuder, Plat, Magerøy, Moen, van der Klink, Groothof and Roelen (2011a, p. 843) complement this by showing that problem-solving coping styles were associated with less sickness absence in terms of less frequent lengthy episodes of sickness absence. On the other

hand, previous survey results from Roelen, Schreuder, Koopmans, Moen and Groothof (2009, p. 502), of 350 women working in hospital care, pointed to a positive association between high problem-solving coping scores and higher frequencies of shorter episodes of sickness absence, that is, 1-7 consecutive days). With reference to the latter, Schreuder *et al.* (2011a, p. 843) noted that cross-sectional nature of the survey and low reliabilities of the coping scales ought to be taken into consideration when their results as indicated above, are reported. An association was found between an autocratic leadership style and more days of sickness absence while inspirational leadership was associated to lesser days of sickness absence being taken by employees (Nyberg, Westerlund, Magnusson Hanson & Theorell, 2008, p. 803).

The management of absenteeism and work commitment: Research conducted by Chênevert *et al*. (2013, p. 355) has shown that absenteeism was a response to either low organisational commitment exhibited in short-term episodes of absence, or as a result of exhaustion. While they argued that absenteeism can be interpreted from various viewpoints, longer-term absenteeism could also be an outcome of psychosomatic dissatisfactions. In this study a night ANM did not agree with these sentiments. She stated the following:

"*So, they abuse sick leave and here also, the people stay out* (away from duty/ absent) *too easily* ..." (II P1).

Davey *et al*. (2009, p. 326) indicate that the best predictors of nurse absenteeism in hospitals include previous attendance and apparent norms of absence. Where apparent absenteeism norms, previous individual absenteeism or poor attendance records are found to be high, absenteeism is bound to increase and reinforce an absence culture. Poor attendance or the practice of absenteeism is reinforced in a salient culture that supports an absenteeism culture (Nicholson & Johns, 1985, p. 397). Collaborative working rather than working as individuals is seen as essential to improve a workplace culture. Progressive leadership empowers staff, reduces patient mortality, and enhances nurses' health and job fulfillment. Absenteeism, staff turnover and incivility were also seen to decrease with constructive and progressive leadership (Day & Leggat, 2015, p. 288). The perception of job-involvement is the mark of the importance of the job to the self-image (Scrima, Lorito, Parry & Falgares, 2014, p. 2161). It is also seen as the extent to which a person actively participates in his job (Scrima *et al*., 2014, p. 2161) or the measure to which one's self-worth or self-esteem is influenced by perception of own work performance level (Scrima *et al*., 2014, p. 2161). On the other hand work-involvement is reflected as employment commitment, whilst others refer to work-involvement as work centrality (Stiglbauer, Selenko, Batinic & Jodlbauer, 2012, p. 355). Davey *et al.* (2009, p. 319) reflected on the findings relating to the significant negative relationship between job involvement and absenteeism when job involvement and organisational commitment were both high.

A number of studies have been conducted related to the professional style of engagement of a manager/ supervisor and/ or decision-maker with employees and have consistently shown that there is a link between the absenteeism of certain levels of staff and effective leadership that is seen to demonstrate respect towards employees (Schreuder *et al*., 2010, p. 575; Schreuder, Roelen, Zweeden, Jongsma, van der Klink & Groothoff, 2011b, p. 64.). It has been found that an association exists between managerial leadership and self-reported absenteeism due to illness in Swedish people between the age of 16 and 64 who were gainfully employed (Schreuder *et al*., 2011b, p. 60). In line with these findings, Nyathi and Jooste (2008, p. 34) found that higher absenteeism rates are associated with poor group cohesion, poor delegation of autonomy, ambiguity of role fulfillment, poor routinisation and workload in relation to workplace in hospital nursing staff. Suby (2009, p. 98) has cautioned on an imperative aspect in managing absenteeism referring to the huge staffing numbers in nursing that appropriate support should be for nursing work by ensuring that there is sufficient complementary staff when resident nurses are absent or need to be away. A negative relationship between absenteeism and organisational commitment is likely to show that the more committed a staff member is to the organisation, the less she would stay out (of work) (Davey *et al.,* 2009, p. 320).

The ANMs stated that staff absenteeism negatively affects the work situation and needs a concerted management approach:

"… that we can be aggressive towards handling those kinds of situations to help them also and also for the service because they're not how can I say their performance is not good when they even here, so it's not good for the staff that they are working with, as well as for the units' performance and overall performance -caring of the patient, and how they are working, their quality of work" (II P4).

Daouk-Öyry *et al*. (2014, p. 96) emphasise that absenteeism and turnover are to be addressed holistically from many levels. If absenteeism and turnover are not addressed in this manner, effective and lasting solutions to these problems may remain hard to achieve. The systematic review on absenteeism of nurses in hospitals by Davey *et al.* (2009, p. 328) showed eight predictive categories of absenteeism to be more prominent. These included previous attendance record indication of individual nurses, attitude towards work that included work or job involvement, organisational commitment and job satisfaction, retention factors that have a reducing effect on nurse absenteeism, and absenteeism where burnout and job stress are found to be have an increasing effect on absenteeism. Research on predictors of hospital nurse absenteeism however remained inconclusive on 'staff' nurse absenteeism. This has led to uncertainty about such predictors and therefore the costly problem of absenteeism was said to remain a challenge (Davey *et al*., 2009, p. 328).

The ANMs supported new initiatives developed by their colleagues to manage absenteeism. One ANM participant in this study working the day shift complemented, supported and implemented a absenteeism management strategy introduced by her night shift counterpart at the same hospital

that attempted to understand and manage the nuances of absenteeism by conducting a retrospective interview with each absentee after every period of absence from work, to gather data/ information on the absence and thus improve attendance. The following illustrates their adoption of the initiative of having a 'post absence interview' which the participant claimed was useful especially where there has been perceived abuse of sick leave:

"…because we implemented now also this …i.e. the abusers. They come from sick leave, and you must ask them certain questions, and ask them … how was their sick, are they feeling better now … that kind of thing that you never ask, sometimes how are they feeling... how they are what do they think what was the impact of their illness on themselves, or on the work place and how can we help them to improve or is there anything they want us to do for them. That is for me nice and there was one person that I did this questionnaire with … and since that time her profile improved because there's also like there's somebody interested in my well-being" (II P4).

Within the FBU there was an expectation that costs be curtailed. Absenteeism was seen as incurring costs. A night ANM shared this sentiment:

"…about that responsibility, responsibility of facilitating - let's call it facilitating -the functioning or the effective and efficient functioning of the service on night duty. Obviously if you need to look … in order to have it efficiently and effectively for that night, just to sort out your absentees …" (II P19).

Mckenna *et al*. (2011, p. 62) state that nursing care hours are expensive. The nurse managers in this study believed that absenteeism came at a cost:

"When we look at the absenteeism of the people... we were actually now under tremendous pressure with the use of overtime" (II P12).

Clark, Moule, Brodie and Topping (2014, p. 5) concur, asserting that staff request for a change in shifts at short notice, or unanticipated workload demands, staff illness, absenteeism, staff development and essential training are frequently invisible tasks of many nurse managers. Such activities do present a financial burden on a possibly already constrained budget and consumes significant management time in health-care settings. Suby (2009, p. 98) asserts that nursing leaders are compelled to reduce labour costs whilst still having to maintain quality. Simultaneously they are required to defend the available nursing staffing numbers they had over many years secured for a safe service at the patients 'bedsides'. The perception and understanding other staff has of the management of finances also appeared to be important to the ANMs. They stated that at times they needed to deal with the fall-out of the attempt by management, inclusive of nurse managers, to manage finances effectively as well as the staff's misunderstanding. They reiterated the perception the staff has of an association existing between the need to work cost-effectively with the restrictions on making use of complementary staff to work overtime when there was a real service need. It seemed important to the ANMs but more so to the HONs that staff inclusive of the ANMs understand the complexities of having to do financial management. Hence they proposed that there be formalised education in this regard:

"A short one week, two week training but that must come from a central point or what, to give them (ANMs) *guidance regarding budgeting and all that sort of things, … because there is*

shortages (meaning shortcomings) *by my ADs. Sometimes they can't understand but why is there no money to buy a fridge or that. I must explain to them that's how it works. We got a BMI, you've got that and that and that, that …'"* (FG2 P2).

From the findings of the sub-category regarding *managing absenteeism* in relation to the Business Unit and managing finance, concluding statements were made (Annexure X).

4.7 KPA 4: SUPPORT FUNCTION

4.7.1 KPA 4: Understanding the KPA support function

The support of staff by a nurse manager is viewed either with high esteem or ostensibly overlooked even in the absence of specific nurse manager supportive behaviour (Schmalenberg & Kramer, 2009, p. 62). This study identified that a key performance area of the ANM in provincial health-care settings has a support function. The ANMs in this study identified three groups of stakeholders to whom they provide support and guidance. These are nursing staff, doctors and external stakeholders/ private parties. In managing the ONM supervisees, coaching done by the ANMs was seen as supportive and developmental. The support function includes being accessible. A participating ANM in this regard stated:

"… to assist and to guide the Operational Managers in all their key performance areas… but for me it's always been the support and the guidance …and I always avail myself" (II P9).

The HONs recognised the strong supportive arm the ANMs render to the specialist doctors at the provincial health-care settings. In this regard the ANMs also give support to ONMs which enables them in turn to support the specialist in co-managing the FBU. At times this support was indirect.

"The key performance...the other one (referring to the other KPA) *is the FBU because all the Operational Managers, FBU managers … so they must run with the FBU* (referring to the operationalisation there of), *they must run within their budget, procurement of stuff, and that kind of thing …"* (II P25).

An HON expressed his delight with the support that is given to the Head-Specialist doctors by the ANMs by stating the following:

"I think what also is good for me is that I find that they (ANMs) *work very well with the other disciplines especially in my case the heads of those... like the Head-Specialist doctors"* (FG2 P1).

The sentiments of the ANMs in this study, who are also required to deal with external service providers, also deem their required engaging with these parties as involving a considerable degree of support:

"…who our stakeholders are our PPP ('public-private partnership), *our contractors. So we need to see that processes are in place to accommodate the wards as well as the PPP processes so, we need to see that... I'm just now thinking about my dealings with the PPP …"* (II P3).

On the night shift at each of the hospitals, an ANM is the overall manager in charge of and responsible for giving support to ensure smooth operating (i.e. logistical and other) systems (field notes from each individual interview; personal researcher experience).The following statement made by a night ANM characterises this nursing managerial situation:

"There is... the guys… work as a team, and not as a department. Because we are on the Night Shift, it works like this. We have three, there are only three people in a department -I am referring to a ward with 28, 30 patients. Then there's only three -the Sister, the Staff Nurse and the Nurse or a Student or a Nurse Aid. And they know -each individual knows what is expected of him and each one does (emphasised) *his part… the team is oiled well. The machine is rolling very well"* (II P23).

The focus groups revealed that the feasibility of the existence of the role and the official position of the ANM was being questioned, the counter argument being that ONMs might be able to fulfill this need as asserted by a participating ANM:

"You know, I am first going to mention the negative side because ... I just wander sometimes if there really is a place for an Assistant Manager because we now have Operational Managers in the Ward! It feels to me as if I am just the medium between the Operational Manager, the Ward and then HON. Because I mean the Operational Managers do everything. We only really have to do cooperation... the collaboration together. … I say this is the negative side" (II P13).

Based on the responses elicited in the focus group discussions of this study, the HONs were appreciative of the support they received from the ANMs. In response to the above, they indicated that the support function of the ANM was invaluable by the following statements:

"I think it's a question that have been asked before (said slowly and seriously - field notes) *whether there's a need for Assistant Managers... that question has come up* (other HONs in the group acknowledged this statement with affirmed m m m's - field notes)*"* (FG1 P2); (utterances from P2 heard in the background but P3 comes into the discussion loud and assertive - field notes) "*yea, you know with FBUs, the FBUs implementation"* (FG1 P3). *"In psychiatry* (confirming - field notes)" (FG1 P1). *"Yes...is there a need for your Assistant Managers? Definitely there's a need for ANMs because you need to have that interface between the HON and the ONMs. If you don't have that… and they* (the ANMs) *play that vital role to oversee the Operational Managers and the Clinical Services operations… they're the link between the HON and the nursing service"* (FG1 P2).

According to McKenna *et al.* (2011, p. 57), ward shift supervisors as the intermediate level managers, are vital in reciprocating support and could provide both senior levels of nurse managers and unit staff nurses, with valuable guidance on staffing numbers to make suitable and cost-effective staffing decisions. The HONs though made reference to *'the old days'* (FG2 P2) when they had the additional support of the two distinguished support positions of a clinical and an administrative nurse manager. It was:

"They are very supportive I think, to the HON, and (murmurs of support heard in the background from fellow HONs - field notes) *help where they can. In the old days, I always go back to the old days. In the old days we've had two Deputies* (i.e. deputies to the HON) *the one was originally*

'clinical' and the one was 'administrative' (supported in the background by fellow HONs - field notes). *Uh okay ja* (affirming) *so then in those days as you can tell. Okay, you must do the clinical things, you must do the admin things* (meaning more managerial things) *and it was of great help for the HON"* (FG2 P2).

The ANMs themselves acknowledged that they had an inevitable support function towards their senior. This was illustrated by a response from an ANM participant:

"I mean you always have a support function that you then give to your direct head or whoever would come to you" (II P18).

Schmalenberg and Kramer (2009, p. 61) identified leading behaviours which identify the most supportive behaviours by nurse managers as perceived by staff nurses (equated to Professional Nurses in the South African context). These behaviours are the display of diplomacy, and fairness and honesty when conflict needs to be managed. Diplomacy refers to the manner in which mediation and negotiation would occur (Morley & Stephenson, 2015, p. 22). This was important for one participating ANM:

"I thought I would never apply for this position because I'm one of them (ONMs), *then they will not respect me, because I'm also maybe younger than some of them. But now I experience it's not so. It's not the truth because it's the way you handle yourself, the way you manage yourself, it's the way you solve problems and you approach people, that is what makes the difference then"* (II P4).

There was also a perception that a manager who ensured that resources and staffing were adequate, was seen as being supportive. Another indication of nurse manager support is when sound decisions are made and feedback, both positive and negative is provided (Schmalenberg & Kramer, 2009, p. 61). A manager said:

"...the point that I want to also tell you is when I receive an audit back from my wards, because in my three wards they go and audit different people, you know, it isn't the ward who audit themselves ... and I audit, then when I receive it back, then I go back to the people and I discussed it" (II P13).

With regard to self-awareness, an ANM participant stated:

"You must also be honest to yourself about your own shortcomings and not look at yourself, you know everything" (II P4).

Referring to the importance of having an open relationship with her HON, an ANM said:

"'Be honest' even with Mrs. HON now, my DD. If I was not sure how to do it or/ and if somebody told me something and I think I should rather keep it for myself, the next minute I thought 'no' I must share it because she's the one that must know also about this things ..." (II P4).

Loyalty and support transcended adversity. This was the experience of a HON at one of the study hospitals. She described the period between the official announcement of the OSD and the actual implementation of the designated nursing managers and other nursing posts according to the official organisational design for nursing, as a transitional period of flux and uncertainty. However, she stated that once an organogram was proposed at the setting at the time, though not

accepted by all, much support was received. The manner assumed by the senior nurses placed in these interim Assistant Manager positions per the organogram was described by the HON as loyal and responsive. The following was said:

"Everybody was extremely supportive even if they didn't like it, to me. They were loyal and they were supportive and they would do what they were asked to do" (FG1 P3).

Staff nurses at Magnet Hospitals, known for their superior nursing recruitment ratings, identified nurse manager support as one of eight imperatives of a healthy work environment (Schmalenberg & Kramer, 2009, p. 62). They associated support in regard to performance as being primarily leadership behaviour (Schmalenberg & Kramer, 2009, p. 64). Other sources have shown that progressive employment policies provided organisational support and satisfaction for nurses, as they have demonstrated enhanced levels of workplace safety, superior patient outcomes and improved patient satisfaction (Shaw, 2006, p. 2). The study of MacKusick and Minick (2010, p. 338) describes situations in which managers display indifference and fail to address inappropriate behaviours in the workplace. It was the support deficit which was firstly reported to be the cause of why nurses were leaving clinical nursing practice (MacKusick & Minick, 2010, p. 339). The clinical practice environment actively focuses on eliminating horizontal hostility, vertical indifference and moral distress, and increased support to nurses with job satisfaction and retention of nurses (MacKusick & Minick, 2010, p. 339). The link with the issue of nursing attrition associated with job dissatisfaction, lack of support, horizontal hostility and bullying, and moral distress. The support of a nurse manager is perceived to be crucial for a healthy work setting (Schmalenberg & Kramer, 2009, p. 61). In response to the question on how a nurse managers' time should be apportioned, Suby (2009, p. 100) asserts that time is to be invested in support of staff, monitoring the delivery of care and providing leadership. Night ANMs perceived the day managers to have a more supportive work milieu because of the nature of the day operation as opposed to that on the night shift. One night ANM stated the following:

"I must plan fast... Look the day people, they have others Day Matrons, they can phone each other ..." (II P28).

An ANM (II P6) who did not want to be recorded, held the view that it was imperative to go back to check on nurses who needed to be shifted from their 'normal' duties and 'go behind the action or operation' especially when they did not seem happy about the move, and that a special effort be made to see how they were doing later both work-wise and emotionally. They need to be reminded of their worth in the attempt to get them more settled in the reallocated work place as maximum performance output was still expected for the duration of the shift. He claimed that this intuition was amongst his best work performance experience. A manager who understands the authoritative role of emotions in the workplace is amongst the best leaders as they are perceptive and able to adjust to situations, and build relationships (Goleman, Boyatzis & McKee,

2013, pp. 5 & 6). From the findings of the category understanding the *Support Function*, concluding statements were made (Annexure X).

4.7.2 KPA 4: Discover

INPUT: Best work performance experience in the KPA support function

This study found that the best work performance experience in relation to the KPA support function, involves communication and interpersonal skills.

4.7.2.1 Sub-category 4.1: Communication and interpersonal skills in relation to support function

Research has consistently identified a number of vital nurse manager competencies. These include communication and interpersonal skills (Chase, 2010, p. 51). The ANMs in this study depicted and elaborated on how well they apply their interpersonal skills. In turn, some of the participating HONs expressed how well the ANMs would engage with others and meaningfully use their interpersonal skills. In regard to this conviction, the responses of a day ANM and a night ANM respectively were positive as the sentiments were repeated. In this regard, they alluded to their resilience as they are always willing and available to listen:

"… open communication… they can come to me, they can talk to me …" (II P4). *"Yes, I've got an open door policy, yes they can come to me with everything from the lowest to whoever, they can come in here, we'll talk …"* (II P12).

In 2007, a literature review completed by Jennings, Scalzi, Rodgers and Keane (2007, p. 172) on nursing leadership and management competencies, found personal qualities, thinking and business skills and the ability to initiate change, knowledge of health-care, and interpersonal and communication skills to be inherent in both leadership and management. In this study, another ANM also made reference to the good working relationship she had with the staff on her night shift, which came about as a result of her communication that lent itself to accessibility. She proclaimed:

"What I am good in is communication né. When I came on to Night Duty as Assistant Manager, it was about immediately opening up to the people, so they accepted me, and we've got a good working cooperation" (II P23).

Based on order of priority, Nursing Directors who had given input into another study rated nursing administration leadership skills as power, negotiation skills, organisational skills, planning ability, long-term-care knowledge with communication as the highest (Dever, 2010, pp. 31-32). The participating night ANM also reflected on her teams' effective communication that enhanced team cohesion:

"We can speak to each other about everything and stuff and more. …There is a good team spirit. Everyone works very well together …" (II P23).

When the issue of quality in health-care gained momentum, emphasis was placed on three key nurse leader distinctions namely: (1) the quality of facilities and the health-care milieu; (2) the quality of technical service; and (3) the quality of interpersonal relationships within the health-care setting (Potter, Morgan & Thompson, 1994, p. 4; Dever, 2010, p. 44). A notion exists that the ability to lead in nursing, requires the ability amongst others, to communicate well and initiate and sustain sound interpersonal relationships (Dever, 2010, p. 44). Communication and interpersonal skills are one of the three sets of chief characteristics of nurse leaders. The effective use of communication and interpersonal skills by ANMs led to the development of other strengths that additionally was enjoyed by the ANMs such as the ability to organise. The following was stated in this regard:

"I've got good interpersonal skills, so I get on well with people and I like organising... I can organise ..." (II P25).

Based on the responses in this study, positivity prevailed in the nursing managerial arena along with a belief that a synergy exists between communication, interpersonal skills and the ability to organise.

"… Then we must also look at our skills, the Labour Relation Skills. We look at interpersonal communication skills with regard to how we speak to our employees and colleagues in the work circumstances, and then it is so -we must be therapeutic. We must have good relations amongst each other and then I have mentioned the Labour Relations part also our Management Skills. We must have good Managerial Skills, and then Organisational as well... with regard to work, we must be able to organise and also within 'time frame'" (II P12).

In line with best work performance experience, the ability to organise team building events for the nursing corps and the MDT are based on sound communication and interpersonal skills as fellow colleagues in the health-care setting need to be recruited and engaged positively. It also means that ANMs need to use communication and interpersonal skills effectively to see successful outcome of their efforts. The success of the MDT and nursing events reported in this study, relate to the skillful use of communication and interpersonal skills by a veteran ANM. He stated the following:

"… We have a 'wors braai' every year, so I organise the wors braai. The Hospital Board gives us a little sum of money each year. This is just an appreciative thing at the end of the year you know and then in the morning we braai and all the Operational Managers, we make salad and I come in at night and I come and braai the sausage" (II P25).

The ANMs also viewed communication and sound interpersonal work relationships from an existentialistic view. The following was said:

"I think I must start with myself, though it sounds a bit selfish but if I'm enthusiastic… I will, I might be able to empower somebody else to be that drive… uhm friendliness because interpersonal relationships is very important especially seeing that we working with human beings" (II P8).

The view of Chase (2010, p. 2) is that a nurse leader should possess superior horizontal and vertical communication skills, and demonstrate this at the management forums, as the nurse

leader role represents the vote of the nurse who renders direct care, as well as those who have vested unit level interest. A HON in this study stated:

"... and if it's something that they feel strongly about, they will support it but also I think what I appreciate is that they (the ANMs) *can say very assertively if they believe that 'this is not what should happen' or 'this thing is going to have a negative consequence' or 'we just don't have enough staff, we cannot take on that task'"* (FG2 P1).

It was assumed (Chapter 1) that in every society, organisation, or group, something works. It seemed that the ANMs knew when to be assertive and how to negotiate the MDT relationship. An organisational culture that fosters communication and collaboration enhances a healthy and effective workplace environment (Shirey, 2006, p. 258). Timmins (2011, p. 30) states that it is important that nurse managers create environments that endorse and support good communication where the communication skills of nurses are developed both officially and experientially. A night ANM pointed out how she would always strive to do the handover from night to day shift soundly as it (handover) had proven to be a nursing management activity that could hamper communication and interpersonal relationships between these two time-shifts, if not done well:

"If I now say (report) *something in the morning, then there's always someone that pulls to the other side that leaves me feeling that it isn't worth the effort, why have I raised it? ...we indeed have our people who play us up, play us up against each other ... But the thing is we have to work more closer with each other"* (II P12).

The researcher found that there were supportive bonds among HONs as well as they often supported each other in the focus group discussions. Timmins (2011, p. 30) previously identified that the nurse communication paradigm in health-care settings included having to communicate with multidisciplinary team members. The provision of sound health-care and having to ensure patient safety in health-care settings are thus critical components of contemporary health-care delivery. Communication is a common thread through all of these, hence the need for effective communication between team members is a solid means of support according to the Health Information and Quality Authority, a statutory, government funded monitoring agency in Ireland (Timmins, 2011, p. 30). The influential nurse leader creates a culture of open communication which led to improved patient care (Harris, Bennett & Ross, 2014, p. 1629). The ANMs all had their various communication systems at the various hospitals that ensured that communication was practiced well. A set of opposite night shift ANM partners at one particular hospital supported each other by means of telephone communication to keep the other updated regarding hospital matters:

"...phoning each other" (II P18); *"But that's the sister that is allocated to Psycho-geriatric* (ward) s*o I will communicate with her and will convey the things to her and will say 'Please will you now further carry this over to your three wards?' And for the rest of the wards, I will communicate on a one-to-one basis to the guys. It's 4, 5, 6, 7, 8, 9 uhm 12, 13, 15 --9 wards"* (II P18).

In terms of interpersonal skills, the participating HONs in this study expressed their confidence in the ability of the ANMs to work fairly collaboratively with other disciplines, and the Medical Heads and specialists, to the point that they are even able to understand their (the Medical Heads and specialists) ways of thinking:

"I think what also good for me is that I find that they work very well with the other disciplines especially in my case the Heads of those... like the Head-Specialist doctors. The FBUs ... ja. So they understand what is going on in that one's mind" (FG2 P1).

The night ANM at a busy General Regional Hospital, who was required to persistently consult with the Head of Institution and the Head of Clinical Services, stated the following:

"The people who are standing in for her as 'SUP', the doctors are also to be consulted -with which I do not have a problem with but sometimes it just feels that you are on the spot, that you must be able to make the decision but now you have to phone there first to them to ask them. Ne, it makes it a bit difficult. But in general, we have a very good relationship with each other -well they are both doctors (i.e. medical doctors employed at the hospital), *they have a bit of an understanding and they both did their intern -housemanship year here and have worked here for many years so they are coming along here for many years. So they have an understanding/ a comprehension of what is happening in the hospital. We have good relationship"* (II P26).

The findings indicated that nurses ought to be re-taught how to write reports. One ANM professed to have contributed meaningfully to improving the standard of nursing report writing, a form of communication done by the nurses and needed for sound patient procedures. She indicated the following:

"The nurses no longer know how to complete the forms. They can't even do admission properly. You know that accurate assessment of the patient, and accurate reporting. They can't even write a report properly so there I played a big role there you know so ..." (II P1).

The use of standard language positively impacts the flow of daily work processes and improves patient safety (Saranto *et al*., 2014, p. 629). This is in line with the AI paradigm used in this study which recognises language as the dominating tool in which the ANMs carried out their work performance. It also confirmed the AI assumption in Chapter 1 that language used becomes the reality. In the UK nurses are expected to be proficient in communication from the point of registration. However organised consistent assurance of competency in communication skills beyond this initial point of registration is not sufficiently ensured (Timmins, 2011, p. 30). This has led to the development of a 2010 UK Nursing and Midwifery Council guidelines that address communication proficiency unequivocally. It requires that nurses use a number of means and approaches inclusive of technological means to facilitate the acquisition of information and communication effectively with all service users so that optimum health and equal access to health-care services result. These guidelines describe the detail of the communication and interpersonal competencies that are to be mastered by nurses, for instance, the ability to respond warmly and positively to persons of all ages who may be compromised in any way or specifically in health and/ or well-being (Nursing and Midwifery Council, 2010, p. 15).

The ANMs believed that they made a difference in assisting the staff to discern between social and the required official relationships on the job. An ANM stated:

"I will, I might be able to empower somebody else, to be that drive, and friendliness because interpersonal relationships is very important especially seeing that we working with human beings, and also to motivate the staff and learn to know the staff better, not social relationships but kind of professional relationships" (II P8).

Another example of the current communication flow between the night ANMs and the day ONMs who take on the late and after-hour shifts, is the handover between ANMs and ONMs. These two groups interacting very directly with each other, illustrated by:

"And then with the day managers (ONMs on the late shift) *...we lot amongst each other, have a good relationship .... In the previous hospital where I had worked, myself and the other sister worked for six months without a day off opposite each other doing 12 hour shifts ---- for six months long ..."* (II P26); And: *"... look, the two of us we relieve each other. When he isn't here, then I do his wards as well and when I am not here then he does my wards"* (II P24); *"we do 'call'* (i.e. hospital on call/ standby duties) *for each other so ..."* (II P25).

The characteristic of being approachable, safe and promoting staff cohesion is also perceived to be reminiscent of nurse manager support (Schmalenberg & Kramer, 2009, p. 61). The HONs expressed their appreciation for the assertiveness in communication the ANMs have developed, which they apply in the work place so that the best interest of the patient remains the uppermost consideration. This confirmed the AI assumption in Chapter 1, that in every society, organisation, or group, something works. In this regard the ANMs could work well with others; and knew when to be assertive and how to negotiate in relationships. Acting in this manner corresponds with the South African Nurses Pledge of Service, 2004-2015 (SANC, 2013) whilst they also maintained a balanced view of what can be realistically achieved. This was illustrated by a response of a HON:

"So I feel good that they are assertive. There was a time that they weren't like that but I think they've moved toward that point where they can actually say that is not going to be in the best interest of the service or of the patients or whoever, so unfortunately we cannot support whatever you put on the table" (FG2 P1).

A professional duty requires of nurses to uphold good quality communication skills with the assistance of the nurse managers. In the UK the Department of Health has specified that communication is a core performance skill for nurse managers and for every level of care (Timmins, 2011, p. 30). The ANMs have taken up leadership roles because of the nature of the senior positions they occupy. They have also indicated how they at times need to do the work of their supervisees, the ONMs (Unit Managers). The experienced ANMs, who worked the night shift at the psychiatric hospitals where therapeutic services were provided, would also engage with patients. This strengthened patient rehabilitation as they used their communication skills and embarked on educating and reassuring patients:

"Something that I do that doesn't appear at all on the Job Description is that we administer medication on night duty, so you take responsibility for the medication -administer and do health

education with the patient in this regard, because these are long-term patients to whom we administer medication as well as those in the Alcohol Rehabilitation Unit and even there as well, the patient must be given health education regarding medication, and motivate them and say 'Are you feeling alright?…' that 'it's comfortable to be here (i.e. in the hospital) *but the moment you are discharged…!'; to make them aware of all the pitfalls that they could fall in. So you give them some information -I really try to prepare them realistically of what is waiting on them on the outside"* (II P18).

In this regard, the ANM used the teachable moment (Marshall, 2016, p. 13), which is the opportunity a nurse takes to help patients to learn to manage their own care. The behavioural work performances of the ANMs in this study can be equated to the behavioural performance of the ONMs in a study conducted by Anderson, Issel and McDaniel (2003, pp. 3-4). They used a relationship orientated leadership instrument. It was found that where leaders were relationship focused, open communication and interpersonal relationships between staff by their behaviour was ensured that in turn resulted in increased positive patient outcomes.

The study of the leadership practices of Nursing Unit Managers conducted by Peregrina (2009, p. 76) identified that the most essential leadership skills could also be seen as transformational leadership characteristics, that include good quality communication and interpersonal skills along with having internalised other personal skills such as honesty, fairness and transparency. Therapeutic communication and relationships are listed as required competencies for the Professional Nurse, as well as that of the Nurse Specialist (International Council of Nurses (ICN), 2009, p. 22). Interpersonal relations are not limited to skills alone, but also entail the effectiveness of the communication to others. The interpersonal relation dimension put forward by the ICN involves trust, promise and teamwork, and the acknowledgement of a culture and beliefs of others. It also supports the documentation of patient care needs to be clearly and succinctly scripted (Western Cape Health, Directorate Nursing Services, 2014). Timmins (2011, p. 31) had listed 'field competencies' relating to communication and interpersonal skills, for a division of nurses, working with adult patients. From the findings of the sub-category of *communication and interpersonal skills* in relation to the KPA Support Function, concluding statements were made (Annexure X).

4.7.3 KPA 4: Dream

OUTPUT: Best possible work performance opportunities in the KPA support function

This study found that best possible work performance opportunities in relation to the KPA support function, involve staff orientation and in-service training, and workshops for nurses.

4.7.3.1 Sub-category 4.2: Staff orientation and in-service training, and workshops for nurses in relation to support function

The experiences of the ANMs in this study revealed that clarity of role is secured when orientation and in-service training is provided:

"And if that thing (referring to orientation) *isn't there, then it's going to be like this but if those things are there, and the people go on orientation or induction or whatever, they know exactly what is expected of them"* (II P21).

When appropriate orientation and induction are given to newly qualified nurses, the culture shock is reduced and their working experiences are optimised, facilitating a smoother transition into the new professional role (Thopola, Kgole & Mamogobo, 2013, p. 178). Thopola *et al*. (2013, p. 178) based on the positive view of the experiences of newly qualified nurses held of orientation, have compiled recommendations for the creation of working conditions and a working environment that would enhance patient safety and QNC. Crucially this includes the development of orientation programmes for new staff members where these programmes are absent. The ANM participants stated that own capabilities, resources and their self-determination should not be undervalued in this regard. Both day and night ANMs believed that success in orientation and in-service training lies in using the existing staff capabilities. It was said:

"I am thinking about in-service training but actually utilising their skills" (II P22); *"... in-service training doesn't happen off the premises of Hospital No. 8, it happens right here. Because we're a speciality, we should actually look after ourselves ...because if you don't say it. I need to go and sit in on that ward round' or whatever, 'nobody's going to push you* (i.e. the ONM)*"* (II P9).

In-service training and workshops are important formats for nursing training as they eliminate 'trial and error' practice and enable and strengthen quality improvements, patient safety and promote professional development and ethics (Thopola *et al*., 2013, p. 178). Best possible work performance opportunities were found in relation to the support function involving staff training and workshops for nurses:

"...So I'm trying to foster a spirit amongst the staff to say 'I'm responsible for my own training' and to demand to be given the opportunity ..." (II P9).

De Jager and Swanepoel (2008, p. 181) identified levels of satisfaction in a large provincial hospital in South Africa, and found that aspects of staff orientation was lacking. They suggested that: (1) the explanation of hospital objectives/ goals; (2) the assurance that the various departments understood the goals; (3) the functioning of the HRs department; and (4) the functioning of the overall hospital management needed to be attended to by the management team. The ANMs in this study recommended that training within the current clinical practice be improved, and that model-based clinical supervision be implemented when nursing and other staff are to be orientated to the job:

"They (the nurses) *are struggling I am not saying our nurses are not working yes they are working very hard - but that extras, I can't even say extras because it is still part of nursing care*

because I'm thinking ... this curriculum in front of me, I'm seeing that where it comes to that kind of basic nursing care - so at the end of the day just to improve on what they need to do - I want to see that change" (II P21).

A sense of a dream in work performance, and the training needs being fulfilled were conveyed by one ANM as she disclosed that the responsibility of orientation and in-service training with specific reference to aspects of HRM were vested in her. She stated the following:

"…They normally ask me to orientate new personnel about leave and absence in the public service" (II P14).

Proper orientation is not confined to only showing the novices the physical layout nor is it informing them that they are to commence with work to curtail the nursing shortage. Newly qualified nurses in the South African study said that they needed to be orientated as it is a pathway for professional growth (Thopola *et al*., 2013, p. 173). The night ANMs kept abreast with the needs their night staff had for in-service training, and would arrange with the hospitals' nurse trainer for the required training in a more proactive manner, a move away from the trial and error practice. The training needs were corporate in nature as well. The night ANM verbalised the following:

"…I have informed Mrs. Tutor Hospital No. 7 that the staff would very much like to have in-service training on so… that… or from human resource, so they (the staff) *can be enlightened about pensions …"* (II P12).

Operational managers also needed development and training. ANMs verbalised that the ONMs still require a lot of support as many had been working as ward sisters. Therefore, coaching ONMs in the management of HRs and disciplinary processes when required, was deemed developmental and supportive. Yet another perception of nurse manager supportiveness was said to be when the latter would ensure staff learning by making the opportunities available. Loo and Thorpe (2004, p. 88) emphasise the need to better first-line nurse managers for their evolving and challenging roles. The e-learning medium has been shown to aid own-management of learning, be cost-effective and delivery-efficient for staff training and development and may be accessed on demand without requiring conventional training space (Cheng, Wang, Yang, Kinshuk & Peng, 2011, p. 1317). A critical success factor in workplace e-learning however is the alignment of e-learning programmes and required work capabilities and performance requirements (Cheng *et al*., 2011, pp. 1317-1318).

Evidence on workplace training and HRD has also shown that mentoring and peer relationship activities are considered to be of critical importance to employee development (Cheng *et al*., 2011, pp. 1318-1319). As compared to the historical perception that training and development incurs expense, James (2006, p. ii) states that organisations in South Africa are becoming increasing aware that a skilled worker is an investment to the organisation. Amongst the best possible opportunities envisioned by the ANMs in which to flourish in work performance, training and workshops for nurses were identified. Aspects of the dream of training and

workshops that were mentioned related to: (a) approach and need for training and workshops; (b) the role in people management and self-directed learning; and (c) the stimulation of development. The latter was were further sub-classified into: (i) rotation of nurses; (ii) the practice of a training routine; (iii) the teachable moment; (iv) training in relation to trends; and (v) that teaching is to be viewed as a means of support especially for the night shift staff:

(a) Approach and need for training and workshops

The ANMs are aware and also dreamt about the need to share knowledge acquired from training, vertically from seniors/ supervisors to lower levels of staff, as well as horizontally from one department to another. The ANMs listed a broad range of training and workshop related needs. They identified a training format which ought to be developed more comprehensively in order to re-dress their work performance development based on the domains of the WCP health-care services operational plans of service delivery and transformation, clinical governance and QA, and corporate governance. The communication skills of negotiation, conflict resolution and dialogue are increasingly being recognised as important in the clinical setting for aiding good clinical relationships. In this regard, it is claimed that 'good people relationships' could supersede professional competency (Stapleton *et al*., 2007, p. 814). An ANM desired her staff to be able to see the patient other than just the tasks needed at hand. She stated the following:

"I would like to change the mind-set of all the nurses to think more holistically and not just one thing you know! ...I want them to go to workshops you know to go that extra mile for the patients and for their department and to have that pride ..." (II P21).

The researcher sensed the ANMs frustration related to the poor staffing situation that restricted nurses from attending training programmes or to upgrade, as relief staff were not available to complement those needing to go for training. The statements made in this regard included:

"What I also, that is also a problem that I feel that they can give more attention to is that we, the night… look, there are personnel that are working permanent night duty. Now ---that they send these people for training more so, or that we could more so get the people in (meaning the trainers to come in and offer training). *They say I must identify whether there is a need* (training need) *but now you have the need but you cannot accommodate the person in your working time who is coming to do the training, as the patient would then be waiting -, and we must get to the patients. Okay, my other dream would be that I will be able to let my staff go for more training. Because of the shortage of staff, it is not always possible for them to go to training ..."* (II P22);
"So that more relief staff is given to the night shift, so that these people can receive in-service training more so, on a continuous basis, in order for in-service training to happen as it is mostly the day people receive in-service training because they are invariably more, they get the opportunity to receive in-service training ..." (II P23);
"And you only do that. You do nothing.... you don't go further out (referring to development) *and do something even better. That is if you get more in-service training, almost in a manner that a relief is given, that our people* (night staff) *can develop more"* (II P23).

At some hospitals, there was no nursing tutor, or nurse training to effect training and workshops, even during the day shift. The AMNs dreamt of how things could be done better was having an

on-site mentor, who could assist with training. An ANM indicated that a tutor or trainer was needed…:

"…back into the hospital, maybe on a contract or something just to mentor staff… definitely we need more internal in-service training" (II P10).

On a broader perspective, Africa's Public Service Delivery and Performance Review has pronounced that there is a need for public servants to be trained and re-developed in order to promote the non-tolerance of a culture of inferior and sub-standard service delivery. Training is to empower public servants not to reinforce such a culture (Mle, 2012, p. 30). Based on the collective sentiments of the ANMs, the desire for the implementation of a training programme that would respond to the identified needs to facilitate best possible opportunities for nurses to flourish in their work seemed evident. The facilitation of relevant training in the department where the study was conducted commences annually with the identification and collation of needed workplace skills, followed by the creation of a 'workplace skills plan' per provincial health-care settings:

"… but it is true training and to put examples in place to help them. If there's shortages or whatever or needs, then you must then see what you can do! And ask for help in …there's the Skills Development (other participants were softly in agreement - field notes), *money that we've got, what we can use"* (FG2 P2).

Personal development plans should be based on the careful analyses of opportunities and learning needs of each individual in accordance with set performance standards for a set time period. When performance management plans are drafted, the overall goals of each department or division are a consideration. Goals and objectives for performance are to be quantifiable, attainable and enforceable in order to achieve the most promising results (Pillai, 2012, pp. 72-73). Along with what other scholars have said, efficient HRs in health-care settings can impact considerably positively on the quality of health-care delivered and the enhancement of work performance standards of the staff at health-care settings. A study investigating the impact of HRM on the quality of health-care proposes though that the continuous development and training of staff performance and the work of the managers of the HRs department at a hospital is to first occur, before starting a performance development process (Elarabi & Johari, 2012, p. 13).

The ANMs assigned a special importance to in-service training. The perception of in-service training in South Africa has transformed from a type of practical training complemented by short courses and formal training programmes, to wider parameters that now includes professional development (Bailey, 2013, p. 6). However, Louw (2008, p. 1) with reference to teacher training, holds a view that 'professional development' is a re-worked term for 'in-service training', a view supported by Bayrakci (2009, p. 10). Whilst the two are sometimes used interchangeably (Engelbrecht, Ankiewicz & De Swardt, 2007, p. 581), in-service training is used in this study as

a form of professional development pertaining to nurses. The ANMs stated that in-service training is to be extended to empirical clinical fields:

"I think like I said with us we do, definitely we need more internal in-service training and not just not just to touch disease processes you know …" (II P10).

The ANMs expressed confidence in the strength they have to provide in-service training using their own resources as opposed to going to the central formal training center, the proximity being a great advantage. There was also a lot of credibility given to the learning opportunities that were available on-site because of the speciality services that were often overlooked and not given the credit it duly deserves. In this regard, they said that the formal courses offered by the external sources should not be seen as the only credible source of learning/ training. They therefore recognised their fields of speciality as unique and dynamic and able to make a contribution to learning if the opportunity was taken advantage of. The ANMs verbalised:

"We must stop looking for in-service training out there! It doesn't happen at training center No. 1. We're a speciality and on these premises ther a lot of in-service training opportunities …" (II P9).

(b) The role in people management and self-directed learning

In envisioning that things could be done better, the HONs indicated as hospital middle-managers and as nurses that ANMs should also be exposed to various kinds of learning and be allowed to develop in management. They emphasised formalised training as the means to pursue such desired development as they believed it would enhance the ANM's ability to work better with people. In this regard a HON verbalised:

"But definitely, they would at the most need different courses … say (alluding to needed development) *especially the middle-management and the people management kind of courses"* (FG1 P3).

Apart from formal training and workshops in service delivery, caring and other areas outside of the person, training regarding the nurse-person was also recognised by the ANM. The importance of self-training by the ANM to get to know a nurse better was pointed out. There was a perception that when training is offered, that this served to motivate nurses. The following was verbalised:

"I think we must give them (staff) *more information, more service training …motivate staff … learn to know staff better"* (II P8).

The HONs also emphasised self-determined service training/ development likened to that described by Julie (2014). They suggested that ANMs step out of the operational role and reflect by means of deliberate thinking and forecasting. The following was verbalised:

"And also the management (i.e. nursing management) *-but then also the strategic thinking and planning I think is what you need to look at because their focus still is very much on the 'here*

and now'" (FG1 P3). Another HON concurred with the above suggesting that the ANMs should adopt a more forward thinking approach, denouncing the current stagnating style. The following was verbalised:

"… and there's no long term planning and thought about consequences you know…, in a few years' time …" (FG1 P3).

The HONs in this regard, supporting each other's responses were also alluding (as per below) to the fact that even though a large emphasis has been placed on nursing training, the Assistant Managers who are the hospital middle-management cadre ought to recognise and utilise the available skills training programme:

"I want the Assistant Manager to see that she's an Assistant Manager, and that is her portfolio and that is her work to do… And that is the OM … There's a lot of small things that you can do to help them" (FG2 P1).

The nurturing of sound and supportive relationships between clinical staff has been shown to be vital for learning (Stapleton *et al.,* 2007, p. 814). Emanating from good relations in the clinical working setting, effective delegation also has to be learnt and internalised by the less senior nursing managers. When fitting tasks are delegated effectively, it allows senior nurse managers to engage and develop juniors more, which in turn offers a degree of permanency and ownership. Time and efficiencies gained in this manner could consequently contribute to overall efficiency if invested in ward leadership training. In this regard, the ANM fulfills a strategic ward leadership role, a role that is not necessarily intuitively acquired but needs to be planned for and taught (Hinchliffe, 2014, p. 32).

(c) The stimulation of development

The commitment to deliver work performance in regard to training the HRH for strategic health planning in South Africa also takes cognisance of the changing technical and health environment, which stipulates that policy responses and strategic actions are to be developed in such a manner that it is amendable to facilitate learning in a culture of critical inquiry (National Department of Health, 2011a, pp. 99 & 114). The critical thinking process allows for discernment, making the decision as to what in truth matters and what the key issues are. Critical thinkers demonstrate liberalism, open-mindedness and forbearance for the views of others with constant sensitivity to the possibility of their own preconception (Van Dyk & Jooste, 2005, p. 17). Even though the clinical nurse instructor had an awareness of the existing need to contribute to the development of critical thinking skills of student nurses, she did not focus on critical thinking development. In-service training programmes are therefore needed, that allows for such development in student nurses (Van Dyk & Jooste, 2005, p. 16).

The HRH further stipulates that the HR Department and HRM strategies have to support line functionaries in various HR processes that include ensuring that training and development

opportunities correspond to individual strengths and weaknesses. Training opportunities also serve as support to staff. An employment package has been planned by the National Department of Health (2011a, p. 114) in South Africa for training, tutoring and educating health workers. The overall need nonetheless for nurses is to receive in-service training in their specific area of service delivery. Work places that provide training and opportunities to develop are viewed with high esteem (Segnon, 2014, p. 26).

(i) Rotation of nurses

Further suggestions also related to the prevention of stagnation of staff and that best possible opportunities to flourish in work performance, in line with training/ development related to the importance of moving nurses within the hospital and between the day and night shifts which allows opportunity for learning and growth. In this regard, a night ANM verbalised:

"And then, they must actually rotate the people, -there are those with personal, domestic stories that requires them to work night duty; it works better for them. But they must actually allow these people to work a little bit on day duty that they can just develop a little bit more because one does become stunted. You are just on your night routine ..." (II P23).

Even though the night ANMs were appointed to night posts, a HON indicated her plan to strengthen the capacity of this group by means of a re-orientation period on the day shift:

"I would have like them to rotate on (to) *day duty, even just for a three months stint at a time… just for them to get the exposure and a feel of all the responsibilities on day duty ..."* (FG1 P2).

Such a planned rotational cycle therefore for the night ANMs regarded as an initiative that strengthens capacity could inevitably led to improved patients outcomes.

(ii) The practice of a training routine

The realisation of the dream of one participating night ANM was her achievement of already having an in-service training programme in place which she viewed as support to the staff. She verbalised the following:

"…and with the in-service training I am going to connect to that, the support system" (II P22).

The night ANM, apart from wanting to avoid that the nursing systems on the night duty become routine and therefore be void of learning, ensured that there was an in-service training schedule. The assurance of such a routine eliminated the risk of uncertainty of whether the night in-service training session will take place. The identified aspects that ANMs put forward as potential training matter also emanated from those events and situations that had gone wrong and was in need of correcting by nursing re-learning. These were often adverse event indicators which drew attention to the shortcomings in work performance:

"We've got on night duty, and this is where we're different from Day -- we've got a monthly programme where in-service training is concerned so it's not 'Oh I feel like doing in-service training tonight'. I actually, from the staff found out, and through my incident reports I deduct that this is the in-service training that will be held and we've got a structured format. Every month, every week we will have one in-service training and Nurse Hospital No. 1 for example, she's the emergency nurse so I incorporated her with the CPR …" (II P22).

Letlape et al. (2014, pp. 1 & 7) assert that nurses and their managers should identify and confront deterrence of in-service training. Pre-planning in-service training schedules and other identified recommendations are to be operationalised as on-going in-service training holds many benefits for nurses providing psychiatric services. ANMs described other more expansive forums of in-service training programmes inclusive of those that were conducted on Saturdays during the day and at night, the latter revealing that they are not given support in this regard. There was a desire that they (night shift) be supported formally by the current training mechanisms that the day staff enjoyed. The debate it seems will continue for a while, still as the times of trainer availability did not complement quieter time or Saturday nights which was said to be the time when more nurses could be free.

(iii) The teachable moment

Full use of the teachable moment should be made. The researcher on the whole observed that the night ANMs displayed a particular affinity and tolerance for teaching and learning, and the deeper rationale for wanting training and workshops for nurses was predominantly to enhance nursing skills and secure improvement in the work sphere. They said that they often made use of the informal unplanned 'on-the-spot' teaching moment:

"…and then it's the in-service training. It's actually now 'on-the-spot' teaching, that's if I now recognise a deficit" (II P12).

The teachable moment is virtually every interaction between nurses, patients and families. These are activities that nurses embark on which are distinct from parallel or formal processes. The concept 'teachable moment' is recommended to be informal and relational (Marshall, 2016, p. 13). The teachable moment involves shared exploration of a subject or subject matter of common concern (Pacifici & Garrison, 2004, p. 120). The teachable moment presents itself when the nurse gives appropriate counsell at the right time in the right place in the pertinent situation, which could also be unplanned (Naranjee, 2012, p. 54; Grover, 2013, pp. 1710-1712). An ANM stated:

"In-service training, we have lots, as we are now in the FBUs and those people who are coming on to night duty, some are going back to day, so it's a whole rotation, then there are times when there are persons -you see 'no no no...!' with this person there is a lack of the skill that is required then I just do 'on-the-spot' teaching and or I will go to our staff development Mrs. Tutor Hospital (name fictitious), and say to her that this one (staff) *has a lack in this specific subject …"* (II P12).

