A model for transformational leadership by nursing unit managers

by

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SOLI DEO GLORIA

Dedicated to my two sons :

Diederick and Jaco

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SUMMARY

It was very clear that dramatic transformation is needed in the new South Africa to accommodate the transformation demanded by the Reconstruction and Development Programme, the National Health System, and other political, economic, social, technological and staff management changes. It was also evident that transformational leadership was needed in nursing in general and in nursing management in particular.

This is a qualitative, contextual, exploratory, descriptive and theory-generating study, with the overall aim of exploring and describing a model for transformational leadership by nursing unit managers to facilitate individual and nursing unit transformation. To accomplish this aim, specific objectives were formulated. Firstly, a conceptual framework and model were explored and described by means of analysis, synthesis, derivation and deductive reasoning.

The model was described within the metatheoretical assumptions of the Nursing for the Whole Person Theory (ORU 1990; RAU 1992). The theoretical assumptions were derived from the Nursing for the Whole Person Theory whereas the methodological assumptions were based on the Nursing Research model of Botes (1995). This Nursing Research model proposed a functional reasoning approach. During the exploration and description of the model, concept identification and classification were handled according to the survey list of Dickoff, James and Wiedenbach (1968).

Thereafter, an education programme was explored and described by deriving the theoretical content on transformational leadership from the conceptual framework and the model. The principles of adult education (Knowles 1984, Gravett 1991) and the constructivistic learning theory (Klopper 1994 (a)) were utilised for the didactical development of the education programme. This education programme was then implemented in a nursing service.

Through purposive sampling, four nursing units in the same nursing service were selected and the model implemented for a period of 12-14 weeks. The case study method was utilised.

Data was collected through questionnaires to leaders and followers, nursing audit instruments, narrative sketches, direct observation and unstructured interviews. The model was also further evaluated, validated and refined by a panel of experts utilising the criteria proposed by Chinn and Kramer (1991:138-139).

Lastly, recommendations were made for nursing unit management, nursing education and nursing research.

The value of this study lies in the uniqueness of the model it develops for transformational leadership in the nursing management context. This model was also implemented in the context of nursing units and this provided conclusively to the researcher that this model is implementable and functional.

OPSOMMING

Dit was baie duidelik dat dramatiese omvorming in die nuwe Suid-Afrika benodig word om die transformasie wat deur die Heropbou en Ontwikkelingsprogram, die Nasionale Gesondheidsisteem, ander politieke, ekonomiese, sosiale, tegnologiese en personeelbestuur veranderinge vereis word, aan te spreek. Dit was duidelik dat omvormingsleierskap in verpleging in die algemeen maar ook spesifiek in verpleegbestuur benodig word.

Hierdie is 'n kwalitatiewe, kontekstuele, verkennende, beskrywende en teorievormende studie met die doel om 'n model vir omvormingsleierskap deur verpleegeenheidbestuurders vir die fasilitering van individuele en verpleegeenheid omvorming te verken en te beskryf. Om hierdie doel te bereik, is spesifieke doelwitte geformuleer. Eerstens is 'n konseptuele raamwerk en model verken en beskryf deur middel van analise, sintese, derivasie en deduktiewe beredenering.

Hierdie model is beskryf binne die metateoretiese aannames van die Verplegingsteorie vir Mensheelheid (ORU 1990; RAU 1992). Die teoretiese aannames is gederiveer van die Verplegingsteorie vir Mensheelheid en die metodologiese aannames is gebaseer op die verpleegnavorsingsmodel van Botes (1995). Hierdie verpleegnavorsingsmodel stel 'n funksionele denkbenadering voor. Gedurende die verkenning en beskrywing van die model is konsepidentifikasie en klassifikasie gedoen aan die hand van die opnamelys van Dickoff, James en Wiedenbach (1968).

Daarna is 'n onderrigprogram verken en beskryf deur middel van derivasie van die inhoud van die konseptuele raamwerk en die model. Die beginsels van volwasse leer (Knowels 1984; Gravett 1991) en die konstruktivistiese leerteorie (Klopper 1994 (a)) is gebruik vir die didaktiese ontwikkeling van die onderrigprogram. Hierdie onderrigprogram is geïmplementeer in 'n verpleegdiens.

Deur middel van doelgerigte streekproeftrekking is vier verplegingseenhede in dieselfde verpleegdiens geselekteer en die model vir 'n tydperk van 12-14 weke geïmplementeer. Die gevallestudie metode is gebruik.

Data is ingesamel deur middel van vraelyste aan leiers en volgelinge, verpleegouditinstrumente, spontane sketse, direkte observasie en ongestruktureerde onderhoude. Die model is verder geëvalueer, gevalideer en verfyn deur 'n paneel van kundiges deur gebruik te maak van kriteria soos voorgestel deur Chinn en Kramer (1991:138-139).

Laastens is aanbevelings gemaak vir verpleegeenheidsbestuur, verpleegonderwys en verpleegnavorsing.

Die waarde van hierdie studie is in die uniekheid van 'n model vir omvormingsleierskap kontekstueel tot verplegingeenheidsbestuur. Die model is ook geïmplementeer binne die konteks van verpleegeenhede wat aan die navorser die versekering gee dat hierdie model implementeerbaar en funksioneel is.

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CHAPTER 1

AN OVERVIEW OF THE STUDY

1.1 INTRODUCTION AND RATIONALE

The aim of the study is to explore and describe a model for transformational leadership by nursing unit managers to facilitate individual and nursing unit transformation.

The study was conducted within the Judeo-Christian world view that is based on the whole Bible as a source of truth. The Nursing for the Whole Person Theory of the Anna Vaughn School of Nursing at the Oral Roberts University (ORU 1990), as accepted by the Nursing Department of the Rand Afrikaans University (RAU 1992), was used as a theoretical framework.

The study was conducted in the period following the first democratic elections in South Africa, whereupon the Government of National Unity came to power. In the Government of National Unity, the Reconstruction and Development Programme (RDP) of the African National Congress (ANC) dominates. This is a totally different approach from the former Government and therefore it necessitates major political, economic and social change.

The RDP (ANC 1994:4-6) lists an integrated and sustainable programme; a people-driven process; peace and security for all; nation building; and linking reconstruction and development as the six basic principles that constitute the political and economic philosophy underlying the RDP. The RDP (ANC 1994:43-46) promotes a National Health System (NHS) to co-ordinate public and private providers of resources and services at national, provincial, district and community levels.

According to the RDP, reconstruction should involve the complete transformation of the health care system. This transformation includes reviewing and restructuring all relevant legislation, organisations, institutions and statuary bodies to reflect the diversity of the South African people. Systems and practices that are in line with international norms and standards should be developed as well as management practices that promote efficient delivery of services and that ensure human rights and accountability to the public.

The NHS focuses on the Primary Health Care approach where community participation, empowerment, collaboration and cost-effective care are emphasised. Preventive, promotive, curative and rehabilitative services should be integrated. The following preventive and promotive health programmes should be promoted: breast feeding, immunisation, mental health services and counselling, combatting the spread of sexually transmitted disease and Aids, 24-hour emergency services, appropriate care for chronic diseases, occupational health services, and programmes to co-ordinate and monitor services aimed at the youth. Budget allocation should also be shifted towards Primary Health Care to address the needs of the majority of the people (ANC 1994:46-51).

With regard to the human resources for the NHS, the RDP proposes a programme of retraining and re-orienting existing health workers according to the Primary Health Care approach (ANC 1994:50-51). Redistribution of personnel would be achieved through more appropriate training, incentives to work in under-serviced areas, limiting openings for private practice in over-serviced areas, strengthening the public sector, and encouraging active co-operation between the public and the private sectors. Contractual obligation for those receiving subsidised training is also proposed.

The effect and the implications of the RDP on nursing management can therefore not be ignored. Some implications are the following:

- better co-operation and collaboration between the private and public sectors;
- transformation of the health system which includes reviewing all legislation and statutory bodies;
- developments of organisations and institutions and the promotion of systems and practices that are in line with international norms and standards;
- budgeting that is geared towards Primary Health Care with less money available to the curative services and
- the implementation of a Primary Health Care approach with less emphasis on curative care.

It is not only the recommendations from the RDP which necessitate transformation in the nursing service. Morrison (1993:255) states: "Change is a universal fact. Seasons change; plants change; people change. No one escapes it." Constant change is also true for nursing. There is a constant change in the available knowledge body; technical equipment; diagnostic and treatment methods; cultural values, philosophies, and norms. Gillies (1994:449) states that as the social values and norms change, there is an increased incidence of certain diseases. Scientific discoveries such as improved diagnostic and treatment methods improve the prognosis for some diseases. As treatment procedures improve, the life expectancy of the individual increases. Therefore the health needs of the community change. The health service should change accordingly to be able to comply with the public demand. The public is also better informed about health risks and treatment opportunities and thus demands up-to-date quality nursing care.

Computerisation in the health services also increases the need for change as this can pose a major threat to some of the nurses who are not computer literate. Nursing managers are expected to analyse the data produced by computer programmes, to anticipate and find solutions to problems. All these proposed changes also hold true for the South African nursing context.

Toffler (1994:443) states: "Change is avalanching upon our heads." This perception may be true for the current South African nurse as he/she is currently surrounded by numerous demands for change. It is necessary that health services change their structure and function to remain responsive to public demands and political circumstances. All the above-mentioned demands for change as well as the proposals by the RDP imply transformation in the health services.

According to Koerner and Bunkers (1992:1) transformation occurs when "inner and outer realities are brought together in ways that assist individuals to integrate their unique inner world (values and beliefs) and outer world (life experiences) into a unified whole." Koerner and Bunkers (1992:2) define transformation as the development of an individual to his/her potential through the continual integration of the inner world of the soul or psyche (specific view) with the outer world of human endeavour and external expectations (wholistic view).

Successful transformation requires leadership. According to Robbins (1986:262), an organisation depends largely on the quality of its leadership. "Successful leaders anticipate change, exploit opportunities, motivate the followers to higher levels of productivity and lead the organization and the followers to reach the set objectives."

Individuals, groups and communities need leaders with a vision of life, for life and for the future - leaders who can effect change. According to Bader and O'Malley (1992:39) the transformational leader is truly powerful and is a leader who knows how to effect change as he/she has the ability to create visions in the minds and hearts of others. The leader view risks as opportunities, is a master at managing change and empower followers at all levels of the organisation. He/she has the ability to commit people to action and to convert followers into leaders.

The nursing unit is a subsystem of a whole system including the nursing service, health service and the community. Major changes (such as the first democratic election, implementation of the RDP and the NHS, other demands for change) cause a disharmony in the system and therefore transformational leadership to facilitate individual and nursing unit transformation is required to restore the harmony.

Koerner and Bunkers (1992:3) state that transformational leadership involves change, innovation, growth and empowerment of the self and others. Bennis and Nanus (in Marriner-Tomey 1993:4) describe effective change (transformation); attention through vision; meaning through positioning; empowerment (enablement); and self development as behaviours of transformational leadership.

As the specific characteristics of the transformational leader are unique for affecting change and as these unique characteristics are not found in other leadership styles, the researcher selected transformational leadership for the study. Transformational leadership is the only leadership style where specific behaviours have been identified by Nanus and Bennis (in Marriner-Tomey 1993:4) that can be utilised and implemented. The other leadership styles only include specific characteristics of the leader and not specific behaviours to implement. By implementing transformational leadership, individual and nursing unit transformation is facilitated.

1.2 PROBLEM STATEMENT

A model for transformational leadership by nursing unit managers could not be found. However, the ontological dimension ("what is") of transformational leadership is well described in the literature. This type of leadership is needed to create the transformation in health services (including nursing) which is required and therefore transformational leadership was selected by the researcher as a framework for the study. A model for transformational leadership by nursing unit managers to facilitate individual and nursing unit transformation or change is needed. Guidelines for the implementing of such a model are also required.

From this problem statement the following research questions arose:

- what is transformational leadership, within the Nursing for the Whole Person Theory and nursing unit management?
- how should transformational leadership be reflected in a model?
- how can transformational leadership in a nursing service be developed?
- how effective is this described model in a nursing unit?

1.3 OVERALL AIM AND OBJECTIVES

The "problem," a brief statement of which was offered above, led to the study. The overall aim of the study was to describe a model, with guidelines for implementation, for transformational leadership by nursing unit managers. To accomplish this overall aim, the study was conducted in two phases and the following objectives were formulated.

Phase one

- to explore and describe a conceptual framework and a model for transformational leadership by nursing unit managers.

Phase two

- to implement the model in three steps, namely:
  - * explore and describe an education programme for transformational leadership;
  - * implement this education programme in a nursing service and
  - * evaluate, validate and refine the described model.

1.4 PARADIGMATIC PERSPECTIVE

The study is conducted within the framework of the Judeo-Christian philosophy and the Nursing for the Whole Person Theory. Transformational leadership is therefore explored and described within this paradigm.

Field and Morse (1985:138) define a paradigm as "a collection of logically connected concepts and propositions that provides a theoretical perspective or orientation that frequently guides research approaches towards a topic." According to Bailey (1987:25) a paradigm is a mental window through which the researcher views the world and therefore if two researchers describe the same phenomena from two different paradigms, the results of the research will be different. In the opinion of Kuhn (Mouton, 1993:54-58) a paradigm is one or more scientific achievements acknowledged and accepted by a specific scientific community as a basis for further research within this science. These achievements take the form of theories, models, predictions and laws.

Botes (1995:9) states that as no research is free of values, the assumptions of the researcher should be stated explicitly. The metatheoretical, theoretical and methodological assumptions for the study are now described.

1.4.1 Metatheoretical assumptions

The study is conducted within the Judeo-Christian world view which is based on the whole Bible as the source of truth. The Nursing for the Whole Person Theory of the Anna Vaughn School of Nursing (1990) as accepted by the Nursing Department of the Rand Afrikaans University (1992) is used as a theoretical framework for the study.

accepted by the Nursing Department of the Rand Afrikaans University (1992) is used as a theoretical framework for the study.

Within the Nursing for the Whole Person Theory, the emphasis is on the continuous quest for wholeness of the individual within a group and/or community. According to this theory, man is a spiritual being who functions in an integrated biopsychosocial manner in his/her quest to achieve wholeness. The Nursing for the Whole Person Theory focuses on the whole person (body, mind and spirit) as well as the parameters of the nursing service and beliefs about man, health, illness and nursing.

The patterns of interaction between the internal environment (body, mind and spirit) and the external environment (physical, social and spiritual) determine the health status (wholeness) of a person. Health and wholeness are used synonymously and can be quantitatively described on a continuum from maximum health to minimum health (ORU 1990; RAU 1992). In the study wholeness implies successful transformational leadership as the resultant pattern of interaction.

The Nursing for the Whole Person Theory is schematically represented by figure 1.1.

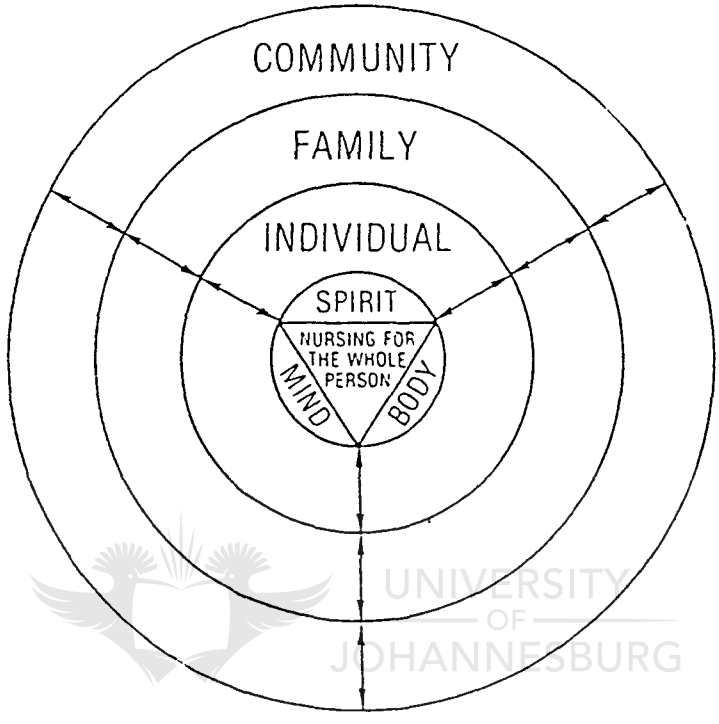


Figure 1.1: Nursing for the Whole Person Theory

The key concepts from this theory are stated as follows:

Person: "A person is a spiritual being who functions in an integrated biopsychosocial manner to achieve his/her quest for wholeness. The person interacts with his/her internal and external environment wholistically" (ORU,1990). In the study the person refers to the leader (nursing unit manager) and the followers (registered nurses and/or midwives, enrolled nurses and/or midwives and auxiliary nurses in interaction with the leader) in the nursing unit.

Health: "Health is a state of spiritual, mental and physical wholeness. The person's pattern of interaction with his/her internal and external health determines his/her health status" (ORU, 1990). In the study, health refers to successful transformational leadership to facilitate individual and nursing unit transformation or change.

Nursing: "Is a goal-directed service to assist the individual, family and/or community to promote, maintain and restore health." In the study, "nursing" is replaced with transformational leadership by nursing unit managers, as the act required to facilitate individual and nursing unit transformation.

Parameters of nursing: The parameters of nursing include the individual, family and/or group and the community. The individual is a "spiritual being who functions in an integrated biopsychosocial manner within the family or community" (ORU,1990). In the study the individual refers to the leader (registered nurse and/or midwife in-charge of a nursing unit) and followers (registered nurses and/or midwives, enrolled nurses and/or midwives and auxiliary nurses in interaction with the leader).

The family and/or group is "the basic unit of society composed of individuals mutually valued and interacting" (ORU, 1990). In the study the family and/or group refers to the leader and the followers (as a group) in the nursing unit within a private hospital.

The community is "an identifiable group of persons who share a common interactive pattern and/or geographical location" (ORU, 1990). In the study the community refers to the nursing unit within the nursing service and the health service.

1.4.2 Theoretical assumptions

The theoretical assumptions are the testable statements of the topic under study. They also include applicable theories and models. As the Nursing for the Whole Person Theory (ORU 1990; RAU 1992) is used as the central theoretical framework, all theoretical statements of the Nursing for the Whole Person Theory regarding the individual, group and the community, are accepted for the study.

Assumptions of the researcher

The researcher believes in the following assumptions:

(a) Successful transformational leadership facilitates individual and nursing unit transformation or change.

(b) The implementation of the education programme empowers the nursing unit manager to practice transformational leadership.

1.4.2.1 Central theoretical statement

In the study the central theoretical statement is as follows: Successful transformational leadership facilitates individual and nursing unit transformation or change.

1.4.2.2 Theories and/or models

No theory or model for transformational leadership in nursing could be found. A conceptual framework and a model for transformational leadership are explored and described by utilising information from various authors namely, Charlton (1992), Marriner-Tomey (1993), Hater and Bass (1988), Bennis and Nanus (1985) in Marriner Tomey (1993), Van der Erve (1989), Bader and O'Malley (1992), Conger and Kanungo (1988).

For the didactical principles of the education programme, the theories and models of Knowles (1984) and Gravett (1991) on adult education and Klopper (1994 (a)) on the constructivistic learning theory are utilised.

1.4.2.3 Definitions

Within the theoretical assumptions the following concepts are described. Final conceptual definitions are developed in the conceptual framework (chapter three).

Leader: The leader is the nursing unit manager (registered nurse and/or midwife) who practices transformational leadership to facilitate individual and nursing unit transformation.

Follower: The follower is the registered nurse and/or midwife, enrolled nurse and/or midwife and the auxiliary nurse as a member of the nursing team in a nursing unit who support the leader in transformational leadership.

Transformational leadership: Transformational leadership includes specific leadership behaviours and strategies implemented by the nursing unit manager to facilitate individual and nursing unit transformation or change.

Behaviour: Behaviour is the action or the "what" which the leader implements for successful transformational leadership.

Strategy: The strategy or the "how" comprises the actions required to enhance transformational leadership.

Validation: Validation in this study does not refer to the testing of hypotheses but to determining the operational value of the model.

1.4.3 Methodological assumptions

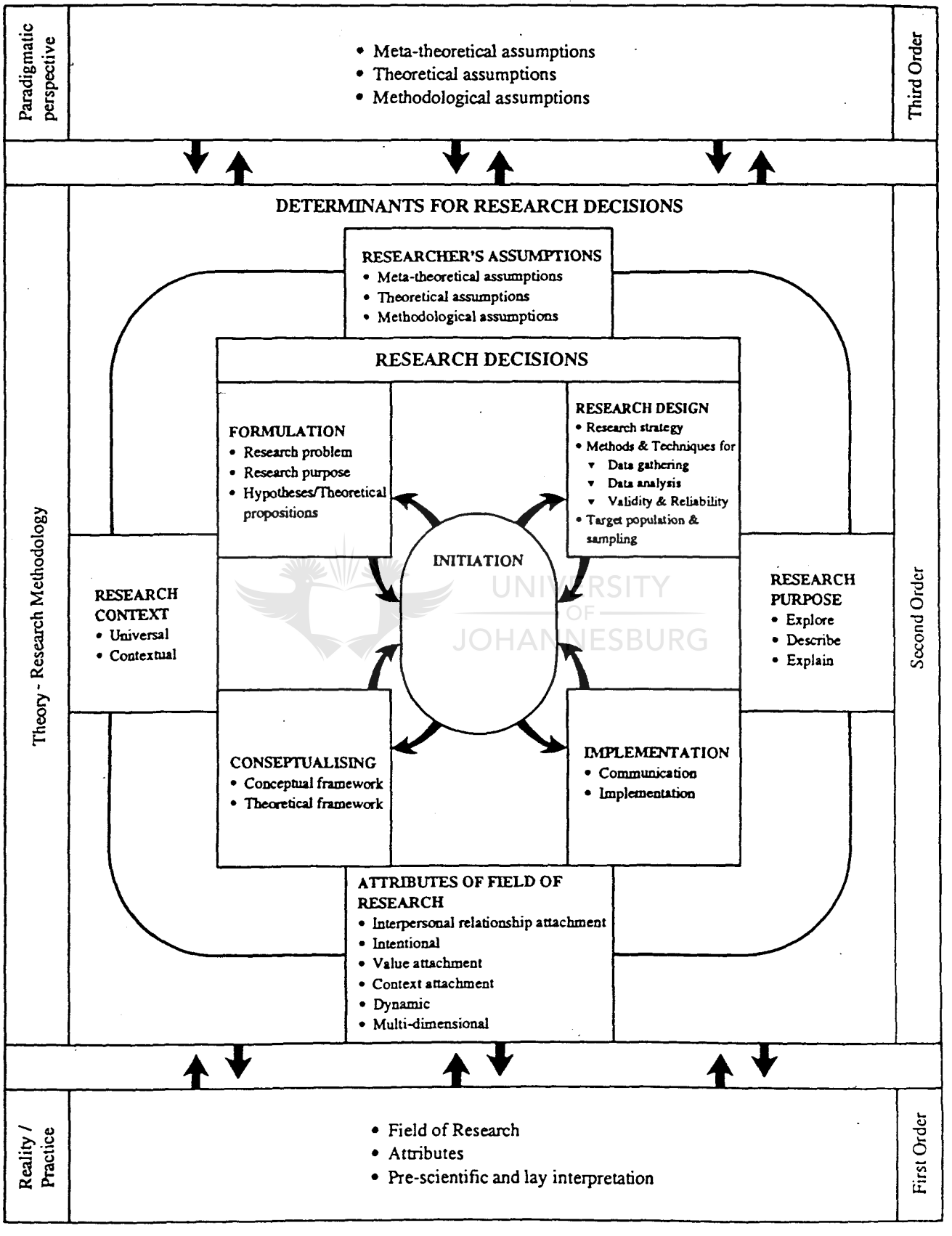
This is a contextual, exploratory and descriptive study within a functional reasoning approach where action-related prescriptions are given in a specific time-spatial and value context. Research within a functional reasoning approach is not conducted merely to gain knowledge on the topic of research, but to apply the gained knowledge to improve the practice (Botes 1995:13).

The Botes (1995) model for Nursing Research provides a wholistic perspective of the research process rather than a detailed description of the methods and techniques of research. Therefore the Botes (1995) model for research in nursing was used as a methodological framework for the study. The Nursing Department of the Rand Afrikaans University also accepted this model as a research model for quantitative and qualitative research.

Botes (1995:6-7) describes three orders within this model, namely:

- the first order that represents the practice of nursing and the activities taking place in the practice of nursing. In the study this order represents the implementation of the model for transformational leadership by nursing unit managers;
- the second order represents the theory of nursing and research methodology. The activities are research and theory development. In the study the conceptual framework for transformational leadership (as described in chapter three) acts as theory generation. The methodology followed is a qualitative, contextual, exploratory and descriptive method and
- the third order is the paradigmatic perspective that includes the metatheoretical, theoretical and methodological assumptions for the study. These assumptions for the study have already been described.

These three orders are in constant interaction and also influence each other (see figure 1.2 for this model).



(Botes AC)

Figure 1.2: A Research Model

1.5 RESEARCH STRATEGY, METHODS AND TECHNIQUES

This is a qualitative, contextual, exploratory and descriptive study for theory generation and the exploration, description and implementation of a model for transformational leadership by nursing unit managers. A qualitative, descriptive case study is utilised for the implementation of the described model. For a summary, see table 1.1.

Table 1.1: Research strategy, methods and techniques

Strategy	Application in the study
Qualitative	- Collection of data through qualitative techniques (case study strategy using questionnaires, nursing audit instruments, narrative sketches, direct observation - Analysis of data through qualitative techniques for example analysis of narrative sketches (unstructured data) according to Tesch (1990) in Cresswell (1994:142-145)
Contextual	Value attachment - Judeo-Christian philosophy and values; Nursing for the Whole Person Theory; Nursing Credo Ethical and professional framework - Nursing Act (Act no 50 of 1978); Related Nursing Regulations from SANC Time - Time of transitional change in South Africa; Immediate post-election era Context attachment - Nursing unit within the nursing service and health service Intention - Successful transformational leadership to facilitate individual and nursing unit transformation Dynamics - To practice successful transformational leadership in nursing units to facilitate individual and nursing unit transformation.
Explore	- A conceptual framework and an education programme for transformational leadership by nursing unit managers. - Transformational leadership by nursing unit managers
Describe	- Educational programme for transformational leadership by nursing unit managers - The practice of transformational leadership by nursing unit managers - A model and guidelines for implementation of transformational leadership by nursing unit managers
Theory generation	- A literature analysis of the phenomenon of transformational leadership by means of deductive reasoning and other reasoning strategies such as analysis, synthesis and derivation (Walker & Avant 1988)

Table 1.2 elucidates the research methods utilised in the study.

Table 1.2: Research methods

Sample population	Data-gathering	Data-analysis
Phase 1: Exploration and description of conceptual framework and model		
- International, national, theoretical, empirical, primary, and secondary sources (Purposive sampling)	- Skimming, comprehending, analysing, synthesising - Inferences from literature - Survey list (Dickoff, James and Wiedenbach 1968) - Analysis, synthesis and derivation (Walker & Avant 1995)	- Select and define concepts (Copi and Cohen 1990) - Develop relational and hierarchical statements - Construct conceptual framework - Derive model
Phase 2: Operationalisation of the model		
Exploration and description of education programme		
- Explored and described conceptual framework and the model - Models/theories of: Knowles (1984); Gravett (1991); Klopper (1994 (a)) - Nursing unit managers (n=12) in a private hospital	- Inferences, derivation from conceptual framework. - Analysis, synthesis, derivation, deductive reasoning.	- Analysis, synthesis, derivation, deductive reasoning
Evaluation, validation and refinement of model		
- Nursing unit managers in a private hospital (n=4) (Purposive sampling)	Case study - Questionnaires to leaders and followers - Narrative sketches - Nursing audit - Direct observation - Cross-case analysis - Unstructured interviews Model evaluation Panel of: - model development experts (n=2) - nursing service managers (n=2) - nursing unit managers (n=4)	Case study Questionnaires Quantification Narrative sketches Analysis of data as described by Tesch (1990) Nursing audit Instrument Quantification Model evaluation Criteria by Chinn and Kramer (1991:138-139)

1.6 TRUSTWORTHINESS OF THE STUDY

To establish and maintain trustworthiness for the study, the model of Lincoln and Guba (1984:291-327) is utilised for both the phases of the study. The specific suggestions of Merriam (1988:166-170) and Yin (1989:95-103) on the trustworthiness of the case study are also implemented. The trustworthiness of the study is described in detail in chapter two. A condensed summary is provided in table 1.3.

Table 1.3: Strategies for trustworthiness

Lincoln and Guba	Merriam	Yin
Truth value (credibility)		
- Triangulation • sources • methods • investigators - Prolonged engagement	- Triangulation • sources • methods • investigators - Long-term observation - Member checks - Peer examination - Researcher's bias	- Multiple sources of evidence - Creating a case study data base - Maintaining a chain of evidence - Member checks
Transferability (applicability)		
- Rich, thick description - Establish typicality	- Rich thick description - Further replication	- Replication
Neutrality (confirmability)		
	- Audit trail	
Consistency (reliability)		
- Audit trail - Triangulation - Investigator's position		

1.7 REASONING STRATEGIES

In the study the reasoning strategies of analysis, synthesis, derivation, induction and deduction are utilised. These reasoning strategies are described in detail in chapter two.

1.8 DIVISION OF CHAPTERS

The division of chapters are as follows:

Chapter 1: An overview of the study

Chapter 2: Research methodology, design, strategies and research method

Chapter 3: Conceptual framework

Chapter 4: A model for transformational leadership by nursing unit managers

Chapter 5: Education programme

Chapter 6: Implementation and evaluation of the model

Chapter 7: Evaluation of the study, conclusions and recommendations

1.9 CONCLUSION

The rapid and vast changes within South Africa, caused by the new dispensation and other factors, requires nursing leadership that will empower nursing leaders and followers to face the challenges for the necessary transformation to provide quality health care.

No model for transformational nursing leadership by nursing unit managers could be found for South Africa. For this reason the overall aim of the study is to explore and describe a model, with guidelines for implementation, for transformational leadership by nursing unit managers. This overall aim is in support of the central theoretical statement of the study which states: Successful transformational leadership facilitates individual and nursing unit transformation or change.

In this chapter an overview was given of the rationale, aim, research strategy, and the trustworthiness of the study. Chapter two focuses on the research methodology, design, strategies and methods.

CHAPTER 2

RESEARCH METHODOLOGY, DESIGN, STRATEGIES AND METHODS.

2.1 INTRODUCTION

The aim of this chapter was to describe the research methodology, design, strategies and methods for the study. The research methodology refers to the research decisions taken within the framework of specific determinants unique to the research study. The aim of a research design is to plan and structure a study in such a way that the validity of the research findings is maximised, whereas the research strategies include the different techniques used to attain the aim of the study. The research design is the plan of action and included the research methods (sampling, data collection and data analysis). The study was conducted in two phases and the research methods for each phase are described separately. The ethical considerations and trustworthiness are also elucidated.

2.2 RESEARCH METHODOLOGY

Botes (1995:8) states that the "determinants of each research project are unique, and provide a framework within which research decisions can be made and justified." Botes (1995:9) also states that no research is value free and that the assumptions of the researcher direct the research decisions. The metatheoretical, theoretical and methodological assumptions of the researcher in the study were therefore described in chapter one.

2.3 RESEARCH DESIGN

According to Mouton and Marais (1990:33) the aim of a research design is to "plan and structure a given research project in such a manner that the eventual validity of the research findings is maximized." A research design therefore implies rational decision-making before and during the research process. Botes (1995:10) states that each research topic lends itself to exploration, description, explanation, or a combination of these. The research objectives direct the research decisions.

This was a contextual, exploratory, descriptive and theory-generating study. A qualitative, descriptive case study was also utilised. The overall aim was to describe a model, with guidelines for implementation, for transformational leadership by nursing unit managers.

In order to achieve this overall aim, the following objectives were formulated:

Phase one:

- to explore and describe a conceptual framework and a model for transformational leadership by nursing unit managers.

Phase two:

- to operationalise the model in three steps namely:
  - * explore and describe an education programme for transformational leadership;
  - * implement this education programme in a nursing service and
  - * evaluate, validate and refine the described model (with guidelines for implementation).

From the above-mentioned it is clear that the testing of hypotheses is not applicable to the study and was therefore not attempted. However, hypotheses were generated from the study and these are elucidated in chapter seven. A central theoretical statement was given in chapter one (1.4.2.1).

The contextual, exploratory, descriptive and theory-generating nature of the research design is now discussed.

2.3.1 Contextual

Botes (1995:10) states that the contextual approach is uniquely descriptive in that distinguishing characteristics are described. The methodological assumptions of the researcher and the characteristics of the research domain influence the research context. The findings of a contextual study are only valid within the particular time-spatial context in which the study is conducted. Botes (1995:13) adds that the functional reasoning approach is always contextual in nature and guidelines for action within a stated context can be given. The final criterion for validity is the usefulness of the knowledge to the specific nursing practice.

This is a contextual study, conducted within the following framework.

(a) Naturalistic paradigm

The study was conducted within the context of the naturalistic paradigm as described by Lincoln and Guba (1984:37-38). This paradigm includes five axioms (beliefs). Axiom one indicates the nature of reality (ontology). According to the naturalistic paradigm, there are multiple constructed realities that can only be studied wholistically. Axiom two indicates the relationship of knower to known (epistemology) and states that the knower and the known are inseparable. Axiom three indicates the possibility of generalisation. The aim of naturalistic inquiry is to develop a body of knowledge in the form of a workable hypothesis that describes the individual case. Axiom four indicates the possibility of causal linkages and states that it is impossible to distinguish causes from effects. Lastly, axiom five indicates the role of values in inquiry (axiology).

The naturalistic paradigm states that inquiry is value-bound, and this can be described by means of corollaries:

- Corollary one: Inquiry is influenced by values of the inquirer;
- Corollary two: Inquiry is influenced by the choice of the paradigm that guides the investigation;
- Corollary three: Inquiry is influenced by the choice of the substantive theory utilised to guide the collection, analysis and interpretation of data;
- Corollary four: Inquiry is influenced by the values that inhere in the context and
- Corollary five: Inquiry is either value-resonant (reinforcing or congruent) or value-dissonant (conflicting).

According to Lincoln and Guba (1984:187-189), naturalistic inquiry is conducted in the natural setting of the phenomenon, since context is heavily implicated in meaning. The ontological positions as defined by axiom one (on constructed realities) and axiom three (on generalisations) specify that the reality constructions cannot be separated from their context and that all observations are time- and context-dependent. The specific context of the nursing leader and the follower is described in chapter three (conceptual framework) and the model (chapter four). The context of the leaders and the followers in the selected nursing units is analysed and described in chapter six.

Naturalistic inquiry focuses on meaning in context, and humans are best suited for this task by utilising methods such as interviewing, observing and analysing. Non-probability sampling and inductive data analysis are suitable, valid and reliable methods (Merriam 1988:3). Lincoln and Guba (1984:193-194) also propose the use of a human-as-instrument, because of unique characteristics like responsiveness and adaptability. The human is competent to use propositional and tacit knowledge simultaneously to come to a wholistic understanding of the phenomena. Another characteristic is processual immediacy, where the human instrument can process, analyse, clarify and summarise data as soon as it becomes available. Lastly, the human instrument can test responses for validity and also achieve a higher level of understanding that might otherwise be possible.

(b) Value attachment

The study is conducted within the framework of the Judeo-Christian philosophy and values and Nursing for the Whole Person Theory. These constitute the metatheoretical assumptions of the researcher (see chapter one). The study is also conducted within the philosophical framework of nursing.

Searle (1968) described several philosophical light beacons in a South African Nursing Credo that describes Nursing as a belief in the uniqueness and irreplacability of every human being. It also states that the Creator charged every person with the responsibility of his/her own well-being as well as the well-being of his/her fellow man; a faith in the continual source of inner strength; a yearning to be a worthy servant of humanity; an acceptance that every person is unique; a belief in the transcendence into a human life through change; assistance and support to patients and health staff; a technology and love made visible through the therapeutic use of the self. All the aspects described in the Credo are also congruent with the beliefs of the Judeo-Christian philosophy and the Nursing for the Whole Person Theory.

(c) Legal, ethical and professional framework

As the Nursing Act (Act no 50 of 1978) and the guidelines for practice determine the boundaries for the practice of nursing, transformational leadership should also be described within these boundaries to be acceptable to the nursing unit manager. Therefore the study was conducted within the legal, ethical and professional framework of the Nursing Act (Act no. 50 of 1978), as amended, and the applicable guidelines for practice, such as:

- R387 of 15 February 1985, as amended, for acts and omissions and conditions of service and
- R2598 of November 1984, as amended, for the scope of practice of persons registered or enrolled in terms of the Nursing Act (Act no. 50 of 1978).

(d) Time

The study was conducted at a time of large transitional and other changes in South Africa. As nursing leaders are practicing in a very difficult, insecure and constantly changing external environment, there is a great need among these leaders and followers for a model, with guidelines for implementation, for transformational leadership.

(e) Intention

The intention of the study was to explore and describe a model, with guidelines for implementation, for transformational leadership by nursing unit managers. The aim of transformational leadership is to facilitate individual and nursing unit transformation.

(f) Dynamics

The dynamics of the study was transformational leadership by nursing unit managers to facilitate individual and nursing unit transformation.

2.3.2 Exploratory

Mouton and Marais (1990:43) state that an exploratory study aims to acquire new insights into a phenomenon rather than collect accurate and replicable data; to explicate the central concepts; to determine priorities for further research and to develop new hypotheses about an existing phenomenon. The research design of an exploratory study tends to be open and flexible. Therefore methods such as literature reviews, interviews and case studies were utilised.

The aim of the study was to explore a conceptual framework, model (with guidelines) and an education programme for transformational leadership by nursing unit managers. This was achieved through an overview of existing literature, through the practical experience of transformational leadership and through a qualitative, descriptive case study. New insights will be acquired into the phenomenon of transformational leadership by nursing unit managers. The central concepts were explicated through the conceptual framework and model. Recommendations for further research and the hypotheses developed from the study are elucidated in chapter seven. The study is also descriptive in nature.

2.3.3 Descriptive

A study is descriptive when it intends to describe a phenomenon accurately within its specific context, and when it bases itself on the collected data. The emphasis is on the in-depth description of an individual, group, situation or organisation (Mouton & Marais 1990:44). Merriam (1988:7) supports this by stating that descriptive research is undertaken when description and explanation of a phenomenon is needed and not prediction based on cause and effect.

This study intended to describe a conceptual framework, model (with guidelines) and education programme for transformational leadership by nursing unit managers within the Judeo-Christian philosophy and Nursing for the Whole Person Theory. Theory generation was utilised in phase one of the study.

2.3.4 Theory generating

Dickoff, et al. (1968:198) define theory as "a conceptual system or framework invented to some purpose." Walker and Avant (1995:126) add that a theory is "an internally consistent group of relational statements that presents a systematic view of a phenomenon and is useful for description, explanation, prediction and/or control." Chinn and Kramer (1991:79) state that theory is "a creative and rigorous structuring of ideas that project a tentative, purposeful, and systematic view of phenomena." Theory generation, according to Walker and Avant (1995:23), includes three basic elements: namely, concepts, statements and theories.

Walker and Avant (1995:126) define concepts as the most elementary symbolic constructions through which people classify and categorise reality to make sense of and give meaning to their worlds.

Woods and Catanzaro (1988:20) add that concepts are the building blocks of a theory and that concepts are abstract characteristics, categories, persons or events to be studied. A concept is a term to which meaning is attached through formal definition or through common usage. Concepts may be abstract, such as anxiety, pain or may be concrete, such as electrolyte or imbalance. Concrete concepts are generally observable (Field & Morse 1985:4).

According to Field and Morse (1985:4), a construct may consist of several concepts. The construct of caring consists of concepts such as assertive and supportive acts. Chinn and Kramer (1991:60) define a construct as a highly abstract concept that is open to many interpretations for example well-being. Some constructs have little or no meaning outside the context of a theory or discipline. In the study the concepts relating to the notion of transformational leadership were identified and defined.

According to Mouton and Marais (1990:136), concepts and/or constructs are structured to form statements. A statement is a specific knowledge claim concerning an aspect of reality. Woods and Catanzaro (1988:20) state that a statement holds concepts in a theory together by indicating a relationship between the concepts. A statement is also called a proposition and is defined by Chinn and Kramer (1991:202) as a statement of relationship between two or more variables. These related statements are then combined to form the conceptual framework. The conceptual framework is then integrated into the paradigm for the study. (See figure 2.1 for a diagrammatic presentation of theory generation taken from Mouton and Marais (1990:125)).

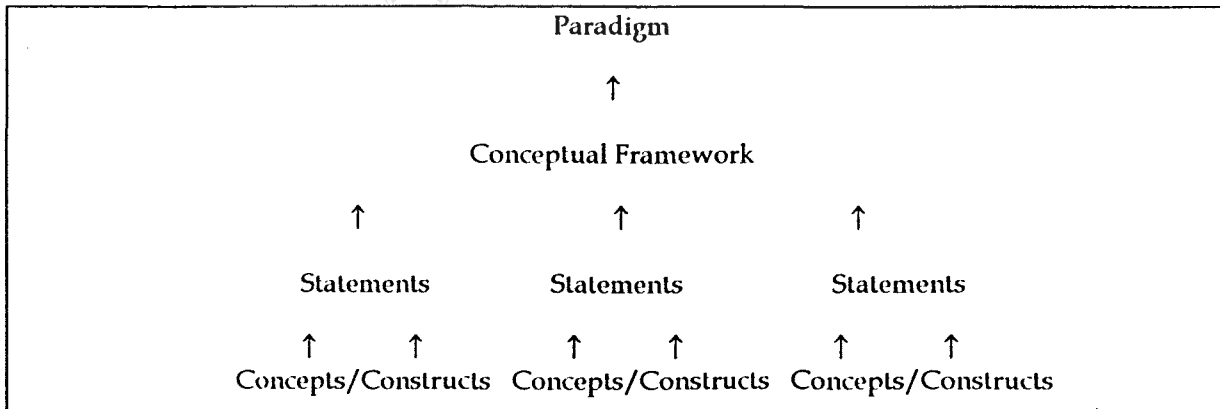


Figure 2.1: Theory generation

Botes (1990:3) states that theory generation takes place on the second level of research where phenomena and constructs from reality are explained. Theory generating focuses on the constructs of research (second level) and orders and arranges the statements obtained from research. In this way theories and models are developed to describe and explain the nursing practice or aspects thereof.

For the purpose of the study the researcher uses the levels of theory generation as described by Dickoff, et al. (1968:415-433), namely:

- Level one: Factor-isolating;
- Level two: Factor-relating;
- Level three: Situation-relating and
- Level four: Situation-producing.

This classification was done from a functional thought process, as Dickoff, et al. (1968:423) are of the opinion that if nursing theory is to have impact on the nursing practice it should be at the level of a situation-producing theory. As the researcher accepted the functional reasoning approach methodologically, this classification by Dickoff, et al. was suitable for the study. The researcher only progressed until level three (situation-relating) of this classification. The first three levels are now described briefly.

During level one (factor-isolating theory) concepts and ideas are named, classified and categorised. In the study, this level involved the identification, classification and categorisation of concepts and ideas from literature sources according to the survey list of Dickoff, et al. (1968:423). This survey list includes the following aspects:

- Agency: Who or what performs the activity ?
- Patiency or recipiency: Who or what is the recipient of the activity ?
- Framework: In what context is the activity performed ?
- Terminus: What is the end point of the activity ?
- Procedure: What is the guiding procedure, technique or protocol of the activity ?
- Dynamics: What is the energy source of the activity ?

Identified concepts were defined according to the guidelines of Copi and Cohen (1990:151-154) who state that a definition should state the essential attributes, not be circular, neither be too narrow nor too broad, not be ambiguous and not be stated negatively where it can be stated positively.

During level one, an extensive literature review was conducted, utilising national, international, primary and secondary sources. Factor-isolating was refined by utilising the first two steps of Wandelt and Stewart's (1975:64-69) three-step method, namely to write a dictionary definition for each concept and to write a handbook or other source definition for each concept. After this level a conceptual framework for transformational leadership by nursing unit managers was described (see chapter three).

During level two (factor-relating theory) the concepts were placed in relation to each other. This level required correlating factors in such a way that these concepts become a larger meaningful unit that depicts a situation. In this level, factor-relating was conducted according to the guidelines of Chinn and Jacobs (1987:135). After this level a model, with guidelines for implementation, for transformational leadership by nursing unit managers was described (see chapter four).

Level three (situation-relating theory) is composed of descriptive statements that indicate the presence, absence or range of variation between two factors. In this level the predictive and promotive theories are included. During the study, this level was implemented in two steps. Firstly, an education programme was explored, described and implemented (see chapter five). Thereafter, the described model (and guidelines) were implemented in four nursing units and evaluated through a qualitative, descriptive case study (see chapter six). Lastly, the model was also evaluated and validated by a panel of experts according to the guidelines proposed by Chinn and Kramer (1991:138-139).

Walker and Avant (1995:5-14) identify four levels of theory.

- Meta-theory: Meta-theory focuses on philosophical and methodological questions related to the development of a theory base for nursing.
- Grand nursing theory: Grand nursing theory (like the Nursing for the Whole Person Theory) consists of global conceptual frameworks that define the broad perspectives for practice and the ways of looking at nursing phenomena.
- Middle-range theory: Middle-range theories fill the gap between grand nursing theories and the nursing practice, are tested in reality, and therefore act as reference points for further refining grand nursing theories.
- Practice theory: The essence of practice theory is a desired goal and prescriptions for action to achieve the stated goal.

Walker and Avant (1995:14) also indicate the linkages among the levels of theory development as indicated by figure 2.2.

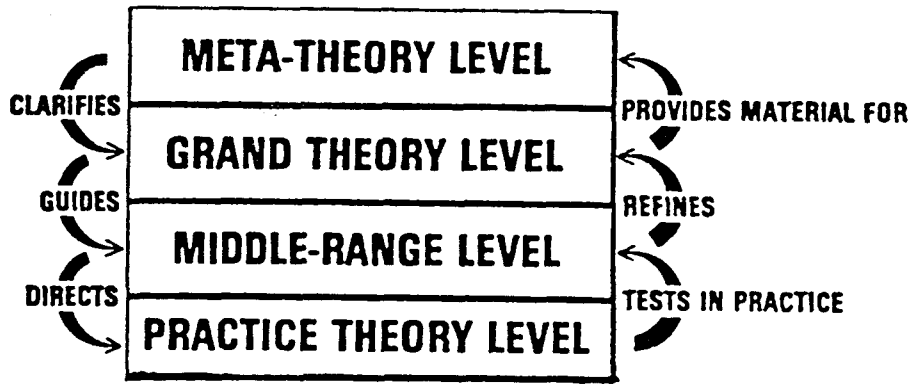


Figure 2.2: Linkages among levels of theory development

This study is on the level of a practice theory (level three). Concepts were identified, classified, defined and analysed in a conceptual framework (see chapter three). Statements and relational statements were described, and the structure and the process of transformational leadership were described by means of a model (chapter four).

During this phase of theory generation, a model was also developed. Chinn and Kramer (1991:75) describe a model as a symbolic presentation of an empirical phenomenon. Mouton and Marais (1990: 141) list the following characteristics of models:

- models identify central problems; limit, isolate, simplify and systematise the domain that is investigated and
- models provide a new language within which the phenomenon may be discussed and provide means for making predictions.

In the study the model provides a framework for transformational leadership by nursing unit managers. The conceptual framework as explored and described during phase one was utilised for the development of the model. The assumptions, theoretical statements and process of the model was derived from the conceptual framework by means of deductive reasoning. The model is described in chapter four.

2.3.5 Qualitative case study

Yin (1989:23) defines the case study as:"... an empirical enquiry that investigates a contemporary phenomenon within its real life context, when the boundaries between phenomenon and context are not clearly evident; and in which multiple sources of evidence are used."

In the study the researcher investigated transformational leadership by nursing unit managers within the nursing unit by utilising multiple sources of evidence such as literature sources, leaders, followers and a panel of experts. According to Woods and Catanzaro (1988:156), a case study does not denote a single specific strategy, but a general strategy over a time-period utilising multiple data-collection methods. It is an in-depth investigation of an individual, group or organisation.

Yin (1989:20) states that in a case study the "how" and the "why" are asked about a contemporary set of events over which the researcher has little or no control. To enable the researcher to gain precision in formulating the questions for investigation, a literature review should be done on the topic. In this study the researcher formulated a conceptual framework for the case study (see chapter three). A model for transformational leadership was derived from the conceptual framework by means of deductive reasoning. This model is described in chapter four.

Merriam (1988:xii) states that qualitative case studies focus on a wholistic approach to gain an in-depth understanding of a specific situation and the people involved. The interest of the researcher was in the process rather than the outcome and in the discovery rather than confirmation. This study was concerned with transformational leadership by nursing unit managers. Merriam (1988:11-14) also describes four essential characteristics of the case study: namely, particularistic, descriptive, heuristic and inductive. These characteristics are elucidated briefly.

(a) Particularistic

The case study focuses on a particular situation, event, programme or phenomenon and therefore makes it applicable to the investigation of practical problems. In the study the focus was on transformational leadership by the nursing unit managers in specific nursing units within a specific nursing service.

(b) Descriptive

The end product is a rich description of the phenomenon under study. It includes a complete, literal description of the incident or entity being investigated over a period of time. It presents documentation of events, quotes and samples and is wholistic and lifelike. In the study a rich, complete and literal description of transformational leadership by nursing unit managers within a specific nursing service is given in chapter six.

Merriam (1988:14) lists several aspects that address the descriptive nature of the case study: namely, that it illustrates the complexities and the influence of personalities on the situation; that it includes vivid material, like quotations from interviews; that it obtains and presents information from a wide variety of sources and from the viewpoint of different groups.

(c) **Heuristic**

This indicates that the case study broadens the researcher's understanding of the phenomenon under study because previously unknown variables and relationships can emerge that lead to the rethinking of the phenomenon. The heuristic quality of a case study can manifest itself in:

- explaining the reasons and the background of a situation;
- explaining why an innovation is effective or ineffective and
- discussing and evaluating alternatives and therefore increasing the potential applicability (Merriam 1988:14).

(d) **Inductive**

An inductive process implies that generalisations, concepts or hypotheses emerge from the examination of data grounded in the context itself. Inductive reasoning was used in phase two of this study. Data collected by means of questionnaires, narrative sketches, nursing audit instruments, direct observation and contact sessions was interpreted in the context of transformational leadership by nursing unit managers (see chapter six). The hypotheses that emerged from the study are elucidated in chapter seven. The case study, according to Merriam (1988:11-14), also has other special features as summarised in table 2.1.

Table 2.1: Characteristics of qualitative case studies

Helmstadter (1970)	Guba and Lincoln (1981)	Hoaglin and Others (1982)	Stake (1981)	Wilson (1979)
• can be used to remedy or improve practice • results are hypotheses • design is flexible • can be applied to troubled situations	• "thick description" • grounded • wholistic and lifelike • conversation style format • illuminates meaning • builds on tacit knowledge	• specificity • description of parties and motives • description of key issues • can suggest solutions	• inductive • multiplicity of data • descriptive • specific • heuristic	• particularistic • wholistic • longitudinal • qualitative

(Table taken from Merriam (1988:12)).

There are specific disadvantages to the case study.

Disadvantages of the case study

According to Wilson (1989:144) and Yin (1989:21-22), the case study has the following disadvantages:

- there are still problems with the generalizability as it is difficult to argue with certainty that what is learned from a single case is representative of patterns in the entire population. In this study the researcher did not generalise to the entire population but explored and described transformational leadership by a specific constituency (nursing unit managers) in a specific context (nursing unit). The aim was therefore not to generalise;
- the methods for compiling case study data are not very rigorously described and this can be a source of ambiguity. In this case study the methods and protocols for data-collection and data-analysis were explicitly described to prevent this;
- researchers have very few guidelines on how much data is enough. In this study data was collected until a saturation point is reached and no new information is identified from the data-sources and
- data is collected by the researcher after a relatively long-term and close association between the researcher and the participants and this can lead to researcher bias influencing the findings and conclusions. In the study bias by the researcher was limited by the implementation of credibility strategies (see discussion of trustworthiness).

One of the characteristics of the naturalistic paradigm (as accepted by the researcher) is that it employs qualitative research methods because these methods are more responsive to the complexities of multiple realities. These methods also expose the nature of the transaction between researcher and participant more clearly and are more sensitive and adaptable to the numerous shaping influences and value patterns that may be encountered (Lincoln and Guba 1984:40). For a summary of the characteristics of qualitative research see table 2.2.

Table 2.2: Characteristics of qualitative research

Aspect	Qualitative Research
Focus	Quality (nature)
Philosophical roots	Phenomenology, symbolic interaction
Associated phrases	Fieldwork, ethnographic, naturalistic, grounded, subjective
Goal of investigation	Understanding, description, discovery, hypothesis-generating
Design characteristics	Flexible, evolving, emergent
Setting	Natural, familiar
Sample	Small, non-random, theoretical
Data collection	Researcher as primary instrument, interviews, observations
Mode of analysis	Inductive
Findings	Comprehensive, expansive wholistic

Table adapted from Merriam (1988:18).

The researcher selected a qualitative case study for the study because:

- transformational leadership is a relatively unresearched topic in the South African context, and the case study is suited to topics not very well studied;
- as transformation occurs over time, this study would not be able to make use of a once-only data-collection situation. Case studies are well suited to the study of a process over a period of time. In the study data was collected over a period of 12-14 weeks;
- the aim of the researcher is to develop a model (with guidelines) for transformational leadership by nursing unit managers. Case studies are suited to provide rich and diverse information that can be utilised to refine the model that the researcher has derived by means of deductive reasoning from the conceptual framework;
- as the researcher needs insight into transformational leadership by nursing unit managers, the case study is a suitable strategy as it focuses on discovery, insight and understanding of a phenomenon and
- a case study can test or build theory such as the model for transformational leadership, incorporate purposive sampling, include quantitative and qualitative data within the naturalistic paradigm as used by the researcher.

(The above-mentioned reasons are based on the advantages of case studies described by Wilson (1989:143), Burns and Grove (1993:300), and Yin (1981 (b):98).

A qualitative design was also selected because of the specific characteristics described by Cresswell (1994:162-163) and other authors:

- qualitative research occurs in natural settings. In the study the researcher explored and described transformational leadership by nursing unit managers in nursing units in a specific nursing service;
- the data from a qualitative study is descriptive through words, rather than numbers, with the focus on the participants' perceptions and experiences. In the study the focus was on the experience and perception of the leaders and the followers (as participants) of transformational leadership;
- qualitative research focuses on the process as well as the outcome (product). In the study the researcher focused on the process by exploring and describing the implementation and experience of transformational leadership in the nursing unit. The researcher focused on the product (outcome) by exploring and describing the individual and nursing unit transformation;
- data is interpreted in the context of a case rather than generalised. In the study the researcher explored and described the data within the context of a nursing unit in a specific nursing service;
- objectivity and truthfulness is based on a process of trustworthiness and verification. This researcher utilised the strategies of trustworthiness as described by Lincoln and Guba (1984) and Merriam (1988) and
- during qualitative research, the researcher is not interested in causal laws, but in people's beliefs and experiences. Phenomena are viewed wholistically and contextually (Brink 1993:35). In this study the researcher viewed transformational leadership wholistically within the context of the nursing units. The researcher was not interested in the causal laws but in the leader's beliefs and experiences on transformational leadership.

2.4 RESEARCH STRATEGIES

The research strategies are the techniques utilised during the research process. According to Walker and Avant (1995:29-28), the approaches to theory building include analysis, synthesis and derivation. A discussion of these aspects follows.

(a) Analysis

During analysis the researcher clarifies and refines concepts, statements and theories. The concept is divided into parts to understand the use, nature and properties of the concept. Analysis was utilised throughout the study.

(b) Synthesis

Synthesis combines isolated pieces of information and important relationships between concepts are sifted out. In synthesis, information collected through observation is used to construct a new concept, statement or theory. In the study concepts and statements were developed for transformational leadership by the nursing unit managers. Synthesis was also utilised throughout the study.

(c) Derivation

Derivation is when a concept, statement or theory is redefined and transposed from one context to another. The strategy of derivation was utilised in phase one (description of the conceptual framework - chapter three) where concepts, statements and theory on transformational leadership were transposed from the general framework to the framework of nursing unit management. The model (as described in chapter four) was then derived from the described conceptual framework through deductive reasoning. Deduction is discussed later in this chapter.

The following reasoning strategies were also utilised.

(d) Induction

Mouton and Marais (1990:103) state that in induction the researcher enters into a research project without a clear conceptual framework. After the data has been generated, relationships or patterns are formed resulting in a systematic explanation or a conceptual framework. The strategy is applicable to exploratory and descriptive studies. Chinn and Kramer (1991:20) define induction as reasoning that moves from the specific to the general where a series of particulars are combined into a larger whole. In inductive research, particular events are observed and analysed as a basis for formulating general theoretical statements.

Mouton and Marais (1990:112) are of the opinion that "an inductive argument, genuine supporting evidence (as expressed in the premises) can only lead to highly probable conclusions." In an inductive argument, supporting statements lend gradual support to the conclusion. The strategy was utilised in phase one (conceptual framework) of the study.

(e) Deduction

Chinn and Kramer (1991:197) define deduction as a form of reasoning moving from the general to the specific. In deductive logic, two or more premises are used as relational statements to come to a conclusion. In deductive research processes, an abstract theoretical relationship is used to arrive at specific questions or hypothesis (hypotheses for the study are elucidated in chapter seven).

Mouton and Marais (1990:112) state that "in a deductive argument, true premises necessarily lead to true conclusions; the truth of the conclusion is already either implicitly or explicitly contained in the truth of the premises. In deductive logic the relational statements include variables that can be categorised in relation to each other." It is also a "system of reasoning in which propositions are interrelated in a consistent way" (Chinn & Kramer 1991:65). Deduction was used in the literature analysis and the description of the conceptual framework for transformational leadership by nursing unit managers (phase one).

2.5 ETHICAL CONSIDERATIONS

The position paper of the South African Nursing Association (1991:1-5) on ethical standards for nurse researchers was used.

2.5.1 Quality of the researcher

The researcher and the supervisor adhere to the highest possible standards and do not attempt aspects beyond their capabilities. In the study the researcher and the supervisor have the necessary knowledge, skill and experience to maintain the highest possible standards. The researcher has approached the study with integrity and has tried to remain aware of personal biases and values. (The metatheoretical assumptions for the study and of the researcher are described in chapter one). The study was done honestly, without fraud, acts of bad faith or misconduct at any stage. All findings are reported fully, without the omission of significant data. The identity and qualifications of the researcher were known to the participants, as the education programme and the implementation of the study were handled by the researcher.

2.5.2 Confidentiality and anonymity

Confidentiality means that any information that a participant divulges is not made public or made available to other people. When a person agrees to participate in a research study he/she waives this right because information is made available in the research report. The anonymity of a person and an institution should however be protected by making it impossible to link the specific data to the participant or to the institution. Anonymity is safeguarded as all raw data is destroyed after the compilation of the final thesis. No participant and/or group and/or institution is referred to by name.

2.5.3 Privacy

Privacy means that a person can think and behave without the possibility of private behaviour or thoughts later being used to embarrass the participant. Only the quantity of data required to achieve the aims of the study should be collected. In this study data was only collected until the data became saturated.

2.5.4 Consent

Written informed consent should be obtained from all participants. In the study the aims, objectives, methods, duration and participation needed in the study were explained to the participants (see the overview - annexure A). Participants were also informed that no remuneration is given. Written consent (see annexure B) was obtained from all the participants.

2.5.5 Harm

No known or expected side-effects or harmful aspects to the nursing unit manager (leader), other nursing staff members (followers) or patients were expected or have resulted from this study.

2.5.6 Termination

The study is terminated if it no longer adheres to the standards that were formulated during the planning phase. Any participant may also terminate participation if he/she wishes, despite initially consenting to participate.

During all research studies, trustworthiness should be established and then maintained throughout. A discussion of the trustworthiness of the study follows.

2.6 TRUSTWORTHINESS OF THE STUDY

To establish and maintain trustworthiness for the study, the model of Lincoln and Guba (1984) is used for all phases. The specific suggestions of Merriam (1988:166-170) and Yin (1989:95-103) on the trustworthiness of case studies are also implemented. The first aspect mentioned is truth value (credibility).

2.6.1 Truth Value (credibility)

Truth value addresses the question as to whether the research has established confidence in the truth of the findings and deals with the question of how the findings of the research match reality. One of the assumptions of qualitative research shared by naturalistic inquiry of the research is that reality is wholistic, multidimensional and ever-changing. The case study researcher attempts to portray the world as it appears to the people in it (Merriam 1988:167). The researcher portrayed transformational leadership by the nursing unit manager as it appears to and is experienced by the leader and the followers in that nursing unit. Specific strategies can be implemented to enhance truth value. One of these strategies is triangulation.

(a) Triangulation

Triangulation includes the utilisation of multiple investigations, multiple sources of data and multiple methods to confirm the emerging findings.

Multiple investigations

Merriam (1988:169-170) and Lincoln and Guba (1984:301) propose the utilisation of multiple investigators. As multiple investigators were not involved in this study, the researcher utilised different independent researchers as external coders or co-analysts at different phases of the study to enhance the trustworthiness. A study leader and two other senior academic persons (members of the doctoral committee) were also involved in the study from the planning phase until the final report.

An independent researcher was utilised to validate the analysis, quantification and interpretation of the results from the questionnaires to the leaders and the followers. The researcher also used an external, independent coder to assist with the data-analysis of the narrative sketches of the leaders. Final conclusions were decided upon after joint discussions between the researcher and the coder. To enhance the consistency of the validation of questionnaires and the analysis of the narrative sketches, specific protocols were utilised (see annexures I, K). For the nursing audit in the nursing units, the researcher utilised a standardised and tested nursing audit instrument (this instrument is standardised and tested throughout this group of hospitals - see annexure O). The nursing audit was conducted by a nursing audit committee of this hospital (as described later in this chapter). The researcher was not a member of this nursing audit committee and therefore had no input into or influence on the outcome of the nursing audit for the selected nursing units.

Multiple sources of data

Merriam (1988:169-170), Yin (1989:95) and Lincoln and Guba (1984:301) support the utilisation of multiple sources of evidence to provide multiple measures of the same phenomenon. Findings and conclusions made from these sources are thus more convincing and accurate, as they are based on several sources of information, following a corroboratory mode.

For the exploration and description of the conceptual framework and the model several national and international, published and unpublished, primary and secondary literature sources were utilised as multiple sources of evidence (see bibliography). In the exploration and description of the education programme the conceptual framework (chapter three) and model with guidelines (chapter four) were used as sources of evidence. For the educational principles to develop the education programme, several literature sources of evidence were also consulted (see bibliography). For the implementation of the model, the leaders, followers and the selected nursing units (as natural settings) were the multiple sources utilised to provide evidence. Lastly, a panel of experts was utilised as sources of evidence in the evaluation, validation and refinement of the model.

Multiple methods

Merriam (1988:169) and Lincoln and Guba (1984:301) propose triangulation by multiple (different) methods.

In the study the following methods of data-collection were utilised:

- questionnaires to the leaders and the followers to explore the behaviours of transformational leadership by the leaders (see annexures D and E);
- narrative sketches to explore the experience of the leaders and followers upon the implementation of transformational leadership in the nursing unit;
- nursing audit instruments (see annexure O) to evaluate the nursing care rendered in the nursing unit;
- direct observation by the researcher in the selected nursing units to collect data on the setting, participants, activities and interactions;
- contact sessions between the leader and the researcher by means of individual, unstructured interviews to collect feedback on the implementation of the model and to work on the objectives, strategies and actions planned for the nursing unit and
- a list of criteria as suggested by Chinn and Kramer (1991:138-139) to evaluate the model.

Merriam (1988:169) suggests member checks, peer examination, long-term observation (prolonged engagement), and the clarification of researcher biases as other methods to enhance truth value.

(b) Member checks

Member checks refer to a process whereby data is referred back to the participants for evaluation and validation throughout and at the end of the study (Merriam 1988:169). Yin (1989:44) supports this strategy as he states that the draft case study report should be reviewed by the key informants.

This strategy was implemented during the qualitative, descriptive case study. All collected data was clarified with the leaders throughout the study. After four to five direct observation and contact sessions, the analysed data was given to the leaders to evaluate and validate. Inaccurate or unclear findings, interpretations and presentations were corrected or clarified. At the end of the qualitative, descriptive case study, the draft case study report was presented to the leaders for evaluation and validation before the final thesis was compiled.

(c) Peer examination

Merriam (1988:169) states that peer examination is where the research process and the outcome are discussed with a colleague who is an experienced researcher. During the study, outcomes were discussed with colleagues and the study leader. This external and independent study leader monitored the study from the planning stage through to the final report.

Two senior researchers (as members of the doctoral committee for the study) also monitored the study. The methodology and the outcome of the study were presented for validation and clarification at two seminars.

(d) Prolonged engagement

Merriam (1988:169) and Lincoln and Guba (1984:301) advise long-term observation (prolonged engagement) to enhance the truth value of a study. Prolonged engagement is when data is collected over a period of time in order to increase the validity of the outcomes. The researcher should spend an extended period of time with the participants to allow the researcher to check perspective; to allow the participants to be acquainted with the researcher and for mutual trust to develop.

In the study prolonged engagement was obtained as the researcher:

- presented the education programme to the nursing unit managers in three sessions over a two-week period, totalling 16 hours and
- the researcher arranged direct observation sessions in the nursing units and conducted contact sessions with the leaders on a continuous basis over a period of 12-14 weeks to provide support and to collect data from the leaders, followers, interactions and the setting.

Lastly, Merriam (1988:170) states that researcher biases should be clarified.

(e) Researcher biases

Researcher biases are clarified by elucidating the researcher's assumptions and theoretical orientation at the outset of the study. In the study the researcher described the metatheoretical, theoretical and methodological assumptions for the study in chapter one. The assumptions and the theoretical statements upon which the model were based, are described in chapter four. The assumptions for the education programme (adult education and constructivism) are described in chapter five.

Yin (1989:99-103) adds the creating of a case study database and maintaining a chain of evidence as strategies to enhance the truth value (validity) of a case study.

(f) Creating a case study database

Notes are likely to be the most common component of a database. These notes take a variety of forms and should be divided into groups and/or categories and be stored in such a manner that they can be retrieved efficiently by the researcher and also by any other person. In the study the researcher used different files to store the received feedback. The outcome and all the data collected were stored individually for each nursing unit. All these files were marked clearly to ease identification. The analysis of the evidence from the case study (chapter six) was stored on the hard disk of a personal computer with back-up copies on floppy disks.

(g) Maintaining a chain of evidence

To maintain a chain of evidence means that an external observer (any reader of the case study) can follow the derivation of any evidence from the initial research questions to the ultimate case study conclusion. The external observer should be able to trace the steps from the conclusion back to the research questions and then back to the conclusion (Yin 1989:301).

Yin (1989:103) suggests the following strategies to maintain a chain of evidence:

- the case study report should repeatedly cite the case study data-base;
- the data-base should reveal the actual evidence and also include and indicate the circumstances under which the evidence was collected and
- it should be evident that the data-collection followed the procedures stipulated in the protocol.

In the study the chain of evidence was obtained as follows:

- the researcher provided a rich, detailed description of all strategies utilised and the evidence obtained during the case study. Evidence was supported by means of direct quotations from the case study database;
- the researcher revealed the actual evidence and included and indicated the circumstances under which the evidence was collected and
- in all the procedures (data-collection, data-analysis and data-validation) the compiled protocols (see annexures F to N) were implemented and adhered to.

2.6.2 Transferability (applicability)

Merriam (1988:173) states that transferability (external validity) is concerned with the extent to which the outcomes of a specific study can be applied to other situations. However, the purpose of a case study is not to generalise from one situation to the next but to understand the particular aspect intimately. There are however certain aspects of one case study that can be applied to other case studies and the researcher has to enhance the possibility of transferability.

According to Merriam (1988:177), the researcher can improve the transferability of a study by providing a rich, thick description so that anyone interest in transferability has a base of information. Lincoln and Guba (1984:298) support this strategy in the statement that to enable anyone to make a transfer, evidence should be accumulated about contextual similarity. This is attained by providing sufficient descriptive data to make similarity judgements possible. Lincoln and Guba (1984:16) also propose a thick description with the widest possible range of information to "enable someone interested in making a transfer to reach a conclusion about whether transfer can be contemplated as a possibility."

During the study a detailed description of the aims and objectives, methodology and outcome of the study was given so that anyone interested in transferability has a solid framework for comparison.

Another strategy to enhance the transferability is to establish the typicality of the case by describing how typical the programme, event or individual is compared to others, so that users can compare this with their own situation (Merriam 1988:173-177). The data from the study is of a contextual, exploratory and descriptive nature in order to explore and describe a conceptual framework and a model for transformational leadership by nursing unit managers.

Yin (1989:43-44) states that case studies rely on analytical generalisation where the researcher strives "to generalize a particular set of results to some broader theory." Generalisation is not automatic, however. A theory should be tested through replication. As the study included a once-off study with four nursing units, it is therefore recommended (see chapter seven) that this model for transformational leadership be tested more broadly. Several hypotheses have also been generated for testing to confirm transferability.

2.6.3 Confirmability (neutrality)

Neutrality refers to the objectivity of data and to inter-relational confirmability. Lincoln and Guba (1984:318-319) state that the technique for establishing confirmability is the audit trail during which an inquiry audit is conducted. The following records are included in the audit:

- raw data (field notes, instruments for data-collection);
- data-reduction and analysis products (condensed notes, quantitative summaries);
- data-reconstruction and synthesis products (outcomes and conclusions);
- process notes (protocols, designs, strategies) and
- materials related to intention and dispositions.

In the study the following were made available to the study leader or any other person wishing to conduct an inquiry audit:

- questionnaires to the leaders and the followers, narrative sketches, nursing audit instruments, nursing audit outcome reports, field notes and other information collected during the case study (raw data);
- outcome from the analysis of raw data (data-reduction and analysis products);
- research protocols for all procedures (see annexures F to N) and
- the research proposal (material related to intentions and dispositions).

Merriam (1988:172-173) suggests the audit trail as a measure calculated to establish the consistency (reliability) of a study. He adds that the audit trail also includes the detail on how the data is collected, how categories are derived and how decisions are made through inquiry (the research methodology, design, methods and strategies are described in this chapter). Lastly, consistency should be enhanced.

2.6.4 Consistency (reliability)

Merriam (1988:170-171) states that consistency refers to the extent to which the researcher's outcomes can be replicated. However, qualitative research does not seek to isolate the laws of human behaviour, but to describe and explain the world according to these laws in the world. As there are many interpretations to happenings, studies cannot be repeated.

Merriam (1988:170-172) is of the opinion that the researcher should implement the following strategies to enhance consistency:

- the researcher's position: The researcher should explain the assumptions and theory for a study. In the study the researcher described the metatheoretical, theoretical and methodological assumptions in chapter one. The conceptual framework (chapter three) and the model for transformational leadership (chapter five) were described in detail;
- triangulation: The aspect of triangulation was discussed earlier in this chapter (see "truth value") and
- audit trail: The aspect of the audit trail was discussed earlier in this chapter ("confirmability").

Miles and Huberman (1984) identified characteristics that are necessary to assess the trustworthiness of the researcher, namely:

- the degree of familiarity with the phenomena and study setting;
- a strong interest in conceptual or theoretical knowledge, and the ability to conceptualise large amounts of qualitative data and
- good investigative skills and experience in qualitative research.

This researcher has the cognitive knowledge concerning transformational leadership and the conducting of qualitative research. She is skilled in quantitative research strategies and has also conducted a qualitative research study. A well-qualified study leader and two other senior academic persons provided support and guidance to the researcher.

All the above-mentioned aspects concerning the trustworthiness apply to both phases of the study. When there are additional aspects ensuring trustworthiness that are applicable to a specific phase of the study only, those aspects of trustworthiness are described separately within the description of the research method of that particular phase.

2.7 RESEARCH METHOD

The research method includes the population, sampling, sample, data-collection and analysis techniques. The study was conducted in two phases.

2.7.1 Phase one: Exploration and description of a conceptual framework and a model for transformational leadership by nursing unit managers

2.7.1.1 Sample population

The population for this phase of the study included international and national theoretical and empirical resources on the topic of transformational leadership. Theoretical literature includes models, theories and conceptual frameworks whereas empirical literature includes relevant studies in journals and books and also unpublished material such as masters and doctoral dissertations. Primary and secondary sources were utilised for the study. A primary source is written by the person who originated or generated the published ideas, or who conducted the research study and secondary source summarises or quotes content from primary sources, which were only utilised when the primary source was not available in South Africa. An attempt was made to increase the depth of the literature used by including a vast number of quality sources. In an attempt to broaden the literature the researcher utilised as many different authors' opinions on the topic as possible and where relevant (see bibliography).

2.7.1.2 Sampling criteria

The following sampling criteria were applied:

- preference was given to primary sources because secondary sources are already an interpretation of another author`s ideas;
- preference was given to the most recent sources;
- attention was given to the sources from well-known experts on leadership and transformational leadership;
- the researcher started the search with articles, dissertations and theses, as these literature sources are usually easily available and the most up-to-date. These also put the researcher on the track of other relevant resources and
- models and theories developed in the South African context were given preference.

2.7.1.3 Sampling method

Public, academic and special libraries were visited and a bibliography was compiled from the available card and computer catalogues, indexes of journal articles, lists of abstracts of journal articles, lists of references of previous research studies, academic and research articles and information in books.

Purposive sampling was used. Burns and Grove (1993:246) state that purposive sampling is the conscious selection of a participant into a study. The selection of sources is based on their quality and relationship to the aim and objectives, and according to the sampling criteria.

2.7.1.4 Theory generation and model development

The process for theory generation and model development was described earlier in this chapter. Burns and Grove (1993:158-159) describe the techniques of skimming, comprehending, analysing and synthesising for the extraction and utilisation of relevant information and content from selected sources.

Skimming is a quick review of a source to gain a broad overview of the content. Comprehending includes the careful reading of the source to understand the flow of idea. Ideas useful to the conceptual framework are highlighted and this may include relevant concepts, definitions of those concepts and the relationships among the concepts. Analysing is when content is divided into categories. Through synthesis, interrelated ideas from several sources can be grouped (clustered) together to form a whole. These techniques were used in the exploration and description of the conceptual framework.

According to Field and Morse (1985:4) a conceptual framework "is a theoretical model that the researcher has developed to show the relationship among constructs and/or concepts for that particular study." This is supported by Wilson (1989:724) who states that a conceptual framework is "a preliminary stage of a theory wherein interrelated concepts provide a structure for organising phenomena of interest in nursing practice or research." A conceptual framework is a product of creative appraisal and the use of literature by evaluating each statement for its relevance.

Burns and Grove (1993:43,171) define a conceptual framework as "the abstract, logical structure of meaning that guides the development of the study and enables the researcher to link the outcomes to nursing body of knowledge." Existing theories and models provide a basis for developing a conceptual framework. The conceptual framework should be carefully structured, clearly presented and integrated into the methodology of the study.

The specific steps for forming a conceptual framework according to Mouton and Marais (1990:127) were described earlier in this chapter and implemented in the study as follows:

- concepts for transformational leadership were identified, classified according to the survey list of Dickoff, et al. (1968:423) and defined according to the criteria stated by Copi and Cohen (1990:151-154);
- statements were developed;

- all concepts and statements were refined and then applied to the setting of transformational leadership and
- a conceptual framework for the study was then described (chapter three) by utilising the survey list of Dickoff, et al. (1968:423), as described earlier in this chapter.

2.7.1.5 Evaluation, validation and refinement of the model

The model (as described in chapter four) was evaluated by a panel of experts (n=8) according to the criteria by Chinn and Kramer (1991:138-139). These experts were two model development experts who hold doctoral degrees in nursing and the two nursing service managers in the participating hospital (nursing service). The nursing service managers hold masters degrees in nursing. The four nursing unit managers involved in the case study also evaluated the model 12-14 weeks after the implementation of transformational leadership in the nursing units. The model was evaluated for clarity, simplicity, generality, acceptability, and importance. It was further validated and refined through the outcome from the qualitative descriptive case study and the feedback received during the education programme. Validation in this study does not refer to the testing of the hypotheses but to the operational value of the model.

2.7.1.6 Specific trustworthiness of the conceptual framework and model

The general criteria for trustworthiness as described by Lincoln and Guba (1984), and cited earlier in this chapter, apply to the conceptual framework and model and were further enhanced because the following techniques were utilised:

- levels of theory development and survey list by Dickoff, et al. (1968:415-433);
- guidelines for defining concepts by Copi and Cohen (1990:151-154);
- three-step method for concept definition of Wandelt and Stewart (Wandelt & Stewart 1975:136);
- the model was evaluated according to the criteria by Chinn and Kramer (1991:138-139) and through the qualitative, descriptive case study and
- the researcher utilised and included representative sources, such as international, national, theoretical and empirical literature sources.

Phase two of the study included the implementation of the model.

Phase two: Implementation of the model

The implementation of the model comprised the exploration and description of the education programme and the evaluation, validation and refinement of the model.

2.7.2 Exploration and description of the education programme

2.7.2.1 Sampling criteria

The following sampling criteria were applied:

- preference was given to primary sources over secondary sources and
- models and theoretical frameworks developed within the South African context were given preference.

2.7.2.2 Sampling method

Purposive, non-selective sampling was used, based on the quality and applicability in relation to the objectives for this phase of the study and the sampling criteria.

2.7.2.3 Sample

The conceptual framework and model, as explored and described during phase one of the study, was utilised for the theoretical content of the learning package for the education programme. For the didactical development of the programme the following theories and models were utilised:

- Klopper (1994 (a)): A model for self-guided learning in nursing.
- Knowles (1984): Andragogy.
- Gravett (1991): Adult education.

These theories and models were utilised as they are based on adult education (Gravett 1991, Knowles 1984) and the constructivistic learning theory (Klopper 1994 (c)). The model of Klopper (1994 (a)) is also based on the Judeo-Christian philosophy and the Nursing for the Whole Person Theory.

2.7.2.4 Data-gathering and data-analysis

The conceptual framework and model, as explored and described during phase one, was utilised for the theoretical content of the education programme. For the didactical development of the education programme, the principles of adult education and the constructivistic learning theory were utilised. These principles are described in detail in chapter five. For the collection of relevant data the techniques of skimming, analysis and synthesis (as described earlier in this chapter) were utilised. The aim, duration, scheduling, presentation, structure and content of the education programme were described in chapter five (see annexure C for the learning package).

2.7.2.5 Specific trustworthiness of the education programme

The general criteria for trustworthiness as described by Lincoln and Guba (1984), and described earlier in this chapter, apply to the education programme.

The following factors enhanced the trustworthiness of the education programme:

- the didactical development of the education programme was based on valid and trustworthy models by Gravett (1991) and Klopper (1994 (a)) and
- the content for the education programme was based on the trustworthy conceptual framework and model that are described in chapters three and four.

2.7.3 Evaluation, validation and refinement of the model

The evaluation, validation and refinement of the model also forms part of phase two. A descriptive qualitative case study was utilised. The detail of the case study strategy was discussed earlier in this chapter. To implement the case study strategy, the specific steps as described by Wilson (1989:143-145) and Merriam (1988:41-49) were utilised. According to Wilson (1989:143), case studies are more flexible, open and vulnerable to bias than other strategies because the researcher makes judgements regarding sources, amount and credibility of data, without many rules. However, to provide structure and enhance the credibility of the case study, the following steps should be followed:

- Determining the purpose of the case study;
- Identifying the unit of analysis;
- Determining the selection of data sources;
- Specifying the data collection plan and methods;
- Analysing and interpret the data and
- Preparing a report on the outcome.

A discussion of each of these steps follows.

2.7.3.1 Determining the purpose of the case study

In the study, the purpose of the case study was to evaluate, validate and refine the described model (with guidelines for implementation) for transformational leadership by nursing unit managers.

2.7.3.2 Identifying the unit of analysis

Merriam (1988:44) states that the unit of analysis can be an individual, a programme, an institution, a group or an event. In the study the units of analysis were:

- individual: the leader and the followers;
- group: group of followers in the nursing unit and
- organisation: nursing unit within a nursing service.

2.7.3.3 Determining the selection of data-sources

The data-sources for the study were selected according to the sampling method and the sampling criteria described.

(a) Sampling population

The sampling population included:

- leaders in charge of nursing units in a specific nursing service (private hospital);
- followers (registered nurses and/or midwives, enrolled nurses and/or midwives and auxiliary nurses in interaction with the leaders in the specific nursing units) and
- nursing units in a specific nursing service (private hospital).

(b) Sampling method

Merriam (1988:48) states that purposive sampling is based on the assumption that the researcher wants to discover, understand, and gain insight. The researcher therefore selects a sample from which the most information can be collected.

The researcher selected purposive sampling, as this method was suited to the objective of this phase of the study and also to the naturalistic paradigm used by the researcher. It was non-selective sampling as any leader or follower within the nursing service who complied with the sampling criteria and was willing to participate in the study was included, and not only ideal participants. Purposive sampling was used to include leaders and followers who complied with the following sampling criteria.

(c) Sampling criteria

The sampling criteria included the following:

- four leaders (registered nurses and/or midwives in charge of a nursing unit). Leaders from typical and non-typical nursing units were included;
- the leader should have completed the education programme for transformational leadership successfully;
- preference was given to the leaders with the most years of experience as in-charge nurses;
- followers (registered nurses and/or midwives, enrolled nurses and/or midwives and auxiliary nurses) in these four selected nursing units;
- the participant should have given informed consent and
- the participant should be able to speak, read and write English and/or Afrikaans.

In the study the data-collection plan and methods, and the analysis and interpretation of data were described simultaneously as data-collection and analysis were conducted simultaneously.

2.7.3.4 Specifying the data-collection plan, methods, analysis and interpretation

The data-collection method or instrument, aim for data-collection and the analysis of collected data are summarised in table 2.3.

Table 2.3: Data-collection, aims and analysis: phase two

Data-collection	Aims	Analysis
- Questionnaires to leaders • based on the strategies for transformational leadership - Utilised before and 12-14 weeks after implementation of model	- Explore individual transformation - Determine baseline for behaviours of transformational leadership as experienced currently by the leader	- Likert scale - Quantified
- Questionnaires to followers • to evaluate the leader on the strategies of transformational leadership - Utilised before and 12-14 weeks after implementation of model	- Explore individual transformation - Determine baseline for behaviours of transformational leadership as experienced currently by followers	- Likert scale - Quantified
- Nursing audit instrument - Assessment before and 12-14 weeks after implementation of model (Based on nursing unit documents)	- Explore nursing unit transformation regarding nursing care	- Assessment against pre-set criteria - Quantified
- Narrative sketches from leaders 12-14 weeks after implementation of the transformational leadership	- Explore the experience of leaders on transformational leadership	- Content analysis according to Tesch (1990)
- Direct observation • observation by researcher	- Collect data on the: • setting • participants • activities • interactions	- Analysis by researcher
- Contact sessions • unstructured interviews with leader	- Collect data on: • implementation of model • formulated objectives, planned strategies and actions	- Analysis by researcher

Each of these data-collection methods is discussed in detail.

(a) Questionnaires to the leaders and the followers

Two sets of questionnaires were developed. One set was developed for completion by the leaders before the implementation of the model (see annexure D). Twelve to fourteen weeks after the implementation of the model in the nursing unit, the leader completed this questionnaire again. Another set of questionnaires was developed for completion by the followers in the nursing unit (see annexure E). The followers evaluated their leader's implementation of the behaviours and strategies of transformational leadership before and 12-14 weeks after the implementation of transformational leadership in the nursing unit. These outcomes were compared to the outcomes obtained from the leader's own evaluation. The difference in the outcomes from the "before" and the "after" questionnaires indicated the individual transformation by the leader.

The content of these questionnaires was based on the specific strategies for each of the behaviours of transformational leadership described in the conceptual framework and the model (chapters three and four). The content included the specific strategies of self-awareness, trust, communication, vision and empowerment. The strategies were grouped within each behaviour and each of these behaviours were quantified as a category.

In these questionnaires the researcher utilised a Likert scale. According to Burns and Grove (1993:377), a Likert scale was designed to determine the opinion or attitude of a participant. It contains a number of declarative statements with a scale after each statement. Values are placed on each response. In the questionnaires the researcher intended to explore the degree to which the leaders have implemented the behaviours and strategies for transformational leadership. Frequency responses were thus needed. The researcher utilised a one-to-four scale. A rating of four represented always, three represented mostly, two represented often and one represented never. The researcher used an even Likert scale to avoid a middle scale of "sometimes" or "uncertain". This was done to ensure a specific positive or negative response from the participants.

Content validity was ensured as the content of the questionnaire is based on the conceptual framework. Face validity was obtained as these questionnaires were scrutinised by three experts on research strategies.

The collection of data from the questionnaires issued to the leaders was managed by the researcher according to the protocol for data collection: questionnaires to leaders (see annexure F). The collection of data from the questionnaires issued to the followers is managed by the leaders in the nursing units according to the protocol for data collection: questionnaires to followers (see annexure G).

In the analysis of the data from the questionnaires, each of the categories (self-awareness, trust, communication, vision and empowerment) were quantified to explore to what degree the leader implemented these strategies before and 12-14 weeks after the implementation of the model in the nursing unit. The outcomes, within each of these behaviours, were quantified to enable comparison in the outcomes prior to the implementation of the model and outcomes obtained after the implementation of the model in the nursing unit. After quantification the outcome were reflected by means of a percentage. Where a participant left an item blank, that item was disregarded for the quantification process. The analysis and quantification was conducted according to the protocol for data analysis: questionnaires (see annexure H).

As discussed earlier in this chapter, the researcher utilised an independent, external researcher to validate the analysis and quantification of the data from the questionnaires to the leaders and the followers. This validation process was conducted according to the protocol for the external controller regarding the questionnaires (see annexure I).

(b) Nursing audit instrument

A nursing audit was conducted in each of these nursing units prior to the implementation of transformational leadership and the outcome utilised as a baseline. The behaviours (with specific strategies) for transformational leadership were then implemented for a 12-14 week period. After this period, the nursing audit was conducted again to determine the transformation that occurred in the nursing audit outcome.

The nursing service utilised for the study was already using a nursing audit instrument that was standardised and implemented throughout this group of hospitals. It was therefore a tested and valid instrument and thus adopted by the researcher (see annexure O).

To enhance also the credibility of the nursing audit, the researcher utilised the same nursing audit committee to conduct the nursing audits. This nursing audit committee consisted of two nursing service managers, one clinical lecturer and in-charge nurses (on a rotation basis). The nursing audit was conducted by this audit committee according to the protocol for nursing audit (see annexure N). The researcher was not a member of this audit committee and could therefore not influence the outcome.

(c) Narrative sketches

After 12-14 weeks of the implementation of transformational leadership in the nursing units, the leaders were requested to write a narrative sketch and the following question was posed: "Please describe your experience of the implementation of the model for transformational leadership in your nursing unit." This data-collection session was conducted according to the protocol for data collection: narrative sketches (see annexure J).