In this study the night ANMs who embarked on training related that they maximised learning, as the teaching and learning night hours were limited and dark. The teachable moment is conceivably one of the most desired educational outcomes, according to Pacifici and Garrison (2004, p. 119). A number of the ANMs who worked the night shift demonstrated a passion for staff development and training and had embarked on night nursing training programmes, on their own accord. This was illustrated by the following statement:

"Where patients is concerned I am thinking about in-service training and incorporating staff to participate not only in coming to the in-service training but actually utilising their skills like um emergency personnel ---actually incorporating their skills by giving the in-service training to other staff ... . Which from there works through the patients -of course the skills which they have learnt for example CPR they can carry through to the patient" (II P22).

(iv) Training in relation to trends

Therefore, in line with strategic and operational objectives, envisioned training and workshops should address these needs. The need for training in infection control and breast feeding was singled out in this regard with the following verbalised:

"But also not only the training of outpatients (Department) *but the training of all the wards, all the wards under me for example like now, there are different things that are important in different wards like your... breast-feeding is important, because as I said 'the best care'* (Best Care Always quality initiative at some of the provincial health-care settings), *your potential bed-falls, your potential bed-sores. There are certain things that everyone must know and I must ensure that these personnel that are under me, not only the Operational Managers, but also those people who are under them, that everyone gets the training that they must get"* (II P24); *"... And then of course we must ensure that in the ward, that all the personnel receives their training regarding Infection Control"* (II P24).

They even appealed to the researcher for more training and re-training in areas other than quality patient care, work performance areas in other technicalities of nursing and caring, service delivery and corporate governance (field notes). In some of the night training instances the training content, although geared at improving in-house work performance was not only confined to local sources but was also sourced from educational literature from the world wide web (II P20). In regard to fulfilling the expected ANM standard as stated by a HON previously, one ANM stated that she portrayed the 'resourceful role':

"So for example with the 'Best Care Always', we must start it with the CAUTI (Catheter Associated Urinary Tract Infections, and its prevention). *They* (ONMs) *didn't know. I also hadn't received training about this. I then went and ensured that I got to learn how it works and I went from ward to ward to show them. So!* (laughed modestly - field notes)*"* (II P24).

The training dream was also expressed by an ANM who was guided by the outcome of having measured aspects of training:

"I must look at the statistics of the training, if it is done as it must" (II P24); *"And then we get the statistics from the septic cases, how many hospital acquired infections there were, and that is also things that I have to address when I see this* (indication), *that there are too many septic cases"* (II P24); *"And through my incident reports I deduct that this is the in-service training that will* (needs to be) *be held"* (II P22).

Results of a key study of hospitals in Britain found a strong association between the quality of HRM and patient mortality. The quality of in-house training, along with the superiority of staff appraisal and the level of teamwork in particular were found to be factors that impacted on patient health (West *et al.,* 2002, p. 1299; Shaw, 2006, p. 2). The idea nonetheless prevailed that nursing and its related training be more nursing focused as opposed to caring for the patient based on the medical model:

"…upgrading for nursing staff …their general skills…we must now start moving away from diagnosis and actually start" (II P22).

The spinal injuries course has almost become a legacy course the ANM informed the researcher and will soon become extinct and therefore not legitimate once the last course is conducted. Spinal training was however particularly recognised as a definite ongoing need. One ANM verbalised:

"... Because you know that is something that happens every day, accidents always happen, it will never 'die out'" (II P1).

Across the spectrum of night and day shift ANM participants they also expressed the desire to receive generic in-service training, for instance on matters such as conditions of service. The ANMs also expressed the need for the broader nursing system to recognise that up-skilling of Professional Nurse's post basic registration should occur in their speciality field as opposed to the historical post basic training of midwifery. In as much as the focus above is on training, learning has to occur. An ANM also indicated the need for training in the work situation to learn to be adept to change:

"Once again, one should surely start with in-service training, 'what is change management?' you know. You go to ICAS for this kind of training …" (II P13).

(v) Teaching as a means of support especially for the night shift staff

They confirmed that nurse training and re-training occurred experientially even when a crisis occurred. A night ANM verbalised the following:

"I can recall also in December there was a fire in Ward T. I was informed and so I went over. The situation was under control… The patients were evacuated and no patients were injured. The staff was a bit distressed … they were in shock so and I reassured them. I assisted them and gave support with the writing of the statements" (II P8); "And when the wards are constantly overfull: *And try and find … the best way for situations that create like a crisis …"* (II P9).

Supervision and guidance should be available as a fundamental part of the training process of crisis intervention (Varcarolis, 2013, p, 390). For structured learning, an individual performance

and development plan is to be contracted between each individual worker and their supervisor based on strategic and operational performance objectives of provincial health-care settings (Western Cape Provincial Administration, DOH, 2002, p. 2). In another instance on the night shift, staff received tuition in line with some of the various regulated SANC courses (II P6). The night ANM identified and responded to the need for supportive training for those nurses already registered in the nursing bridging courses and would offer voluntary tuition to them for an hour before the commencement of the night shift.

In line with using own and/ or inner resources, the night ANM at a center for persons with intellectual disability, had a plan to embark on in-service training using the work expertise and skills of resident staff at the health-care setting. This initiative meant that there would be an arrangement where staff from the various wards (sub-specialties within the intellectual disability services) would be rostered to do training by means of a presentation of the special kind of nursing and other care that was applied in their specific ward. This led to a sense of intrinsic reward for the staff and a shared active onus. It was envisaged that the night shift nursing corps would become both the recipients of training and the givers of training. The health-care setting also benefitted from the shared knowledge. The plan also included, involving other experts such as paramedics. Letlape, Koen, Coetzee and Koen, (2014, p. 3) reiterate that psychiatric nurses working in centers for the intellectually impaired (previously termed mentally retarded), are to receive in-service training on an on-going basis so that quality of care can be assured. The teaching potential of the current resident staff was being considered for in-service training (field notes - II P22). However, at some provincial health-care settings, within the study cluster of General Specialist Hospitals, there seemed to also be extraordinary devotion by the night nursing corps to attend such training either before or after the shifts. One ANM addressed the issue of training not only in skills directly related to technical care, but training on how things get done/ are done/ are embarked on. A night ANM found it useful to embark on relevant 'on-the-spot' in-service training as part of corrective counselling. The following was verbalised:

"To develop people just in terms of one-on-one behaviour; to develop people in terms of just being easy with one another -tolerant of one another …" (II P10).

A night ANM expressed the need for their day counterparts to demonstrate to night staff how to do certain procedures, as this held relevance for consistency of care. From the findings of the sub-category *staff orientation and in-service training and workshops for nurses* in relation to the KPA support function, concluding statements were made (Annexure X).

4.7.4 KPA 4: Design
OUTPUT: Initiatives for the future in KPA support function

This study found that the initiatives or best / ideal expectations for the future in relation to the KPA support function, involve appreciation of staff, staff incentives and motivation.

4.7.4.1 Sub-category 4.3: Appreciation of staff, staff incentives and motivation in relation to initiatives/s or best/ ideal expectations for the future in support function

In describing these expectation/s and initiative/s for the future, there was an accompanying sense of hope expressed by the ANMs actions and initiatives can improve the future (researcher observation and field notes):

"One of the key issues that especially let me make an example here at Hospital No. 2 … I hope one day … and I was discussing it with P4, to work towards boosting the staff morale, and the staff morale's are very very low here from one person to another and also having an impact on the service delivery and evidence base (scientific approach), *the high rate of absenteeism, the attitudes towards patients and I think I'll would like to play a role in sort of motivating staff and I even discussed with her maybe we can start appreciating and implementing things like issuing certificates at the end of the year …"* (II P5).

The ANMs who worked the night shift held the view that if relief staff could be applied to complement the resident night shift staff so that in-service training could in turn be attended, such an initiative would promote training and indirectly be a show of appreciation to staff. A night ANM also echoed these sentiments as day staff could be relieved:

"So that more relief staff is given to the Night Shift, so that these people can receive in-service training more so on a continuous basis, in order for in-service training to happen as it is mostly the day people receive in-service training because they are invariably more, they get the opportunity to receive in-service training …" (II P23).

An inquiry conducted by Keys (2014, p. 102), into nurse managers of Generation X, showed that none of the nurse manager participants in an inquiry embarked on recommended improved remuneration to promote the retention of Generation X nurse managers. Instead, better preparation for the role was the recommendation that reflected most frequently. The ANMs expressed the view that when effort is made by the nurse manager to get to know them, it leads to a greater inspiration of staff. One verbalized the following:

"… motivate staff... learn to know them better …" (II P8).

On the other hand previous research has indicated that the provision of motivation and incentives improves the performance of staff working in hospitals which is a key factor when it comes to distinguishing between organisations that excel and those that produce work of a poor quality (Elarabi & Johari, 2014, p. 13). The ANMs held a positive regard for granting incentives to nursing staff for various reasons. One ANM stated that nurses work hard and that nurse

managers should be able to reward such arduous work. She acknowledged that the prevailing hospital finances however were restrictive in regard to monetary incentives:

"And the people really work very hard I mean and there isn't anything to give them (referring to arduous workers')… *except for the monthly salary which is the reward and the bonus is what is regarded* (by the employer) *as the reward. You may not give* (the staff) *an extra day off. And you know these days it's about incentives like money so you understand, so I mean that is actually the most important…. So I actually think that if there can be one or other type of recognition system or reward system in place for people who work hard*" (II P16).

The researcher interpreted these utterances to be a plea that other incentives should be considered for staff appreciation and motivation however the reward of money was perceived to be a strong motivator. The following was said:

"You may not give (the staff) *an extra day off, you may not...or anything else. And you know these days it's about incentives like money"* (II P16).

There is no denying that there is a need for using the appropriate incentives for people to get work done (Martínez & Martineau, 2001, p. 4). There was general support for staff incentives and staff motivators from ANMs especially those who worked the night shift. A participating night ANM who worked at a general hospital, indicated that staff needed to be shown appreciation for hard work, a demonstration tantamount to service delivery and for that reason he already had initiatives in place for staff appreciation and motivation, and pledged to continue to do so at his own costs. He firmly stated that incentivising the staff he managed, served to motivate them (field notes, II P6). The belief that incentives motivate, was reiterated by another night ANM who worked at a psychiatric hospital:

"...then you appreciate what they're doing and you know some incentives, 'you are the worker of the month' maybe or something to lift their spirits …" (II P7).

However not all initiatives to incentivise the staff were supported by the HONs or the hospital. An ANM stated that he nonetheless carried on incentivising staff bearing the financial cost personally. In these instances, the certificates he awarded the staff with did not have signature of the higher level which might have given it more prestige (field notes, II P6). Further examples of motivational input and incentives mentioned were team building efforts, though team building sessions and year-end functions presented a particular challenge as it required food, utensils, stationery and decorative elements. Other concrete examples of staff incentives and motivation listed by other ANMs were public recognition of their achievements. An ANM verbalized:

"…implementing things like staff appreciation maybe issuing certificates at the end of the year and uh looking at the employee of the month, things like that, …the best attendance just to sort-of giving them small tokens …" (II P5).

Empowering nurse manager practices include better incentives (Tibandebage, Kida, Mackintosh & Ikingura, 2016, p. 379). The ANMs in this study related that incentivising staff was also seen as motivation. The non-financial rewards relate to aspects such as the importance of people having job satisfaction. People who work in a health-care setting should experience a sense of

identification and ownership - the vital and clear mission of their employing organisation. The work should be enjoyed and provide a measure of fulfillment. People want acknowledgement and admiration from peers and managers for the tasks well done (Martínez & Martineau, 2001, pp. 3-4; Shaw, 2006, pp. 109-110).

The literature on the other hand links incentives to the quality of care produced. The report on quality of health-care in America, aimed at significant improvement in quality of care highlights this fact. It stressed the necessity that policies related to remuneration be linked to performance improvement, and that there should be a strengthening of incentives for enhancement of care. Even though it has been said that most health workers draw satisfaction from performing better than what the expected standard require, more concrete inducements (incentives) have been given by employers elsewhere. These include high rated quality rewards, certificates of endorsement and money. However a review of the association between the payment of doctor monetary incentives and process and results of care, found that the latter could suffer as a result of the former (Chaix-Couturier, Durand-Zaleski, Jolly & Durieux, 2000, pp. 134-135). In one such case the practice of granting monetary incentives impacted negatively on patient access and continuity of care, and consequently resulted in conflict of interest in the doctor-patient relationship (Chaix-Couturier *et al*., 2000, p. 133).

Monetary incentives could also sway availability and usage of resources negatively as adherence to the teachings of clinical practice is ordinarily expected to be enhanced as work performance unfolds. It is a fact that goals are achieved when the system provides for monetary incentives to be granted for work performance (Shaw, 2006, p. 110). In the United Kingdom, the performance of general medical practitioners is assessed in four performance fields namely: (1) standards in the clinical sphere, (2) standards in the organisational sphere, (3) patient experience and (4) supplementary services (Shaw, 2006, p. 110). The PM system in which the ANMs in the General Specialist health-care settings operate is similar, as work performance is rated individually and score ratings of 75% are incentivised (researcher experience). In other circumstances, other non-financial incentives though not as impressive have been applied to alter clinician behaviour in particular ways (Iversen & Luras, 2000, p. 208; Shaw, 2006, p. 110). The study by Mathauer and Imhoff (2006, p. 2) concluded that non-financial incentives as well as HRM means are vital contributing factors to boosting the motivation of health professionals. It has been found that when HRM means are effectively used, it maintains and reinforces professional ethos of nurses and doctors. The incentives listed are the acknowledgement of professionalism and giving appreciation to professional goals, career development and assistance towards further qualification. Health-care organisations ought to consider practicing participative management. Participative management also incorporates mentoring of first-line managers to empower and strengthen their effectiveness. In suggesting initiatives for the future in regard to appreciation of

staff, incentivisation and motivation, the ANMs have also stated that motivation is sometimes all that is required as the face of the provincial health-care settings change. In this regard they said:

"....one must continually motivate and everything, so it's only just the motivating to just hold them ... as the patient population has changed, understand? So I mean! And the patient numbers have increased and the patients are more difficult and they (the patients) *do not to have respect anymore for the nurses and things"* (II P16).

The work performances of the ANMs in relation to working towards staff incentives and motivation was already evident in other initiatives other than tangible incentives where the ANMs extended themselves in terms of time and nursing knowledge. Coaching sessions for nurses in training were already being conducted by a night ANM before the night shift would commence. In conjunction to the latter personal nursing text books were made available by the ANM participant of this study at no cost. The night ANM who did this complementary teaching reported that these tuition sessions had since become sought after and were even being attended by nurses from other provincial health-care settings. Work performance is said to be rewarding when it becomes an extension of the individuals' self-image and inherent principles (McNeese-Smith, 2001, p. 174). In this study, the night ANM was gratified in his work performance as he verbalised his intention to continue assisting the nurses who were striving to improve their qualifications. The researcher perceived his effort as an extension of his himself. Two expansive trusts exist in performance management, namely: (1) remuneration-driven performance and (2) development-based performance. Performance management can play a significant role in a reward-based system whilst performance management should be about developing and rewarding people in the broader sphere (Mlambo, 2010, pp. 47-48; Armstrong 2009, p. 250). Similarly, Martínez and Martineau (2001, pp. 3-4) distinguish between two types of PM systems on the basis of its reward and/ or development orientation, a feature that has been a prolific topic of discussion in literature. Based on short-term targets, remuneration-driven PM systems are reward-driven in that performance is related to pay and often referred to as 'performance-related-pay' which resultantly underrates other activities of a HRs nature (Mlambo, 2010, p. 48).

Even though cash rewards may stimulate enhanced performance, they aren't viewed as fundamental to PM. The strong likelihood also exists that it is the influence of the organisational culture and context that facilitates the drive for a cash reward system. Cash rewards are however said to not be appreciated by all staff members due to an individual being rewarded for what is perceived to be group work (Martínez & Martineau, 2001, pp. 3-4). A view is held that the reward-driven approach is restricting in that it possibly strengthens the short-term performance achievement approach, at the cost of overall longer term sustained organisational effectiveness. However, short of being fired, automatic pay rises in traditional reward systems have become an expectation that is almost always fulfilled. For this reason therefore, traditional reward systems do not improve work performance (Mlambo, 2010, p. 48). In relation to team work, a hospital in Taiwan, using the Balanced Score Card incorporated an incentive plan geared at improving

hospital performance (Chu *et al.*, 2009, p. 401). Even though some data showed a steady increase in the use of BSC by organisations, little was known about implementing the BSC in combination with an incentive plan (Chu *et al.*, 2009, p. 402). Before the implementation of the 'BSC-based incentive plan', nurses were paid according to a scale which differentiated remuneration in terms of seniority and rank and performance assessments were based on the subjective system of supervisor rating according to which bonuses were paid out (Chu *et al.*, 2009, p. 402). The new proposed incentivised plan was that there is a basic salary for nurses (as was the case) with an apportioned share of the collective bonus based on the group's overall performance scores which should be worked out according to a specific formula (Chu *et al.*, 2009, pp. 402-403). It was intended to persuade nurses to improve their work performance through teamwork as calculated by the scorecard (Chu *et al.*, 2009, p. 403). In the WCP where the study was conducted, the individual sought after incentivised system was used. Many termed it as '*the SPMS* (staff PM system)'.

"And everyone wants SPMS and I mean, everyone cannot be given SPMS as once again there's only an amount (fixed) *for those people who can get that"* (II P16).

A revision of the National Public Service Act of 2009 in Japan, announced a new personnel evaluation system which proposed that staff appraisal be linked to remuneration increases, bonuses and promotion criteria. In this way the Japanese government strove to transform the customary 'career system' determined by seniority rule to a system that upholds and appraises worker capacity and work performance (Koike, 2013, p. 351). This Act of 2009 stipulates that if a good performance record was not achieved by individual workers, they would suffer a reduction in pay. Furthermore if employees' appraisal in the ability or performance area was rated at the lowest mark, they could be demoted to a more junior duty position or alternatively to a lower remunerative scale (Koike, 2013, p. 351). The outcome of the new performance evaluation system in Japan seemed to be inadequate. Those at management level were inclined to offer small pay incentives to those who acquired some results whilst the personnel evaluation system produced a small number of downgraded cases suggestive of the difficulty to change the 'culture of seniority' in Japan (Koike, 2013, p. 351). The new Democratic Party of Japan, in an attempt to promote civil service reform, has only just established a personnel agency and put forward a restructured package that would manage higher-ranking executives in an included way and engage with civil servants and enter into collective labour. The restructured model was yet to be implemented according to Koike (2013, p. 351). Another initiative for staff incentivisation and motivation was believed to be formal training and workshops in service delivery, as well as training oneself as a nurse manager to get to know a nurse better. The following was verbalised:

"…I think we must do more give them (staff), *more information, more service training… motivate staff … learn to know staff better"* (II P8).

The HONs indicated that even the ANMs need to be praised as it serves as a form of training and positive reinforcement. In this regard the following was verbalised:

"... yesterday I've had performance session with one of my Assistant Managers and said.... I looked and I said 'You know you've grown so much over the last few years... and it's so nice to see (positive response of acknowledgement made by another group participant - field notes) *how you have developed in your career, and in what you do and how you help me and how you support me' and that's nice to say that it's so true* (soft passionate response - field notes)*"* (FG2 P2).

The further statement below was interpreted by the researcher as a feeling of being committed to support the staff on her shift:

"I'm quite a lot for the staff… (meaning 'I care a lot about my staff')*"* (II P22).

The ANMs themselves conveyed the notion that if the employing department demonstrated the will (willingness) to offer workshops and training for nurses, a sense of pride would be instilled in nurses:

"…and off-course also further training, to get the personnel to be skilled, that makes them positive. It's something that motivates them. If they are skilled in their work and you give them the opportunity to go for further training…. praise them, *all of this motivates* (emphasised - field notes) *your personnel. And you must have good relationship* (impressing upon - field notes)*, a human relationship. You must act professionally and be fair because this is what de-motivates people a lot; unfair management*" (II P24).

From the findings of the sub-category of *appreciation of staff, staff incentives and motivation* in relation to the KPA support function, concluding statements were made (Annexure X).

4.7.5 KPA 4: Deliver

OUTCOME: Commitment to deliver work performance in the KPA support function

This study found that commitment to deliver work performance in relation to the KPA support function, involves ANMs' own need for training.

4.7.5.1 Sub-category 4.4: ANMs' own need for training in relation to the support function

Nurse managers are to be trained to be managers and to manage. A point raised by a HON in this study relating to the need for ANM specific ('own') training was that current nurse managers were not trained to be managers as illustrated by a HON:

"Because our training did not equip us to be managers" (FG2 P1).

Zori and Morrison (2009, p. 76) list the acquisition of financial acumen, HRM, collective negotiation, multifaceted liaison and communication, and quality management as needed knowledge and skills for nurse managers to be able to function effectively in a nursing management role. The ANMs also by means of self-assessment, identified their 'own need' for

training in order to deliver work performance. The fervent 'own training' need expressed by an ANM in this regard was reiterated by:

"Development of staff and myself … I'm not going to leave myself. Development of staff and myself" (II P22).

In relation to self-assessment and based on literature, supervisor and manager training in self-assessment has been found to be minimal. Their approach to assist supervisees manage their own learning stipulates having to define own goals and monitor own progress (Kaslow, Rubin, Bebeau, Leigh, Lichtenberg, Nelson, Portnoy & Smith, 2007, p. 446). The HONs pointed out though that ANM learning has to occur in structuring their (ANM) day and make deliberate time for self-learning and teaching. One HON stated:

"I don't think they have enough time to sit back and reflect… I don't think that they have enough time to go to the internet and look for things and broaden their scope of understanding. I mean I think of the day when they will be able to look and see -this is what happens overseas in this country, --there (referring to place) *are psychiatric hospitals, this is what they do, and we can learn from that. But at the moment it's* (the day is…) *such a pace that they are just working most of the time…. And I'm also thinking if they can get to that point, they will be more of a resource. What kind of a resource shall I call it…? Even a teaching resource at a slower pace and decide that this is what I'm going to tackle for this period whether it's clinical, whether it's administrative"* (FG2 P1).

The researcher found that the ANMs were aware that formal courses offered could potentially meet some of their learning needs (field notes). In this regard the ANMs conformed to the principle of adult learning that purports that it is necessary for adults to know why they need to learn what they are learning (Finn, 2011, p. 34). HONs in one of the focus group discussions re-emphasised amongst themselves, the need to support ANM training by seeking funding provided for upliftment such as the Skills Development Funds:

"There are a lot of small things that you can do to help them, but it is true training, training and… If there's shortages or whatever or ever needs, then you must just see what you can do! And ask for help in... . There's the skills development …" (FG2 P1).

An inquiry conducted by Keys (2013, p. 101) to identify elements of professional success, and personal and professional fulfillment as defined by Generation X nurse managers, revealed that several of the nurse manager participants thought that the acquisition of a Master's of Science in Nursing degree, prior to having accepted the position of nurse manager, would have been useful rather than something they were working towards, after their appointment. The inquiry also showed that the greater majority of the Generation X nurse manager participants sought learning opportunities for improvement through recognised schooling and nurse manager training programmes (Keys, 2013, p. 102). With regard to their learning and training, the ANMs themselves admitted that a certain level of knowledge/ skills needed to be reached, and expressed the regret that the situation could have been different had they been given the learning opportunity. It was stated:

"If I had somebody… who trained me, I would've done better …" (II P4).

In a number of ways nursing management and nursing leadership are intertwined. Johansson *et al.* (2007, p. 150) state that a number of authors believe that nursing leadership should be further developed. The focus on management development however seems to have disadvantaged leadership development as nursing programmes have laid the foundation for nurses to be good in clinical work but failed in preparing nurses to be good managers. Hence the role of nurse manager is often associated with internal conflict. An ANM who supported the need for own training in the commitment to work performance and wished to do well forward stated:

"I think one must be coached how to go about doing this correctly …" (field notes, II P18).

The HONs recognised the noteworthy managerial potential the ANMs had already achieved which stemmed from their experience but that they needed assistance, training and support to develop further 'into' the post of ANM. Simultaneously the HONs expressed appreciation for this expertise even though it was differently perceived by the Head of the health-care setting. There was nonetheless agreement by both the HON and the head of the health-care setting that the ANMs still needed to expand on nurse managerial learning:

"So we/ I had to do a lot of supporting and training and teaching and all that…" (FG2 P1).

A study on attaining managerial integrity by Bergin (2009, pp. 68-69), shows that managers initially commenced their careers as nurses or physiotherapists, much like the ANMs of this study. They were acquainted with the operational work performance that required them to take responsibility, resolve disagreements, demonstrate reverence and execute duties with influence. The transitioning process experiences of managerial development therefore imposed substantial readjustment for these individuals/ groups. Nurses and physiotherapists who became middle-managers had a different work context with other work performance prerequisites and work relationships. It became necessary for them to find new roles and identities through training. This learning proved to be both positive and negative but occurred through *"learning by doing"* (Bergin, 2009, p. 69). The new responsibilities required of the ANM that needed to be learnt and internalized, related to managerial oversight and knowing the direction. The following was articulated:

"*I think the responsibility is to, in the first place to understand surely that you are on par from what the vision and the mission really is and all of these requirements of the province and that of your hospital"* (II P18).

There was recognition that nurses were not trained in having to manage finances. The HONs all supported this notion. A HON stated:

"… that is one of the big problems because we actually not trained (stated with authenticity - field notes) *in the financial aspects …"* (FG2 P2).

Scoble and Russel (2003, p. 324) suggest that the preparation of the future nurse leader in three areas namely educationally, have a specific curriculum content and desirable managerial experiences for future nurse managers. The emphasis on the need for ANMs to be trained in

finances by both the participating HONs and the ANMs, however does correspond to the priority list of the curriculum content of Scoble and Russel (2003, p. 327). The ANMs further related that financial management required involvement in the supply chain processes:

"I think because of my involvement in the procurement, I have added value in to that department because I can make sure that what we order now is what we need -in the last three years I would say, we have been able to really, you know, just look at our emergency equipment, make sure that each ward has the equipment on hand whereas before we had to share" (II P10).

In South Africa where this study was conducted, a national HRs strategy for the health sector recommends that all public sector health-care HR managers are to receive training in government prescripts on HR, recruitment, induction, procurement and finance in addition to general health-care management skills, (National Department of Health, 2011a, p. 61). ANMs reported that their role regarding finances required them to be involved in the vetting, tender procedures and procurement. Knowledge of supply chain and other financial management processes, and how it is complied with, was identified as needed ANM learning for service delivery. As part of this learning the ANMs also needed to acquaint themselves with financial prescripts.

" *...and under finance I think our main accountability there now of the FBUs is to ensure that your department functions without wasteful expenditure, to ensure that your stock control is in place, to make sure that the staff is aware of you know the checking and maintaining equipment to prevent wasteful losses and things like that ..."* (II P10).

The ANMs belong to a cluster of nurse managers in the WCP. Dowling *et al*. (2008, p. 331) point out the importance of standardisation at all sites of the cluster so that individual PM be premised on consistent goal categorisation, the means of scoring, the template, and the PM cycle where coordination to the critical corporate processes are deliberate. In line with the South African national initiative to strengthen HRM, key elements of the planned strategy include training, and coaching or leadership development routes that would ensure a stipulated degree of competency for all those in leadership and HRM positions. In this regard PM of the HRM role of managers and the incorporation of HRM objectives into the work performance plans of managers are to occur (National Department of Health, 2011a, pp. 113-114). Some participants claimed that *"learning by doing"* or on-the-job experiential training could come about by mere managerial exposure, such as an ANM shadowing a HON. This stance was supported by:

"*And that is a lack. Many lacks/ gaps can improve for the Area Manager* (i.e. the ANM) *if she can be given the opportunity to maybe act as HON for a month or two or three - he or she* (HON), *he can still be there but allow that person* (i.e. the ANM) - *something similar to what we do with mentoring, we will let get those people to think differently*" (II P13).

There was a distinct desire for such exposure as this had happened in the past. There was a yearning to accompany the HON to meetings and to be part of the top management of the health-care setting. There appeared to be some difficulty with the change especially in the peculiar situation where there were only two day ANMs – one newly appointed and the other a seasoned nurse manager. It was stated:

"… what happened previously… she (i.e. the CEO) *empowered the Assistant Managers so much …whenever I go to a meeting, especially in the hospital, if there's a meeting a Top Management meeting, they will form part of top management*" (II P25).

Stories have always played a vital connecting role in human traditions, civilization and development. Greco (1996, p. 68) found that stories could be used more decisively for management learning and development. With conviction Greco (1996, p. 68) claim that stories are powerful teaching tools and that management development has not taken full advantage of story-telling in assisting managers to enhance their own learning in the workplace, neither has the value of stories been explored as a learning tool (Greco, 1996, p. 44). The AI approach, as well as the constructivist approach, in this study, has nonetheless allowed for the nurse manager story of performance to be told and for its potential use for future learning as each participant told their own story (researcher experience). In the support function, the manager who uses stories as a teaching tool has an understanding of the important cornerstones of management and of the principles of story-telling which embraces self-understanding, self-insight and self-respect (Gray, 2007, p. 499). From the findings of the sub-category on *ANMs' need for own training* in relation to the support function, concluding statements were made (Annexure X).

4.8 THE FRAMEWORK DEVELOPMENT PROCESS

Table 4.5 presented an overview of the main identified themes, categories (KPAs) and sub-categories, and concluding statements of the findings from the interviews with the ANMs and the HONs. In the process of developing the framework, concepts were deconstructed and categorised. Here themes, categories, sub-categories with the concluding statements were reviewed to identify main features such as roles, characteristics and other attributes, and consequently to organise the concepts according to their feature clusters. Using the AI dimensions, the concepts were then organised in an adapted Logic Model format.

4.9 CONCLUSION

In this chapter, the viewpoints on work performance of the ANM and HONs and hence the findings from the individual semi-structured interviews with the ANMs and the focus group discussions with the HONs were described in conjunction with supporting literature. Four main categories were discussed, namely: (1) Strategic planning, and QA and nursing care, (2) HRs, (3) the Business Unit and managing finances and (4) support function. These four categories emerged from Theme 1. Aspects of these four categories emerged in Themes 2 to 5 that were then classified under sub-categories. The adapted Logic Model and the AI dimensions were interwoven in these categories and sub-categories. Concluding statements were drawn on the findings (Annexure X). From the findings and conclusions the contemporary framework was finally described (Chapter 5).

CHAPTER 5

CONTEMPORARY PERFORMANCE MANAGEMENT FRAMEWORK FOR THE ASSISTANT NURSE MANAGER IN THE PROVINCIAL HEALTH-CARE SETTING

5.1 INTRODUCTION

This chapter fundamentally focuses on describing the PM framework to be used in contemporary ANM performance management that could lead to best contemporary practice in nursing management in the General Specialist health-care settings in the Western Cape, South Africa. The findings used to develop the contemporary performance management framework are depicted in Table 4.5 and Figure 5.1. The purpose of the framework was reached by having obtained the objectives of the study. These were to:

a) Explore the understanding of the ANMs and the HONs with regard to the key performance management areas of the ANM in the workplace.
b) Explore the ANMs and the HONs experiences of the ANMs best work performance experience in the work situation.
c) Describe the best work performances regarding the ANM, to improve work performance practices.
d) Explore the ideas of the ANMs and the HONs on the ideal work performance opportunities of the ANM for the future.
e) Describe how the ANMs and the HONs view the commitment of the ANM to deliver actions towards work performance in the workplace.

5.2 DEVELOPMENT OF THE PERFORMANCE MANAGEMENT FRAMEWORK

The main themes, categories and sub-categories were identified and aligned into the adapted Logic Model format (Table 4.5) by the researcher with the support of the research supervisor.
The underlying dynamic from the findings is staff development. The four main categories were realised as the four main contemporary KPAs, from the ANMs understanding. These KPAs are:

a) Strategic planning, and quality assurance and nursing care
b) Human resources
c) The Business Unit and managing finances
d) Support function

In this study the questions were asked from a contemporary perspective of the activities in PM related to ANMs who work in provincial health-care settings. In developing the framework, the

AI approach was also followed. The basic assumptions of the underlying AI philosophy adopted for this study (2007, pp. 27-28) revealed the following:

"In every society, organisation, or group, something works": It was believed that the ANMs work well especially within the MDT; they know when to be assertive and how to negotiate that MDT relationship.

"What we focus on becomes our reality": It was anticipated that ANM and HON awareness of what best ANM work experience is, would lead to deliberate practice of best work performance.

"Reality is created in the moment, and there are multiple realities": It was believed that the ANM responses on their work performance related to best experience, best possible opportunities, initiatives for the future and commitment to deliver put forward at the interviews, were their reality of the many realities of work performance they had experienced.

"The act of asking questions of an organisation or group influences the group in some way": It was assumed that the research questions based on the positive AI approach put to the ANMs, would affect their standards, will to improve, innovation and commitment individually and as a collective.

"The person has more confidence and comfort to journey to the future (the unknown) when they carry parts of the past (the known)": It was believed that the ANMs would be inspired and feel appreciated if work performance done in the past was recognised as they go forward.

"If we carry parts of the past forward, they should be what are best about the past": It was accepted that the knowledge of past best work performance practices of ANMs discussed in the interviews would allow the ANMs forthwith to feel more self-assured to follow and build on these best practices and experiences even further.

"It is important to value differences": It was assumed that valuing the differences of ANM performance promoted openness, respect and inclusivity and therefore upheld AI. This is opposed to the traditional ways of finding a common way for all to follow.

"The language we use creates our reality": It was accepted that language (verbal and body) is the tool used by ANMs to perform in work, and therefore also their reality.

The AI approach allowed the four main KPAs to be depicted as themes according to the AI dimensions of:

(i) Best work performance experience
(ii) Best possible work performance opportunities
(iii) Initiatives/ ideal work performance expectations for the future
(iv) Service delivery commitment

The survey list of the Practice Orientated Theory of Dickoff *et al.* (1968, p. 425) (Figure 1.1) was used to organise the concepts, guide the reasoning and map the framework (Figure 5.1).

Based on the findings, the concluding statements and confirming literature were considered and integrated in the development of the contemporary PM framework for ANMs. Furthermore the framework is also grounded in the assumptions of the researcher based on own perception of the world, and its constructs and phenomena. The survey list set out to provide answers to six key questions. According to the framework as set out by the survey list of the Practice Orientated Theory of Dickoff *et al*. (1968, p. 425), the questions were:

1. In what context is the activity performed (i.e. the framework)?
2. Who or what performs the activity (i.e. the agent)?
3. Who or what is the recipient of the activity (i.e. the recipient)?
4. What is the energy source for the activity (i.e. the dynamic/s)?
5. What is the guiding procedure, technique, or protocol of the activity (i.e. the procedure)?
6. What is the end point of the activity (i.e. the terminus)?

In developing the framework the processes applied were synthesis, re-synthesis and clarification.

5.3 CONTEMPORARY PERFORMANCE FRAMEWORK

The six concepts namely the: (i) context, (ii) agent, (iii) recipient, (iv) dynamic/s, (v) procedure and (vi) terminus formed the key parts of the framework (Figure 5.1).

5.3.1 In what context is the activity performed?

The study setting comprises of state facilities in a province in South Africa, a developing country, where the ANMs and their HONs are employed. The services rendered by the health-care settings vary within the scope of general specialist services each health-care setting comprising a number of wards. An ANM manages/ co-manages a cluster of hospital wards that constitutes a functional Business Unit (FBU).

The context of the FBU involves professional, legal and ethical dimensions, and the managerial workplace environment. The hospital workplace nursing managerial environment is diverse and unpredictable, with lines of authority and communication relationships involving the profession and the MDT. A transformational-oriented environment prevails within the context, where a caring philosophy is upheld. The context follows a developmental approach, has a service delivery orientation, and strives to enhance well-being in a stressful environment.

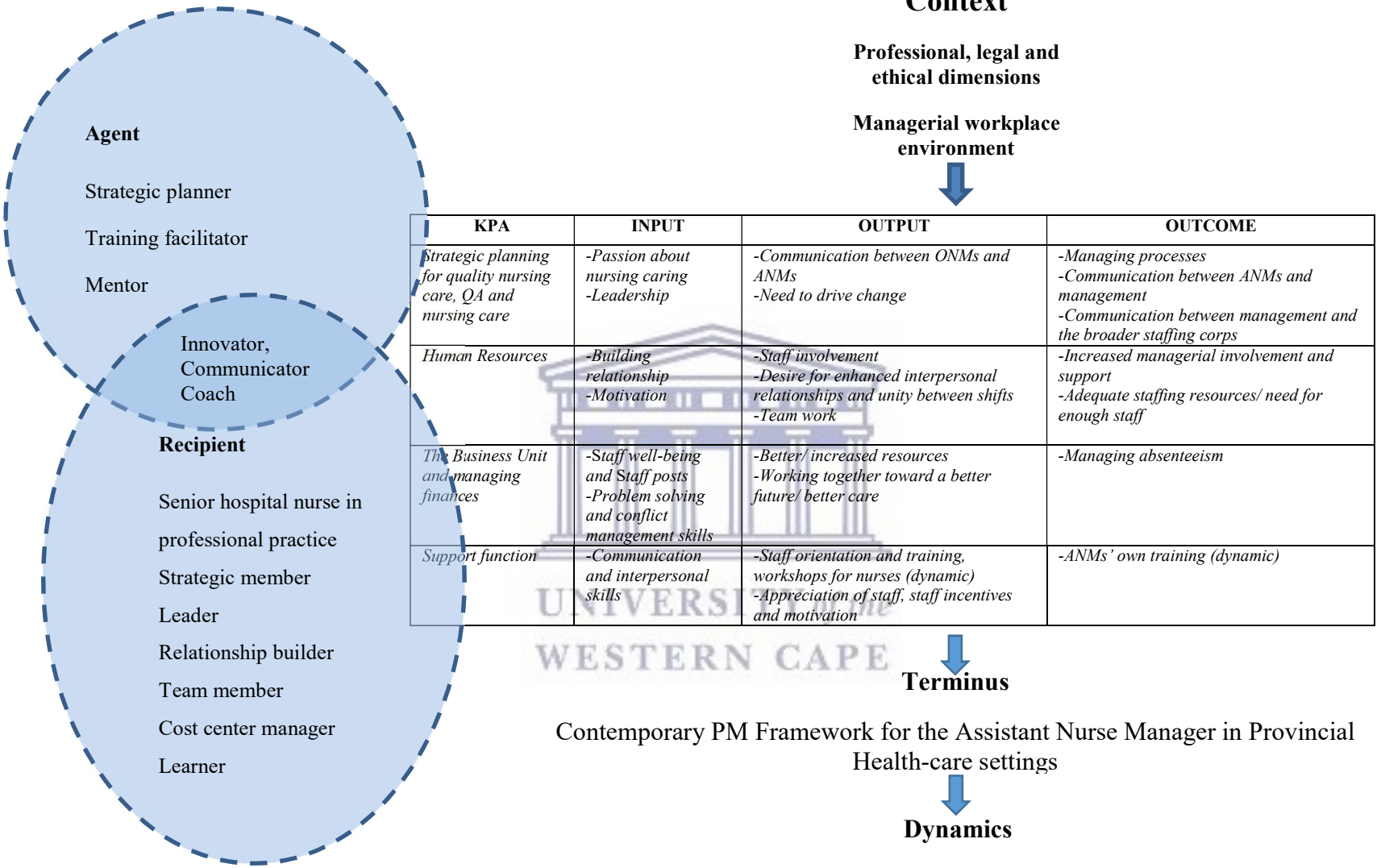

Figure 5.1: PM framework for the ANM in the provincial health-care setting

The context has two main spheres: (i) the professional, legal and ethical dimensions, and (ii) the managerial workplace environment (Figure 5.2).

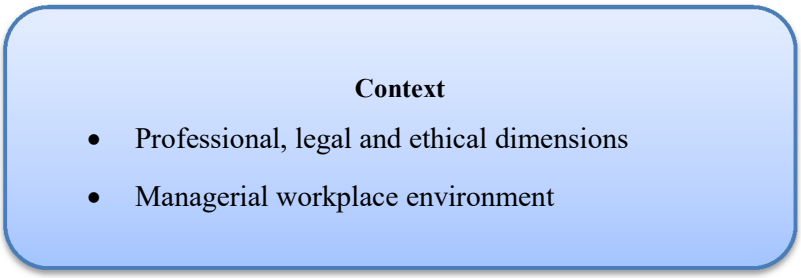

Figure 5.2: **Performance management context**

5.3.1.1 Professional, legal and ethical dimensions

Professional, legal and ethical dimensions influence the nursing management environment within the health-care settings. The South African professional, legal and ethical dimensions in the context of this study relates to the PFMA (Government Gazette No. 33059, 2010), the National Health Act of South Africa (Government Gazette No. 26595, 2004), the Nursing Strategy for South Africa (National Department of Health: Republic of South Africa, 2008), the Human Resources for Health Strategy: Health Sector - 2012/13 - 2016/17 (National Department of Health: Republic of South Africa, 2011a), the National Core Standards for Health-care Establishments (National Department of Health: Republic of South Africa, 2011b), the Strategic Plan of the Department of Health - 2014/15 - 2018/2019 that includes the National 10-Point Plan for Health (National Department of Health: Republic of South Africa, 2014), Health-care 2030 Road to Wellness (Western Cape Government: Health, 2014), the C^2AIR^2 values (Western Cape Government: Department of Health, 2015), the 2020 Draft framework for dialogue: The future of health-care (Western Cape Government: Department of Health, 2011), and the Visible leadership internal memorandum (Department of Health, Provincial Government of the Western Cape, 2016a).

- The Public Finance Management Act of South Africa, No. 1 of 1999

The PFMA serves to regulate all financial management in governmental provincial health-care settings by ensuring that all revenue, expenditure, assets and liabilities of those settings are managed efficiently and effectively. The PFMA directs the responsibilities of those persons in government such as ANMs, entrusted with financial management to provide for the required financial matters (Government Gazette No. 33059, 2010, p. 1).

- The National Health Act of South Africa, No. 61 of 2003

The National Health Act of South Africa (Republic of), No. 61 of 2003 provides the legal framework for a uniform health-care system. This Act considers the obligations required by the Constitution as well as other national, provincial and local government prescripts on health services and related matters (Republic of South Africa, Constitution, 1996, pp. 56-57; Government Gazette No. 26595, 2004, p. 2). The objectives of this act include having a system of co-operative governance and management of health services (Government Gazette No. 26595, 2004, p. 3).

- The Nursing Strategy of South Africa

The nursing manager in her performance of managing the nursing workforce plays an important role in the recruitment and retention of nurses that has an impact on the existing and prospective supply of nurses. The Nursing Strategy for South Africa (2008) stipulates that in assuring the quality of work life of nurses, recruitment and retention can be positively affected; one of the most important activities in nursing management. The Nursing Strategy also directs certain issues such as workload, professional leadership and clinical support and continuous professional development for nurses which the nurse manager is to ensure (National Department of Health, 2008, p. 11).

- Human Resources for Health in South Africa (HRH)

The Human Resources in SA is addressed in the Strategy for the Health Sector: 2012/13 - 2016/17 (2011) that intends to develop new policy and programmes, undertake a range of activities that includes compiling detailed staffing plans for new service strategies, and manage the health-care workforce in ways that would motivate them to provide quality health-care (National Department of Health, 2011a, p. 7). The strategy places emphasis on the value and support of the health work force in the attempt to deliver the service. Performance management, job design, occupational relationships, workplace cultures and HRs practices, affect the motivation and abilities of health-care professionals (National Department of Health, 2011a, p. 9).

- National Core Standards

The National Core Standards (National Department of Health, 2011b) reflect a vision for South Africa's health services and directs the performance of health-care managers like ANMs to meet the vision. These standards are intended to take up the challenge in transforming the health-care delivery system, to both meet the patients' expectation of good quality care and to improve the critical health-care outcomes linked to the Sustainable Development Goals. The nurse manager plays an important in, amongst others, aspects of health workforce development and planning of

staffing norms and standards, facilitating in-service training of nurses that would also include the capacitation of the Community Service Professional Nurses as set out in a strategic plan for health (National Department of Health, 2014, p. iv). In line with what this study set out to do, the National 10-Point Plan for health of 2009 (Public Health Institution of South Africa), has a bearing on the following imperatives: (i) *'Provision of Strategic Leadership and creation of a Social Compact for better health outcomes'*: Provision of strategic leadership will unfold using the contemporary PM framework for ANMs as they are the more senior cadre in the nursing as well as in the services hierarchy, (iv) *'Overhauling the health-care system and improving its management'*: A PM framework for ANMs contributes to managerial improvement in that performance activities of ANMs for which they are accountable, are stipulated, and (v) *'Improving Human Resources Management, Planning and Development are essential'* (National Department of Health: Republic of South Africa, 2009). The PM framework for ANMs can be used as the HRM tool for staff development.

- Health-care 2030

The provincial health-care service priorities influence nurse manager performance directly, with its strong focus on ensuring the best patient experience and dominated by the need for practicing a patient-centered approach. The nurse manager is predisposed to having to mitigate the service pressure in the study setting hospitals whilst there is an imperative to improve maternal, neonatal and child, HIV and TB, and non-communicable diseases outcomes in service delivery performance (Western Cape Government: Health, 2014).

- Western Cape Health: C^2AIR^2 values

The Government of the Western Cape has fundamentally linked care values for staff to the patient service delivery experience. These values are being caring, having competence, being accountable, having integrity, showing respect and being responsive, along with being innovative (Western Cape Government: Department of Health, 2015). The Western Cape Government: Department of Health (2015) has also launched Management Onboarding C^2AIR^2 Club Challenge for health-care settings that stimulate competition between the settings on the extent to which the values are internalised (Western Cape Government: Department of Health, 2015).

- Western Cape Government: Department of Health. (2011). *2020: The future of health-care in the Western Cape; A draft framework for dialogue*. Cape Town: Western Cape: Department of Health

The Department of Health in the Western Cape has developed a strategic plan for execution by 2020, having taken the 1995 Health Plan and the 2010 Comprehensive Service Plan as its

foundation. Seven guiding principles direct this strategy. These are patient-centered quality of care, a move towards an outcomes-based approach, the retention of a Primary Health-care philosophy, strengthening the District Health Services model, equity, affordability, building strategic partnerships (Western Cape Government: Department of Health, 2011).

- Visible leadership - internal memorandum

The communiqué of the Department of Health (Provincial Government of the Western Cape, 2016a) speak to the range of major adverse incidents that have occurred at the health-care settings in the study province, and the increasing medico-legal cases and intensity of political inquiry into leadership. The outcomes of the NCS surveys questions the staff's commitment to the service quality and standards upheld. The Western Cape Health Department had recently pointed out the pertinent need for managers to be more visible especially at health-care settings where major adverse incidents were prevalent such as the emergency centers, psychiatric wards, and neonatal services; all of which fall within the ambit of this study services setting.

5.3.1.2 Managerial workplace environment

The context of the managerial workplace environment encompasses a diverse, though stressful and unpredictable hospital nursing managerial work place environment. The setting however also allows for the focus on transformation and developmental dynamisms, whilst the lines of authority in the team are upheld. The managerial workplace environment also fosters a caring philosophy, with a focus on well-being.

- The managerial workplace environment is a diverse and unpredictable hospital nursing managerial environment

The nursing managerial workplace environment at each of the health-care settings is led by a HON, with the title, Deputy Manager: Nursing. Each HON has a span of direct control of ANMs of six to eight. The ANMs were seasoned individuals with many years of hospital experience. It was found that the age of the ANM participants were either close to 50 years of age or older because of the nine years managerial experience required for the post of ANM. By the time this study ended, six HONs of the ten hospitals who had participated, had already retired. Nurse managers such as ANMs are selected to their positions based on their clinical and managerial skills.

The role of the ANM in the provincial health-care settings has evolved. The ANMs all operate in a live FBU management model. The role has now acquired an overall importance and one within the FBU where they take on financial governance managing the allocated budgets of the wards allocated by them. The nature of the work however is associated with unpredictability and new

challenges daily/ nightly and therefore the execution of planned managerial activity needs to be assured. The National Department of Health in South Africa (2008, p. 11) has recognised that there is diversity in the nursing workforce, practice and health-care settings. A workplace environment that recognises and accepts generational diversity also makes it possible for a nurse manager to apply approaches that harnesses communication leading to staff cohesion (Hendricks & Cope, 2012, p. 717). The ANM works well with the MDT, with the different generations/ cohorts of nurses and nursing managers, and still has the ability to work independently where needed. This also confirmed the AI assumption in Chapter 1 that of in ever society, organisation, or group, something works.

- The managerial workplace environment is a transformational focused environment

The context favours the transformational leadership approach where talent is used to influence attitudes, transcend individual needs, and influences productivity positively in the broader interest of the discipline or hospital. The transformational approach moves beyond the management of business to motivate followers to exceed standards expected of them, and where strong organisational commitment is aspired to (McGuire & Kennerly, 2006, p. 179). The ANM inspires staff to attain higher standards of performance once a standard has already been achieved. Sound orientation of staff (input) leads to post alignment and clarity of job performance (output) and ensures effective service delivery (outcome). There is an environmental transformation in consciousness and an acceptance of the National Core Standards for Health Establishments in South Africa as set out by the National Department of Health (2011b), the start of a process of continuous improvement, consistent with the objective to enhance patient outcomes. The transformational style that an ANM could adopt is one that crafts a vision for the organisation so that leaders could be trusted. In so doing they would speak unambiguously and without using force. A vision shared, orientates and gives meaning to leaders and their teams in this environment. Having a vision inspires leaders and teams to be committed to the shared goal (Martin, McCormack, Fitzsimons & Spirig, 2014, online).