The narrative sketches were analysed according to the strategy for the analysis of unstructured data described by Tesch (1990) in Cresswell (1994:142-145). Tesch includes the following steps:

1. Read through all the documents and get a sense of the whole.
2. Select one document and read through it, concentrating on the underlying meaning. Record thoughts in the margin.
3. List the topics and cluster similar topics together in categories.
4. Select codes for the different topics and record these codes next to the topics in the documents.
5. Endeavour to reduce the number of categories by grouping related categories together.
6. Decide on the final codes for categories.
7. Assemble the data belonging to each category.
8. Re-code the data.

The researcher condensed these steps to five and then utilised these steps as the protocol for the analysis of the narrative sketches (see annexure K).

To enhance the trustworthiness of the data-analysis and interpretation the researcher utilised an independent, external coder (as recommended by Merriam and also by Lincoln and Guba and described earlier in this chapter). To promote consistent and valid coding, analysis and consensus discussions, a protocol (based on the steps described by Tesch) was used by the researcher and the external coder (see annexure K).

(d) Direct observation and contact sessions

During direct observation the researcher collected data on the setting, participants, activities and interactions in the nursing unit. During the contact sessions the researcher conducted unstructured interviews with the leaders to collect data on the implementation of the model in the nursing unit. Data was collected according to the protocol for data collection: direct observation and contact sessions (see annexure L). As soon as possible after each contact and direct observation session the researcher analysed the data according to the protocol for data analysis: direct observation and contact sessions (see annexure M).

To enhance the trustworthiness of the direct observation, specific methods suggested by Merriam and also by Lincoln and Guba (and described earlier in this chapter) were utilised.

2.7.3.5 Preparing a report on the outcome

According to Yin (1981 (a):64), a case study report is usually a lengthy narrative without a predictable structure. Structure can, however, be provided if the study is built on a clear conceptual framework. For the study a conceptual framework was explored and is described in chapter three (phase one) of the study. In the study this thesis acts as a case study report.

Yin (1989:25) states that there are four applications for case studies, namely to:

- explain the causal links in real-life interventions that are too complex for surveys;
- describe the real-life context in which an intervention has occurred;
- explore situations in which the intervention has no clear, single set of outcomes and
- evaluate a specific intervention.

During this case study the objective was to evaluate, validate and refine the described model for transformational leadership by nursing unit managers. No explanation of the causal links in transformational leadership or testing of hypotheses were attempted. The researcher attempted to evaluate, validate and refine the described model against the real-life context of transformational leadership by nursing unit managers.

In the study the case study report was presented as a multi-case report with separate sections of the report devoted to the individual cases (nursing units). According to Yin (1989:134), a multi-case report includes a cross-case analysis. In the cross-case analysis of the study the data collected during the case study was utilised to evaluate, validate and refine the model (with guidelines for implementation) for transformational leadership by nursing unit managers.

The researcher also utilised a linear-analytic and chronological structure for the report. Yin (1989:137-139) describes a linear-analytic structure as a report where a "sequence of subtopics involves the issue or problem being studied, the methods used, the outcomes from the data collected and analysed, and the conclusions and implications from the outcomes." This type of structure is applicable to descriptive and exploratory case studies. The chronological structure is "to present the case study evidence in chronological order." This structure can also be used for exploratory and descriptive case studies.

2.7.3.6 The role of the researcher

According to Burns and Grove (1993:80), the use of the self is an important factor in the process of qualitative research. Merriam (1988:36) confirms this by stating that "the investigator is the primary instrument for gathering and analysing data." The researcher should respond to the situation by maximising opportunities for collecting and producing meaningful information by keeping an open mind during the data-collection and data-analysis process. This is also supported by Mouton and Marais (1990:43) who state that in an exploratory study the researcher should be willing to examine new ideas and be open to new stimuli. Merriam (1988:38) mentions sensitivity to the physical setting, the people and the communication between the people as an important factor. The researcher should also be a good communicator by establishing rapport, asking questions and listening attentively. Empathy and trust are the foundation of rapport.

One of the strategies recommended by Burns and Grove (1993:36) to facilitate openness, is bracketing, or the deliberate suspension of previous knowledge. This was done by the researcher to allow new knowledge and perspectives on transformational leadership. In order to achieve effective bracketing continual self-evaluation was needed. Merriam (1988:37) mentions that the case study researcher should have an enormous tolerance for ambiguity as the researcher should be able to adapt to unforeseen events and also change direction in the pursuit of meaning. In this study the researcher was guided by the objectives and the outcomes of each contact session. To enable the researcher to determine the direction for the case study, the data collected during each contact session was analysed as soon as possible after the collection thereof. Planning for the next contact and direct observation session was then done.

Contact was made and rapport was established between the researcher and the leaders during the education programme offered by the researcher (as discussed for phase two). Contact was made with the followers during the direct observation sessions in the nursing units. The researcher acted as facilitator and consultant to support and encourage the leaders and followers during the implementation of transformational leadership in the nursing unit. Therefore the researcher in this study was not seen as a stranger or an intruder. Mouton and Marais (1988:82) state that where the researcher is seen as a stranger or an intruder who interrupts the normal activity, this image of the researcher can effect the outcome of the study.

Feedback on the implementation of the model in the nursing unit was obtained through pre-arranged contact sessions (lasting between 30 and 90 minutes) between the leader and the researcher. During the sessions, feedback was given on aspects that needed follow-up, for example the progress made in attaining the formulated objectives for the nursing unit. After this specific feedback the contact session was allowed to follow a pattern of non-directiveness. The leaders usually responded by giving feedback on the implementation of the other aspects of the behaviours of transformational leadership, for example communication between the followers.

During these contact sessions the researcher listened attentively, showing interest and empathy. Feedback was encouraged by using specific interview skills, such as paraphrasing, head-nodding. Minimal questions were asked by the researcher. Field notes were utilised for recording.

The contact sessions were conducted in a general atmosphere of freedom of expression to encourage participants to discuss their opinion openly. A non-judgmental and unbiased attitude was adopted by the researcher. Only data that was absolutely necessary to reach the objectives of the study was collected. Data was only collected until saturation was reached.

The primary role of the researcher in qualitative research is that of a data collector. It therefore necessitates the identification of personal values and assumptions at the outset of the study. A description of personal values and assumptions as well as the metatheoretical assumptions for the study was offered in chapter one.

The role of the researcher also includes the obligation to respect the rights, needs, values and desires of the participants. In the study the research adhered to the ethical considerations for research as described by the South African Nursing Association and earlier in this chapter.

2.7.3.7 Specific trustworthiness of the case study

The researcher adhered to and implemented the strategies for trustworthiness as described by Lincoln and Guba (1984), Yin (1989) and Merriam (1988). These strategies were described earlier in this chapter.

2.8 SUMMARY

In this chapter it was argued and justified that a qualitative research methodology was followed in this study. Why and how a contextual, exploratory, descriptive and theory generating research design was followed was also discussed. The research strategies and methods utilised were described in detail and the strategies to enhance the trustworthiness of the study were elucidated. To conduct the study according to acceptable ethical standards, the researcher implemented the aspects described in a standpoint memorandum for nurse researchers (SANA 1991) and these aspects were also discussed in this chapter.

In chapter three the conceptual framework is explored and described.

CHAPTER 3

CONCEPTUAL FRAMEWORK

3.1 INTRODUCTION

The aim of this chapter is to explore and describe a conceptual framework for transformational leadership by nursing unit managers to facilitate individual and nursing unit transformation. The processes of analysis, synthesis and derivation as described by Walker and Avant (1995:28-29) are utilised and the conceptual framework is structured according to the survey list of Dickoff, et al. (1968:423) as follows:

- Agent: Who practices transformational leadership?
- Recipient: Who receives the activity of transformational leadership?
- Framework: In what context is transformational leadership practiced?
- Dynamics: What is the energy source for the practice of transformational leadership?
- Procedure: What is the guiding procedure, technique or protocol for transformational leadership?
- Terminus: What is the end point of transformational leadership?

Concepts were identified by means of a literature analysis. For the definition of identified concepts the first two steps of the three-step method by Wandelt and Stewart (1975:64-69) are utilised, namely to write a dictionary definition for each concept and then to write a handbook or other source definition of the concept. Essential characteristics are identified for each concept. Through derivation the concept is then written within the framework of the Nursing for the Whole Person Theory (NWPT). Lastly, a conceptual definition and statements are formulated for each concept (see figure 3.1).

Identify concepts through literature analysis

↓

Classify identified concepts according to survey list (Dickoff, et al. 1968:423)

↓

Define concepts by writing a dictionary and handbook definition (Wandelt & Stewart 1975:64-69)

↓

Identify essential characteristics for each concept

↓

Derivate each concept to the NWPT

↓

Formulate conceptual definition for each identified concept

↓

Formulate statements for each identified concept

Figure 3.1: Process for concept identification, classification and definition

3.2 THE LEADER AS AGENT

Dickoff, et al. (1968:425) identify the agent as the person performing the activity. The agent in transformational leadership is the professional nurse in charge of a nursing unit who is a clinical practitioner, nursing unit manager, transformational leader and researcher. In the study the agent is the leader (professional nurse in charge of a nursing unit) who practices transformational leadership to facilitate individual and nursing unit transformation. This leader (agent) is a spiritual being who functions in an integrated (body, mind, spirit) manner (see figure 3.2).

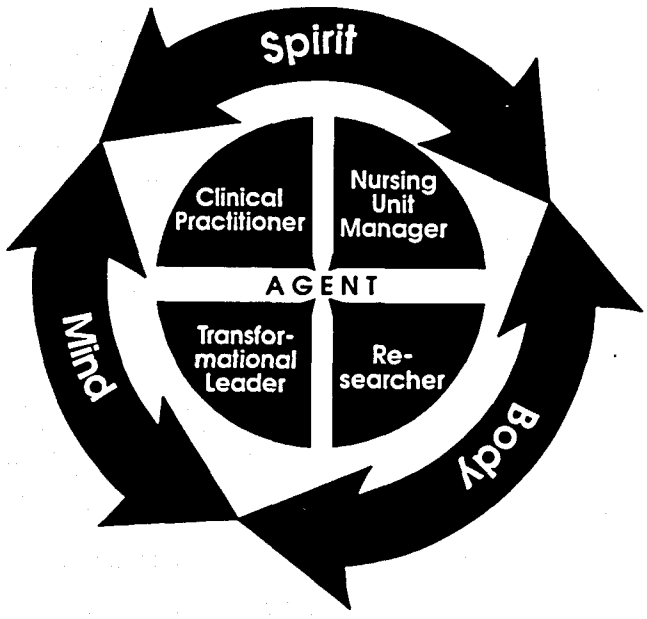


Figure 3.2: The leader as agent

The professional nurse is a person who is registered as a nurse under section 16 of the Nursing Act (Act no. 50 of 1978). This registration entitles the person to practice within the Republic of South Africa as an independent practitioner, and it also includes interdependent and dependent functions.

Independent functions include aspects that the person can implement and execute independently, such as the nursing process and supervision. The interdependent functions are the functions which include the interrelationship between the nurse and other members of the health team, such as doctors and physiotherapists. Each member of the health team acts as an independent practitioner and is personally accountable for his/her own acts and omissions, but individual members co-operate with each other (Mellish & Wannenburg 1992:5-6). The professional nurse also functions within the ethical norms and values of the nursing profession.

The scope of practice for the professional nurse is laid down by the South African Nursing Council (S.A.N.C.) in Regulation R2598 of 30 Nov. 1984 as amended. To enable the professional nurse (and therefore the leader/agent in the study) to function within the scope of practice for registered nurses (R2598, 1984 as amended) and to be personally accountable for his/her acts and omissions, this person is trained post-matric at a University (obtaining a basic degree) or at a College or Nursing affiliated to a nursing department at a University (obtaining a basic diploma). It is comprehensive training, lasting for a minimum period of four years. After successful completion the person is registered as a Nurse (General, Psychiatric and Community) and Midwife according to R425 of 25 February 1985.

After this basic comprehensive training (degree or diploma) the registered nurse has to decide in which discipline he/she prefers to build a career. For many specialised disciplines such as orthopaedic nursing, paediatric nursing, and theatre nursing, the registered nurse should follow a post-basic training course to equip himself/herself for his/her duties in that specific discipline. If the registered nurse chooses to practice in one of the four speciality disciplines for which he/she has been registered (general, psychiatry, community and midwifery) he/she can do so and develop specialised knowledge in the discipline of his/her choice by means of gaining more experience or by following an advanced course. The leader also practices as a clinical practitioner. A clinical practitioner is a registered nurse who has the necessary knowledge, skill and experience to function optimally in a specific discipline to provide quality nursing care to specific patients.

The clinical practitioner is the professional nurse responsible for the rendering of quality nursing care to the patient. As the patient is an individual and therefore dimensions such as the body, mind and spirit are included, the professional nurse as a clinical practitioner should provide quality and wholistic nursing care, paying attention to all the dimensions of the individual. In the provision of quality, wholistic nursing care, the professional nurse as clinical practitioner implements the nursing process, including the following element: assessing, planning, implementing and evaluating. Record-keeping is an integral part of each of the mentioned elements as the nurse registered under the Nursing Act (Act no. 50 of 1978) is personally accountable for his/her own acts and omissions and should thus be able to provide proof of the nursing care provided to the patient. Record-keeping therefore safeguards the patient as well as the professional nurse. The leader/agent in the study also acts as nursing unit manager.

The nursing unit manager is the professional nurse in charge of a nursing unit who has to manage the day-to-day running of the unit (Mellish & Lock, 1992:101). Morrison (1993:179) describes specific characteristics of a successful manager. Firstly, the manager should have a positive professional self-image; be committed to becoming an effective manager and believe that people are of worth and that all workers can contribute positively to the organisation. The manager should develop effective and therapeutic communication skills as well as competent leadership and motivational skills. Skills for conflict management, time management, problem solving, critical thinking and the management process should be enhanced. Lastly, the successful manager should also develop effective negotiation, delegation and team-building skills.

Mellish and Lock (1992:186-193) ascribe up-to-date knowledge, the ability to assess needs, calmness, a sense of fairness, good interpersonal relationships and an organising ability to the successful manager. Rabey (1994:195) defines a manager as "a senior in-charge position. The primary task is to achieve objectives through leadership by the use of objective setting, planning, action and control techniques." As the nursing unit manager, the leader implements the process of management.

Management is defined as a process by which a group directs others towards a common goal. It is also a process of achieving organisational goals by using and co-ordinating limited resources in order to achieve a goal in a changing environment (Morrison 1993:166-167). In the management of the nursing unit, the nursing unit manager implements the management process comprising planning, staffing, organising, leading and control.

Morrison (1993:167) defines planning as "the process of setting goals and deciding on the methods of achieving them." Morrison (1993:252) states that planning is the foundation of the management process and, without planning, the organisation will wander aimlessly and will eventually perish. Planning therefore interrelates with and influences all the other steps of the management process. According to Rabey (1994:37), planning is "looking into the future and preparing for it - it is the thinking that precedes the doing of a piece of work." When the planning is well done, the rest of the task is easier. Conditions may change at any time and therefore plans should be reviewed constantly. Planning is deciding how, when and where the work can best be done and by whom.

The nursing unit manager is involved in two kinds of planning: namely strategic and operational planning. Strategic planning is broad-based and includes planning of long-term goals and strategies. These long-term and broad-based plans extend three to five years into the future. Strategic planning helps the manager improve efficiency, eliminate duplication of efforts, concentrate resources and co-ordinate activities that assist in meeting organisational goals (Morrision 1993:183). According to Rabey (1994:196) strategic planning is "concerned with organisational objectives, and the policies that govern the acquisition, use and disposition of those resources."

Operational planning is the development of short-term plans for achieving the goals of the strategic plan. Through operational planning day-to-day business is transacted and new programmes are implemented. Both types of planning are important to the success of the organisation, according to Morrison (1993:183). Rabey (1994:196) describes operational planning as the "tactics and procedures for converting the strategic plan into reality."

Rabey (1994:42) states that organising is "the process of translating plans into action." Organising requires the use of resources such as personnel, time, money, facilities, equipment and supplies. The function of controlling is also referred to as evaluating. Control is an on-going process to:

- gather information that measures recent performance within the organisation and
- compare present performance to pre-established performance standards from this comparison, and to determine if the plan should be modified (Morrison 1993:170).

According to Morrison (1993:169), directing can be defined as "the process of guiding the activities of organisation members in appropriate directions." Directing also includes monitoring - that is, the over-seeing of the progress made towards goal achievements. To direct is to get work done through others and to enable the manager to do this he/she should be able to lead, handle conflicts and keep the group focused on the goal.

Morrison (1993:183) includes the following tasks in the function of leading: guide group towards goal; problem solving and decision making; manage conflict; review job performances and monitor progress towards goal.

Rabey (1994:8) states that leading includes coaching the people in the work discipline to work together to the best of their abilities and to work as a team to achieve agreed objectives. In the study, leading is coaching the followers in the nursing unit to work together to the best of their abilities as a nursing team in transformational leadership to facilitate individual and nursing unit transformation.

In the function of directing (leading), the professional nurse in charge of the nursing unit acts as a leader. Webster's Collegiate Thesaurus defines a leader as "one that takes the initiative" (Kay 1976:480) and Webster's Third New International Dictionary defines the leader as "a person who guides, conducts" (Kay 1981:1283). Collins Cobuild (1988:444) defines a leader as "a person who is in charge of an organisation." Seivwright (1988:99) describes the leader as "a person who sees the end, aim or purpose to which the effort should be directed more clearly than any other group member. The leader also demonstrates more commitment and determination to reach a goal. The person inspires a level of trust and confidence that enables that person to motivate a group towards attainment of the goal."

The agent as leader implements the process of leadership in the nursing unit. The Concise Oxford Dictionary defines leadership as "the quality of being able to lead." Marriner-Tomey (1993:182) defines leadership as "people who motivate or inspire followers to identify and work towards goals that represent mutual values, needs, and expectations of both leaders and followers." The transformational leader is a person who can provide this style of leadership which recognises and builds on followers' need and search of meaning in its entirety.

According to Charlton (1992:32), leadership is "a unique alliance between managers and workers that fully engages the talents and potential of everyone in the organisation." Charlton defines leadership as "competencies and processes required to enable and empower ordinary people to do extraordinary things in the face of adversity, and constantly turn in superior performance to the benefit of themselves and the organisation."

Bernard and Walsh (1990) state that "nursing leadership is a multidimensional process that depends on the relationship between a nurse leader and a group, the setting or organisation of the interaction, and the theory of leadership chosen by the nurse leader." Every leadership situation therefore consists of three parts: the group, the organisation and the leadership theory (Morrison 1993:91). In the study the group is the nursing team in the nursing unit who includes the followers and the leader. The organisation is the nursing unit within a health service and the leadership theory of transformational leadership is utilised.

It should be emphasised that leaders and managers are interdependent. To be effective, a good manager should also be a good leader. However, there are distinct differences between leadership and management (see table 3.1).

Table 3.1: Management vs. leadership

Category	Management	Leadership
Change	• Peacemakers - maintenance work, sustaining the present situation • Repeats and follows what is desirable and necessary • Maintains first order change	• Pacemakers - fostering change and creating the future • Changes the way people think about what is desirable and necessary • Develops second order (fundamental) change
People	• Relates to people according to their role • Relies on systems	• Relates to people personally • Relies on people
Attention	• Does things right	• Does the right things right
Planning	• Thinks of today • Maintains an orderly, controlled and rational structure	• Strategic thinking - day after tomorrow • Interest in risk-taking and exploring new ideas
Thinking	• Focuses on the present • Reactive thinking	• Vision of the future and the strategy to get there • Pro-active thinking
Role	• Brings about implementation of ideas • Dressmaker (follows the pattern) • As an attitude of others serving management	• Influences, guides toward new ideas • Designer (vision, new creative ideas) • An attitude of leader serving others
Attitude to Goals	• Impersonal, if not passive attitude • Goals arise out of necessity • External locus of control • Responds to change • Expectations (You owe me)	• Active attitude to goals • Influencing and changing organisation • Internal locus of control • Responsible for change • Aspirations (I can create)
Work	• Reliant on planning, budgeting and other tools of management	• Prepared to invest faith in others and to take risks
Interpersonal	• Maintains low level of emotional involvement (task orientated)	• Ability to empathise; sends and receives feedback (people orientated)
Sense of self	• Sees self as conservative regulator of an existing order of affairs with which he/she personally identifies	• Sense of self does not depend on membership, work roles or social indicators of identity • Seeks opportunity for change
Motivation	• Uses threats and rewards as motivation	• Develops intrinsic motivation • Creates purpose/hope
Power	• Win/lose orientation • Relies on control	• Expandable-pie orientation • Gives power to get power • Counts on trust
Appointment	• Appointed officially to the position	• May or may not have official appointment

(Charlton, 1992:25-27; Douglas, 1984 in Hodges et al. 1988:72).

Covey (1992:101) summarises the difference between management and leadership as follows: "Management is doing things right; leadership is doing the right things. Management is efficiency in climbing the ladder of success; leadership determines whether the ladder is leading against the right wall."

As the nursing unit manager does not act as leader or implement his/her leadership in a stagnant context but in a dynamic and continuously changing context, constant transformation is needed. Transformation is to "change, alteration, conversion, switch" (Kay 1981:371) and to transform is to "change completely in composition or structure" (Kay 1981:2427). Synonyms for transform include "change, convert, metamorphose, alter" (Kay 1976:844).

The researcher in the study therefore proposes the practice of transformational leadership to facilitate individual and nursing unit transformation. In this type of leadership people are committed to accept and moving towards achieving a vision through planned change (Cottingham 1989:71-72). In transformational leadership leaders can shape, alter and elevate the motives, values and goals of followers. Persons are united in the pursuit of goals (Burns & Grove 1992:38).

A transformational nursing leader "challenges the process, searches for opportunities, inspires a shared vision, enables others to act, models the way and encourages the heart" (Al-Kandari 1993:110). Kuhnert and Lewis (1987:468) state that transformational leadership is "based on more than the compliance of followers, it involves shifts in the beliefs, needs and the values of followers."

Transformational leaders induce change, innovation, growth and empowerment of the self and others. It is when one or more persons engage with others in a way that leaders and followers move to higher levels of motivation and morality. Positive effect occurs on the well-being of the leader and the follower because choices are offered that are consistent with their collective values (Koerner & Bunkers 1992:3). McDaniel (1993:22) states that transformational leadership shapes and alters the goals and values of followers to achieve a collective purpose that benefits society. Table 3.2 summarises the characteristics of the transformational leader.

Table 3.2: Characteristics of the transformational leader

Characteristics
• not discouraged by failure;
• ability to learn from others;
• charisma; individualised consideration; intellectual stimulation;
• energises himself/herself and his/her followers (high drive and energy level);
• pro-active; innovates; involves growth; self-confident;
• challenges processes; searches for opportunities;
• models the way; tries to simplify matters;
• shift in beliefs, needs and values of followers;
• inspires and achieves vision through planned change and long-term focus;
• instils loyalty, pride, faith and respect;
• ability to learn from, but not discouraged by failure;
• takes moderate risks;
• responds constructively to criticism;
• motivates followers; empowers followers and
• sets challenging and realistic goals.

(Sources: Broom (1990:20); Lippit (1993:108); Marriner-Tomey (1993:23)).

Bennis and Nanus in Marriner-Tomey (1993:4) state that transformational leadership includes the following behaviours by the leader:

- creating vision;
- encouraging self-development;
- empowerment;
- creating meaning through communication and
- positioning through trust.

To implement each of the above-mentioned behaviours, specific strategies are used by the transformational leader. Each of these behaviours and the support strategies are discussed later in this chapter and in the described model (chapter four). To enable the agent to practice effectively as a clinical specialist, nursing unit manager and transformational leader research is of vital importance. Therefore the agent also acts as researcher. The agent as researcher implements quantitative and/or qualitative research in the nursing unit to investigate, validate and refine existing practices in the nursing unit and to generate new knowledge that can help him/her to facilitate quality nursing unit management and quality nursing care.

Mellish and Lock (1992:293) state that the word "researcher" means "a careful search for additional knowledge or a systematic re-look at existing knowledge. It strives to find reasons for occurrences and to find answers to problems." According to Burns and Grove (1993:778), nursing research is defined as "a scientific process that validates and refines existing knowledge and generates new knowledge that directly and indirectly influences clinical nursing practice." It is a systematic and diligent process that implies planning, organising and persisting.

As nurses are accountable to their clients and to society for providing quality nursing care and for finding ways of improving nursing care, nursing research provides a solid base for nursing activities that are effective in promoting positive client outcomes. The knowledge generated through research is essential for description, explanation, prediction and control of nursing phenomena. There are two main types of research: namely quantitative and qualitative research.

Burns and Grove (1993:26) define quantitative research as "a formal, objective, systematic process in which numerical data is utilised to obtain information about the world." In this research method, variables, relationships between variables and cause-and-effect interactions between variables are examined. The different types of quantitative research include descriptive, correlational, quasi-experimental and experimental research. Qualitative research is defined as a "systematic, subjective approach used to describe life experiences" (Burns & Grove 1993:27). The purpose of qualitative research is to describe and promote an understanding of human experiences such as pain and caring. The types of qualitative research include phenomenological, grounded theory, ethnographic, historical and philosophical inquiry research.

According to Mellish and Lock (1992:47) it is important that the nursing researcher initiates and encourages research in his/her nursing unit, but it is also important that he/she participates in the research done by other members of the health team. It is therefore important that the leader/agent in the study initiates and encourages research in his/her nursing unit, but also participates in research done by other members of the health team.

The leader as agent within the context of the Nursing for the Whole Person Theory

According to the Nursing for the Whole Person Theory (ORU, 1990: RAU 1992) the individual person is "a spiritual being who functions in an integrated bio-psychosocial manner to achieve his quest for wholeness. The person interacts with his external; and internal environment wholistically." In the study the "quest for wholeness" is replaced by transformational leadership by nursing unit managers to facilitate individual and nursing unit transformation.

The internal environment includes the body, mind and spirit and the external environment includes the physical, spiritual and social environment. The body includes all the anatomical structures and physiological processes. The mind includes all intellectual, emotional and volitional processes and the spirit refers to the part of the individual that is in relationship with God. The external environment includes those situations or conditions outside the individual that exert an influence on his/her life and includes the physical, spiritual and social environment.

Physical refers to "all significant stimuli or objects within the individual's external environment. Stimuli refer to any aspect (object, item or occurrence) that leads directly or indirectly to any change in one or more aspects of behaviour. Object refers to any aspect of the environment the individual is conscious of and to which he has a specific attitude or to which he reacts" (RAU 1992). Physical environment for the agent includes:

- the nursing unit within a nursing service with all the facilities, equipment and also lighting, ventilation and noise in the unit;
- the nursing service and health service in which the nursing unit functions;
- the Reconstruction and Development Programme (RDP) and
- other demands for change/transformation.

Social refers to "all people or significant others within the individual's external environment. Social also refers to the organisational structure between people and communities. Social in other words refers to all human resources" (RAU 1992). The social environment for the agent includes interaction with other nursing unit managers (leaders) and interaction with followers.

Spiritual refers to "significant spiritual elements or occurrences in the individual's external environment including values, beliefs, norms and ethical principles, religion and meaning in life as well as relationships with others" (RAU 1992). The spiritual environment for the agent includes:

- the personal values, beliefs, norms and ethical principles, religion and meaning in life as well as relationships with other leaders and followers;
- the Nursing Act (Act no. 50 of 1978);
- the regulations for scope of practice and other applicable regulations and
- the ethical norms and values of the nursing profession.

Patterns of interaction

This concept refers to "the unique characteristic patterns of interaction between the internal and external environment of the individual" (RAU 1992). The unique characteristic patterns of interaction is the transformational leadership to facilitate individual and nursing unit transformation.

The essential elements of the agent as leader are reflected in table 3.3.

Table 3.3: Essential elements (characteristics and function) of the leader as agent

Clinical specialist	Nursing unit manager	Transformational leader	Researcher
Characteristics	Characteristics	Characteristics	Characteristics
- comprehensive four year training - sometimes post-basic training - registered at S.A.N.C. under section 16 of Nursing Act (Act no 50 of 1975) - functions within specified scope of practice (R2598) and ethical norms and values of nursing profession - includes: independent, dependent and interdependent functions - has extensive knowledge, skill and experience in a specific discipline of nursing.	- commitment to become an effective manager - belief that people are worthy - positive, professional self-image - effective communication and leadership skills - effective conflict management, time management, negotiation, team building, delegation, planning, organising, evaluation skills - uses problem-solving and critical thinking skills effectively - motivates and inspires followers - up-to-date knowledge - ability to assess needs; lead - calmness; sense of fairness - good interpersonal relationships - co-ordinator - controller - facilitates patient safety - responsible for day-to-day running of nursing unit	- empowers; inspires by vision, ideals - has long-term focus - consideration, intellectual stimulation; motivates followers; charisma - energises himself/herself and followers - pro-active, innovative - challenges processes; searches for opportunities - rewards informally, personally - models the way - tries to simplify matters - shift in beliefs, needs and values of followers - inspires and achieves vision through planned change - instils loyalty, pride, faith, respect - learns from experience - takes moderate risks - responds constructively to criticism	- diligent, systematic engagement in research - initiates, implements, encourages and participates in research - generates new knowledge to facilitate quality nursing care
Function	**Function**	**Function**	**Function**
- implements nursing process: assessing, planning, implementing, evaluating and record-keeping	- implements nursing process: planning, organising, leading and controlling	- implements behaviours of transformational leadership: self-awareness, trust, communication, vision and empowerment	- implements: quantitative and qualitative research

Conceptual definition: the leader as agent

The leader is the registered or professional nurse and/or midwife in-charge of a nursing unit who is a clinical practitioner, nursing unit manager, transformational leader and researcher. He/she is an individual who functions in an integrated biopsychosocial manner and implements the specific behaviours of transformational leadership in the quest for individual and nursing unit transformation.

Statements for the leader as agent

The following statements are derived from the conceptual framework by means of deductive reasoning.

- The leader is an individual who functions as a spiritual being in an integrated bio-psychosocial manner and practices effective transformational leadership to facilitate quality nursing unit management and quality nursing care. The leader interacts wholistically with the internal and external environment.
- The leader has the necessary knowledge, skill and experience to practice as clinical practitioner, nursing unit manager, transformational leader and researcher.
- The variety of dimensions of the leader (clinical practitioner, nursing unit manager, transformational leader and researcher) are not regarded as separate entities but as inter-dependent and interrelated in transformational leadership.
- The leader, as clinical practitioner, has up-to-date knowledge on the newest developments in his/her clinical discipline and practices by implementing the nursing process.
- The leader is a competent nursing unit manager who implements the management process (planning, staffing, organising, leading and controlling) and practices successful transformational leadership to facilitate individual and nursing unit transformation.
- The leader, as transformational leader, implements the behaviour patterns of transformational leadership, including self-awareness, trust, communication, vision and empowerment.
- The leader as researcher diligently and systematically initiates, implements, participates in and encourages quantitative and/or qualitative research to investigate, validate, and/or refine existing practices in the nursing unit and to generate new knowledge to facilitate individual and nursing unit transformation.
- There is an inter-relationship between leadership and management.
- A dynamic and interactional relationship exists between the leader and followers, and furthermore between the leader or follower and the nursing unit or nursing service or health service.
- The leader is an independent practitioner co-accountable for the outcome of transformational leadership in the nursing unit.

3.3 The followers as recipient

According to Dickoff, et al. (1968:423), the recipient is the receiver of the activity. The recipient of transformational leadership is the follower who is an individual (body, mind, spirit) and is in interaction with the leader, the other followers and the context. The followers include the registered, enrolled and auxiliary nurses (see figure 3.3).

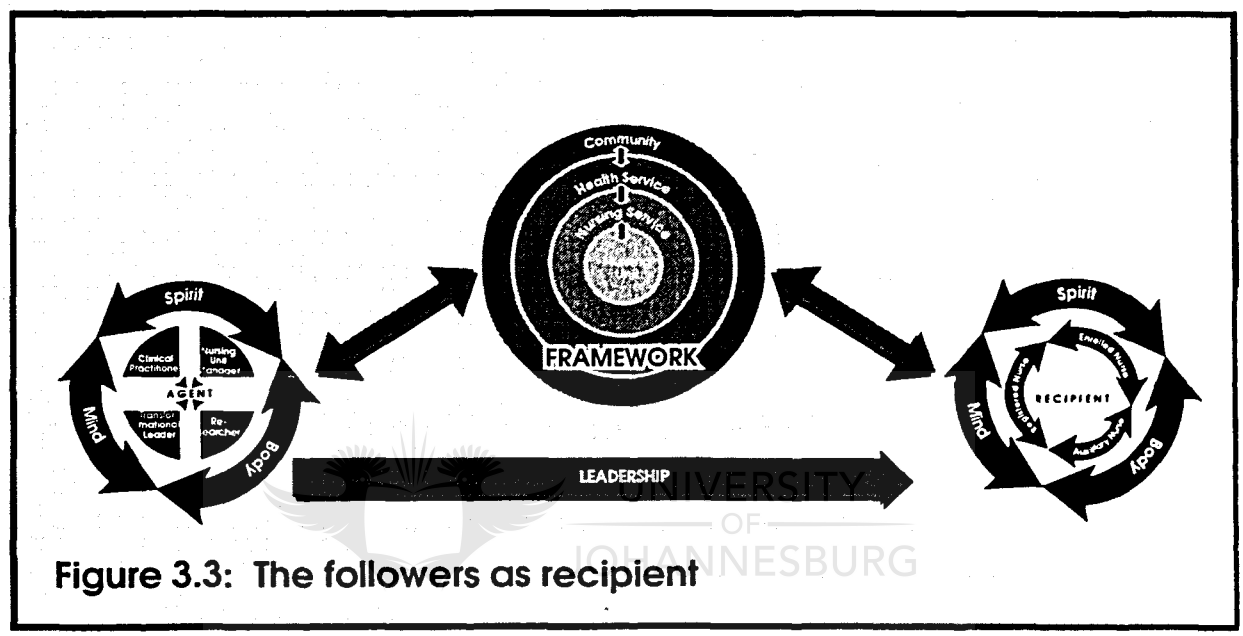


Figure 3.3: The followers as recipient

The followers of a person or belief are the people who support the person or belief (Collins Cobuild 1988:303). Kay (1976:346) defines the follower as: "one who attaches himself to another." Smirchich and Morgan (1982:373) describe followership as "the process of attaining the follower's goals by being influenced by a leader into participating in individual or group efforts toward organisational goals."
In this model the followers are the nurses in the nursing team within the nursing unit, in a nursing service. The nurses in the nursing team include the registered nurse, enrolled nurse and nursing auxiliary.

The training, registration and the scope of practice of the registered nurse as follower is the same as for the registered nurse as leader. The registered nurse as follower, however, still needs to grow personally and professionally by gaining more knowledge, skill and experience to enable him/her to also become a leader. Therefore, every follower is a potential leader. The registered nurse (follower) develops personally and professionally under the guidance and direction and/or indirect supervision of the registered nurse as leader.

All categories of nurses are registered under section 16 of the Nursing Act (Act no 50 of 1978) and the scope of practice is guided by R2598 of 1984 as amended. All categories of nurses practice within the ethical norms and values of the nursing profession. These nurses also practice under the guidance and direct and/or indirect supervision of the leader.

The enrolled nurse follows a minimum training of two years whereas the auxiliary nurse follows a minimum training of one year. Each training period is followed by a qualifying examination.

Rabey (1994:152) lists the following reasons why followers follow and encourage them to put in extra effort to do their best:

- a goal: doing something worthwhile. The follower understands why the work is important and the set standards are reasonable;
- participation: doing one's share. The follower's ideas are listened to and the leader discusses aspects with them;
- recognition: counting for something. The follower is recognised as a person and for what he/she can do. They get credit for good work and help when the need arises. They feel part of a group;
- communication: knowing what's going on. The follower knows where he/she fits, what is going on and why. Changes are discussed in advance and the follower's ideas are sought;
- fair wages: getting a decent living. The remuneration seems right for the follower's skill;
- learning: preparing for the future: The follower is encouraged to develop new skills and to acquire new knowledge and
- team work: doing things together: The followers know the target and take pride in being a team that achieves results.

The essential characteristics of the recipient are summarised in table 3.4.

Table 3.4: Essential characteristics of the followers as recipient

Characteristics
• supports leader;
• is influenced by leader;
• participates in individual and group efforts;
• reaches organisational goals;
• is a potential leader;
• practices under guidance of leader and
• practices under direct and/or indirect supervision of the leader.

Table 3.5. elucidates the specific characteristics of the different team members.

Table 3.5: Specific characteristics of the team members

Registered nurse and/or midwife	Enrolled nurse and/or midwife	Auxiliary nurse
Nurse registered under section 16 of Nursing Act (Act no. 50 of 1978)	Nurse enrolled under section 16 of the Nursing Act (Act no. 50 of 1978)	Nurse enrolled as auxiliary nurse under section 16 of Nursing Act (Act no. 50 of 1978)
four years comprehensive training (degree/diploma)	two years training	one year training
Can practice independently as Nurse (General, Psychiatry, Community) and Midwife	Practices under the guidance and supervision of a registered nurse	Practices under the guidance and supervision of a registered nurse
Scope of practice guided by R2598	Scope of practice guided by R2598	Scope of practice guided by R2598
Functions within the ethical norms and values of the nursing profession	Functions within the ethical norms and values of the nursing profession	Functions within the ethical norms and values of the nursing profession

The recipient within the context of the nursing for the Whole Person Theory

The followers as recipient (follower) is an individual according to the Nursing for the Whole Person Theory , "the individual/person is a spiritual being who functions in a bio-psychosocial manner to achieve his/her quest for wholeness and is in interaction with his/her external and internal environment wholistically."

Conceptual definition: the followers as recipient

The followers are the registered nurses and/or midwives, enrolled nurses and/or midwives and the auxiliary nurses as members of the nursing team in a nursing unit within a nursing service who support the leader and is influenced by the leader in the practice of transformational leadership. Followers are potential leaders and participate in individual and group efforts to reach organisational goals. Followers comply with the minimum educational requirements of SANC and practice under the guidance and direct and/or indirect supervision of the leader.

Statements for the followers as recipient

The following statements are derived from the conceptual framework by means of deductive reasoning.

- The follower is an individual as a spiritual being who functions in an integrated bio-psychosocial manner to support the leader in the practice of effective transformational leadership to facilitate quality nursing unit management and interacts with his/her internal and external environment wholistically.
- The followers are individuals as members of the nursing team within the nursing unit that is part of the nursing service or health service. The followers include the registered nurse and/or midwife, enrolled nurse and/or midwife and the auxiliary nurse.
- The followers function within a dynamic, interactional relationship with one another as team members and with the nursing unit manager as transformational leader.
- The follower is a potential leader.
- Each follower is personally accountable for his/her own acts and omissions but interacts as an individual and as a member of a nursing team under the guidance and direct and/or indirect supervision of the leader to support the leader in transformational leadership.

Heller and van Til (1982:405-414) state the following propositions regarding the relationship between leadership and followership.

- Leadership and followership are linked concepts, neither of which can be comprehended without understanding the other.
- Leadership and followership are best seen as roles in relationship.
- The leader should lead and do it well to retain leadership; the follower should follow, and do it well to retain followership.
- Good leadership enhances followers, just as good followers enhance leaders.
- In many cases, the follower is a potential leader who chooses not to become active in a given situation.
- Where all seek to lead, or all seek to follow, there can be no leadership or followership.
- Levelling or equalising the leader-follower relationship does not eliminate the need for role differentiation.
- Leaders and followers may become so independent of each other that the synergy of the relationship is lost.
- By reducing the distance between leader and follower, the leader may lose much- needed protection because the psychological distance between the leader and the follower is lessened.
- In successful leadership, the behaviour of both leaders and followers changes for the better.
- Deviations from the hierarchical leader-follower model are still unusual.
- The successful leadership can utilise outside intervention aimed at organisational development.

- Leadership and followership are arts in which people can become more highly skilled.
- A rapidly changing environment places changing demands on leaders and followers alike.
- In a society of reduced resources, the leader acts less often as a facilitator of programme and more frequently as the adversary of followers; the one who fires them.
- In a transformational crisis, leadership and followership become profoundly disoriented.

Statements for the relationship between the leader as agent and follower as recipient

The following statements are derived from the conceptual framework by means of deductive reasoning.

- Leadership and followership are inter-linked and interdependent concepts that should be seen as differentiated roles within a leader-follower relationship.
- Effective leaders and followers enhance one another so that the behaviour of both leaders and followers improves.
- Usually the follower is a potential leader, but when all followers wish to lead or only follow there can be neither leadership nor followership.
- There is a dynamic interaction between the leader, follower and the nursing unit within the nursing service and health service.
- A rapidly changing (transforming) environment places changing demands on the leader as well as the follower.

3.4 THE CONTEXT AS FRAMEWORK

Dickoff, et al. (1968:423) define the framework as "the context in which the activity is taking place." In the study the framework for transformational leadership is the nursing unit within the nursing service, health service and community (see figure 3.4).

Figure 3.4: The context as framework

The framework (nursing unit, nursing service, health service and community) functions as a system. Gillies (1994:603) defines a system as "a set of objectives or elements in interaction to achieve a specific goal." There is also a specific relationship between the elements and their attributes. A system is also a "logical and orderly arrangement of parts and an ongoing process that consists of diverse elements and their relationships to each other" (Gillies 1994:71).

Each system consists of interconnected and interrelated subsystems. Each of the subsystems has its own objectives that contribute positively towards the goals of the larger system. As the framework for the study is a complex system, it can also be divided into subsystems: namely, the health service, nursing service and the nursing unit. Each of these subsystems has its own objectives that contribute positively to the goals of the system. The objective (terminus) for the nursing unit manager as transformational leader and the followers in the nursing unit is transformational leadership to facilitate individual and nursing unit transformation.

A nursing unit is the smallest specialised discipline within a nursing service - for example the paediatric nursing unit. The nursing unit is a ward, clinic or specialised department (Mellish & Lock 1992:18). Mellish and Lock (1992:25) defines a nursing service as "a service which includes specialised units such as medical, surgical, orthopaedic, paediatric units." These specialised units form subsystems of the nursing service.

Different subsystems form part of the health services including the:

- nursing service;
- medical service (concerned with medical diagnosis and treatment);
- related professional disciplines (physiotherapy, radiography, occupational therapy);
- supply services (linen, food, equipment supplies);
- financial control services (budget control) and
- protection and security services (security and safety of patients and their property).

(See figure 3.5).

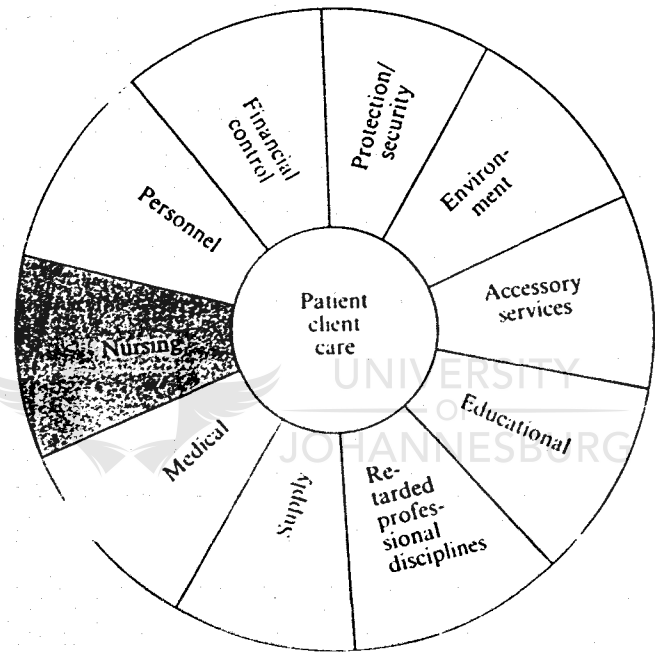


Figure 3.5: The nursing service as a subsystem in the Health Service

As each of the subsystems are interrelated and interconnected and the system is a dynamic network of interconnected and inter-relational subsystems, a change in any one of the subsystems or in the system should influence and produce a change in the other subsystems. Gillies (1994:75) states that all systems tend towards harmony which is a balance between the various forces operating within and on the system. The forces operating within the nursing unit can be regarded as the internal environment of the nursing unit. The forces operating upon the nursing unit can be regarded as the forces in the external environment of the nursing unit. The internal environment (and forces within the internal environment) of the nursing unit include structural and functional elements. The structural elements include all the individuals in the nursing unit.