The health-care environment should also be much more focused on leadership succession. Succession does not only involve planning for the replacements of seniors. It also requires thinking about what needs to be done when most of the experienced people leave the organisation (Rothwell, 2010, p. xviii). For this, the agent and the recipient should have a good interpersonal relationship for also demonstrating servant and authentic leadership characteristics. Working well together toward a better future should be important for the development of new nurse leaders (Sherman & Bishop, 2007, p. 295). ANMs should be leaders who are able to apply the management principle of control of staff in a balanced and constructive way, and inspire

others by having a good grasp of finances/ accounting. ANMs should be able to influence recruitment positively by the support demonstrate in their leadership role (Suby, 2009, p. 100).

In fulfilling the recipients' role, the ANMs should be sensitive and perceptive, and devote attention to the new generation-specific cohorts of nurses and nursing managers to promote positive transformation in nursing and in health-care that aids working together towards a better future/ better care. The suggestions to devote generation-specific attention to younger cohorts of nurses who are usually outnumbered by baby boomer nurses denote a way to promote positive changes in nursing and in health-care, a likely way of promoting working together towards a better future (Wendler, Olson-Sitki & Prater, 2009, p. 327; Keys, 2014, p. 98).

- The workplace managerial environment comprises lines of authority and communication in the team

In the context of the work environment and work performance, the ANM fulfills the essential need of the intermediate position between the HON, and the ONM and the services. The ANMs recognise how important effective communication between the ONMs and themselves are as it contributes to participatory management. They are therefore simultaneously subjected to another 'chain of command' of having to report to the Head of the FBU whilst they still have some degree of autonomy within the FBU. Authority is important. Authority is official power to act, designated by the organisation so that the work of others is directed (Marquis & Huston, 2009, p. 278). Using communication, ANMs work considerably well with specialist doctors whilst the night ANMs in particular work pointedly effectively with medical superintendents/ CEOs. ANMs and HONs should also consolidate their working relationship over time.

Involvement of ANMs in higher levels of functions is positive and the participatory manner in which the ANM and other managers such as the quality manager are involved in projects could lead to successful outcomes. Team relationship with colleagues are said to be more co-operative, intimate and profound, whilst difficulties, concerns and fears are shared (Zannini *et al*., 2015, p. 261). The ANM on the night shift holds a crucial position because of the direct work relationship they maintain with the Head Specialist and the CEO. Within the managerial setting where the nurse managers perform work, operational leaders such as ONMs who are supervised by the ANMs also fulfill lead roles in the Business Unit, such as the direct management of wards. Macphee *et al*. (2010, p. 1016) confirm that it was the operational leaders who were found to be the most important structural support for teams. Even though positive work relationships between team members and their front line leader enhanced team work, it was found that the relationship with team-operations leaders that contributed to the most success to effective work relationships among teams (Macphee *et al*., 2010, p. 1016).

- The managerial workplace environment accentuates having a caring philosophy

The nursing managerial environment in which the ANM performs her tasks is one with a philosophy of being passionate about nursing and caring for others. The ANMs should similarly expect nurses to inherently have respect and demonstrate treating patients with dignity. Caring is central to nursing reflected in an ANM expressed love in caring for the mentally ill said to have been instilled by nursing leaders; similarly love expressed by caring in relationships and how the relationships are conducted, can be seen in African Ubuntu principles that demonstrate a culture of caring (Downing & Hastings-Tolsma, 2016, p. 214).

- The context upholds a quality service delivery orientation

The context of the health service should be a safe and quality service. It has to comprise of and support quality assured nursing care including providing for the needs of the patient and the family, and be able to address complaints and problems. The process of recruitment and selection must allow newly appointed staff to be orientated into the post, as this facilitates effective service delivery by the individual. The ANM should be a co-partner to the quality manager whilst she also takes for QNC; the ANM is instrumental in ensuring continued QA especially at night. Quality care means being patient-entered and a continuous strive to improve the level of care. The belief that 'good nursing documentation measured by audits improves quality of care' is to be upheld in the context in which the ANM performs work. Audits allow the ANM to gauge quality of service delivery in safety which could include staffing expertise, knowledge and norms, infection control (hygiene and cleanliness), and waste management. The lead and support role of the ANM is acceded to when she is able to, in this context assure that resources and staffing are adequate (resourceful). Additionally, the ANMs should be able to make sound decisions, and provide both positive and negative feedback. The ANM must be able to assume a deputising/ acting role in the absence of the HON. The context therefore requires the ANMs to lead by their ability to take responsibility in service delivery.

5.3.2 Who or what performs the activity (agent)?

The agent in this study on nursing management in hospitals is a more senior figure in the General Specialist Hospitals in the Western Cape, accountable for quality patient care. The primary agent is the HON, a Professional Nurse registered with the SANC. She is in the post of a deputy nursing manager on Level 11 of the Department Public Service South Africa (DPSA). The secondary supporting agents are the CEOs, Heads of FBUs, and Head Specialists in the FBUs, other Heads of Departments, and the MDTs, with whom the recipient has to interact with, in the course of performing her duty. It was assumed that the secondary agents also have the same characteristics as the primary agent (Figure 5.3). The agent influences the performance of the ANM in the provincial health-care settings. The agent engages in and manages the work

performances of the ANMs. The agent is a strategic planner, communicator, innovator, coach, training facilitator, mentor and leader.

Figure 5.3: Characteristics of the agent

- **Strategic planner**

The agent embarks on strategic planning as a strategic member of the strategic planning team (primary and secondary agents) that involves the recipient and ensures that there are measures in place to assure quality of patient and nursing care. When plans are embarked on, the agent must inform the recipient formally of what the overall vision, mission and objectives of the nursing service are. This allows the recipient to clearly envision the direction the hospital needs to plan for and therefore direct their work performance. Recipients who are responsible for work force planning have to forecast the knowledge, skills and abilities necessary to lead health-care delivery at hospitals (West, Smithgall, Rosler & Winn, 2016, p. 26). However, health-care has become no longer hospital-based. The model of managing health-care now is multi-complexed that further includes external stakeholders who influence health-care. The nurse manager strategic planner therefore needs to make provision for a collaborative environment where all voices can be heard. Health-care planners though are prompted to establish how strategic planning is embarked on in other industries (VanVactor, 2012, p. 300).

- **Communicator**

The nursing managerial system, for example the authority lines, should allow for focused communication between ONMs and ANMs, and stimulate emotional acumen of nurse managers in order to foster such open communication. ANMs also believe that the role of the hospital management as the secondary agent should be that they (the hospital management) speak at times directly to the broader staffing population. The agent should be interested and committed to resolve conflicts and disputes by demonstrating the willingness to listen to all parties in order to find amicable solutions (Manolitzas *et al*., 2016, p. 215). ANMs ought to greet staff in their (staff) mother tongue as an act of emulating management values, though at the validation of the findings of this study, English was proposed as the common language for ANMs to use. The night ANM in particular could play an effective role in strategic and operational problem solving

and conflict management as they manage the entire hospital and make key decisions. In the present-day setting, it has become imperative for a manager (agent) to be a communicator (Hodge, 2011, pp. 511-512).

The agent as a communicator should also promote research, and the role that information technology plays in enhancing the efficiency and effectiveness of communications, considering that a large number of adverse hospital incidences originate from communication failures (Angst *et al*., 2012, p. 257). Openness to new modes of communication is indicative of one of the processes of change that has to come about.

- **Innovator**

In the WCP where the study was conducted, innovation had been adopted as an organisational value (Western Cape Provincial Government (Budget Speech), 2012, online; Western Cape Government: News (April, 2014)). In order to stimulate innovation, the agent could facilitate a supportive organisational climate to help ANM (employees) to transform creative ideas into innovative production (Sarros, Cooper & Santora, 2008, p. 154; Weng *et al*., 2013, p. 428). The agent herself is innovative and can bring about change by recognising ANMs who have good organisational skills and who initiate new ideas even on the night shift that benefits the functioning of the service, like the example of a night ANM who brought his own books and innovatively allowed for sought-after learning that in turn trained staff studying part-time. The agent needs to have the ability/ innovation to individually respond to rapid changes and improvement in health-care settings (Brand, 2013, p. 28) for example to devise an improvement plan after an audit.

- **Coach**

The agent takes on a coaching role for the ANM whom she supervises. The recipient should be prepared for the role of nurse manager that should include postgraduate education and business management training. A formal organisational management trainee programme and continuous support in the clinical supervisory role would be beneficial (McCallin & Frankson, 2010, p. 319). Supporting secondary agents (hospital management, FBU Heads) are to be cognisant that the ANMs have a need for 'own' coaching/ training as many have not set out to be managers from the outset. They therefore have to be trained in this regard. The agent as a coach needs to support the provision of staff incentives, motivation and appreciation for the ANM (especially on night shift), while keeping in mind staff well-being and changes in the work environment. As coach, the agent is cognisant of the unique position of the ANM who manages the hospital and maintains its integrity and credibility at night when the need arises to deal with complaints from the public, with the utmost professionalism. In this regard, the agent reinforces professionalism. This practice is in line with creating a new image and world for nurses, where nurses portray value (Cherry & Jacob, 2015, p. 33). The contemporary workplace presents a composite

environment with supervisors and managers such as ANMs, having to acquire new skills sets in the management of people.

- **Training facilitator**

Training in relation to QA is also to be facilitated as ANMs need to know how to analyse trends on adverse incident indicators. The agent acts as a training facilitator to make recommendations to the Skills Development Fund to support ANMs in their development and learning of HRM. ANMs should be educated and trained in HRM that includes problem solving, conflict management and absenteeism/ staffing shortages. The agent should reinforce and nurture the effort of an ANM, who embraces staff development opportunities. An obligation resides with the HONs (primary agent) to demonstrate increased managerial involvement and support to recipients that need guidance in clinical and managerial skills. Being better resourced is a means to perhaps change work performance behaviour from mediocre to innovative (Weng *et al*., 2013, p. 436).

The agents' role is to provide learning opportunities for ANMs to become more visible and to engage more with staff in the wards. The role of the agent is therefore to assist the ANMs with time management to limit distractions in order that they (ANMs) may fulfill their strategic work performance and managerial involvement support role. When nursing management shows understanding for the needs of front line staff to be effectively supplied with learning resources and opportunities to assure quality care, ANMs could meet their own performance obligations and be more effective (Loo & Thorpe, 2004, p. 88).

ANMs are to be taught to apply critical evaluation to new management and financial systems, and night shift managers should remain up to date with reference to FBU management. Agents need to orientate ANMs on effective capacitation in all administrative steps in the process of recruitment and selection in accordance with the required documentation prescript/s.

- **Leader**

The agent should have the ability to lead a nursing corps. The dynamism of the teaching and developing approach proposed incorporates an ability to interact and converse with people. Even moods have an impact on the climate of the organisation and nurse leaders in particular in this regard are able to positively affect the organisational mood in their individual or group engagements (Stapleton *et al*., 2007, p. 814). ANM dynamism includes leadership resilience as they demonstrate helping out voluntarily in crisis situations and use their composure to contain and appease staff.

A transformative leadership role is one that empowers ANMs, and contributes to their ability to lead efficiently and inspire others. In executing their leadership role, nurse managers show fervour, openness, flexibility, talent for reflection, and the ability to be focused. They (nurse managers) are able to interact and converse with people. When ANMs are involved in a positive conversational engagement with staff, it is likely that both conversationists will physiologically

also feel good as the feelings are emulated (Stapleton *et al*., 2007, p. 81). An aura of respect should abound when the nurse manager leader enters a room of followers. In this regard nurse managers who lead are extremely professionally attired and well-groomed. The image created influences others meaningfully (Musker, 2004, p. 45). The agent should also show influence as a servant leader and act authentically.

5.3.3 Who or what is the recipient of the activity?

A *recipient* is someone who receives something (Cambridge English Dictionary, 2016, online) and is an addressee or beneficiary; someone who receives or benefits. In this study, the recipient is the ANM who should be flexible and works in a hospital managerial environment on both the day and the night shift according to key performance areas. The ANM has an important clinical role to play and others should experience their presence. Their work is influenced by primary and secondary agents, doctors, the MDT, nurse manager peers, nursing staff and the public. The recipient is a senior hospital nurse in professional practice, strategic member/ partner, leader, relationship builder, team member, cost center manager, innovator, learner and coach (Figure 5.4).

- **Senior hospital nurse in professional practice**

The recipient is a trained Professional Nurse at the SANC, in a **senior** position in the professional corps of the nursing hierarchy (Department: Public Service and Administration, 2016). ANMs are in senior positions at provincial health-care settings.

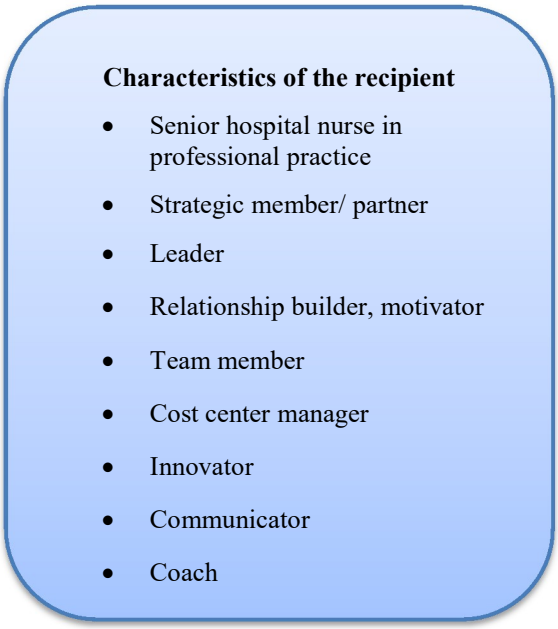

Figure 5.4: Characteristics of the recipient

Their visibility is important as it signifies managerial involvement (Sole, 2009, p. 7; Department of Health, Provincial Government of the Western Cape, internal memorandum, ref. 16/4, 2016a).

ANMs should have the capacity to follow all administrative steps in the process of recruitment and selection of staff in accordance with the required documentation prescript/s. ANMs should illustrated a great deal of passion about how caring in nursing is demonstrated. The ANMs, in particular those who worked the night shift, should ensure that the importance of continuous quality basic nursing care is promoted and that such skill is practiced and executed. An advantage is to be trained in the area of infection prevention and control, and all recipients should be able to use and distinguish between nursing and medical terminology. In the Western Cape where three official languages are spoken in provincial health-care settings, it appeared that it might be advantageous if ANMs could speak a third/ another African language. To the contrary the validation of this study suggested that the use of English remains the ANM's common language of engaging with the staff should either's mother tongue differ.

- **Strategic member/ partner**

The ANM could serve on the strategic management team of the hospital on an adhoc basis or have observer status. The ANM is valuable in driving and managing inevitable changes in health-care, with unique HR work performance experience in an unpredictable work environment. By means of their strategic partnership in decision-making with others at a senior level, the recipient ANM could contribute to organisational processes in health-care organisations (Wong, Laschinger, Cummings, Vincent & O'Connor, 2010, p. 122). Bradley (2014, p. 621) also uphold the notion that a nurse manager as a strategic member of the health-care system could ensure that nursing is represented, and would strategically engage in decision making that could remould the system that is aimed at improving patient health outcomes.

- **Leader**

The ANM is expected to be competent and able to represent seniors, for instance, in meetings. They are also expected to influence members in the MDT during strategic planning and other processes and matters, as well as to obtain the vision of the organisation. This position requires the ANM to know and have the authority to exemplify the content of the AOP of the hospital and the province, to her followers. The ANM is required to use their power and knowledge to ensure that patient care audits are conducted and to vehemently ensure that nursing documentation reflect decision making as opposed to only making logged nursing entries (Salmela, 2013, p. 58). A passion for caring in nursing is an emblematic characteristic of the ANM that describes their positive emotions related to leading a unit.

The ANM is a front-line leader. Front-line leaders know their people, are able to maintain the psychological perspective in their relationship with the workers, are credible and can tell compelling stories, contribute to an advocacy culture that inculcate an employer-employee covenant. The role also requires the ANM to hold people accountable, build loyalty and engagement from the center of the hierarchical structure, bring people together, and integrate innovation and a general openness to change by continuously asking *"what if"* (Van Gorder,

2015, pp. 44-46). Nursing managerial leadership requires an innovative and transformational approach that works well with others and that is committed to addressing the broader issues of the work environment (Patton, 2013, online; Porter-O'Grady & Malloch, 2009, p. 246). A needed leadership characteristic for an ANM is the building of interpersonal relationship with fellow and lower levels of staff and patients. Leadership is intertwined with the ability to cherish relationships with staff and colleagues (Mackoff, 2011, p. 19).

- **Relationship builder, motivator**

Relationship building refers to positive involvement with followers, an effective supervisory style and motivation of staff. The ANM has a crucial role in building relationships and is required to have a positive and constructive involvement with followers. Relationship building should be the deliberate *carving of relationships* which lead to enhanced service delivery. Explicit manager behaviour that lends itself to staff satisfaction and positive relations is important. Such behaviour traits were perceived by RNs to be the endeavor to remain professional, having the value of respect and fairness, and be the 'go to person' that would assist in addressing concerns relating to staff and patients (Feather *et al*., 2014, pp. 130 & 132).

ANMs on day and night shifts should demonstrate *good interpersonal relationships* and unity in managing staff. The building of relationship should be promoted by their characteristics of effective consultation and inspiration, confidence and positive staff self-esteem in the workplace. The ANM characteristic of warmth and trust could build relationship, which contributes to happiness and motivation of nursing staff (Jooste, 2003, p. 26). ANMs can contribute to a friendly work environment and must be able to demonstrate appreciation for operational work and the workload of ONM. Saying *'thank you'* to staff is essential in supporting and motivating staff. It is important for the ANM to ensure that the stress staff is experiencing is not dismissed. The ANMs work well with the MDT and are able to do their required nursing work. The role of the ANM is to be accessible and to work well with others.

The role of the ANM as recipient is also to motivate nursing staff. The position of the ANM is meaningful as a senior position, and therefore an ANM must firstly identify aspects of their own performance that lead to job fulfillment. Secondly, to assist others, the ANMs should have a focus on staff satisfaction and training. The responsibility of the recipient is to be a motivator, to motivate nursing staff to achieve their goals in their career and assist incumbents with managerial development if so desired by the staff member. A means of motivation is seen when the nursing staff are allowed time off for training purposes. The ANM must make a sincere attempt to know staff better as this serves as motivation/ appreciation of staff. As opposed to simply assigning someone to do a job, it is well-known that a motivator prompts others to act (Pola & Ihlenheld, 1980, p. 4). The motivator nurse manager behaviour includes using motivational language and sharing feelings, publicly complementing good work and offering

meaningful rewards that could aid employee performance and job satisfaction (Jones, 2007, pp. 34-35; Poquette, 2011, p. 9). In this regard the AI assumption in Chapter 1 is confirmed that the language used creates the reality.

- **Team member and supporter**

The ANM should be a team member by facilitating the well-being of staff, building interpersonal relationships, and providing support where needed.

In enacting the role of the ANM, it is important to be a *team member*. She could flourish through involvement of ONMs in work performances and by developing teams that participate in events, activities and even work tasks. Better work engagements lead to better work performance while addressing problems and finding solutions (Srsic-Stoehr *et al.*, 2004, p. 38). In regard to the day and night working shifts of nurses, the desire for enhanced interpersonal relationships and unity between shifts is essential. ANMs from both the day and the night shifts should be creative and involve the nursing staff in transversal hospital events such as Madiba Days. ANMs on the day shift are to make a deliberate effort to involve the ANMs on the night shift to facilitate the former.

The ANM should facilitate staff well-being, and ask those staff working under pressure, - what they perceived as support, - and act on it. The ANM should be able to identify staff challenges and swiftly refill (appoint) nursing staff posts or start processes once they know about possible vacant posts. Being mindful of work interactional strategies facilitates staff well-being. Hence, the nurse manager should be able to use the strategies of pitching-in, reciprocation, showing appreciation, respecting, thanking, praising, receiving information and, explaining (Anderson *et al.*, 2014, pp. 9-11). HONs recognise the essential support role played by the ANM and are proud with the support the ANMs give to the Head-Specialists doctors. ANMs render their support function to the nursing staff, doctors, Head Specialists doctors and external stakeholders and other private parties who the service engages with for service provision.

The supporting role of the ANM involves being a problem solver and conflict manager that displays diplomacy, fairness and honesty (Schmalenberg & Kramer, 2009, p. 61; Suby, 2009, p. 101). Approachability, the knack to offer a safe space and promoting staff cohesion are also seen as supportive behaviour. ANMs have characteristically inculcated a willingness to avail themselves in their supportive function. For Such ANM support behaviour could be viewed as loyalty.

- **Cost center manager**

The recipient should have an understanding of the Business Unit, and the ability to apply sound financial management. ANMs have to be more astute with regard to finances than before. ANMs are to be capacitated in financial procedures such as budgeting, financial management, procurement and vetting in relation to the management of FBUs. The ANM plays an important

role in securing cost effectiveness by, for instance, managing absenteeism. She links absenteeism/ staff shortages directly with the budget. As the nursing HR manager she also ought to steer the process of managing absenteeism in a remedial direction first. Nurse absenteeism has been found to compromise quality of care and financial outcomes in health-care (Daouk-Öyry *et al*., 2014, p. 93). The ANM should take ownership of and pride in ensuring that new staff have an orientation programme that addresses the corporate aspects of the job, such as duty times.

- **Innovator**

The daily clinical settings in hospitals stimulate nurses to be innovative and in this regard the HONs view the ANM as a potential teaching resource. An innovator would introduce new means, notions or creations often referred to as workarounds (Collins, 2014, p. 17). Allowing innovation in health-care, could at times complement the need for resources, and aid the commitment to service delivery. The ANM as recipient has to emphasise the importance of those who initiate change projects, to manage and thus see it through to its completion. The ANM recipient has the expectation that innovation of new work tasks, projects and processes still be linked to timely notification, and verbalised the need for routinisation and order in the work environment. The recipient should be innovative, that is, allowed to manage nursing processes, and sit at the executive management table as recipients facilitate continuity broadly in many aspects of nursing management.

- **Communicator**

The recipient ANM communicates well within the working matrix which includes the primary and secondary agents such as HONs and medical staff respectively for success in team work, which the agent should be cognisant of. As communicator the recipient is expected to have had prior learning in managing units, which is useful in prospective ANM development. Open communication or facilitation of communication should be practiced by the recipient. In the attempt to work toward a better future and better care delivery, it is incumbent on an ANM to be a good communicator with the supervisee, the ONM in particular, and as a communicator to demonstrate how to be committed to one goal even if they work in different departments or shifts in the hospitals.

The recipient, in particular the night ANM, should be a good communicator in order to build relations and enhance team spirit. ANMs defend a specific position or situation very well when they believe that a negative consequence could come about. In this regard ANMs recipients as communicators show maturity and assertiveness when engaging with others especially the Medical Heads and specialists. Communicators would meaningfully use their interpersonal skills. The ANM should also be the advocate for effective nursing report writing. In this regard the ANM astutely listens and invariably demonstrates leadership (Dolamo, 2015, p. 4). The ability to listen, liaise closely and demonstrate support and respect towards each other are key

ANM communicator characteristics. When communicating, ANMs should show an openness and accessibility to nursing staff through an open door practice, even with the lowest level worker. Open communication by nurse managers that also leads to better patient outcomes, is premised on a principle of emotionally intelligent leadership (Peregrina, 2009, p. 6). The face-to-face handovers (hand-offs) and other indirect operational discussions between ONMs and ANMs can be facilitated by applying prioritised essential communication qualities for nurse managers as identified by Rouse and Al-Maqbali (2014, p. 196). These are:

- Explain and teach needed competencies for the work situation
- Collaborate
- Use appropriate tone
- Listen
- Be knowledgeable
- Solve problems
- Provide feedback
- Be fair
- Be a role model
- Maintain confidentiality
- Trust (Rouse & Al-Maqbali, 2014, p. 196).

- **Coach**

Similar to the agent, the recipient too is a coach within the nursing hierarchical structure and the contemporary workplace where they have to manage people. As a coach, mentor and trainer, the ANM invests in building working relationships with the staff, to get to know the staff member as a person. It is important for the ANM to motivate staff by recognising their nature as people as opposed to only fulfilling the functional role of manager. The dynamism required to be a nurse manager revolves around: "…what does it take to encourage your employees to fall in love with the company? Knowing staff well; knowing what motivates each employee…!" (Taylor & Stern, 2009, p. 96). The ANM recipient as coach should have a positive regard for and embrace staff training (development). Managerial coaching is the explicit dyadic relationship between the nurse and the nurse manager for the purpose of improving knowledge and skills in relation to the expected work performance (Batson & Yoder, 2012, p. 1658). The recipient should take on a coaching role for the ONM. The recipient should coach by means of supervisory engagement and discussion to guide and develop ONMs, and in particular in the management of HRs and disciplinary processes. When coached by the recipient, the performance ability of the ONM and others in turn improve. A coach could add full efficiency to the work performance of those they manage using specific communication efforts (Bommelje, 2015, p. 69; Hagen, 2012, p. 19). Both the agent and the recipient should to be communicators, innovators and coaches (Figure 5.5).

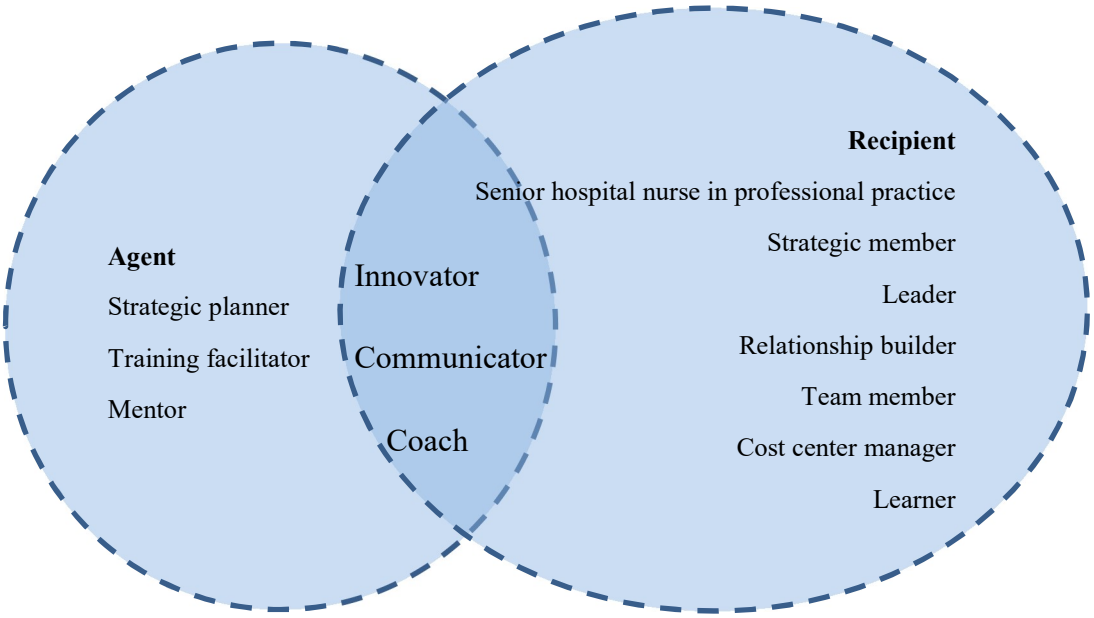

Figure 5.5: Overlapping characteristics of the agent and the recipient

5.3.4 What is the guiding procedure, technique or protocol?

There are four processes involved in the performance management of ANMs in the provincial health-care settings. These are (i.) strategic planning, and quality assurance and nursing care, (ii.) HRs processes, (iii.) processes related to the Business Unit, and (iv.) the support function. These processes follow the adapted Logic Model of input, output and outcome.

Figure 5.6: Main processes/ procedures in performance management

5.3.4.1 Strategic planning, and quality assurance and nursing care

Overview:

Strategic planning is the effort to structure the processes that enable an organisation to reach its goals and objectives (Ogutu, 2017, p. 18). Quality assurance is any systematic process of establishing whether a service or a product being offered or developed, meets specified quality

standards. Quality assurance increases patient confidence (Das, 2017, online), and includes audits. A nursing audit is a management tool that assists in the improvement of care quality. The record by professionals in the patient history is the chief means of investigation (Viana, Bragas, Lazzari, Garcia & Moura, 2016, online). Nursing care is described as interactive and participatory, for the promotion of health, and to aid, support, teach and develop the patient by releasing her resources. Nursing care is based on the premise of satisfying universal and personal needs in relation to daily life that have become disrupted due to the presence of ill health (Johansson, Oléni & Fridlund, 2002, p. 337). Nursing care continues to relate to the needs of an individual. Berthelsen and Frederiksen (2017, p. 41) state that nursing care involves recognising the patient as a unique being by taking care of their needs at various or a specific point in their life. The work procedures of strategic planning, and quality assurance and nursing care, collectively form four main processes in the contemporary performance management framework for the ANMs.

- **Input into best ANM work performance requires passion and leadership**

- *Passion*

Passion was described by the ANMs as their fervour, warmth and earnestness they have for people; staff and patients, and the desire to do well in caring.

Nurses generally understand caring to include answerability, compassion, competency development and holistic service (Roland, 2014, p. 2). The show of care and commitment should be pervasive (a widespread and general approach) in the approach of an ANM. In this regard respect should be an encompassing value built into the performance of an ANM. Therefore, an ANM must identify the aspects of her work performance that she is passionate about as it is a precursor to job fulfillment.

The ANM can cultivate love for caring for the mentally ill potentially by being inspired by the nursing leaders and veterans. Smith, Turkel and Wolf (2013, p. 391) describe a veteran nurse as someone who exemplifies caring. The veteran nurse is a PN and an authoritative clinical expert providing sound leadership who displays skilled caring for patients. She fulfills the role of patient advocate for the period of the patients' stay. The role of the veteran nurse transforms caring for patients to a model of caring that becomes the desired way of caring. There is a strong sense of interconnectedness between this care facilitator and the patient and the family. Nurses in these positions demonstrate how this role liberates their passion for nursing. Caring is said to be the 'soul' of the role of such a nurse (Roland, 2014, p. 2).

Table 5.1: Procedure of performance management

KEY PERFORMANCE AREAS	PERFORMANCE OBJECTIVES	INPUTS	OUTPUTS	OUTCOMES
Strategic planning, and quality assurance and nursing care including audits in the work situation	*The ANM should be able to ensure the rendering of strategic planning, and quality assurance and nursing care including audits in the work situation*	*-Passion about nursing caring* *-Leadership*	*-Communication between ONMs and ANMs* *-Need to drive change*	*-Managing processes* *-Communication between ANMs and management* *-Communication between Management and the broader staffing corps*
Human resources	*The ANM should be able to follow adequate processes of human resources management in her area of operation with her staff members*	*-Building relationship* *-Motivation*	*-Staff involvement* *-Desire for enhanced interpersonal relationships and unity between shifts* *-Team work*	*-Increased managerial involvement and support* *-Adequate staffing resources/ need for enough staff*
The Business Unit and managing finances	*The ANM should be able to manage finances cost effective in the Business Unit*	*-Staff well-being and Staff posts* *-Problem solving and conflict management skills*	*-Better/ increased resources* *-Working together toward a better future/ better care*	*-Managing absenteeism*
Support function	*The ANM should be able to implement her support function in relation to seniors and followers in the work place*	*-Communication and interpersonal skills*	*-Staff orientation and training, workshops for nurses(dynamic)* *-Appreciation of staff, staff incentives and motivation*	*-The need for own training (dynamic)*

The ANM is to adopt a nursing caring approach. Passion for nursing and caring is an inherent characteristic required in nurse manager agency in both HONs and ANMs to be able to manage and develop staff. An ANM should have the ability to describe the positive emotion/ s relating to managing. When work experience has purpose for the individual, and stimulates positive emotion, it results in meaningfulness (Lee, 2015, p. 2). Passion in work performance also relates to the ANM enhancing her performance by own-orientation, energy and zest. A meaningful approach focuses on staff and training, conveys care and commitment, and is viewed as a show of passion.

The notion of embarking on basic nursing care with the required efficiency is passionately embraced and promoted by the ANMs as the 'back-to-basics' nursing care principles with the imperative inclusion of training in infection prevention and control, and rehabilitation in psychiatric nursing should be regarded as an important KPA. In the attempt to improve the patients experience, ward culture change is needed and the teams need to change their behaviour and go 'back-to-basics' (Bolton, 2009, pp. 1-2). When training is facilitated by the ANM, use should be made of a nursing model approach to care as opposed to the often-followed medical approach. The passion of an ANM can be portrayed by hopefulness, forming personal networks with staff, role modeling and mentorship, and the ability to manage crisis while still upholding moral principles. Passionate and caring is said to come from the 'soul' of a nurse.

- *Leadership*

Leadership in nursing is distinctive behaviour and talent in health-care settings at all levels.

The ANM must be able to take up the acting role as HON when the latter is away and lead by their ability to take up the responsibility that expected of the HON. Nurse manager leaders manage staff well by balancing the amount of control exerted along with the amount of latitude the staff have given. In fulfilling a leadership role, nurse managers must be able to lead and inspire others. ANM leaders should show fervour, openness, flexibility, talent for reflection, prioritising, transformation and ability to be focused. They should have the ability to interact and converse with people. When this occurs, the physiological findings mimic the positivity being experienced by the conservationists (Stapleton *et al*., 2007, p. 814).

The health-care environment should be much focused on leadership succession. In the health-care environment, others should feel the aura of the ANM leader by her demeanour when she enters the room. ANMs ought to be extremely professionally attired and well-groomed, because the image of the nurse manager as a leader influences others (Musker, 2004, p. 45). Professionalism in performance and appearance earns recognition and respect. The professional uniform serves as a powerful form of non-verbal communication that relates to the ANMs'

identity, authority, status, and occupation as a leader (Splendore, Burns & Choby, 2016, online). ANMs who opt for the transformational leadership approach transcend individual needs and influence productivity positively in the broader interest of the discipline or hospital. They demonstrate using their talent to influence attitudes and move beyond the management business to motivate followers to exceed standards expected of them (McGuire & Kennerly, 2006, p. 179). ANMs ought to have a good grasp of the finances/ accounting system.

The assertion of Scoble and Russel (2003, p. 324), that a nurse manager must be educationally prepared and should have internalised the required skills and knowledge for the prospective managerial and leadership position, still holds sway today. Communication, interpersonal skills and the ability to organise regarded as soft or behavioural attributes are necessary to prepare a nurse as a leader who is to provide quality care in a complex health-care environment (Williams-Buenzli, 2015, p. 2). The night ANM as leader promotes a process whereby new nurses to the night shift are 'led into the shift'. Three types of leadership styles should be implemented:

- Transformational leadership:

The focus of transformational leadership is on nurturing leadership talent in others and goals that transcend the immediate needs of the work cluster. Transformational leadership is further characterised by mutual trust (Barnett, 2011, online). When transformational leaders in nursing, are supported by the hospital's executive and management structures, it can lead to staff satisfaction and retention (Patton, 2013, online).

- Servant leadership:

Servant leadership addresses the needs of all the members of the MDT. WWhen servant leadership is embodied, empathy, stewardship; however there is special commitment to the personal, professional and spiritual growth of subordinates. A focus on empowerment, trust, compassion and role modeling is also present in servant leadership (Jooste & Jordaan, 2012, pp. 79 & 79; Barnett, 2011, online).

- Authentic leadership:

Authentic leadership is characterised by increased conviction, better congruence in aspects of work life and less adverse patient outcomes (Wong & Giallonardo, 2013, p. 740).

An ANM can show leadership by their appeal to staff, and inspiring and advising them.

- **Output into best possible work performances related to communication between ONMs and ANMs.**

- *Communication between ONMs and ANMs*

Communication is a skill required by managers. Effective ANM-team communication is critical for the provision of sound health-care and patient safety.

ANMs who communicate well facilitate patient QA and rehabilitation. However, participatory communication is immensely important for ANM-OMN teams and is to be prioritised by the ANMs as an output. It has been identified as the highest required skill for a nurse administrator leader (Dever, 2010, p. 32). The ANM seeks the imperative feedback from the ONMs on matters pertaining to the wards. The ANM should promote more free flowing communication between the day and the night shifts and advocate meetings between the day and the night nursing manager to facilitate sound communication as an output for quality nursing care.

Relationship and hence effective communication between the night ANMs and the day ONMs are vital, as these two groups should meet for shift hand-overs; important in the work performance of ANMs as it facilitates the effective management of the health-care setting overall. Rouse and Al-Maqbali (2014, p. 192) believe that a supportive and communicative work environment promotes nurses' dignity and respect.

Communication enhances interpersonal relationships and nurse managers play a crucial role in the facilitation in staff communication between departments. Such communicative engagement can be achieved by the construction of interactive communication forums between the departments to share ideas and further create a positive working environment for nurse managers (Wagner, Bezuidenhout & Roos, 2015, p. 974). The hospitals could benefit from major sought after nursing and other health-care activities that have come about as a result of effective communication of ANMs, such as the annual drive to enhance cancer awareness. Effective communication contributes to a positive milieu in the nursing managerial climate and to a healthy and effective workplace environment. Enhanced communication facilitated by the ANM has to be timely, accurate and relevant.

- **Output into best possible work performances also related to the initiative of the need to drive change in the future**

- *The need to drive change*

ANMs are change agents who initiate and drive inevitable change because they lead and implement change meaningfully in health-care.

Change is seen as the process of engaging with followers (Willcocks, 2012, p. 13). Agents ought to be aware of the notion that women are seen as being more likely to adopt a transformational

approach (Barr & Dowding, 2015, p. 42), which is more focused on the process of change that could be either individual or organisational (Willcocks, 2012, p. 13).

In driving change management processes, ANMs have at their disposal the use of new resources, thinking processes, technological, quality and HR practices that include efforts to retain staff, to implement change in the health-care setting. Factors that could affect change include whether the perception of change is a prospect or a threat, the organisational milieu and compensation, the record of effort embarked on previously (Hiatt, 2006, p. 18), and the inherent or individual dynamism of the nurse manager related to the motivation for change (Willcocks, 2012, p. 13). The ANM also sees a change process through to its completion. Compelling leaders are said to show visionary leadership associated with leading change (Daft *et al*., 2010, p. 582). ANMs are to be mindful of the fact that the leader motivates and inspires change, the change process being an occurrence that sometimes emerges naturally whilst it can also be planned (van der Voet, 2013, p. 380). However leadership of change in clinical practice is a role for all nurses, not just those in formal leaders and manager positions (Willcocks, 2010, p. 13; Department of Health, Provincial Government of the Western Cape, video, 2016b). The ANM is to be astutely aware of the more complex and mutated disease profiles, along with the demands of patients that have led to the quickening pace of change in health-care delivery.

- **Outcome -The commitment to deliver work performances related to work processes, communication between ANMs and management, and communication between management and the broader staffing corps**

- *Work processes*

The commitment to deliver work performance relates to: (1) work processes that incorporate administrative, nursing documentation and supply chain processes, and (2) communication processes that incorporate communication between ANMs and management, and communication between management and the broader staffing corps.

- Administrative work processes

Administrative work processes are important for commitment to delivery in ANM work activities. ANMs are committed to delivery work performance and will use the management of processes in HRs (i.e. the management and processing of documents) to assure quality outcomes.

- Nursing documentation processes

Nursing documentation processes are important for commitment to deliver in ANM work activities. The process of documenting in nursing by the professional cadre is a vital function to nursing practice (Okaisu *et al*., 2014, p. 1). The ANM ensures that 'nursing process' documentation as the nursing patient record is implemented. The use of the 'nursing process' and the nursing documentation auditing process, the means of measuring care, is applied for quality

assurance in nursing care. The audits allow for assessment of the progress and status of patient care, and in this regard the ANMs orchestrate the auditing of the nursing documentation to evaluate nursing care for improved service delivery. The nursing process, also referred to as the nursing documentation (records) or record of patient care, is recognised as one of the most common processes being used world-wide in 'nursing data structure' and in patient care plans (Saranto *et al*., 2014, p. 629). The ANM assures quality of patient care processes by ensuring that nursing documentation reflects decision making as opposed to logged entries. The ANM also assures quality by means of conducting audits on nursing documentation.

- Supply chain processes

Supply chain processes are important for commitment to deliver in ANM work activities. The ANMs should be knowledgeable about the industrial processes of their job in relation to supply chain efficiency, and losses in for instance warehousing, vetting, and condemning and replacements procedures. ANMs engage in the processes of rationalisation and modernisation, to reduce expenditure and improve value respectively in service delivery, and regard supplies in hand as important. In order to commit to work performance, the ANMs must have an understanding of the logical flow of the supply chain processes that includes what the required work performance outcomes should be and how to be an ANM participant meaningfully. The ANMs should be committed to improve supply chain work performance. They are expected to be ideologically prepared to take on new work for service delivery in an orderly manner in their work setting with some degree of predictability being provided. The ANM must engage with the SC processes as continuous learning and development, and empowerment.

- *Communication processes*

- Communication between ANMs and management

ANMs facilitate communication between management and the broader staffing corps through monthly FBU management meetings with the entire team including cleaning staff, and ensure that more direct feedback is receive from the wards.

- Communication between management and the broader staffing corps

Nurse managers who understand cultural differences within the nurse manager cohort, improves communication.

5.3.4.2 Human resources management (HRM)

Overview:

Armstrong (2014, p. 4) supports the understanding that HRM comprehensively deals with all the employment (work) features of people (employees) and how people (employees) are managed in the institution. HR processes guide contemporary performance management of ANMs and have been incorporated into the framework. The procedures for HRs in a contemporary performance management framework for the ANMs include building relationship, motivation, staff

involvement, the desire for enhanced interpersonal relationships and unity between shifts, increased managerial involvement and support, and adequate staffing resources/ need for enough staff.

- **Input into the best work performance experience of the ANM relates to building relations and motivation**

- *Building relationship*

Building relationships are amongst the best work place performance experiences of ANMs. The ANM builds relationships as part of the work performance realm, whilst enhancing interpersonal relationships and unity between shifts, as best possible work performance opportunities.

The relationship between the day and the night shifts can be improved with consistency in communication and in the application of disciplinary measures by the day and the night ANMs. ANMs are instrumental in contributing to a friendlier work environment that promotes interpersonal relationships between shifts. Building a relationship is facilitated by consultation that inspires and secures staff confidence and self-esteem in the workplace. The work performance of the nurse manager is supported by an organisational culture that fosters quality interpersonal relationships (Warshawsky, Havens & Knafl, 2012, p. 418). In building relationships, the ANMs maintain their high regard for professionalism at work. Relationship building requires the ANM to be able to adapt their supervision and instill learning and growth. Building relationship necessitates positive and constructive ANM involvement. The ANM should further embrace the work of night nurses and discourage the perception that night nurses sleep on duty and lose ward assets. On the other hand, the night ANMs should enhance relationships naturally when they carry out quality night rounds. Building relationships lends to the happiness and motivation of the nursing staff.

Night ANMs who conduct teaching sessions for nurses in training before the shift starts, contribute enormously to a positive spirit and attitude to learning amongst the staff, and 'carve out a relationship' with the staff, thereby enhancing service delivery. Building relationships also requires trust. Relationship building, compassion, realness and respect are very useful attributes for the supervision of nurses (Stapleton *et al*., 2007, p. 814). In facilitating relationship building, the value of respect is expected to be personally adopted by the ANM (Western Cape Government: Department of Health, 2015). In this regard, the willingness and ability of speaking the language of the staff aids in building a relationship of respect (witnessed by the researcher).

The ANM believes that their supervisees could be directed to be motivated, and resultantly have a positive attitude. Preparation for the role of a manager, understanding such internal and external motivation, nurturing the internal motivation amongst the nursing corps and investing in relationships are pragmatic concepts that could be implemented in the clinical setting (Stapleton

et al., 2007, p. 811). In regard to the relationship the ANM has with her HON, they (the ANMs) advocate openness and honesty always as an ANM value. In building relations, ANM could mimic other chief nursing officers who has internalized ardor (excitement, warmth, animation).

- *Motivation*

Motivation is also amongst the best work place performance experiences of ANMs. The motivating scenarios described all related to having a positive attitude.

Nurse managers and nurse leaders' augment the performance of nurses when they show understanding and explore nurses' inability and motivation to perform (Germain & Cummings, 2010, p. 425). Motivating staff by acknowledging hard work is crucial, especially when the work situation becomes critical. The EAP practices aid ANM ability to motivate their staff even when staffing challenges are experienced. In HRM, an ANM can motivate staff by recognising them as people. Supporting and motivating staff is also attained by saying *'thank you'*. Motivational factors that serve as retention in nursing ought also to be considered, to reward nurses. These could include the relook of shift work, the threat of violence at work and the work environments, and remuneration (Bogossian, Winters-Chang & Tuckett, 2014, p. 377). Staff training serves as a motivator. The ANM should also motivate staff by allowing them time off for training. The 'contemporary, people orientated' style of managing that the ANMs who were EAP practitioners have also served to motivate staff as these ANMs have an inherent good relationship with the staff. The ANM could play an instrumental role in alleviating demotivation by being aware of the causes in the clinical work place environment, such as a hostile place of work, emotional strain associated to the delivery of patient care, and tiredness and exhaustion.

- **Output for best possible work performance opportunities for the ANM in human resources relates to staff involvement and the desire for enhanced interpersonal relationships and unity between shifts, whilst output into future work performance initiatives relate to team work.**

- *Staff involvement*

Involving staff is seen as a needed ANM performance task as it demonstrates support and value.

ANMs view ONM involvement important for ANM best work performance opportunities in which to flourish. Day shift ANMs should view the ANMs on the night shift as co-partners and make deliberate effort to involve them. In this regard nursing management should demonstrate support and value of the night shift and the night ANM.

Nurse managers should be mindful of the importance of generating a climate of involvement of day and night nursing staff in celebrating transversal health setting events. ANMs should also work collaboratively well across silos, that is, working on a project with the quality manager or with groups or individuals from other disciplines as have been shown to be successfully. Nursing

staff should also be allowed to be active participants in health promotion for patients. When staff are involved in this way, they are likely to internalise the learning and improve their own health status.

Both ONMs and ANMs should be allowed to be involved in higher levels of work performance functions. Such involvement is viewed as positive and is well recommended. A buddy system in the nurse managerial workplace context lends itself to mutual support and involvement, where HONs, ANMs and ONMs could all benefit. However Generation Y's (the millennials) want to be stimulated, engaged and involved.

- *Desire for enhanced interpersonal relationships and unity between shifts*

The enhancement of interpersonal relationships and unity between shifts, and the promotion of team work, lend a sense of trust to the various groups of nurse managers and the shifts who are required to interact with each other. An ANM should be able to embrace, enhance appreciation for night work and exhibit a sense of trust to the various groups working the shifts. Nursing Management should show support and value of the night shift (inclusive of the night ANM). In this regard the ANMs can create a friendlier work environment that promotes interpersonal relationships between shift rounds. The upholding of consistency in communication and the application of disciplinary measures for all is to be striven for. When a shift is undervalued and left with little or no resources, patient care could be affected. In order to enhance interpersonal relationships and unity between shifts, ANMs should ensure that there is no discrimination between shifts and that each shift, including the night shift, has access to needed resources.

- **Output into best possible work performances related to the initiative of team work**

- *Team work*

The ANM should be able to cultivate collegial relationship amongst staff and commit to work together and regard team work as vital on the night shift.

Night nursing offers a deeply intimate experience. The relationship with colleagues is more co-operative, intimate and profound, allowing for difficulties, concerns and fears to be shared (Zannini, Ghitti, Martin, Palese & Saiani, 2015, p. 261). The ANM could create a safe space for the staff to feel free to call on them. An ANM's awareness of team work is to translate into real appreciation for the operational work. The ANM is able to voluntarily help in a crisis. The ANM works well with the MDT. Night ANMs have close working relationships with the Head of Institution and the specialists. They experience their staff endearingly. In this regard, the ANM on the night shift nurtures a team spirit by getting nurses from different departments to work well together despite the night nursing staffing pressure. The nurse managers contribute to a consolidated relationship established over time between ANMs and HONs using a group vision,

encouraging cooperation and strengthening team work. ANMs as lead or higher-ranking managers at a hospital, must show clear and noticeable involvement.

- **Outcome as commitment to deliver in best work performances relates to increased managerial involvement and support and adequate staffing resources/ need for enough staff.**

- *Increased managerial involvement and support*

Managerial involvement and support facilitate a positive work environment and a happy workforce.

The ANMs ought to be given support, teaching and training by the HONs in their endeavour as managers, to be involved by being visible and visit the wards. ANMs show commitment when they incorporate being present and visible, and involved. A senior managerial position at health-care settings needs to be visible in her managerial duties as it lends formality to performance management reviews and could influence employee performance positively (Sole, 2009, p. 7; Department of Health, Provincial Government of the Western Cape, internal memorandum, ref. 16/4, 2016a). ANMs who facilitate managerial involvement, also facilitate workplace spirituality. In this way emotional needs of the nursing staff are also met (Suhonen & Paasivaara, 2011, p. 1029). Managerial involvement is also illustrated when the ANM uses her composure to contain and appease staff.

The ANM should create and be involved in a buddy or mentorship system for ONMs where a protective relationship is created that allows for learning and experimentation. Mentorship opportunities for nurse managers/ leaders such as ONMs facilitated by ANMs are means to support in such operational public health nurse leaders (Reyes, Bekemeier & Issel, 2013, p. 344).

- *Adequate staffing resources/ need for enough staff*

Adequate staffing resources are as an important notion consistent with that of the HR being the most valuable asset in the commitment to work performance.

Contemporary South African nursing pioneers have pointed out the resources problems amongst others in the practice environment proposing high level investment in preparing nurses which includes adequate staffing (Rispel & Bruce, 2014/2015, p. 117). It is also a well-known fact that nurses play a vital role in health-care provision (Browne, 2012, p. 2). The ANM should have knowledge of staffing level requirements; staffing being one of the most fundamental factors affecting the quality of nursing care and having a direct bearing on patient care. The ANMs should be aware that when ward staff are insufficient, that the 'stand-in' attempts to cover by the higher levels has an upward cascading that is felt up to the ANM level. The ANMs should be able to express their need for more staff in the wards when they perceive the staff numbers to be inadequate. Insufficient numbers of staff compromise the therapeutic milieu (Ridley, 2007, p.

439), and potentially patient safety and quality of nursing care with staffing levels having the most profound direct impact on nursing care (Numata *et al*., 2006, 436). The need therefore, for adequate staff is related to services (Foglia, 2008, p. 201). When nursing staff especially night nursing staff are away on training or on leave, complementary relief staffing resources are to be sought as replacement. Securing adequate staffing resources means that punctuality and attendance are additional impact factors to be considered in relation to adequate staff, with sick leave being a resource burden (Cowman & Keating, 2013, p. 380).

Night ANMs commit to also seeking other staff to be available for emotional support when an adverse incident has occurred, so that they do not have to deal with such matters on their own. The night ANMs in the IDS service need doctors and social workers to be accessible at night. They also desire a teaching resource/ nursing tutor in the wards. The WHO reiterates the vital role needed to be played by HR managers as support to managers in health-care such as ANMs. The role is to advocate and enforce sound HRs policies and practices, at health-care settings according to the 'Integrated Employee and Well-being Strategy', 2009-2014 (Browne, 2012, p. 2). High incidences of sick leave absence at hospitals are resource burdens. Absenteeism including sick leave should be well managed by the ANM at hospitals.

5.3.4.3 The Business Unit

Overview:

The Business Unit is a live microcosm within and of the health-care setting. The term Business Unit is synonymous with Functional Business Unit (FBU). The understanding of the key performance management areas of ANMs also relates to the Business Unit and financial management. The ANMs work within the Business Unit involves managing finances. The world of economics is re-writing and re-designing health-care in order to gain efficiency and for rationalising services (Bergin, 2009, p. 59). Guiding Business Unit and financial management processes, procedures, technique or protocols that have been identified for the contemporary performance management framework for ANMs are staff well-being and staff posts, problem solving, conflict and absenteeism management as set out below.

- **Input into the best work performance of the ANM with reference to the Business Unit and managing finances relating to staff well-being and staff posts, and problem solving and conflict management.**

- *Staff well-being*

A nurse manager guides a hospital nursing environment and in turn can affect staff moral and well-being.

Staff support is the astute awareness that an ANM is to have in relation to staff well-being. Occupational stress is exacerbated when nurse managers and hospital administrative support are

not visible or absent (Smit, 2005, p. 26). As the manager, the ANM is cognisant of many hours that nursing staff spend at work and their need for rest and sleep in preparation for and after having worked a shift. She gets to know what the stressors are by the supportive managerial gesture of asking them (the staff) what they perceive to be work stress and then takes active steps to eliminate or reduce the stress. The attempts of the ANM to eliminate or reduce staff stress can occur irrespective of limited resources. Additionally the ANM can also call on chaplaincy support to assist with staff well-being (Foreman, 2014, pp. 63-64).

ANMs are to offer ongoing support to staff in the overfull wards where aggressive, violent and psychotic male patients are housed on mattresses on the floors in psychiatric hospitals, in the attempt to alleviate the stress caused by these work situations. The ANM should be in a position to deal with the stress and grief nurses experience at work, though they should also be supported by the health-care settings when a critical event occurs. The ANM renders both support and guidance with the writing of the incidents reports. Further means of supporting staff well-being under such circumstances include a preliminary debriefing break for a staff member, an assigned mentor to follow-up after the shift to assess and offer additional support and the re-arrangement of the shift (Foreman, 2014, p. 61). The ANM has to ensure that the seriousness of the stress being experienced by the staff is not down-played.

A working environment that is well resourced reduces stress and provides support for nurses (Smit, 2005, p. 22). ANM success in managing staff well-being is related to their knowledge and the internalised experience referred to as the *'knowledge within myself'*. The practice of superior management standards allows staff to feel appreciated and morally reaffirmed (Sofohlo, 2008, pp. 1-2). The ANM initiates improvements in acquiring assets and in aesthetics. When a transformational leadership style is adopted by a nurse leader, the environment in which staff in the caring profession such as nurses work, contribute positively to staff well-being. Manager interest can be linked to staff well-being and therefore when the well-being of nurses is attended to, and they are shown interest, they give their best work performance. Managerial features that assist staff well-being include: (a) job involvement (in relation to staff being content with their job), (b) manager influence and (c) meaningfulness (in relation to staff well-being). A link between staff well-being and nurse manager leadership behaviour could exists (Nielsen *et al*., 2008, p. 465). The ANMs who have EAP counsellor experience, could impact the well-being of the staff positively and thus meaningfully because of the relationship they build with the staff, and the benefits of the ANMs' accumulated experience in this field. An ANM is expected to be passionate about the staff they supervise. The staff, on the other hand are able to speak to the ANM directly when they (staff) experience problems. Staff generally want personal (face-to-face) contact with the ANM.

- *Staff posts*

Staff posts are important. ANMs should be knowledgeable about, and seek 'much needed' money for more posts and/ or scientific nursing staffing ratios based on required performance outcomes, burden of disease and patient acuity. Nursing staffing posts should be managed with pride, and guarded so that they aren't lost to other disciplines or departments. The filling of all posts should be viewed as essential; ANMs should strive to keep all nursing posts filled by embarking on the refilling administrative procedure swiftly once there is knowledge that a post will be vacated. The ANM should follow the required steps of the recruitment and selection prescripts, and also ensures that appropriate persons are appointed. Subsequent to recruitment and selection, orientation (input) of the new employee into the post is facilitated. The required performance of the job is clarified and simultaneously posts are aligned when recruitment and selection processes are done correctly. To this extent Africa's Public Service Delivery and Performance Review has indicated that for services to be delivered by a department, the need exists for personnel to be employed and attached to specific posts within the organisational structure of a particular department (Mle, 2012, p. 22). According to Weiner (2012, online), a guide to implement mandatory minimum nurse-to-patient ratios, involves: (a) 'staffing by outcome', (b) 'staffing by diagnosis related groups' and (c) 'staffing by acuity'.

The ANMs are strengthened, and efficiency improves when all the ONM (supervisee) posts are filled, which allows the ANMs to focus on doing the intended work for an ANM post. The 2007 OSD's intention to attract, motivate and retain health professionals however did not achieve all it set out to achieve (Ditlopo, Blaauw, Rispel, Thomas & Bidwell, 2013, p. 138). Therefore ANMs who were translated into their positions by means of the OSD, should be reoriented to the ANM post for the required renewed focus. Nursing staffing posts are internationally associated with *'hard-won nurse-patient ratios'* that are not to be compromised (Suby, 2009, p. 28).

- *Problem solving and conflict management*

The ANM takes up various roles within the Business Unit that could include the sub-Business Unit manager position. An important task in this regard is problem solving and conflict management.

The ANM incorporates problem solving and conflict management when she conducts monthly Business Unit management meetings entire team that includes the cleaning staff. On the night shift the ANMs play an important role in strategic and operational problem solving and conflict management as they manage the entire hospital and make major decisions related to emergency aspects that otherwise could have huge cost implications, to resolve problems, for instance, of a mechanical nature, so that service delivery can be sustained.

The ANMs should conduct themselves professionally when they are required to deal with problems and conflict in the public domain especially when confronted by irate health-care users

in trying to find a solution so that the credibility of the health-care setting is maintained. There is an obligation on a hospital as an organisation to have the means in place to manage and negotiate the coordination and collaboration of problems as well as disagreements, and any conflict that consequently would follow (Skjørshammer, 2001, p. 156; Western Cape Public Health and Social Development Sectoral Bargaining Chamber, 2011).

Problem solving and conflict management are higher level skills. The ANMs are preemptive in solving problems. Preemptive problem solving is recognised as self-directedness, described in the context of student nurse learning as the degree of accountability and control the individual is willing to assume, which is largely dependent on their attitude, abilities and personality (Eley *et al*., 2011, p. 564). ANMs work night shifts for months on end, if the shift arrangement was forecasted. In some cases the ANMs who work the night shift recognise a potential night shift staffing challenge and would start the problem solving process even before they physically come on duty by calling into the health-care setting to ascertain what the foreseeable staffing situation is for the night ahead, and then put steps in place to avert a staffing shortfall. Formal staff referral to the independent counselling services aids problem solving and conflict management. Overall participative management should be practiced by ANMs to problems that needs to be solved ensuring that the answers also come from the staff. The allocation of an assigned mentor to help nurses recover after an adverse incident is viewed as helpful and transformative (Patton, 2013, online; Porter-O'Grady & Malloch, 2009, p. 246).

The AMNs should also be led by the organisational rights agreement processes for constructive and proactive engagement relating to matters of conflict between management and workers.

- *Better/ increased resources*

Nurse managers as leaders have a good grasp of the accounting in the financial unit in regard to acquiring better or increased resources while stringent adherence to supply chain procedures is required when resources are purchased.

In relation to improvement in stock and resources, it is necessary for engagement between day and night staff. Night staff are to have their own stock to realise best work performance opportunities. Lack of resources corrodes energy, and predisposes the staff to burnout (Chênevert *et al*., 2013, p. 353). On the other hand resource availability can potentially transform work performance behaviour from a mediocre standard to that of innovation (Weng *et al.*, 2013, p. 436). The organisational climate of a hospital affects its resourcing. However increased resourcing plays a positive role in working towards innovation in a health-care setting, which is the work sphere of nurse managers. Being better resourced can assist the ANMs' desire to improve basic ward aesthetics so that higher levels needs could be met (Yahaya, 2014, online).

- *Working together toward a better future*

Working well (collaboratively) together is a required leadership competency according to the American Association of Critical Care Nurses, the American Organisation of Nurse Executives and the National League for Nursing (Patton, 2013, online). Rabie (2012, p. 207) investigating positive practice environments in community health settings too found that instilling teamwork was seen as an important leadership characteristic of managers. ANMs are committed to better work performance by working towards working together for one goal especially when there is only two day ANMs. The ANMs recognised that even though the work situation demanded change in provincial health-care settings, they needed to strive to understand each other in order to work better together especially night opposite partners. Working well together has a new importance in the context of developing new nurse leaders (Sherman & Bishop, 2007, p. 295). A sound working ethic, sound communication and respect are needed to work well together. The slogan of the health department within which the research was conducted had simultaneously adopted the slogan working together. Collectively work performance efforts have shown to contribute to better organisational work performance, which invariably leads to healthier work environments (Stichler, 2009, p. 177).

It is innovative transformational leaders skilled in knowledge and ability to visualise broader issues of the work environment including coaching and mentoring that works well with others (Patton, 2013, online) as well as Porter-O'Grady and Malloch (2009, p. 246). Working well together could also be viewed as being accessible. Accessible nurse leaders/ nurse managers play a momentous role in helping nurses articulate the need to improve patient care environments (Sherman & Pross, 2010, online). The conceptualisation of managers and staff working together stimulates the creation of a profoundly fulfilling ward organisational culture where work performance takes place. In this manner staff members can engage in the development of shared work values (Sherman & Pross, 2010, online). A 'working together' managerial style brings about a paradigm shift away from the 'command-and-control' toward the 'transformational style' of leadership.

Team work requires managers to listen, liaise closely and demonstrate support and respect towards each other. In this regard the ANM should offer insight to staff with regard to the expectation of more staff will secure a better future. ANMs should come together, have discussion and reject divisive utterances. ANMs should be sensitive to, yet devote attention to generation-specific cohorts of nurses and nursing managers to promote positive changes in nursing and in health-care, a likely way of promoting working together towards a better future/

care. The ANMs should create a vision of understanding and engagement with the potential next generation of nurse managers in order to work together towards a better future and better care.

- **Outcome as commitment to deliver in best work performances involves managing absenteeism.**

- *Managing absenteeism*

The ANM should have knowledge of the relationship between the management of absenteeism and how well the service is delivered. Their turnover and absenteeism could potentially incur severe negative consequences on provincial health-care settings. Nurse absenteeism compromises quality of care and financial outcomes in health-care (Daouk-Öyry *et al*., 2014, p. 93). In the 1980s, Nicholson and Johns (1985, pp. 401-402) stated that where poor attendance records were found to be high, absenteeism was bound to increase and reinforce an absenteeism culture. Nurse managers also ought to be aware of some of the best predictors of nurse absenteeism in hospitals which include previous attendance and apparent norms of absence and previous individual absenteeism. An individual nurses' previous record of poor work attendance, work attitude, burnout and stress related to the job, are factors that can be taken into account to predict absenteeism (Davey *et al*., 2009, p. 312). The management of absenteeism is a HRM task that should be executed with ease though robustly. Absenteeism is to be managed consistently in compliance with the absenteeism management protocol in its entirety to deem the management of absenteeism effective in the commitment to service delivery. The AMNs are to hold each other accountable to follow these practices. In managing absenteeism, work environmental factors that relate to the nurse's job satisfaction, and reduce burnout and job stress, needs to be considered (Davey *et al.,* 2009, p. 312).

There appears to be an association between frequent short spells of sickness absenteeism and poor health, misaligned effort-reward and lowered commitment to work (Schreuder *et al*., 2010, p. 575). A relationship exists between absenteeism and organisational commitment. The more committed a staff member is to the organisation, the less she will stay out of work (Davey *et al.,* 2009, p. 320). The ANM should conduct a retrospective interview with each absentee after the period of absence as this demonstrates manager concern and has shown to decrease absenteeism as managers and staff members both become more aware of the absenteeism. ANMs and other staff are to be given more information on the relationship between staffing shortages and the budget expenditure. Where staff work collaboratively, and not as individuals of a group, the workplace culture improves. Such progressive leadership empowers staff, reduces patient mortality, and enhances nurses' health and job fulfillment. Absenteeism, staff turnover and incivility are also likely to decrease (Day & Leggat, 2015, p. 288). Schreuder *et al*. (2010, p. 575) suggest that when female staff frequently absent themselves from work, that they be assessed by the occupational health practitioner for association to chronic illness, but that work

efforts-reward, work-related welfare and wellness, and respect in the work place be inquired into. The ANM should always seek a remedial outcome after a period of absence by a nursing staff, should it be required. Leadership and the professional style of managerial/ supervisory style of engagement with employees including the respect shown towards employees and/ or decision-making can also be linked to absenteeism of lower levels of staff (Schreuder *et al*., 2010, p. 575; Schreuder *et al*., 2011b, p. 64). An imperative in managing absenteeism is the appropriate support to be shown for nursing work by ensuring that there is sufficient relief staff when resident nurses are absent or need to be away (Suby, 2009, p. 98). Absenteeism, staff turnover and incivility were also seen to decrease with constructive and progressive leadership (Day & Leggat, 2015, p. 288). The extent of how involved a person is with the job is indicative of the importance of job to the self-image. Therefore the ANMs are to give attention to the attendance or presenteeism of nurses as they are key players involved at hospitals and provincial health-care settings.

5.3.4.4 Support function

Overview:

The support function involves guiding processes, procedures, techniques or protocols for the contemporary performance management framework for ANMs.

The ANMs work well in the areas or communication and interpersonal skills. They seek workshops, staff orientation and training as improvement in work opportunities for nurses. The ANMs have appreciation for what the staff does that makes their (ANM) work performance meaning, and demonstrate gratitude to nursing staff whilst their attend to their own training needs.

The guiding support function processes, procedures, technique or protocols are as follows:

- **Input into the best work performance of the ANM relating to communication and interpersonal skills.**

- *Communication*

Communication is regarded as important as it contributes to sound interpersonal relationships in nursing. The HONs concur with the ANMs that they (ANMs) use communication well.

The ANM by making use of open communication, assert their position very well when they believed that a negative consequence could result from a decision brought to the table by another team member. ANMs should be able to engage well with and support specialist doctors in the service, using communication. The night ANM must work effectively with medical superintendents/ CEOs using communication. Furthermore when communicating, ANMs should show openness of character by being accessible to the nursing staff when ‘open door policy’ even for the lowest level worker is demonstrated. Open communication is an imperative need at night when the night ANM acts as the communication facilitator for the hospital.

Communication is seen as the most superior skill a nurse administrator leader requires (Dever, 2010, p. 32). The ANM needs to be effective in communication to facilitate team cohesion and good team spirit. Effective communication produces a positive milieu in the nursing managerial climate and a healthy and effective workplace environment. The ANM is the custodian for and teacher of nursing report writing and in this regard effective communication within the ANM-cohort is vital for the provision of sound health-care and patient safety. The ANM should be able to demonstrate superior communication skills at management forums as they carry the vote of the unit nurses who render direct care (Chase, 2010, p. 2). ANMs could facilitate the use of a host of ways and approaches inclusive of technological means to facilitate the acquisition of information and communication effectively with all health-care service users so that optimum health and equal access for users are achieved (Nursing and Midwifery Council, 2010, p. 18). The ANM should use communication to facilitate a relationship-focused workplace culture that builds and strengthens networking.

- *Interpersonal skills*

The ANMs should show support for each other and believe that their interpersonal skills enhance the service. The staff could be referred to endearingly.

ANMs should assist staff in maintaining professionalism in interpersonal work relationships. The HONs should support ANMs to develop the interpersonal skills that strengthen ANM maturity and assertiveness in work performance for meaningful engagement with others especially the Medical Heads and specialists. ANMs should be able to nurture and sustain the interpersonal receptiveness the night nurses have towards them for their leadership. In nursing management performance, communication, interpersonal skills and the ability to organise are linked whilst interpersonal and communication skills are inherent in both leadership and management. Nurse managers ought to be sensitive to how nurses experience reallocation and use communication to reassure staff of their worth. Therefore, in relation to both communication and interpersonal skills, nurse managers as leaders are to be aware that relationship-focused cultures place importance on relationships and networks (Bryan & Bird, 2017, p. 234). ANMs, by their persona, are able to motivate staff which could result in all the staff having a positive attitude. ANMs adopt a transformational approach and direct staff well by carefully balancing control with the autonomy the staff is given.

ANMs derive pride from the positive team spirit the shift exudes despite the pressured workload, and willingly share knowledge of having only a ‘few’ problems on the shift that required disciplinary action. Managers draw on their personal positive disposition (i.e. the passion for nursing care, patient-centeredness and the goal of patient satisfaction) when staffing shortages are encountered and give the staff information when coverage is needed elsewhere, for their

understanding and ease of mind. The ANM should be able to lead in nursing using judicious communication skills and be able to initiate and sustain sound interpersonal relationships.

- **Output for best possible work performance opportunities relates to staff orientation and training, and workshops for nurses.**

- *Staff orientation and training, and workshops for nurses.*

Orientation of new nursing staff and in-service training is important. It gives staff security and clarity of role in work performance.

ANMs ought to be critical and consider shifting the historical training focus from midwifery to that of the various required specialities. ANMs should therefore align in-service training to incorporate specific clinical training as per hospital speciality. In-service training and workshops are important formats for nursing training as they eliminate 'trial and error' practice and enable and strengthen quality improvements, patient safety and promote professional developments and ethics (Thopola *et al*., 2013, p. 178). In line with Loo and Thorpe (2004, p. 88) ANMs are to encourage the use of nursing terms as opposed to medical terms when training occurs. The ANM takes ownership of and pride in ensuring that new staff are orientated and that there is a focus on the corporate aspects of the job.

The ANM is able to assess the training needs of the staff and make recommendation regarding training resources needs such as the need for a tutor, to facilitate reorientation and in-service training. Training for re-development and empowerment of public servants is to unfold as per the pronouncement of Africa's Public Service Delivery and Performance Review (Mle, 2012, p. 30).

At times the ANM takes on the work performance role required in first-line management. It is important for ANMs as middle-management, to be exposed to various kinds of learning to develop in management however formalised training is desired as ANMs themselves believe that it would enhance their ability to work better with people. The skills development programme should be utilised to develop ANMs. There is though a need to better prepare first-line nurse managers for their evolving and challenging roles (Loo & Thorpe, 2004, p. 88). The ANM should ensure staff orientation, and training and workshops for nurses. Deliberate learning and training should be planned for ONMs as well. When the ANM coaches the ONM in the management of HRs and disciplinary processes, they have recognised needed learning. The ANM should promote the use of and facilitate e-learning. ANMs are to advocate for development and support of staff, thereby fulfilling the support function. Experiential work performance learning available for ANMs is middle-manager development that includes work performance needs, knowledge sharing, post-crisis re-training and self-directed learning. Improvement in the preparation for the role of the ANM was a priority.

The ANM should be able to facilitate learning by rotation of nurses and the practice of a work training routine for in-service training and workshops for nurses stimulate the job performance development. Saturdays and Sundays ought to be considered for training as well. Seizing the 'teachable moment' historically also spoken of as 'on-the-spot training' is advocated. On-the-spot teaching and training also stimulates development. It is the shared exploration of a subject or subject matter of common concern (Pacifici & Garrison, 2004, p. 120). ANMs should make use of trends and adverse incident indicators for training and re-training, and incorporate the basic retraining of prevention and promotional aspects of nursing such as infection prevention and infection control in the wards. The ANM should have planned training and workshops for staff learning and development, as they are seen to eliminate trial and error practice.

- **Output on initiatives for the future in ANM work performance relates to appreciation of staff, staff incentives and motivation**.

- *Appreciation of staff, staff incentives and motivation*

ANMs should have an instilled sense of hopefulness that reflects optimism and positivity about their work performance initiatives for the future, likened to having a sense of appreciation or a sense of reward.

The ANM who has a good relationship with the staff and who acts professionally, and is fair, serves to motivate staff. A great number of people working in the health field are motivated and draw satisfaction from performing better than what the expected standard requires (Chaix-Couturier *et al*., 2000, pp. 134-135) whilst Shaw (2006, p. 109) citing Grindle and Hildebrand (1995) pertinently stated though that *"... the pay packet is not the only motivator, even in low income countries".* ANM commitment to support night staff on the shift (night shift) is a particular motivator. Staff motivation is required as changes occur in the provincial health-care settings.

Incentives however does fulfill a role in change management and the process of change management (Shaw, 2006, p. 108) whilst inducements (and resources) play a role in PM. Non-financial incentives as well as the HRM means of incentivisation are vital contributing factors to boosting the motivation of health professionals. When the HRM means are effectively used to incentivise, it maintains and reinforces professional ethos of nurses and doctors (Mathauer & Imhoff, 2006, p. 1). ANMs should believe that incentives serve as motivation and lifts the spirit of the staff. They perceived that the staff wanted a monetary bonus for their work performance, but that it was impossible to meet this expectation because of the fixed amount of money available for this purpose. ANMs should support the importance of incentives and play a role in motivating the staff to demonstrate their appreciation of staff by encouragement and praise. This also serves as motivation for staff. Incentives/ enhancements for staff could be used such as tokens, a day-off, team-building efforts and year-end functions. Certificates for hard work/

worker of the month, acknowledgement of professionalism, appreciation for the achievement of professional goals, career development and assistance towards further qualification also serve as enhancements for staff (Mathauer & Imhoff, 2006, p. 2). Other initiatives for staff incentivisation and motivation are formal training and workshops. Further training that allows the personnel to become skilled, serves to motivate staff positively. An initiative to further train even those who are skilled should be encouraged. ANM support by providing relief staff to replace night shift staff to attend in-service training is also viewed as an initiative for the future. Preparing an ANM for the job is seen as incentivizing. The motivator to be better prepared for the role of nurse manager as opposed to the monetary incentive is supported by Keys (2014, p. 102). A strong perception of appreciation, incentivisation and motivation as nurse manager output, is the sincere attempt by the ANM to *"get to know your* (their) *staff better"*. Such performance gestures also serve to motivate, and is sometimes all the staff in the health-care setting requires, where the work input occurs and continuously changes. The ANM has to have the ability to motivate staff even when staffing challenges are experienced.

- **Outcome commitment in ANM work performance relates to ANMs' own training.**

- *ANMs' own training*

ANMs also have a need for training and development. In their case prior learning could be useful.

To assist supervisees ANMs manage their own learning means that they ought to define their own goals and monitoring their own progress/ principle of adult learning (Kaslow *et al*., 2007, p. 446). Furthermore, they ought to learn to time manage a day to access training. The Skills Development Fund should be sourced to support ANM development and learning. Nurses and other clinical practitioners who become middle-managers have to find new roles and identities through training (Bergin, 2009, p. 69) and could be coached in this regard. Story-telling has proven to be a powerful learning source and tool in nursing management (Greco, 1996, p. 68) and could still be used. The principle of 'learning by doing' is another sound principle of learning in nursing management. This is related to shadowing/ acting as HON (learning, for succession planning), attending top management meetings. Important areas to be focused on are budgeting and financial management including procurement and vetting.

In conclusion, the first identified contemporary ANM key performance area of strategic planning, and quality assurance and nursing care, the procedures to be followed by the agents are that there be communication between ONMs and ANMs, that change be driven and that processes be managed. In relation to the second identified contemporary ANM key performance area, HRs, the procedures to be followed by the agents are that relationship are built, that staff

are motivated, and that staff and management are involved in team work, and that there are adequate resources and recognition for the need for enough staff. In relation to the third identified contemporary ANM key performance area, the Business Unit and managing finances, the procedures to be followed by the agents are that staff well-being and staff posts be given attention, that problems are solved, and conflicts and absenteeism are managed. In relation to the fourth identified contemporary ANM key performance area which is the support function, the procedures to be applied by the agents are sound communication and interpersonal skills, staff orientation and training, and appreciation of staff. ANMs, in line with the principles of adult learning, need to know why they need to learn.

5.3.5 What is the energy source for the activity (dynamic/s)?

The term, '*dynamics'* relates to forces that stimulate progress or change within a process or system (English Oxford Living Dictionaries, 2016, online). In the context of the survey activity in this study, dynamics refer to the energy source for the activity of ANM performance (Dickoff *et al.,* 1968, p. 43). The contemporary framework includes the dynamics (see Table 5.7), in this case the energy source or motivating factors needed in the specific context by the agent and the recipient, to later aid the successful implementation of the framework. The underlying dynamic for performance management of ANMs is staff development. Staff development involves the following:

- A developmental approach
- Staff orientation and training, workshops for nurses
- Coaching
- Mentoring
- Facilitation of own training

Figure 5.7: Underlying dynamics: Staff development

- *A developmental approach*

The context of the health-care setting is subject to continuous change. A developmental approach is needed in facilitating competencies of ANMs whilst the ANMs themselves ought to adopt a developmental approach in the leadership role held by enhancing own energy and zest, and should demonstrate fervour, openness, flexibility, and talent for reflection, the ability to be focused and prioritise, and be transformative. As a self-developer the ANM must also be motivated and enthusiastic. A developmental dynamic in nursing builds relationship between nursing management and nurses, and contributes to a learning environment.

The change to a training and developmental approach that the ANM assumes, evokes respect naturally, also bearing in mind that compelling leaders show visionary leadership associated with leading organisational change (Cameron & Green, 2015, p. 136). The special effort made by a night ANM to teach part-time bridging course students from his own hospital and elsewhere, before the shift started displays such dynamism. It serves to build a positive spirit and attitude toward learning, promoting a learning environment and a developmental approach. The ANM is also able to take up the acting head-leadership role and responsibility of the HON when the HON is away. Such informal development is to be accredited as ANM learning. A training workplace environment contributes positively to job satisfaction, and retention, offers staff stability, and is also a means of improving professional practice and clinical competence (Mokoka, Oosthuizen & Ehlers, 2010, p. 106). The training and developmental dynamic ought to benefit both the ANMs who were translated to their posts and those who had subsequently formally applied for the post, and were appointed. Training for preparation in the role of manager, understanding the internal and external motivation and nurturing internal motivation amongst the nursing corps as well as investing in relationships are pragmatic concepts that the agent should teach the recipient (ANM) to implement in the clinical settings (Stapleton *et al*., 2007, p. 811).

- *Staff orientation and training, workshops for nurses*

The day ANMs want the health-care setting to invest in having one nursing tutor per ward for training and development purposes. The night ANMs want a tutor for some hours of the night to facilitate formal learning/ in-service training.

The idea of nursing managers imparting knowledge by means of their own experience (story) could serve as a useful tool as story-telling in management is a powerful learning source and tool, (Greco, 1996, p. 68) and could be used by nursing managers to teach. The correction of adverse incidents also serves as a teaching focus when training and development is being planned as it serves to redress shortcomings in work performance facilitates learning, and prepares a future workforce.

- *Coaching*

ANMs should also be coached in their development. Coaching is personal, often a one-to-one engaging approach that aids in strengthening people skills and knowledge and results in improving performance (Armstrong & Taylor, 2014, p. 622). The allocation of an assigned mentor to help nurses recover after an adverse incident is viewed as helpful and transformative (Patton, 2013, online; Porter-O'Grady & Malloch, 2009, p. 246). Mentoring is a process. Specifically chosen and skilled individuals perform the mentoring role that facilitates guidance, practical advice and on-going support and allows the allocated mentee to learn and develop (Armstrong, 2014, p. 318). The agent as the mentor would support staff well-being by follow-up after the shift (or ensure that it is done by the assigned mentor), support by doing an assessment and ensuring preliminary debriefing and offer additional support (Foreman, 2014, p. 61). Coaching rendered by the agent as supervisor or manager improves the ability of the employee as it strives to add maximum value to the performance of those they manage. Coaching that focuses on job performance using specific communication efforts can also improve the employee-manager relationship (Bommelje, 2015, p. 69; Hagen, 2012, pp. 18-19).

The ANM should be acknowledged as a learner. Firstly, the ANM should manage their own learning by defining own learning goals and monitoring their own progress. This notion is in line with knowledge in adult education that suggests that they want to control their learning based on their personal goals and believe thus that learning will consequently increase (Knowles, Holton III & Swanson, 2015, p. 156; Kaslow *et al*., 2007, p. 446). Important learning in the role of a nurse manager is that of time. ANMs learn to manage time so that they prioritise dedicated time for themselves for training and to be knowledgeable to measure quality by knowing how to analyse trends on adverse incident indicators.

Staff development includes coaching. ANMs in particular should be coached in their development. Coaching is personal, often a one-to-one engaging approach that aids in strengthening people skills and knowledge and results in improving performance (Armstrong & Taylor, 2014, p. 622). Coaching rendered by the agent as supervisor or manager improves the ability of the employee as it strives to add maximum value to the performance of those they manage. Coaching that focuses on job performance using specific communication efforts can also improve the employee-manager relationship (Bommelje, 2015, p. 69; Hagen, 2012, pp. 18-19).

- *Mentoring*

Mentoring is a process. Specifically chosen and skilled individuals perform the mentoring role that facilitates guidance, practical advice and on-going support and allows the allocated mentee to learn and develop (Armstrong, 2014, p. 318). The agent as the mentor should support staff well-being by follow-up after the shift (or ensure that it is done by the assigned mentor), support

by doing an assessment and ensuring preliminary debriefing and offer additional support (Foreman, 2014, p. 61). The HON as a leader and mentor is to play a supporting role. ANM followers to articulate the need for and strive to create health work environment (Sherman & Pross, 2010, online).

- *Facilitation of own training*

ANM development is important, and development also includes learning. The ANMs should recognise that as seniors and managers of the nursing fraternity, they have a need for their own training in professional and personal development and growth, parallel to the training and development organised for and directed at nursing staff. For this purpose an own skills development plan outlining the strategic direction professionally and personally is required, for the service they are to managed. It is therefore expected that each ANM enhances his/ her performance by also taking ownership of their 'own orientation'. The ANM should be acknowledged as a learner. The ANM, benefits from the teachable moment/ on-the-spot training the agent does which is said to stimulate development. It is shared exploration of subject matter or of common concern (Pacifici & Garrison, 2004, p. 120) in nursing management and other broader spheres. On the spot training can produce effective learning results academically and practically for staff at health-care setting (Dendle & Gurr, 2015, online). An ANM could be orientated to the role by being educationally prepared in work performance, having internalised the required skills and knowledge for the prospective managerial and leadership positions (Scoble & Russel, 2003, p. 324).

In a contemporary context, ideally an ANM should also position herself to promote the use of and facilitate e-learning for followers such as the ONM. ANMs though have prior learning which should be taken advantage of. The ANM should manage own learning by defining own learning goals and monitoring own progress. This notion is in line with knowledge in adult education that suggests that they (adults) want to control their learning based on their personal goals and believe thus that learning will consequently increase (Knowles *et al*., 2015, p. 156; Kaslow *et al*., 2007, p. 446). In order for ANMs as supervisees to be assisted to manage their own learning, the development of time management skills could serve them well to deliberately structure the day to include dedicated time for own learning. Areas that ANM training and development is to be focused on are budgeting and financial management including procurement and vetting. They are to be knowledgeable to measure quality by knowing how to analyse trends on adverse incident indicators. The principle of 'learning by doing' can be applied to the ANMs' own need for training as an outcome in nursing management performance. In this regard learning by doing includes orientation to the role of the HON by means of shadowing, and accompanying the HON to top management meetings. Generic training and development should include infection prevention and rehabilitation. The Skills Development Fund should be sourced to support ANM development and learning. Learning the ropes of the ANM position requires ongoing learning

therefore nurses and other health-care practitioners who have become middle-managers, have to find new roles and identities through training (Bergin, 2009, p. 69).

5.3.6 What is the endpoint of the activity (terminus)?

The terminus is the end or finishing point. It is also regarded as the last stop. The description of the terminus (contemporary work performance framework) also comprises the AI dimensions of best work performance experience, best possible work performance opportunities, initiatives for the further and commitment to deliver work performance. The terminus in this study is the development of a contemporary performance management framework for ANMs in provincial health-care settings. Four key performance areas were identified in the contemporary performance management framework identified as discovery of best, dreaming of better, designing ideal and delivery commitment in work experience, and are discussed as: (i.) strategic planning, and quality assurance and nursing care, (ii.) HRs, (iii.) the Business Unit and managing finance and (iv.) the support function.

5.3.6.1 Strategic planning, and quality assurance and nursing care

The framework indicates that the best practice of the ANM in nursing management is having a passion for nursing and caring, thus upholding the notion that nursing is a caring profession. The ANMs take pride in being nursing managers and nursing leaders, a task that is being performed well because of personal talent and experience. The framework appeals to the mastery of nurse manager communication in regard to best possible work performance opportunities and initiatives for the future with specific reference to communication between ANM on both the night and the day shift, and the ONMs as these two groups manage the crucial twenty-four hour shift at health-care settings. The framework in this regard also addresses the need to drive change and proposes that in steering change, nursing leadership is shared and adopted by all nurses across the setting, not just those in formal leader and manager positions as Willcocks (2012, p. 13) and the Department of Health, Provincial Government of the Western Cape, video (2016b) indicates. The framework recognises that change initiatives that are started, are carried through to term, and commitment to managerial processes that ensures that service delivery and supplies in hand are important. In relation to performance commitment, the terminus for this framework is the point of managing processes of communication between ANMs and management, and communication between management and the broader staffing corps.

5.3.6.2 Human resources

In the framework, regarding HRs, a best practice is relationship building and motivation amongst the staff that emanates in HRs management and development. In managing HRs, the terminus of best possible work performance opportunities and initiatives for the future ANMs is getting staff involved and enhanced relationships and unity between shifts to produce team work. In regard to service commitment, the framework relates to increased managerial involvement and support.

ANMs are committed to pay more attention to visiting the wards, support night staff in the need for resources and support in managing after a crisis. A recurring and valued HRs setting is having adequate staffing resources or acting on the need for enough staff.

5.3.6.3 The Business Unit and managing finances

The framework indicates that staff well-being and staff posts are advocated in the Business Unit and in managing finance for best practice. Best possible work performance opportunities and initiatives for the future points to strengthened ANM capacity the effectiveness of having 100% of the ONM posts filled. Nursing ratios should not be compromised as they have been *"hard fought for"* (Suby, 2009, p. 98). The acquisition of more nursing posts or the promise of more money for more much needed nursing posts remained an expectation. The framework shows how the ANM co-managing the Business Units and taking financial responsibility aligns itself with the tasks of resolving problems and managing conflict, and ultimately working well to be better resourced. When staff well-being and staff post are attended to, the terminus of working toward a better future and better care seems attainable. Best possible work performance opportunities and initiatives for the future are having better resources and working together towards a better future and better care. Managing absenteeism was concluded as a crucial in the commitment to deliver work performance for the ANM. An imperative in managing absenteeism is that there is sufficient staff who could substitute those resident nurses who are absent or need to be away as nursing staffing collectively is the largest in number (Suby, 2009, p. 98).

5.3.6.4 Support function

Best practice is to have well developed (trained) ANMs in line with having well orientated staff who has access to in-service training and workshops. The framework outlines best possible work performance opportunities and initiatives for the future, that refer to the ability to appreciate staff and working toward the sincere consideration of staff incentives and/ or enhancements, such as acknowledgement, tokens, certificates, team-building efforts, year-end functions, and provision of relief staff for others to attend training and career development. The show of support could also focus on attaining professional goals, and on assistance towards further qualification (Mathauer & Imhoff, 2006, p. 1). The search for learning opportunities for staff training signals support to staff. Formal training, furtherance of training and workshops to get the personnel skilled is believed to motivate them positively; those who are skilled can even be trained further. ANMs should receive training and development. A motivator for the role of a nurse manager is also to be better prepared (Keys, 2014, p. 102).

5.4 VALIDATION OF THE CONTEMPORARY FRAMEWORK

Credibility is the foundation of high quality research. Validation, also referred to as respondent validation, is a part of the process of determining the credibility of the research findings of the study. The results were returned to the participants for accuracy and resonance with their

experience (Birt, Scott, Cavers, Campbell & Walter, 2016, p. 1802). Some of the participants of this study were therefore asked to verify if the findings reflected their social world, that is, their work performance experiences. This process also allowed for the assessment of participant impressions, reactions and comments that would ascertain whether the developed framework would address their needs (Birt *et al*., 2016, p. 1802).

The last phase in this study of developing a contemporary performance management framework, as adapted from the basic Logic Model, was to validate the proposed performance management framework with the study participants, the ANMs and HONs to ensure that the described concepts made sense to them.

In October 2016, a formal presentation and discussion of the findings of the study was held (Annexure Y). Fourteen ANMs and three HONs who had participated in the study earlier, and three other newly appointed HONs and one ANM from the General Specialist Hospitals attended, and validated the developed framework. The presentation and discussions were conducted at an independent central venue. The framework highlighting the four identified key performance areas individually was presented to the entire group formally, followed by small group discussions on each performance area. The researcher received verbal and written commentary. The validation process took just under four hours (09h00-12h45); (Section 5.4).

Validation of the research to develop this contemporary performance management framework was conducted at the final phase of the research process. The criteria used were clarity, adequacy, usefulness and significance (Pearson *et al*., 2005, p. 226). The participants were therefore asked if the developed framework was clear, adequate, useful and important for nurse manager performance. The research participants indicated a number of responses at the time of the validation. Feedback was positive and constructive. There was no need to revise the framework. The main theme that emerged from the responses was that the framework reflected people development that is to be incorporated in all performance areas of the ANM. On the other hand the contemporary framework allows for a renewed look at ANM performance and the opportunity for a modernised approach. They also indicated that the validation was comprehensive, that the group was diverse and that it supported management. The developed contemporary PM framework is offered to be used by nurse managers and the hospital management in the realm of nursing and nurse manager performance management. The developed contemporary performance management framework (Figure 5.1) is offered, for use by HONs in nursing management, to manage ANM performance.

The ANMs and the HONs of the study hospitals, some of whom were participants in the study were of the opinion that the contemporary performance management framework is indeed modern and apt. It addresses the performance management as it pertains to ANMs at health-care settings, and that the scientific contemporary views that had contributed to the development of the framework allowed for a common understanding of the performance prescripts (key performance management areas). The following are examples of some of the comments of the participants at the time of the validation process in relation to the questions asked within the framework of Pearson *et al*. (2005, p. 226).

5.4.1 Clarity and adequacy

The questions in this regard posed asked if the framework was easy to understand. It also inquired if the framework addressed the performance of the ANM/ if the development of the key performance areas is sufficient for the purpose it set out to achieve?

"Yes because the PM of the ANM was poorly understood. The framework will it contribute to ANM work performance in the Health Department Yes -Transformational change - change agents, lead by example …will lead to standardisation in the workplace"

The practice at one health-care setting revealed that night ANMs like their day counterparts, were involved in recruitment, supply chain management duties, FBU meetings, strategic planning, change-lists, and other day ANM related tasks. The developed key performance areas in the framework are seen as being adequate for the purpose it set out to achieve.

Supported by the literature, this study shows an appreciation of the ANM HR experience in the KPAs that aspire to achieve scientific nursing ratios and adequate staffing.

"HR: clear yes, relevant yes, make sense yes"
"Support peer training on night (development plan)"

The participants at the validation also indicated that in the absence of the EAP coordinators, this function was now in the realm of others.

"Support functions e.g. Goodwill Tea, Nurses Day celebration. Allow them to be part of the preparation and make them feel appreciated"
"Strategic planning-Clear yes, contribute yes -covers framework of the greater organisational objectives i.e. corporate governance -HR, Finance, clinical governance -patient care, QA processes, SCM (supply chain management)*, patient-centered approach, audits"*

Those present also indicated that they enjoyed the validation session tremendously because of its adequacy in the current contemporary nursing management era.

5.4.2 Usefulness

The question in this regard inquired if the contemporary performance management framework would be useful to nursing management practice?

"Yes, because in situations of critical events, staff not supported enough- There is a focus on the impact on Institution e.g. Financial Burden instead of on Human Resources despite positive response by staff to prevent adverse incident"
"Yes … the nurses are not interested in accumulating basic nursing skills and knowledge"
"Yes, because it is not always possible to meet the nurses' requests because of VL (vacation leave)*, study leave, operational requirements…."*
"In Human Resources yes clear -relevant to our vision yes"
"Staff acknowledgement: Yes. Acknowledgement to staff by saying 'thank you' end of shift"

They agreed that audit processes are to involve subordinates instead of only ONMs and ANMs in order for the former to gain insight and improve patient care.

5.4.3 Significance

The question in this regard inquired if the contemporary performance management framework would make an important contribution to current nursing management practice?

"Yes, because understanding is not always clear as financial instructions and procurement processes change rapidly-need for training; understand it much better now"
"Yes, because FBU not implemented successfully"
"Leadership strategic planning is clear yes, relevant yes, make sense yes"
"Yes, because communication is a problem between shifts, ranks… and workshops between ANMs and ONMs are recommended"
"Business Unit and Managing Finances and support role: Clear -yes, relevant -yes, make sense –yes"
"Business Unit was clear, made sense, does contribute framework can be used"
"It will be useful for the night shift to have lockable cupboards. Day managers to ensure night managers get information, stock. The night ANM should get a computer and internet access"
"Yes: No training---no staff growth ---contributes to 100% of the staff morale, medical legal incidents, medication errors, bed falls, pressure sores. Also insufficient staffing…"
"Yes, because basic nursing care needs to be DONE!"

Some of the participants indeed indicated that the validation clarified the performance areas for them and found it useful. The new HONs were particularly appreciative of the information and wanted further support.

Consensus was reached at the validation that English is recommended as the common language in which the ANMs communicate, as opposed to learning a third/ African language.

5.5 CONCLUSION

This chapter described the contemporary performance management framework to be used by the primary agent, the Heads of the Nursing Departments, and by the secondary supporting agents who are the hospital management figures: CEOs of the hospital, Heads of FBUs, Head Specialists, Departmental Heads and the multi-disciplinary teams. The framework is based on the findings from the individual semi-structured interviews conducted with the ANMs and the focus group discussions conducted with the Heads of Departments of nursing in the study settings, as well as confirmation by literature.

The survey list of the Practice Orientated Theory of Dickoff *et al.* (1968, p. 422) that comprises six key components, agent, recipient, framework, dynamics, procedure and terminus, served as the guide for the discussion of the contemporary framework. Both the primary and secondary agents were acknowledged as having the characteristics of being senior, strategic, in a partnership, leaders, relationship builder, team member, cost center manager, innovator and/ or learner. Equally so, in the agent-recipient relationship the recipient is a senior hospital nurse in professional practice, a strategic member/ partner, a leader, a relationship builder, a team member, a cost center manager, an innovator, a learner and a coach for her to operate using best and contemporary nursing management practices.

The researcher discussed the context of the study taking cognisance of the professional, legal and ethical prescripts, and the managerial workplace environment in which the nurse manager does work performance in the identified spheres of strategic planning, and quality assurance and nursing care, HRs, the Business Unit and managing finance, and the support function. In this regard, the researcher also reflected on the underlying dynamics of staff development with reference to the identified key performance areas in nursing management.

In conclusion of this chapter, the process that was used in validating the developed framework was depicted to reflect the experiences of the study participants. In the following chapter, the conclusion, limitations and recommendations of the study is deliberated upon.

CHAPTER 6

CONCLUSIONS, RECOMMENDATIONS AND LIMITATIONS OF THE STUDY

6.1 INTRODUCTION

In the previous chapter the developed contemporary framework that describes ANM best work performance experience, best possible work performance opportunities, work performance initiatives for the future and commitment to deliver work performance was discussed by using the survey list proposed by the Practice Orientated Theory of Dickoff *et al.* (1968, p. 422). In this concluding chapter, an overview of the research process, conclusions of the study, dissemination proposal, limitations of the research, as well as recommendations for nursing practice, nursing education and research, are presented.

6.2 OVERVIEW OF THE RESEARCH PROCESS AND CONCLUSION

The purpose of this qualitative study was to develop a performance management framework that can be utilised as best yet contemporary nursing managerial practice in provincial health-care settings, that is, the General Specialist Hospitals of the WCP. This purpose was achieved by conducting semi-structured individual interviews with 28 ANMs from the day and night shifts and focus group discussions with six HONs at ten General Specialist Hospitals in the WCP in South Africa.

6.2.1 Outcome of study objectives

The aim of the study was to *develop a contemporary work PM framework for ANMs in the provincial health-care setting* by using the adapted Logic Model, AI and a Practice Orientated Theory survey list (1968).

The findings on the performance of ANM yielded four key performance areas. Strategic planning, and QA and nursing care, was the *first performance theme* in which the ANMs had a passion about nursing caring and leadership. Communication between the ONMs and the ANMs and the need to drive change were valued for current and future opportunity in performance in relation to strategic planning, and QA and nursing care, whilst process management was identified as commitment to deliver in ANM work performance in this key performance area. HRs was the *second performance theme* where success in building relationship and motivation were emphasised. The need to enhance interpersonal relationships by having unity between the shifts, involving staff and securing team work were valued for current and future opportunity in relation to HRs, whilst increased managerial involvement and support, and adequate staffing resources were identified as commitment to deliver in ANM work performance in this key

performance area. The Business Unit and managing finances, the *third performance theme* illustrated people management as important in staff well-being and staff posts, and problem solving and conflict management skills in relation to the Business Unit and managing finances. The ANMs recognised that better or increased resources assisted in enhancing performance opportunities and that there was a need to work together toward a better future, whilst the effective management of absenteeism was seen as commitment to deliver in ANM work performance in this key performance area. The support function was identified as the *fourth performance theme,* engendering communication and interpersonal skills as an area of best performance experience in relation to the support function. The ANMs ranked staff orientation and training, and workshops for nurses high, with showing appreciation which were all seen as motivating and inspiring staff as current performance opportunities and future initiatives. The contention is that when attention is given to the ANMs own training needs, service delivery would follow.

The findings of the first, second, third and fourth objectives were synthesised to achieve the fifth objective to develop a contemporary performance management framework for ANM in provincial health-care setting. The framework is depicted using the adapted Logic Model, whilst the key elements of the survey list of the Practice Orientated Theory of Dickoff *et al*. (1968, p. 422) namely agent, recipient, context, dynamic/s, procedure and terminus, were applied as a reasoning map (Dickoff *et al.*, 1968, p. 423) for describing the developed contemporary performance management framework.

The primary agent were identified as the Heads of the Nursing Departments, who are supervisors to the ANMs, The secondary supporting agents were identified as hospital management/ senior hospital figures, CEOs of the hospitals, Heads of FBUs, Head Specialists, Departmental Heads and the MDTs. The agents are instrumental and are described characteristically as strategic planners, communicators, innovators, coaches, training facilitators and mentors. Reciprocally the recipients, the ANMs are described characteristically as senior hospital nurses in professional practice, strategic member/ partners, leaders, relationship builders, team members, cost center managers, innovators, learners and coaches. The agent and the recipient share the characteristics and therefore have a mutual responsibility of enacting the roles of innovator, communicators and coach.