Other structural elements include the physical structure, facilities, and equipment to be utilised by the nursing unit manager as transformational leader and the unit team in transformational leadership. Organisational structure, such as the organogram and policy-making structures also influence transformational leadership by the nursing unit manager as transformational leader and the nursing team. Functional elements include the functioning of each individual in the nursing unit. Transformational leadership in the nursing unit is influenced by each individual's internal and external environment (as discussed under 3.1 the leader as agent and 3.2 the followers as recipient).

The interaction between the individuals acts as internal forces within the nursing unit. The group dynamics such as group cohesion, group conflict, communication in the group, decision-making, norms, and values and beliefs in the group also influence the functioning of the individuals within the group and within the nursing unit.

Major changes have occurred in the external environment (community) of the nursing unit. The first democratic election took place in South Africa, and the RDP of the Government of National Unity was implemented. This programme has significant social, political and economical implications for the South African community as well as the health services (including nursing). To implement the RDP major transformational changes are needed in the South African community as well as in the health services.

According to the RDP reconstruction should involve the complete transformation of the health-care system (ANC 1994:43-45). This transformation includes the review of all relevant legislation, organisations and institutions. Systems and practices should be in line with international norms and standards. Management practices should promote efficient delivery of systems and to ensure human rights and accountability to users, clients and the public. The National Health System (NHS) focuses on the Primary Health Care approach that emphasises community participation, empowerment, collaboration and cost-effective care. Preventative, promotive, curative and rehabilitation services should be integrated. Preventative and promotive health programmes for children should be improved. Breast-feeding should be encouraged and immunisation programmes should be expanded. Reproductive health services should be promoted (ANC 1994:46-47).

The RDP aims to promote mental health and to increase the accessibility, quality and quantity of mental health support and counselling services. Community care, rehabilitation and education for all disabled people should be improved. According to the RDP, statutory bodies should be rationalised and restructured to reflect the diversity of the South African people and should be better able to promote and protect the standards of health-care and training. Other programmes that should be developed, according to the RDP, include: programmes to combat the spread of sexually transmitted disease and Aids; 24-hour emergency services; appropriate care for chronic diseases; occupational health services and programmes to co-ordinate and monitor services aimed at the youth.

With regard to the human resources for the NHS, the RDP proposes a programmes of re-training and re-orienting of existing health workers. Redistribution of personnel is achieved through more appropriate training and through incentives to work in under-serviced disciplines, through limiting openings for private practice in over-serviced disciplines. Contractual obligations for those receiving subsidised training are also proposed.

According to the RDP, efforts should be made to strengthen the public sector and to encourage active participation between the different sectors. A complete transformation of health-worker training is proposed. This complete transformation includes improving human resource planning and management systems, reviewing of selection of new and short training programmes to re-orient existing personnel. The RDP also proposes a specific need to train new staff in the Primary Health Care approach and in the management of Primary Health Care. Budget allocation should also be shifted to allocation towards Primary Health Care to address the needs of the majority of the people (ANC 1994:48-50).

Some implications of the RDP plan on nursing management are as follows:

- better co-operation and collaboration between the private and public sectors should be sought;
- transformation of the whole delivery system which includes reviewing of all legislation;
- organisation and institutions and the promotion of systems and practices that are in line with international norms and standards;
- budgeting that is geared towards Primary Health Care and an approach that emphasises community participation, empowerment, collaboration and cost-effective care. Less money should be available to the curative services and
- a Primary Health Care approach with less emphasis on curative care should be implemented.

The RDP proposes the complete transformation of health services. This therefore suggests that complete transformation in nursing management will occur.

As it is clear from the RDP that all relevant legislation, organisations and statutory bodies are to be reviewed, these changes influence the mission, philosophy and policies of the health service, nursing service and also the nursing unit. The RDP also influences the budget of the whole system as money is channelled towards primary health care and less money is available to the curative services (like service in a nursing unit). The time context for the community in the new South Africa includes new concepts and actions such as democracy, transparency, equal opportunities and rights, no discrimination (like sexism or genderism), affirmative action. All these concepts and actions are also to be implemented and utilised in the health services and also influence the other subsystems (such as the nursing unit). Currently the health services function within the Nursing Act (Act no. 50 of 1978) and the related nursing regulations, but changes are also underway.

All the discussed changes and factors in the external environment (see figure for a summary) cause a disharmony in the system and therefore necessitate the practice of transformational leadership to create harmony and to facilitate quality nursing unit management and quality nursing care. Table 3.6 depicts the essential characteristics of the context as framework.

Table 3.6: Essential characteristics of the context as framework

Characteristics
• nursing unit; • within a health service; • internal and external environment impacts on the outcome of transformational leadership and • different dimensions of leader (clinical practitioner, nursing unit manager, transformational leader, researcher) are included.

Conceptual definition: the context as framework

The context is the nursing unit within a nursing service and a health service with internal and external environments interacting to impact on the outcome of transformational leadership. The context also includes the context of the leader in which the leader functions as clinical practitioner, nursing unit manager, transformational leader and researcher.

Statements for the context as framework

The following statements are derived from the conceptual framework by means of deductive reasoning.

- Transformational leadership necessitates a wholistic approach by the leader as clinical practitioner.
- There are several internal and external forces impacting on the practice and the outcome of successful transformational leadership.
- The context is dynamic and consists of a variety of dimensions namely, clinical practice, nursing unit management, transformational leadership and research.
- There is a dynamic interaction between the internal environment (within the individual and the nursing unit) and the external environment (the nursing service, health service and community).
- External changes in the nursing service, health service and community necessitates transformational leadership in the nursing unit.

3.5 THE MOTIVATING FACTORS AS DYNAMICS

According to Dickoff, et al. (1968:422), "dynamics is the energy source for the activity." In the study the dynamics are the motivating factors demanding transformational leadership to facilitate individual and nursing unit transformation (see figure 3.6).

Figure 3.6: The motivating factors as dynamics

The internal and external environment (discussed in 3.1) impacts on the agent (leader) and recipient (followers) and motivates transformational leadership. The impact of the framework context (discussed in 3.4) also motivates transformational leadership.

The study is conducted in the period following the first democratic elections in South Africa. In the Government of National Unity the Reconstruction and Development Programme (RDP) of the African National Congress (ANC) dominates, and this programme has significant social, political and economic implications for the South African community. To implement the RDP, major transformational changes are needed in the South African community as well as in the health services. As nursing is practiced within the context of the new South Africa, and as this is also the milieu in which this study is conducted, the transformation in the South African community has a direct and specific effect on nursing as well as on the study. The impact of the RDP on nursing management and nursing practice can therefore not be ignored. (Details of the RDP are discussed in 3.4 framework.) Political, economic, social, technological and staff management changes also impact on nursing management and nursing practice and this therefore necessitates transformation (see detailed discussion in 3.4 framework.)

To accommodate all these changes the agent strives towards transformational leadership to facilitate individual and nursing unit transformation. The nursing unit manager (as agent) and the follower (as recipient) should remain dynamic in the transformation process to facilitate survival of the individual (leader and follower), the group (nursing unit) and the community (nursing service and health service) and therefore transformational leadership is needed. Table 3.7 summarises the essential characteristics of the motivating factors as dynamics.

Table 3.7: Essential characteristics of the motivating factors as dynamics

Characteristics
• motivating factors are interaction between internal and external environment of the leader and followers;
• framework of nursing unit impacts on transformational leadership

Conceptual definition: the motivating factors as dynamics

The motivating factors for transformational leadership are the interaction between the internal and external environment of the leader and the followers, and the framework of the nursing unit which impacts on the practice of transformational leadership.

Statements for the motivating factors as dynamics

The following statements are derived from the conceptual framework by means of deductive reasoning.

- The interaction between the external and internal environment of the leader and the followers impacts on transformational leadership and conversely.
- The interaction between the internal and external environment of the nursing unit impacts on transformational leadership.

3.6 SUCCESSFUL TRANSFORMATIONAL LEADERSHIP AS THE GOAL

According to Dickoff, et al. (1968:423), the terminus (goal) is the end point of the activity. In the study the goal is successful transformational leadership to facilitate individual and nursing unit transformation. A synonym for transformation is change. Figure 3.7 reflects successful transformational leadership as the goal.

Figure 3.7: Successful transformational leadership as goal

Webster's Collegiate Thesaurus (Kay 1976:128-844) defines change as "to make or become different" and defines transform as "to make over to a radically different form, composition, state, disposition." Synonyms include: "change; convert; metamorphose, alter, modify; alter." The Oxford paperback dictionary (Pollard 1994:133) defines change as "make or become different; pass from one phase to another."

According to Rabey (1994:173) change is "the process by which the future invades our lives." Change is inevitable as everything either improves, deteriorates or undergoes change. It is common for people to resist change because of the fear of redundancy, loss of security, disorganisation, loss of status, inability to cope. However, people co-operate if they feel they will gain benefit or avoid loss. The advantages of the change should outweigh the disadvantages.

Morrison (1993:256) defines change as "a process of making or becoming different" and states that "change is continually occurring, it is dynamic in nature and possesses several special characteristics." As change is a dynamic process it is influenced by many variables and the effects thereof are widespread.

According to Dunham and Klafehn (1990:29) the transformational leader facilitates second-order change whereby the system is affected and answers to the question "what". Second-order change "lifts the solution out of the paradox and re-frames the situation." It looks at effects and not causes. As more followers become committed to the vision of the organisation, the organisation changes. Transformational leaders develop end values and are able to see situations from a new perspective. The end values become more important than the group values. The leader in the study therefore also facilitates second-order change.

In mastering change the leader will also make the vision come to life. It includes taking risks and encouraging others to do so, to encourage feedback. It is necessary to change the organisational design to fit the vision. All the followers and the leader should be committed to the vision and goals of an organisation to ensure that change takes place effectively. However, it is the leader who should take the initiative and provide the focus for change.

To effect positive change, the leaders and the followers should become stakeholders in their process of change and creating the vision for the organisation. It means that strategic alliances should be formed, competition should be discouraged and co-operation encouraged. It should also be understood that no person (leader or follower) can function in isolation.

Van der Erve (1989:3) states that "the power of tomorrow's management" is related to the awareness of change and also to the impact of change on the management vision and corporate culture. There is also a growing awareness that the process of change is inevitable and constant. Silber (1993:60) states that change is "an inevitable, complex and continuous process" that "affects everyone." Change is a function of time which we may not or may be able to control and is present in every facet of everyday life.

Change consists of two dimensions: namely, unplanned and planned change. Drake (1993:71) describes unplanned (reactive) change as the unplanned renewal and transformation in the individual and or organisation, as a result of the needs, demands and expectations from the internal and or external environment in the strive towards personal and professional development. Unplanned change is described by Morrision (1993:264) as accidental change (without prior planning and preparation) or change by drift. Resulting from an imbalance in the system, unplanned change is always met with more hostility and resistance as individuals feel surprised, uninformed and threatened.

Planned change is described by Drake (1993:72) as goal-oriented, well-planned and deliberate transformation of the individual (body, mind, spirit) or the nursing service (physical, social, spiritual) in the striving for personal professional development. Morrision (1993:264) argues that planned change occurs as a result of an intended effort to deliberately move the system and these changes are carefully planned and deliberately and slowly implemented. When done appropriately, planned change meets with the minimum hostility and resistance.

For the purpose of this conceptual framework and the following model, the researcher concentrates on planned change only. Drake (1993:72) identifies three phases in the change-management process, namely mobilising, dynamic transformation and stabilising.

Firstly, mobilising is the realisation of the needs, expectations and demands of the internal and external environment by means of the plan for change in the nursing service and the identification and removal of the stumbling blocks that prohibits the change. Dynamic transformation is the dynamic individual and/or nursing unit transformation and renewal according to the internal and external needs, expectations and demands in the striving towards personal and professional development. Lastly, stabilising is the integration of the transformation as part of the leader, followers and nursing unit's value system.

The leader should realise and acknowledge that transformation may provoke negative feelings from the followers and may lead to resistance to change, because transformation tampers with the status quo and may cause feelings of insecurity.

Morrison (1993:259) lists the following as reasons for resistance to change:

- threatened self-interest: when a person feels that his/her job, security or pay cheque is at risk;
- inaccurate perceptions: when an individual does not understand the nature and implications of change and that individual believes that the change will not be beneficial;
- objective disagreement: when an individual truly disagrees with the objective of change and truly believes that the change will not benefit the organisation and
- psychological resistance: when individuals have a low tolerance for change. Intellectually they can understand the reasons for change but emotionally they cannot make the transition.

Kruger (1994:47-50) lists poor timing, general reluctance to change, people taken by surprise, lack of confidence and comprehension and low tolerance for change as reasons leading to resistance to change.

Perlman and Takacs (1990) in Marquis and Huston (1994:94-95) maintain that there are ten emotional phases in the change process. These ten emotional phases are summarised in table 3.8.

Table 3.8: Emotional phases in planned change

Emotional phase	Description
1. Equilibrium	Characterised by high energy and emotional and intellectual balance. Personal and professional goals are synchronised.
2. Denial	Individual denies reality of the change. Negative changes occur in physical, cognitive, and emotional functioning.
3. Anger	Energy is manifested by rage, envy, and resentment.
4. Bargaining	In an attempt to eliminate the change, energy is expended by bargaining.
5. Chaos	Characterised by diffused energy, feelings of powerlessness, insecurity, and loss of identity.
6. Depression	Defence mechanisms are no longer operable. No energy left to produce results Self-pity apparent.
7. Resignation	Change accepted passively, but without enthusiasm.
8. Openness	Some renewal of energy in implementing new roles or assignments that have resulted from the change.
9. Readiness	Wilful expenditure of energy to explore new event. Physical, cognitive and emotional reunification occurs.
10. Re-emergence	Individual again feels empowered and begins initiating new projects and ideas.

There are, however, strategies that the leader can utilise to limit or overcome resistance to change. Kruger (1994:50-52) recommends the following strategies in this regard.

(a) Involvement and participation

As people tend to support what they helped to build, they also tend to integrate the available information in the planning of the envisaged change. However, the disadvantage of this strategy is that it is very time-consuming as all parties should be allowed sufficient time to contribute to the change process. Silber (1993:61) also states: "When introducing change, don't spend time on people, invest time in people." Leaders should communicate openly and avoid surprises.

(b) Facilitation and support

Facilitation is used to help people gain the required new skills for the implementation of change. Support implies that management should make the transformation as easy as possible and will consistently encourage the people's efforts to change.

(c) Negotiation and reward

Negotiation implies continuous deliberation and bargaining to arrive at an agreement. There should be a spirit of give and take from all participants. Management can also offer concrete rewards like bonuses, salary adjustments and recognition for co-operation from the staff.

Kruger (1994:53) summarises a few guidelines. Change is more acceptable if:

- it does not threaten the person's security;
- those who are affected participate in the change process;
- it follows a series of successful changes rather than arises from a series of failures;
- it is well-planned and well-structured;
- the participants share in the advantages;
- staff have been trained to plan and strive continually for improvement;
- communication is direct and honest with complete and factual information. The specific purposes and objectives should be provided to minimise apprehension and make follower feel less threatened. It is not true that people do not like change. People, however, resist the methods and styles which management use to put changes into effect and
- followers derive security, influence and self-esteem from belonging to a group. The degree of trust a follower feels as well as the social pressures of the work group will affect a person's (follower's) attitude towards change (Silber 1993:60-61).

It is therefore important in the implementation of change (transformation) in the nursing unit, that the leader should communicate to and support and educate the members of the nursing team (as followers). The members of the nursing team (as followers) should become stakeholders and participate in the planned change and all change in the nursing unit should be implemented slowly.

The essential characteristics of the goal are reflected in table 3.9.

Table 3.9: Essential characteristics of the goal.

Characteristics
• successful practice of transformational leadership;
• within a specific context;
• facilitate individual and nursing unit transformation;
• followers co-operate/participate as individuals and as nursing team and
• support leader in transformational leadership.

Conceptual definition: successful transformational leadership as the goal

The goal is successful transformational leadership by the leader within a specific context facilitating individual and nursing unit transformation. It is also the successful co-operation and/or participation of the followers as individuals as well as a nursing team to support the leader in this activity.

Statements for successful transformational leadership as the goal

The following statements are derived from the conceptual framework by means of deductive reasoning.

- The leader practices successful transformational leadership to facilitate individual and nursing unit transformation.
- The leader practices transformational leadership by implementing the behaviours of transformational leadership and by utilising his/her capacities as a leader.
- The followers interact as individuals and as a nursing team under the guidance and direct and/or indirect to support the leader in successful transformational leadership.

3.7. THE BEHAVIOURS OF TRANSFORMATIONAL LEADERSHIP AS THE PROCEDURE

According to Dickoff, et al. (1968:423) "the procedure includes the guiding procedure, technique or protocol of the activity." The procedure of transformational leadership includes the implementation of specific behaviours (with supportive strategies) in the quest for successful transformational leadership to facilitate individual and nursing unit transformation (see figure 3.8).

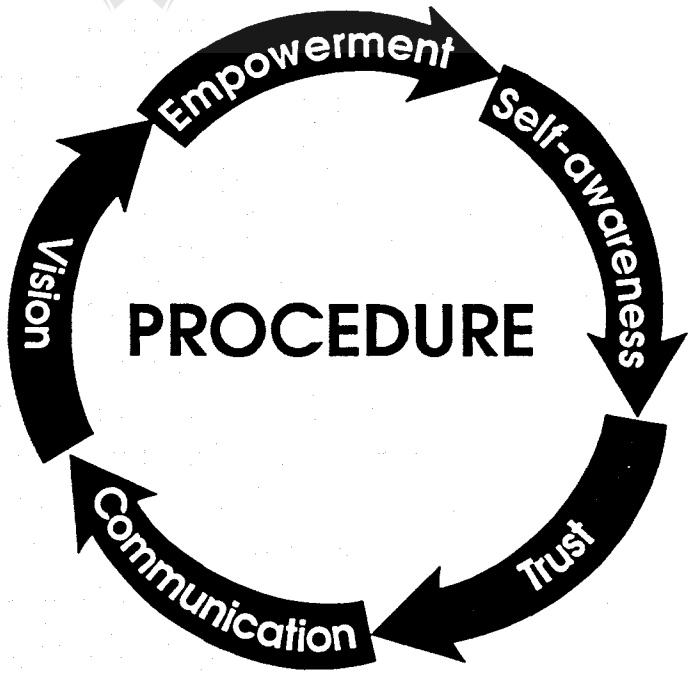


Figure 3.8: Behaviours of transformational leadership as procedure

A behaviour is "the way in which something or someone acts or functions" (Collins Cobuild 1988:65). A behaviour is the "what" that the leader implements for successful transformational leadership. Bennis and Nanus (1985) in Marriner-Tomey (1993:4) identify increasing self-awareness, building trust, creating meaning through communication, developing the vision and empowerment as transformational leadership behaviours.

By implementing these specific behaviours the leader strives for successful transformational leadership. To attain the desired behaviours the leader implements specific supportive strategies. A strategy or the "how" comprises the needed actions which leadership should be implemented to enhance the behaviours of transformational leadership. The first behaviour that the leader implements is to increase his/her self-awareness and to increase the self-awareness of the followers in the nursing unit.

3.7.1 Self-awareness

Self-awareness is defined by the Oxford Paperback Dictionary (Pollard 1994:727) as "conscious of one's feelings, motives" and the Shorter Oxford English Dictionary (Onions 1980:1933) defines self-awareness as "self-conscious. Having a consciousness of one's own identity, acts, thoughts."

Tappen (1989:66) defines self-awareness as "knowing yourself as a thinking, feeling being interacting with an ever-changing world. Its focus is 'getting in touch with your feelings' or being 'open to experience.' Covey (1989:67) states that self-awareness "enable us to stand apart and examine even the way we 'see' ourselves - our self-paradigm." Self-awareness does not only affect our attitudes and behaviour but also how we see other people. It becomes our map of the basic nature of mankind. Only when we are able to see ourselves will we be able to understand how others see and feel about themselves and their world. According to Charlton (1992:87), self-awareness includes knowledge of one's strengths and weaknesses and the ability to discern gaps between one's strengths and weaknesses.

For the leader, self-awareness means to be aware and conscious of his/her own identity, acts, thoughts, feelings and motives. The leader should know himself/herself as a thinking, feeling being interacting with an ever changing world and to be open to experience.

Self-awareness and self-understanding should not be regarded as synonyms. Taylor (1994:68) defines self-awareness as becoming aware of what a person believes and feels. Self-understanding implies knowledge and understanding of why one feels and believes as one does. For the scope of the study and the purpose of the model of transformational leadership in the nursing unit, the researcher concentrates on self-awareness only.

Stuart and Sundeen (1991:95) describe four interconnected parts in self-awareness, namely the:

- Psychological component of self-awareness. This component includes awareness of one's emotions, motivations, self-concept and personality. It means being sensitive to one's feelings and to external elements that affect those feelings.
- Physical component of the self is the awareness of personal and general physiology, one's bodily sensations and one's physical potential.
- Environmental aspect of the self consists of one's social environment, relationship with others and the awareness of the relationship between humans and nature.
- Philosophical component refers to the sense that one's life has meaning. One's personal philosophy of life and death may or may not include a formulation of a superior being, but it does take into account the world in which one lives and the ethics of one's behaviour.

The purpose of self-awareness is to achieve open and personal communication. The leader and the followers should be able to examine personal feelings and reactions and have a clear understanding and acceptance of the self to enable them to function optimally in the nursing unit.

Strategies to increase self-awareness according to Stuart and Sundeen (1991:95-97), include listening to oneself, listening to and learning from others and self- disclosure. Firstly, listening to oneself means allowing oneself to experience genuine emotions, identify and accept personal needs by exploring one's own thoughts, feelings, memories and impulses. Listening to and learning from others through active listening and openness to feedback is necessary as knowledge of oneself is not possible in isolation. Lastly, self-disclosure involves revealing yourself to others, sharing perceptions and allowing the gain of new information.

The leader should implement strategies to increase his/her own self-awareness and should also encourage the followers to implement these strategies to increase their self-awareness to facilitate transformational leadership in the nursing unit.

The process of increasing self-awareness can sometimes be a painful experience, especially when one is in conflict with one's self-ideal. The advantages of increasing self-awareness include an integration of the aspects of one's being, more vitality, readiness for action, more committed choices and more authenticity in relationships. Authenticity also means to be open to explore one's self, one's thoughts, needs, emotions, values, defences, communications, problems and goals. Increasing self-awareness presents a challenge to the person to accept the limitations of the self or to change the behaviours that support these limitations (Stuart & Sundeen 1991:95-97).

According to Taylor (1994:69), increasing self-awareness leads to acceptance of the self and others. As one becomes more self-accepting, one values oneself more and can therefore value others more. It becomes possible to judge oneself and others less harshly and to develop skill in affirming oneself and others. These skills are important to one's own mental health. Increased self-awareness also frees energies for other activities and makes control over one's own behaviour possible.

Charlton (1992:90) adds the following advantages that accrue to self-awareness:

- development of personal strengths and weaknesses;
- commitment to self development and continual learning (growth and change);
- perception of change and threatening situations as a challenge and opportunity for change (cognitive hardiness);
- acceptance of responsibility for creating individual life-experiences rather than blaming people or circumstances for misfortune (responsibility and internal locus of control) and
- ability to diagnose and change inappropriate behaviour and independently take constructive action (personal mastery).

According to Tappen (1989:67), self-awareness leads to effective interpersonal relationships. If a person is aware of his/her thoughts, feelings and reactions he/she can communicate more clearly and openly with others. Covey (1989:92) states that through self-awareness we become conscious of disciplines of weakness, disciplines of improvement, disciplines of talent that could be developed or changed in our lives. The advantages of increased self-awareness by the leader and the followers can thus be summarised as follows:

- it increases knowledge of the leader and the followers' strengths and weaknesses. Is also presents a challenge to accept the limitations or to change the behaviour to overcome limitations and accept oneself;
- it promotes open and honest communication;
- it promotes open exploration of one's self, one's thoughts, needs, emotions, values, defences, problems and goals;
- it frees energies for transformational leadership activities and makes control over one's own behaviour possible;
- the leader and the follower becomes committed to continual learning and personal as well as professional development;
- the leader and the follower accept the responsibility to create individual life-experiences, rather than blaming people or circumstances for misfortune;
- it promotes the ability to diagnose and change inappropriate behaviour and to independently take constructive action to change this behaviour and
- it leads to effective inter-personal relationships in the nursing unit because the leader and the followers communicate more clearly and openly.

Self-awareness within the Nursing for the Whole Person Theory

The Nursing for the Whole Person Theory proposes that the individual consists of body, mind and spirit and that there is interaction between the internal and external environment of the individual. These aspects are similar to the components of self-awareness including the physical, psychological, environmental and philosophical environment.

The essential characteristics of self-awareness are reflected in table 3.10.

Table 3.10: Essential characteristics for self-awareness

Characteristics
• leader and follower should be aware and have knowledge of internal environment (body, mind and spirit);
• leader and follower should be aware and have knowledge of external environment (physical, psychological, spiritual) and
• strategies to utilise include listening to oneself, listening to others and learning through the feedback from others.

Conceptual definition: self-awareness

Self-awareness occurs when the leader and the followers are aware of and have knowledge of their internal environment (body, mind and spirit) as well as their external environment (physical, psychological and spiritual) by means of listening to themselves and listening to and learning from others.

Statements for self-awareness

The following statements are derived from the conceptual framework by means of deductive reasoning.

- Self-awareness is to be aware of oneself and to have knowledge of the internal (body, mind and spirit) as well as the external environment (physical, psychological and spiritual).
- The leader increases his/her own self-awareness with the purpose of having a clear understanding of the self, and encourages followers to increase their self-awareness.

The next behaviour that the leader engages in is the building of trust.

3.7.2 Trust

There are many dictionary definitions of trust (see table 3.11).

Table 3.11: Definitions for trust

Dictionary	Definition
Webster's Collegiate Thesaurus (Kay 1976:854)	complete assurance and certitude regarding the character. Synonyms include : confidence, dependence, faith, hope, reliance.
Webster (Kay 1981:2456)	an assured attitude toward another which may rest on blended evidence of experience and more subjective grounds such as knowledge, admiration, respect. It is assured reliance on a person. Synonyms include : confidence, reliance, faith, dependence.
The Chambers Pocket Dictionary (Davidson & Seaton 1988:822)	confidence, belief in the reality, truth of something "confidence, belief in the goodness of someone"
The Shorter Oxford English Dictionary (Onions ed 1980:3374)	to have faith or confidence in; to rely or depend upon

Covey (1989:188) defines trust as the feeling of safeness you have with another person.

Trust is therefore confidence, dependence, hope, faith, reliance, respect and a feeling of safeness between all members in the nursing unit. Charlton (1992 : 80) states that building trust should take place on both an individual and an organisational level. Trust is gained by doing the right things with clarity and reliability and trust also implies accountability and predictability. It is the leader's commitment to the vision of the nursing unit as well as the leader's commitment to the followers in the nursing unit that promotes trust. Trust is dependent on the followers' contributions being recognised and their accomplishments celebrated.

Charlton (1992:77, 78) states that trust is a two-way process and has to be earned by the followers as well as the leader. Trust is essential in allowing the potential of the leader and the followers to develop. Trust includes consistency, reliability, predictability, congruency in word and deed, and is also about fairness in dealing with people. Trust forms the basis for all human activity. For the leader, trust is a two-way process that should be implemented on an individual and nursing unit level and building trust includes specific strategies to be implemented.

Trust forms the basis of any successful human activity and it leaves the followers satisfied, opens the door to future relationships and interaction between the leader and the followers and between the followers. Fundamental to trust is the understanding of follower expectations. Leaders can only lead when they have followers and leaders can only deliver and achieve things through followers. The only way that the leader-follower relationship can be complementary to both parties is when it is built on trust.

Charlton (1992:79) states that "credibility can only be earned by being in touch with the people. It is not enough that the leader understands the concerns, needs and aspirations of people - the understanding should be demonstrated. Management cannot occur from an office seat; the leader should get in contact with the people and also spend time with them." The leader should therefore not manage from his/her office but should be into contact with the followers by spending time with them in the nursing unit and demonstrate understanding of the followers' concerns, needs and aspirations.

According to Marriner-Tomey (1993:346), trust is a prerequisite for any communication as no person would share ideas, thoughts and / or feelings with a person he/she does not trust. It is important that the leader builds trust, as without trust successful communication is not possible. Successful communication is also one of the behaviours of transformational leadership.

According to Morrison (1993:288), workers feel free to try new methods when trust exists in the work environment. Trust develops over time and requires consistent and caring behaviours, built on respect for each person and a belief that each person will do his/her best. Trust is an essential ingredient of any positive work environment.

Morrision (1993:134) lists the following strategies to increase trust:

- always tell the truth: honesty should be expected and encouraged;
- keep your word: followers remember what was promised and keeping your word is the primary rule for building integrity;
- encourage others: recognise other people's positive traits and accomplishments and
- practice excellence: the manager should also work to create a climate that encourages excellence.

Gunden and Crissman (1992:8) add the following strategies:

- constancy: leaders should stay on course and not create surprises for the followers;
- reliability: leaders are there when they are needed and they are ready to provide the necessary support and encouragement to the followers;
- congruity: leaders do what they say and there are no gaps between what they say and what they do and
- integrity: leaders honour their commitments and promises.

Murphy and de Back (1991:77) state that unless the leader is worthy of trust and is honest, dependable and honourable there can be no trust. Without trust no vision can come to life. The leader should therefore set high standards of personal integrity from the followers. It also means that followers in the nursing unit people should be treated as professionals and be trusted to make decisions and use their knowledge and skills to the advantage of the nursing unit and the nursing service.

The leader should implement the discussed strategies to build trust. If the followers trust the leader, they will follow and support the leader.

Another way that transformational leaders can communicate trust is through a decentralised structure where authority, accountability and responsibility for problem-solving and decision-making are delegated to the most appropriate level in the organisation. The followers' knowledge, skill and experience will determine how much authority, accountability and responsibility are delegated to them. By implementing a decentralised structure to which authority, accountability and responsibility for problem-solving and decision-making are delegated, the leader communicates trust and encourages the followers to participate in the management of the nursing unit. The followers' knowledge, skill and experience are recognised and utilised. Risk-taking by the followers in the nursing unit is encouraged and new ideas from the followers are sought and implemented.

The transformational leader also creates trust by providing constant and honest feedback to the followers. He/she should always respect effort, even though mistakes are made from time to time. Transformational leaders are honest but sensitive to the followers' feelings, communicate the followers' strengths and encourage followers to develop to the full. Followers working for transformational leaders do not have to wonder about the quality of their work because they receive the appropriate feedback (Wolf 1986: 27, 8). Therefore, the leader in the nursing unit gives honest, open feedback to the followers but is sensitive to the followers' feelings.

Covey (1989:120-22; 188) states that courtesy, kindness, honesty and keeping commitments increases the level of trust between people, and that trust leads to open, mutual learning and communication and real creativity.

Covey (1989:190-199) describes the following strategies to build and maintain trust:

- understanding the individual: Really seeking to understand the other person is a very important way to build trust;
- attending to the little things: In any relationship the little things, like kindness, being courteous, are the big things;
- keeping commitments: If commitments are broken often, trust is broken;
- clarifying expectations: This will prevent misunderstandings and conflict in future and will build trust between the parties;
- showing personal integrity: Personal integrity generates trust as it means to keep promises and to fulfil expectations and
- apologising for mistakes: Apologies should be made sincerely.

The leader should implement the above-mentioned strategies in the day-to-day practice of successful transformational leadership in the nursing unit. The essential characteristic for trust are summarised in table 3.12.

Table 3.12: Essential characteristics of trust

Characteristics
• confidence, dependence, faith, hope, reliance;
• assured attitude/reliance toward another;
• confidence, belief in reality, truth of something;
• rely upon, depend on;
• feeling of safeness with another person and
• two-way process.

Conceptual definition: trust

Trust is a two-way process of confidence, dependence, faith, hope, reliance and a feeling of safeness between the leader and followers and also between the different followers within the nursing team.

Statement for trust

The following statement for trust is derived from the conceptual framework by means of deductive reasoning:

- After the leader has increased his/her own and the follower's self-awareness he/she engages in building trust, as trust forms the basis of all the behaviours and strategies for transformational leadership.

The next behaviour that the leader implements in transformational leadership is communication.

3.7.3 Communication

The Oxford Paperback Dictionary (Pollard 1994:160) defines communication as "to make known; transfer; transmit; pass information to and fro; have social dealing; have a meaningful relationship." Covey (1989:237-240) states that communication consists of writing, listening, speaking and reading. Hansen and Avadian (1989:18-21) and Strydom (1991:65-68) state the following principles to implement for effective written communication:

- all the facts, statistics and statements should be accurate and attention should be given to technical detail;
- when using quotations, they should be accurate and applicable (the source should be stated);
- do not use unnecessary words or abbreviations;
- use short sentences and paragraphs but give enough detail to be understandable;
- use scientific language and terminology in a document;

- be exact with statistical data for example 25,7% and not more or less 25%;
- order information logically and systematically by providing headings and sub-headings and utilising the decimal system for numbering;
- proof-read all documentation;
- write in the third person for example "the writer or the researcher" and not "I";
- always be polite and tactful;
- do not generalise by using "sometimes, all" but use objective data and
- use the correct punctuation and capitalisation and avoid quantifiers like "very, little."

The leader in the nursing unit should adhere to these principles in all his/her written communication such as writing of reports, memoranda, appraisals and motivations. He/she also guides and supervises the followers in the implementation of these principles. Effective written communication is not the only inter-personal skill that the leader utilises.

According to Covey (1989:240), the main principle of good inter-personal skills is "seek first to understand, then to be understood." To be able to really understand the follower, the leader should listen to the followers. According to Strydom (1991:55-56), certain strategies can be used for effective listening, namely:

- concentrating on what the follower is saying and how the follower is conveying the message;
- avoiding false or selective listening;
- limiting external disturbances such as noise, disturbances;
- establishing good rapport by listening in a non-judgmental manner and using empathy;
- clarifying unclear messages through asking questions and verifying facts;
- being patient and allowing enough time for people to express words and feelings;
- keeping cool, calm, alert and attentive by showing interest in the person who is speaking and in the subject that is addressed;
- regularly summarise what you are hearing and clarify the content with the follower and
- being a critical listener.

It is important that the leader implements these principles for effective listening and also guides, supports and supervises the follower in the implementation of these principles. As a leader, it is important to be able to verbally communicate effectively with other members of the multi-professional team and also with the followers.

Van Loggerenberg (1988:35-37) and Strydom (1991:57-58) describe specific strategies for effective verbal communication. Firstly, the person should avoid unclear or double or vague messages. Quick thought processes (thinking on behalf of the other person); language problems (not understanding the person's language) and external environment disturbances (noise; interruptions) should also be avoided.

The person should also analyse and improve on the quality of his/her voice by talking loud enough with enthusiasm and conviction and to pronounce words clearly and correctly. Lastly, the person should avoid mannerisms like "um; ok; you know," should control the tempo of speech; maintain eye contact and use pauses effectively while speaking.

The leader implements these principles in his/her verbal communication in the nursing unit. Lastly, the leader should also be able to read effectively.

Burns and Grove (1993:158-159) describe specific strategies for effective reading. Skimming is a quick review of a source to gain an overview of the content. Comprehending is reading the entire source carefully to understand the major concepts and the logical flow of ideas. During analysis the content is divided into parts to be examined in-depth. Synthesis is to cluster ideas together to form a new meaningful whole.

To facilitate individual and nursing unit transformation the leader implements all the principles for effective communication and also guides, supports and supervises the follower in the development and implementation of these principles.

The transformational leader should also communicate informally with the followers concerning their work, hobbies etcetera. Followers should also be invited to informal gatherings, for example teas, to meet each other and also to enable them to communicate on an informal basis.

The essential characteristics of communication are elucidated in table 3.13.

Table 3.13: Essential characteristics of communication

Characteristics
• the leader provides meaning through communication;
• communication includes listening, speaking, reading, writing;
• communication is also expressed through symbols;
• the same message is communicated in different ways to the individuals in the nursing unit and
• the leader also communicates the vision.

Conceptual definition: communication

The leader communicates a vision and provides meaning through communication (listening, speaking, reading, writing) and expression through symbols and further communicates the same message in a variety of ways to the followers in the nursing unit.

Statement for communication

The following statement is derived from the conceptual framework by means of deductive reasoning.

- To create meaning through communication the leader communicates a vision and provides meaning through communication employing listening, speaking, reading and writing skills.

Another behaviour that the leader implements is to develop a vision.

3.7.4 Vision

Vision is defined as "a mental picture of a possible situation or state of affairs, in which you imagine how things might be different from the way they are now." Collins Cobuild (1988:1627-1628). The Webster Collegiate Thesaurus (Kay 1976:912) defines vision as "to envisage, visualise, imagine, feature" and the Oxford Paperback Dictionary (Pollard 1994:897) defines vision as "imaginative insight into a subject or problem; foresight and wisdom in planning".

Rabey (1994:31) defines a vision as an ideal to aim for. The leader should be able to transfer the vision to the followers in such a way that the followers will follow the vision because they want to. The followers should see the purpose of the vision, accept ownership of it and be committed to achieve it. According to Charlton (1992:47), the vision is "a picture, target or goal of the future that is realistic, credible and consequently better than the present." McMahon (1992:52) states that transformational leadership requires that "we pull the organisation towards a vision, profoundly different from pushing toward a goal." In the nursing unit the vision is aiming at the ideal of successful transformational leadership. It should be a realistic picture, target, goal that is credible and better than the current situation in the nursing unit.

Charlton (1992:50) states that the vision has several purposes, namely to:

- create an attractive future that motivates people and encourages the individuals to find their role in the organisation;
- help people to engage in a creative and purposeful venture;
- provide a sense of focus as to where the organisation is going;
- provide focus concerning the central focus and purpose of the organisation;
- align human energies towards a common end, rather than be fragmented and
- engender commitment, rather than compliance to the purpose of the organisation.

The purpose of a vision for the nursing unit is therefore to:

- create a purposeful and attractive future that motivates the leader as well as the followers;
- encourage the leader and the followers to each find their role in the nursing unit;
- provide a sense of focus as to where the nursing unit is aiming;
- provide focus on successful transformational leadership to facilitate individual and nursing unit transformation;
- align the energies of the leader and the followers in the practice of successful transformational leadership in the nursing unit and
- engender commitment, rather than compliance, to successful transformational leadership in the nursing unit.

According to McDaniel (1993:26-28), a vision is an image of a potential and it implies anticipation. A well-formulated vision provides a focus for all member in the institution. The vision also provides direction to action. The role of the leader is to formulate and develop a comprehensive view and vision after analysing the past and the present of the specific institution. In the nursing unit the vision is an image of the potential in the nursing unit. A well-formulated vision provides focus and direction for action to the leader and the followers in the nursing unit. The role of the leader and the followers is to formulate and develop a comprehensive vision after analysing the past and the present situation of the nursing unit.

McDaniel (1993:28) states that developing a vision includes four cognitive skills, namely: expressing, explaining, extending and expanding the vision.

The development of a vision for the nursing unit is done by means of creating, explaining and implementing the vision.

(a) Creating a vision

According to Mann (1988:20, 22), the vision should include workable solutions to significant problems. The more significant the problems the more workable should be the solutions. In this manner such problem-solving will create sufficient purpose to the followers to rise above self-interest and work together to transform the situation. Therefore the vision for the nursing unit should include workable solutions to significant problems. The workable solutions should be created in a way that it will create sufficient purpose to the followers to raise above their own self-interest and work together to transform the nursing unit.

There should be an atmosphere of openness and participative response. As each person's opportunity to achieve personal recognition, integrity and authenticity increases so the organisational integrity should also develop (Marriner-Tomey 1993:176-178).

According to Jackson-Frankl (1993:43-44), transformational leaders have visions that are clear. The significant corporate concepts are identified and the vision is also expressed in logical and meaningful ways. The expectations are articulated and also reinforced. The vision is understood and shared, and every person has an important task in the future development of the vision. Elements of fun, self-worth and creativity are also included. To encourage commitment to the vision it is important that the process of creating a vision is a participative process between the leader and the followers. Every individual's expectations and opinions are articulated and recognised.

Stewart (1994:74, 89) states that a clear shared vision should emphasise priorities, common goals and collaboration. A vision goes beyond a brief mission statement. It describes what an organisation wishes to achieve and it also includes what an organisation wishes to be. It encapsulates the organisation's aspirations as well as its intentions. Developing a joint, shared vision is a way of empowering the individuals in an organisation. In the process of creating a vision, the leader can use different techniques such as brainstorming, fish-bowling and use the questions why, what, where, when, how, who, as guidelines to get started.

The vision of the nursing unit should emphasise priorities, common goals and collaboration. The vision should describe the nursing unit's aspirations and intentions and should also indicate how these aspirations and intentions are to be reached. Developing a shared, joint vision is a way of empowering the followers (another behaviour of transformational leadership). In the process of creating the vision the leader utilises techniques such as brainstorming.

(b) Explaining the vision

In order to communicate a vision in such a way that other people will assimilate it, the transformational leader should develop coalitions and support. There will always be people that will not support the vision. This will require sensitivity to others and also the ability to negotiate agreement and trust (Lynch 1993:77).

Young (1992:25) states that the vision should be clearly and consistently communicated when the leader interacts with individuals or groups throughout the organisation.

The leader should aim at an open, honest, clear and participative statement of support for the vision. The final version of the vision should be expressed and explained so that it becomes clear, meaningful and motivational to the followers. If the final version is in a written and printed format, each follower in the nursing unit should receive a copy as well as an explanation, if necessary. If the vision is pictorial or abstract it should be explained verbally, followed by a written explanation. The final step in the development of a vision is the implementation thereof.

(b) Implementing the vision

When the vision is implemented it should be used in the day-to-day practice of successful transformational leadership within the nursing unit. It should be integrated into every aspect of the nursing unit such as the mission statement, philosophy, goals, policies and procedures.

Vision within the Nursing for the Whole Person Theory

In the Nursing for the Whole Person Theory, the end vision is the quest for wholeness. In the study the end vision is the quest for successful transformational leadership by the leader to facilitate individual and nursing unit transformation. The essential characteristics for the vision are reflected in table 3.14.

Table 3.14: Essential characteristics of the vision

Characteristics
For a vision to be effective it should:
• include clear, realistic, credible, workable solutions to significant problems;
• be clearly and consistently communicated through open and honest support;
• include a participative process between the leader and the follower;
• emphasise priorities, common goals and collaboration and
• encapsulate the individual's/organisation's aspirations and intentions.

Conceptual definition: vision

The vision of a leader is a mental picture or target or goal for a prospective situation. A vision is realistic or credible and a working solution to significant problems when it is clearly and consistently communicated by means of open and honest support for the vision through increased trust between the members of the nursing team in the nursing unit.