The context within which the contemporary performance management framework for ANMs plays itself out is its professional, legal and ethical dimensions and the managerial workplace environment. The procedures in the identified KPA of strategic planning, quality nursing care, are communication between ONMs and ANMs, driving change, managing processes, communication between ANMs and management, and communication between management and

the broader staffing corps. The procedures in the identified KPA of HRs are building relationship and motivation, staff involvement, team work, increasing managerial involvement and support and having adequate staffing and resources/ recognising the need to have enough staff. The procedures in the identified KPA of the Business Unit and managing finances are attending to staffing well-being, staffing posts, better/ increased resources and managing absenteeism. The procedures in the identified KPA of the support function are staff orientation and training, workshops for nurses and the show of appreciation.

Lastly, the developed framework needed to be validated among the research participants. Some of the ANMs and HONs, who participated in the research study, participated in the validation process. All the participants of the validation process indicated that there was no need for substantial modification to the framework except that instead of a third language having to be learnt by the ANMs, that English be the common language medium spoken.

In conclusion, the overall performance identified dynamic of this study was staff development. The dynamic of staff development points to the need for constant nurse manager awareness and consciousness and to facilitate development, training (including in-service training), orientation, induction, workshop and own learning. Such an approach, in compliance with the professional, legal and ethical dimensions listed in Section 5.3.1.1, also provides support to the ANMs, HONs, seniors, peers, subordinates and other staff in the health-care settings where the contemporary framework will be implemented.

6.2.2 Dissemination of results

Information acquired through this research study has been shared with all participants prior to public dissemination and results of the study will be published in an accredited journal. The researcher, with the support of the research supervisor will disseminate the developed framework as follows:

- The study will be communicated in writing to the Western Cape Department of Health for endorsement. This would be done to garner support and to inspire successful implementation.
- The study will be made accessible in electronic format to the target population (HONs, ANMs and CEOs).
- The framework will be used in facilitating training programmes for Nurse Managers and other agents.
- The study will be shared with other scholars and academic peers through presentation at research conferences locally, nationally and internationally.

- The framework should be adopted as part of strategic planning, orientation and induction for nurse managers at health-care settings in the General Specialist Hospitals and elsewhere.
- It is expected that the framework will be incorporated as part of the service learning component at the Higher Education Institutions in the Nursing Management courses.

6.3 RECOMMENDATIONS OF THE RESEARCH

The developed contemporary framework has integrated study findings and is the first of its kind put forward for use by HONs, and hospital systems in the performance management of ANMs. The study itself offers a good overview and gives insight into the work performance story of the ANM. Even though it has been developed for the General Specialist Hospitals, it can be adopted in other contexts with similar contextual realities. The need for partnership and collaboration in improved contemporary nursing management has increased and is ongoing.

6.3.1 Recommendations for practice

- A written communiqué will be sent to the Department of Health, Provincial Government of the Western Cape, for endorsement of the research and hence the framework and allow for meaningful implementation thereof.
- The framework should become part of the General Specialist Hospitals/ provincial health-care settings in the Western Cape and will be used as a document for strategic planning, and quality assurance and nursing care, HRs management, management of the Business Unit and finance, and the support function of the ANM.
- Nurse managers are to regularly update their knowledge and skills in managing people and the related nursing service as it will enhance competence and confidence.
- It is important for the Western Cape Department of Health to invest to achieve an appropriate matrix of personnel at health-care settings. Other health-care agents have an important interrelated role in supporting ANMs.
- Special development training should be given to ANMs who were translated at the time of the OSD.
- This framework also will be used for the performance management of ANMs yearly, promotion
    - Yearly monitoring of performances
    - For promotion to nurse manager posts
    - To identify performers for opportunities to serve on national committees
    - To train new nurse managers
    - To be part of the leadership succession planning programme to prepare upcoming leaders
    - For career planning

6.3.2 Recommendations for nursing education

- The dissertation will be made accessible via the library of the University of the Western Cape where the researcher was registered as a student.
- The dissertation and the framework will be shared with other scholars and academic peers through presentations at scientific research forums and otherwise; nursing education institutions can also use this study to devise or adapt their own curriculums in the nursing management courses.
- The framework put forward in this study will be used in facilitating orientation and induction for new nurse managers. It will be used for training to prepare new nurse managers for their role, and for mentorship in nursing management geared at ANMs and HONs. It is suggested that a training session conducted by the agent, of at least one day should be attended by the recipient. This framework could also be adapted and used for newly appointed nurse educators (Soekoe, 2014, p. 1).

6.3.3 Recommendations for nursing research

- Management, health and nursing forums will be sought to present the framework provincially, nationally and internationally to enhance evidence based practice.
- The research study as well as various aspects of the research will also be published in peer-reviewed journals to further increase the accessibility of the results.
- After a period of 12 months, the researcher will re-evaluate the framework and any further feedback will be used to refine the framework. All stakeholders will be informed of any modification to the framework.

6.3.4 Recommendations for research

Given the fact that nursing is varied and diverse, it would be of interest to health-care settings, Nursing Directorates, Health Departments and the SANC to duplicate this study in single speciality areas and other health-care settings.

It is recommended that this framework be tested in other similar health-care settings.

It is further recommended that this research investigation be repeated with other levels of management.

This framework could potentially be used for designing a questionnaire to assess how managers view or rate key performance areas.

6.4 LIMITATIONS OF THE RESEARCH

The incorporation of the adapted Logic Model, an underlying AI philosophy and the use of a Practice Orientated Theory survey list for the development of this contemporary performance management framework was complex.

The study was limited to only the General Specialist Hospitals in the Western Cape, South Africa which does not represent the entire population of nurse managers in South Africa and therefore cannot be widely generalisable.

The validation process might have been a limitation as it included experts in management processes.

6.5 SUMMARY

This chapter concludes the research report of this study. In this chapter an overview of the research process is given and the conclusions from the findings of the study are put forward. In the attempt to describe the outcomes coherently and competently, the researcher had constantly distilled and customised her outlook (Knight & Cross, 2012, online) and portrayed the conclusions in relation to the main objectives that were set out to be achieved in the study. Throughout the researcher remained committed to the set proposal of the study. The researcher also reflected on the significance of the research, as well as the potential impact of the study. The guidelines that are recommended for use in the implementation of this developed framework are emphasised while consideration is to be given to the particular background of the study and its contemporary nature. This approach was used because the researcher supports a contemporary approach to nursing management. The researcher upheld transparency and presented the limitations that were encountered in conducting this research study, as clearly as possible. Finally, the researcher offers recommendations for improving performance management in nursing management, health-care, nursing education and nursing research. These recommendations have been made in a fashion that could resonate with the findings of the study and the researcher's knowledge and expertise.

REFERENCES

Adhikari, R. (2015). Vacant hospitals and under-employed nurses: a qualitative study of the nursing workforce management situation in Nepal. *Health Policy Plan*, 30(3), 289-297.

Aguinis, H. (2009). *Performance Management: Putting Research into Action*. Smither, W. & London, M. (Eds.). Edinburgh: Edinburgh Business School.

Al-Busaidi, Z. Q. (2008). Qualitative Research and its uses in health-care. *Sultan Qaboos University Medical Journal*, 8(1), 11-19.

Aluttis, C., Bishaw, T. & Frank, M. (2014). The workforce for health in a global context-global shortages and international migration. *Global Health Action*, 7(23611). Retrieved December 27, 2016, from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3926986/.

Amestoy, S. C., Schubert Backes, V. M., Thofehrn, M., Martini, J. G., Hörner Schlindwein Meirelles, B. & de Lima Trindade, L. (2014). Conflict management: challenges experienced by nurse-leaders in the hospital environment. *Revista Gaúcha de Enfermagem,* 35(2). Retrieved April 15, 2017, from http://www.scielo.br/scielo.php?script=sci_arttext&pid=S1983.

Anderson, R. A., Issel, L. M. & McDaniel, R. R. (2003). Nursing homes as complex adaptive systems: relationship between management practice and resident outcomes. *Nursing Research*, 52(1), 12-21. Retrieved December 16, 2016, from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1993902/.

Anderson, R. A., Toles, M. P., Corazzini, K., McDaniel, R. R. & Colón-Emeric, C. (2014). Local interaction strategies and capacity for better care in nursing homes: a multiple case study. *BMC Health Services Research*, 14(244). Retrieved September 18, 2015, from http://www.biomedcentral.com/1472-6963/14/244.

Angst, C. M., Devaraj, S. & D'Arcy, J. (2012). Dual Role of IT-Assisted communication in patient care: A Validated Structure-Process-Outcome Framework. *Journal of Management Information Systems*, 29(2), 257-292.

Anonson, J., Walker, M., Arries, E., Maposa, S., Telford, P. & Berry, L. (2014). Qualities of exemplary nurse leaders: perspectives of frontline nurses. *Journal of Nursing Management*, 22(1), 127-136.

Armstrong, M. & Taylor, S. (2014). *Armstrong's Handbook of Human Resource Management Practice.* (13th ed.). London: Kogan Page Limited.

Armstrong, M. (2006). *A Handbook of Human Resource Management Practice.* (10th ed.). London: Kogan Page.

Armstrong, M. (2009). *Armstrong's handbook of performance management: An evidence-based guide to delivering high performance.* (4th ed.). London: Kogan Page Limited.

Armstrong, M. (2014). *Handbook of Human Resource Management Practice.* (10th ed.). London: Kogan Page Limited.

Armstrong, S. J., Rispel, L. C. & Penn-Kekana, L. (2015). The activities of hospital nursing unit managers and quality of patient care in South African hospitals: a paradox? *Global Health Action*, 8: 26243. Retrieved February 07, 2016, from http://dx.doi.org/10.3402/gha.v8.26243.

Armstrong-Stassen, M., Freeman, M., Cameron, S. & Rajacic, D. (2015). Nurse managers' role in older nurses' intention to stay. *Journal of Health Organisation and Management*, 29(1), 55-74.

Arthur, J., Waring, M., Coe, R. & Hedges, L. V. (2012). *Research Methods & Methodologies in Education*. London: Sage Publications Ltd.

Atkinson, M. (2012). Developing and using a performance management framework: a case study. *Measuring Business Excellence*, 16(3), 47-56.

Atkinson, P. & Delamont, S. (Eds.). (2011). *Sage Qualitative Research Methods.* Los Angeles: Sage.

Babbie, E. & Mouton, J. [Contributions by Payze, C., Voster, J., Boshoff, N. & Prozesky, H.]. (2011). *The practice of social research.* Cape Town: Oxford University Press Southern Africa (Pty) Ltd.

Bailey, R. (2013). Information Technology teachers' experience of multimedia-based professional development. Master's thesis. University of the North-West.

Baker, A., Peacock, G., Cozzolino, S., Norton, A., Joyce, M., Chapman, T. & Dawson, D. (2009). Applications of appreciative inquiry in facilitating culture change in the UK NHS. *Team Performance Management*, 15(5), 276-288.

Barker, P. (2002). Barker's Beat. *Mental Health Practice*, 5(8), 39.

Barnes, J., Conrad, K., Demont-Heinrich, C., Graziano, M., Kowalski, D., Neufeld, J., Zamora, J. & Palmquist. *Generalizability and Transferability*. Writing guide, Colorado State University. Retrieved December 04, 2016, from http://writing.colostate.edu/guides/guide. cfm? guideid=65.

Barnett, T. (2011). Leadership Theories and studies. Retrieved May 09, 2017, from http://www.referenceforbusiness.com/management/Int-Loc/.

Barr, J. & Dowding, I. (2015). *Leadership in Health-Care.* (3rd ed.). Los Angeles: Sage Publications Ltd.

Batson, V. D. & Yoder, L. H. (2012). Managerial coaching: a conceptual analysis. *Journal of Advanced Nursing*, 68(7), 1658-1669.

Bayrakci, M. (2009). In-service teacher training in Japan and Turkey: a comparative analysis of Institutions and Practices. *Australian Journal of Teacher Education*, 34(1), 10-22.

Bazeley, P. (2009). Analysing Qualitative Data: More Than 'Identifying Themes'. *The Malaysian Journal of Qualitative Research*, 2(2), 6-22.

Becker, H. S. (2010). *Terrorized by the Literature in Writing for Social Scientists: How to Start and Finish Your Thesis, Book, or Article*. Chicago: The University of Chicago Press.

Bergin, E. (2009). On becoming a manager and attaining managerial integrity. *Leadership in Health Services*, 22(1), 58-75.

Berthelsen, C. B. & Frederiksen, K. (2017). Orchestrating care through the fast-track perspective: A qualitative content analysis of the provision of individualised nursing care in orthopaedic fast-track programmes. *International Journal of Orthopaedic and Trauma Nursing*, 24, 40-49.

Bessire, D. & Baker, C. R. (2005). The French Tableau de bord and the American Balanced Scorecard: a critical analysis. *Critical Perspectives on Accounting*, 16(6), 645-664.

Birt, L., Scott, S., Cavers, D., Campbell, C. & Walter, F. (2016). Member Checking: A Tool to Enhance Trustworthiness or Merely a Nod to Validation? *Qualitative Health Research*, 26(13), 1802-1811.

Björvell, C., Thorell-Ekstrand, I. & Wredling, R. (2000). Development of an audit instrument for nursing care plans in the patient record. *Quality in Health-care*, 9(1), 6-13.

Blöndal, J. R., Hawkesworth, I. & Choi, H. (2009). Budgeting in Indonesia. *Organisation for Economic Cooperation and Development Journal on Budgeting*, 2009/2, 1-31.

Bogossian, F., Winters-Chang, P. & Tuckett, A. (2014). "The Pure Hard Slog That Nursing Is…": A Qualitative Analysis of Nursing Work. *Journal of Nursing Scholarship*, 46(5), 377-388.

Bolton, M. (2009). Developing Practice to Improve Ward Culture: Back to Basics. In Sanders, K. and Shaw, T. (Eds). *Foundation of Nursing Studies Dissemination Series*, 5(4), 1-4.

Bommelje, R. (2015). Managerial coaching. *New Direction For Adults And Continuing Education*, 148, 69-77.

Bond, M. & Holland, S. (2011). *Skills of Clinical Supervision for Nurses: A Practical Guide for Supervisees, Clinical Supervisors and Managers.* (2nd ed.). New York: McGraw-Hill, Open University Press.

Borman, W. C. & Motowidlo, S. J. (2014). *Organisational Citizenship Behavior and Contextual Performance: A special issue of human performance*. Oxfordshire: Psychology Press.

Bourne, M. (2014). Perspectives on Performance. *Performance Management Association*, 11(2), 1-22.

Bourne, M., Franco, M. & Wilkes, J. (2003). Corporate performance management. *Measuring Business Excellence*, 7(3), 15-21.

Bradley, C. (2014). Leading Nursing Through Influence and Structure: The System Nurse Executive Role. *The Journal of Nursing Administration*, 44(12), 619-621.

Brand, C. G. M. (2013). Factors influencing change management in a selected hospital in Saudia Arabia. Master's thesis (partial fulfillment), Stellenbosch University. Retrieved May 10, 2016, from http://scholar.sun.ac.za/handle/10019.1/80141.

Brannen, J. (2005). Mixing Methods: The Entry of Qualitative and Quantitative Approaches into the Research Process. *International Journal of Social Research Methodology*, 8(3), 173-184.

Brink, H. I. L., van der Walt, C. & van Rensburg, G. (2012). *Fundamentals of Research Methodology for Health-care Professionals*. Cape Town: Juta & Company Ltd.

Browne, P. (2012). Management Re-Imagined. An investigation of Nurse's Work-Life Balance in Public Sector Hospitals in Ireland. (Paper). The 11th World Congress of the International Federation of Scholarly Associations of Management.

Brudan, A. (2010). Rediscovering performance management: systems, learning and integration. *Measuring Business Excellence*, 14(1), 109-123.

Bryan, V. C. & Bird, J. L. (2017). *Health-care Community Synergism between Patients, Practitioners, and Researchers*. Hershey: Medical Information Science Reference. Retrieved October 10, 2016, from http://www.igi-global.com/book/health-care-community-synergism.

Bryman, A. (2012). *Social Research Methods*. Oxford: Oxford University Press.

Budimir, V., Lutilsky, I. D. & Letinić, S. L. (2016). Performance Indicators Development in Functions of Croatian's Hospitals Efficiency and Quality Monitoring (Note 1). *Research in Economics and Management*, 1(1), 47-62.

Busi, M. & Bititci, U. S. (2006). Collaborative performance management: present gaps and future research. *International Journal of Productive and Performance Management*, 55(1), 7-25).

Cambridge English Dictionary. (2016). Meaning of 'recipient'. Retrieved January 7, 2017, from http://dictionary.cambridge.org/dictionary/english/recipient.

Cameron, E. & Green, M. (2015). *Making Sense of Change Management: A complete guide to the models, tools and techniques of organisational change.* (4th ed.). London: Kogan Page Limited.

Campbell, M. F. & Corpus, K. (2015). Fieldwork Educator' Perspectives: Professional Behavior Attributes of Level II Fieldwork Students. *The Open Journal of Occupational Therapy*, 3(4). Article 7/ pp. 1-15. Retrieved October 01, 2016, from http://dx.doi.org/10.15453/2168-6408.1146.

Carter, N., Bryant-Lukosius, D., DiCenso, A., Blythe, J. & Neville, A. J. (2014). The Use of Triangulation in Qualitative Research. *Oncology Nursing Forum*, 41(5), 545-547.

Cascio, W. F. (2012). *Handbook of Research in International Human Resources Management.* (2nd ed.). Stahl, G. K., Björkman, I. & Morris, S. (Eds.). Global performance management systems. Cheltenham: Edward Elgar Publishing Limited.

Chaix-Couturier, C., Durand-Zaleski, I., Jolly, D. & Durieux, P. (2000). *International Journal for Quality in Health-care*, 12(2), 134-135.

Chana, N., Kennedy, P. & Chessell, Z. J. (2015). Nursing staff's emotional well-being and caring behaviours. *Journal of Clinical Nursing*, 24(19-20), 2835-2848.

Chase, L. K. (2010). Nurse manager competencies. Doctoral thesis. University of Iowa. Retrieved December 21, 2016, from http://ir.uiowa.edu/etd/2681.

Chen, D. Q., Preston, D. S. & Xia, W. (2013). Enhancing hospital supply chain performance: A relational view and empirical test. *Journal of Operations Management*, 31(6), 391-408.

Chênevert, D., Jourdain, G., Cole, N. & Banville, B. (2013). The role of organisational justice, burnout and commitment in the understanding of absenteeism in the Canadian health-care sector. *Journal of Health Organisation and Management*, 27(3), 350-367.

Cheng, B., Wang, M., Yang, S. J. H., Kinshuk & Peng, J. (2011). Acceptance of competency-based workplace e-learning system of individual and peer learning support. *Computers and Education*, 57(1), 1317-1333.

Cherry, B. & Jacob, S. R. (2015). *Contemporary nursing: Issues, trends, & management.* (7th ed.). St. Louis: Elsevier. Retrieved September 30, 2016, from https://scholar.google.co.za/scholar?hl=en&q=Cherry+jacob+2015&btnG=&as_sdt.

Chinn, P. L. & Kramer, M. K. (2015). *Knowledge Development in Nursing: Theory and Process.* (8th ed.). St. Louis: Elsevier Mosby.

Choi, Y. & Kim, H. (2016). Analysis of the Saemaul (New Community) Movement Policy Based on a Program Logic Model. *International Journal of Applied Engineering Research*, 11(9), 6676-6688.

Chu, H., Wang, C. & Dai, Y. (2009). A study of a Nursing Department Performance Measurement System: Using the Balanced Scorecard and the Analytic Hierarchy Process. *Nursing Economic$*, 27(6), 401-407.

Citation of Constitutional Laws. (2005). Constitution of the Republic of South Africa (1996). Pretoria: Government Printers, 1-215.

City of American Canyon. (2012). Connecting Performance Management and Employee Evaluations. *Government Finance Review*, 28(2), 53-55.

Clark, A., Moule, P., Brodie, L & Topping, A. (2014). The challenge of rescheduling nursing staff; informing the development of a mathematical model decision tool. Project Report, Bristol University of West England. Retrieved March 29, 2016, from http://eprints.uwe.ac.uk/24459/.

Clark, P. A., Wolosin, R. J. & Gavran, G. (2006). Customer Convergence: Patients, Physicians, and Employees Share in the Experience and Evaluation of Health-care Quality. *Health Marketing Quarterly*, 23(3), 79-99).

Claus, L. & Briscoe, D. (2009). Employee performance management across borders: A review of relevant academic literature. *International Journal of Management Reviews*, 11(2), 175-196).

Cloete, F. (2007). Data Analysis in Qualitative Public Administration and Management Research. *Journal of Public Administration*, 42(6), 512-527.

Cockell, J. & McArthur-Blair, J. (2012). *Appreciative Inquiry in Higher Education: A Transformative Force*. San Francisco: Jossey-Bass. Retrieved December 20, 2016, from https://books.google.co.za/books?hl.

Colbert, A. E., Kristof-Brown, A. L., Bradley, B. H. & Barrick, M. R. (2008). CEO Transformational Leadership: The role of goal important congruence in top management teams. *Academy of Management Journal*, 51(1), 81-96.

Collins, S. (2014). Nurses spurring innovation. *Nursing Management*, 45(10), 17-19.

Coombs, M. (2004). *Power and Conflict between Doctors and Nurses. Breaking through the inner circle in clinical care*. New York: Routledge Taylor and Francis Group.

Cooperrider, D. L. & Whitney, D. D. (2005). *Appreciative Inquiry: A Positive Revolution in Change*. San Francisco: Berret-Koehler Publishers, Inc. Retrieved November 16, 2015, from https://books.google.co.za/books?hl.

Cooperrider, D. L. & Whitney, D. D. (2011). *Appreciative Inquiry: A Positive Revolution in Change*. San Francisco: Berret-Koehler Publishers.

Corcoran, C. (2006). Performance Management conducting appraisals. *Accountancy Ireland*, 36(6), 42-45.

Cosgrove, D. M., Fisher, M., Gabow, P., Gottlieb, G., Halvorson, G. C., James, B. C., Kaplan, G. S., Perlin, J. B., Petzel, R., Steele, G. D. & Toussaint, J. S. (2013). Ten Strategies To Lower Costs, Improve Quality, And Engage Patients: The View From Leading Health System CEOs. *Health Affairs*, 32(2), 321-327.

Cowman, J. & Keating, M. A. (2013). Industrial relations conflict in Irish Hospitals: a review of Labour Court cases. *Journal of Health Organisation and Management*, 27(3), 368-389.

Cox, J. W. & Hassard, J. (2005). Triangulation in Organisational Research: A Re-Presentation. *Organisation*, 12(1), 109-133.

Creswell, J. W. (2013). *Qualitative Inquiry & Research Design, Choosing among five approaches.* (3rd ed.). Los Angeles: Sage.

Creswell, J. W. (2014). *Research Design: Qualitative, Quantitative and Mixed Methods Approaches.* (4th ed.). California: Sage Publication Ltd.

Cummings, G. G., Olson, K., Hayduk, L., Bakker, D., Fitch, M., Green, E., Butler, L. & Conlon, M. (2008). The relationship between nursing leadership and nurses' job satisfaction in Canadian oncology work environments. *Journal of Nursing Management*, 16(5), 508-518.

Daft, R. L., Kendrick, M. & Vershinina, N. (2010). *Management*. Hampshire: South-Western Cengage Learning EMEA.

Daouk-Öyry, L., Anouze, A., Otaki, F., Dumit, N. Y. & Osman, I. (2014). The joint model of nurse absenteeism and turnover: A systematic review. *International Journal of Nursing Studies*, 51(1), 93-110.

Das, N. C. (2017). Quality Assurance System. Hospital Quality Assurance System: Hospiad. Retrieved March 27, 2017, from http://hospiad.blogspot.co.za/2012/02/hospital-quality-assurance-system.

Davenport, T. H. (2013). *Process innovation: reengineering work through information technology*. Boston: Harvard Business Press.

Davey, M. M., Cummings, G., Newburn-Cook, C. & Lo, E. A. (2009). Predictors of nurse absenteeism in hospitals: a systematic review. *Journal of Nursing Management*, 17(3), 312-330.

Davies, K. & Jones, R. (Eds.). (2016). *Skills for Social Work Practice*. London: Palgrave.

Day, G. E. & Leggat, S. G. (2015). *Leading and Managing in Health Services. An Australasian perspective*. Melbourne: Cambridge University Press.

De Cordova, P. B., Phibbs, C. S. & Stone, W. (2013). Perceptions and observations of off-shift nursing. *Journal of Nursing Management*, 21(2), 283-292.

De Jager, J. W. & Swanepoel, S. (2008). Internal Marketing Strategy: Focusing on Staff Orientation in Health-care in South Africa. *Acta Commercii*, pp. 181-193. Retrieved July 19, 2016, from www.actacommercii.co.za/index.php/acta/article/viewFile/81/80.

De Jong, P. & Berg, I. K. (2012). *Interviewing for Solutions.* (4th ed.). California: Brooks/Cole Cengage Learning.

De Waal, A. (2013). *Strategic Performance Management: A Managerial and Behavioral Approach.* (2nd ed.). New York: Palgrave Macmillan.

Dendle, J. & Gurr, B. (2015). On-the-Spot: Training nurses about effective communication with acute stroke patients. Retrieved April 15, 2017, from https://www.webmedcentral.com/article_view/4800.

Department of Health, Provincial Government of the Western Cape. Republic of South Africa. (2016a). Visible leadership, internal memorandum, ref. 16/4. Cape Town: Department of Health.

Department of Health, Provincial Government of the Western Cape. Republic of South Africa. (2016b). Leadership. Internal departmental communiqué (video). Cape Town: Department of Health.

Department of Health: Provincial Government of the Western Cape. Republic of South Africa. (2014). Annual Operational Plan, 2013/2014 [Policy document]. Cape Town: Department of Health.

Department of Health: Provincial Government of the Western Cape. Republic of South Africa. (2015). Annual Operational Plan, 2014/2015 [Policy document]. Cape Town: Department of Health.

Department of Health: Provincial Government of the Western Cape. Republic of South Africa. (2016). Annual Operational Plan, 2015/2016 [Policy document]. Cape Town: Department of Health.

Department of Health: Provincial Government of the Western Cape. Republic of South Africa. (2016). Annual Operational Plan, 2016/2017 [Policy document]. Cape Town: Department of Health.

Department: Health - Province of Kwazulu-Natal. (2017). Definitions of Health Facilities. Retrieved April 19, 2017, from http://www.kznhealth.gov.za/definitions.htm. Durban: Department of Health.

Department: Public Service and Administration: Republic of South Africa. (2007). Employee Performance Management and Development System. Retrieved September 13, 2016, from http://www.dpsa.gov.za/dpsa2g/documents/ep/2007/EPMDS.pdf.

Department: Public Service and Administration: Republic of South Africa. (2016). Appendix B to DPSA Circular 3 of 2016 Salary scale. Pretoria: Government Printers.

Dever, K. H. (2010). The Skills, Competencies, Expertise, and Embedded Knowledge of Nurse Managers, as Leaders, in Long-Term Care. Doctoral thesis. St John Fisher College.

Diamond, J. (2005). Establishing a Performance Management Framework for Government. Working paper, 1st draft. Barbados: CARTAC Workshop on Program and Performance Budgeting.

Dickoff, J., James, P. & Wiedenbach, E. (1968). Theory in a practice discipline, Part 1: Practice orientated theory. *American Journal of Nursing*, 17(5), 415-435.

Dillon, K. A., Barga, K. N. & Janiszewski Goodin, H. (2012). Use of the Logic Model Framework to Develop and Implement a Preceptor Recognition Program. *Journal for Nurses in Staff Development*, 28(1), 36-40.

Ditlopo, P., Blaauw, D., Rispel, L. C., Thomas, S. & Bidwell, P. (2013). Policy implementation and financial incentives for nurses in South Africa: a case study on the occupation-specific dispensation. *Global Health Action*, 6, 19289.

Dolamo, B. L. (2015). Preparing the new nurse leader for health-care delivery in South Africa in the twenty-first century. *African Journal for Physical, Health Education, Recreation and Dance (AJPHERD)*, Supplement 1:2, 485-497.

Dowling, P. J., Festing, M. & Engle, A. D. (2008). *International Human Resources Management: Managing people in a multinational context.* (5th ed.). Victoria: Thomson.

Downing, C. & Hastings-Tolsma, M. (2016). An integrative review of Albertina Sisulu and ubuntu: Relevance to caring and nursing. *Health SA Gesondheid*, 21, 214-227.

Dransfield, R. (2000). *Human Resource Management (Studies in Economics & Business)*. Oxford: Heinemann.

Duffield, C., Roche, M. A., Blay, N. & Stasa, H. (2010). Nursing unit managers, staff retention and the work environment. *Journal of Clinical Nursing*, 20(1-2), 23-33.

Duffield, C., Roche, M. A., Blay, N., Thoms, D. & Stasa, H. (2011). The consequence of executive turnover [Focus Paper]. *Journal of Research in Nursing*, 16(6), 503-514.

Elarabi, H. M. & Johari, F. (2014). The impact of human resources management on health-care quality. *Asian Journal of Management Sciences & Education*, 3(1), 13-22.

Eley, D., Eley, R., Young, L. & Rogers-Clark, C. (2011). Exploring temperament and character traits in nurses and nursing students in a large regional area of Australia. *Journal of Clinical Nursing*, 20(3/4), 563-570.

Elo, S., Kääriäien, M., Kanste, O., Pölkki, T., Utriainen, K. & Kyngäs, H. (2014). *Qualitative Content Analysis: A Focus on Trustworthiness*. Sage Open, pp. 1-10. Retrieved December 03, 2016, from http://sgo.sagepub.com/content/spsgo/4/1/2158244014522633.full.pdf.

Eneh, V., O. & Vehviläinen-Julkunen, K. (2012). Nursing leadership practices as perceived by Finnish staff: high ethics, less feedback and rewards. *Journal of Nursing Management*, 20(2), 159-169.

Engelbrecht, W., Ankiewicz, P. & de Swardt, E. (2007). An industry-sponsored, school-focused model for continuing professional development of technology teachers. *African Journal of Education*, 27(4), 579-595.

English Oxford Living Dictionaries. (2016). Definition of 'analysis' in English. Retrieved January 14, 2016, from https://en.oxforddictionaries.com/definition/analysis.

English Oxford Living Dictionaries. (2016). Definition of 'dynamics' in English. Retrieved November 4, 2016, from https://en.oxforddictionaries.com/definition/dynamics.

Eschenbruch, N. (2007). *Nursing Stories: Life and Death in a German Hospice*. New York: Berghahn Books.

Espinoza, D., Lopez-Saldana, A. & Stonestreet, J. (2009). The Pivotal Role of the Nurse Manager in Healthy Workplaces: Implications for Training and Development. *Critical Care Nursing Quarterly*, 32(4), 327-334.

Etikan, I., Musa, S. A. & Alkassim, R. S. (2016). Comparison of Convenience Sampling and Purposive Sampling. Retrieved June 13, 2016, from http://article.sciencepublishinggroup. com/pdf/.

Feather, R. A., Ebright, P. & Bakas, T. (2014). Nurse Manager Behaviours that RNs Perceive to Affect Their Job Satisfaction. *Nursing Forum*, 50(2), 125-136.

Ferreira, A. & Otley, D. (2009). The design and use of performance management systems: An extended framework for analysis. *Management Accounting Research*, 20(4), 263-282.

Finn, D. (2011). Principles of Adult Learning: An ESL Context. *Journal of Adult Education: Information Series*, 40 (1),1.

Fitriati, R. & Rahayu, A. S. (2013). Revitalization Jakarta One Stop Service Office as an Effort to Improve doing Business Ratings in Indonesia. *American Journal of Economics*, 3(1), 7-11.

Flick, U. (2007). *Managing Quality in Qualitative Research*. Los Angeles: Sage Publications.

Flick, U. (2009). *An Introduction to Qualitative Research.* (4th ed.). Los Angeles: Sage.

Foglia, D. (2008). Factors that influence pediatric intensive care unit nurses to leave their jobs. Doctoral thesis. Graduate School of the Texas Woman's University.

Foreman, S. (2014). Developing a process to support Perinatal Nurses after a critical event. *Nursing for Women's Health*, 18(1), 61-65.

Forni, S., Tijerina, L., Hunter, B. & Davenport, D. (2009). Engaging the Nursing Workforce. *Nurse Leader*, 7(6), 36-44.

Franco-Santos, M., Kennerley, M., Micheli, P., Martinez, V., Mason, S., Marr, B., Gray, D. & Neely, A. (2007). *International Journal of Operations & Production Management*, 27(8), 784-801.

Frankson, C. (2009). The Charge Nurse Manager Role. Master's thesis. AUT University of New Zealand.

Fransworth, J. S., Baldwin, L. & Bezanson, M. (2014). An Invitation for Engagement: Assigning and Assessing Field Notes to Promote Deeper Levels of Observation. *The Journal of Natural History Education and Experience*, 8, 12-20.

Friesen, M. A., White, S. V. & Byers, J. F. (2014). Handoffs: Implications for Nurses in Patient Safety and Quality: An Evidence-Based Handbook for Nurses. Retrieved July 06, 2016, from http://www.ncbi.nlm.nih.gov/books/NBK2649/?report=reader.

Furnham, A. (2004). Performance management systems. *European Business Journal*, 16(2), 83-94.

Gaskin, C. J., Ockerby, C. M., Smith, T., Russel, V. & O'Connell, B. (2012). The challenges acute care nurse unit managers face and the strategies they use to address them: Perceptions of directors of nursing and nurse unit managers. *Journal of Management & Organisation*, 18(5), 625-640.

Gergen, K. J. (1985). The Social Constructionist Movement in Modern Psychology. *American Psychologist*, 40(3), 266-275.

Germain, P. B. & Cummings, G. G. (2010). The influence of nursing leadership on nurse performance: A systematic literature review. *Journal of Nursing Management*, 18(4), 425-39.

Gill, P., Stewart, K., Treasure, E. & Chadwick, B. (2008). Methods of data collection in qualitative research: interviews and groups. *British Dental Journal*, 204(6), 291-295.

Glaser, B. G. & Strauss, A. L. (2012). *The Discovery of Grounded Theory: Strategies for Qualitative Research*. London: Aldine Transaction.

Goleman, D., Boyatzis, R. & McKee, A. (2013). *Primal Leadership: Unleashing the Power of Emotional Intelligence*. Massachusetts: Harvard Business Review Press.

Gopee, L. N. (2003). The nurse as a lifelong learner. An exploration of Nurses' Perceptions of Lifelong Learning within Nursing, and of Nurses as Lifelong Learners. Doctoral thesis. University of Warwick, Department of Continuing Education.

Gordon, S., Buchanan, J. & Bretherton, T. (2008). *Safety in numbers: Nurse-to-patient Ratios and the Future of Health-care*. New York: Cornell University Press.

Government Gazette No. 26595. (2004). National Health Act, No. 61 of 2003. Pretoria: Government Printers.

Government Gazette No. 33059. (2010). Public Finance Management Act, No. 1 of 1999. Pretoria: Government Printers.

Grandy, G. & Holton, J. (2010). Mobilizing change in a business school using appreciative inquiry. *The Learning Organisation*, 17(2), 178-194.

Gray, D. E. (2007). Facilitating Management Learning. Developing Critical Reflection Through Reflective Tools. *Management Learning*, 38(5), 495-517.

Gray, J. R., Grove, S. K. & Sutherland, S. (2017). *Burns and Grove's The Practice of Nursing Research: Appraisal, Synthesis, and Generation of Evidence.* (8th ed.). St. Louis: Elsevier.

Greco, J. (1996). Stories for executive development: An isotonic solution. *Journal of Organisational Change Management*, 9(5), 43-74.

Grindle, M. S. & Hildebrand, M. E. (1995), in Shaw, C. (2006). *Human resources for health in Europe*. Dubois, C., McKee, M. & Nolte, E. (Eds.). Managing the performance of health professionals. Berkshire: Open University Press.

Grove, S. K. & Cipher, D. J. (2016). *Statistics for Nursing Research. A workbook for Evidence-Based Practiced.* (2nd ed.). St. Louis: Elsevier.

Grove, S. K., Burns, N. & Gray, J. R. (2013). *The Practice of Nursing Research: Appraisal, Synthesis and Generation of Evidence.* (7th ed.). St. Louis: Elsevier.

Grove, S. K., Burns, N. & Gray, J. R. (2014). *Understanding Nursing Research: Building an Evidence-Based Practice.* (6th ed.). St. Louis: Elsevier.

Grove, S. K., Gray, J. R. & Burns, N. (2015). *Understanding Nursing Research: Building an Evidence-Based Practice.* (6th ed.). St. Louis: Elsevier.

Grover, V. K. (2013). Teachable Moments: A Tool for Improving Learner's Learning in Depth and Breath. *International Journal of Science and Research*, 4(2), 1710-1713.

Guba, E. G. & Lincoln, Y. S. (1985). Epistemological and Methodological Bases of Naturalistic Inquiry. *Education Communication and Technology Journal*, 30(4), 233-252.

Hagen, M. S. (2012). Managerial Coaching: A review of the Literature. *Performance Improvement Quarterly*, 24(4), 17-39.

Hansell, K. & Kirby, E. M. (2015). Team Engagement and Improvement Through Huddles. Evidence-based quality improvement projects; proceedings of the 2015 AWHONN Convention (California).

Harris, R., Bennet, J. & Ross, F. (2014). Leadership and innovation in nursing seen through a historical lens. *Journal of Advanced Nursing*, 70(7), 1629-1638.

Hartas, D. (2015). *Educational research and inquiry: Qualitative and quantitative approaches*. Hartas, D. (Ed.). London: Continuum International Publishing Group.

Harwell, M. R. (2011). *The Sage Handbook for Research in Education: Pursuing ideas as the keystone of exemplary inquiry*. Conrad, C. F. & Serlin, R. C. (Eds.). *Research Design in Qualitative/ Quantitative/ Mixed Methods.* (2nd ed.). California: Sage Publications Inc.

Havens, D. S., Vasey, J., Gittell, J. H. & Lin, W (2010). Rational coordination among nurses and other providers: impact on the quality of patient care. *Journal of Nursing Management*, 18(8), 926-937.

Hellqvist, N. (2011). Global performance management: a research agenda. *Management Research Review*, 34(8), 927-946.

Henderson, L. N. & Tulloch, J. (2008). Incentives for retaining and motivating health workers in Pacific and Asian countries. Retrieved March 30, 2015, from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2569066/.

Hendricks, J. M. & Cope, V. C. (2012). Generational diversity: what nurse managers need to know (Discussion paper). *Journal of Advanced Nursing*, 69(3), 717-725.

Hennink, M., Hutter, I. & Bailey, A. (2011). *Qualitative Research Methods*. London: Sage Publications Ltd.

Hesse-Biber, S. N. & Leavy, P. (2011). *The Practice of Qualitative Research.* (2nd ed.). Los Angeles: Sage.

Hiatt, J. M. (2006). *ADKAR (Awareness, Desire, Knowledge, Ability, Reinforcement): A model for change in business, government and our community. How to Implement Successful Change in Our Personal Lives and Professional Careers*. Colorado: Prosci Learning Centre Publications.

Hinchliffe, S. (2014). Delivering Quality Care Through Effective Nursing Establishments. The Leeds Teaching Hospitals, NHS Trust. Retrieved December 17, 2016, from http://docplayer.net/3944781-Delivering-quality-care-through-effective-nursing-establishments.html.

Hodge, S. (2011). Learning to manage: Transformative outcomes of competency-based training. *Australian Journal of Adult Learning*, 51(3), 498-517.

Hodgkinson, B., Haesler, E. J., Nay, R., O'Donnell, M. H. & McAuliffe, L. P. (2011). Effectiveness of staffing models in residential, subacute, extended aged care settings on patient and staff outcomes. *The Cochrane Library.*

Holliday, A. (2007). *Doing and Writing Qualitative Research: What Counts as Data*. London: Sage Publications Ltd.

Holloway, I. & Wheeler, S. (2010). *Qualitative Research in Nursing and Health-care.* (3rd ed.). Oxford: Wiley-Blackwell.

Househam, K. C. (September, 2015). Telephonic interview.

Hudelson, P. M. (1994). Qualitative Research for Health Programmes. *World Health Organisation*, WHO/MNH/PSF/94.3.

Instefjord, M. H., Aasekjær, K., Espehaug, B. & Graverholt, B. (2014). Assessment of quality in psychiatric nursing documentation - a clinical audit. BMC Nursing, 13(32). Retrieved February 23, 2016, from http://www.biomedcentral.com/1472-6955/13/32.

International Council of Nurses (ICN). (2009). *ICN Framework of Competencies for the Nurse Specialist*. Geneva: ICN.

Iversen, T. O. R. & Luras, H. (2000). The effect of capitation on GPs' referral decisions. *Health Economics*, 9(3), 199-210).

Ivey, A. E., Ivey, M. B. & Zalaquett, C. P. (2013). *Intentional Interviewing and Counseling. Facilitating Client Development in a Multicultural Society.* (7th ed.). California: Brooks/Cole Cengage Learning.

James, M. A. (2006). The impact of technology on human resources management at the Breede River Valley Municipality. Master's thesis. Stellenbosch University.

Jarbandhan, D. B. & Schutte, D. W. (2006). Using the survey procedure and interview data collection technique. *Journal of Public Administration*, 44(3.1), 669-681.

Jehanzeb, K. & Ahmed Bashir, N. (2013). Training and Development Program and its Benefits to Employee and Organisation: A Conceptual Study. *European Journal of Business and Management*, 5(2), 243-252.

Jennings, B. M., Scalzi, C. C., Rodgers III, J. D. & Keane, A. (2007). Differentiating nursing leadership and management competencies. *Nursing Outlook*, 55(4), 169-175.

Johansson, G., Pörn, I., Theorell, T. & Gustafsson, B. (2007). Issues in clinical nursing: A first-line nurse manager's goal-profile. *Journal of Clinical Nursing*, 16(1), 149-159).

Johansson, P., Oléni, M. & Fridlund, B. (2002). Patient satisfaction with nursing care in the context of health-care: a literature study. *Scandinavian Journal of Caring Sciences*, 16(4), 337-344.

Jones, R. A. P. (2007). *Nursing Leadership and Management: Theories, Processes and Practice*. Philadelphia: F. A. Davis Company.

Jonker, J. & Pennink, B. (2010). *The Essence of Research Methodology*. New York: Springer.

Jooste, K. & Jordaan, E. (2012). Student Nurses' Perceptions of the Nurse Manager as a 'Servant Leader'. *African Journal of Nursing and Midwifery*, 14(1), 76-88.

Jooste, K. (2003). Essential managerial attributes of the nowadays nursing service manager in the South African context. *Curationis*, 26(2), 19-29.

Josephson, M., Lindberg, P., Voss, M., Alfredsson, L. & Vingard, E. (2008). Employment and Sickness Absence. The same factors influence job turnover and long spells of sick leave-a 3-year follow-up of Swedish nurses. *European Journal of Public Health*, 18(4), 380-385.

Julie, H. (2014). *The development of an implementation framework for service-learning in the undergraduate nursing programme in the Western Cape*. Doctoral thesis. University of the Western Cape.

Kallas, K. D. (2011). *Profile of an Excellent Nurse Manager*. Doctoral thesis. University of Minnesota.

Kanigel, R. (1996). Frederick Taylor's Apprenticeship. *The Wilson Quarterly*, 20(3), 44-51.

Kaplan, R. S. & Norton, D. P. (1992a). The Balanced Score Card - Measures That Drive Performance. *Harvard Business Review*, 71-79.

Kaplan, R. S. & Norton, D. P. (1992b). *The Balanced Scorecard: Translating Strategy Into Action*. Boston: Harvard Business Press.

Kaplan, R. S. & Norton, D. P. (2000). *The Strategy-focused Organisation: How Balanced Scorecard Companies thrive in the New Business Environment*. Massachusetts: Harvard Business School Press.

Kaslow, N. J., Rubin, N. J., Bebeau, M. J., Leigh, I. W., Lichtenberg, J. W., Nelson., Portnoy, S. M. & Smith, I. L. (2007). Guiding Principles and Recommendations for the Assessment of Competence. *Professional Psychology: Research and Practice*, 38(5), 441-451.

Kasunic, M. (2014). Developing Effective Performance Measures. Software Engineering Institute, Carnegie Mellon University. Retrieved December 24, 2016 from http://oai.dtic.mil/oai/oai?verb=getRecord&metadataPrefix=html&identifier=ADA611604.

Kennerley, M. & Neely, A. (2003). Measuring performance in a changing business environment. *International Journal of Operations & Production Management*, 23(2), 213-229.

Keys, Y. (2014). Looking ahead to our next generation of nurse leaders: Generation X Nurse Managers. *Journal of Nursing Management*, 22(1), 97-105.

Kgomotso, R. E. (2011). Improving the performance management and development system in the Department of Health and Social Development, Limpopo Province. Master's thesis. University of Limpopo. Polokwane.

Khan, S. & Ukpere, W. I. (2014). Employee Performance Management at a South African Government Organisation. *Mediterranean Journal of Social Science*, 5(3), 661-671.

Kim, J. M. & Park, N. (2007). Performance Budgeting in Korea. *Organisation for Economic Cooperation and Development Journal on Budgeting*, 7(4), 1-11.

King, N. & Horrocks, C. (2010). *Interviews in Qualitative Research*. Los Angeles: Sage Publications Ltd.

Knight, S. & Cross, D. (2012). Using Contextual Constructs Model to frame Doctoral Research Methodology. *International Journal of Doctoral Studies.* Retrieved September 13, 2016, from http://ijds.org/Volume7/IJDSv7p039-062Knight234.pdf.

Knowles, M. S., Holton III, E., F. & Swanson, R. A. (2015). *The Adult Learner: The Definitive Classic in Adult Education and Human Resource Development*. London: Routledge.

Koike, O. & Hiromi, K. (2008). Performance Evaluation and "Good Governance" in Asia (Draft). Paper presented at the Annual Meeting of International Political Science Association in Santiago, Chile, July 16th, 2008. Retrieved November 24, 2016, from www.paperroom.ipsa.org/papers/paper_1921.pdf.

Koike, O. (2013). Institutionalizing performance management in Asia: looking East or West? *International Journal of Public Sector Management*, 26(5), 347-360.

Koike, O., Hori, M. & Kabashima, H. (2007). The Japanese Government Reform of 2001 and Policy Evaluation System: Efforts, Results and Limitations. *Ritsumeikan Law Review*, No. 24, 1-12.

Krueger, R. A. & Casey, M. A. (2014). *Focus groups: A Practical Guide for Allied Research.* (5th ed.). New Delhi: Sage Publications Asia-Pacific Pte. Ltd.

Kumi-Kyereme, A. & Boachie-Mensah, F. O. (2012). Human Resource Practices in the Informal Sector in Cape Coast, Ghana. (Report). *Journal of Management Research*, 4(1). Retrieved August 28, 2014, from http://dx.doi.org/10.5296/jmr.v4i1.1160.

Kvale, S. & Brinkmann, S. (2009). *Interviews: Learning the craft of Qualitative Research Interviewing.* (2nd ed.). London: Sage.

Kvale, S. (2007). *Doing Interviews*. Los Angeles: Sage Publications Ltd.

Laker, C., Callard, F., Flach, C., Williams, P., Sayer, J. & Wykes, T. (2014). The challenge of change in acute mental health services: measuring staff perceptions of barriers to change and

their relationship to job status and satisfaction using a new measure (vocalise). *Implementation Science*, 9(23). Retrieved November 06, 2016, from http://www.implementationscience.com/content/9/1/23.

Langer, J. (2006). *The Mirrored Window: Focus Groups from a Moderator's Point of View*. New York: Paramount Market Publishing, Inc.

Langfield-Smith, K. (2007). *Handbook of Management Accounting Research*. Chapman, S., Hopwood, A. G. & Shields, M. (Eds.). *A review of Quantitative Research in Management Control Systems and Strategy*. Oxford: Elsevier Ltd.

Lawler III, E. (2003). Reward Practices and Performance Management System Effectiveness. *Organisational Dynamics*, 32(4), 396-404.

Lee, C. K. & Moon, M. J. (2010). *Public Administration in East Asia*. Berman, E. M., Moon, M. J. & Choi, H. (Eds.). Performance management reforms in South Korea. Boca Raton: Taylor and Francis Group.

Lee, S. (2015). Meaning in work in nursing as a positive personal attribute. Doctoral thesis. University of Michigan. Michigan.

Leech, N. L. & Onwuegbuzie, A. J. (2007). An Array of Qualitative Data Analysis Tools: A Call for Data Analysis Triangulation. *School Psychology Quarterly*, 22(4), 557-584.

Lepine, B. (2011). *Quantitative and Qualitative Research Methods*. Research methods paper. University of Calgary. Calgary.

Letlape, H. R., Koen, M. P., Coetzee, S. K. & Koen. V. (2014). The exploration of in-service training needs of psychiatric nurses. *Health SA Gesondheid*, 19(1), 1-9. Retrieved December 21, 2014, from http://dx.doi.org/10.4102/hsag.v19i1.763.

Limpopo Provincial Government. Republic of South Africa, (2004). *Performance Management System (PMS) Information Manual For Employees signing the Memorandum of Understanding On Performance.* (2nd ed.). Simeka Management Consulting, 1-125.

Lin, L., Wu, J., Huang, I., Tseng, K. & Lawler, J. J. (2007). Management Development: A study of Nurse Managerial Activities and Skills. *Journal of Health-care Management*, 52(3), 156-169.

Lincoln, Y. S. & Guba, E. G. (1985). *Naturalistic Inquiry*. London: Sage Publications.

Lincoln, Y. S. (1986). The Development of Intrinsic Criteria for Authenticity: A Model for Trust in Naturalistic Researches. (Paper). *American Educational Research Association*.

Lindo, J., Stennett, R., Stephenson-Wilson, K., Barret, K. A., Bunnaman, D., Anderson-Johnson, P., Waugh-Brown, V. & Wint, Y. (2016). An Audit of Nursing Documentation at three Public Hospitals in Jamaica. *Journal of Nursing Scholarship*, 48(5), 508-516.

LoBiondo-Wood, G. & Haber, J. (2014). *Nursing Research: Methods and Critical Appraisal for Evidence-Based Practice.* (8th ed.). St. Louis: Elsevier.

Loo, R. & Thorpe, K. (2004). Making first-line nurse managers more effective: a Delphi study of occupational stress. *Women in Management Review*, 19(2), 88-97.

Louw, T. A. (2008). Online Learning Ecologies: Towards Supporting Teachers of Information Technology for the New Curriculum. Master's thesis. University of Johannesburg. Johannesburg.

Lovrien, K. & Peterson, L. (2011). Hospital-physician alignment making the relationship work: hospitals should develop physician alignment around clinical activity, economics, and purpose. *Health Financial Manager*, 65(12), 72-76 & 78.

Lyon, L. M. & Hardesty, L. H. (2005). Traditional Healing in the Contemporary Life of the Antanosy People of Madagascar. *Ethnobotany Research & Applications*, 3, 287-294.

Mackoff, B. L. & Triolo, P. K. (2008). Why do nurse managers stay? Building a model of engagement: Part 1, dimensions of engagement. *The Journal of Nursing Administration*, 38(3), 118-124.

Mackoff, B. L. (2011). *Manager engagement. Strategies for excellence and commitment*. Boston: Jones and Bartlett Publishers.

MacKusick, C. I. & Minick, P. (2010). Why Are Nurses Leaving? Findings From an Initial Qualitative Study on Nursing Attrition. *Medsurg Nursing*, 19(6), 335-340.

Macmillan Dictionary. (2015). Definition of 'framework'. Retrieved December 19, 2015, from www.macmillandictionary.com/dictionary/british/framework.

Macphee, M., Wardrop, A. & Campbell, C. (2010). Transforming work place relationships through shared decision making. *Journal of Nursing Management*, 18(8), (1016-1026).

Mahapa, M., Dzimbiri, L. & Maphosa, F. (2015). Performance Management in Public Sector Organisations: Benefits and Complexities. *Online Journal of Social Sciences Research*, 4(2), 18-22.

Maley, J. F. (2011). The influence of various human resource management strategies on the performance management of subsidiary managers. *Asia-Pacific Journal of Business Administration*, 3(1), 28-46.

Manolitzas, P., Grigoroudis, E., Matsatsinis, N. & Yannacopoulos, D. (2016). Manolitzas, P. (Ed.). *Effective Methods for Modern Health-care Service Quality and Evaluation*. Hershey: Medical Information Science Reference.

Manyaka, R. K. & Sebola, M. P. (2012). Impact of Performance Management on Service. Delivery in the South African Public Service. *Journal of Public Administration*, 47(1), 299-310.

Map of the Western Cape, South Africa. Retrieved January, 06, 2016, from www.wikimapia.org.

Marczyk, G., DeMatteo, D. & Festinger, D. (2005). *Essentials of Research Design and Methodology*. Kaufman, A. S. & Kaufman, N. (Eds.). New Jersey: Wiley.

Marinus, G. G. (2014). Personal discussion: Provincial Government of the Western Cape. Cape Town.

Marquis, B. L. & Huston, C. J. (2009). *Leadership Roles and Management Functions in Nursing. Theory and Application.* (6th ed.). Philadephia: Wolters Kluwer | Lippencott Williams & Wilkins.

Marshall, L. C. (2016). Teachable moments. *Nursing Management*, 23(2), 13-13.

Martin, B. & Healy, J. (2009). Changing Work Organisation and Skill Requirements. *Australian Bulletin of Labour*, 35(3), 393-437.

Martin, J. (2010). *Key concepts in Human Resource Management*. London: Sage Publications Ltd.

Martin, J., McCormack, B., Fitzsimons, D. & Spirig, R. (2014). The importance of inspiring a shared vision. *International Practice Development Journal*, 4(2), 4. Retrieved March 29, 2017, from https://www.fons.org/Resources/Documents/Journal/.

Martínez, J. & Martineau, T. (2001). Introducing Performance Management in National Health Systems: issues on policy and implementation. An IHSD Issues Note, 1-11.

Martinez, V., Kennerley, M., Harpley, R., Wakelen, R., Hart, K. & Webb, J. (2008). Impact of Performance Measurement and Management Systems. Engineering and Physical Sciences Research Council, Cransfield University School of Management. Retrieved July 05, 2016, from https://dspace.lib.cranfield.ac.uk/bitstream/1826/3091/3/.

Mathauer, I. & Imhoff, I. (2006). Health worker motivation in Africa: the role of non-financial incentives and human resource management tools. *Human Resources for Health*, 4(24). Retrieved January 01, 2014, from http://www.human-resources-health.com/content/.

Mayor, E., Bangerter, A. & Aribot, M. (2011). Task uncertainty and communication during nursing handovers. *Journal of Advanced Nursing*, 68(9), 1-10. Retrieved December 15, 2015, from http://www.doi:10.1111/j.1365-2648.2011.05880.x.

McAlearney, A, S. (2008). Using Leadership Development Programs to Improve Quality and Efficiency in Health-care. *Journal of Health-care Management*, 55(5), 319-332.

McCallin, A. M. & Frankson, C. (2010). The role of the charge nurse manager: a descriptive exploratory study. *Journal of Nursing Management*, 18(3), 19-325.

McCarthy, G. & Fitzpatrick, J. J. (2009). Development of a Competency Framework for Nurse Managers in Ireland. *The Journal of Continuing Education in Nursing*, 40(8), 346-350.

McGuire, E. & Kennerly, S. M. (2006). Nurse Managers as Transformational and Transactional Leaders. *Nursing Economic$*, 24(4), 179-185.

McKenna, E., Clement, K., Thompson, E., Haas, K., Weber, W., Wallace, M., Stauffer, C., Frailey, J., Anderson, A., Deascenti, M., Hershiser, L. & Roda, P. I. (2011). Using a Nursing Productivity Committee to Achieve Cost Savings and Improve Staffing Levels and Staff Satisfaction. *Critical Care Nurse*, 31(6), 55-65.

McNeese-Smith, D. K. (2001). A Nursing Shortage: Building Organisational Commitment Among Nurses. *Journal of Health-care Management*, 46(3), 173-187.

Merriam, S. B. (2014). *Qualitative Research: A Guide to Design and Implementation. Revised and Expanded from Qualitative Research and Case Study Applications in Education.* (3rd ed.). San Francisco: Jossey-Bass.

Merriam-Webster Dictionary. (2016). Definition of 'contemporary'. Retrieved January 12, 2017, from https://www.merriam-webster.com/dictionary/contemporary.

Miah, M. K. & Hossan, C. G. (2012). Performance Management System in the UK Retail Industry. *Far East Journal of Psychology and Business*, 7(3), 13-25.

Mishra, P. & Bhatnagar, J. (2012). Appreciative Inquiry: Models & Applications. *The Indian Journal of Industrial Relations*, 47(3), 543-558.

Mitchell, G. (2015). Use of interviews in nursing research. *Nursing Standard*. 29(43), 44-48.

Mlambo, Z. L. (2010). A performance management system in the office of the premier of the Limpopo Provincial Government. A critical analysis. Master's thesis (mini-dissertation). North West University.

Mle, R. T. (2012). Professional and Ethical Conduct in the Public Sector. *Independent Service Delivery Monitoring Networks*, 1(1), i-iv & 1-78.

Mokoena, J. D. (2012). Construction of a model for human rights education in the health professions. Doctoral thesis. University of Limpopo.

Mokoka, E., Oosthuizen, M. J. & Ehlers, V. (2010). Retaining Professional Nurses in South Africa: Nurse Managers' Perspectives. *Health SA Gesondheid*, 15(1), 103-111.

Mokoka, K. E. (2015). Managing a multigenerational nursing workforce to strengthen staff retention. *Professional Nurse Today*, 19(4), 42-45.

Morgan, D. L. & Scannell, A. U. (2014). *Planning Focus Groups*. California: Sage Publications.

Morley, I. & Stephenson, G. (2015). *The Social Psychology of Bargaining*. London: Psychology Press.

Motacki, K. & Burke, K. (2017). *Nursing Delegation and Mangement of Patient Care.* (2nd ed.). St. Louis: Elsevier.

Mucha, M. J. (2012). The Performance Management Toolkit. PM2 Connections Performance Measurement and Management. *Government Finance Review*, 43-45. Retrieved June 04, 2016, from http://www.gfoa.org/sites/default/files/GFR_JUN_12_43.pdf.

Musker, M. (2004). *Leading, Motivating and Enthusing in Nurse Managers -A Guide to Practice*. Crowther, A. (Ed.). Melbourne: Ausmed Publications Pty. Ltd.

Mykkänen, M., Saranto, K. & Miettinen, M. (2012). Nursing Audit as a method for developing nursing care and ensuring patient safety. N1 2012: Proceedings of the 11th International Congress on Nursing Informatics, vol. 2012. Retrieved February 23, 2016, from www.ncbi.nlm.nih.gov/pmc/articles/PMC3799087/pdf/.

Naranjee, P. (2012). Bridging programme graduates' perception of their preparedness to manage a nursing unit. Master's thesis. University of South Africa.

National Department of Health: Republic of South Africa. (2008). Nursing Strategy for South Africa. Pretoria: Government Printers.

National Department of Health: Republic of South Africa. (2009). 10-Point Plan for Health in South Africa presentation and launch by the National Minister of Health, Motsoaledi, A. National Department of Health.

National Department of Health: Republic of South Africa. (2011a). Human Resources for Health South Africa (HRH) Strategy for the Health Sector: 2012/13-2016/17. Pretoria: Government Printers.

National Department of Health: Republic of South Africa. (2011b). *"Towards Quality Care for Patients"*. National Core Standards for Health Establishments in South Africa. Pretoria: Government Printers.

National Department of Health: Republic of South Africa. (2014). Strategic Plan 2014/15-2018/19. Pretoria: Government Printers.

National Department of Public Service and Administration: Republic of South Africa. (2007). OSD JD for ANM (Generic). Pretoria: Government Printers.

Nel, Z. J. C. (1986) in Letlape, H. R., Koen, M. P., Coetzee, S. K. & Koen. V. (2014). The exploration of in-service training needs of psychiatric nurses. *Health SA Gesondheid*, 19(1). Retrieved December 21, 2014, from http://dx.doi.org/10.4102/hsag.v19i1.763.

Newcomer, K. E., Hatry, H. P. & Wholey, J. S. (Eds.). (2015). *Handbook of Practical Program Evaluation.* (4th ed.). New Jersey: Jossey-Bass.

Nicholson, N. & Johns, G. (1985). The Absence Culture and the Psychological Contract-Who's in control of Absence? *Academy of Management Review*, 10(3), 397-407.

Nielsen, K., Yarker, J., Brenner, S., Randall, R. & Borg, V. (2008). The importance of transformational leadership style for the well-being of employees working with older people. *Journal of Advanced Nursing*, 63(5), 465-475).

Numata, Y., Schulzer, M., van der Wal, R., Globerman, J., Semeniuk, P., Balka, E. & FitzGerald, J. M. (2006). Nursing staffing levels and hospital mortality in critical care settings: literature review and meta-analysis. *Journal of Advanced Nursing*, 55(4), 435-448.

Nursing and Midwifery Council, United Kingdom. (2010). Standards for pre-registration nursing education. Retrieved December 17, 2016, from https://www.nmc.org.uk/globalassets/ sitedocuments/standards/.

Nyathi, M. & Jooste, K. (2008). Working conditions that contribute to absenteeism among nurses in a provincial hospital in the Limpopo Province. *Curationis*, 31(1), 28-37.

Nyberg, A., Westerlund, H., Magnusson Hanson, L. L. & Theorell, T. (2008). Managerial leadership is associated with self-reported sickness absence and sickness presenteeism among Swedish men and women. *Scandinavian Journal of Public Health*, 36(8), 803-811.

O'Brien, M. E. (2011). *Servant Leadership in Nursing. Spirituality and Practice in Contemporary Health-care*. Boston: Jones and Bartlett Publishers.

Odhiambo, O. (2013). Employee Performance Management Practices in East Africa Breweries Limited Kenya. Master's thesis. University of Nairobi. Nairobi.

Ogunbameru, O. A. (2003). Focus Groups: Issues and Approaches. *Anthropologists*, 5(1), 1-8.

Ogutu, M. (2017). Strategic Planning and Performance of State Corporations in Kenya: The Moderating Effects of Firm Characteristics. *DBA Africa Management Review*, 7(1), 17-39.

Oivo, M., Kuvaja, P., Pulli, P. & Similä, J. (2004). *Software Engineering Research Strategy: Combining Experimental and Explorative Research Strategy*. International Conference on Product Focused Software Process Improvement, LNCS Vol. 3009, 302-317.

Okaisu, E. M., Kalikwani, F., Wanayana, G. & Coetzee, M. (2014). Improving the quality of nursing documentation: An action research project. *Curationus*, 38(1), Art#1251, 11pages. Retrieved March 28, 2016, from http://dx.doi.org/10.4102/curationis.v37i1.1251.

Okiro, K. & Ndungu, J. (2013). The impact of mobile and internet banking on performance of financial institutions in Kenya. *European Scientific Journal*, 9(13), 146-161.

Olaogun, J. A. & Fatoki, O. I. (2009). Theory Building Approach Using Qualitative Data Analysis. *The Social Sciences*, 4(1), 12-23.

Olson, S. M. (2006). A Model for Transformational Nurse Leadership and Intrapreneurism: The Nursing Leadership Cycle of Integrity. Master's thesis. Washington State University College of Nursing. Washington.

Onwuegbuzie, A. J. & Collins, K. M. T. (2007). A Typology of Mixed Methods Sampling Designs in Social Science Research. *The Qualitative Report*, 12(2), 281-316.

Onwuegbuzie, A. J., Dickinson, W. B., Leech, N. & Zoran, A. (2009). A Qualitative Framework for Collecting and Analyzing Data in Focus Group Research. *International Journal of Qualitative Methods*, 8(3), 1-21.

Onwuegbuzie, A. J., Leech, N. L. & Collins, K. M. T. (2010). Innovative Data Collection Strategies in Qualitative Research. *The Qualitative Report*, 15(3), 696-726.

Onwuegbuzie, A. J., Leech, N. L. & Collins, K. M. T. (2012). Qualitative Analysis Techniques for the Review of Literature. *The Qualitative Report*, 17(56), 1-28.

Onwuegbuzie, A. J., Leech, N. L., Slate, J. R., Stark, M., Sharma, B., Frels, R., Harris, K. & Combs, J. P. (2012). An Exemplar for teaching and Learning Qualitative Research. *The Qualitative Report*, 17(1), 16-77.

Overstrand Municipality. (2008). *Performance Management System- Implementation Policy*. Pro-active Management Services, P1, 001-040. Cape Town.

Oxford Dictionaries, Language matters: 'Ethical' retrieved January 14, 2016, from www.oxforddictionaries.com/definition/english/ethical.

Pacifici, L. & Garrison, J. (2004). Imagination, Emotion and Inquiry: The Teachable Moment. *Contemporary Pragmatism*, 1(1), 119-132.

Partanan, A. (2014). Nurse Managers' Experiences of the Goal-Orientated Job Rotation. Master's Thesis. Jyväskylän Ammattikorkeakoulu University of Applied Science. Jyväskylä (Finland).

Patton, M. (2013). A Pilot Intervention To Engage Nurses To Lead Transformation of The Workplace. Doctoral thesis. University of South Carolina, Scholar Commons. Retrieved December 23, 2015, from http://scholarcommons.sc.edu/etd/2277/.

Pearson, A., Vaughan, B. & FitzGerald, M. (2005). *Nursing Models for Practice.* (3rd ed.). London: Butterworth-Heinemann.

Peregrina, M. (2009). Lost In transition: A Study of the Leadership Practices of Nursing Unit Managers. Master's thesis. University of Western Sydney. Perthy.

Performance Management. (2017). Office of Human Resources, University of Minnesota. Retrievd April 15, 2017, from https://humanresources.umn.edu/supervising-u/performance-management.

Philips, I. S. (2010). The effects of recruitment and selection procedures on the efficiency of the public service in Nigeria: a case study of Oshimili South Local Government of Delta State. Master's thesis. University of Nigeria. Nsukka.

Phillips, N. (2004). *Selecting, Recruiting, and Retaining Staff in Nurse Managers -A Guide to Practice.* Crowther, A. (Ed.). Melbourne: Ausmed Publications Pty Ltd.

Pillai, R. R. (2012). *Performance Management.* (1st ed.). New Delhi: Laxmi Book Publications.

Plowright, D. (2011). *Using Mixed Methods: Frameworks for an integrated methodology*. London: Sage.

Plummer-D'Amato, P. (2008). Focus group methodology -Part 1: Considerations for design. *International Journal of Therapy and Rehabilitation*, 15(2), 69-73.

Pola, Y. & Ihlenheld, G. (1980). Women Reaching Women. Volunteer Coordinator's Training Program. ERIC. Madison.

Polit, D. & Beck, C. T. (2008). *Nursing Research: Generating and Assessing Evidence for Nursing Practice.* (8th ed.). Philadelphia: Wolters Kluwer Health | Lippincott Williams & Wilkins.

Polit, D. F. & Beck, C. T. (2013). *Essentials of Nursing Research: Appraising Evidence for Nursing Practice.* (8th ed.). Philadelphia: Wolters Kluwer Health | Lippincott Williams & Wilkins.

Polit, D. F. & Beck, C. T. (2014). *Essentials of Nursing Research: Appraising Evidence for Nursing Practice.* (4th ed.). Philadelphia: Wolters Kluwer Health | Lippincott Williams & Wilkins.

Poquette, R. E. L. (2011). Improving Business Performance thorough Effectively Managing Employees. Johnson & Wales University: Honors Advisory Seminar. Retrieved December 19, 2016, from http://scholarsarchive.jwu.edu/ac_symposium/11.

Porr, C., Dawe, D., Lewis, N., Meadus, R. J., Snow, N. & Didham, P. (2014). Patient perception of contemporary nurse attire: A pilot study. *International Journal of Nursing Practice,* 20(2), 149-155.

Porter-O'Grady, T. & Malloch, K. (2009). Leaders in Innovation Transforming Postindustrial Health-care. *The Journal of Nursing Administration*, 39(4), 245-248.

Potter, C., Morgan, P. & Thompson, A. (1994). Continuous Quality Improvement in an Acute Hospital: A Report of an Action Research Project in Three Hospital Departments. *International Journal of Health-care Quality Assurance*, 7(1), 4-29.

Powell, I. (2013). Can you see me? Experiences of nurses working night shift in Australian regional hospitals: a qualitative case study. *Journal of Advanced Nursing*, 69(10), 2172-2184.

Price, A. (2011). *Human Resource Management.* (4th ed.). South-Western Cengage Learning.

Public Health Institution of South Africa: Medium Term Strategic Framework (10-Point Plan). Retrieved December 27, 2016, from http://www.phisa.co.za/Ten%20Point%20Plan.

Rabbani, F., Lalji, S. N. H., Abbas, F., Wasim, S. M., Jafri, S. M. W., Razzak, J. A., Nabi, N., Jahan, F., Ajmal, A., Petzold, M., Brommels, M. & Tomson, G. (2011). Understanding the context of Balanced Scorecard Implementation: a hospital-based case study in Pakistan. *Implementation Science*, 6(31). Retrieved March 06, 2015, from http://www.implementation science.

Rabie, T. (2012). Positive practice environments in community health centres of the North West Province: A case study. Doctoral thesis. North-West University. Potchefstroom.

Rabiee, F. (2004). Focus-group interview and data analysis. *Proceedings of the Nutrition Society*, 63, 655-660.

Radnor, Z. J. & Barnes, D. (2007). Historical analysis of performance measurement and management in operations management. *International Journal of Productivity and Performance Management*, 56(5/7), 384-396).

Ramsay, N. (2006). Absenteeism among Public Health Nurses: Does commitment matter? Master's thesis. University of Cape Town.

Rao, T. V. (2016). *Performance Management. Toward Organisational Excellence.* (2nd ed.). New Delhi: Sage Publications India Pvt Ltd.

Redknap, R., Twigg, D., Rock, D. & Towell, A. (2015). Nursing practice environment: A strategy for mental health nurse retention? *International Journal of Mental Health Nursing*, 24(3), 262-271.

Reed, J. (2007). *Appreciative Inquiry: Research for change*. California: Sage Publications.

Rego, A., Cunha, M. Pina. E. & Souto, S. (2007). Workplace spirituality, commitment, and self-reported individual performance: An empirical study. Management Research: *Journal of the Iberoamerican Academy of Management*, 5(3), 163-183.

Reyes, D. J., Bekemeier, B. & Issel, L. M. (2013). Challenges faced by Public Health Nursing Leaders in Hyperturbulent Times. *Public Health Nursing*, 31(4), 344-353.

Richie, J. & Lewis, J. (Eds.). (2003). *Qualitative Research Practice. A Guide for Social Science Students and Researchers*. London: Sage Publications Ltd.

Ridley, C. (2007). Relating nursing workload to quality of care in child and adolescent mental health inpatient services. *International Journal of Health-care*, 20(5), 429-440.

Rispel, L. & Bruce, J. (2014/2015). A profession in peril? Revitalising nursing in South Africa. *South African Health Review*, 117-125.

Robertson, K. (2005). Active listening. More than just paying attention. *Australian Family Physician*, 13(12), 1053-1055.

Roe, D. J. (2008). *Encyclopedia of Survey Research Methods*. California: Sage Publications, Inc.

Roelen, C. A. M., Schreuder, J. A. H., Koopmans, P. C., Moen, B. E. & Groothoff, J. W. (2009). Sickness absence frequency among women working in hospital care. *Occupational Medicine*, 59(7), 502-505.

Roland, G. (2014). The Meaning of Caring From Nurses Working at an Intensive Coronary Care Unit in Mauritius. *International Journal of Scientific and Research Publications*, 4(8). Retrieved August 08, 2015, from http://www.ijsrp.org/research-paper-0814/ijsrp-p3237.pdf.

Ronnie, L. (2009). SA managers must improve their skills. Sunday Times, 9 April, p. 13.

Rothwell, W. (2010). *Effective Succession Planning: Ensuring Leadership Continuity and Building Talent from Within*. New York: Amacom.

Rouse, R. A. & Al-Maqbale, M. (2014). Identifying nurse managers' essential communication skills: an analysis of nurses' perceptions in Oman. *Journal of Nursing Management*, 22(2), 192-200.

Rowley, J. (2012). Conducting research interviews. *Management Research Review*, 35(3/4), 260-271.

Rubin, H. J. & Rubin, I. S. (2012). *Qualitative Interviewing: The Art of Hearing Data*. Los Angeles: Sage Publications, Inc.

Russ, M., Jones, J. G. & Jones, J. K. (2007). Knowledge-Based Strategies and Systems: A Systematic Review. (An early draft of the chapter was presented at the APAMB conference, Singapore). Retrieved December 12, 2016, from http://www.uwgb.edu/russm/chapter_russ.

Rynes, S. L., Gerhart, B. & Minette, K. A. (2004). Importance of pay in employee motivation: discrepancies between what people say and what they do. *Human Resource Management*, 43(4), 381-394.

Salleh, K. M. & Sulaiman, N. L. (2015). Technical Skills Evaluation Based on Competency Model for Human Resources Development in Technical and Vocational Education. *Asian Social Science*, 11(16), 74-79.

Salmela, M. (2013). Better Health via Research. von Schantz, M. & Lind, K. (Eds.). *Nursing Documentation - Not only documentation, but planning and decision making*. Turku University of Applied Sciences, Finland.

Saranto, K., Kinnunen, U., Kivekäs, E., Lappalainen, A., Liljamo, P. & Hyppönen, H. Impacts of structuring nursing records: a systemic review. (2014). *Scandinavian Journal of Caring Sciences,* 28(4), 629-647.

Saravanja, M. (2010). Integrated performance management systems and motivation in the South African public sector. Doctoral thesis. University of the Western Cape.

Sarros, J. C., Cooper, B. K. & Santora, J. C. (2008). Building a Climate for Innovation Through Transformational Leadership and Organisational Culture. *Journal of leadership & Organisational Studies*, 15(2), 145-158.

Savič, B. S. & Robida, A. (2013). Capacity of middle-management in health-care organisations for working with people -the case of Slovenian hospitals. Human Resources for Health, 11(18), 1-15. Retrieved December 31, 2013, from http://www.human-resources-health.com/.

Schjoedt, L., Monsen, E., Barnett, T. & Chrisman, J. J. (2013). New Venture and Family Business Teams: Understanding Team Formation, Composition, Behaviours, and Performance. *Entrepreneurship Theory and Practice*, 37(1), 1-15.

Schmalenberg, C. & Kramer, M. (2009). Nurse Manager Support: How Do Staff Nurses Define It? *Critical Care Nurse*, 29(4), 61-69.

Schooley, S. E. (2013). Appreciative Inquiry: Answering the call of the new public service by creating a democratic discursive space through positive storytelling wherein direct citizen participation can flourish. *International School of Social Research*, 1, 28-36.

Schreuder, J. A. H., Plat, Magerøy, N., Moen, B. E., van der Klink, J. J. L., Groothof, J. W. & Roelen, C. A. M. (2011a). Self-rated coping styles and registered sickness absence among nurses working in hospital care: A prospective 1-year cohort study. *International Journal of Nursing Studies*, 48(7), 838-846.

Schreuder, J. A. H., Roelen, A. M., Koopmans, P. C., Moen, B. E. & Groothoff, J. W. (2010). Effort-reward imbalance is associated with the frequency of sickness absence among female hospital nurses: A cross-sectional study. *International Journal of Nursing Studies*, 47(5), 569-576).

Schreuder, J. A. H., Roelen, C. A. M., van Zweeden, N. F., Jongsma, D., van der Klink and Groothoff, J. W. (2011b). Leadership styles of nurse managers and registered sickness absence among their nursing staff. *Health-care Management Review*, 36(1), 58-66.

Scoble, K., B. & Russell, G. (2003). Vision 2020, Part 1. Profile of the Future Nurse Leader. *The Journal of Nursing Administration*, 33(6), 334-330.

Scrima, F., Lorito, L., Parry, E. & Falgares, G. (2014). The mediating role of work engagement on the relationship between job involvement and affective commitment. *The International Journal of Human Resources Management*, 25(15), 2159-2173.

Seemela, V. P. P. (2005). Framework for a Performance Management System for Municipalities. Master's thesis. North West University.

Seethalakshmi, R. (2012). Human Resources Management Practices in Specialized Hospitals: A Study on Competencies of Human Resource Professionals at Tiruchirappalli Corporation. Doctoral thesis. Bharathidasan University.

Segnon, N. (2014). The experiences and perceptions of nurses working in a public hospital, regarding the services they offer to patients. Master's thesis. University of the Witwatersrand.

Seidman, I. (2013). *Interviewing as Qualitative Research: A Guide for Researchers in Education & the Social Sciences.* (4th ed.). New York: Teachers College Press.

Shane, J. M. (2010). Performance management in police agencies: a conceptual framework. *Policing: An International Journal of Police Strategies & Management*, 33(1), 6-29.

Shannon, P. & Hambacher, E. (2014). Authenticity in Constructivist Inquiry: Assessing an Elusive Construct. *The Qualitative Report*, 19(52). Retrieved February 07, 2016, from http://nsuworks.nova.edu/tqr/vol19/iss52/3.

Sharif, A. M. (2002). Benchmarking performance management systems. *Benchmarking: An International Journal*, 9(1), 62-85.

Shaw, C. (2006). *Human resources for health in Europe*. Dubois, C., McKee, M. & Nolte, E. (Eds.). *Managing the performance of health professionals*. Berkshire: Open University Press.

Shdaimah, C. R. & Stahl, R. W. (2011). *Change Research: A Case Study on Collaborative Methods for Social Workers*. New York: Columbia University Press.

Sherman, R. O. & Bishop, M. (2007). The Role of Nurse Educators in Grooming Future Nurse Leaders. *The Journal of Nursing Education*, 46(7), 295-296.

Sherman, R. O. & Pross, E. (2010). Growing Future Nurse Leaders to Build and Sustain Healthy Work Environments at the Unit Level. *Online Journal of Nursing Issues*, 15(1). Retrieved February 09, 2015, from www.medscape.com/viewarticle/723409.

Shields, J., Brown, M., Kaine, S., Dolle-Samuel, C., North-Samardzic, A., McLean, P. & Johns, R., Robinson, J., O'Leary, P. & Plimmer, G. (2016). *Managing Employee Performance and Reward: Concepts, Practices, Strategies.* (2nd ed.). Cambridge: Cambridge University Press.

Shirey, M. (2006). Authentic Leaders Creating Healthy Work Environments for Nursing Practice. *American Journal of Critical Care*, 15(3), 256-268.

Sikora, D. M. & Ferris, G. R. (2014). Strategic human resource practice implementation: The critical role of line managers. *Human Resource Management Review*, 24(3), 271-281.

Silverman, D. (Ed.). (2016). *Qualitative Research,* Los Angeles: Sage.

Singh, A. (2013). A Study of Role of McKinsey's 7S Framework in Achieving Organisational Excellence. *Organisational Development Journal*, 31(3), 39-50.

Sinha, B. R. K. (2015). A methodology of measuring human health. Human Geographies. *Journal of Studies and Research in Human Geography*, 9(2), 225-240.

Sink, D. S. (1991). The Role Of Measurement In Achieving World Class Quality And Productivity Management. *Management Strategies*, 23-28, 70.

Sinkovics, R. R., Penz, E. & Ghauri, P. N. (2008). Enhancing trustworthiness of Qualitative Research in International Business. *Management International Review*, 48(6), 689-714.

Skjørshammer, M. (2001). Conflict Management in a hospital: Designing processing structures and intervention methods. *Journal of Management in Medicine*, 15(2), 156-166.

Smit, R. (2005). HIV/AIDS and the workplace: perceptions of nurses in a public hospital in South Africa. *Journal of Advanced Nursing*, 51(1), 22-29.

Smith, D. C. (2009). What can we expect from performance management activities that we cannot expect from performance measurement? *Journal of Policy Analysis and Management*, 28(1), 496-516.

Smith, M. C., Turkel, M. C. & Wolf, Z. R. (2013). *Caring in Nursing Classics: An Essential Resource*. New York: Springer Publishing Company.

Soekoe, E. (2014). A model for mentoring newly-appointed nurse educators in nursing education institutions in South Africa. *Curationis*, 37(1), Art, #132, 8 pages. Retrieved December 12, 2016, from http://www.curationis.org.za/index.php/curationis/article.

Sofohlo, P. M. (2010). Critical assessment of the management practices of Yusuf Dadoo Public Hospital. Master's thesis. Stellenbosch University.

Soklaridis, S. (2014). Improving hospital care: are learning organisations the answer? *Journal of Health Organisation and Management*, 28(6), 830-838.

Sole, F. (2009). A management model and factors driving performance in public organisations. *Measuring Business Excellence*, 13(4), 3-11.

South African Nursing Council. (2013). Code of Ethics for Nursing Practitioners in South Africa, 1-9. Pretoria.

Splendore, R, Burns, H. & Choby, C. M. (2016). Dress for respect: A shared governance approach. *Nursing Management*, 47(4), 51-53. Retrieved on March 30, 2017, from http://journals.lww.com/nursingmanagement/Fulltext/2016/04000/.

Srsic-Stoehr, K., Rogers, L., Wolgast, K., Chapman, T. & Douglas, R. L. (2004). Success skills for the nurse managers: Cultural debut and sustainment. *Nurse Leader*, 2(4), 36-41.

Stake, R. E. (2010). *Qualitative Research. Studying how things work*. New York: The Guilford Press.

Standard Bank Ltd. (2015). HR management best practice. Retrieved February 06, 2016, from http://bizconnect.standardbank.co.za/manage/human-resources.

Stapleton, P., Henderson, A., Creedy, D. K., Cooke, M., Patterson, E., Alexander, H., Haywood, A. & Dalton, M. (2007). Boosting morale and improving performance in the nursing setting. *Journal of Nursing Management*, 15(8), 811-816.

Stewart, C., Snyder, K. & Sullivan, S. C. (2010). Journal clubs on the Night Shift: A Staff Nurse Initiative. *Medsurg Nursing*, 19(5), 305-306.

Stewart, D. W. & Shamdasani, P. N. (2015). *Focus Groups: Theory and Practice.* (3rd ed.). Los Angeles: Sage.

Stichler, J., F. (2009). Healthy, healthful, and healing Environments: A Nursing Imperative. *Critical Care Nursing Quarterly*, 32(3), 176-188.

Stiglbauer, B., Selenko, E., Batinic, B. & Jodlbauer, S. (2012). On the link between job insecurity and turnover intentions: Moderated mediation by work involvement and well-being. *Journal of Occupational Health Psychology*, 17(3), 354-364.

Streubert, H. J. & Carpenter, D. R. (2011). *Qualitative Research in Nursing: Advancing the Humanistic Imperative.* (5th ed.). Philadelphia: Wolters Kluwer Health | Lippincott Williams & Wilkins.

Strohl, R. (2005). Celebrating 30 years; Past President Remarks on Nursing Manager Responsibilities. *Oncology Nursing Society News*, 20(4), 4-4.

Strople, B. & Ottani, P. (2006). Can Technology Improve Intershift Report? What the research reveals. *Journal of Professional Nursing*, 22(3), 197-204.

Suby, C. (2009). Indirect Care: The measure of how we support our Staff. *Creative Nursing*, 15(2), 98-103.

Suhonen, M. & Paasivaara, L. (2011). Nurse managers' challenges in project management. *Journal of Nursing Management*, 19(2), 1028-1036.

Sukamolson, S. (2010). Fundamentals of quantitative research. Language Institute, Chulalongkorn University. Retrieved November 18, 2016, from www.culi.chula.ac.th/Research/e-Journal/bod/Suphat%20Sukamolson.pdf.

Tabak, N. & Koprak, O. (2007). Relationship between how nurses resolve their conflicts with doctors, their stress and job satisfaction. *Journal of Nursing Management*, 15(3), 321-331.

Tahvanainen, M. (2000). Expatriate Performance Management: The case of Nokia telecommunications. *Human Resource Management*, 39(2 & 3), 267-275.

Taylor, J. C. & Stern (Jr.), G. M. (2009). *The Trouble with HR: An Insider's Guide to Finding and Keeping the Best People*. New York: American Management Association.

Tenblad, S. (2012). *The Work of Managers - Towards a Practice Theory of Management*. United States: Oxford University Press.

Terre Blanche, M., Durrheim, K. & Painter, D. (2006). *Research in Practice: Applied Methods for the Social Sciences.* (2nd ed.). Cape Town: University of Cape Town Press (Pty) Ltd.

Thomas, K. (2007). Malaysia: Integrated Results-Based Management - the Malaysia Experience. *Sourcebook on Emerging Good Practice.* (2nd ed.), 95-103.

Thompson, P. A. (2009). Creating Leaders for the future. *American Journal of Nursing*, 109(11), 50-52.

Thomson, W. (2008). Lord Kelvin Quotations. Retrieved February 05, 2016, from http://zapatopi.net/Kelvin/quotes.

Thopola, M. K., Kgole, J. C. & Mamogobo, P. M. (2013). Experiences of newly qualified nurses at University of Limpopo, Turfloop Campus executing community services in Limpopo Province, South Africa. *African Journal for Physical, Health Education, Recreation and Dance (AJPHERD)*, Supplement 1, 169-181.

Thorne, S. (2000). Data analysis in qualitative research. *EBN notebook, British Medical Journal*, 3, 68-70.

Thorpe, R. & Holloway, J. (Eds.). (2008). *Performance Management: Multidisciplinary perspectives*. London: Palgrave Macmillan.

Tibandebage, P., Kida, T., Mackintosh, M. & Ikingura, J. (2016). Can managers empower nurse-midwives to improve maternal health-care? A comparison of two resource-poor hospitals in Tanzania. *International Journal of Health Planning and Management*, 31(4), 379-395.

Timmins, F. (2011). Managers' duty to maintain good workplace communications skills. *Nursing Management*, 18(3), 30-34.

Tobin, G. A. & Begley, C. M. (2004). Methodological Issues in Nursing Research. Methodological rigour within a qualitative framework. *Journal of Advanced Nursing*, 48(4), 388-396.

Tong, A., Sainsbury, P. & Craig, J. (2007). Consolidated criteria for reporting qualitative research (COREQ): A 32-item checklist for interviews and focus groups. *International Journal for Quality in Health-care*, 19(6), 349-357.

Toye, C., Matthews, A., Hill, A. & Maher, S. (2014). Experiences, understandings and support needs of family carers of older patients with delirium: a descriptive mixed methods study in a hospital delirium unit. *International Journal of Older People Nursing*, 9(3), 200-208.

Trueland, J. (April, 2010). My focus will be the patient's experience of nursing care. *Nursing Standard*, 24(32), 13-14.

Turabi, A. E., Hallworth, M., Ling, T. & Grant, J. (2011). A novel performance monitoring framework for health research systems: experiences of the National Institute for Health Research in England. *Health Research Policy and Systems*, 9(13), 1-15. Retrieved February 15, 2013, from http://www.health-policy-systems.com/content/9/1/13.

Valeriano, V. (Undated). Civil Service Commission's Performance Management System. Retrieved January 06, 2017, from https://core.ac.uk/download/pdf/20880853.pdf.

van der Voet, J. (2013). The effectiveness and specificity of change management in a public organisation: Transformational leadership and a bureaucratic organisational structure. *European Management Journal*, 32(3), 373-382.

Van Dyk, A. & Jooste, K. (2005). The contribution of the Clinical Nurse Instructor to the development of critical thinking skills of the student nurse in Namibia. *Health SA Gesondheid*, 10(4), 16-28.

Van Gorder, C. (2015). The Front-line Leader. *Leader to Leader*, 2015(77), 42-47.

Van Rhenen, W., Schaufeli, W. B., Van Dijk, F. J. H. & Blonk, R. W. B. (2008). Coping and sickness absence. *International Archives of Occupational and Environmental Health*, 81(4), 461-472.

Vance, C. & Paik, Y. (2015). *Managing a Global Workforce: Challenges and Opportunities in International Human Resource Management.* (3rd ed.). New York: Routledge Taylor & Francis Group.

VanVactor, J. D. (2012). Strategic health-care logistics planning in emergency management. *Disaster Prevention and Management: An International Journal*, 21(3), 299-309.

Varcarolis, E. M. (2013). *Essential of Psychiatric Mental Health Nursing: A Communication Approach to Evidence-Based Care*. (2nd ed.). Missouri: Elsevier Saunders.

Viana, C. D., Bragas, L. Z. T. D., Lazzari, D. D., Garcia, C. T. F. & Moura, G. M. S. S. D. (2016). Retrieved March 29, 2017, from http://www.scielo.br/pdf/tce/v25n1/0104-0707-tce-.

Vollers, D., Hill, E., Roberts, C., Dambaugh, L. & Brenner, Z. R. (2009). AACN's Healthy Work Environment Standards and an Empowering Nurse Advancement System. *Critical Care Nurse*, 29(6), 20-28.

W. K. Kellogg Foundation. (2004). Using Logic Models to Bring Together Planning, Evaluation, and Action; Logic Model Development Guide. Michigan: W.K. Kellogg Foundation.

Wagner, J., Bezuidenhout, M. C. & Roos, J. H. (2015). Communication satisfaction of professional nurses working in public hospitals. *Journal of Nursing Management*, 23(8), 974-982.

Walker, A. G. (2007). Is performance management as simple as ABC; Effectively managing employee performance breeds organisational success. *American Society for Training & Development*, 54-57.

Walker, R. M., Damanpour, F. & Devece, C. A. (2011). Management Innovation and Organisational Performance: The Mediating Effect of Performance Management. *Journal of Public Administration Research and Theory*, 21(2), 367-386.

Walker, R., Cooke, M. & McAllister, M. (2008). A Neophytes Journey through qualitative analysis using Morse's Cognitive Processes of Analysis. *International Journal of Qualitative Methods*, 7(1), 81-93.

Wang, V. C. X. (2015). *Handbook of Research on Scholarly Publishing and Research Methods*. Hershey: Information Science Reference.

Warshawsky, N. E. & Havens, D. S. (2014). Nurse manager job satisfaction and intent to leave. *Nursing Economics*, 32(1), 32-39.

Warshawsky, N. E., Havens, D. S. & Knafl, G. (2012). The influence of Interpersonal Relationships on Nurse Managers' work Engagement and Proactive Work Behavior. *Journal of Nursing Administration*, 42(9), 419-425.

Watkins, J. M., Mohr, B. J. & Kelly, R. (2011). *Appreciative Inquiry: Change at the Speed of Imagination*. San Francisco: Pfeiffer.

Weger (Jr), H., Castle, G. R. & Emmett, M. C. (2010). Active listening in peer interviews: The Influence of Message Paraphrasing on Perceptions of Listening Skill. *International Journal of Listening*, 24(1), 34-49.

Weiner, E. (2012). The Effects of Mandated Nurse-to-patient Ratios on Reducing Preventable Medical Error and Hospitals Costs, Part I. Seton Hall University. Retrieved August 01, 2015, from http://scholarship.shu.edu/student_scholarship.

Wendler, C., Olson-Sitki, K. & Prater, M. (2009). Succession planning for RNs implementing a Nurse Management Internship. *The Journal of Nursing Administration*, 39(7/8), 326-333.

Weng, R, Huang, C, Chen, L. & Chang, L. (2013). Exploring the impact of transformational leadership on nurse innovation behaviour: a cross-sectional study. *Journal of Nursing Management*, 23(4), 427-439.

West, E. (2001). Management matters: the link between hospital organisation and quality of patient care. *Quality in Health-care*, 10(40), 40-48.

West, M., Borril, C., Dawson, J., Scully, J., Carter, M., Anelay, S., Patterson, M. & Waring, J. (2002). The link between the management of employees and patient mortality in acute hospitals. *International Journal of Human Resources Management*, 13(8), 1299-1310.

West, M., Eckert, R., Steward, K. & Pasmore, B. (2014). Developing collective leadership for health-care. TheKingsFund, Centre Creative Leadership. Centre for Creative Leadership. Retrieved February 07, 2016, from http://www.ctrtraining.co.uk/documents/Developing.

West, M., Smithgall, L., Rosler, G. & Winn, E. (2016). Evaluation of a nurse leadership development programme. *Nursing Management*, 22(10), 26-31.

Western Cape (Government) Health: Republic of South Africa. (2012). Clinicom summary report. Cape Town: Western Cape Government.

Western Cape (Government) Health: Republic of South Africa. (2013). Clinicom summary report. Cape Town: Western Cape Government.

Western Cape (Government) Health: Republic of South Africa. (2014). Clinicom summary report. Cape Town: Western Cape Government.

Western Cape (Government) Health: Republic of South Africa. (2015). Clinicom summary report. Cape Town: Western Cape Government.

Western Cape Government: Department of Health (2015). Management Onboarding C^2AIR^2 Club Challenge, Health Facilities. Cape Town: Western Cape Government.

Western Cape Government: Department of Health. (2011). 2020 The future of health-care in the Western Cape; A draft framework for dialogue. Cape Town: Western Cape: Department of Health.

Western Cape Government: Health. (2014). Health-care 2030: The Road to Wellness. Cape Town: Western Cape Government.

Western Cape Government: News. (10 April, 2014). Western Cape Government Health embarks on Organisational Change. Cape Town: Western Cape Government.

Western Cape Health, Directorate Nursing Services: Republic of South Africa. (2014). Nursing Competencies presentation by Provincial Nursing Manager, Makie, V. Western Cape: Department of Health.

Western Cape Health, Directorate Nursing Services: Republic of South Africa. (2015). PNMF workshop & meeting minutes, chaired by Provincial Nursing Director, Africa, F. Western Cape: Department of Health.

Western Cape Provincial Administration (later known as Western Cape Provincial Government). (2002). Staff Performance Management System guide. Western Cape: Department of Health.

Western Cape Provincial Government: Republic of South Africa. (2012). Department of Health Budget Speech by Minister of Health, Botha, T. Retrieved November 01, 2016, from www.westerncape.gov.za/speech/department-health-budget-speech-2012.

Western Cape Provincial Legislature: Republic of South Africa. (2016). Game-Changer Roadmap address by Premier of the Province, Zille, H. Western Cape Government.

Western Cape Public Health and Social Development Sectoral Bargaining Chamber: Republic of South Africa. (2011). Organisational Rights Agreement. Western Cape Government.

Wildemuth, B. M. (Ed.) (2017). *Applications of Social Research Methods to Questions in Information and Library Science.* (2nd ed.). California: ABC-CLIO.

Willcocks, S. G. (2012). Exploring leadership effectiveness: nurses as clinical leaders in the NHS. *Leadership in health Services*, 25(1), 8-19.

Williams-Buenzli, W. J. (2015). A measure of soft skill gains acquisition with engagement in baccalaureate nursing programs. Doctoral thesis (partial fulfillment). Paper 100. The University of Southern Mississippi. Mississippi

Wilson, J. R. & Sharples, S. (Eds.). (2015). *Evaluation of Human Work.* (4th ed.). Boca Raton: CRC Press.

Wisdom, J. P., Cavaleri, M. A., Onwuegbuzie, A. J. & Green, C. (2012). Methodological reporting in qualitative, quantitative, and mixed methods health services research articles. *Health Services Research*, 47(2), 721-744.

Wong, C. A. & Giallonardo, L. M. (2013). Authentic leadership and nurse-assessed adverse patient outcomes. *Journal of Nursing Management*, 21(5), 740-752.

Wong, C. A., Laschinger, H., Cummings, G. G., Vincent, L. & O'Connor, P. (2010). Decisional involvement of senior nurse leaders in Canadian acute care hospitals. *Journal of Nursing Management*, 18(2), 122-133.

Wong, S. T., Yin, D., Bhattacharyya, O., Wang, B., Liu, L. & Chen, B. (2010). Developing a performance measurement framework and indicators for community health service facilities in Urban China. *BMC Family Practice*, 11(91). Retrieved June 13, 2016, from http:// www.biomedcentral.com/1471-2296/11/91.

Wood, C. (2014). Choosing the 'right' people for nursing: can we recruit to care? *British Journal of Nursing*, 23(10), 538-530.

World Bank. (2006). "Thailand: Country Development Partnership: Governance and Public Sector Reform - Program Assessment and Implementation Completion Report" Retrieved December 24, 2016, from http://documents.worldbank.org/curated/pt/559701468118474809/.

World Health Organization. (2017). Definition of 'hospital'. Retrieved April 19, 2017, from healthhttp://www.who.int/hospitals/en/.

Wright, S., O'Brien, C. & Nimmon, L. (2016). Research Design Considerations. *The Journal of Graduate Medical Education*, 8(1), 97-98.

Xie, Z., Wang, A. & Chen., B. (2011). Nurse Burnout and its association with occupational stress in a cross sectional study in Shanghai. *Journal of Advanced Nursing*, 67(7), 1537-1546).

Yahaya, A. (2014). Abraham Maslow: The Needs Hierarchy. Retrieved July 18, 2015, from http://eprints.utm.my/6091/.

Yiannis, T., Ioannis, S. & Nikolaos, K. (2009a). Performance Management and Reward. *American Institute of Physics Conference Proceedings*, 1148(2), 909-912.

Yiannis, T., Ioannis, S. & Nikolaos, K. (2009b). Computational Methods in Science and Engineering, Advances in Computational Science. Simos, T. E. & Maroulis, G. (Eds.). Learning, a Critical factor for the Performance Management of an Organisation. *American Institute of Physics Conference Proceedings*, 1148 (vol. 2), 913-916.

Yin, R. (2014). *Case Study Research Design and Methods*. California: Sage Publications, Inc.

Yoder-Wise, P. S. (2015). *Leading and Managing in Nursing.* (6th ed.). St. Louis: Elsevier Mosby.

Zannini, L., Ghitti, M. G., Martin, S., Palese, A. & Saiani, L. (2015). Narratives, memorable cases and metaphors of night nursing: findings from an interpretive phenomenological study. *Nursing Inquiry*, 22(3), 261-272.

Zeppou, M. & Sotirakou, T. (2003). The "STAIR" model A comprehensive approach for managing and measuring government performance in the post-modern era. *The International Journal of Public Sector Management*, 16(4), 320-332.

Zori, S. & Morrison, B. (2009). Critical Thinking In Nurse Managers. *Nursing Economic$*, 27(2), 75-80).

ANNEXURE A: HEI ETHICAL CLEARANCE LETTER

UNIVERSITY of the
WESTERN CAPE

OFFICE OF THE DEAN
DEPARTMENT OF RESEARCH DEVELOPMENT

30 July 2013

To Whom It May Concern

I hereby certify that the Senate Research Committee of the University of the Western Cape has approved the methodology and ethics of the following research project by:
Mrs B Swartz (School of Nursing)

Research Project:	A contemporary work performance management framework for assistant nurse managers in the provincial health care setting.
Registration no:	13/6/16

Any amendments, extension or other modifications to the protocol must be submitted to the Ethics Committee for approval.