Statement for the vision

The following statement regarding the vision is derived from the conceptual framework by means of deductive reasoning:

- To develop an effective vision for the nursing unit, it should be created, explained and implemented.

After the development of an effective vision, the leader engages in empowerment.

3.7.5 Empowerment

According to Lynch (1993:184), empowerment occurs when the traditional hierarchy starts to fade or fall away and the need arises for the employee to take responsibility for the success of the organisation. Networks start to form and power changes hands.

This is when a new political paradigm emerges. New values are developed and assimilated. The nurse executive (leader) should recognise these changes and direct energies and powers in a constructive and positive way to form effective and shared networks (organisations). This involves the transformational leaders who are self-empowered and who should also empower others to discover and use their unique skills, knowledge, experience and creativity.

The above-mentioned is true for the current external environment of the nursing unit. The traditional hierarchy and values of the previous Government fell away with the election of the Government of National Unity. The RDP and the National Health System were introduced, and this necessitates a total transformation in the Health Services (including nursing). This necessitates a total transformation to a new political paradigm with new goals and objectives where new values and norms, such as democracy, transparency and lack of discrimination emerge. The leader in the nursing unit should acknowledge these changes and should direct nursing management efforts towards constructive and positive transformation. This transformation is facilitated by successful transformational leadership in the nursing unit. One of the identified behaviours to be implemented by the leader is empowerment.

The leader should be self-empowered, by means of increased self-awareness (also one of the behaviours of transformational leadership), and should also empower the followers in the nursing unit to utilise their unique knowledge, skill, experience and creativity in the support of and participation in transformational leadership.

The Chamber Pocket Dictionary (Davidson & Seaton 1988:235) defines empower as "to authorise; to enable." According to the Shorter Oxford English Dictionary (Pollard 1988:649), empower is "to invest legally or formally with power, to authorise" and empowerment is defined as "the action of empowering; the state of being empowered".

Webster's Collegiate Thesaurus (Kay 1976:281) defines empowerment as to "authorise, accredit, commission, enable." Webster (Kay 1981:744) defines empower as "to give official authority to; to delegate legal power to" and the Oxford Paperback Dictionary (Pollard 1994:262) defines empower as "give power or authority to".

Empowerment is defined as "the process by which a leader or manager shares his/her power with subordinates." Power is interpreted as the possession of control or authority over organisational resources. The emphasis is on the sharing of authority (Conger & Kanungo 1988:473). Charlton (1992:33) defines empowerment as the act of investing and authorising, where people and organisations are enabled to achieve goals. This involves the sharing of power and authorising people to think and make decisions.

According to Cottingham (1989:72) empowerment is "the capacity to create an environment in which people are encouraged to work towards achieving their potential." It is a process of focusing on the needs of the individuals and encouraging self-responsibility by altering self-limiting beliefs. This involves the transformational leaders who are self-empowered and can also empower others to discover and use their unique skills, knowledge, experience and creativity to the fullest. Thus in the nursing unit empowerment means to:

- authorise, enable followers by giving authority and delegating power to them;
- enhance a feeling of self-sufficiency amongst the followers through identification of conditions that foster powerlessness;
- develop competent, motivated followers to use authority and responsibility to utilise their full potential;
- invest power and share power by authorising the followers to think and make decisions;
- create an environment in the nursing unit that encourages the leader and the followers to work towards achieving their potential and
- focus on the needs of the leader and the followers to encourage self-responsibility by altering self-limiting beliefs.

According to Tebbitt (1993:18-19), empowerment is composed of specific conceptual components, namely a:

- cultural change process: this means defining new, or revising and reaffirming existing values and
- paradigm shift: this means changing what an organisation believes about itself and also how it thinks and acts. There should be a move from organisational domination to person participation and partnership.

The paradigm shift results in a feeling of commitment. The participants are proud of the service they render and are therefore more committed. Employee actions are freely chosen, owned and committed to on behalf of the organisation without any requests or requirements to do so.

The nursing unit can redirect and redesign its goals, roles, systems and management procedures. This is possible because of the support and commitment by the leader and the followers. The leader should, in co-operation with the followers, define new or revise and reaffirm existing values to encourage the paradigm shift necessary to result in a feeling of commitment from the leader and the followers so that goals, roles and management systems can be revised and reaffirmed to facilitate the practice of successful transformational leadership in the nursing unit.

Tebbit (1993:19- 20) describes certain variables affecting organisational empowerment, namely:

- organisational beliefs about authority and status: the more the organisation's management depends on authority and power as motivational factors to achieve their mission and strategic direction, the less likely it is that empowerment will occur;
- control perceptions, needs and attitudes: organisations with management that emphasises rules and regulations leave little room for empowerment;
- organisational inertia: inertia occurs when management does not understand the empowering principles or believes that empowerment should occur naturally;
- personal and inter-departmental barriers: obstacles occur sometimes as a result of internal rivalries between departments and because of the competition for resources, time, priorities;
- employee numbers, mix and skills: the greater the numbers, mix and skills of the employees the greater the responsibility is to develop focused yet flexible strategies for empowerment;
- ability and willingness of the staff to assume responsibility and accountability for their attitudes and behaviours: specific training, education and development is needed to ensure that staff have the knowledge and ability to do the job and to understand the nature of the existing systems and processes. If employees are well equipped with applicable knowledge and skill they should be more able and willing to assume the responsibility and accountability for their attitudes and behaviours and
- managerial competence: the better the management competence the easier it will be to initiate, facilitate and sustain empowerment.

The leader should acknowledge that the above-mentioned variables affect empowerment in the nursing unit and also in the nursing service. Stewart (1994:73-84) describes the following rules (canons) for effective empowerment:

- Envision: The first rule is a shared vision so that the leader as well as followers know what the entire department is striving towards. It includes a clear picture of what is wanted. The leader and the followers should work together to create an acceptable and common vision.
- Educate: The followers should know the why and the what of a needed action and that requires education and not only training.
- Eliminate: The leader should strive to eliminate the barriers to empowerment by ensuring that organisational systems and procedures are aligned with the goals of the department.
- Express: The leader should explain what empowerment is and what benefits it can bring to the individual, the group (team) and the organisation.
- Enthuse: The leader should not only be open and honest about empowerment but should also generate excitement about it.

- Evaluate: Once the empowerment process is implemented it is important and essential to monitor progress and to evaluate results.
- Walk and talk: This means modelling the behaviour that you encourage by showing the followers what you want. It is important to remain motivated to encourage empowerment and not to slide back into old habits.

Empowerment ensures that the followers obtain the power they need to become creative and innovative. The main role of leaders will be to empower other people to be their own leaders should be persuasive, creative and intuitive to enhance the skills of the followers. Gunden and Crissman (1992:6, 9) state that it is important that before people can lead others that they should be able to lead themselves as a feeling of being personally empowered is essential to empowering others. Personal empowerment means self-comfort and the ability to manage oneself effectively.

When implementing empowerment in the nursing unit the leader should adhere to and apply the above-mentioned rules to effect successful empowerment in the practice of successful transformational leadership to facilitate quality nursing unit management and quality nursing care.

Tebbit (1993:21) and Stewart (1994:12) state the following advantages of empowerment:

- improves services through experimentation with the application of new or different management practices in work methods;
- emphasises collaboration, compromise and consensus building as problems and people are dealt with directly;
- promotes the seeking of productive solutions to problems - facilitates involvement and commitment. A "can do" attitude and a high energy level are sustained;
- promotes self-expression and self-growth;
- fosters integrity and respect at all levels and information is shared throughout the organisation. The truth is told and honesty honoured;
- is a way of getting the best from the leader and followers by enhancing and expanding personal skills;
- improves customer service (quality nursing unit management and quality nursing care in this study);
- offers the followers a greater sense of achievement and control leading to improved motivation and
- enables organisations to react quickly, appropriately and effectively to a fast changing environment as empowerment is a key ingredient in achieving the mission, vision and strategic direction of an organisation.

Empowerment in the nursing unit can enhance and expand personal skills of the followers; offer the followers a greater sense of achievement to facilitate improved motivation. Empowerment increases the followers' sense of control by enabling them to make their own decisions. Followers feel that they can really make a difference and have an impact on the practice of successful transformational leadership. This increases the success of transformational leadership and leads to transformation and repositioning reflected in quality nursing unit management and quality nursing care.

Tebbitt (1993:21) describes certain steps to organisational empowerment, namely :

Step one: Determine values

The personal and organisational values critical to accomplishing the vision, mission and strategic direction of the organisation are revised or reaffirmed.

Step two: Identify goals, plan actions, set priorities and allocate resources.

This generates commitment to the organisation's vision by formulating focused, flexible strategies while maintaining balance between the internal and external environment and potentially scarce health care resources.

Step three: Define product or service performance, satisfaction measurements and improvement methods. This step leads to continued quality improvement, emphasising processes and systems, and by continually developing review, feedback, and acknowledgement.

Step four: Delineate individual versus team roles.

All role responsibility, authority and accountability are to be defined and outlined. Teams should also have a defined scope of responsibility and authority, specific goals and objectives, time-frames and resources.

Step five: Define components and criteria for relationship and boundary management.

Boundaries should be defined and relationships managed.

Step six: Assess organisational and personal risk-taking capacity.

Assessment of risk-taking is done by addressing expectations, regards, support systems and resources.

Step seven: Limit organisational and personal values.

Continuously improving service and satisfaction through a united team effort should be implemented with consideration to the personal and organisational values.

In the process of empowerment the leader implements the above-mentioned steps/strategies in the nursing unit.

Empowerment also includes shared governance. Porter O'Grady (1989:350) states that shared governance is when nurses at every level in the nursing service play a role in the decisions that affect nursing. Authority and accountability are shared in a systematic format among all members of the nursing service.

The old hierarchy, where power was at the centre, is falling away and is making room for an organisational network with shared power. This network forms the basis that links the leader and the followers to such a way that each of them forms an important link in identifying and working towards common goals and a common purpose. The new paradigm for leadership can be fulfilled by transformational leadership, in which the leader uses positive strategies to create an openness and also to put the followers at the heart of the action. Empowerment occurs when everybody in the network (organisation) shares the same vision and employs their energy and creativity to move towards a common and shared goal and purpose that is effective and meaningful (Marriner-Tomey 1993:193).

Shared governance allows each follower an equal vote in major decisions and the practice of nursing is converted from subservient to autonomous. In transformational leadership it is the responsibility of the leader to create an environment that stimulates and inspires individuals and that promotes staff development. The central aspects of shared governance are autonomy, authority and accountability of followers (Boeglin 1993:91-96).

Table 3.15 reflects the essential characteristics of empowerment.

Table 3.15: Essential characteristics of empowerment

Characteristics
• to enable; authorise;
• to invest legally or formally with power;
• implementation of the steps of empowerment;
• obtain power to become creative and innovative;
• self empowerment;
• defines new or revises and reaffirms existing values;
• sharing power; authorising people to think and make decisions; encourage the needed paradigm shift and
• feelings of commitment.

Conceptual definition: empowerment

Empowerment occurs when the leader invests the followers legally and formally with power through the implementation of specific steps for empowerment. The leader, in interaction with the followers, defines new values or revises and reaffirms existing values; shares power and authorises people to think and make innovative and creative decisions to encourage the paradigm shift needed to result in feelings of commitment. Empowerment also includes self-empowerment.

Statements for empowerment

The following statements regarding empowerment are derived from the conceptual framework by means of deductive reasoning.

- The leader, in interaction with the followers, defines new values or revises and/or reaffirms existing values to encourage the needed paradigm shift that results in feeling of commitment so that the nursing unit and the nursing service redirect and redesign goals, roles and management systems.
- The leader realises that variables such as nursing unit beliefs about authority and status; control perceptions, needs and attitudes; nursing unit inertia; personal and inter-departmental barriers; follower number, categories of followers and their skills, ability and willingness of followers to assume responsibility as well as accountability, together with management competence affects empowerment in the nursing unit.
- When empowering the followers in the nursing unit, the leader adheres to certain rules for empowerment, such as envisioning a shared vision and removing barriers to empowerment; to express notions on empowerment educate on and enthuse on empowerment; evaluating the empowerment process and building trust through open and two-way communication.

3.8 SUMMARY

In this chapter a conceptual framework for transformational leadership by nursing unit managers was explored and described by means of the theory-building approaches of analysis, synthesis and derivation as described by Walker and Avant (1995:28-29). The survey list of Dickoff, et al. (1968:423) was utilised as a framework for the identification and classification of the concepts. For the definition of identified and classified concepts, the first two steps of Wandelt and Stewart's (1975:64-69) three-step method were utilised. Through derivation the concept is then written within the framework of the Nursing for the Whole Person Theory. Lastly, a conceptual definition and statements were derived for each of the identified concepts. The conceptual framework for transformational leadership is summarised in figure 3.9. In chapter four a model is explored and described by means of derivation and deductive reasoning from the conceptual framework.

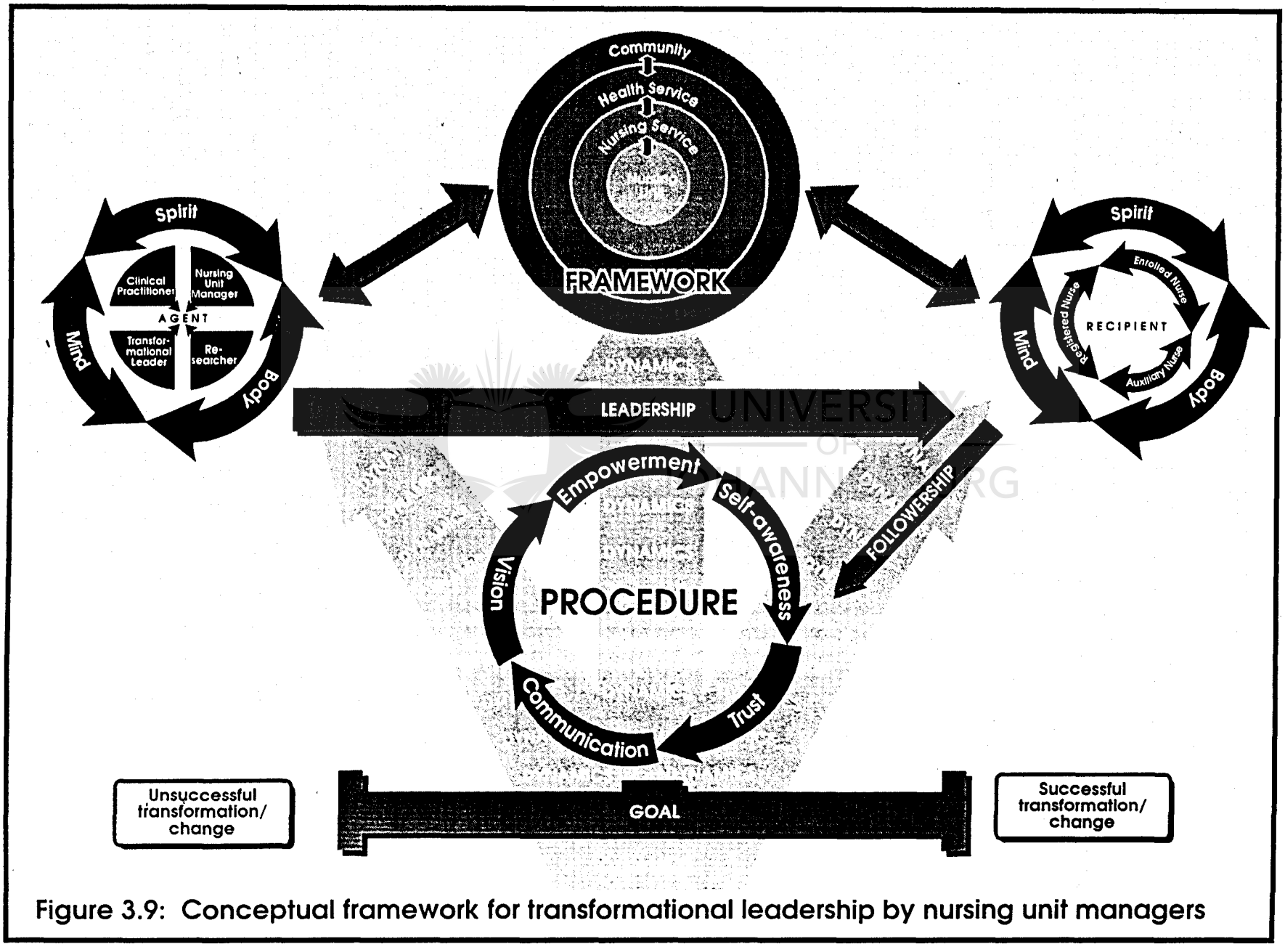


Figure 3.9: Conceptual framework for transformational leadership by nursing unit managers

CHAPTER 4

A MODEL FOR TRANSFORMATIONAL LEADERSHIP BY NURSING UNIT MANAGERS

4.1 INTRODUCTION

The aim of this model is to describe transformational leadership by the nursing unit manager to facilitate individual and nursing unit transformation.

This model is described within the context of the period following the first democratic elections in South Africa which put the Government of National Unity into power. The Government of National Unity has a totally different approach from the former Government to health service delivery. In the Government of National Unity the Reconstruction and Development Programme (RDP) of the African National Congress (ANC) dominates, and this programme has significant social, political and economic implications. To implement the RDP, major transformational changes are needed in the South African community as well as in the health services. Transformation in the South African community and in the health services has a direct and specific effect on the leaders, followers and nursing unit management and can therefore not be ignored. Changes in technology, diagnostic and treatment procedures also impact on the leader, follower and the nursing unit.

The nursing unit functions as a subsystem within the system of the nursing service, health service and community. All the discussed changes/forces cause a disharmony in the system and in the subsystem (nursing unit). They therefore necessitate the practice of transformational leadership in the nursing unit to facilitate individual and nursing unit transformation.

This model is derived from the conceptual framework by means of synthesis and deductive reasoning. The assumptions, an overview, as well as the structure (concepts and relationships) and the process of transformational leadership are described. Figure 4.1 provides a visual presentation of the model for transformational leadership by nursing unit managers.

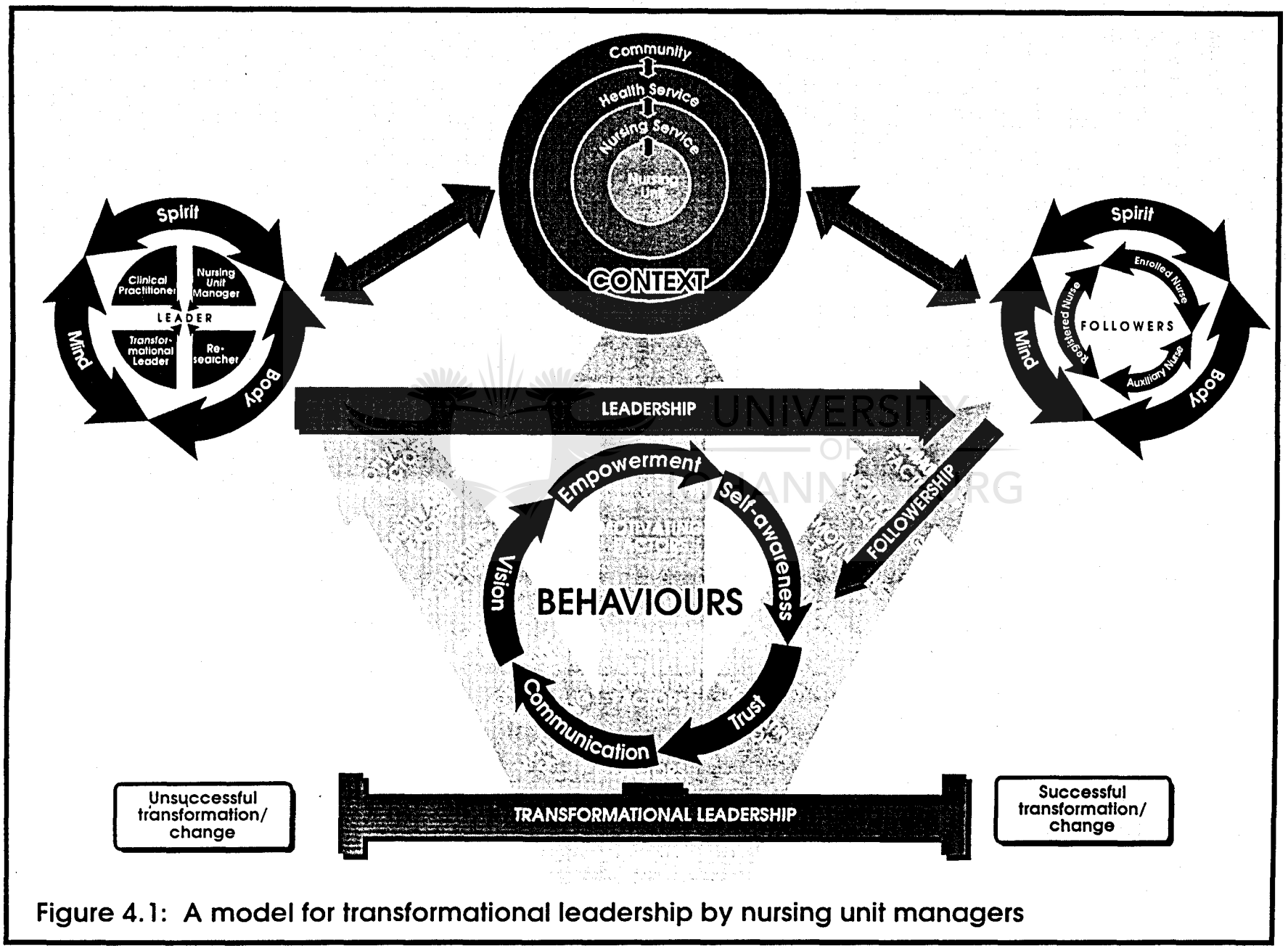


Figure 4.1: A model for transformational leadership by nursing unit managers

4.2 ASSUMPTIONS FOR THE MODEL

The model is based on the Judeo-Christian philosophy and values and Nursing for the Whole Person Theory. The conceptual framework as described in chapter three of this study is utilised as a theoretical framework. Based on these theories and conceptual framework, the following assumptions are derived by means of deductive reasoning.

- Leaders and followers are individuals. They are spiritual beings who function in an integrated biopychosocial manner.
- The leader and the followers interact with their internal environment (body, mind and spirit) and external environment (social, physical and spiritual) wholistically.
- These individuals strive towards individual and nursing unit transformation.
- Leadership is a God-given gift and talent which should be developed and the researcher believes that the leader can learn the specific behaviours of transformational leadership.
- The leader practices transformational leadership by implementing specific interdependent and interrelated behaviours.
- The followers support the leader in transformational leadership and practice under the guidance as well as the direct and/or indirect supervision of the leader.
- The practice of transformational leadership is a dynamic process which depends on the interaction between the leader, followers, nursing unit, nursing service, health service and community (context), goal, motivating forces and behaviours of transformational leadership.
- Through transformational leadership the leader facilitates individual and nursing unit transformation but there is no cause-and-effect relationship between successful transformational leadership and the transformation of the individual and the nursing unit.
- The behaviours of transformational leadership in this model are described within the context of the nursing unit and are therefore context-bound.
- The nursing unit functions as a subsystem within the nursing service and community as a system.

4.3 DEFINITIONS OF MAIN AND RELATED CONCEPTS

The main concept and related concepts are now described.

(a) Main concept

Transformational leadership: Transformational leadership is leadership based on a person's need for meaning in its entirety. The transformational leader exhibits certain leadership characteristics and implements specific behaviours in the practice of transformational leadership.

(b) Related concepts

Leader: The leader is the registered/professional nurse and/or midwife in-charge of a nursing unit who is a clinical practitioner, nursing unit manager, transformational leader and researcher. He/she is an individual who functions in an integrated biopsychosocial manner and implements the specific behaviours of transformational leadership in the quest for individual and nursing unit transformation.

Followers: The followers are the registered nurses and/or midwives, enrolled nurses and/or midwives and the auxiliary nurses as members of the nursing team in a nursing unit within a nursing service who support the leader and is influenced by the leader in the practice of transformational leadership. Followers are potential leaders and participate in individual and group efforts to reach organisational goals. Followers comply with the minimum educational requirements of SANC and practice under the guidance and direct and/or indirect supervision of the leader.

Context: The context is the nursing unit within a nursing service and a health service with internal and external environments interacting to impact on the outcome of transformational leadership. The context also includes the context of the leader in which the leader functions as a clinical practitioner, nursing unit manager, transformational leader and researcher.

Motivating factors: The motivating factors for transformational leadership are the interaction between the internal and external environment of the leader and the followers, and the framework of the nursing unit which impacts on the practice of transformational leadership.

Goal: The goal is successful transformational leadership by the leader within a specific context facilitating individual and nursing unit transformation. It is also the successful co-operation and/or participation of the followers as individuals as well as a nursing team to support the leader in this activity.

Transformation: Transformation is to change or alter in composition and/or function of the individual (leader and follower) and the nursing unit.

Facilitate: To facilitate requires bringing about individual and nursing unit transformation. It is a dynamic action to promote individual and nursing unit transformation by means of creating a positive environment for transformation by identifying and mobilising aspects needed to enhance the change or transformation.

Procedure: Procedure is the practice of transformational leadership by implementing the behaviours of transformational leadership to facilitate individual and nursing unit transformation.

Behaviour: Behaviour is the action or the "what" which the leader implements for successful transformational leadership to facilitate individual and nursing unit transformation. These behaviours include self-awareness, trust, communication, vision and empowerment.

Self-awareness: Self-awareness occurs when the leader and the followers are aware of and have knowledge of their internal environment (body, mind and spirit) as well as their external environment (physical, psychological and spiritual) by means of listening to themselves and listening to and learning from others.

Trust: Trust is a two-way process of confidence, dependence, faith, hope, reliance and a feeling of safeness between the leader and followers and also between the different followers within the nursing team.

Communication: The leader communicates a vision and provides meaning through communication (listening, speaking, reading, writing) and expression through symbols and further communicates the same message in a variety of ways to the followers in the nursing unit.

Vision: The vision of a leader is a mental picture or target or goal for the prospective situation. A vision is realistic or credible and a working solution to significant problems which is clearly and consistently communicated by means of open and honest support for the vision through increased trust between the members of the nursing team in the nursing unit.

Empowerment: Empowerment occurs when the leader invests the followers legally and formally with power through the implementation of specific steps for empowerment. The leader, in interaction with the followers, defines new values or revises and reaffirms existing values; shares power and authorises people to think and make innovative and creative decisions to encourage the paradigm shift needed to result in feelings of commitment. Empowerment also includes self-empowerment.

Strategy: The strategy or the "how" comprises the needed actions which should be implemented in order to enhance the behaviours of transformational leadership.

4.4 THEORETICAL STATEMENTS FOR THE MODEL

All the theoretical statements for this model are derived from the conceptual framework by means of deductive reasoning.

Leader

- The leader has the necessary knowledge, skill and experience to practice as clinical practitioner, nursing unit manager, transformational leader and researcher.
- The different dimensions of the leader (clinical practitioner, nursing unit manager, transformational leader and researcher) are not regarded as separate entities but as interdependent and interrelated in transformational leadership.
- The leader, as clinical practitioner, has up-to-date knowledge on the newest developments in his/her clinical discipline and practices by implementing the nursing process.
- The leader is a competent nursing unit manager who implements the management process (planning, organising, leading and controlling) and practices successful transformational leadership to facilitate individual and nursing unit transformation.
- The leader, as transformational leader, implements the behaviours of transformational leadership, including self-awareness, trust, communication, vision and empowerment.
- The leader as researcher diligently and systematically initiates, implements, participates in and encourages quantitative and/or qualitative research to investigate, validate, and/or refine existing practices in the nursing unit and to generate new knowledge to facilitate individual and nursing unit transformation.
- There is an interrelationship between leadership and management.

- A dynamic and interactional relationship exists between the leader and followers and furthermore between the leader/follower and the nursing unit/nursing service/health service.
- The leader is an independent practitioner co-accountable for the outcome of transformational leadership in the nursing unit.

Followers

- The followers are individuals as members of the nursing team within the nursing unit that is part of the nursing service or health service. The followers include the registered nurse and/or midwife, enrolled nurse and/or midwife and the auxiliary nurse.
- The followers function within a dynamic interaction with one another as team members and with the leader.
- The follower is a potential leader.
- Each follower is personally accountable for his/her own acts and omissions but interacts as an individual and as a member of a nursing team under the guidance and direct and/or indirect supervision of the leader to support the leader in transformational leadership.

(a) Relationship between the leader and the followers

- Leadership and followership are interlinked and interdependent dimensions that should be regarded as differentiated roles within a leader-follower relationship.
- Effective leaders and effective followers enhance one another so that the behaviour of both leaders and followers improves.
- Usually the follower is a potential leader, but when all followers wish to lead or only follow there can be neither leadership nor followership.
- There is a dynamic interaction between the leader, follower and the nursing unit within the nursing service and health service.
- A rapidly changing or transforming environment places changing demands on the leader and the followers.

(b) Context

- Transformational leadership necessitates a wholistic approach by the leader as clinical practitioner, nursing unit manager, transformational leader and researcher.
- There are several internal and external forces impacting on the practice and the outcome of successful transformational leadership.
- The context is dynamic and consists of in a variety of dimensions namely, clinical practice, nursing unit management, transformational leadership and research.

- There is a dynamic interaction between the internal environment (within the individual and the nursing unit) and the external environment (the nursing service, health service and community).
- External changes in the nursing service, health service and community necessitate transformational leadership in the nursing unit.

(c) **Motivating forces**

- The interaction between the external and internal environment of the leader and the followers impacts on transformational leadership and conversely;
- the interaction between the internal and external environment of the nursing unit impacts on transformational leadership.

(d) **Goal**

- The leader practices transformational leadership to facilitate individual and nursing unit transformation.
- The leader practices transformational leadership by implementing the behaviours of transformational leadership and by utilising his/her dimensions as a leader.
- The followers interact as individuals and as a nursing team under the guidance and direct/indirect support of the leader to support the leader in transformational leadership.

(e) **Self-awareness**

- Self-awareness is to be aware of oneself and to have knowledge of the internal (body, mind and spirit) as well as the external environment (physical, psychological and spiritual).
- The leader increases his/her own self-awareness with the purpose of having a clear understanding of the self, and encourages followers to increase their self-awareness.

(f) **Trust**

- After the leader has increased his/her own and the follower's self-awareness he/she engages in building trust, as trust forms the basis of all the behaviours and strategies for transformational leadership.

(g) **Communication**

- To create meaning through communication the leader communicates a vision and provides meaning through communication employing listening, speaking, reading and writing skills.

(h) Vision

- To develop an effective vision for the nursing unit it should be created, explained and implemented.

(i) Empowerment

- The leader, in co-operation with the followers, defines new values or revises and/or reaffirms existing values to encourage the needed paradigm shift that results in feelings of commitment so that the nursing unit and the nursing service redirect and redesign goals, roles and management systems.
- The leader realises that variables such as nursing unit beliefs about authority and status; control perceptions, needs and attitudes; nursing unit inertia; personal and interdepartmental barriers; follower numbers, categories of followers and their skills, ability and willingness of followers to assume responsibility as well as accountability, and management competence affect empowerment in the nursing unit.
- When empowering the followers in the nursing unit the leader adheres to certain rules for empowerment, such as envisioning a shared vision and removing barriers to empowerment; expressing notions on empowerment, educating in and enthusing about empowerment; evaluating the empowerment process and building trust through open and two-way communication.

4.5 DESCRIPTION OF THE MODEL

A description of the context, overview and structure of the model for transformational leadership follows.

4.5.1. Context of the model

The context of this model is the nursing unit within the nursing service, health service and community with internal and external environments interacting to impact on the outcome of transformational leadership. The central focus in the context of this model is transformational leadership in the nursing unit.

4.5.2. Overview of the model

The leader is the registered, professional nurse and/or midwife in-charge of the nursing unit who integrates different dimensions: namely that of clinical practitioner, nursing unit manager, transformational leader and researcher. The leader practices transformational leadership by implementing the behaviours and strategies of transformational leadership, whilst the followers support the leader and practice under the guidance and direct and/or indirect supervision of the leader.

Transformational leadership is practiced in the nursing unit which is part of the nursing service, health service and community. The interaction of the internal and external environment (of the leader and the followers) and the framework of the nursing unit encourages the practice of transformational leadership.

The goal is successful transformational leadership to facilitate individual and nursing unit transformation.

4.5.3. Structure of the model

The structure of the model gives overall form to the conceptual relationships within the model and emerges from the relationships within the model. The structure includes the central elements of the model and consists of concepts, statements and relationships between the concepts. The following concepts are addressed in this model: transformational leadership; leader; followers; goal; motivating factors; context; behaviours. These concepts were described earlier. The model is visually displayed by means of different structures such as circles and arrows. A description of the nature of these structures follows.

4.5.3.1 The nature of the structure of the model

The nature of the structure of the model provides a description of the structure (circles, arrows and other structures) used in the description of this model. It describes the nature and the aim of these structures.

In the model for transformational leadership the researcher utilises circles, derived from Nursing for the Whole Person Theory, to indicate the individual as a whole person and to indicate the continuous interaction between the elements of the internal environment (body, mind and spirit) of the individual (leader and followers). See figure 4.2.

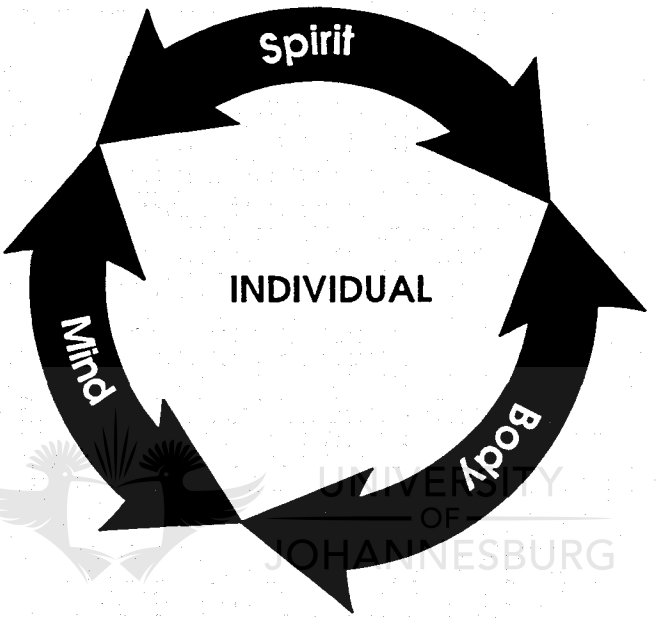


Figure 4.2: The individual in transformational leadership

The context is presented by means of four circles within each other to indicate that the nursing unit functions as a subsystem within the other systems of the nursing service, health service and community. It also indicates that each of these systems is a subsystem of another system and the arrows indicate that such subsystems are interdependent, interacting and interrelated as indicated by figure 4.3.

Figure 4.3: The context of transformational leadership

Arrows are utilised to indicate the interaction between individuals (leaders and followers) and the context as indicated by figure 4.4.

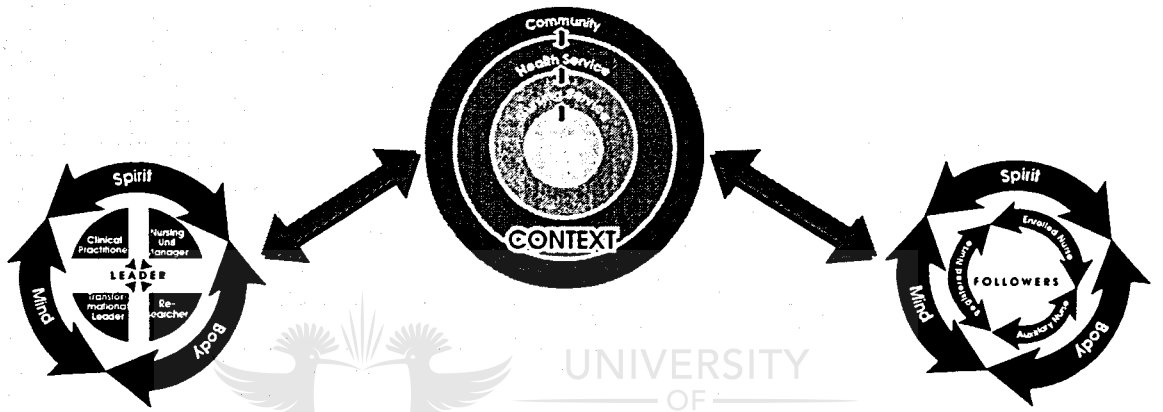


Figure 4.4: The interaction between the individuals and the context

The motivating factors in transformational leadership (internal and external environments of the leader, followers and nursing unit) are depicted by means of an arrow with three open ends. This arrow is open-ended towards the individual (leader and followers) and towards the context to indicate the impact of the motivating factors and the ongoing interaction between these entities. It is this ongoing interaction that motivates the leader and the followers toward transformational leadership to facilitate individual and nursing unit transformation as indicated by figure 4.5.

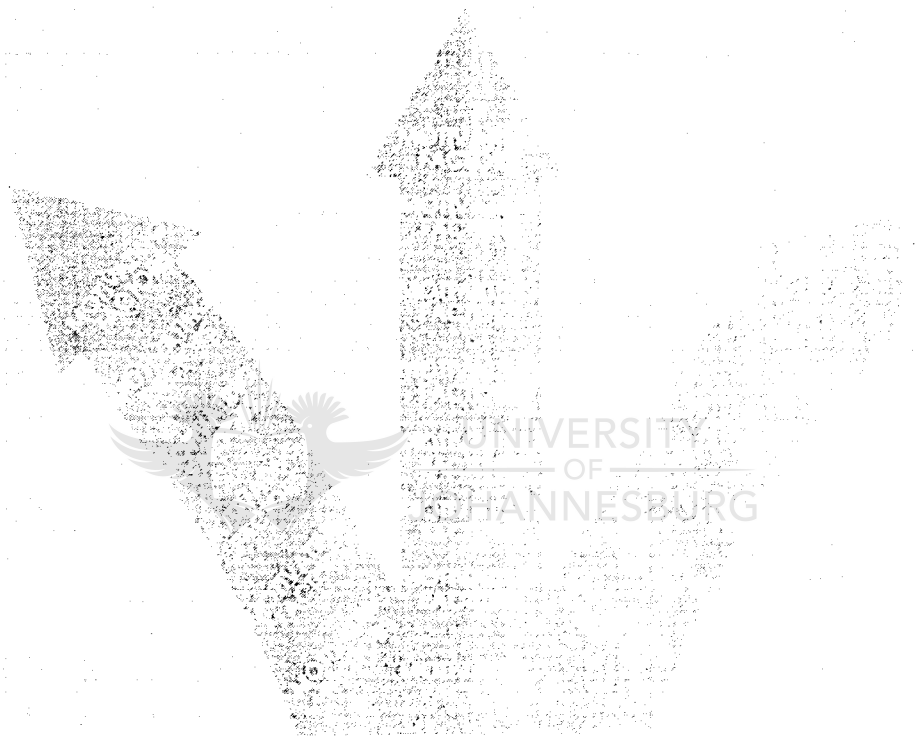


Figure 4.5: The motivating factors in transformational leadership

The interaction between leadership and followership (support of transformational leadership) is presented by means of a linear action to indicate that the leader initiates the process of transformational leadership by implementing the behaviours of transformational leadership (self-awareness, trust, communication, vision and empowerment) and that the followers support the leader in this action as indicated by figure 4.6.

Figure 4.6: Interaction between leadership and followership

The circular structure of the behaviours of transformational leadership suggests that it is a dynamic, ongoing, interactive and interrelated process. This circular structure also indicates the interlinking and interdepending nature of the behaviours of transformational leadership in sequence of action. The process is progressive movement, reflected in the different behaviours that the leader implements as indicated by figure 4.7.

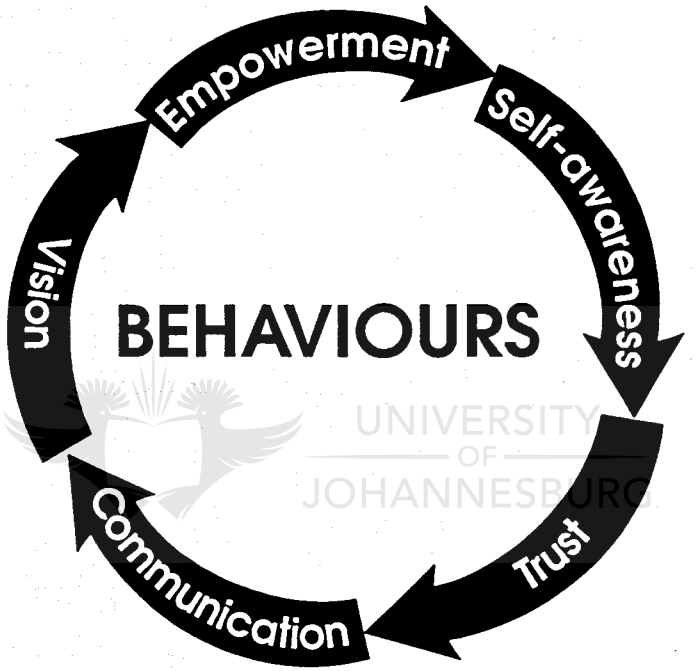


Figure 4.7: Behaviours for transformational leadership

The aim of the model (successful transformational leadership) is indicated on a continuum ranging of unsuccessful transformational leadership to successful transformational leadership. This structure suggests that successful transformational leadership is in a linear relationship to unsuccessful transformation leadership. Successful and unsuccessful transformational leadership are placed at the opposite ends of the continuum. It is therefore conceptualised that transformational leadership is a continuous variable and that degrees of transformational leadership are possible. Successful transformational leadership is reflected in individual and nursing unit transformation. The more successful the transformational leadership, the greater the individual and nursing unit transformation as indicated by figure 4.8.

Figure 4.8: The goal of transformational leadership

4.5.3.2 Relationship statements for transformational leadership

- There is a dynamic and interrelational interaction between the leader and the followers as the leader practices transformational leadership and the followers support the leader in this action.
- The leader and followers interact with their internal and external environments.
- The interaction between the internal and external environment of the leader and the followers motivates the leader to practice transformational leadership and the follower to support the leader in this action.

- The motivating factors (interaction of the internal and external environments of the individuals and the nursing unit) impact on the outcome of transformational leadership.
- Transformational leadership is practiced in a variety of dimensions namely: clinical practice, nursing unit management, transformational leadership and research.
- Transformational leadership is based on the implementation of the behaviours of transformational leadership namely, self-awareness, trust, communication, vision and empowerment.
- The behaviours as the process of transformational leadership are mostly commenced by self-awareness and followed by trust, communication, vision and empowerment.

4.5.4 Process description for transformational leadership

The leader is the registered, professional nurse and/or midwife in-charge of a nursing unit and he/she functions within a variety dimensions such as that of clinical practitioner, nursing unit manager, transformational leader and researcher.

As a clinical practitioner, the leader is a professional nurse and/or midwife registered under section 16 of the Nursing Act (Act no 50 of 1978). The professional nurse and/or midwife practices within the scope of practice (R2598 as amended) as well as the ethical professional norms and values of the nursing profession. Such a person practices as clinical practitioner by implementing the steps of the nursing process: namely, assessing, planning, implementing, evaluating and record-keeping. He/she practices as a member of a multi-professional team and is personally accountable for his/her own acts and omissions and therefore co-accountable for quality health care to the individual, group and community.

The leader is in charge of the nursing unit and manages the day-to-day running of the nursing unit by implementing the management process (planning, organising, leading and controlling). Staff management is included throughout the management process.

As researcher the leader diligently and systematically initiates, implements, participates in and encourages quantitative and/or qualitative research to investigate, validate and/or refine existing practices in the nursing unit and to generate new knowledge.

The followers in the nursing unit include the registered nurse and/or midwife, enrolled nurse and/or midwife and auxiliary nurses who support the leader in transformational leadership and practice under the guidance as well as direct and/or indirect supervision of the leader.

Although the followers function under the guidance and direct and/or indirect supervision of the leader, each follower is personally accountable for his/her own acts and omissions.

The leader strives towards successful transformational leadership by implementing the behaviours of transformational leadership: namely, self-awareness, trust, communication, vision and empowerment. The followers support the leader.

Increasing his/her own self-awareness and encouraging the followers to increase their self-awareness is the first behaviour that the leader implements as it provides the leader with confidence and self-knowledge to engage in other behaviours required for transformational leadership. Self-awareness also provides the follower with self-knowledge and confidence to support the leader in transformational leadership.

After the leader has increased his/her own self-awareness and encouraged the followers to do likewise, he/she engages in the building of trust. Thereafter, the leader implements the behaviour of communication which consist of reading, writing, speaking and listening skills.

Through communication the leader communicates the vision to provide meaning to followers within the nursing unit. It is a meaning shared between the leader and the followers that needs to be communicated by means other than verbal expression only. The leader looks for innovative ways of conveying a message through symbols and graphic depiction to create emotional richness to a message.

Thereafter the leader, in interaction with the followers, develops the vision for the nursing unit by creating, explaining and implementing the vision. Support and commitment to the vision is encouraged. The purpose of communication and interaction with the followers is to empower them.

In empowerment the leader, in a process of interaction with the followers, defines new values or revises and reaffirms existing values to encourage the paradigm shift needed to result in a feeling of commitment to the goals.

The interaction between the external and internal environment of the leader and the followers impacts on transformational leadership and conversely the interaction between the internal and external environment of the nursing unit impacts on transformational leadership.

4.6 GUIDELINES FOR IMPLEMENTATION OF THE MODEL

As the researcher utilised a functional reasoning approach as a metatheoretical assumption in this study it is necessary to describe guidelines for the implementation of the model for transformational leadership in the nursing unit. By implementing these guidelines in the nursing unit, the leader should be able to implement successful transformational leadership to facilitate individual and nursing unit transformation. These guidelines are written in the format of strategies to be implemented to enhance each of the described behaviours for transformational leadership and were derived from the conceptual framework by means of deductive reasoning.

Supportive strategies for transformational leadership

(a) Self-awareness

For the leader to increase his/her own self-awareness the following strategies are utilised:

- acknowledge your own strengths and limitations;
- accept the limitations or change the behaviours that support these limitations;
- be aware and conscious of your own identity, acts, thoughts, feelings and motives;
- gain knowledge on your body and physical potential;
- acknowledge your spiritual needs;
- acknowledge your interaction with the followers and the external environment (nursing unit);
- listen to yourself by allowing yourself to experience genuine emotions; identify and accept personal needs by exploring your own thoughts, feelings, memories and impulses;
- listen to and learn from others by active listening and openness to the feedback from other people;
- exercise self-disclosure by revealing and sharing perspectives with others;
- enlarge your experiences by criteria and engaging in unfamiliar and new activities;
- utilise role play and other strategies to encourage self knowledge;
- develop a commitment to continual personal and professional learning and development;
- accept yourself and also accept other people unconditionally and
- judge yourself and other people less harshly.

The leader should also encourage the above strategies in the follower to encourage the follower to increase self-awareness.

(b) Trust

To build trust the leader implements the following strategies:

- keep you word and keep promises;
- encourage followers by recognising positive traits and accomplishments;
- practice excellence and create an environment that encourages excellence by setting high personal and professional standards;
- display reliable and dependability by being available to provide guidance and/or support when needed;
- display congruency and predictability by practicing what you preach;
- demonstrate personal integrity by honouring commitments;
- display honesty and always tell the truth;
- use open communication;
- demonstrate respect by treating followers as professional adults;
- acknowledge the followers' knowledge, skill and experience;
- give open and honest feedback to followers in a sensitive manner;
- acknowledge respect and value the input and effort from the followers, even though it was unsuccessful;
- acknowledge and communicate the followers' strengths;
- be kind and courteous by demonstrating understanding of the followers' needs and aspirations;
- encourage creativity by encouraging new projects and allowing for calculated risk-taking;
- attend to the little things such as congratulating a follower on his/her birthday;
- clarify expectations to prevent future misunderstanding and conflict;
- apologise for mistakes;
- display personal and professional accountability;
- demonstrate commitment to the followers and the nursing unit;
- spend time with the followers to build contact;
- keep personal information of any follower confidential;
- respect each follower as an individual and do not judge the feelings of the followers and
- create an environment of caring.

(c) **Communication**

Verbal Communication (Speaking)

For effective verbal communication (speaking) the leader implements the following strategies:

- avoid stumbling blocks in verbal communication such as:
  - unclear/double/vague messages;
  - quick thought processes (thinking on behalf of the other person)
  - language problems (not understanding the person's language) and
  - external environment disturbances (noise; interruptions).
- analyse and improve on the quality of your voice:
  - talk loud enough but do not shout;
  - talk with enthusiasm and conviction and
  - pronounce words clearly and correctly.
- avoid mannerisms like "um: ok; you know";
- control the tempo of your speech and pronounce words clearly and correctly;
- maintain eye contact with the person or persons you are speaking to;
- use pauses and silences effectively while speaking and
- if presenting a paper or addressing a group of followers, prepare well in advance.

Listening

For effective listening the leader implements the following principles:

- concentrating on what the follower is saying and how the follower is conveying the message to avoid false and selective listening;
- limit external disturbances such as noise and interruptions;
- listen in a non-judgmental manner;
- establishing good rapport by listening in a non-judgmental manner and by demonstrating empathy;
- clarify unclear messages through regular summarising of discussed content, asking questions and verifying facts;
- display patience and allow enough time to the follower to express words, ideas and feelings;
- keep cool, calm, alert and attentive by showing interest in the person who is speaking and in the subject that is addressed and
- be a critical listener by analysing the discussed content.

Written communication

For effective written communication the leader implements the following principles:

- state all the facts, statistics and statements accurately for example 25,7% and not more or less 25%;
- when using quotations, they should be accurate and applicable (the source should be stated);
- use short sentences and paragraphs but give enough detail to be understandable;
- do not use unnecessary words;
- do not use abbreviations;
- give attention to the technical detail of a document;
- use scientific language and terminology in a professional document or when writing to another professional person or medical professional;
- order information logically and systematically by means of providing headings and subheadings and utilising the decimal system for numbering the headings and subheadings;
- proof read all documentation carefully
- write in the third person for example "the writer or the researcher" and not "I";
- always be polite and tactful;
- do not generalise by using "sometimes, all" but use objective data to support statements;
- use the correct punctuation and capitalisation and
- avoid quantifiers like "very, little".

Reading

The leader uses:

- skimming - quick review of a source to gain an overview of the content;
- comprehending - read the entire source carefully to understand the major concepts and the logical flow of ideas;
- analyse - dividing the content into parts to be examined in-depth and
- synthesis - cluster ideas together to form a new meaningful whole.

(d) Vision

Create the vision

To create a vision the leader implements the following strategies:

- use an open participative two-way process between the leader and the followers;
- state a clear, concise, logical and meaningful vision by including workable solutions to significant problems and emphasising priorities and common goals;

- encapsulate the individual's and the nursing unit's aspirations, expectations, intentions and opinions;
- create sufficient purpose to the followers to rise above self-interest and work together as a team and
- demonstrate trust and sensitivity.

Explain the vision

The following strategies are utilised to explain the vision:

- communicate the vision clearly and consistently when interacting with individuals and/or groups within the nursing unit;
- express the vision in meaningful ways by;
- explaining it so that it becomes clear and understandable and
- use written and/or verbal format to explain the vision.

Implement the vision

To implement the vision the leader utilises the following strategies:

- hand a copy and explanation of the vision to each follower;
- encourage support and commitment to the vision and
- integrate the vision into every aspect of the day-to-day nursing unit management.

(e) Empowerment

- display self-empowerment by demonstrating self-comfort and self-management;
- invest power in and share power with the followers by utilising participative management and by delegating responsibility and authority to the followers to decentralise decision making;
- enhance feeling of self-efficiency by limiting aspects and conditions which foster powerlessness;
- create an environment in the nursing unit where the followers can utilise their unique knowledge, skill, experience and creativity to the fullest;
- strive to eliminate the barriers to empowerment by redirecting and redesigning goals, roles and management system in the nursing unit;
- focus on the individual needs of the follower and encourage self-responsibility by altering self-limiting beliefs;

- create a paradigm shift by moving from nursing unit domination to personal participation and partnership;
- develop a shared vision;
- educate followers on this shared vision and the purpose ("why") of the nursing unit;
- demonstrate commitment to empowerment ("walk the talk");
- monitor progress and evaluate the results of empowerment;
- encourage open communication system;
- provide autonomy from bureaucratic restraint;
- set goals that are meaningful and inspirational to the followers;
- encourage self-expression and self-growth by the followers;
- encourage integrity from and respect to all individuals;
- implement shared governance;
- revise or reaffirm or redefine existing values in the nursing unit in participation with the followers to enhance a feeling of commitment and
- display an openness, honesty and excitement regarding empowerment.

4.7 SUMMARY

In this chapter the structure and process of transformational leadership were described by means of derivation and deductive reasoning from the conceptual framework. As a functional reasoning approach was utilised (see the methodological assumptions for the study) guidelines for implementation was also formulated.

An education programme was derived from this described model and this education programme (through a learning package) was implemented in a nursing service to empower the leaders in this nursing service to practice transformational leadership in their specific nursing units. Thereafter, the model for transformational leadership was implemented in four nursing units and evaluated, validated and refined through the case study strategy.

This model was also evaluated, validated and refined by a panel of experts according to the criteria of Chinn and Kramer (1991:138-139). A refined version of the model is reflected in figure 6.21.

CHAPTER 5

EDUCATION PROGRAMME

5.1 INTRODUCTION

The aim of this chapter is to explore and describe an education programme for transformational leadership by nursing unit managers.

The conceptual framework (chapter three) and model (chapter four) as explored and described during phase one of this study, was utilised for the theoretical content of the education programme. For the didactical development of the programme the following theories and models were utilised:

- Gravett (1991): Principles of adult learning;
- Knowles (1984): Androgogy and
- Klopper (1994 (a)): A model for self-guided learning in nursing.

The model of Klopper (1994 (a)) is already in line with the Judeo-Christian Philosophy and the Nursing for the Whole Person Theory.

5.2 DIDACTICAL DEVELOPMENT OF THE EDUCATION PROGRAMME

As the sample group for the education programme are nursing unit managers, and therefore adult learners, the researcher implemented the principles for adult learning (androgogy) according to Knowles (1984). A description of these principles follows.

5.2.1 Principles of adult education

Knowles (1984) focuses on adult learning (androgogy) as the art and science of teaching adults. The implementation of the androgogical model involves a process design and consists of several elements. The first element is that a climate for learning should be set. This involves the physical environment, such as seating arrangement and decor. It also involves the psychological climate, such as openness, mutual respect and trust, collaboration and supportiveness. Learners should also be involved in mutual planning of programmes.

Learners should not only be involved in the planning of programmes but also in the diagnosing of their learning needs; formulating of objectives, designing and evaluating of learning plans. Gravett (1991:33-43) describes the following characteristics of the adult learner.

(a) Self-concept

Adults have a psychological need to be self-directive (to make their own decisions and take control of their lives). Therefore, it is an explicit need of the adult learner to be regarded as self-directing learners who take responsibility for self-learning. The adult learner is someone who accepts responsibility for learning, sets learning goals, plans his/her own learning strategies and who applies self-evaluation. The self-concept of the adult learner focuses on self-direction, and this requires an interactive approach to learning.

(b) Experience

The accumulative experiences of the adult learner contribute significantly to the learning process. Adult learners find it easier to integrate new learning matter with existing knowledge from a wide field of experience. In the didactic situation the adult's previous experience should be used. A special emphasis should be placed on methods that require active participation and that utilise the previous experience and knowledge of the adult learner. The role of the educator is that of a facilitator of learning.

(c) Learning readiness and learning orientation

Adults show learning readiness when they experience a need to learn something to achieve a goal. Adults are also problem- and task-orientated and therefore the function of the facilitator is to point out the relevance and value of application of the study content to the learner and to encourage an attitude of questioning that can contribute to meaningful discussion.

In this learning package for the educational programme the researcher acts as facilitator in an interactive process of learning. Learning objectives and references are provided as guidelines for learning. The strategies for teaching and learning are individual self-study projects, group discussions and group participation in the practical exercises. The participant is expected to participate actively in the teaching and learning situation. An attitude of questioning and analysis is encouraged to contribute to meaningful discussion.

In this learning package the researcher (as facilitator of learning) builds on the participant's previous knowledge and experience of leadership. All the leaders have completed a programme on leadership. This programme was offered as part of the inservice education programme of this hospital. Each module in the learning package also builds on the previous module.

The researcher therefore anticipated that learners were ready for this learning experience as leaders need to implement transformational leadership in the nursing units. The content of this education programme could immediately be implemented in the different nursing units and therefore also fulfilled the problem- and task-oriented learning attitude of the adult learner. Throughout the education programme the researcher (as facilitator) emphasised the value of the application of the study content as the application of the behaviours and strategies for transformational leadership. Practice exercises were also aimed at developing and enhancing the behaviours and strategies that the leader needed to implement for transformational leadership in the nursing unit to facilitate individual and nursing unit transformation. When developing a learning package the facilitator should not only recognise the characteristics of the adult learner, but should also recognise the different learning theories.

Klopper (1994 (a):107) states that there are different learning theories such as the behaviouristic learning theory of Skinner, Piaget's view on learning, the learning theory of Ausubel, Russian learning theory of Vygotsky and the constructivistic perspective of learning (as described by Klopper (1994 (c)). For the purpose of this study (and this education programme) the constructivistic perspective of learning as described by Klopper (1994 (c)) was utilised.

5.2.2 Constructivistic learning perspective

According to Klopper (1994 (a):15-33), the constructivistic theory of learning consists of specific characteristics. Firstly, learning is regarded as a process of knowledge construction and not merely recording or absorbing of knowledge. The learner is an active constructor of new knowledge, based on existing concepts. Learning is also regarded as an active, constructed, goal-oriented and cumulative process depending on the thinking activities of the learner. In this study the learner (leader) participated actively in the learning process. Learning was constructed and goal-oriented as learning objectives were provided and implemented for each module. The new knowledge built on the knowledge that the participant already had concerning leadership. Each module also built on the previous module to empower the learner (leader) to construct a wholistic picture of the strategies needed for successful transformational leadership.

Another characteristic is that learning is regarded as conceptual change in the way in which the learner experiences, understands and conceptualises a phenomenon or aspect of reality. Learning is not possible without comprehension. The conceptual change in this study was from little knowledge and/or understanding of transformational leadership to a wholistic understanding of the behaviours and strategies required to facilitate transformational leadership. Qualitative change is expected in the way that the learner (leader) experiences, understands and conceptualises transformational leadership. Learning is not possible without comprehension. Quantitative change is also expected with regard to the implementation of the behavioural pattern.

Intentional knowledge construction implies that the learner accepts responsibility for his/her own learning by consciously looking for meaning. Knowledge construction is controlled in a meta-cognitive manner with the learner as the active constructor of his/her own knowledge through deliberate learning. In this learning package the learner (leader) accepted responsibility for his/her own learning as some of the learning objectives and also some of the practical exercises were handled on a self-study basis. The learner (leader) was encouraged to construct his/her own knowledge and should learn deliberately in the process.

Lastly, this approach to learning indicates the association among learning intention, learning process and learning outcome in a specific context. There is a direct relation between the learning process and the learning outcome. The learner who merely memorises facts without trying to communicate the deeper level of meaning of text shows poor comprehension of the material studied.

The following premises are structured by Klopper (1994 (c):34):

- the self-concept of the adult learner is tuned to the self-direction and requires an interactive approach in the didactic situation;
- the implications of the accumulated experience of the adult learner in the didactic situation is the application of methods that utilise experience, dialogue and reflection the adult learner's readiness to learn is indicated by his pointing out the relevance of the learning content, by moving from known to unknown and by developing a questioning attitude in the didactic situation;
- the learning orientation fixes on problem- and task-orientation and determining the immediate applicability of the learning content and
- learning is a process of active construction and entails conceptual change.

After considering/recognising the characteristics of the adult learner and the different learning theories, the facilitator has to adhere to the basic educational principles. The atomistic (superficial) approach to learning fragments the learning task, whereas the wholistic (deep) approach integrates parts of the whole in the search for underlying associations.

Klopper (1994 (c):30) also argues that the task of the facilitator is to accompany the learner to accomplish deep wholistic and lifelong learning. Figure 5.1 summarises the deep wholistic approach.

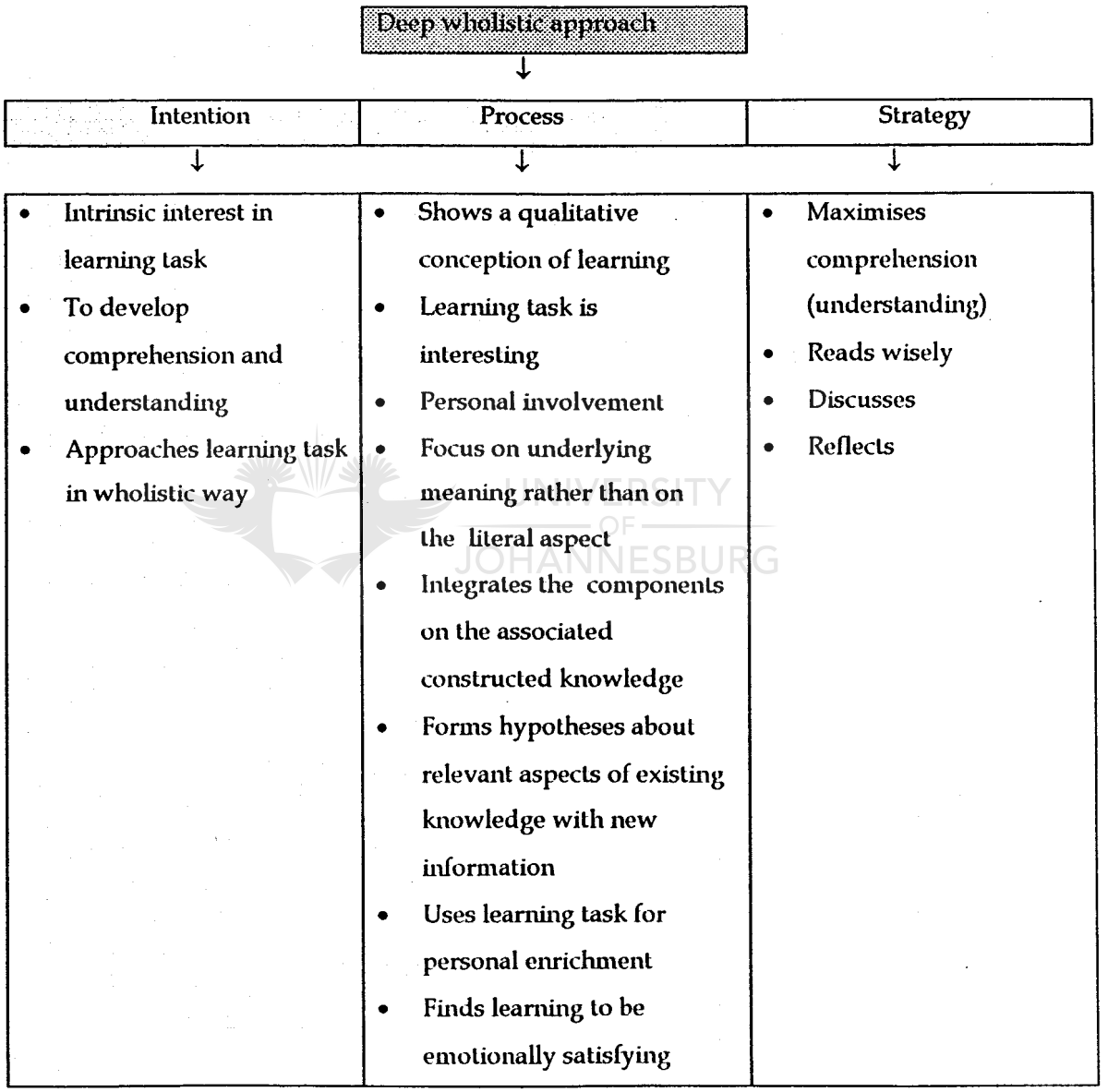


Figure 5.1: The deep-wholistic approach (Klopper 1994 (c):31)

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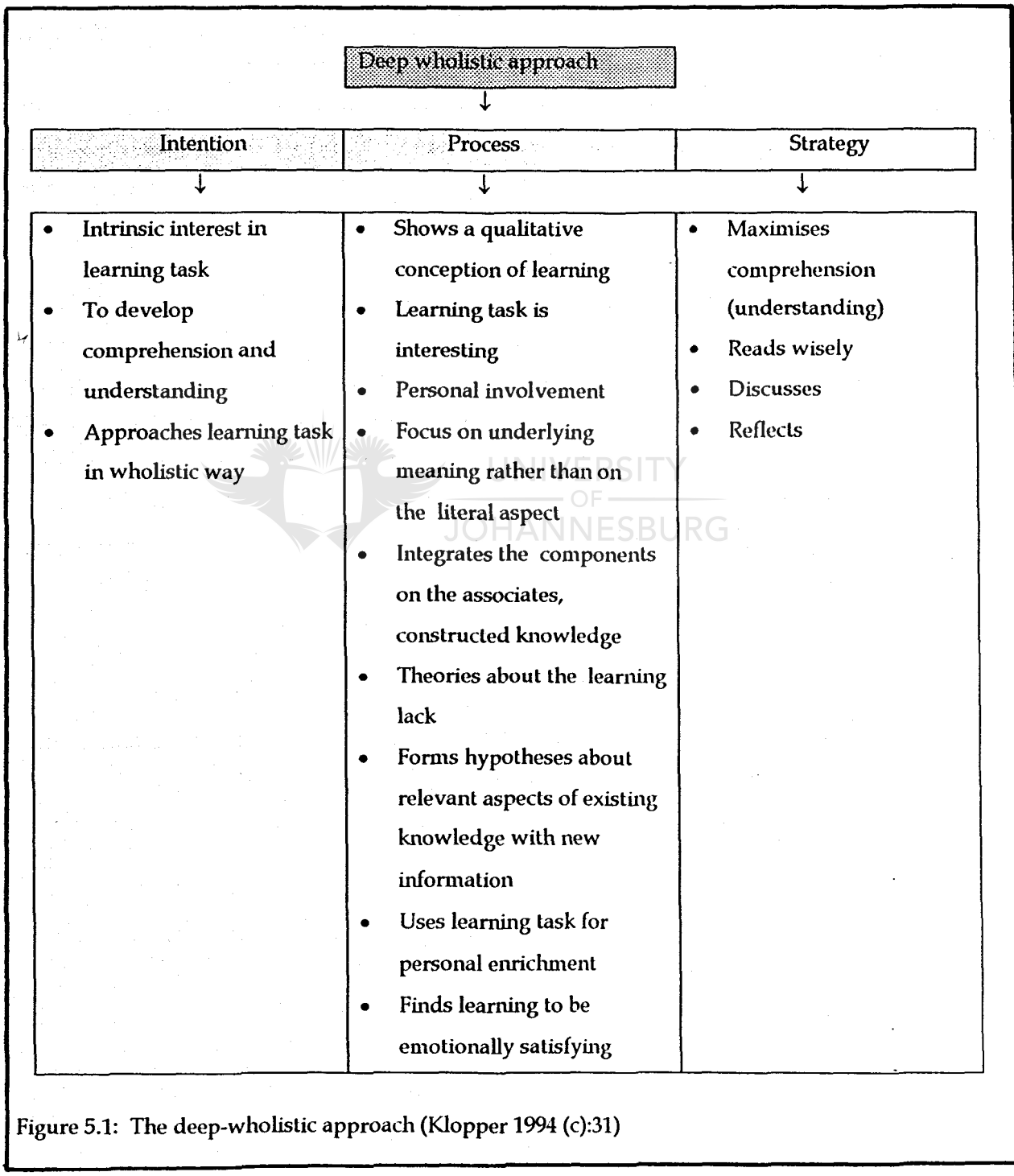


Figure 5.1: The deep-wholistic approach (Klopper 1994 (c):31)

5.3 THEORETICAL DEVELOPMENT OF THE EDUCATION PROGRAMME

For the theoretical content of the education programme the researcher utilised the content on transformational leadership as explored and described in the conceptual framework (chapter three) and the model (chapter four).

5.4 AIM OF PROGRAMME

The overall aim of this programme was to develop transformational leadership in nursing unit managers to empower them to practice transformational leadership to facilitate individual and nursing unit transformation.

5.5 DURATION, SCHEDULING AND PRESENTATION OF THE PROGRAMME

The education programme was presented by the researcher in three sessions totalling 16 hours. A specific date for each session was selected in collaboration with the nursing service managers and the nursing unit managers involved. The programme was presented by means of introductory lectures by the researcher, small-group discussions and individual self-study sessions with the researcher acting as a facilitator. All the lecture material was provided by the researcher.

5.6 EVALUATION

The acquisition of knowledge and skills were evaluated on a continuous basis through interaction and feedback between the participants and the researcher.

5.7 STRUCTURE AND CONTENT OF THE PROGRAMME

A study guide was used as a teaching aid. This study guide was divided into modules (see table 5.1).

Table 5.1: Division of modules

Module	Topic
1	Model for transformational leadership
2	Self-awareness
3	Trust
4	Communication
5	Vision
6	Empowerment

(See annexure C for an example of the learning package).

5.8 THE ROLE OF THE RESEARCHER IN THE IMPLEMENTATION OF THE EDUCATION PROGRAMME

The researcher contacted the chief nursing service manager in charge of the selected nursing service and discussed the aim of the study, the education programme, the implementation of transformational leadership in the selected nursing units and the assessment of the individual and the nursing unit transformation.

The chief nursing service manager requested that all the nursing unit managers (n=12) participate in the education programme, although their nursing unit may not be selected for the implementation of the model. She valued this education programme as a good learning opportunity to all the nursing unit managers.

This nursing service manager contacted the nursing unit managers and discussed the study with them. A date to start the education programme was set with the nursing unit managers wanting to join the project. It was explained to the nursing unit managers that even though everybody was attending the education programme, only four nursing units were to be selected for the implementation of the model. The two other nursing service managers within this nursing service were also invited to participate in the education programme.

During the first contact session with the participants, the researcher discussed the aim of the study, the education programme and the implementation of the model in four nursing units with the participants. The participation expected from the participants was explained. A letter was also handed to the participants to request their informed, written consent (see annexure B).

During the education programme the role of the researcher was to:

- select and utilise a suitable venue. This venue should be comfortable, private, well ventilated and free from noise. A venue used by this nursing service for education programmes, such as inservice education was utilised. It was therefore within easy reach of the participants and it also had the needed equipment, such as overhead projectors, whiteboards etcetera;
- prepare extensively and present the education programme to the participating leaders;
- implement the principles of adult education and learning (as discussed earlier in this chapter);
- build rapport with the participants, that is also conducive to the implementation of the model in the nursing unit;
- evaluate the participants' acquisition of knowledge and skill on an ongoing basis;
- create a psychological atmosphere conducive to learning. Aspects that are emphasised are openness, mutual respect and trust, collaboration and supportiveness;
- encourage participants to participate actively in the learning as well as the evaluation process;
- support and encourage participants to fulfil their learning objectives and learning plan and
- ensure that all study material is provided and used effectively.

5.9 CONCLUSION

In this chapter it was argued that the leader is an adult learner. Therefore the researcher based the didactical development of this education programme on the principles of adult education (as described by Knowles (1984) and Gravett (1991) and the constructivistic learning theory (as described by Klopper (1994 (a)). The theoretical development of the education programme as based on the derivation of the content of transformational leadership from the conceptual framework and the model was also elucidated. Lastly, the aim, structure, presentation and evaluation of this education programme as well as the role of the researcher were discussed.

In chapter six the focus is on the outcome of the evaluation, validation and refinement of the model through a case study in four nursing units and the evaluation of this model by a panel of experts.

CHAPTER 6

IMPLEMENTATION AND EVALUATION OF THE MODEL

6.1 INTRODUCTION

The aim of this chapter is to describe the implementation and evaluation of the model (as described in chapter four).

As discussed in chapter two, the researcher utilises an exploratory, descriptive, qualitative case study as a research design for the implementation of the model. The specific data-collection aims and analysis are discussed in chapter two and summarised in table 2.3. The data is collected and analysed according to specific protocols, as described in chapter two and included in the annexures to this study.

The model for transformational leadership by nursing unit managers is evaluated, validated and refined by utilising the sources and methods as described in chapter two. A detailed discussion of the evaluation, validation and refinement of the model follows at 6.3.

6.2 IMPLEMENTATION OF THE MODEL

6.2.1 The context

The following four nursing units within the same private hospital (nursing service) are included in the case study:

- nursing unit A: Mixed nursing unit (medical, septic, neurologic and short-term psychiatric patients);
- nursing unit B: Short-term orthopaedic nursing unit;
- nursing unit C: Neurosurgic and neuro-orthopaedic nursing unit and
- nursing unit D: High-care nursing unit (neurology, medical, surgical, thoracic patients).

This nursing service is a private hospital in a middle-class urban area and has a bed capacity of 358 patients. It consists of 12 nursing units, 10 operating theatres, a sonar and a radiography department. A trauma unit is to open soon.

The bed capacity and bed occupancy rates for each of these nursing units are reflected in table 6.1.

Table 6.1: Bed capacity and average bed occupancy rates

Nursing unit	Bed capacity	Average bed occupancy rate
A	29	80,0-100,0%
B	34	54,0-100,0%
C	33	75,0-100,0%
D	21	65,0-100,0%

The general research findings from the case study are analysed, synthesized, interpreted and described against the background of the described conceptual framework (chapter three) and model (chapter four). The specific research findings for each nursing unit are analysed individually.

According to the described conceptual framework, the internal environment of the nursing unit includes structural and functional elements. The structural elements (individuals within the nursing units) are depicted in table 6.2.

Table 6.2: Individuals in the nursing units

	Nursing unit A	Nursing unit B	Nursing unit C	Nursing unit D
Day duty				
Registered nurses	4	5	4	4
Staff nurses	1	1	1	1
Auxiliary nurses	4	4	4	4
Night duty				
Registered nurses	2	2	3	2
Staff nurses	1	2	0	2
Auxiliary nurses	4	4	6	4
Total	16	18	18	17

Other structural elements include the physical structure, facilities and equipment in the nursing unit. The physical structure is well-maintained and adequate facilities, equipment and supplies are available. All the nursing units consist of four bed as well as private rooms. At the entrance to the hospital there are beautiful plants and a water feature. Throughout the hospital there are also beautiful plants, curtains and wall hangings to make it feel more like home than like a hospital.

The physical environment (structural elements) of the nursing unit forms the external environment of the nursing unit, the leader and the followers. As stated in the model for transformational leadership, the external environment impacts on transformational leadership. It is also stated in the model that there is a dynamic interaction between the internal environment (within the individual and the nursing unit) and the external environment (the nursing service, health service and community).

The functional elements include the functioning of each individual in the nursing unit. According to the described conceptual framework and the model, the leader practices as a clinical practitioner, nursing unit manager, transformational leader and a researcher. The data collected for the leader is described within this framework.

6.2.2 The leader as clinical practitioner

Each leader practices as a clinical practitioner in her specific nursing unit. All the leaders are professional nurses and/or midwives, registered with the South African Nursing Council under the Nursing Act (Act no 50 of 1978). They therefore practice as independent practitioners, within the scope of practice for registered nurses and/or midwives, R2598 of 30 November 1984 as amended, chapter two. This forms the legal framework for their nursing practice. All the leaders practice as members of the multi-professional health team, but are personally accountable for their own acts and omissions. The leaders also practice within the ethical norms and values of the nursing profession.

One of the characteristics of the leader as a clinical practitioner is that she possesses the necessary knowledge, skills and experience to practice optimally in a specific discipline, and to provide guidance and support to the followers for the rendering of quality nursing care to these specific patients. The profiles of the leaders are depicted in table 6.3.

Table 6.3: Profile of leaders

*Leader	Academic qualifications	Professional registration
A	Diploma in Nursing B.Cur (I et A)	General nursing, midwifery, psychiatric nursing, community nursing, nursing education
B	Staff nurse training; Diploma in Nursing	General nursing
C	Diploma in Nursing	General nursing, midwifery
D	Diploma in Nursing	General nursing

*The leader of nursing unit A is referred to as leader A and the leader of nursing unit B is referred to as leader B etcetera.

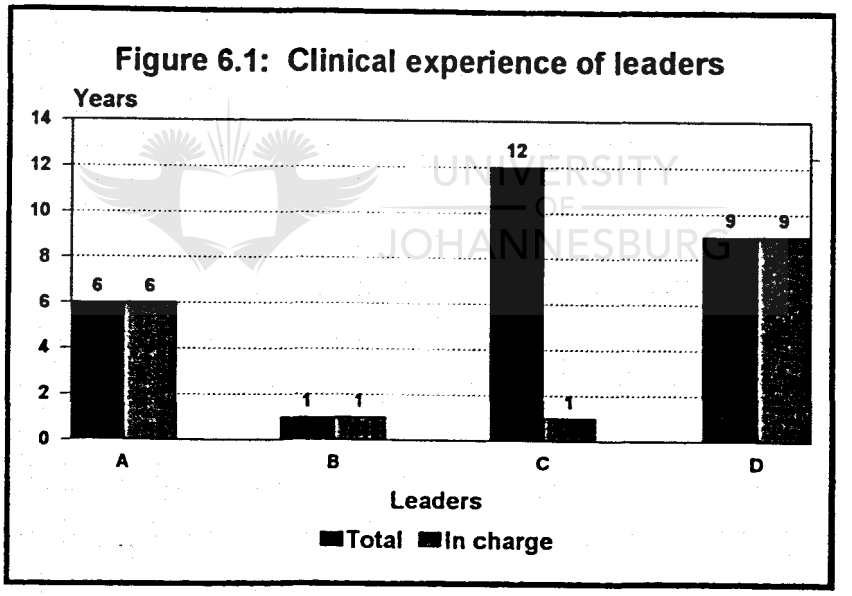
All the leaders have extensive and varied clinical experience. Table 6.4 depicts the clinical experience of the different leaders.

Table 6. 4: Clinical experience of leaders

Leader	Total Years	Area
A	13	Medical nursing, psychiatric nursing, intensive care
B	8	Orthopaedic nursing
C	13,5	Paediatric nursing, psychiatric nursing, neurosurgery
D	12	Gynaecology, thoracic nursing

After completion of her nursing training, the leader of nursing unit B also worked as a cabin attendant for the Airways for six years.

All the leaders have extensive clinical experience in the nursing units that they are currently practicing in (see figure 6.1).



As the patient is an individual and therefore dimensions such as the body, mind and spirit are included, the leader as a clinical practitioner renders quality and wholistic nursing care paying attention to all these dimensions. In the provision of quality, wholistic nursing care all the leaders in the specific nursing units implement the nursing process (assessing, planning, implementing and evaluating). Record-keeping is an integral part of all the elements of the nursing process. The leaders as clinical practitioners also provide the necessary guidance and support to the followers to implement (under their direct and/or indirect supervision) the nursing process. The patient refers to the individual and the family to whom the wholistic, quality nursing care is rendered.

A characteristic of the leader as nursing unit manager is that she possesses the necessary up-to-date knowledge and skills to practice optimally in a specific nursing unit and to provide guidance and support to the followers for the rendering of quality nursing care to specific patients.

In this nursing service an extensive inservice education programme is offered to the leaders. One of the specific topics offered is leadership. This provides a good basis to the researcher for the education programme on transformational leadership. The leaders already have the knowledge and skills of leadership, and therefore the researcher can concentrate on mastery of the knowledge and skills of transformational leadership.

6.2.3 The leader as nursing unit manager

The total number of years of clinical experience of the leaders as nursing unit managers in the different nursing units were rendered in figure 6.1. All the leaders as nursing unit managers implement the management process (planning, organising, leading/directing and controlling) in the management of the nursing unit.

One of the behaviours of transformational leadership is to develop a vision for the nursing unit. Transformational leaders are committed to accept and move towards achieving a vision through planned change. In all the nursing units the vision was set as follows: To provide quality nursing care to the patients.

As the vision is made operational by the identification and implementation of specific objectives, the leaders as nursing unit managers formulated specific objectives (in interaction with the followers) for the specific nursing units (see the description of these objectives at the analysis of the individual nursing units' data). A nursing audit was conducted during February or March 1995 in all the nursing units. The researcher started the implementation of this study during April 1995. The researcher utilised the results from this nursing audit as a baseline. The nursing audit is then again conducted 12-14 weeks after the implementation of transformational leadership in the nursing unit. (See the discussion in chapter two).

As this nursing audit is based on four to eight files of discharged patients, it can be regarded as retrospective evaluation. Concurrent evaluation is also carried out on a continuous and informal basis by means of nursing rounds by the nursing service managers involved in the nursing units. Prior to the nursing rounds the nursing service managers sample specific patients in each of the nursing units to visit. These patients usually include critically or acutely ill, high-risk and immediate post- operative patients. Evaluation of the nursing care of these patients is done and feedback provided during the nursing round. When a pattern of problems is identified by the nursing service manager, it is also referred to the clinical tutor to be taken up during inservice education. It is also sometimes necessary that patient files are evaluated in relation to third-party claims.

Whenever problems or shortcomings are identified, the feedback is given to the personnel involved. Figure 6.18 illustrates the outcomes of the nursing audits before and 12-14 weeks after the implementation of transformational leadership. The concluded percentage should however not be regarded as the chief indicator of shortcomings, but as a basis to use for the measurement of the change in nursing care.

6.2.4 The leader as transformational leader

Before entering into the education programme, all the leaders completed a questionnaire (see annexure D) on the behaviours and strategies of transformational leadership as described in the conceptual framework (chapter three) and model (chapter four). This questionnaire was also completed 12-14 weeks after the implementation of transformational leadership in the nursing unit. The outcomes of this questionnaire are described during the analysis of data of each nursing unit.

All the leaders attended the educational programme offered by the researcher. The development of this education programme is described in chapter five. The content (on the behaviours and strategies of transformational leadership) is divided into modules and a study guide is utilised as an educational tool (see annexure C).

Before implementing transformational leadership in the nursing unit, the followers in the nursing units also completed a questionnaire (see annexure E) on the degree to which the leader in their nursing unit displays the behaviours and strategies of transformational leadership. This questionnaire is repeated 12-14 weeks after the implementation of transformational leadership in the nursing unit, to determine the change/transformation in the degree to which the leader displays the initiatives and strategies of transformational leadership. The analysis of this data is described at the analysis of data for each nursing unit.

Twelve to fourteen weeks after implementation of transformational leadership in the nursing units, the leaders wrote a narrative sketch on their experience (thoughts and feelings) of transformational leadership. The leaders' experiences are described at 6.5.2.

6.2.5 The leader as researcher

The leader, as well as the followers, are accountable to their patients, the families and communities for rendering quality nursing care and for finding ways to improve nursing care. Nursing research provides a solid base for nursing actions that are effective in promoting positive patient care outcomes. The knowledge generated through research is essential for description, explanation and prediction of nursing phenomena.

The leader acts as a participant in this research study by assisting the researcher to implement transformational leadership in the nursing unit and therefore to evaluate, validate and refine the described model and guidelines for implementation.

The followers in the nursing units also participate in the implementation of transformational leadership in the nursing unit by providing feedback by means of questionnaires regarding the transformational leadership behaviours and strategies of the leaders in their nursing units.

6.3 IMPLEMENTATION IN THE DIFFERENT NURSING UNITS.

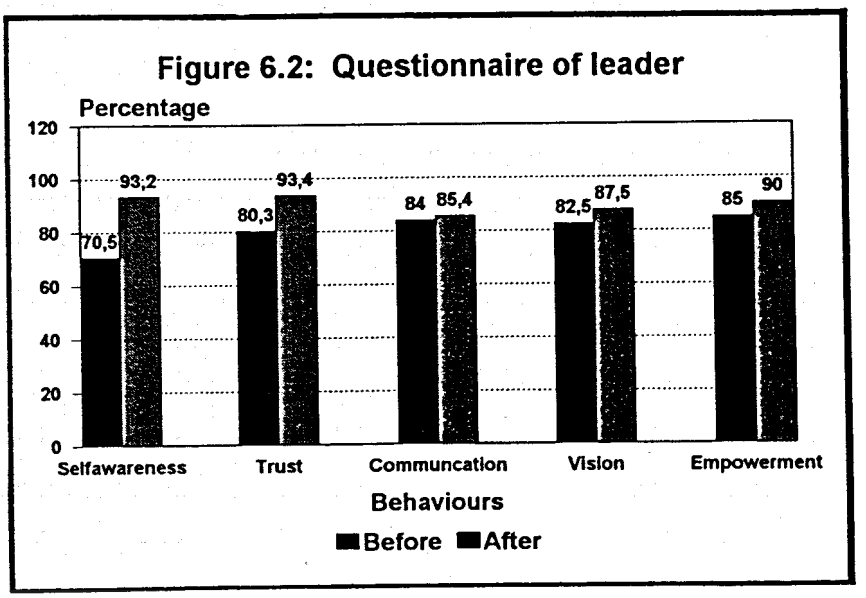
Henceforth, the data from each nursing unit is described separately.

6.3.1 Nursing unit A : Mixed nursing unit.

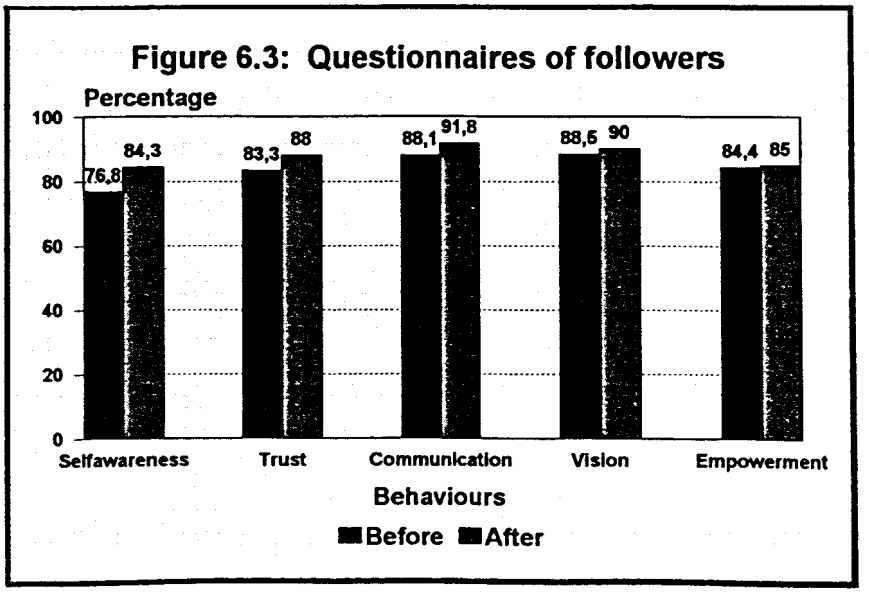
She shares her life with three dogs and a cat, which she regards as her children. She describes herself as follows: "Ek is 38 jaar oud en ongetroud. Ek is vriendelik, entoesiasties, redelik, luister na ander, 'n goeie organiseerder en het 'n goeie selfbeeld. My swak punte sluit die volgende in: hardkoppig, opvlieënd en dominerend met tye. My stokperdjies is lees, speel brug en "ten pin", brei en ry fiets. Ek is ook lief vir fliek en tuinmaak."