The Committee must be informed of any serious adverse event and/or termination of the study.

Ms Patricia Josias
Research Ethics Committee Officer
University of the Western Cape

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E: pjosias@uwc.ac.za
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ANNEXURE B: REQUEST LETTER TO THE DEPARTMENT OF HEALTH, WC

TO MS CHARLENE RODERICKS

THE RESEARCH COORDINATOR

DEPARTMENT OF HEALTH, HEAD OFFICE

PROVINCIAL GOVERNMENT OF THE WESTERN CAPE

FROM BERYLDENE SWARTZ

PART-TIME PhD NURSING STUDENT

UNIVERSITY OF THE WESTERN CAPE

DATE 30 JULY 2013

REFERENCE REQUEST TO CONDUCT RESEARCH AT GENERAL SPECIALIST HOSPITALS

Dear Ms Rodericks,

Herewith I would like to make application to conduct my research at the 10 General Specialist Hospitals in the Western Cape namely:

1. Mowbray Maternity Hospital
2. Somerset Hospital
3. Western Cape Rehabilitation Centre
4. Paarl Hospital
5. Worcester Hospital
6. George Hospital
7. Valkenberg Hospital
8. Stikland Hospital
9. Alexandra Hospital
10. Lentegeur Hospital

The target groups for this research are the:

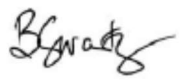
- Assistant Managers: Nursing (Individual semi-structured interviews) and
- Heads of Nursing (focus group/s).

In this regard please find the following attachments:

- Proof of ethical acceptance from the university's research ethics committee
- My proposal comprised of
    - front pages
    - index
    - content

Do note that I am employed at Lentegeur Hospital and strategically in relation to the research, in a position of Head of Nursing. As you would see from the proposal, an independent fellow student researcher will conduct the interviews at my work site should data saturation not yet have occurred.

Hoping for a favourable response



Beryldene Swartz

Contactable on:

082 804 3727 (mobile)

021 370 1400/04 (work)

blswartz@telkomsa.net

ANNEXURE C: PROPOSAL SUMMARY (DEPARTMENT OF HEALTH)

[Referred to below by the Department of Health as Annexure 2]

ANNEXURE 2 PROPOSAL SUMMARY	For official use: Research proposal
Name of Institution/organisation conducting research	UNIVERSITY of the WESTERN CAPE
Name of Investigator	B L SWARTZ
Postal Address	100 David Atkins Street, Charlesville, 7490 **Cape Town**
Telephone Numbers	Cell : 082 804 3727 Home : 021 943 1417 Work : 021 370 1400/04
Fax number	Home : 0865561417
Mobile Number	082 804 3727
Email Address	blswartz@telkomsa.net
Institution which gave ethical approval	UNIVERSITY of the WESTERN CAPE
Date of Ethical approval	Date of sitting: 25 July 2013 Date of letter of approval (attached): 30 July 2013
Date research expected to commence	04 November 2013
Proposed data collection dates at requested facilities	Mowbray Maternity, Valkenberg, Alexandra, Somerset, Stikland, WCRC and Lentegeur Hospitals

ANNEXURE 2 PROPOSAL SUMMARY	For official use: Research proposal
	between 4 and 29 November 2013. Paarl, Worcester and George Hospitals between 30 December 2013 and 24 January 2014.
Date research expected to end	21 March 2014 as I expect that all the willing ANMs would not all have been available on my scheduled dates for the visits
Date research reports should be expected	30 June 2014
Western Cape Districts where research will be done: **(Please mark with an X)**	Metro X **Westcoast** CapeWinelands **Overberg** **Central Karoo** **Eden**
WC DOH Facilities where research will be done: **(Please list the name of the facility under appropriate category)**	<u>General Specialist Hospitals:</u> Mowbray Maternity Hospital Valkenberg Hospital Alexander Hospital Somerset Hospital, Stikland Hospital Western Cape Rehabilitation Centre

ANNEXURE 2 PROPOSAL SUMMARY	For official use: Research proposal
	Lentegeur Hospital Paarl Hospital Worcester Hospital George Hospital
Other facilities in the WC DOH where research will be done (Please specify)	Psychiatric Hospitals: (Includes all 4 psychiatric hospitals listed above under General Specialist Hospitals) TB Hospitals Other: Databases :
Research title	A contemporary work performance management framework for Assistant Nurse Managers in the Provincial Health-care setting
Research aim	The aim of the study is to develop a contemporary work performance management framework for ANMs in the provincial health-care setting

ANNEXURE 2 PROPOSAL SUMMARY	For official use: Research proposal
Research objectives	The objectives of the study are to: **-Explore and interpret (understand) the key performance areas that is needed for the** **Assistant Nurse Manager** **- Explore and describe the ANMs' best work performance experience of each key** **performance area** **- Explore and describe how the best work performance experience of the ANMs' influences the best work performance in practice** **- Develop a contemporary work performance management framework for ANM's in the** **provincial health-care setting**
Key Words	Appreciative inquiry, Assistant nurse manager, Best experiences, Focus groups, Framework, Individual interviews,

ANNEXURE 2 PROPOSAL SUMMARY	For official use: Research proposal	
	Performance management, Provincial hospital, Qualitative design, Work performance	
Brief description of methodology **(Please specify estimated sample size and duration of contact with each participant e.g. interview length, clinical exams)**	Qualitative research All interviews will not be longer than 60 minutes	
Type of Study Design: e.g. Case Control, RCT, Survey	Design: Exploratory, contextual and descriptive making use of individual semi-structured interviews and a focus group	
Budget for research	Projected to cost less than R10, 000 - 00	
Source of funding for the research	**Self funded**	
The research will have implications for the requested facilities regarding:	**Yes or NO**	**If Yes what are these implications and how does your project plan to mitigate the impact**
Additional load on nursing	No	
Support services	No	
Consumables	No	
Laboratory tests	No	

ANNEXURE 2 PROPOSAL SUMMARY	For official use: Research proposal	
Equipment	No	
Space	Yes	A private office will be required for the individual interviews with the ANMs at each of the health-care settings/ hospitals. A board room will be required to conduct the focus group with the group of Nursing Heads; it is envisaged that this could take place at the Metro Regional Board Room.
Communications	No	
Additional OPD visits	No	
Admission of patients	No	
How will the sites be prepared to participate in your research?	The Nursing Heads would be approached as the study focuses on Assistant Nurse Managers	
Results dissemination plan **Tick which groups will be affected by your research findings**	Provincial managers ☐ District Directors ☐ Facility manager and staff ☐ Patients ☐	

ANNEXURE 2 PROPOSAL SUMMARY	For official use: Research proposal
	Community ☐ Other (please specify) **Nursing Heads and Assistant Managers: Nursing**
2. What is the earliest date or time frame from the end of research collection that the feedback (at least the minimum requirements*) will be expected? *** Minimum research findings feedback template**	Within one month ☐ Within one to three months ☐ Within three to six months ☐ Longer than six months ☐X

ANNEXURE D: APPROVAL LETTER 1 FROM DEPARTMENT OF HEALTH

Western Cape Government
Health

STRATEGY & HEALTH SUPPORT
Health.Research@westerncape.gov.za
tel: +27 21 483 6051; fax: +27 21 483 9896
5th Floor, Norton Rose House, 8 Riebeek Street, Cape Town, 8001
www.capegateway.gov.za

REFERENCE: RP 149 /2013
ENQUIRIES: Ms Charlene Roderick

100 David Atkins Street
Charlesville
7490
Cape Town

For attention: B L Swarts

Re: A contemporary work performance management framework for Assistant Nurse Managers in the Provincial Health Care setting

Thank you for submitting your proposal to undertake the above-mentioned study. We are pleased to inform you that the department has granted you approval for your research.
Please contact the following people to assist you with any further enquiries in accessing the following sites:

Valkenberg Hospital	E Malgas	Contact No. 021 440 3260
Alexander Hospital	L Meyer	Contact No. 021 503 5009
New Somerset	D Stokes	Contact No. 021 402 6992
Western Cape Rehabilitation Centre	J Hendry	Contact No. 021 370 2316
Lentegeur Hospital	N Jacobs	Contact No. 021 402 6434
Mowbray Maternity	S Fawcus	Contact No. 021 685 5570

Kindly ensure that the following are adhered to:

1. Arrangements can be made with managers, providing that normal activities at requested facilities are not interrupted.

Page 1of 1

2. Researchers, in accessing provincial health facilities, are expressing consent to provide the department with an electronic copy of the final report within six months of completion of research. This can be submitted to the provincial Research Co-ordinator (Health.Research@westerncape.gov.za).

3. The reference number above should be quoted in all future correspondence.

We look forward to hearing from you.

Yours sincerely

DR NF Noleedi
DIRECTOR: HEALTH IMPACT ASSESSMENT
DATE: 11/11/2013

ANNEXURE E: APPROVAL LETTER 2 FROM DEPARTMENT OF HEALTH

Western Cape Government
Health

STRATEGY & HEALTH SUPPORT
Health.Research@westerncape.gov.za
tel: +27 21 483 6857; fax: +27 21 483 9895
5th Floor, Norton Rose House,, 8 Riebeek Street, Cape Town, 8001
www.capegateway.gov.za

REFERENCE: RP 149 /2013
ENQUIRIES: Ms Charlene Roderick

100 David Atkins Street
Charlesville
7490
Cape Town

For attention: **B L Swartz**

Re: A contemporary work performance management framework for Assistant Nurse Managers in the Provincial Health Care setting

Thank you for submitting your proposal to undertake the above-mentioned study. We are pleased to inform you that the department has granted you approval for your research.
Please contact the following people to assist you with any further enquiries in accessing the following sites:

George Hospital	**M Vonk**	**Contact No. 044 802 4533**
Worcester Hospital	**W Marais**	**Contact No. 023-348-4637**
Paarl Hospital	**B Kruger**	**Contact No. 021 872 1711**
Stikland Hospital	**C Bernardo**	**Contact No. 021 503 5004**

Kindly ensure that the following are adhered to:

1. Arrangements can be made with managers, providing that normal activities at requested facilities are not interrupted.
2. Researchers, in accessing provincial health facilities, are expressing consent to provide the department with an electronic copy of the final report within six months of completion of research. This can be submitted to the provincial Research Co-ordinator (Health.Research@westerncape.gov.za).
3. The reference number above should be quoted in all future correspondence.

Yours sincerely

DR NT Naledi
DIRECTOR: HEALTH IMPACT ASSESSMENT
DATE: 15/11/2013

CC	**DR L PHILLIPS**	**DIRECTOR: CAPE WINELANDS**
CC	**DR L BITALO**	**DIRECTOR: NORTHERN / TYGERBERG**

Page 1of 1

ANNEXURE F: SAMPLE OF REQUEST LETTER TO THE INSTITUTIONS

Permission Letter for Worcester Hospital

UNIVERSITY OF THE WESTERN CAPE

PRIVATE BAG X 17, BELLVILLE 7535, SOUTH AFRICA

Tel: +27 21-9592274, Fax: 27 21-9592271

17 October 2013

Ms. Elbie Vosloo, Chief Executive Officer

Worcester Hospital, Worcester

REQUESTING PERMISSION TO CONDUCT A RESEARCH STUDY AT THE ABOVE-NAMED GENERAL SPECIALIST HOSPITAL

I hereby request to conduct a research study at Worcester Hospital, Worcester.

The study is entitled: *A contemporary work performance management framework for assistant nurse managers in the provincial health care setting.*

This study forms part of the requirements for acquiring a PhD Degree in Nursing Science at the School of Nursing at the University of the Western Cape. The study will be done under the supervision and guidance of Professor K. Jooste of the School of Nursing, University of the Western Cape.

The aim of this research project is to explore and describe the best work performance of nurse managers and to develop a work performance management framework and guidelines for its use, for nurse managers working in hospitals in the Western Cape.

All the Assistant Nurse Managers working at the General Specialist Hospitals in the Western Cape are potential participants and will be approached for voluntary participation in the study. The researcher will adhere to the rights to privacy and confidentiality of clients and participants.

The identity of all participants in the study will be protected as the researcher will allocate a number to each participant or group of participants that will be used when the data of the individual and focus groups, and field notes are reflected on, instead of real names. The name of the hospital will not appear on the research report. All records will be kept for 5 years after publication of the results after which it will be destroyed. Only the researcher, supervisor, independent coder and research study examiners will have access to the data. The participants will not be coerced into participation and should they wish to withdraw at any time during the study, their wish will be respected. The researcher will ensure adherence to the highest standards of research planning, implementation and reporting. If you have any questions about the research study itself, please contact:

Researcher: Beryldene Swartz (student number 8722516)

University of the Western Cape

Private Bag X17, Bellville 7535

Cell: 082 804 3727

Email: blwartz@telkomsa.net

Should you have any questions regarding this study in relation to your hospital, the rights of the hospital or individual nurse managers as research participants or if you wish to report any problems you have experienced related to the study, please contact the:

Research supervisor, Professor and Director of School of Nursing: Professor Karien Jooste

University of the Western Cape

Private Bag X17, Bellville 7535

Telephone: (021) 959 2271

Email: kjooste@uwc.ac.za

and/ or the

Dean of the Faculty of Community and Health Sciences: Professor Hester Klopper

University of the Western Cape

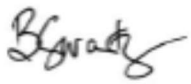
Private Bag X17, Bellville 7535

Telephone: (021) 9592631

Email: hklopper@uwc.ac.za

This research has been approved by the Senate Research Committee and Ethics Committee of the University of the Western Cape.

Thank you for considering this request



Beryldene Swartz

ANNEXURE G: PARTICIPANT INFORMATION SHEET

UNIVERSITY OF THE WESTERN CAPE

PRIVATE BAG X 17, BELLVILLE 7535, SOUTH AFRICA

Tel: +27 21-9592274; Fax: 27 21-9592271

PARTICIPANT'S INFORMATION SHEET

Project Title: A contemporary work performance management framework for assistant nurse managers in the provincial health care setting

What is this study about?

I am Beryldene Swartz, a registered (part-time) PhD student at the School of Nursing (Faculty of Community Health Sciences) at the University of the Western Cape. I hereby invite you to participate in this research project because you are a nurse manager managing a component of the nursing department, and hence you are a valuable resource person in the field of nursing management, the heart of this study. The purpose of this research project is to develop '**A contemporary work performance management framework for assistant nurse managers in the provincial health care setting**' in the Western Cape. The focus of the investigation relates to the JD of the Assistant Manager: Nursing. The researcher will conduct the individual semi-structured interview that you are being invited to partake in. This study will make use of an independent transcriber to capture the interview data.

What will I be asked to do if I agree to participate?

You will be asked to participate in the interview. This means that your contribution to the interview discussion on your work performance experience would be sought as it relates to the job of the Assistant Manager: Nursing. Your input would also inform the development of guidelines for the use of a performance management framework for assistant managers in nursing. The interview will be recorded. You will be required to give written permission to partake in the interview on the consent form. The reason for audio recording the interviews is for transcribing purposes only as it maximizes the benefit of the seeking data and information in this manner.

Would my participation in this study be kept confidential?

The initiatives that the researcher has taken to ensure that your participation in this study is confidential are the following:

- The recording devices that will be used for audio recording the interviews will be taken directly and securely from the interview venue which will be arranged to be at your hospital, to the transcriber.
- Reflective notes and interview transcripts will be numbered and dated. No other means of identification will be used to identify the data/ recordings hence your personal identity will remain anonymous.
- All notes and printed documents will be stored in a locked filing cabinet in the office of the researcher. The research team that includes the researcher, researcher supervisor, transcriber and research examiners will strive to maintain unconditional confidentiality of any personal information. For this reason, all audio tapes will also be kept locked in a filing cabinet in the office of the researcher. The information will not be available to any person, other than the team.
- All computer files related to this research project will be password-protected on the personal computer of the researcher.
- If a report or article is written about this research project, your identity will be protected to the maximum extent possible.

What are the risks of this research?

There are no risks associated with participating in this research project.

What are the benefits of this research?

The research is not designed to personally benefit the researcher, but to inform the research investigation that should lead to the development of a contemporary work performance management framework for the position of assistant manager in nursing, and guidelines for the implementation thereof. This work performance management framework should benefit nursing management at health care settings/ hospitals in the Western Cape and likely elsewhere. The development of such a framework should also benefit future nurse managers.

Do I have to be in this research and may I stop participating at any time?

Your participation in this research is completely voluntary. You may choose not to take part at all. If you do decide to participate in this research, you may still withdraw at any point. If you decide not to participate in this study or if you stop participating at any point time, it will not be held against you.

What if I have questions?

This research is being conducted by Beryldene Swartz, a registered part-time student (researcher) at the School of Nursing at the University of the Western Cape.

If you have any questions about the research study itself, please contact:

Researcher : Beryldene Swartz [student number: 8722516]

Telephone : 021 934 1417

Cell : 082 804 3727

Email : blswartz@telkomsa.net

Should you have any questions regarding this study and your rights as a research participant or if you wish to report any problems you have experienced related to the study, you may contact the:

Research Supervisor and Director of the School of Nursing

Professor Karien Jooste

University of the Western Cape

Private Bag X17, Bellville 7535

Telephone: (021) 959 2271

Email: kjooste@uwc.ac.za

Dean of the Faculty of Community and Health Sciences

Professor Hester Klopper

University of the Western Cape

Private Bag X17, Bellville 7535

Telephone: (021) 959 2631

Email: hklopper@uwc.ac.za

This research has been approved by the Senate Research Committee and Ethics Committee of the University of the Western Cape.

.....

Beryldene Swartz

ANNEXURES H - O: APPROVAL FROM HEALTH-CARE SETTINGS

ANNEXURE H

From: Lynette Meyer [mailto:Lynette.Meyer@westerncape.gov.za]
Sent: 19 December 2013 08:56 AM
To: Beryldene Swartz; Charlene Roderick
Cc: Genni Engelbrecht; Joy Wheeler; Keith Ganasen; Nashareen Morris; Renee Fisher; Zandre Filby
Subject: RE: RESEARCH REQUEST

Dear Beryl

Kindly be informed that your request for access for research purposes is approved at Alexandra Hospital.

Please facilitate the necessary contact via the Head of Nursing- Mrs R Fisher.

Best wishes

Lynette Meyer

Chief Executive Officer

Alexandra Hospital

Chief Directorate: General Specialist and Emergency Services

Department of Health

Western Cape Government

Cnr Alexandra & Annex Roads, Maitland, 7405

Tel: (021) 503 5004 / 9

Cell: 084 5600 056

Fax: (021) 511 8841

Lynette.Meyer@westerncape.gov.za

www.westerncape.gov.za

ANNEXURE I

From: Michael Vonk [mailto:Michael.Vonk@westerncape.gov.za]
Sent: 18 November 2013 08:19 AM
To: Beryldene Swartz
Cc: Ge Sellars
Subject: RE: RESEARCH REQUEST

Dear Ms Swartz

Thank you for your email – please liaise with Mrs Sellars regarding the logistics

Regards

Mike

Michael Vonk

Chief Executive Officer

George Hospital

Tel: 044 802 4534

Fax: 086 6111 892

E-mail: michael.vonk@westerncape.gov.za

Website: www.westerncape.gov.za/health

ANNEXURE J

From: Donna Stokes [mailto:Donna.Stokes@westerncape.gov.za]
Sent: 11 December 2013 03:42 PM
To: Beryldene Swartz
Subject: RE: RESEARCH REQUEST

Dear Beryldene

Gloria has kindly reminded me to contact you as I have just returned from leave. You are most welcome to conduct research here. Please make contact with Gloria. I apologise for this derlay!!

Regards

Donna

ANNEXURE K

From: Breslau Kruger [mailto:Breslau.Kruger@westerncape.gov.za]
Sent: 06 January 2014 02:49 PM
To: 'Beryldene Swartz'
Subject: RE: RESEARCH REQUEST

Dear Beryldene

I have no objection to the research as proposed by you.

Regards.

ANNEXURE L

On 21 Nov 2013, at 7:50 AM, Carol Dean <Carol.Dean@westerncape.gov.za> wrote:

Thank you, have a wonderful day, your research is approved Estelle will send you a formal letter.

ANNEXURE M

From: Jenny Hendry [mailto:Jenny.Hendry@westerncape.gov.za]
Sent: 20 November 2013 09:22 AM
To: 'Beryldene Swartz'
Cc: Maryna Smit
Subject: RE: RESEARCH REQUEST

Thanks Beryl! Seen it all now.

You have the go-ahead and good luck!

Liaise with Maryna further?

Jenny

Jenny Hendry

CEO

Western Cape Rehabilitation Centre

Tel: 021-3702316

Fax: 021-3702400

Email: Jenny.Hendry@westerncape.gov.za

Website: www.wcrc.co.za

ANNEXURE N

From: Elbie Vosloo [mailto:Elbe.Vosloo@westerncape.gov.za]
Sent: 07 January 2014 08:32 AM
To: Beryldene Swartz
Subject: RE: RESEARCH REQUEST

Me. Beryldene Swartz

Apologies for the delay in response to your request as I was not in office. All documents including ethical clearance seems to be in order, you are therefore more than welcome to conduct your research at Worcester hospital. I will ask my assistant, Chantal Ried to send you an official approval on a letter head for your records.

Mrs Driver is on leave this week and will only be back in office on Monday 13 January, you are welcome to contact Mr Chris Smit who is acting on her behalf to make further arrangments.

Kind regards

Mrs. Elbie Vosloo

Chief Executive Officer

Worcester Hospital

Murray Street

Worcester

Fax: 086 771 0068

Tel: 023 348 1113

Email: Elbie.Vosloo@westerncape.gov.za

Website: www.westerncape.gov.za

ANNEXURE O

Western Cape Government
Health

CHIEF EXECUTIVE OFFICER: MR C BARNARDO

Reference:
Enquiries: Mr C Barnardo

Ms Beryl Swartz
HOD: Nursing Department
Lentegeur Hospital

Dear Ms Swartz

REQUEST TO CONDUCT RESEARCH:

This is to confirm that permission has been granted to you to conduct the research at Stikland Hospital.

Please contact Mr Barnardo; Tel 021 940 4403.

Thank you

.....

MR C BARNARDO
CHIEF EXECUTIVE OFFICER
DATE: 11/12/2013

ANNEXURE P: WRITTEN CONSENT FORM -INDIVIDUAL INTERVIEW

UNIVERSITY OF THE WESTERN CAPE

PRIVATE BAG X 17, BELLVILLE 7535, SOUTH AFRICA

Tel: +27 21-9592274, Fax: 27 21-9592271

WRITTEN INFORMED CONSENT

Project Title: A contemporary work performance management framework for Assistant Nurse Managers in the provincial health-care setting

This research is being conducted by Beryldene Swartz, a registered part-time student (researcher) at the School of Nursing at the University of the Western Cape. The study has been explained to me in a language that I understand and I hereby voluntarily agree to participate in this research study. All my questions have been answered and sufficiently clarified. I understand that my identity will not be disclosed and that I may withdraw from the study at any stage without giving any reason.

Participants name: ……

Participants signature: ……

Date: ……

Should you have any questions regarding this study or wish to report any problems you may have experienced related to this study, please contact the researcher or research supervisor:

If you have any questions about the research study itself, please contact:

Researcher: Beryldene Swartz [student number: 8722516]

Telephone : 021 934 1417

Cell : 082 804 3727

Email : blswartz@telkomsa.net

Should you have any questions regarding this study and your rights as a research participant or if you wish to report any problems you have experienced related to the study, you may contact the:

Research Supervisor and Director of the School of Nursing

Professor Karien Jooste

University of the Western Cape

Private Bag X17, Bellville 7535

Telephone: (021) 959 2271

Email: kjooste@uwc.ac.za

Dean of the Faculty of Community and Health Sciences

Professor Hester Klopper

University of the Western Cape

Private Bag X17, Bellville 7535

Telephone: (021) 959 2631

Email: hklopper@uwc.ac.za

ANNEXURE Q: WRITTEN CONSENT FORM - GROUP DISCUSSION

UNIVERSITY OF THE WESTERN CAPE

Private Bag X 17, Bellville 7535, South Africa

Tel: +27 21-9592274, Fax: 27 21-9592271

WRITTEN INFORMED CONSENT

Project Title: A contemporary work PM framework for ANMs in the provincial health-care setting

This research is being conducted by Beryldene Swartz, a registered part-time student (researcher) at the School of Nursing at the University of the Western Cape. The study has been explained to me in a language that I understand and I hereby voluntarily agree to participate in this research study. All my questions have been answered and sufficiently clarified. I understand that my identity will not be disclosed and that I may withdraw from the study at any stage without giving any reason.

Participants name: ……

Participants signature: ……

Date: …….

Should you have any questions regarding this study or wish to report any problems you may have experienced related to this study, please contact the researcher or research supervisor:

If you have any questions about the research study itself, please contact:

Researcher : Beryldene Swartz [student number: 8722516]

Telephone : 021 934 1417

Cell : 082 804 3727

Email : blswartz@telkomsa.net

Should you have any questions regarding this study and your rights as a research participant or if you wish to report any problems you have experienced related to the study, you may contact the:

Research Supervisor and Director of the School of Nursing

Professor Karien Jooste

University of the Western Cape

Private Bag X17, Bellville 7535

Telephone: (021) 959 2271

Email: kjooste@uwc.ac.za

Dean of the Faculty of Community and Health Sciences

Professor Hester Klopper

University of the Western Cape

Private Bag X17, Bellville 7535

Telephone: (021) 9592631

Email: hklopper@uwc.ac.za

ANNEXURE R: INTERVIEW GUIDE – INDIVIDUAL INTERVIEW

UNIVERSITY OF THE WESTERN CAPE

PRIVATE BAG X 17, BELLVILLE 7535, SOUTH AFRICA

Tel: +27 21-9592274, Fax: 27 21-9592271

Researcher: Beryldene Swartz Student Number: 8722516

INTERVIEW SCHEDULE

QUESTIONS TO GUIDE INTERVIEWS

The following questions will be posed as questions during the interviews:

1. *Question 1 (Main question):*

"What is your understanding of your key performance management areas?"

2. *Sub-questions*

"What are your best work performances in your work situation?"

"How do your best work performances improve best work performance practices?"

"What are your ideas of the ideal work performance opportunities of an ANM for the future?"

"How do you view the commitment of the ANMs to delivering of actions towards work performance in the workplace?"

ANNEXURE S: INTERVIEW GUIDE – GROUP DISCUSSION

UNIVERSITY OF THE WESTERN CAPE

PRIVATE BAG X 17, BELLVILLE 7535, SOUTH AFRICA

Tel: +27 21-9592274, Fax: 27 21-9592271

Researcher: Beryldene Swartz Student Number: 8722516

INTERVIEW SCHEDULE

QUESTIONS TO GUIDE INTERVIEWS

The following questions will be posed during the interviews:

1. *Question 1 (Main question):*

"What is the understanding of the key performance management areas of the ANM?"

2. *Sub-questions*

"What are the ANMs' best work performances in their work situation?"

"How do the best work performances of the ANM improve best work performance practices?"

"What are your ideas of the ideal work performance opportunities of the ANM for the future?"

"How do you view the commitment of the ANMs' and the HONs' delivering of actions towards work performance in their workplace?"

ANNEXURE T:
GROUP DISCUSSION AND INDIVIDUAL INTERVIEW EXCERPTS

Excerpt from Focus Group discussion 1:

DISCOVERY:

I: so uhm the first question that I would pose to the 3 of you is:
"When we look at Assistant Managers and Assistant Manager performance, uhm what do they do well?"

HOD9: I am in a very fortunate position that I've got two very good Assistant Managers.

I: uh hm

HOD9: Uhm who do a lot of work well. Uhm they've they're very good at taking initiative

I: m n

HOD9: uh they're very good at problem solving and not just problem-solving, but getting to the root-cause of the problem and taking it from there. Uhm the one manager, I I think I would be open and honest...

HOD7: m

HOD9: ...she a bit of a uhm ... uhm not a task planner, trained 10 years later than me but it's as if she trained 10 years before me, so she's old-school so she is ---there's no grey, it's just rigid and right and very much a disciplinarian

HODu: um

HOD9: and ....but other than that ..... you know

HOD7: I can I can u uh I can also say I've got two at date day duty and two at night duty –the night nigh night u uh matrons or the night Assistant Managers –they run the, the whole hospital and that's a big, big hospital and, and uhm they do everything um except foe u uhm appointments and that kind of stuff. The other two -- the one is Specialised and the other one is General Uhm the one that does the General Side, she is very uhm much into the HR side of of the stuff of the hospital; she's doing my app... the the the appointments and and that kind of stuff. The other one, the one that's working in Specialised Areas, he is more doing the stuff in the specialized areas, but uhm apart from that, he is also very into the, the the equip, the equipment

I: um

HOD7: ordering the equipment, and see that all the wards are being equipped with the correct equipment. So u uhm that that that is having a good influens but also very uhm u uhm un --they are very u uhm hoe kan I say how can I put it now --they know what they are doing, they know their wards, uhm they are very clinical, they are in their wards every day, uhm they know their staff by heart and yes they they as as HOD9 said we..I am also very privileged to have really u people that know what is going on in the hospital, and also all 4 of them I think they are there—if therwe count all the years that they've been in H7, it's it's more than 100 years, so as ----they really know the hospital, by heart.

I: HOD5 xxxx

HOD5: Uhm ja well unfortunately H5's uhm in a very different situation. Uhm because in the last few years there's been major upheaval and major I can't say transformation ---but major changes. Uhm knowing well we were only two, none of which was planned for uhm you know because our Head of Nursing went off sick very suddenly, um the next, the person next in line was kicked out by the computer as they say and so on, so our uhm Nursing Management group are extremely inexperienced, you know. I mean starting with me because I also just found myself having to deal with these things. Uhm so there's in fact and my peers, um who used to be in the Nurse Management group, they are all retirees, but I'm actually managing not young but inexperienced in the management I think.
They're not unenthusiastic I mean that I have to say from the start. But the Assistant Managers that's working –in fact at one time there were no Assistant Managers, it was only me.

HODs: mm HOD5: but as the Assistant Manager and all around were the Operational Managers uhm who had been OSD'd and actually have not been appointed because of their expertise You know about the OSD?

HODu: mm I: If I understand correctly that they were there long enough and then they moved into the positions

HOD5: Well you were in a position at a particular on a particular date and if you and then there was sort-of ---- the different areas was screened; you were either in a Speciality Area or you were in a General Area and so on .....
And if you have been doing the straight shifts at that time, well that was the decision taken at our hospital, then you became the Operational Manager.

I: Ok

HOD5: irrespective of the reason you were doing that

I: so what, what I'm hearing you trying to say --you have Operational Managers that got to that level by default

HOD5: m

HOD7: 30th -------30th of June 2007

HOD5: yes

HOD9: The right place at the right time, ja

HOD5: Yes ja even ..... wrong reasons
So in a sense so that was the situation that uhm I found myself in at the beginning of 2010 uhm well because from 20 ..... from 2008 or 2009 ---I think we then eventually decided how the organogram was gonna look like, and who we now had to work with, uhm we put a sub-title to that plan in place uhm on the assumption that nobody's got the management experience as such so all of that was sort-of developmental, so as I say in the situation we found ourselves -----everybody was extremely supportive even if they didn't like it,

HODu: mm

HOD5: to me. They were loyal and they were supportive and they would do what they were asked to do. Uhm and then we got to the point of appointing uhm Assistant Managers and there's a lot to be said uhm on having people from within and appointing people from outside ----Don't know if you had the same experience! Uhm, there was a General Manager who is from outside uhm and after a few years, is still not quite

HODu: m

HOD5: settled into the responsibilities

HODu: mmm HOD5: and the Speciality who's been there all the time uhm is very keen but what I'm saying there's the lack of attention to detail --and finishing tasks correctly, and a lot of the quality in there is is lost. Uhm the night ones uhm well they're responsible for a pretty busy hospital, and they do it well, one better than the other because of taking on those responsibilities where as I find the two on Day Duty who are reluctant to make decisions uhm especially when it comes to HR issues --those kind of things

HODu: mm

HOD5: uhm despite the fact that I've said you'll only use of ---you look at things on how --what affect it going to have on the service.

	"How's it going to affect the service, how's it going to affect the staff? And then we make a decision irrespective of whether I'm here or whether ---but that is what you base your things on and that's .....uhm so ja xxxxx I: uh but from the
HOD5:	we're in a state of flux
I:	u hm I'm just trying to get some clarity in this discussion because both HOD7 and and HOD5.... P1 and P2 Where do I get P2... !! HOD9 and HOD7 has been, have been telling me what they have been doing well and I understand that you are in a situation where you have, I almost w'like to call them 'novices to management'
HOD5:	mm
I:	although they might be experienced nurses, uhm but in that you said that the one works on night duty and you know she does or he does well. So what do they do well?
HOD5:	They always as I say, I suppose maybe it's moorre ----it's easier to see because they *one operator at night*, uhm whereas on day duty, you are working with other people as well. It's, it's the planning, the organizing uhm it's even ---ok I talking more the one than the other because the one is 60 years old, xxxx but also organising. But let me finish with the one, its organising well uhm coming up with new ideas even on night duty which uhm benefits the functioning of this service you know..... uhm the other one remember -I'm running out of words now but he dwells on the right and wrongness of the staff behaviour and so we sit with a lot of um disciplinary issues and so on. But the focus is on a good service and getting it done. Uhm so as I say it's less obviously during the day because there's so many different activities uhm and there's uhm no "everyone is doing a little bit of everything" so you can't really as I say I mean "I don't ----my concern is the lack of initiative of the two people on day duty and I don't know if it's because of lack of will, if it's being unaware or if there's no time! For uhm for instance if I left the SPMS planning of the process
HOD9:	xxx *[indistinct]*
HOD5:	you know, uhm nobody's shown yet the willingness say *"I will take the lead in this also"*. So it's still very much for me, they are still very much in a learning curve. The day to day things like seeing that the staffing is there, and reallocating and so on uhm that is fine, but the seeing a bit further and looking further uh strategically, uhm I think people have a long way to go
I:	***"HOD9 and HOD7, do you... uhm can you identify with these issues?"***
HOD7:	The issues that HOD5 has?
I:	yes
HOD7:	Ja a Uh I would say wh... one manager, the one is more uhm she will she will she will take responsibility; if I ask them uhm "This is what I want to do", she will always say *"I will do it"* where the other one will ..... if it's not --if he's not interested in that, he won't bother to do that. But then he has other, u uh u strengths that he will ---for instance we have –we are busy now organising the the the International Nurses Day. And he is busy organising everything, he even organize me. So uhm he will take over -he will he will, he w loves it so he will organize it, whereas to the other one will then -----in this case uh organizing an event, she will do what she is being told to do uhm because she's not a very uhm u uhm uhm
I:	xxxxxx *[indistinct]*
P:	yes, she's if she wants to do what is right and things must be done this way 'Tell me what to do and I will do it' uhm where where where the other stuff –with the Clinical stuff –if I tell her, if I ask her -with the SPMSs, she went on leave, everything is being done. I I didn't have to ask anything. She gave all the stuff to me and say *"it's done"*, and uh whereas the other one is still busy but ok, we had a deadline Uhm ja there there is some stuff that they don't do well but uhmm ja I can't complain
I:	Thank you. That's great to hear. Anything that you want to add
HOD9:	Uhm ja, I've got 2 Assistant Managers on night duty so they'll take full responsibility uhm and they both were sort-of fairly new to Management. Uhm but I thi ---they took on that responsibility quite well. Uhm and whether they would performance the same way on Day Duty.....? Because on day duty it's different, on Day Duty there's many other things that needs to be seen to. Uhm I not too sure.....
HOD7:	they would do the same stuff?
HOD9:	Ja I'm I'm not sure, because they very Clinical
I:	okay
HOD7:	yes
HOD9:	.... and both of them uh like the one person, if the second theatre needs to be opened on night duty, she will go and scrub
HODu:	m
I:	okay
HOD9:	so they will get their hands dirty
HODu:	mm
HOD9:	uhm whereas on day duty, uhm I don't think that kind of opportunity will be there for them
HOD7:	On the other hand u one of my Night Night Assistant Managers told me if she must come do Day Duty, she will only last till 10 o'clock and then she will leave the hospital because what's going on on DAY she she won't handle. And I believe...
HOD9:	*[spontaneously interjecting]* Ja they need -----I don't think they like all the responsibility and all the activities that they have to do...
HOD7:	yes
HOD9:	....on day duty
HOD7:	But give her the hospital at night and she will run it with with no phoning you whatsoever She will take all the responsibility that ....., responsibilities at Night but put her in in on Day Duty, as she says *"oh no at 10, she'd chase me away. I won't handle it, I can't handle this"*. So we never switch them also. We never switch them to do ---a u um we in in in my my institution, they they -we don't switch them –like the Assistant Manager do Night Duty and a Night staff to Day Duty. What we do, do is that the Operational Managers uh at Day Duty -they will stand in for them -for the Night Assistant Managers if they aren't there. I don't know what you doing uhm ....!
UNDERSTANDING OF KEY PERFORMANCE AREAS	
I:	And uhm that brought me now to the last question that that I have for you today and I want to ask you ***"What is your understanding of the Key Performance Areas*** *[of the Assistant Managers?"*
HOD7:	*[laughing]* uhm mm
HOD5:	It's the core functions of your
HOD9:	ja
HOD5:	staff
HOD9:	Your KPAs are those things that says that you need to ensure *[emphasized]* that you deliver and then off-course you got your objectives and your other things that will assist you to get to deliver on your KPAs
HOD7:	that is what you, what you are uhm expected from them to do –uhm the key performance areas is the, is what they, what what you are applied *[emphasized]* for and and that it lead to your job -what you are
HOD9:	*[interjects loudly]* accountable for

HOD7: for, and from those you get your activities and your objectives how to get to your key performance areas uhm ja

I: Would HOD5 like to come in here? *[said extremely softly]*

HOD5 : Jaaha, just that I mean that is as I say, it's the core functions and what you are expect... what what you know -the outputs that you are expected to to produce. Uhm but off-course then you also have to xxxxx xxxxx *[indistinct]*, uh you have to see whether it is possible for the person to perform or to achieve those

HOD9 & 7: m mm uh *[consenting]*

HOD5: uh performance areas based on circumstances, what resources you give them, uhm can they then go out and -------I'm talking about you mentoring them, assistance and so-on

I: that brings us to the end of the questions that I have for you. Is there anything else that you think uh you would like that we do ---that still needs to be added to this conversation?

HOD7: it's a it's regarding the Assistant Managers?

I: yes, the Assistant Managers and the performance of Assistant Managers
[there is a short period of silence and/ or thinking]

HOD9: You mustn't let them think so hard this time of the day *[said in jest]*
[all laughing]

HOD7: You know what I, I think with --I can't do without Assistant....

HOD9: no *[confirming what fellow participant is saying]*

HOD7: Managers. Me as Manager as Nursing Manager, I can't do without .....

HODu: um

HOD7: Assistant Managers. They are a very vital link between the Operational and the... and the Management Team

HODu: m

HOD7: uhm ofter, over the past few years –two years, say a year and a half, our Management Team changes, and what happened previously with my previous uh uh u supervisor *[i.e. hospital previous CEO]*, she um empowered the Assistant Managers so much that um whenever I go to a meeting, um especially in the in the hospital, if there's a meeting a Top Management meeting, they will form part of Top Management. Now at the moment we have a new aaa Head of, Head of Establishment *[a new CEO]* and she only wants me there in the meetings so that is a is a link *[linkage/ connection]* that I must I must I must ensure that everything that I uhm learnt or get information from in the management meeting, the top management meeting or the exco or whatever they will call it, I must give through to the to the to the Assistant Managers, because if I, I, if I if I don't do that, they are going to lose, and that is that is that is a mind-change that I can't get use to it. Um I was always uu ---one of them will always tell me *"You know what a few years ago if someone stop me in the mall ask me what is happening with the hospital, um what are you planning for the hospital, I could have I could have give them information, but at the moment I real-don't know".*

I: m

HOD7: *"What I hear is what you tell me or what we read in the in the in the minutes"*. So that is --I think they they should be more uhm uhm be part of....

HOD9: *[in support ...]* be part of exco

HOD7: of exco yes and not sided *[meaning excluded]*. At the moment at our at our institution establishment, the the Head of Clinical Units ---they *[singing tone]*, they in the Exco but not the Assistant Managers and I think that is one of the things that I, I will take back and talk about that.
The the people at Night Duty, I know I can't expect from them to come in for a meeting on Day Duty but I think but the two Managers at Day Duty *[i.e. the Day Assistant Nurse Managers]*, they are my identities and why do they *[CEO and top management]* make difference *[meaning that a distinction is made in this regard marginalising the Assistant Nurse Managers]* between the doctors and the nurses gain once again, once again? That's my closing argument *[set the others off laughing]*

I: Anything else you would like to add in closing?

HOD9: I I think it's a question that have been asked before *[said slowly and seriously]* whether there's a need for for for Assistant Managers... that question has come up

HOD7 & HOD5: *[both acknowledges this statement with affirmed m m m's]*

HOD5: *[there is still some utterances from HOD9 heard in the background but HOD5 comes into the discussion here audible and assertive]* yea, you know with FBUs, the FBUs implementation,

HOD7: ....in psychiatrist *[probably meaning in the psychiatric service]*

HOD9: yes...is there a need for your Assistant Managers? Definitely there's a need for Assistant Managers because you need to have that interface between the Head of Nursing and the Operational Managers. If you don't have that and they play that vital role uh to oversee the Operational uh

HODu: m

HOD9: Operational Managers and the Clinical Services operations

HODu: mh

HOD9: ...and they s, they're the link between the Head of Nursing and the Nursing Service.

HOD5: Ja, we've also changed now from them not *[slightly emphasized]* being needed in the FBU's structure ---we *[Nursing Management and FBU Management]* now in partnerships and there's no talk about that inequality *[equal partners]*, and "you will report to me" *[the likely expectation of the FBU Manager from the Assistant Nurse Manager]*, there are partnerships between Nursing and....

HOD9: yes.....yes *[instantaneous assertive reactionary response]*

HOD5: FBU –who manages that....

HOD9: Now with us the the Assistant Managers is for the two FBUs, Clinical FBUs; they're the Deputy Chair persons of the two Clinical FBUs.

I: Thank you uhm I think we can conclude this session. Thank you so much for participating and I'm sure if there's anything that you- that you think later you need to add, you can contact R

HODu: mm

I: I just going to call her in and you can have a discussion thank you

HODs: thank you

……

Excerpt from Individual Interview no. 9:

UNDERSTANDING OF YOUR KEY PERFORMANCE AREAS:

R: To start off with, I want to ask you ***"What was your understanding….. it's it's just like a prelude to this or an introduction to the actual 'Discovery', 'Dreaming', 'Designing' and 'Delivery' part***

P9D: m

R: ***...What is your understanding…… as an Assistant Manager, what is your understanding of your Key Performance Areas?"***

P9D: Okay. My understanding of my Key Performance Areas...

R: ....and sorry *[interjecting]* could I just say that I am not evaluating you or your is SPMS..

R & P9D: *[both are enthusiastically agreeing]*

P9D: Ja, no no no. I I'm very aware of this...

R: right *[no judgment intended]*

P9D: I think R, uhm my understanding of my key performance areas uhm is *[emphasized]* to assist and to guide the Operational Managers in all their *[emphasized]* key performance areas, which is very closely linked at the moment according to my job description, to theirs. You know there's not a definite demarcation, it's basically a difference in the weight and this is why at the moment we are critically revisiting the job descriptions of all of our categories of staff. I worked with Mr. C9a on the on the JD of the Nursing Assistant just as an example, and we finished that in no time because we called in one or two of the other Nursing Assistants that's been very experienced, that's been here for very long time since that is finished off. Now at this meeting *[the participant's Nurse Managers meeting with her/their Head of Nursing at the hospital where the participant works/ the hospital where the interview was taking place]* Mrs. HOD9 said to us, we still haven't completed the JD of the of the Operational Manager and the ---there is a guideline, but it's not finalized. So my Key Performance Areas is as you said *[the researcher had mentioned at the introduction .....]* to the all those things, but for me it's always been the support and the guidance *[meaning to the Operational Managers and staff]* because if we look just as an example at the National Core Standards, my outputs are their [i.e. the Operational Managers] objectives, like Mrs. HOD9's outputs are my objectives.

R: m

P9D: We need to streamline

R: right right *[no judgement intended]*

P9D: in order to achieve the common goal.

R: right

P9D: So uhm if if if their first Key Performance Area is to provide holistic specialised nursing care then I need to be part of that and it's for the past year I've been chairing our work uhm Male Acute Services Admin Meeting on a Friday morning, which is very helpful in keeping my tasks to -in those areas where we need to get more multidisciplinary input.

R: right, that's right

P9D: I can actually asked because I've got all the role-players together in the one room, so that to me is and especially so with our Operational Managers. Look a lot of them has been working in the past as Professional Nurses on the wards.

R: right

P9D: And they still need a lot of guidance especially when it comes your KPA *[Key Performance Area]* two. Your your uh effective utilization of resources and I –here specifically I'm referring to the management of the human resources, because a lot of them are still struggling, especially when it comes your disciplinary action to be taken.

R: right

P9D: 'yes I know it should be done

R: ya

P9D: but -- and I always avail myself. I said "you know I would really like you guys to do it up to your level and then refer and not wait for me to say what are you doing

R: right

P9D: about this?"

R: right

P9D: so I I think there's still a lot to be -of assistance to be given in that regard. I'm not too worried about the rest. Your *[meaning the Assistant Nurse Manager]* KPA three ---I've got a very definite plan that I work accordingly. I say to the staff, you know it's a simple ---your KPA is as simple as ensuring that all the developmental needs of each and every staff member passing through your unit, which means it's not written in stone ---so all you need to do is to make sure that you take the JD of the new staff member coming into your ward and add *[emphasized]* it to your existing individual skills development plan for your unit, which would be evaluated at the end of April on the developmental needs of your staff as per their SPMS document.

R: mm

P9D: I l, l say to the staff "we must stop looking for in-service training out there! It doesn't happen at Khromm Rhee *[once a central formal training site]*. We are a speciality and on these premises a lot of in-service training opportunities"

R: rm

P9D: avail *[emphasized]* themselves

R: right right

P9D: in the form of ward rounds..

R: right

P9D: in the form of the academic lectures. It's right on the premises and I've made a plan for each and every staff member from the OPM *[referring to the Operational Manager, also known as the Unit Manager]* down to the Nursing Assistant on the ward that I would like all of them to attend at least two and I think this is very liberal -because of the staff shortage, at attend at least two uhm ward rounds because we've got an academic ward round that is done by uh Dr. 9 on a Wednesday afternoon, and I will go down to the wards and I would say "please make sure, pl" –I'd say to the OPMs in the morning handover on a Wednesday, "allocate your staff *[meaning allocate some of them to attend the training/ development]* and you make sure that you as the OPM set –lead by example"

R: right right

P9D: two ward rounds per quarter *[to be attended by the OPM as set by the ANM participant]*, two academic lectures per quarter; you can do xx at least like I do

R: ja

P9D: as if I've, I think I've had enough of Depression for this quarter, then I won't do the d ... but just the other day we had a very interesting one on the epidemiology of suicide

R: oh!

P9D: and I made sure that the staff know about it.

... two week-ends get in-service training sessions, the M & M morbidity and mortality meeting I think is a perfect learning opportunity for everybody, and on your *[i.e. the Assistant Nurse Manager's]* KPA four, I I always say to them, "Don't look at support of Nursing Services as --you must come and work when we ask you. No no no no. That is when I need an investigation to be done like into an adverse incident, and I say to you, or a complaint of a patient, I say to you, ok this is your copy, do the investigation, I'll come

in as soon as you let me know; then I'll come in and I might either interview the patient with the staff member --the OPM, or you know whatever the investigation entails in order to do my [emphasized] own report,

R: m

P9D: but I need [emphasized] that the report because we've only got five to seven days to do it

R: right

P9D: That is your support of Nursing Services is how you support me.

R: rite

P9D: it's it's all those little things, you know.

R: ja

P9D: All those little or reports that it might inquire uhm require [corrected herself]; all the things that I ask to be carried out all the time and then off-course KPA five -it's your conduct and I expect and I must say with a lotta pride that when it comes to the professional conduct of my OPMs, in the Male Acute Nursing Services, it is very good. They really lead by example. So, uhm just to come back to the actual question of ..uhm.....

R: ***"what you understand ....."***

P9D: Ja, what do you understand ---ja yes
It is it is all those things

R: right

P9D: but uhm un I actually think if I look at that, if I look at it properly -- that is basically what we all need to work towards, but it seems R, there needs to be a very specific demarcation according to the amount of time that I [emphasized] spend on each KPA and I [emphasized] thought that if I spend this amount of time in the Male Acute section on a specific KP ---that is how it should be but Mrs HOD said no no no no, we should all have like a ----- I mean I can understand where she comes ---- we should all have uniformity in in that regard

R: right

P9D: because in last year I still did like the whole of this very busy Male Acute System and you know how busy it is at all the hospitals --- the Male Acute because

R: ja

P9D: of our drug problems in the Western Cape but I also did uh uhm the Skills Development of the staff

R: right

P9D: and all the student placements I did. Now because of that portfolio, I had at the time, I thought and I explained that to her like that and a lot of your time is divided between the students and also in KPA 1 example for that.
In KPA three, the same that I would spend a lot of time and –on the ensuring that the students attend all these academic activities

R: okay

P9D: on the premises

R: Can you see?