(Direct translation : "I am 38 years old and unmarried. I am friendly, enthusiastic, reasonable, listen to others, am a good organiser and have a good self-image. My weak points include the following: hard-headed, short tempered and dominating at times. My hobbies are reading, playing bridge and ten pin, knitting and cycling. I also love going to the movies and gardening.")

The outcome from this leader's questionnaire on the behaviours and strategies of transformational leadership before the education programme and 12-14 weeks after the implementation of transformational leadership are depicted in figure 6.2.



Before the implementation of the model, ten questionnaires were distributed to the followers and six (60,0%) were returned. All these questionnaires could be analysed. Twelve to fourteen weeks after the implementation of the model in the nursing unit, ten questionnaires were again handed out to the followers. Five (50,0%) of these questionnaires were returned and all could be analysed. The outcomes are elucidated in figure 6.3.



As indicated through the questionnaires to the followers, the leader in this nursing unit encourages an increase in self-awareness. (An average of 76,8% was obtained for this behaviour. There also seems to be a great degree of trust between the followers and the leader as an average of 83,3% was obtained for this behaviour. It was therefore accepted that the leader can progress to communication as was indicated by the model for transformational leadership. An average of 88,1% was obtained for the behaviour of communication.

During the first contact session the leader reported that she was very enthusiastic about the study and has already informed her followers of the research study and has briefed them on their participation. She has given a short introductory session on the model for transformational leadership and plans to follow this with more detailed discussions and an enlarged copy of the model displayed in the nursing unit.

She believes that the model can be utilised effectively, and states: "Ek dink die model kan werk. Dit is logiese aspekte en dinge wat ons alreeds elke dag toepas. Nou is dit egter wetenskaplik in 'n proses saamgevat." (Direct translation: "I think that the model can work. It is logical aspects and things that we implement every day. However, now it is put together scientifically in a process.") The nursing unit seems to be calm and quiet. The leader states that "dinge rustig is." (Direct translation: "things are calm.") The nursing unit is clean and followers seem to be rendering nursing care at a comfortable and organised pace. Interactions seem to be unhurried.

As participative management is one of the strategies of empowerment, the leader utilises participative management (follower interaction) throughout all the management activities.

Second contact session: The leader still seems to be enthusiastic. The nursing unit is however extremely busy and there was not a lot of time to work on the further discussions on the model of transformational leadership. The followers seem to be hurrying around to render the necessary nursing care. Interactions seem to be hurried, as every person tries to get through the workload of rendering nursing care. The cleaners are also still busy cleaning the nursing unit. As the leader and the followers seem to be very busy the researcher spent little time in the nursing unit.

The researcher requested the leader to formulate, in interaction with the followers, specific objectives (and strategies to attain these objectives) for aspects that need change or transformation in the nursing unit. The leader is requested to utilise the behaviours and strategies as described in the model for transformational leadership.

Third contact session: The leader seems to be tired and not very enthusiastic. She expresses distress at the fact that her dog, that she has owned now for the past ten years, is not well. She states: "Omdat ek nie kinders het nie is sy soos my kind."

(Direct translation: "Because I do not have children she is like my child.") This little dog was bitten by the leader's other bigger dog. Now she has to get rid of one of the dogs and this is creating a lot of conflict for the leader. ("Ek is in konflik oor wat ek moet doen." Direct translation: "I am in conflict over what I must do.")

She is allocated to night duty during the following week, as the senior registered nurse on night duty resigned unexpectedly. She states that she does not like night duty: "Dit is nie lekker as almal slaap en ek moet werk nie. Dit is veral sleg oor naweke as jou bure en vriende se braaivleisvure brand, of almal gaan uit, en jy moet werk." (Direct translation: "It is not nice when everybody is sleeping and I must work. It is especially bad on weekends when your neighbours' and friends' braaivleis fires are burning, or everybody is going out, and I must work.")

Although she does not enjoy working night duty, she sees it as an opportunity to improve contact with the followers. "Dit is 'n geleentheid om die ander personeel beter te leer ken en ook meer kontak met hulle te verkry." (Direct translation: "It is an opportunity to learn to know the other personnel better and also to gain more contact with them.") She also sees it as an opportunity to catch up on work in the nursing unit, as the nursing unit is not so very busy during the night. It creates time to pay attention to aspects like the preparation of lectures for the followers.

As the nursing unit was very busy and there were two long weekends since the previous contact session between the leader and the researcher, the leader and followers only formulated an objective regarding the nursing audit outcome of the nursing unit as follows: To improve the nursing audit outcome from 48,6% to 70,0%. Other specific objectives are to be formulated.

The nursing unit is very busy and the followers are hurrying by to render the expected nursing care and interactions seem to be hurried.

Fourth contact session: The nursing unit is extremely busy with admitting patients. Interactions seem to be extremely hurried.

Photographs of all the personnel are displayed on the notice board at the entrance to the nursing unit. At first the followers reacted negatively and stated that "it feels like being on Police File." Later the idea was accepted and the leader feels that it added to build a good team-spirit in the nursing unit.

The leader seems to be feeling better and less tired. Her small dog has died. She describes this as a relief and adds that she had this dog for ten years and therefore has good memories of the time spend together. It also resolves the problem of deciding which dog to keep.

During the week prior to the contact session the leader was on night duty. She discussed the study again with the followers on night duty and good participation and feedback were received.

Regarding the model she states: "Ek het weer deur die strategieë gegaan. Die lyste lyk volledig en huidiglik is daar niks wat ek nou kan byvoeg nie." (Direct translation: "I went through the strategies again. The lists seem complete and currently there is nothing that I can add.")

When formulating the objectives for the nursing unit, the leader utilised the strategies for communication, vision and empowerment as stated in the model. The strategies for self-awareness and trust are also enhanced throughout and the following objectives and strategies were formulated:

	OBJECTIVE	STRATEGIES
1	To increase the nursing audit from 48,6% to 70,0%	- Feedback to the followers - Inservice education - Leading and supervision
2	To ensure that the urine of 90,0-100,0% of the admitted patients are tested within 24 hours after admission	- On Fridays determine the average for the week - Feedback to the followers - Inservice education - Leading and supervision
3	To ensure that identification bands of all 100,0% admitted patients are secured within one hour after admitting the patient	- Weekly control on Mondays - Feedback to the followers - Inservice education - Leading and supervision

Fifth contact session: The nursing unit seems to be quiet and the leader and the followers also seem to be more relaxed. Interactions seem to be carried out at a relaxed pace.

Since January 1994 four nursing auxiliary posts were declared redundant. This workload is now distributed among the remaining enrolled and auxiliary nurses. According to the leader, this arrangement is effective as the expected nursing care is still provided. She also notes that the forming of cliques in the nursing unit is now reduced. The followers seem to be functioning better as a team as they have to rely on each other to render the necessary nursing care, as she states: "Hulle moet mekaar nou help, anders word die werk nie gedoen nie." (Direct translation: "They must help each other otherwise all the work is not done.")

She also experiences that the gossiping among the followers is less. It does however happen that the enrolled nurses work extremely hard if many patients have to be admitted and when there are many dressings to be done. This is the exception and not the rule. The leader therefore feels that the group cohesion among the followers has improved.

Regarding the model for transformational leadership she reports: "Sover niks wat ek nou aan kan dink nie. Ek het gedink dat ek dit weer wil deurgaan en byvoeg." (Direct translation: "So far nothing that I can think of. I thought that I want to go through it again and add.")

Sixth contact session: The nursing unit seems to be quiet and well organised. The leader states that only routine nursing care is rendered. Interactions seem to be at a relaxed pace. The nursing unit is clean and tidy.

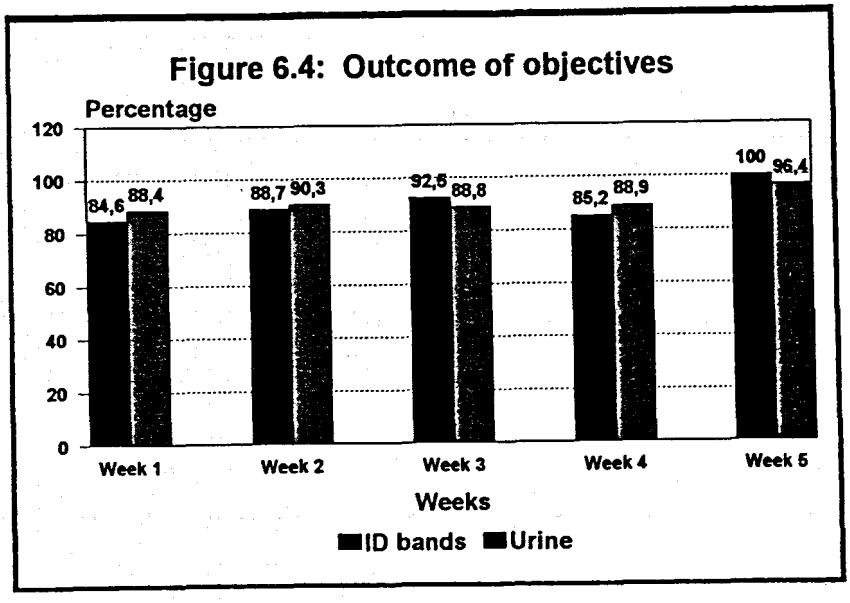
The leader has enlarged a copy of the model for transformational leadership and has displayed it in the duty room. The specific objectives that were formulated (and the strategies to attain these objectives) are displayed in the duty room. She has also started to display the outcomes of the weekly analysis by means of graphs. These graphs are also displayed. The leader states that these displays act as motivation and assist the leader in discussions.

Prior to this contact session the researcher handed a copy of the analysis of the data to the leader to check (member checking) to enhance the truth value (credibility) as described by Merriam (1988:166-170) and Lincoln and Guba (1984:295-311) and described in chapter two of this study. The leader was requested to evaluate the following aspects:

- are the analysis and the outcomes reflected accurately and in line with the issues discussed during the contact sessions?
- are all discussed issues analysed and reflected?
- is there anything that should be added to the analysis?

The feedback of the leader was as follows: "Ek het een sin verander. Al die ander aspekte is korrek. Ek het nie gedink jy gaan alles so goed kan weergee nie. Jy het 'n baie goeie geheue of jou rekordhouding is baie goed. Ek is tevrede en alles kan so deurgaan." (Direct translation: "I changed one sentence, all the other aspects are correct. I did not think that you will be able to reflect everything so well. You have a very good memory or your record-keeping is very good. I am satisfied and everything can go through as is.")

Seventh contact session: The nursing unit is extremely busy and there is very little time for interaction between the leader and the researcher. The leader however proudly handed over the outcomes from the strategies implemented to attain the formulated objectives. These outcomes are reflected in figure 6.4.



Although all of the formulated objectives were not attained and the leader and the followers seem to be very proud of the improvement. After this last session the analysis report was handed to the leader for final validation and the following comments received: "Ek is tevrede. Alles kan so deurgaan en daar is niks wat ek wil byvoeg of weglaat nie." (Direct translation: "I am satisfied. Everything can go through as it is and there is nothing that I want to add or leave out.")

6.3.2 Nursing unit B: Short-term orthopaedic nursing unit

This leader is married and has two children, aged eight and four years. She describes herself as follows: "Ek is 38 jaar oud en die ma van 'n pragtige dogter van agt jaar en een monster van vier jaar. My man is ook oulik. Ek het 1975 die skool verlaat, Augustus maand matriek, net voor die rekord eksamen. Ek het dit gehaat om afhanklik te wees en die skool verlaat na 'n hewige geveg met 'n onderwyser.

Verpleging het in ..... hospitaal begin. My ma het my nie afgekraak nie maar het nie gedink dat haar selfsugtige, ongeskikte dogtertjie ooit meer as 'n katjie kan verpleeg nie. Ons kliniese dosent moes seker my potensiaal raakgesien het, het eers die twee jaar ingeskrewe verpleegster kurses gedoen, met lof geslaag. Die kollege het my 'n bekertjie gegee. Daarna was die groen weivelde vaal en is ek na die ....Hospitaal. Ek het in Hillbrow gewoon en geleer om groot te word. Die hospitaal was 'n riller!!!!! Nagdiens - alleen in 'n urologiese saal met 16 pasiente. Nog nooit in my lewe eers 'n prostaat gesien nie "never-mind genurse". Dit was diepsee duik sonder enige kurses ! Gelukkig het die nuwe hospitaal oopgemaak, daar bo teen die berg - dit was heerlik. Klaargemaak einde 1980 - toe reeds aansoek gedoen by die Lugdiens en die werk gekry. Gevlieg van Maart 1981 tot Mei 1987 - dit was 'HEMELS'.

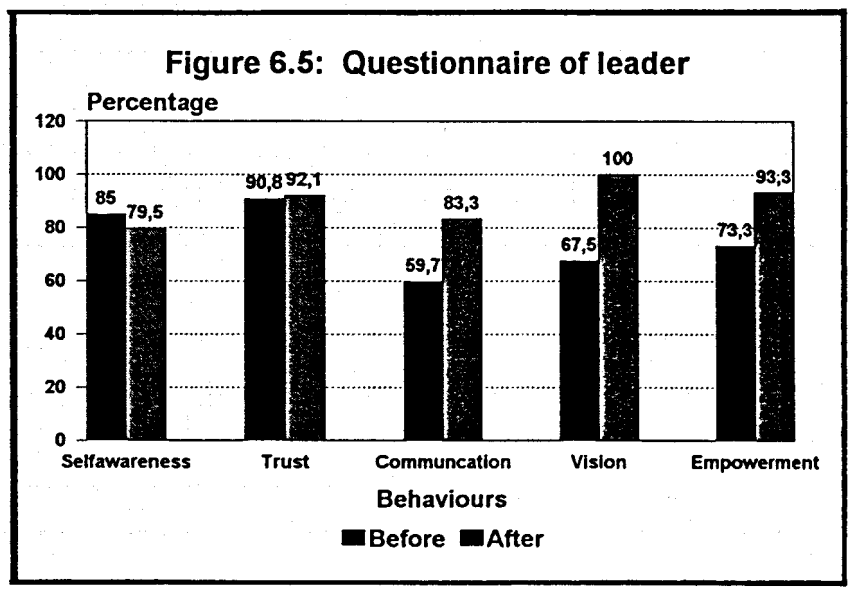
Swangerskap dwing my terug aarde toe and April 1987 begin ek by ..... Weer eens 'n "riller" - twee dae gelede vir die eerste keer my "maroon" epaulette gaan koop, kom in saal vyf aan en moet 'n fraktuur femur verpleeg. Ek kan nie meer onthou waar 'n femur sit nie. Die res is geskiedenis, baie trane, self ondersoek en baie harde werk is ek vandag waar ek is. Baie leiding van my mentors, hulp en bystand en ek is tops. Lui is ek nie - bang vir werk is ek nie - "watch my".

(Direct translation: "I am 38 years old and the mother of a beautiful daughter of eight years of age and a monster of four years of age. My husband is also cute. I left school in August prior to the record examination. I hated it to be dependent and I left school after a terrible fight with a teacher.

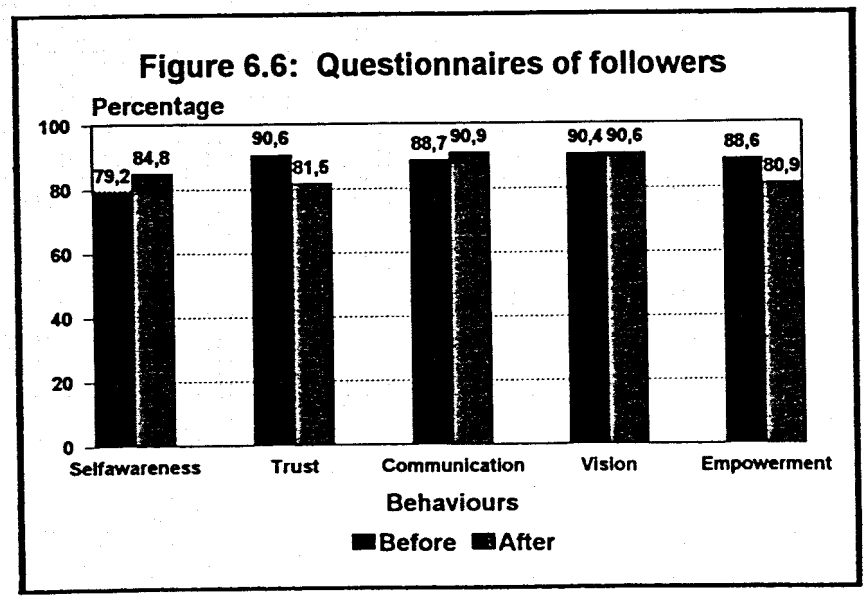
Nursing started in ..... Hospital - my mother never thought that her selfish and rude daughter could ever nurse anything more than a kitten.

Our clinical tutor .... must have recognised my potential. I first did the course for enrolled nurses, with distinction. The college gave me a trophy. Thereafter the green pastures were dull and I went to the .... Hospital. I stayed in Hillbrow and learned to grow up. This hospital was a horror !!! Night duty alone in a urological ward with 16 patients. I had never in my life ever seen a prostate, never mind nursed it. I was like deep-sea diving without a course ! Luckily, the new hospital opened, there on top of the hill - it was fantastic. I finished at the end of 1980 - have already applied and obtained a job with the Airways. I flew from March 1981 until May 1987 - it was like Heaven. Pregnancy forced me back to the ground and in October 1981 I started at ..... . Again a horror. I only bought my maroon epaulettes for the first time two days ago. In ward five I had to nurse a femur fracture. I cannot even remember where the femur was situated. The rest is history, many tears, self-examination and a lot of hard work and I am where I am today. A lot of leading from my mentors, guidance and support and I am tops. Lazy, I am not - scared to work I am not - watch me.")

The outcomes from this leader's questionnaire on the behaviours and strategies of transformational leadership before and after the implementation of the model for transformational leadership are depicted in figure 6.5.



Before the implementation of the model, ten questionnaires were distributed to the followers and seven (70,0%) were returned. Six (60,0%) of the returned questionnaires could be analysed. Twelve to fourteen weeks after the implementation of the model in the nursing unit, ten questionnaires were handed out to the followers. Five (50,0%) of the questionnaires were returned and four (40,0%) could be analysed. The outcomes from the follower's questionnaires on the degree to which the leader displays the behaviours and strategies of transformational leadership are rendered in figure 6.6.



As indicated through the questionnaires to the followers, the leader in this nursing unit encourages an increase of self-awareness. (An average of 79,2% was obtained for this behaviour.) Their also seems to be a great degree of trust between the followers and the leader as an average of 90,6% was obtained for this behaviour. It was therefore accepted that the leader can progress to communication as indicated by the model for transformational leadership. An average of 88,7% was obtained for communication.

During the first contact session, the researcher found the leader busy cleaning, checking and stocking the nursing unit. She reports that she has not implemented the model in the nursing unit, as it is closed for the month of April and the followers are practicing in other nursing units. The leader describes the closing of the nursing unit as a problem as it is extremely difficult to build good group cohesion when the followers are practicing in different nursing units. The followers seem to lose contact with each other and also with the leader and it is then difficult to establish rapport again once the nursing unit reopens. The researcher requested the leader to formulate, in co-operation with the followers, specific objectives regarding any aspect that they want to change or transform in the nursing unit. The leader is requested to utilise the behaviours and strategies as described in the model for transformational leadership.

Second contact session: The nursing unit is open and seems to be very busy. Today 13 patients are scheduled for theatre, ranging from small surgery to hip replacements operations. Although the nursing unit is extremely busy, the atmosphere seems to be friendly and cooperative with good communication and interactions. The leader seems to be dynamic, friendly and assertive in her interaction with the followers, the patients and the visitors. The ward clerk is also not on duty. This increases the administrative load to the nursing personnel.

When formulating the objectives for the nursing unit, the leader utilised the strategies for communication, vision and empowerment as stated in the model. The strategies for self-awareness and trust are also enhanced throughout and the following objectives and strategies were formulated:

	Objectives	Strategies
1	To increase the nursing audit from 32,0% to 60,0%	- Feedback to the followers - Inservice education - Leading and supervision
2	To ensure that urine of all (100,0%) of the admitted patients are tested within 1 hour after admission	- Weekly control on Mondays - Feedback to the followers - Inservice education - Leading and supervision
3	To improve the absence pattern the followers	- Initial interview to determine problem - Weekly follow-up interviews to provide support

Third contact session: The leader seems to be more relaxed than during the previous contact session. Although the nursing unit seems to be quiet, the leader states that the nursing unit is extremely busy. She however has a "wonderlike groep personeel aan diens. Dit is wonderlik om so 'n "back-up system" te he." (Direct translation: "she has a wonderful group of personnel on duty. It is wonderful to have such a back-up system.") It therefore seems to be quiet in the nursing unit as everybody does what is expected from them.

Satisfactory progress is made regarding the attainment of the formulated objectives. The leader also started to illustrate the outcomes by means of graphs. She states that the followers appreciated the graphs, as the outcomes are clear and easy to understand. Feedback is discussed with the followers as the outcomes on each evaluation becomes available. The leader states that she and the followers want to formulate a mission and a philosophy for the nursing unit but they are uncertain on how to proceed. The researcher provides the basic information and articles on the compilation of a mission and a philosophy. The leader attended a refresher course on TQM (Total Quality Management) during which the leadership theory of Hersey and Blanchard was discussed very briefly. The researcher will also provide a source with more information.

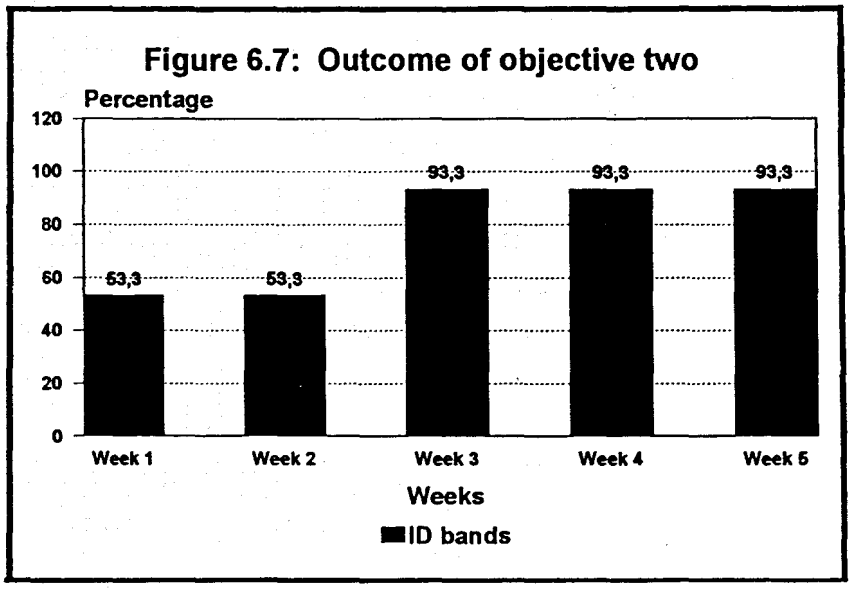
Sixth contact session: Prior to this contact session the researcher handed a copy of the analysis of the data to the leader to check (member checking) to enhance the truth value (credibility) as described by Merriam (1988:166-170) and Lincoln and Guba (1984:295-311) and described in chapter two of this study. The leader was requested to evaluate the following aspects:

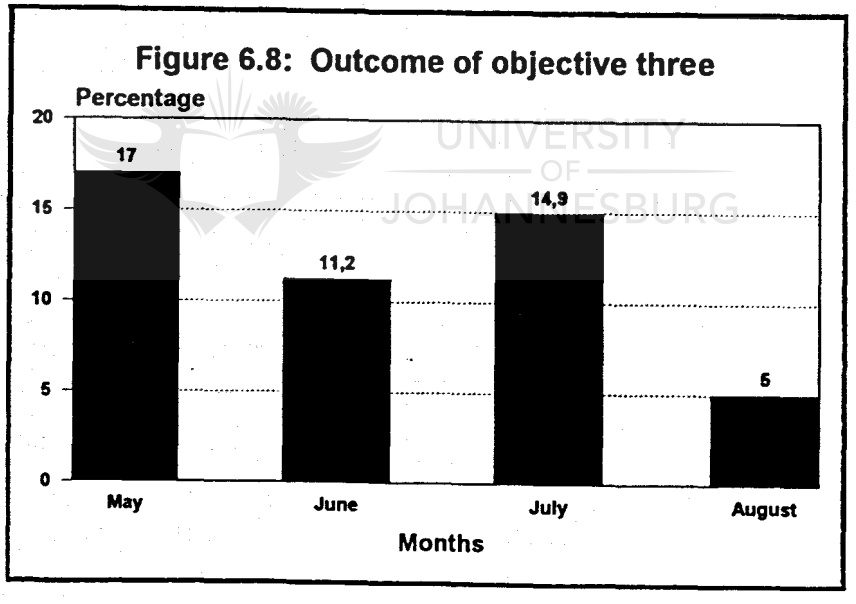
- are the analysis and the outcomes reflected accurately and in line with the issues discussed during contact sessions?
- are all the discussed issues analysed and reflected?
- is there anything that should be added to the analysis?

During the feedback the leader stated that she is satisfied with the analysis and reporting of issues and that she does not suggest any changes.

Seventh contact session: The leader provided feedback on the outcome of the strategies which were implemented to attain the formulated objectives.

These outcomes are reflected in figure 6.7 and 6.8.





Although all the formulated objectives were not reached, the leader and followers seem to be satisfied with the transformation or change.

6.3.3 Nursing unit C: Neurosurgical and neuro-orthopaedic nursing unit

This leader describes herself as follows: "Ek is in 1954 in Nederland gebore en het 'n ouer suster. Op een en 'n half jarige ouderdom emmigreer my ouers na Suid-Afrika en vestig hulle in Pretoria, waar ek nog steeds woonagtig is.

Ek kom uit 'n baie streng godsdienstige huis waar daar baie hoe eise aan ons as kinders gestel is. Ek is na my skoolopleiding eers vir een jaar betrokke as interne ouditeur by die Poskantoor. Ek het baie belanggestel daarin om myself te bekwaam as 'n argeoloog, maar daar was nie fondse vir studie beskikbaar nie. My ouer suster het verpleeg, maar was nie baie suksesvol nie. Ek het besluit ek gaan bewys dat verpleging nie die beroep is wat sy voorgestel het nie. Ek sou my nooit in die posisie as verpleegster indink nie - dit was die laaste beroep waarin ek belanggestel het. Ek het my opleiding voltooi en het nadat ek my finale eksamen geskryf het getrou. Ek is nou amper 19 jaar getroud. Ek het vier kinders - twee dogters en twee seuns. Hulle ouderdomme is 18, 16, 13 en 11.

Ek is baie lief vir lees. Ek is ook lief om vir myself en vir my dogters klere te maak en ook borduurwerk te doen alhoewel daar nie baie tyd daarvoor is nie. Verder hou my kinders my baie besig met naskoolse aktiwiteite en word daar baie rondgery. Ek stel ook hoe eise aan hulle, maar nie onrealisties hoog nie.
Ek stel ook baie hoe eise aan my werk en word dan gefrustreerd as ek nie daaraan kan voldoen nie. Ek is eerlik en die personeel weet waar hulle met my staan Ek stel nie onmoontlike eise nie. Ek gee graag erkenning aan die personeel en glo aan deelnemende bestuur. Ek glo dat die personeel ten volle ontwikkel moet word. Ek hou van 'n goeie sistematiese roetine en dissipline en werk volgens 'n tyd skedule wat soms frustrerend kan wees. Ek is verder baie trots op my personeel en oor die algemeen is daar goeie samewerking. Die personeel is ook trots op hulle eenheid."

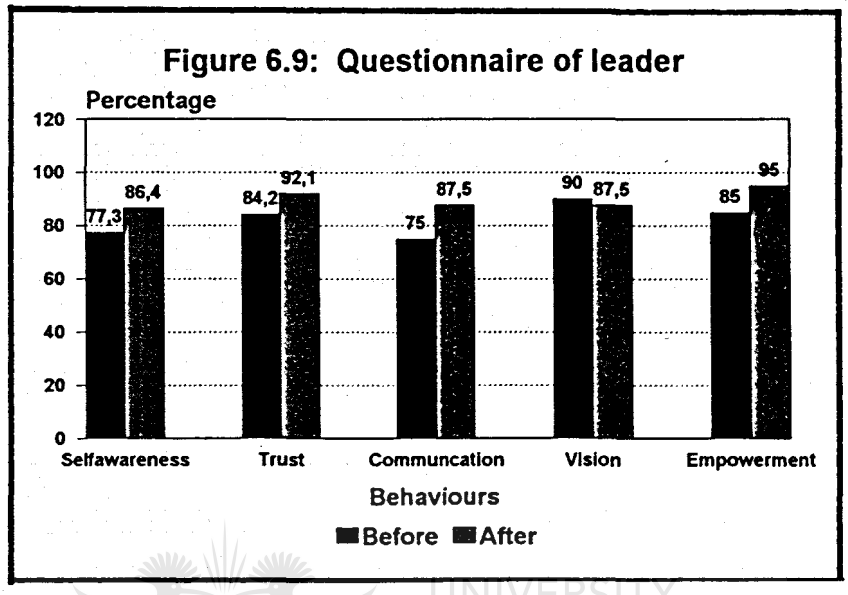
(Direct translation: "I was born in 1954 in the Netherlands and have an older sister. When I was one and a half years old my parents emigrated to South Africa and settled in Pretoria where I am still currently living.

I come from a very strict and religious home where very high demands were made on the children. After my schooling I spent one year as an internal auditor at the Post Office. I was very interested to qualify myself as an archeologist but there were no funds available for studies. My older sister went to nurse but she was not very successful and I decided to show that nursing was not the career that she was suggesting it was. I should never have found myself in the position of a nurse - it was the last career that I was interested in. After I completed my training and written my final examination, I got married. I have been married now for almost 19 years. I have four children - two boys and two girls, with ages 18, 16, 13 and 11.

I am very fond of reading and also like to sew for myself and for my daughters and to do embroidery, but there is not a lot of time for it. My children also keep me very busy with after-school activities as they involve a lot of travelling. I put high demands on my children, but not unrealistically high.

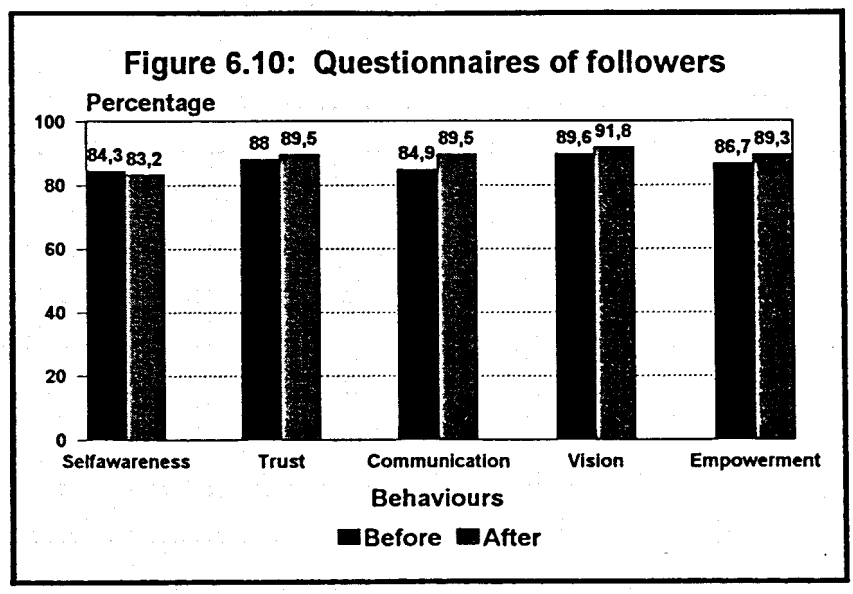
I also put high demands on my work and get very frustrated when I cannot fulfil these demands. I am honest and the personnel know where they stand with me. I do not set unreasonably high demands.

I enjoy giving credit to the personnel and believe in participative management. I also believe that personnel should be developed to the full. I like a systematic routine and discipline and work according to a time schedule which can sometimes be very frustrating. I am further very proud of my personnel and in general there is good participation between the personnel. The personnel are also proud of their unit.") The outcomes from this leader's questionnaire before the education programme and 12-14 weeks after the implementation of transformational leadership are depicted in figure 6.9



Before the implementation of the model, ten questionnaires were handed out to the followers. Nine (90,0%) of the distributed follower questionnaires were returned. Two of these questionnaires could not be analysed, as they were largely incomplete. Therefore the analysis is bases on the outcomes from seven (70,0%) of the distributed questionnaires. Twelve to fourteen weeks after the implementation of the model in the nursing unit ten questionnaires were handed out to the followers. Seven (70,0%) of the questionnaires were returned and all could be analysed.

The outcomes are depicted in figure 6.10.



As indicated through the initial questionnaires to the followers, the leader encourages the followers in the nursing unit to a great degree to increase their self-awareness. (An average of 84,3% was obtained for this behaviour.) Their also seems to be a great degree of trust between the followers and the leader as an average of 88,0% was obtained for this behaviour. It was therefore accepted that the leader can progress to communication as was indicated by the model for transformational leadership. An average of 84,9% was obtained for the behaviour of communication.

During the first contact session the leader reported that she is enjoying her involvement in the study. In this nursing unit the leader, in co-operation with the followers, revised the vision for the nursing unit. As it is one of the strategies (as described in the model) to integrate the vision throughout all the aspects in the nursing unit, the leader and the followers decided also to revise the philosophy of the nursing unit to bring it in line with the vision. The leader utilised participative management (follower interaction) for this process, as participative management is one of the strategies described in the model for the empowerment of the followers.

The leader felt that the older followers have difficulty in participating in this decision-making process. Her conclusion is that the older followers are not used to this method of decision-making and states: "Die ouer persone in die eenheid is miskien nie gewoond aan hierdie manier van dinge doen nie, en hulle was aan die begin traag om deel te neem. Dit is egter 'n goed om almal se idees te kan implementeer." (Direct translation: "The older persons in the unit are maybe not used to this way of doing things, and in the beginning they were slow to participate. It is however good to implement everybody's ideas.") They are still working on the final copy of the philosophy.

The nursing unit seems to be quiet and calm with interactions at a comfortable pace. The nursing unit is clean and seems to be well-organised. The leader also needs to write a specific incident report on a patient, and she states: "Ek haat dit, maar weet dat dit nodig is." (Direct translation: "I hate it, but I know that it is necessary.") The leader requested a group of followers to write down ten of their positive (good) characteristics as a person. The followers participated positively and actively in this exercise. The leader feels that it assisted the followers to increase their self-awareness.

Second contact session: The leader again expresses her enthusiasm for the study and states that she found it very stimulating: "Dit is baie stimulerend en gee 'n mens baie dinge om oor te dink." (Direct translation: It is very stimulating and gives a person many things to think about.") The researcher requested the leader to formulate, in interaction with the followers, specific objectives on any aspect that they want to change/transform in the nursing unit. These specific objectives, as well as the strategies to facilitate change and the assessment strategies before and after the implementation of the strategies for change are discussed during the next contact session between the leader and the researcher. The leader is requested to utilise the behaviours and strategies as described in the model for transformational leadership.

The leader and the followers are still working on the final version of the philosophy for the nursing unit. The nursing unit seems to be quiet and interaction seems to take place at a comfortable pace.

Third contact session: When formulating the objectives for the nursing unit, the leader utilised the strategies for communication, vision and empowerment as stated in the model. The strategies for self-awareness and trust are also enhanced throughout. The following objectives and strategies were formulated:

	Objective	Strategies
1	To increase the nursing audit from 20,6% to 60,0-70,0%	- Feedback to followers - Inservice education - Leading and supervision
2	To ensure that all (100,0%) prescriptions regarding intravenous infusions on the intake and output charts are signed by a registered nurse	- Weekly control on Mondays - Feedback to followers - Inservice education - Leading and supervision
3	To ensure that all (100,0%) the beds are issued with an emergency pack and oxygen, and that the suction equipment is in good working order	- As for objective two

Assessment of these objectives is on a weekly basis. To obtain a baseline assessment, the leader conducted an assessment prior to providing any inservice education.

The nursing unit seems to be quiet and calm. Interactions seem to take place at a comfortable pace. The nursing unit is clean and neat. The leader also seem to be very proud to hand over the revised philosophy for this nursing unit.

Fourth contact session: The nursing unit seems to be very busy. The leader is enthusiastic and positive about the progress regarding the planned strategies for the formulated objectives. Interaction between the followers and the leader and between the followers seems to be hurried and there seems to be a lot of bustle in the nursing unit.

One of the followers in this nursing unit has worked in the nursing unit for the past eight months and still battles to function optimally in this nursing unit. This follower is now transferred to another nursing unit. The leader states that she feels disappointed that she could not help the follower to settle in the nursing unit successfully, but she feels that she tried her best. ("Ek is jammer ek kon haar nie help nie, maar ek het my beste probeer." Direct translation: "I am sorry that I could help her, but I tried my best.")

Fifth contact session: The leader informed the researcher via another leader that she went off duty earlier than planned and can therefore not honour the appointment. The leader and the followers are however progressing well with the strategies stated for the attainment of the formulated objectives.

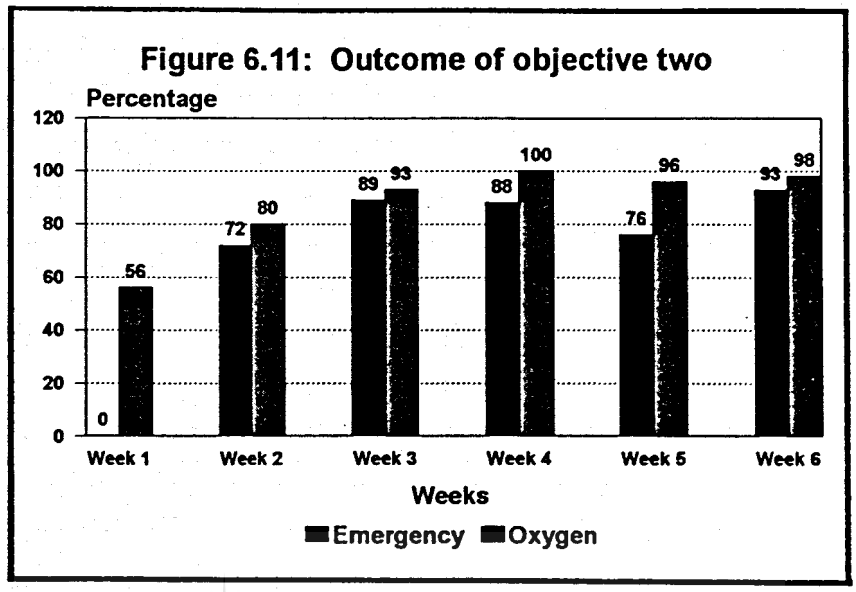
Sixth contact session: The nursing unit seems to be quiet and interactions seem to be at a relaxed pace. The nursing unit is clean and neat.

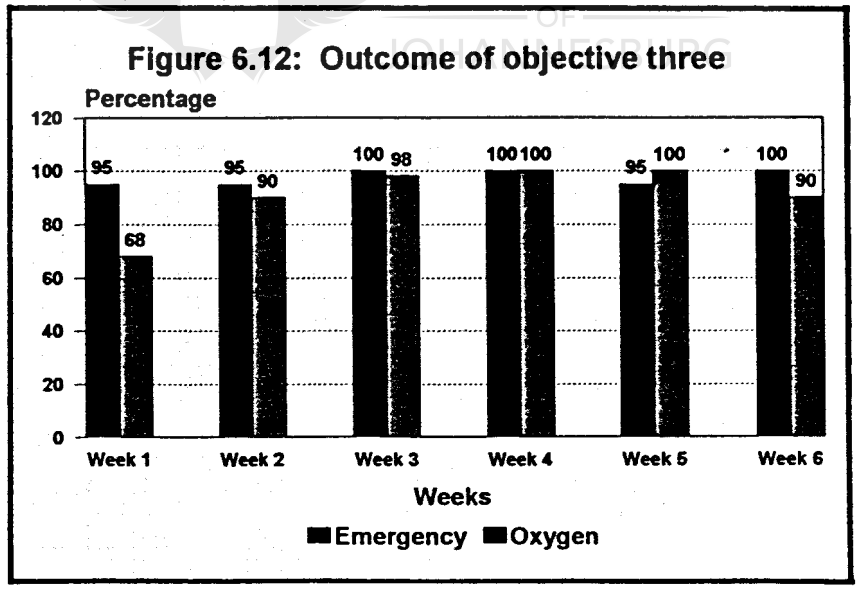
Prior to this contact session, the researcher handed a copy of the analysis of the data to the leader to check (member checking) to enhance the truth value (credibility) as described by Merriam (1988:166-170) and Lincoln and Guba (1984:295-311) and in chapter two of this study. The leader was requested to check the following aspects:

- is the analysis and the outcomes reflected accurate and in line with the issues discussed during the contact sessions?
- are all discussed issues analysed and reflected?
- is there anything that should be added to the analysis?

The leader commented: "Ek stem saam met alles en voel dat dit weergee wat ons bespreek het. Jy het 'n goeie geheue. Daar is niks wat bygevoeg of weggevat moet word nie." (Direct translation: "I agree with everything and feel that it reflects what we discussed. You have a good memory. There is nothing that should be added or left out.")

The assessment of the strategies to attain the set objectives seems to be progressing well. It seems that the objectives will be reached. She is starting to consolidate all the outcomes to be able to come to a final conclusion. There is continuous interaction with the followers on the assessment of the attainment of the objectives. The outcome of the objectives are reflected in figures 6.11 and 6.12.





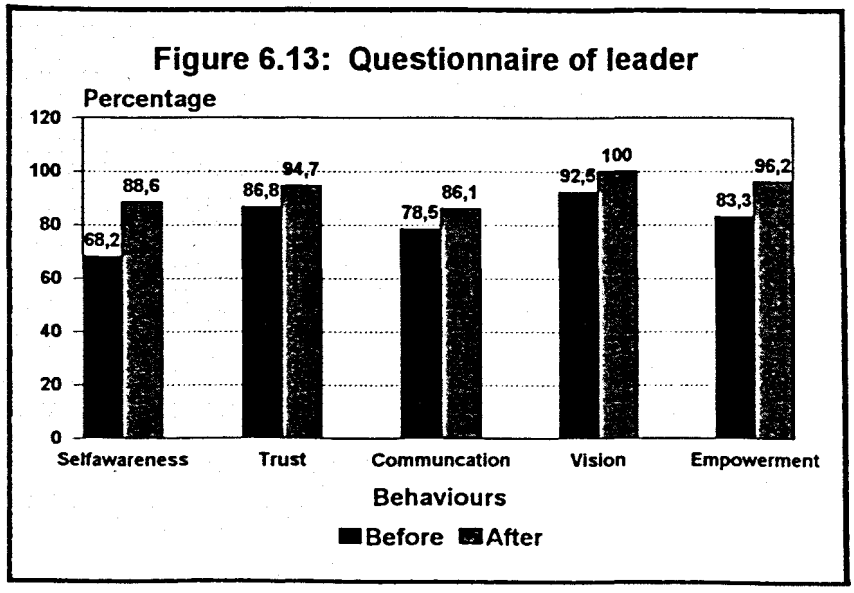
Although all the formulated objectives were not reached, the leader and followers seem to be satisfied with the transformation or change.