R: yes [merely acknowledging]

P9D: now it was taken away [meaning taken away from her] because of the fact that as you know, we have somebody on a contract basis who hav is now leaving at the end of this month and they [the planners/ management assumedly] don't know how it's going to be until such time that we get another person, but I I think if if I look at it properly, I think it is so that it doesn't matter how high you go in your uhm category,
a component of nursing care that you will have to render.

R: right

P9D: There'll always be a component of the utilization of resources. There'll always be the component under your KPA 3 --- the provision and ensuring that the staff are educated, your support of your Head of Nursing and your conduct

R: okay

P9D: but it is the –I think I think what is vitally important is that we, as soon as possible find those demarcations

R: right

P9D: to actually say what so...
so there's not that confusion between you and the OPM

R: ja

P9D: because I know there's a lot of uhm stress in that regard where ----because it's so closely linked.

R: ja ja

P9D: They don't know where does my role stop and theirs start!

R: right

P9D: and

R: right

P9D: Can you see what I'm saying?

R: No, thank you for that [very appreciative]. It sounds as if you have or uh the Nursing Management at H9 based on what you have said –it sounds as if you's have taken the generic job description of the… of the OSD

P9D: um [confirmatory]

R: and uhm specified it or unpacked it or

P9D: um [again confirmatory]

R: or made it with more specifics

P9D: Ya

R: specific

P9D: ja

R: All right, but that is clear. Thank you very much.

……

Excerpt from Individual Interview no. 16:

Introduction …

R: okay, so I'm going to start and ask you, ***"What of your work performance or your work performance experience have you contributed to that worked really well or what was your best work performance experience?"*** It could be more than one thing you know; it could be a a few things....; it could be a series, it could be one incident.... but it's, it's related.....you could relate it to your....what you required to do! [Laughing] ...your required performance, your Key Performance Areas

P16D: yeah, you see, part of the key performance areas is 'mos' now your strategic planning and things like that so that you must have a plan in place for your unit to to to manage your unit as a whole. Uhm, so, so part of that, uhm to make sure that you reach your goals in the

	end, and a vision it were you going to work through, ag work towards [gets stuck with English and reverts to Afrikaans/ she is reassured by the researcher. Participants engagement creates a pleasant ambience.
	*At the old end of the day that you reach your goals and things; you must know what your goals are, toward what you are working and toward what you are actually striving, do you understand. So I mean as part of my piece of work that I do to get on to those things, because the key performance is 'mos' now:
	Quality care and and and uhm aaa.....
	Clinical Governance and and and what is the other.....
	Corporate Governance
R:	ummm m m
P16D:	and all that types of … and Service Delivery and all that different headings then and I mean thereunder with our job description there is:
	'People Management' and your 'druk fine' 'Financial Management' and you're your your 'Nursing Task' that has always been part thereof, and Service Delivery at the old end of the day, so I mean to look that all those goals of Health Care 2010, and the visions and the CSP [she is referring to the comprehensive service plan of the province] you must have a whole strategic plan at the old end of the day and have planning sessions with your subordinates and with your personnel and everything to see that this is achieved at the end of the day. But I mean what is important that's part of this is to assess whether your personnel is competent to do those things. In other words, that they in the old end knows what their shortcomings are, and what the gaps are and what you still must ensure that they know what is expected of them so that they are always 'informed' I almost want to say. I mean 'share' the information, 'share' the goals and the things with them so that they can know why they're actually here [referring to being at work] and why they're actually doing the work in the old end of the day and what you [meaning] would dearly want to achieve…….
	….and then I mean and to 'assess' in terms of each one, to 'assess' each one, and to draw up their 'development plans' with them, 'assess' what they know and what you recognize the shortcomings are, and then continuously to offer more 'training' or things like that to achieve your goals in the old end. So this is my feeling; I'm unsure if I am actually speaking the correct things [referring to having answered the question/s], or whether there are more things that you want me to say uhm
R:	okay, so P16D*
P16D:	im?
R:	Assistant Manager Nursing; *This is what is needed. Are you saying this is what you do well as you have given a good whole picture of the of the 'draad' ne,* the thread that's.....ja
P16D:	[answers quickly almost interjecting] I I think so from the whole thing, [again, in the context of the questioning referring to the entire performance] and at the old end of the day, what is important for me I mean – now I've got to support them because you know it is an eternal processes 'mos' now
	...for instance say you've now given all your input into the assets that you need, for our minor works or things that you would like to alter in the wards or how we want to apply something in the ward.....but it's just 'mos' long processes -do you understand? So I myself, I want to venture to say, I want to make sure that I am abreast of things that is happening in the fields of others. I want to venture to say of Supply Chain and how it works with appointments [i.e. recruitment and selection processes]-okay, I do these things in any case, but I want to ensure that I keep abreast of things so that I can support them at the old end of the day because you know, they become frustrated because they do not see the reaching of the goals because they see it take so long to see the result at the old end of the day. So if I know how to do it, I am then able to let's say 'drive' certain processes in order to get to achieve the end result faster y'know because I then know what happens at Supply Chain and Stores everything that is part thereof and how to initiate a request and to know how the 'financial prescripts' and things work and the people lower down don't necessarily always understand this, so if I now
	---and that's why I try to keep them informed of all the workings so that they don't lose faith. The things ….
	… you will get the things [i.e. the requested items] in the old end but it will take a little while longer to get the requested items and to drive the process because I mean
	[I mean was frequently uttered as a figure of speech]
	if one also doesn't drive a process then nothing comes from it in the old end of the day; you know I am in any event a slave driver [she laughs again squeakily though audible]
R:	It's your best [researcher also laughs] characteristic
P16D:	It must be my best, it is probably my best …. I not going to say....it's probably a bad characteristic [still laughing almost hysterically] for certain …but on the other hand I must say to you
R:	ja
P16D:	I almost want to say that I have such perseverance; I will try to at least attempt to achieve something at the old end of the day and and and
R:	ja
P16D:	to keep the people informed about what must happen so I mean you will AAALLLWAYS [emphasized this] just find me here; I almost want say to go and sit and work and to see, or phone or to follow up or however also that I can at least get results ….
	Now I say I am probably not such a people's person; that I'm telling you honestly. I am not .....
	I will not be asking you if you are married and how many children you have and how is it going at home, but then when you volunteer this information, on that day I will inquire more about your situation, but I will not be going to sit with everyone's personal things otherwise I will not have the time to carry out my management part if I must focus too much on the emotions, families etc.
	It is very important because I mean one can immediately suspect if someone is absent or he has a pattern or whatever else he presents with, that there is something else amiss because someone who never comes late, someone who never takes off sick and they suddenly present with a pattern, then you know it's something wrong at home, understand! There, I mean I will go in on that part. But I will not, I will not uhm get involved in personal issues and that type of things. But I mean, I will listen and I will help where I can help, but I mean I am not and I am saying to you honestly I mean, I do not want to do that type of thing too much because when you start those issues, then you [referring to the manager] are actually never get relieved thereof I mean.
	And then they [i.e. the staff who are being managed by this ANM] say to you, uhm that you 'mos' know, you were aware that my husband was sick or you were aware that it is this you know ... What happens at the old end of the day --you are busy doing those type of things and then someone doesn't come on duty and then they say to you that you 'mos' know that I have a problem but I mean they are still expected to phone that they're not going to present themselves on duty 'today' .....I don't know.... when they are experiencing problems
	and then, then it starts I almost want to say, then they* overstep their boundaries *by thinking that because you are now aware of what is happening in the personal lives, then you should 'mos' have an understanding of why I didn't come to work, so in the old end of the day you [she is refereeing to the worker] still have a work contract, you, you must still phone your workplace, you still have to work your 40 hours [i.e. per week], you still have to comply to all the other principles [she is referring to work related principles] at the old

	end of the day so I don't know but as I say slave driving continues and work 'heads-up' and look at what the things are that needs to be achieved! And as I say with regard to my wards –after everything I that's why my wards have for two consecutive years won the accreditation, but it's probably as I say ..... it might be that everyone is not happy with me receiving that credit *[still cooing]* I do have high standards and things, but I mean you *[meaning she]* get the results *[says this loudly]* at the old end of the day
R:	ja ja ja so uhm if I must sum it up, you are very uhm* there's a lot of order, you …
P16D:	"I am very" 'hands-on' you know, I have the Female Wards and then I have the Outpatient Department with the AC Team, the Outright, uhm the Outreach Team now actually, and then as I said the Day Care Centre, the patients who come in are still ....., so it is so a mixture of a variety of things *[Here she is referring to the types of patients, relating to the various natures of the illnesses]* at the old end

ANNEXURE U: GROUP DISCUSSION AND INDIVIDUAL INTERVIEW FIELD NOTES EXCERPTS

Field notes excerpt from focus group discussion 1:

Welcome

[Interviewer makes his full name known to the scribe and the 3 participants who were present] [named the researcher] [the interviewer introduces the scribe by name] [participant must have asked if she could make notes based on the interviewer's response as indicated hereafter] [responded very reassuringly]

DISCOVERY:

[After 1st question there is a short period of silence] [they all laugh probably out of relief that the silence that had been broken] [the participant Head of Nursing sounds as if she was having real difficulty in describing her particular Assistant Nurse Manager aptly in a certain regard] [some group laughter is heard]

the one is Specialised and the other one is General [referring to the national OSD official professional nurse post classifications where a higher level work performance is expected/ required from the former].

they are in their wards every day [emphasizes this somewhat]

I am also very privileged to have really people that know what is going on in the hospital, and also all 4 of them [participants laughs] [interviewer now directs attention to third participant as she hadn't spoken up to that point yet]

there's been major upheaval and major [slightly emphasized] [acknowledged by peer]

because of their expertise [likely referring to expertise in years and not necessarily in skills].

HODu: mm [noting with understanding what is being referred to]

and then they moved into the positions [referring to the OSD positions]?

irrespective of the reason you were doing [anxious loud single mutter of laughter] HOD5: m [assertively confirming]

The right place at the right time, [All speaking at the same time and laughing including the interviewer] ja

HODu: mmm [sympathetically understood by peers]

Uhm the night ones [referring to the Assistant Nurse Managers on night duty and laughing with peers at this point] they also come from outside; they definitely [with affirmation], uhm

HOD5: Yes [all laughing out loud seemingly in acknowledgement of the recollection of a recognised significant date!] ja even ..... wrong reasons [heard in the background and the laughing continues whilst the simultaneous uttering's briefly continued]

'Tell me what to do and I will do it' [would be a reflection of this ANM stance]

HOD7: [completing HOD9's sentence ...] they would do the same stuff?

HOD9: [spontaneously interjecting] Ja they need -----I don't think they like all the responsibility

HOD7: But give her [speaking in general it appears about these Assistant Nurse Managers on the night shift/ doing night duty] the hospital at night and she will run it with with no phoning you whatsoever [HOD9 says mm m in agreement, softly in the background]. She will take all the responsibility

……

……..

Field notes excerpt from individual interview no. 9:

INTRODUCTORY DIALOG

A generic introduction was done that included thanking the participant for consenting to participate and for participation in the prospective recorded interview. The purpose of the interview was explained as well as the anticipated length of time the interview would take. The questioning phases of the interview and the incorporation of Appreciative Inquiry into the prospective interview were also explained. This introduction lasted 5 minutes and 9 seconds.

…

but it seems R (researchers name) [This participant addressed the researcher personally and directly on a number of times like this, speaking spontaneously from the heart it appeared]

amount of time that I [emphasized] spend on each KPA and I [emphasized]

P9D: Can you see what I'm saying? R: No, thank you for that [very appreciative].

P9D: um [confirmatory]

R: ***"What ....uhm tell me about a work experience and or experiences that has worked really very well?"*** P9D: [responds almost immediately] ok, are you ... can I ask how far can I go back?

……

…….

Field notes excerpt from individual interview no. 16:

….

I mean we are flooded with our admin tasks and stuff "goetertjies" [colloquialism for 'stuff'] in the telephone rings incessantly

but that is now a bad characteristic but I cannot say no [interpreted that she is not assertive enough to decline]

say .....so that they don't see us as you up there and us down here because that is I almost want to venture to say that that is a big thing [meaning that it is regarded as something significant].....

the mothers who has had a breakdown [psychologically hence the nature of the service being rendered which is psychiatric]

you manage to keep those out of the hospital, but more new ones are admitted so it doesn't really help [and she laughs almost hysterically] -

ANNEXURE V: INDEPENDENT CODER CERTIFICATE

Qualitative Data Analysis

Phd in Nursing Management

B. Swartz

THIS IS TO CERTIFY THAT

Dr. Annie Temane has co-coded the following qualitative data:

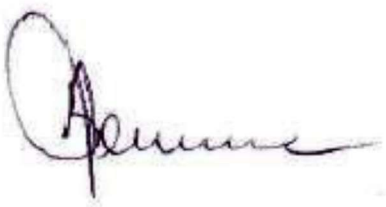
21 Individual Qualitative Interviews

For the study:

A CONTEMPORARY WORK PERFORMANCE MANAGEMENT FRAMEWORK FOR ASSISTANT MANAGERS IN THE PROVINCIAL HEALTH CARE SETTING

I declare that the candidate and I have reached consensus on the major themes, categories and codes reflected by the data during a consensus discussion. I further declare that adequate data saturation was achieved as evidenced by repeating themes.

Annie Temane



ANNEXURE W: CODER PLEDGE OF CONFIDENTIALITY

CONFIDENTIALITY AGREEMENT

CONFIDENTIALITY AGREEMENT WITH REGARDS TO INDEPENDENT CODING OF DATA FOR THE STUDY

A CONTEMPORARY WORK PERFORMANCE MANAGEMENT FRAMEWORK FOR ASSISTANT MANAGERS IN THE PROVINCIAL HEALTH CARE SETTING

I understand that identities of all participants are personal and confidential and may not be revealed to any person.

I understand that the research design and method of this study are intellectual property of the researcher(s).

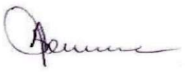
I understand that all material received for coding is personal and confidential.

I understand that all material received will be deleted on completion consensus discussion with researcher(s).

I undertake herewith to treat the following information with utmost professional confidentiality:

a) The name of each participant wherein a name is indicated
b) Material received
c) Content of the information made known to me of each person
d) Content of the research design and method of this study

Independent Coder Name: Dr Annie Temane

Signature: 

Date: 09 August 2014

Researcher's name: .....

Researcher's signature: .....

Date: .....

ANNEXURE X: CONCLUDING STATEMENTS

ANNEXURE X			
KPA	Theme	Category	Concluding statements
4.4 KPA 1: STRATEGIC PLANNING, AND	4.4.1 Understanding the KPA strategic planning, and QA and nursing care	4.4.1.1 (a) Strategic planning in relation to the KPA strategic planning, and QA and nursing care	• The ANM should serve on the strategic management teams in the organisation. • Clear overall objectives of the nursing service should be known by the ANM for effective implementation. • Every ANM should have a skills development plan that clearly outlines her strategic direction of professional and personal growth/ development. • The ANM should be competent and available to stand in for seniors, and to guide members in the multi-disciplinary team in strategic planning, processes and other matters. • The ANM should have a clear vision and mission of the organisation to direct work performance. • The ANM should know and adhere to the AOP.
		4.4.1.2 (b) QA and nursing care in relation to the KPA strategic planning, and QA and nursing care	• Quality assured nursing care should include providing for the needs of the patient and family, address complaints and problems and support quality care. • The ANM should be a co-partner and take ownership for QNC. • The ANM should be instrumental in ensuring continued QA. • The assurance of quality care must be continually assessed at night. • The night ANM plays a positive role when there is staffing shortages by drawing on their passion and patient-centeredness approach (including promotion of patient satisfaction) they (ANM) have for nursing care, and gives the staff necessary information when coverage is needed for understanding and ease.
		4.4.1.3 (c) Audits in relation to the KPA strategic planning, and QA and nursing care	• Audits of the nursing process are accepted to be an inherent part of ANM performance to measuring patient care. The ANM should ensure that audits are conducted. • Structured auditing should be part of the ANMs daily visit to wards. • Nursing audits must include having to measuring safety, infection control (hygiene and cleanliness) and waste management, staffing expertise/ knowledge and staffing norms. • The ANM draws up an improvement plan following the audit being conducted. • The ANM is to internalise the idea and practice the notion that good nursing documentation would improve quality of care when measured using audits. • The performance of the ANM is to be directed by the National Core Standards for Health Establishments in South Africa.
	4.4.2 Best work performance experience in the KPA strategic planning for quality care, QA and nursing care	4.4.2.1 (a) Passion about nursing caring in relation to strategic planning, and quality assurance and nursing care	• Care and commitment should be pervasive in the approach of an ANM. • There should be a meaningful focus on staff and training. • Respect should be an encompassing value built into the performance of an ANM. • An ANM should have the ability to describe the positive emotion/ s relating to managing. • The back-to-basics nursing care principle should be facilitated by the ANM. • A strong focus of ANM performance should be on infection prevention. • In the psychiatric field, rehabilitation in psychiatric nursing should be regarded as an important KPA. • An ANM should enhance performance by 'own-orientation', energy and zest. • An ANM must identify aspects of performance that leads to job fulfillment. • The ANM should adopt a nursing caring approach and to be devoid of the medical approach.

			• ANM love for caring for the mentally ill that was instilled by the leaders
		4.4.2.2 (b) Leadership in relation to strategic planning, and quality assurance and nursing care	• Nurse manager leaders manage staff well including balancing the amount of control exerted and the amount of latitude given. • In fulfilling a leadership role, nurse managers must be able to lead and inspire others. They ought to: -have a good grasp of the finances/ accounting -have fervour, openness, flexibility, talent for reflection, prioritising, transformation and ability to be focused, -have the ability to interact and converse with people • The ANM must be able to take up the acting role of the HON when the latter is away. • ANMs lead by their ability to take responsibility that is advocated by HONs. • Others should feel the aura of the ANM by the manner/ conduct/ demeanour portrayed, when they enter the room *"here is somebody whose whole persona demands that respect…"* (FG2 P1). • ANMs believe in transformational leadership: i.e. using talent to influence attitudes, transcend individual needs and affects productivity positively in the broader interest of the discipline or hospital, use their move beyond the management business to motivate followers to exceed standard expected of them. • The health-care environment should be much focused on leadership succession
	4.4.3 Best possible work performance opportunities in the KPA strategic planning for quality care, QA and nursing care	4.4.3.1 Communication between ONMs and ANMs in relation to strategic planning, and quality assurance and nursing care	• ANMs bestowed immense priority on communication with the ONMs as it also promoted participatory management. • Feedback is required to be received by the ANMs from the wards. • ANMs want more free flowing communication between day and night shifts and between nursing managers. One sector to have a meeting/s with the other. • ANMs believed that mistakes and adverse events could improve if communication is improves. • Nurse managers are to try to understand different cultures within the nurse manager grouping to improve communication.
	4.4.4 Initiatives for the future in the KPA strategic planning for quality care, QA and nursing care	4.4.4.1 The need to drive change in relation to strategic planning, and QA and nursing care	• The ANM has to drive change. • Having to manage change is an inevitable expectation in health-care. • Initiators of change processes are to see change process through to its end. • Change in health-care involves the ability to work with new resources, technology, practices and thinking processes, quality and HR practices that includes retention of staff. • Nursing staff who render service directly to the patients are also major change agents and hereby can affect quality of care. • The agent needs to have the ability to devise an improvement plan after an audit. • It's organising well coming up with new ideas even on night duty which benefits the functioning of this service • He would bring his own books and innovatively allowed for sort-after learning that in turn allowed the health-care setting to be seen as a learning organisation • ANM as the potential teaching resource.
	4.4.5 Commitment to deliver work performance in the KPA strategic planning, and QA and nursing care	4.4.5.1 Managing processes in relation to strategic planning, and QA and nursing care	In relation to HRs, quality of patient care and supply chain • They aspired to applying work performance administrative document handling processes soundly; implementing tracking of documents progression. • ANM to examine the industrial aspects of processes of the job, the SC process, the warehousing for efficiency losses and gains. • ANMs pledged work performance delivery in new work areas but require to be informed well in advance. • ANMs also indicate that they preferred predictability and order related to their work involvement. • Nursing documentation auditing to evaluate nursing care is upheld by ANMs for improved service

			delivery. • Supplies in hand were viewed as important for service delivery in the nursing management context. • The commitment to better work performance was to have an understanding of the logical flow of the supply chain process firstly as an orientation to what the required work performance was/ is and secondly to embark on the process meaningfully. Knowledge of the correct processes of vetting, condemning and replacing is needed in work performance. • Health-care has become obligated to rationalise and modernise its processes to reduce expenditure and improve its value which ANMs are to engage with.
		4.4.5.2 Communication between ANMs and Management in relation to strategic planning, and QA and nursing care	• ANMs yearned back to the time they played and still want to play a role at the executive management table believing that it would assist continuity in many aspects of nursing management.
		4.4.5.3 Communication between management and the broader community	• ANMs desired that management speak more directly to the broader staffing population. • ANMs as part of management ought to greet and engage with staff in their (staff) mother tongue.
4.5 KPA 2: HUMAN RESOURCES	4.5.1 Understanding the KPA human resources		• Human resource management: • The functions that the ANM is responsible in staffing are administration inclusive of ensuring safe staffing norms, staffing shortages, allocation of leave as per conditions of service, breaks (tea, meal) as per conditions of service, management of sick leave, absenteeism, disciplining, recruitment, appointments... • The ANM must be motivated, enthusiastic, trained. • ANM should expect staff to aspire to attain higher standards of performance once a standard has already been achieved. • ANM should build relationship with and get understanding of staff by giving them information when coverage is needed. • The ANMs attached special value to the management of HRs in that they ought to get to know the person as oppose to just managing them. • ANM acquires unique HR work performance experience due to unpredictability of its nature. Human resource development: • ANMs and HONs show a positive regard for and embraced staff development. • Supervisory engagement and discussion can be used as guidance and development of for ONMs. • ANMs should motivate nursing staff to achieve their goals in their career and assists with managerial development if so desired by the protégée. • Staff on night duty must be given and sent for training. Training must address shortcomings in line with work, prevent repeats of adverse incidents and prepare for what the future work force requires.
	4.5.2 Best work performance experience in the human resources	4.5.2.1 Building relationship in relation to human resources	• The ANM builds good interpersonal relationships with fellow and lower levels of staff and patients. • Building relationship should occur by means of consultation with staff and securing staff confidence/ self-esteem/ inspired in the workplace. • In building relations, the ANMs indicated their high regard for still maintaining professionalism at work. It also required them to be able to adapt their supervision and instil learning and growth. • The ANM characteristic of warmth builds relationship. • The effort a night ANM made to teach nurses before his shift had contributed enormously to a positive

			spirit and attitude to learning. • Building relationship requires positive and constructive ANM involvement. • The 'carving out a relationship' was perceived by a night ANM to enhance service delivery. • Building the relationship also requires trust. • Speaking the language of the staff aids building relationship of respect (witnessed by the researcher). • A night ANM believed that she could directly sway all those she supervised to be motivated and resultantly that all have a positive attitude • The ANM should take definitive steps to build relationship in order to improve the happiness and motivation of the nursing staff.
		4.5.2.2 Motivation in relation to human resources	• Motivating staff by acknowledging hard work is crucial when the work becomes critical. • The ANM should motivate staff by recognising them as people. • The ANM should motivate staff by allowing time off for training. • Supporting and motivating staff is attained by saying 'thank you'. • EAP practices aid ANM ability to motivate even when staffing challenges are experienced.
	4.5.3 Best possible work performance opportunities in the KPA human resources	4.5.3.1 Staff involvement in relation to human resources	• ANMs viewed ONM involvement as important for best work performance opportunities in which to flourish. • ANMs on the day shift to make a deliberate effort to involve the ANMs on the night shift. • Involvement of nursing staff in transversal events e.g. Madiba Days. • Involvement of night nursing staff in hospital events (the above). • Improvement in staff health can come about as a result of education to patients. • Involvement of ONMs and ANMs in higher levels of functions is viewed positively and highly recommended. • The involvement of the ANM and the quality manager have shown to work well and together had led to the involvement with other disciplines in the successfully completion of a project.
		4.5.3.2 The desire for enhanced interpersonal relationships and unity between shifts in relation to human resources	• ANM should embrace the work of night nurses instead of perpetuating the perception that night nurse sleep on duty and lose ward assets. • Night ANMs enhance night shift standing by doing random rounds. • Consistency in communication and the application of disciplinary measures from day and night ANMs is desired. • Nursing Management ought to take the steps to demonstrate support and value of night shift (inclusive of the ANM). • ANMs can contribute to a friendlier work environment that promotes interpersonal relationships between shifts.
	4.5.4 Initiatives for the future in the KPA human resources	4.5.4.1 Team work in relation to human resources	• Collegial relationship amongst each other committing to work together, described with pride and satisfaction. • Virtual safe space has been created for the staff to feel free to call on the ANMs. • ANMs will voluntarily help in a crisis. • ANM awareness of team work translated into an appreciation for the operational work being executed. • Team work was regarded as vital on the night shift. • The ANMs work well with the MDT and simultaneously manage to do their required nursing work. • The night ANM also a crucial member of the team because of the close working relationship to the Head of Institution and the specialists. • The night ANM made reference to her staff endearingly.

			• Even though nurses on the night shift were from different departments, a team spirit was nurtured and present, as they would work well together. • The HONs believed that the nurse managers and medical personnel had a collegial relationship. • The ANMs were proud of their positive team efforts and outcomes despite the night nursing staffing pressure, under the circumstances only a very few problems has led to disciplinary action. • A consolidated relationship established over time also existed between ANMs and HONs. They knew what each other were doing. • When someone new rotates onto the night shift, there would be an initial period of establishing ('checking each other out') the relationship from both sides.
	4.5.5 Commitment to deliver work performance in the KPA human resources	4.5.5.1 Increased managerial involvement and support, in relation to human resources	• ANM committed to pay more attention to visiting the ward. They should be given support, teaching and training by the HONs as they strive to fulfill being visible and getting to the wards. • An ANM who is involved in the workplace could foster workplace spirituality. • ANM to be assisted with time management to limit distractions in order to fulfill their strategic work performance and managerial involvement support role. • The ANM uses composure to contain and appease staff. • The ANMs want to cultivate a happy workforce and work environment by means of their managerial involvement and support. • A buddy system lends itself to mutual support and involvement where HONs, ANMs and ONMs can benefit.
		4.5.5.2 Adequate staffing resources/ need for enough staff in relation to human resources	• The ANMs cried out for scientific nursing ratios • The ANMs were confronted by the call for more nurses; the notion that the HR is the most valuable asset in the commitment to work performance. • Staffing levels are one of the most fundamental factors affecting the quality of nursing care, having a direct bearing on patient care. • The ANMs wanted more staff in the wards. • When ward staff is insufficient, a wave of 'stand-in's' commences upwards and is felt right up to ANM. • Relief staff are needed for leaves and when night shift nurses go on training. • Night ANMs also want doctors to be accessible for the night at IDS. • Night ANMs also want a social worker to be accessible at night. • Night ANMs want other staff to be available when there has been an incident at night for emotional support. • ANMs desired a teaching resource (human) in the ward.
4.6 KPA 3: THE BUSINESS UNIT and MANAGING FINANCES	4.6.1 Understanding the KPA the Business Unit and managing finances		• The ANM works in a live Business Unit model within the provincial hospitals. • The ANMs' role is important overall and within the FBU. • ANMs work according to both the nursing hierarchical structure within the health-care setting and the Business Unit chain of command where they make independent decisions. • The ANM takes on a financial governance role within the FBU and is required to manage an allocated budget well within the Business Unit. • The ANMs should receive further training in financial procedures in relation to the management of Business Units. • Nurse managers should apply critical evaluation to new management and financial systems and night managers must remain up to date with reference to FBU management.
	4.6.2 Best work performance	4.6.2.1 Staff well-being in relation to the Business Unit	Prevention of burnout:

	experience in the KPA the Business Unit and managing finances	and managing finances	• Nursing deals with critical events that leaves staff shocked and potentially even grief stricken. • ANMs should offered ongoing support to staff in the overfull wards with aggressive, violent and psychotic male patients housed on mattresses on the floor in psychiatric hospitals in the attempt to alleviate the stress caused by these work situations. • Success in managing staff well-being is related to the ANMs knowledge and experience in complex people (staff) management in health-care settings (within the province). • ANMs ensure that the stress that staff is experiencing is dismissed. • There is a link between staff well-being and nurse manager behaviour. • Employee Assistance/ nurse manager confidante/ nurse manager crisis-interventionist/ counsellor managerial supervision: • If staff are looked after, they then give their best. • Assisting staff with writing a report after a crisis was seen as supportive of staff well-being. • The ANMs who previously were EAP counsellors made an important positive impact on staff well-being because of the relationship they had built up with the staff and their accumulated experience in this field. The nursing management style is described as contemporary and people-orientated. General support of staff well-being: • Staff support was also the astute awareness of an ANM of the stress the staff was working under and taking the appropriate action by asking them what they perceived as support and acting on it. • The astute awareness included the fact that they spend many hours together working and they would need to have a restful sleep after the shift. • There was a will be the ANM to act in regard to the above irrespective of limited resources. • Chaplaincy support was seen as useful. • ANMs were passionate about their staff. Staff could speak to them directly if they experienced problems.
		4.6.2.2 Staff posts in relation to the Business Unit and managing finances	• ANMs act swiftly to refill a post once they have knowledge that the post will be vacated. • The HONs agreed that when all ONM posts are filled, that the ANM arm is strengthened and that efficiency for this cadre improves. ANMs can then focus on doing the work intended for this post. • All the administrative steps in the process of recruitment and selection are to be done in time and according to the required documentation prescript/ s. • When the required processes of recruitment and selection are indeed followed, it facilitates the orientation process of the prospective employee into a post which ensures effective Service Delivery. • ANMs who were translated at the time of the OSD might be less post orientated than those appointed subsequent to the OSD. • Clarity of job performance and post alignment occurs when the recruitment and selection process is embarked on correctly. • Selection must occur appropriately: *"... us as the manager, and you try to recruit people right ...*" (II P21). • It is believed that scientific nursing ratios are required. • Nursing is apprehensive about losing existing posts to other disciplines or departments. • The ANMs held a firm perception that more posts were required and that all the posts must be filled: They await the promise of more money for more much needed posts.
		4.6.2.3 Problem solving and conflict management skills in relation to the Business Unit	• ANMs would embark on improving situations in the hospital wards which was pre-emptively problem solving. • Participative management was practiced by the ANMs to problems needed to be solved ensuring that the

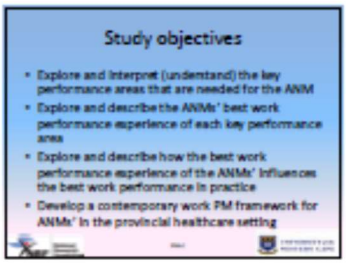
		and managing finances	answers come from the staff. • The ANM as sub-FBU Manager plays an important role in the FBUs in problem solving by having a monthly FBU management meeting with the entire team, including cleaners. • The night ANMs also plays an effective role in strategic and operational role in problem solving and conflict management as they managed the entire hospital. ANMs make decisions after hours to resolve mechanical problems that have cost implications. They manage emergency technical aspects at night particularly well. • Extreme professionalism is put into managing problems and conflict by the night ANMs when they are dealing with the irate public/ users. • The ANMs would try and resolve problems once it reached their levels and would as far as possible attempt to maintain the credibility of the health-care setting. • Night shift ANMs would start problem solving before physically coming on duty by calling in to ascertain what the potential staffing situation was for the night ahead and then already start putting steps in place in an attempt to avert a staffing shortfall. • Two ANMs experienced in EAP who previously were the in-house EAP practitioners at their respective hospitals is an HR asset. • Formal staff referral to ICAS aided problem solving and conflict management.
	4.6.3 Best possible work performance opportunities in the KPA the Business Unit and managing finances	4.6.3.1 Better/ increased resources in relation to the Business Unit and managing finances	• Night staff/ shift to have their own stock to realise best work performance opportunities. Lack of stock on the night shift is avoidable if they are left out stock, if they communicate what they need and the day ONM acts promptly. • The night staff demonstrates a sense of ownership regarding stock and hence performance by using the word "own". • ANMs have to be more astute with regard to finances than before. • Stringent adherence to financial prescripts is required when purchasing of resources occur.
	4.6.4 Initiatives for the future in the KPA the Business Unit and managing finances	4.6.4.1 Working together toward a better future/ better care in the KPA the Business Unit and managing finances	• ANMs committed to better work performance by working towards working together for one goal. The need to work well together where there is only two day ANMs was well recognised especially when working with their ONMs. • The ANMs recognised that even though the work situation demanded change in provincial health-care settings, they needed to strive to understand each other in order to work better together. • Working together for six months opposite each other within taking a day/ night off on the night shift was greatly applauded. The ANM related this stability to knowing what the expectation was (the predictability). • The night opposite partners at the busier general hospitals were found to work well together in particular. • Night ANMs also highlighted the 'working together' ethic they maintained as the night manager with their group of staff. • There was a realisation that working together called for sound communication and respect between day and night managers. • The smaller hospital nurtured a more intimate working relationship naturally. • The slogan of the Health Department within which the research was conducted had simultaneously adopted the slogan working together. • ANMs are to balance the many meetings and be accessible which is indicative of being an accessible leader. • Team work requires night managers to listen, liaise closely and demonstrate support and respect towards each other.

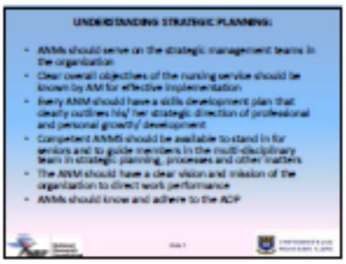
			• The ANM should offer insight to staff with regard to the expectation of more staff will secure a better future. • ANMs should come together, have discussion and deject utterances that cause divisiveness. • ANMs should be sensitive to yet devote attention to generation-specific cohorts of nurses and nursing managers to promote positive changes in nursing and in health-care, a likely way of promoting working together towards a better future/ care.
	4.6.5 Commitment to deliver work performance in the Business Unit and managing finances	4.6.5.1 Managing absenteeism in relation to the Business Unit and managing finances	• The management of absenteeism is a HRM task that is carried out with ease and robust. • The ANMs believed that if absenteeism is managed well and therefore improves, that service delivery will. • The ANMs indicated that it is necessary to comply to the absenteeism management protocol in its entirety to deem the management of absenteeism effective in the commitment to service delivery and that ANMs should speak out to ensure the required processes are followed (absenteeism is to be investigated fully by using the administrative processes). • Nurse manager should manage absenteeism in a manner that steers the process to a remedial outcome after a period of absence should it be required. • Staff absenteeism negatively affects the work situation. • Conducting a retrospective interview with each absentee after the period of absence demonstrates manager concern and has shown to decrease absenteeism as managers and staff member are both more aware of the absenteeism. • HONs propose that ANMs and other staff be educated on staffing shortages in direct relation to budgeting.
4.7 KPA 4: SUPPORT FUNCTION	4.7.1 Understanding the KPA support function		• ANMs render essential support to nursing staff, doctors and external stakeholders/ private parties: • Serves as a coach in assisting and guiding ONMs. • Serves as an important supportive arm to Specialist doctors who manage the services. • Renders needed support to external stakeholders who service the wards. • The ANM fulfills the essential need of the intermediate position between the HON and the ONM and the services. • HONs recognise the important and essential support role played by the ANM and feel proud with the degree of support given to the Head Specialists doctors. • ANM have inculcated a willingness to avail themselves in their supportive function. • The support role of the ANM involves problem solving. • ANM support behaviour is described as loyalty. • The assurance by the ANM that resources and staffing were adequate, making sound decisions, providing both positive and negative feedback were indicative of being supportive. • ANM characteristics of being approachable, safe and promoting staff cohesion are seen as supportive behaviour. • Nurse managers ought to be sensitive to how nurses experience reallocation and needs to reassure staff of their worth.
	4.7.2 Best work performance experience in the KPA support function	4.7.2.1 Communication and interpersonal skills in relation to support function	• Best practices in ANM communication are important for sound interpersonal relationships in nursing. • ANM works effectively with and support Specialist doctors using communication. • Night ANMs work effectively with medical superintendents/ CEOs using communication. • HONs indicated the degree of mature assertiveness ANMs display when engaging with others especially the Medical Heads and specialists and therefore meaningfully use their interpersonal skills/ The HONs concur with the ANMs that they (ANMs) use communication well.

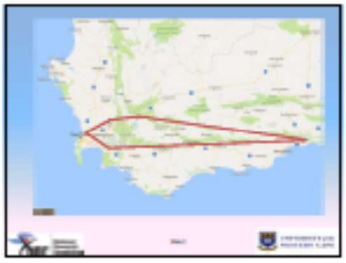
			• ANMs perceived themselves as having open communication/ communication facilitators, night ANMs in particular. When communicating, ANMs show openness of character and being accessible to nursing staff demonstrated by. • Open door policy even for lowest level of worker and be willing to listen. • Effective communication of the ANM facilitates team cohesion and good team spirit. • Effective communication of ANMs was manifested in the organisation of major annual nursing and other health-care events at hospitals. • Effective communication produces a positive milieu in the nursing managerial climate and a healthy and effective workplace environment. • The ANM are able to assert their position very well when they believe that a negative consequence could result. • Effective ANM-team communication is critical for the provision of sound health-care and patient safety. • Night ANMs use their communication skills to facilitate patient QA and rehabilitation. • The ANM should be custodian for and teacher of nursing report writing. • ANMs believe that they make a difference in assisting the staff to discern between the social and required official relationships on the job. • ANMs support each other. • Night nurses are particularly receptive towards the Night ANMs. • ANMs have organisational skills i.e. the ability to arrange and interact with the health-care setting work environment in an orderly fashion. • There is a belief that communication, interpersonal skills and the ability to organise are linked. • Interpersonal and communication skills are inherent in both leadership and management.
	4.7.3 Best possible work performance opportunity in the KPA support function	4.7.3.1 Staff orientation and in-service training, and workshops for nurses in relation to support function	• A sense of devotion prevails regarding attending training • Orientation of new nursing staff is important. It gives staff security and clarity of role in work performance. • In-service training must also should incorporate specific clinical training as per hospital speciality. • Orientation must also focus on corporate and technical aspects of the job helping staff to be adept to change. • Training and development opportunities are to correspond to individual strengths and weaknesses • The ANM should take ownership of, and pride in ensuring that new staff are orientated • Night staff wants to call on a tutor of the health-care setting who works day duty to be accessible for some night hours, to facilitate formal learning/ in-service training for the night shift. • Deliberate learning and training should be planned for ONM growth and development. • The ANM should promote the use and facilitate e-learning. • Orientation, in-service training and workshops for nurses are to adhere to the principles of: (1) Essential for work performance (internal), (2) Knowledge sharing, (3) Re-training after a crisis. • Orientation, in-service training and workshops for middle-managers should take the principle of self-directed learning into consideration. • Train in relation to trends and adverse incident indicators. • Bring training to the staff by utilising own resources in the speciality areas at the hospitals • Up-skilling of Professional Nurses' post basic registration should occur in their speciality field as opposed to the historical post basic training of midwifery.
	4.7.4 Initiatives for the future in KPA	4.7.4.1 Appreciation of staff, staff incentives and motivation	• Asking the ANMs about initiatives for the future instilled a sense of hopefulness which was optimistic

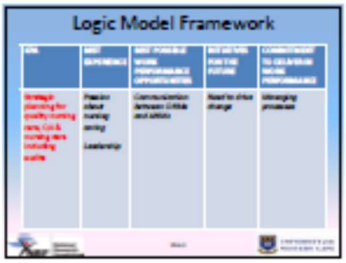
	support function	in relation to initiative/ s or best / ideal expectations for the future in support function	and positive likened to appreciation/ reward. • ANMs support the importance of incentives. • ANMs want to show staff appreciation and want to play a role in motivating the staff. • Incentives were said to lift the spirit of the staff. • Examples indicated by the ANMs of incentives/ enhancement that can be given to staff are: - Tokens (small tokens are singled out) - A day-off - Team building efforts - Year-end functions • Awareness existed that everyone wants SPMS and everyone cannot be given SPMS as once again there's only a fix amount (fixed) for those who are eligible. • Another best possible opportunity for the future is provision of relief staff for night staff to attend in-service training. • Motivation is sometimes all that is required as the face of provincial health-care settings changes: Motivators include the sincere attempt by a manager to get to know their staff better, the commitment shown to support staff on the shift (night shift), and incentives. • Another initiative for staff incentivisation and motivation was believed to be formal training and workshops. Further training to get the personnel to be skilled and resultantly positive will serve to motivate them. Even those who are regarded as skilled can be trained further. • An ANM who has a good relationship/ a human relationship with the staff and who acts professionally and is fair serves to motivate staff. • Staff should be praised; praising staff also motivates personnel. • Improvement in the preparation for the role of the ANM was a priority and motivating and also indirectly reflected staff appreciation. • ANMs who coached ONMs in the management of HRs and disciplinary processes is viewed as developmental, supportive and needed (fulfilling the ANM support function). • The search for learning opportunities for staff training signals support to staff.
	4.7.5 Commitment to deliver work performance in the KPA support function	4.7.5.1 ANMs' own need for training in relation to the support function	• The need for ANM to be trained is well noted by them and the HONs as ANMs were not trained to be managers. • ANMs have prior learning which should be capitalised on. • In order to assist supervisees like ANMs manage their own learning means that they ought to learn to time manage a day to access training. • The Skills Development Fund should be sourced to support ANM development and learning. • ANMs should be coached in their development. • Story-telling could be used by nursing managers to teach. • The principle of 'learning by doing' is another sound principle of learning in nursing management. This is related to shadowing/ acting as HON (learning for succession planning), attending top management meetings, … • Important areas to be focused on are budgeting and financial management including procurement and vetting.

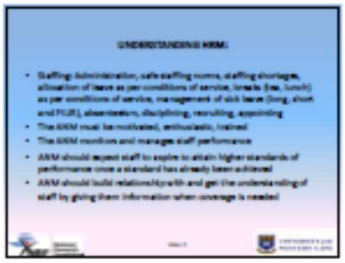
ANNEXURE Y: VALIDATION PRESENTATION











ANNEXURE Z: EDITING CONFIRMATION LETTER

P. O. Box KS 8485
Kumasi, Ghana

13 April 2017

To:
Professor Karien Jooste
Mrs. Beryldene Swartz

EDITING CONFIRMATION LETTER OF PHD DISSERTATION

This is to confirm that the dissertation of Beryldene Swartz titled, ***A CONTEMPORARY WORK PERFORMANCE MANAGEMENT FRAMEWORK FOR THE ASSISTANT NURSE MANAGER IN THE PROVINCIAL HEALTHCARE SETTING,*** was edited by me. It was the product of research towards the candidate's doctoral degree in the School of Nursing, Faculty of Community and Health Sciences, University of the Western Cape.

The work of editing mainly involved ensuring that the language usage and technical layout of the dissertation were in accordance with the required standards.

Sincerely,

.....
David Kwao-Sarbah
Mobile: +233504228334
Email: dksarb@gmail.com

ANNEXURE AA: TURNITIN SUBMISSION RECEIPT

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Digital Receipt

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The first page of your submissions is displayed below.

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Submission title:	A contemporary work performance...
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File size:	1.25M
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Submission ID:	809184810

CHAPTER 1
ORIENTATION TO THE STUDY

1.1 INTRODUCTION

In South Africa where this study was conducted, political influences and managerial change have vehemently dominated all spheres of management. This in turn has impacted on work performance generally yet more so for managers in the government health sector, where staff work performance is directly related to the sustainability and quality of life for hospital health-care users. McCarthy and Fitzpatrick (2009, p. 347) refers to the notion of 'competence' as a job performance indicator which was to be stipulated in a performance plan. This implied that an employer could determine with pre-employment testing, the degree or ability or non-ability of a prospective job taker/ employee to deliver the required standard of the work performance plan. The concept of performance management (PM) emerged late in the 1980s' as a means to assess work that had already been completed by individual workers (Hellqvist, 2011, p. 927). The mark of the successful implementation of a PM system is evident by way of transformation and accountability (Kgomotso, 2011, p. 3-4). Arising from public management, PM has become an important organisational process characteristic, which influences performance (Walker, Damampour & Devece, 2011, p. 367). Required competence in work performance is still being referred to today, and described as the required knowledge, behaviours and skills to perform specific tasks or responsibility (Salleh & Sulaiman, 2015, p. 77).

PM is the managing of work performance in a work setting, where performance is regarded as the prospective and promising execution of deeds which will lead to the achievement of the desired 'objectives' and 'targets' of the job (Dransfield, 2000, p. 69; Walker, 2007, p. 55). In a work setting, PM is seen as a process within the broader human resource management (HRM) system. It involves the attempt to secure the best work performance from the individuals, the working groups and that of the entire work society (Dransfield, 2000, p. 69). A clear PM framework did not exist for ANMs in the Western Cape Province. A framework is a supporting structure of principles and ideas (Macmillan Dictionary, 2015, online). The inferred meaning of 'framework' for PM applied in this study, is that of a supporting structure adapted to the reality of the work performance practices of the Assistant Nurse Manager (ANM), using the Logic Model processes of input, output and outcome (Tumbi, Hallworth, Ling & Grant, 2011, p. 3). Atkinson (2012, p. 48) points out that the preliminary step in the development of a PM framework is the endeavor to define 'PM' from a corporate perspective. Franco-Santos, Kennerley, Micheli, Martinez, Mason, Marr, Gray and Neely (2007, p. 785) emphasise the multiplicity of the matter leading to agreement on PM that is still undefined.

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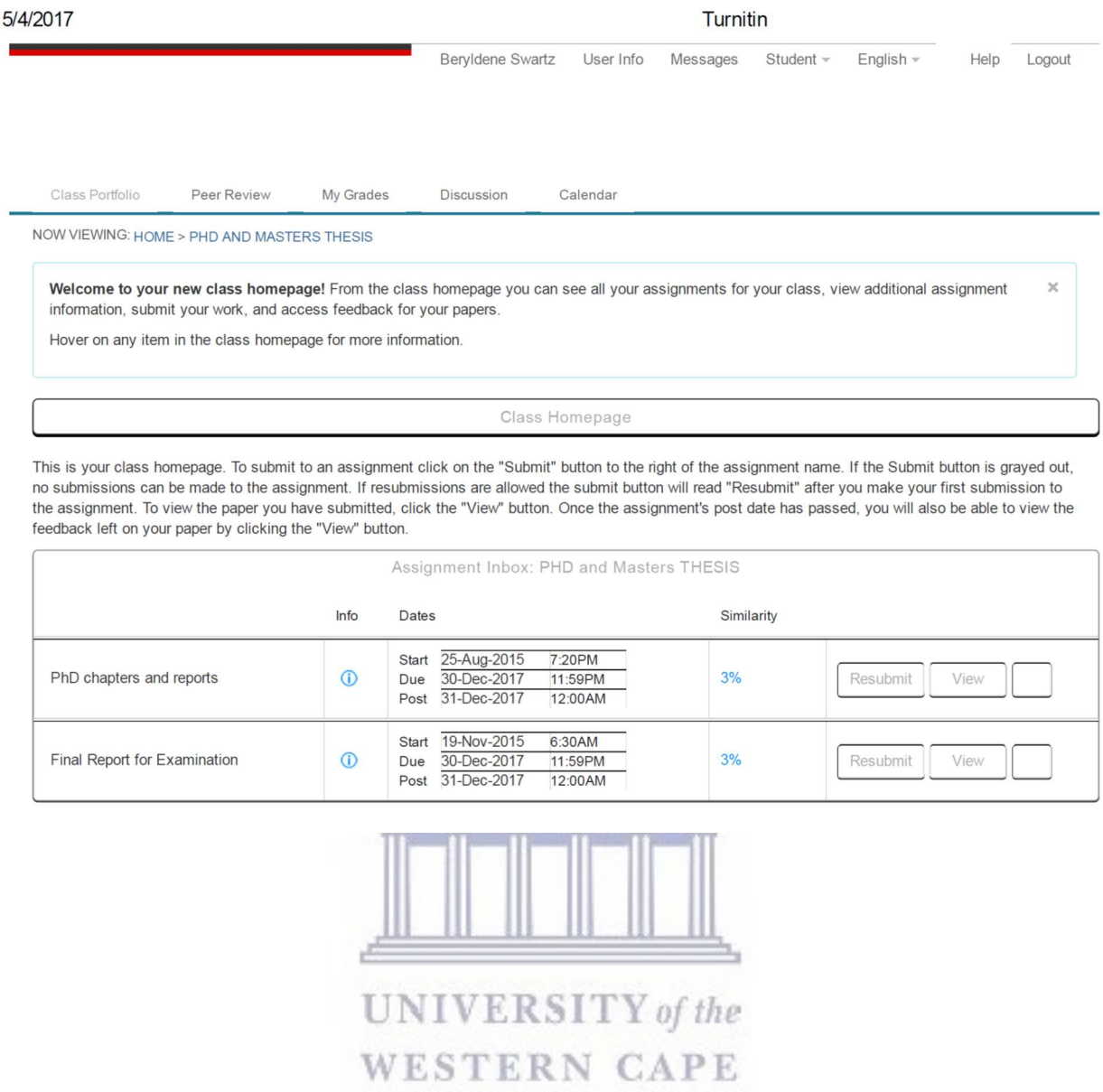

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