6.3.4 Nursing unit D: High-care nursing unit

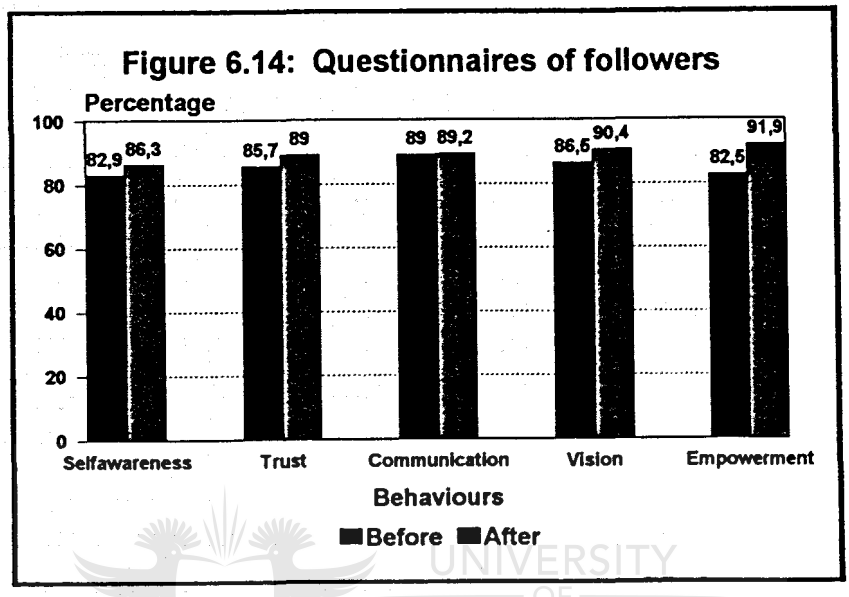
This leader is married, and has two daughters aged five years and 16 months. She describes herself as follows: "My stokperdjies is kosmaak en tuinmaak. Ek is nie lief om sport te beoefen nie, maar ek geniet dit wel om te kyk. My huidige doelwitte vir die verpleegeenheid is om 'n effektiewe hoë sorg eenheid daar te stel wat regtig net hoë sorg patiënte hanteer. Tans word pasiënte oorgeplaas vanaf kritieke sorg verpleegeenheid en bly dan in die eenheid tot en met ontslag (indien ons nie die bed benodig nie) alhoewel hierdie pasiënte nie meer hoë sorg verpleging benodig nie. Dit is 'n frustrasie aangesien hierdie pasiënt dan basiese verpleegsorg ontvang en kan die personeel nie regtig tyd en aandag aan die hoë sorg pasiënt verleen nie. Ek geniet my werk en leer baie. My man is met tye van die huis af weg en is ook tans besig met nagraadse studies. Ek voel soms skuldig dat ek nie meer aandag aan my kinders kan gee nie. My eie studies sal eers so ongeveer vier jaar moet wag. Vir eers wil ek eers aandag aan my kinders gee."

(Direct translation: "My hobbies are cooking and gardening. I do not enjoy playing sport but I do enjoy watching it. My current objectives for the nursing unit are to establish an effective high-care nursing unit that handles only high-care patients. Currently the patients are transferred from a critical-care nursing unit and then stay in the nursing unit until discharged (if we do not need the bed) although this patient does not need high-care nursing anymore. It is a frustration as these patients receive basic nursing care and the nursing personnel cannot really spend time and attention on the high-care patients. I enjoy my work and am learning a lot. My husband is sometimes away from home and he is also busy with post-graduate studies. I sometimes feel guilty that I cannot give more attention to my children. My own studies have to wait for more or less four years as I first want to give attention to my children.")

The outcomes from this leader's questionnaire on the behaviours and strategies of transformational leadership before and after the implementation of transformational leadership are depicted in figure 6.13.



Before the implementation of the model, ten questionnaires were handed out to the followers. Six (60,0%) of the distributed questionnaires were returned. One of the questionnaires could not be analysed and therefore the analysis is based on five (50,0%) of the distributed questionnaires. Twelve to fourteen weeks after the implementation of the model in the nursing unit ten questionnaires were handed out to the followers. Seven (70,0%) of the questionnaires were returned and five (50,0%) could be analysed. The outcomes are depicted in figure 6.14.



As indicated through the questionnaires to followers, the leader in this nursing unit encourages followers in the nursing unit to a great degree of self-awareness. (An average of 82,9% was obtained for this behaviour). Their also seems to be a great degree of trust between the followers and the leader as an average of 85,7% was obtained for this behaviour. It was therefore accepted that the leader can progress to communication as was indicated by the model for transformational leadership. An average of 89,0% was obtained for the behaviour of communication.

During the first contact session the leader reported that she has not implemented the model in the nursing unit, as it is closed for the month of April. Currently followers are practicing in other nursing units. The researcher found the leader checking and stocking the nursing unit.

The researcher requested the leader to formulate, in co-operation with followers, specific objectives on any aspect that they need to transform in the nursing unit. The leader is requested to utilise the behaviours and strategies as described in the model for transformational leadership.

Second contact session: The nursing unit seems to be extremely busy. The leader has 'flu and is therefore not feeling very well. She did not really have the time to discuss the study with the followers as the nursing unit was only open for the past two weeks and during that period they were extremely busy.

Third contact session: The nursing unit is again extremely busy as there are many patients admitted as well as discharged. The leader is extremely busy but manages followers in a friendly, effective and professional manner and also lends a practical hand where needed. In between all the bustle, she makes time for the little but important interpersonal actions, for example saying goodbye and wishing a discharged patient and his family the best of luck for the future. She is overflowing with new ideas to test new methods to simplify or improve the nursing care rendered in the nursing unit. However, she states: "Ek voel partykeer ek probeer te veel dinge gelyk aanpak." (Direct translation: "I sometimes feel that I tackle too many things simultaneously.") The leader found it very difficult to formulate objectives as she states that she has so many ideas and aspects that she wants to change that it is difficult to decide what to handle first. ("Ek het soveel idees en aspekte wat ek graag wil verander of verbeter dat dit moeilik is om te kies watter ek eerste moet hanteer." Direct translation: "I have so many ideas and aspects that I want to change or improve that it is difficult to decide what to handle first.")

In this nursing service, a system is used whereby the number of vaculiters of intravenous fluid and drugs dispensed to the nursing unit is counter checked with the quantities administered to the patients. These numbers should balance in the end. A computer printout to this effect is provided to the nursing units every month. According to the computer printout, there are vaculiters and drugs dispensed that cannot be accounted for. The leader believes that this happens because the recording process is not streamlined and not because vaculiters and drugs are really disappearing. If the recording process is streamlined and there are still unaccounted vaculiters and drugs, other causes can be sought. It was therefore decided to simplify and improve the recording process. The leader also states that new followers rotating through the nursing unit at times also create difficulties, and therefore methods and procedures in the nursing unit should be as simple but effective as possible.

When formulating objectives for the nursing unit, the leader utilised the strategies for communication, vision and empowerment as stated in the model. The strategies for self-awareness and trust are also enhanced throughout and the following objectives and strategies were formulated:

	Objective	Strategies
1	To increase the nursing audit from 46,3% to 70,0%	- Feedback to and from followers - Inservice education - Leading and supervision
2	To improve the record-keeping and control system for vaculiters and drugs	- Evaluation of current system - Feedback to and from followers - Modification of documents - Inservice education - Leading and supervision

Fourth contact session: The nursing unit seems to be extremely busy and everybody seems to rushing around. However, the leader seems to be relaxed although she states that the nursing unit is very busy. The interactions between the leader and followers seem to be at a hurried but friendly pace.

The leader is awaiting the printouts from the dispensary to determine the progress made in attaining the objectives. She states: "Dan sal ons kan sien wat gebeur en hoe ver ons gevorder het." (Direct translation: "Then we can see what is happening and how far we have progressed.")

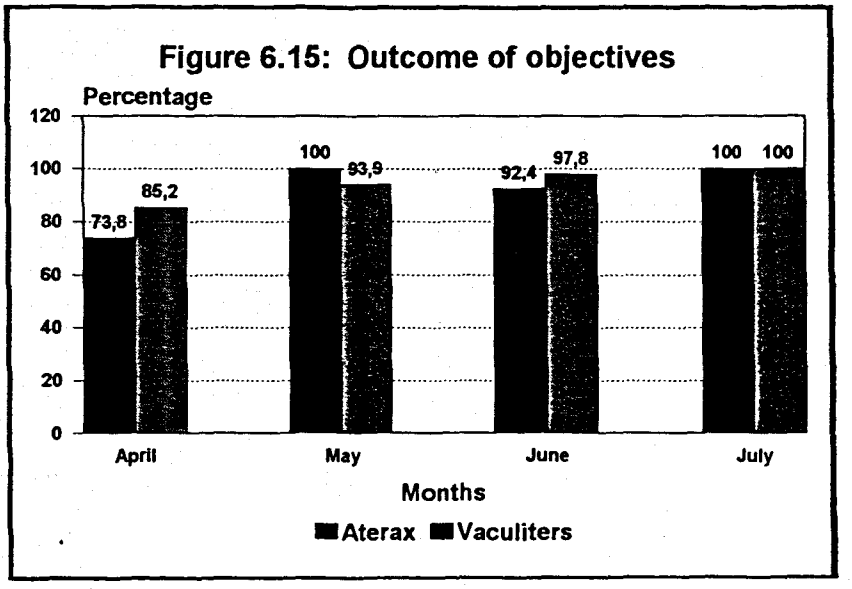
Fifth contact session: The nursing unit seems to be extremely busy and interactions seem to be hurried, but friendly and professional. The leader provides guidance and supervision whenever necessary. None of the printouts were received and therefore the progress regarding the attainment of the objectives cannot be determined.

Sixth contact session: The nursing unit is very quiet with few patients in the nursing unit. The interactions are at a relaxed pace and the leader is utilising the opportunity to catch up on administrative work.

She states that she analysed the model in detail again and she comments as follows: "Ek voel die model is reg soos dit is. Daar is op party plekke baie detail, maar ek glo nie dit kan uitkom nie. Ek moet dit vir enige van my verpleegkundiges kan gee en sy moet dit kan gebruik; tans is die model so geskryf." (Direct translation: "I feel the model is correct as it is. In some places there are a lot of detail, but I do not believe that it can come out. I should be able to give it to any of my nurses and she should be able to use it; currently the model is written like that.")

The leader together with the researcher analysed the printouts from the dispensary with regard to the loss on intravenous infusions and drugs.

The outcomes are depicted in figure 6.15.



Seventh contact session: Prior to this contact session the researcher handed a copy of the analysis of the data to the leaders to check (member checking) to enhance the truth value (credibility) as described by Merriam (1988:166-170) and Lincoln and Guba (1984:295-311) and described in chapter two of this study.

The leader was requested check the following aspects:

- are the analysis and the outcomes reflected accurate and in line with the issues discussed during the contact sessions?
- are all discussed issues analysed and reflected?
- is there anything that should be added to the analysis?

The leader stated that she was satisfied with the analysis and reporting of the discussed issues. She has nothing to add. Although all the formulated objectives were not reached, the leader and followers are satisfied with the transformation.

6.4 SYNTHESIS OF THE OUTCOMES

The averages which the leaders obtained for the behaviours of transformational leadership improved after the implementation of the model.

The outcomes of the questionnaires of leaders are summarised in figure 6.16.

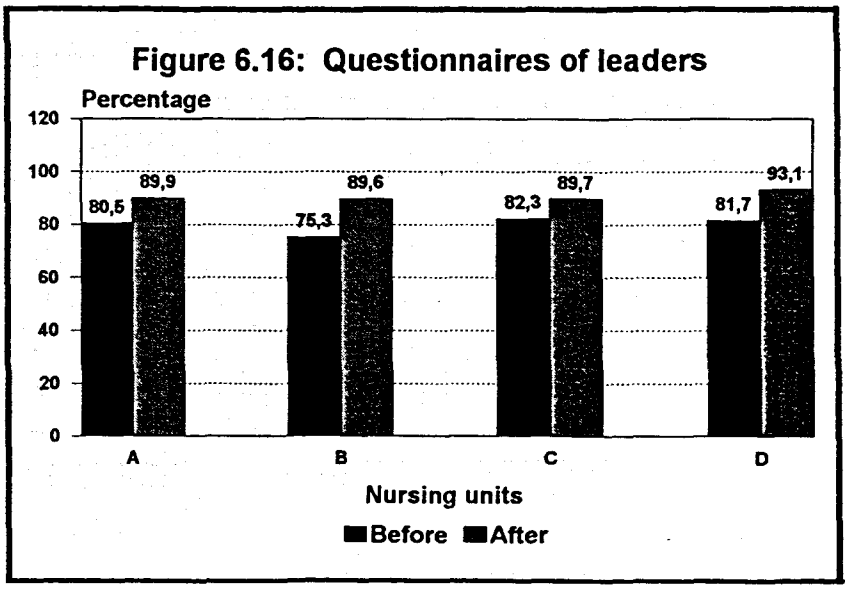
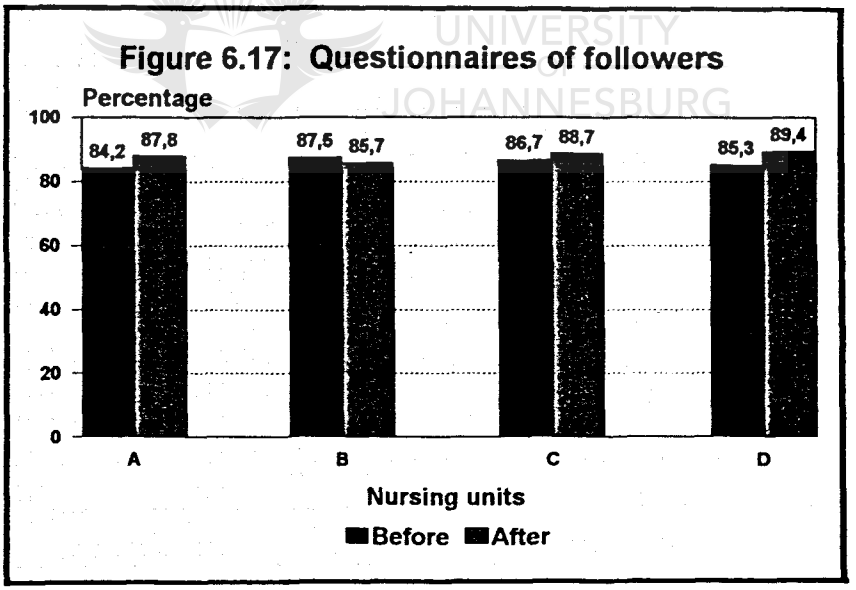
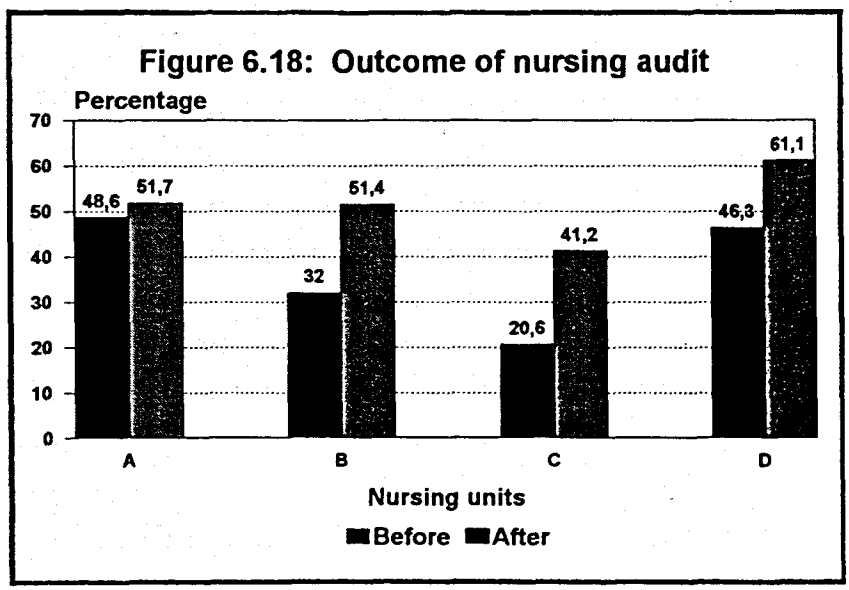


Figure 6.17 elucidates the outcomes of the questionnaires of the followers



In all the nursing units the outcome of the nursing audit evaluations improved after the implementation of the model for transformational leadership.

These outcomes are reflected in figure 6.18.



6.5 EVALUATION, VALIDATION AND REFINEMENT OF THE MODEL

The evaluation, validation and refinement of the model are described as follows:

- feedback from the leaders during the education programme;
- feedback from the narrative sketches of the leaders;
- feedback during the case study (cross-case analysis) and
- feedback from the panel of experts

6.5.1 Feedback from leaders during the education programme

During the education programme general feedback was received from six participants. Although 12 nursing unit managers participated in the education programme, only six participants provided written feedback. This feedback was also analysed according to the criteria for the analysis of unstructured data by Tesch 1990 (in Cresswell 1994:142-145). A discussion of the feedback follows.

(a) Feedback regarding the content

All six participants provided feedback on the content of the model. The following comments were made.

"Ek voel beslis dat as ek 'n persoon nie kan vertrou nie, ek haar beslis nie sal bemagtig nie." (Direct translation: "I definitely feel that if I do not trust a person I will definitely not empower her.")

"All stappe is interafhanklik." (Direct translation: "All the steps are interdependent.")

"Ek kan niks byvoeg nie." (Direct translation: I cannot add anything.")

"Dit is 'n volledige model, ek wil niks byvoeg of weglaat nie." (Direct translation: "It is a complete model, I do not want to add or take away anything.")

"Optrede kan in albei rigtings werk." (Direct translation: "Behaviours can work both ways.")

"Die gedrag of optredes kan nie net in een rigting werk nie, maar in albei rigtings." (Direct translation: The behaviours or actions cannot work in one way only, but in both ways.")

(b) Good, implementable model

Five of the participants mentioned that it is a good and implementable model. The following quotations support this statement:

"Dit klink goed, so ek dink dat dit kan werk." (Direct translation: "It sounds good, therefore I think it can work.")

".....en dit behoort te werk in my afdeling aangesien die filosofie gebaseer is op Mensheelheid." (Direct translation: " ..... and it should work in my unit as the philosophy is based on the Whole Person Approach.")

"Goeie model." (Direct translation: "Good model.")

"Dit is nog baie nuut vir my, maar ek dink dat mens dit wel suksesvol kan implementeer." (Direct translation: "It is still very new to me, but I think that a person can implement it successfully.")

(c) Stimulating model, encouraging growth

Three of the participants commented that it is a stimulating model with growth to the leader and followers as reflected by the following quotations:

"Ek het die model stimulerend gevind." (Direct translation: "I found the model stimulating.")

"Ek het nie net self gegroei nie, maar my personeel is ook besig on deur die model te groei." (Direct translation: It is not only I who have grown, but my staff is also busy growing by means of the model.")

(d) Uncertainty regarding the success of the model

One participant stated that she was uncertain about the success of the model before it was implemented in the practical situation. She commented:

"Ek weet glad nie. Ek wil eers sien hoe dit werk as dit in die praktyk toegepas word. Party dinge lyk wonderlik op papier, maar in die praktyk werk dit glad nie." (Direct translation: "I do not know at all. I first want so see how it works when implemented in the practical situation. Some things look wonderful on paper, but in the practical situation do not work at all.")

Table 6.5 summarises the feedback.

Table 6.5: Feedback from leaders after the education programme

Feedback	Total n=6
- Regarding content	6
- Good, implementable model	5
- Stimulating model, encouraging growth	3
- Uncertainty regarding success of model	1

6.5.2 Feedback from narrative sketches of leaders

The following question was posed to the leaders (n=4) who participated in the case study: "Please describe your experience of the implementation of the model for transformational leadership in your nursing unit." Data was collected by means of narrative sketches according to a pre-formulated protocol (see annexure J). The narrative sketches were then analysed by the researcher and an external coder (see annexure K) according to the steps for the analysis of unstructured data proposed by Tesch 1990 (in Cresswell 1994:142-145). A discussion of the analysed data follows.

(a) Not new or strange

All four participants indicated that the model for transformational leadership is not a new or strange model. It was also indicated that the implementation of this model was easy (n=1). This is evident from the following quotations from the narrative sketches:

"Implementering daarvan was maklik". (Direct translation: "Implementation thereof was easy.")

"Baie van die strategieë was reeds geïmplementeer in die eenheid." (Direct translation: "Many of the strategies have already been implemented in the unit.")

"My leiding gewing, vandat ek in bevel is, is een van bemagtiging, goeie kommunikasie, spanbou en die bou van vertroue. So dit is nie 'n vreemde model in die saal nie." (Direct translation: My leading, ever since I have been in charge, is one of empowerment, good communication, team-building and the building of trust. So it is not a strange model in the ward.")

(b) External factors impact on model

All four participants stated that external factors impact on the model. The stated factors include changes in the personnel component of the nursing unit, a very high workload, resistance to change. These aspects are reflected by the following statements:

"As gevolg van 'n groot aantal personeelsveranderinge is daar nog nie 'n baie sterk vertrouensverhouding tussen die susters en die verpleegsters nie." (Direct translation: "Because of the many changes in the personnel, there is not a very strong relationship of trust between the sisters and the nurses.")

"Werkslading wat baie hoog is wat kommunikasie bemoeilik." (Direct translation: "Workload that is very high hinders communication.")

"Hoe egter teenkanting en negatiwiteit ervaar by the personeel wat geneig is tot stagnasie." (Direct translation: "Encountered resistance and negativeness from the personnel who are inclined to stagnation.")

(c) Workable model

Three participants indicated that it is a workable model as reflected by the following statements:

"Ek het geen probleme ondervind nie." (Direct translation: "I experienced no problems.")

"Dit is 'n goeie model, wat kan werk." (Direct translation: "It is a good model that can work.")

"Die meeste personeel was baie positief toe die model aan hulle bekend gestel is." (Direct translation: The majority of the personnel were very positive when the model was introduced.")

(d) Valuable, learning opportunity

Two participants indicated that the implementation of this model was a valuable learning opportunity. This aspect was reflected by the following statements:

"Waardevolle en leersame geleentheid vir enige persoon." (Direct translation: "Valuable and learning opportunity for any person.")

"Implementering is 'n plesier by baie van die personeelede wat van veranderinge en uitdagings hou." (Direct translation: "Implementation is a pleasure for many of the personnel who enjoy changes and challenges.")

(e) Leadership is needed

Two participants indicated that the model for transformational leadership is needed as followers want leadership. This aspect is supported by the following statements:

"Hulle wil gelei word." (Direct translation: "They want to be led.")

"Waar die eenheidsbestuurder nie direk betrokke is en al die bogenoemde dinge kan implementeer nie, sukkel ek as eenheidsbestuurder." (Direct translation: "When I, as the unit manager, am not directly involved, I struggle to implement all the above-mentioned aspects.")

(f) Empowerment is a new concept

Two participants indicated that some of the personnel in their nursing units experience empowerment as a new and unfamiliar concept. This was especially evident from the older followers in the nursing unit who are not very conversant with the attitudes of empowerment and assertiveness as these followers trained in an era in nursing when empowerment and assertiveness were not emphasised. This is evident from the following quotations for the narrative sketches:

"Sommige personeellede vind dit nog moelik om eie besluite te neem." (Direct translation: "Some of personnel find it difficult to make their own decisions.")

"Sommige personeel het as dit by bemagtiging kom en besluitneming asook verantwoordelikheid aanvaar vir besluitneming, begin terugstaan." (Direct translation: "Some members of staff withdrew when it came to decision-making and acceptance of responsibility for decision-making.")

Table 6.6 summarises the feedback.

Table 6.6: Feedback through narrative sketches

Feedback	Total n=4
- Not new or strange	4
- External factors impact on model	4
• personnel changes	3
• high workload	2
• resistance to change	1
- Workable model	3
- Valuable, learning opportunity	2
- Leadership is necessary	2
- Empowerment is a new concept	2

6.5.3 Feedback from the case study: cross-case analysis

The model is also evaluated, validated and refined according to the feedback and data gained through the descriptive, qualitative case study over a period of 12-14 weeks of implementation of the model in four participating nursing units.

(a) The individuals in transformational leadership

In the model it is stated that leaders and followers are individuals. This aspect was very clear in all the contact between leaders and the researcher. Every leader handled the contact sessions differently and provided different feedback to the researcher. This is also very clear in the self-analysing sketches written by the leaders. Some of the leaders provided a lot of information while others provided only the basic and very important information. Some of the leaders needed a lot of guidance and prompting to formulate the objectives while other leaders had to be warned not to formulate too many objectives.

The individualism of followers and leaders were also displayed in some aspects in the external environment of the individual (nursing unit), for example: In nursing unit A the photographs of the leader and the followers are displayed on the notice board. This is not seen in any of the other nursing units and is special to this nursing unit.

In the model it was stated that the different dimensions of the leader (clinical practitioner, nursing unit manager, transformational leader and researcher) are not regarded as separate entities but as interdependent and interrelated. This interdependence and interrelatedness was observed on many occasions during the contact sessions with the leaders. The leaders incorporated all these dimensions in all their interactions with followers, patients, family of patients and nursing service managers.

(b) The interaction between leadership and followership

During the contact sessions, the researcher observed that in the nursing unit it is the leader who initiates the process of transformational leadership by implementing the behaviours of transformational leadership for example communication to the followers. Followers then support the leader in this action. This is in line with the process description of the model for transformational leadership.

It was also observed that there is a dynamic interaction between followers and between leader and followers (as stated in the model). This was evident in the feedback from leaders after the objectives for the nursing units were formulated. During the formulation of the objectives participative management was utilised by all the nursing unit managers. All leaders also favoured participative management as their leadership style. It was also evident from the outcomes from the questionnaires to the followers that in all the nursing units the behaviour of empowerment was rated very high by all the followers. These outcomes were depicted in figures 6.3, 6.6, 6.10, and 6.14.

(c) The context of transformational leadership

In the model the nursing unit is described as functioning as a subsystem within the other systems of the nursing service, health service and community. It is also stated that all these subsystems are interdependent, interacting and interrelated.

The abovementioned was very clear when the leaders, in co-operation with the followers, formulated the objectives for each of the nursing units. The objectives of the nursing units had to be formulated in line with the vision and mission statement of the nursing service.

(d) The interaction between the individuals and the context

The researcher also observed that the external environment impacts on individuals (as stated in the model). It was clear in all the nursing units that whenever the nursing unit was extremely busy, the leader and followers seem to be less relaxed and to be rushing around. During these busy times it was also evident that the interaction between leaders and followers seemed to be tense and hurried as leaders and followers were trying still to render the quality nursing care to the patient and the family as expected. It was also evident from the feedback from the leader in nursing unit A that whenever there were difficulties in her external environment (for example when her dog was sick) this also impacts on this leader as she seems to be tired and less enthusiastic about the study. Also when her external environment changed from day duty to night duty, she stated that she did not like it. She felt distressed because night duty is a unsociable shift and she has to work while all her friends can socialise.

It was also evident that the internal environment of the individual also impacts on the individual (as stated in the model). When the leader of nursing unit D had 'flu she stated that she was not feeling well. During that contact session she seemed to be distressed and not very enthusiastic about the study.

During this contact session this nursing unit was extremely busy and this aggravated the impact on this leader. Not much progress could be made during the contact session.

It is stated in the model that the followers practice under the direct and/or indirect supervision and guidance of the leader. During many of the contact sessions the leaders were approached by some of the followers for guidance and support. All requests were always handled in a friendly, effective and professional manner by the leaders.

(e) Behaviours of transformational leadership

During the contact sessions with the leaders, the researcher realised that the behaviours of transformational leadership cannot be indicated as a one-way circular (see figure 6.19) process (as stated in the model).

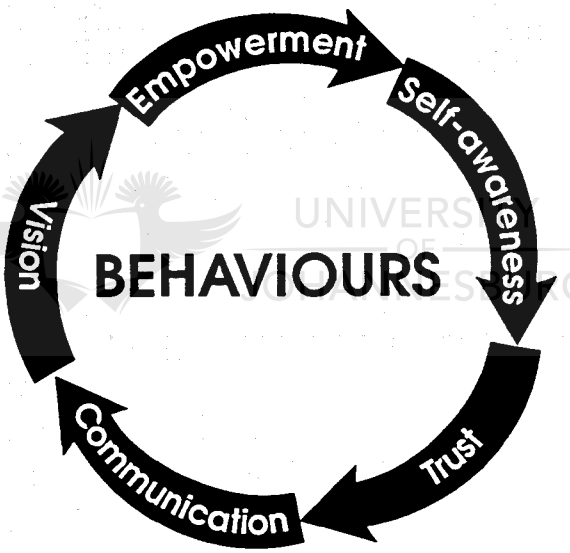


Figure 6.19: One-way circular process

It was clear that the leader moves clockwise (as indicated by the described one-way circular process) but also moves anti-clockwise on the described circular process, and that this creates a two-way circular process.

To be able to implement the strategies for effective empowerment, the leader also implements some of the strategies of communication. In this process the leader also implements strategies for building trust for example, to be honest, reliable, consistent and congruent.

This supported the process description of the model that stated that the behaviours of transformational leadership constitute a dynamic, ongoing, interactional and interrelated process. These behaviours should be regarded as interdependent and interactive. The initiatives of transformational leadership should therefore be described as a two-way circular process (see figure 6.20) as follows:

Figure 6.20: Two-way circular process

This was discussed with the leaders for evaluation, validation and clarification. The leaders reacted as follows:

Leader of nursing unit A commented: "Dit klink goed. Dit lyk of dit beter kan werk. Dit is ook meer toepaslik aangesien die optredes interafhanklik is en die leier van die een na die ander optrede beweeg. Die leier gaan ook gedurig weer terug na die vorige optredes om dit weer te versterk en verder daarop te bou. Geeneen van hierdie optredes kan en moet afsonderlik gesien word nie. Ek steun hierdie verandering." (Direct translation: "It sounds good. It looks as if it can work better. It is more applicable as the behaviours are interdependent and the leader moves from one behaviour to the other. The leader also goes continuously back to the previous behaviour to strengthen it and to build on it. None of these behaviours can and should be seen in isolation. I support this change.") This feedback is also supportive to the statement in the model that the behaviours are interdependent and interrelated.

The leader of nursing unit B commented: "Ek glo dit gaan beter werk as die vorige proses. Ek dink jy moet dit so verander." (Direct translation: "I believe it is going to work better than the previous process. I think that you should change it as such.")

The leader of nursing unit C added: "Ek voel dit werk makliker en beter en dink dat ons die model so moet aanpas. Dit is waar dat die geleentheid daar moet wees sodat die leier terug kan beweeg na die vorige optredes." (Direct translation: "I feel it works more easily and better and think that we should adapt the model as such. It is true that the opportunity should be there for the leader to move back to the previous behaviours.")

Comments from the leader in nursing unit D were as follows: "Dit klink goed. Ja-nou lyk dit makliker om te gebruik. Ek dink ons kan dit so verander. Ek stem saam." (Direct translation: "It sounds good. Yes - now it looks easier to use. I think we can change it as such. I agree.")

(f) The goal of transformational leadership

In the model, transformational leadership is presented on a continuum with unsuccessful transformation/change and successful transformation/change placed at opposite ends of a linear process. It is also stated in the model that transformational leadership is a continuous variable and that degrees of transformational leadership are possible. Successful transformational leadership is reflected in individual and nursing unit transformation. It is also stated that the more successful the transformational leadership, the greater the individual and nursing unit transformation. It was evident from the outcomes that in all the nursing units there were different degrees of transformational leadership (as indicated by the outcomes from the questionnaires to the leader and the followers.)

It was evident that the practice of transformational leadership (as stated in the model) is a dynamic process that depends on the interaction between the leader, followers, context, goal, motivating forces and the behaviours of transformational leadership.

Lastly the model is evaluated, validated and refined by the leaders in the case study nursing units and by a panel of eight experts according to the criteria suggested by Chinn and Kramer (1991:138-139).

6.5.4 Evaluation by panel of experts

The model for transformational leadership was evaluated by a panel (n=8) of experts including:

- model development experts (n-2);
- nursing service managers (n=2) and
- nursing unit managers (n=4).

These experts utilised the criteria proposed by Chinn and Kramer (1991:138-139). The criteria comprise clarity, simplicity, generality, accessibility and importance. A discussion of the feedback follows.

(a) Clarity

Clarity refers to how well the theory can be understood and how consistently the ideas are conceptualised. All eight experts stated that the significant concepts were clearly defined and used consistently throughout the description of the model.

Six (n=6) of the experts stated that the amount of explanation provided was appropriate and enough. However, one of the experts stated that the model did not adhere to the criteria of simplicity by stating: "overview of model: what, how and where, who, why? This needed to be explained in more detail."

One of the experts also stated that the model refers to a system and a subsystem but that these two concepts were not included as part of the assumptions for the model Therefore, the following statement was added to the assumptions for the model: The nursing unit functions as a subsystem within the nursing service and community as a system.

One of the model development experts stated that the definitions for the main and related concepts of the model should be stated earlier in the model, as she found it not very reader friendly to first state the assumptions and theoretical statements and thereafter provide the definitions. She also mentioned that Mouton and Marais (1990:127) recommend that theory generation should be handled as follows: Identify and define concepts, state relationships and then described the model or conceptual framework (also see figure 2.1).

This model development expert also stated that the visual presentation of the model was not clear as:

- leadership was indicated twice and the difference between these two leadership aspects was not clear and caused confusion;
- the circular structure representing the behaviours of transformational leadership was too limited and not display the behaviours congruent to the process description of the model. She proposed a spiral structure to display the behaviours;
- the different dimensions of the leader seem to be separate entities with no interaction between these different dimensions. She proposed that the interaction between the different dimensions should be displayed visually and
- the continuum indicating the goal (individual and nursing unit transformation) should be open-ended.

All the above-mentioned proposals were implemented and are reflected in figure 6.21.

(b) **Simplicity**

Simplicity of a theory means that the number of elements within each descriptive category, particularly concepts and their inter-relationships are minimal. The experts made the following comments:

The majority (n=6) of the experts stated that the theory was simple to understand and use. This is reflected by the following statements:

- the model is "simple to follow and use" and
- the model is "simple and meaningful."

One of the members of the panel of experts stated that "I have real problems with your supportive strategies. You have lists of activities that actually do not make any sense - these are also not guidelines and not al all reader friendly. Clarity and simplicity as criteria are not adhered to." This person proposed that the supportive strategies be re-written in a table format, utilising the headings of objectives, strategies and activities. Table 6.7 reflects these changes.

Table 6.7: Behaviours and strategies for transformational leadership

Behaviours	Strategies
(a) Self-awareness • To promote, improve and/or maintain self-awareness of the leader and followers	• acknowledge your own strengths and limitations; • accept the limitations or change the behaviours that support these limitations; • be aware and conscious of your own identity, acts, thoughts, feelings, and motives; • gain knowledge on your body and physical potential; • acknowledge your spiritual needs; • acknowledge your interaction with the followers and the external environment (nursing unit); • listen to yourself by allowing yourself to experience genuine emotions; • identify and accept personal needs by exploring your own thoughts, feelings, memories and impulses; • listen to and learn from others by active listening and openness to the feedback from other people; • exercise self-disclosure by revealing and sharing perspectives with others; • enlarge your experiences by criteria and engaging in unfamiliar and new activities; • utilise role play and other strategies to encourage self knowledge; • develop a commitment to continual personal and professional learning and development; • accept yourself and also accept other people unconditionally and • judge yourself and other people less harshly.

Behaviours	Strategies
(b) Trust • To promote, improve and/or maintain trust among the leader and followers	• keep your word and keep promises; • encourage followers by recognising positive traits and accomplishments; • practice excellence and create an environment that encourages excellence by setting high personal and professional standards; • display reliable and dependability by being available to provide guidance and/or support when needed; • display congruency and predictability by practicing what you preach; • demonstrate personal integrity by honouring commitments; • display honesty and always tell the truth; • use open communication; • demonstrate respect by treating followers as professional adults; • acknowledge the followers' knowledge, skill and experience; • give open and honest feedback to followers in a sensitive manner; • acknowledge, respect and value the input and effort from the followers, even though it was unsuccessful; • acknowledge and communicate the followers' strengths; • be kind and courteous by demonstrating understanding of the followers' needs and aspirations; • encourage creativity by encouraging new projects and allowing for calculated risk-taking; • attend to the little things such as congratulating a follower on his/her birthday; • clarify expectations to prevent future misunderstanding and conflict; • apologise for mistakes; • display personal and professional accountability; • demonstrate commitment to the followers and the nursing unit; • spend time with the followers to build contact; • keep personal information of any follower confidential; • respect each follower as an individual and do not judge the feelings of the followers and • create an environment of caring.

Behaviours	Strategies
(c) Communication	
• To focus on and practice effective listening skills	• concentrating on what the follower is saying and how the follower is conveying the message to avoid false and selective listening; • limit external disturbances such as noise and interruptions; • listen in a non-judgmental manner; • establish good rapport by listening in a non-judgemental manner and by demonstrating empathy; • clarify unclear messages through regular summarising of discussed content, asking questions and verifying facts; • display patience and allow enough time to the follower to express words, ideas and feelings; • keep cool, calm, alert and attentive by showing interest in the person who is speaking and in the subject which is addressed and • be a critical listener by analysing the discussed content.
• To focus on and practice effective writing skills	• state all the facts, statistics and statements accurately for example 25,7% and not more or less 25,0%; • when using quotations, they should be accurate and applicable (the source should be stated); • use short sentences and paragraphs but give enough detail to be understandable; • do not use unnecessary words; • do not use abbreviations; • give attention to the technical detail of a document; • use scientific language and terminology in a professional document or when writing to another professional person or medical professional; • order information logically and systematically by means of providing headings and subheadings and utilising the decimal system for numbering the headings and subheadings; • proofread all documentation carefully; • write in the third person for example "the writer" or "the researcher" and not "I"; • always be polite and tactful; • do not generalise by using "sometimes, all" but use objective data to support statements; • use the correct punctuation and capitalisation and • avoid quantifiers like "very, little".

• To focus on and practice effective verbal communication skills	• avoid stumbling blocks in verbal communication such as: • unclear/double/vague messages; • quick thought processes (thinking on behalf of the other person); • language problems (not understanding the person's language) and • external environment disturbances (noise; interruptions). • analyse and improve on the quality of your voice: • talk loud enough but do not shout; • talk with enthusiasm and conviction; • avoid mannerisms like "um; ok; you know"; • control the tempo of your speech and pronounce words clearly and correctly; • maintain eye contact with the person or persons you are speaking to; • use pauses and silences effectively while speaking and • if presenting a paper or addressing a group of followers, prepare well in advance.
• To focus on and practice effective reading skills	• skimming - quick review of a source to gain an overview of the content; • comprehending - read the entire source carefully to understand the major concepts and the logical flow of ideas; • analyse - dividing the content into parts to be examined in-depth and • synthesis - cluster ideas together to form a new meaningful whole.

Behaviours	Strategies
(d) Vision	
• To create the vision in the nursing unit	• use an open participative two-way process between the leader and the followers; • state a clear, concise, logical and meaningful vision by including workable solutions to significant problems and emphasising priorities and common goals; • encapsulate the individual's and the nursing unit's aspirations, expectations, intentions and opinions; • create sufficient purpose to the followers to rise above self-interest and work together as a team and • demonstrate trust and sensitivity.
• To explain the vision in the nursing unit	• communicate the vision clearly and consistently when interacting with individuals and/or groups within the nursing unit; • express the vision in meaningful ways by explaining it so that it becomes clear and understandable and • use written and/or verbal format to explain the vision.
• To implement the vision in the nursing unit	• hand a copy and explanation of the vision to each follower; • encourage support and commitment to the vision and • integrate the vision into every aspect of the day-to-day nursing unit management.

Behaviours	Strategies
(e) Empowerment • To establish and maintain empowerment of the leader and followers	• display self-empowerment by demonstrating self-comfort and self-management; • invest power in and share power with the followers by utilising participative management and by delegating responsibility and authority to the followers to decentralise decision-making; • enhance a feeling of self-efficiency by limiting aspects and conditions which foster powerlessness; • create an environment in the nursing unit where the followers can utilise their unique knowledge, skill, experience and creativity to the fullest; • strive to eliminate the barriers to empowerment by redirecting and redesigning goals, roles and management systems in the nursing unit; • focus on the individual needs of the follower and encourage self-responsibility by altering self-limiting beliefs; • create a paradigm shift by moving from nursing unit domination to personal participation and partnership; • develop a shared vision; • educate followers on this shared vision and the purpose ("why") of the nursing unit; • demonstrate commitment to empowerment ("walk the talk"); • monitor progress and evaluate the results of empowerment; • encourage open communication system; • provide autonomy from bureaucratic restraint; • set goals that are meaningful and inspirational to the followers; • encourage self-expression and self-growth by the followers; • encourage integrity from and respect to all individuals; • implement shared governance; • revise or reaffirm or redefine existing values in the nursing unit in participation with the followers to enhance a feeling of commitment and • display an openness, honesty and excitement regarding empowerment.

(c) Generality

Generality of a theory refer to its breath of scope, which is reflected by the scope of the concepts and purposes within the theory. The following comments were made.

Two participants stated that the assumptions of the model (Judeo-Christian) philosophy may sometimes cause problems or hinder nursing when the Judeo-Christian philosophy is not compatible with the world view of the practising leader. This feedback was reflected by the following statements:
"The assumptions of the theory (Judeo-Christian philisophy) - might hinder nursing."
"Jy mag moontlik probleme ervaar wanneer die Christelike filosofie bevraagteken word." (Direct translation: "You may encounter possible problems when the Christian philosophy is questioned.")

Two of the experts commented that the described model is aimed at nursing management specifically but it will be possible to generalise this model to a wider context after a few changes. This is reflected by the following: "Kan veralgemeen word en wyer benut word as slegs binne 'n verpleegeenheid mits aanpassings gemaak word binne die tyd-ruimtelike waarde-konteks van die situasie." (Direct translation: "Can be generalised and used wider than just within the nursing unit if changes were made within the time and value context of the situation.")

"Could be used more generally in any work team or organisation."

(d) Accessibility

All the experts commented that the model is accessible to leaders in nursing units as reflected as follows: "Yes, any leader can use the model."

The aim of the model was to describe transformational leadership by the nursing unit managers. One expert state specifically: "Die navorser bereik haar doel binne eenheidsbestuur." (Direct translation: "The researcher reaches her aim within nursing unit management.")

(e) Importance

Importance of the theory addresses the extent to which the theory leads to valued nursing goals in practice, research and education. The experts all stated that the theory is very important and can make a valuable contribution towards nursing practice, nursing research and nursing education. The following were comments from the experts:

"Die model kan 'n besondere bydrae tot verpleegbestuur in Suid Afrika wees danksy die goed geberedeneerde wyse waarop daar aan teoretiese, operasionele en inferensiële geldigheid voldoen is.

(Direct translation: "The model can make an important contribution toward nursing management in South Africa because of the well reasoned manner in which the theoretical, operational and inferential reliability was fulfilled.")

"Die studie (model) is betekenisvol en relevant vir verpleging en lewer 'n betekenisvolle bydrae tot verpleegbestuur." (Direct translation: "The study (model) is meaningful and relevant to nursing and can make a meaningful contribution to nursing management.")

"This model can improve the standard of nursing."

"The use of this model will help to solve problems."

"Your model will contribute to nursing management's body of knowledge."

"Your model is valuable as it provides behaviours with specific and concrete supportive strategies which the leader can implement to bring about the transformation which nursing and the community needs."

An evaluated, validated and refined version of the model is displayed by figure 6.21.

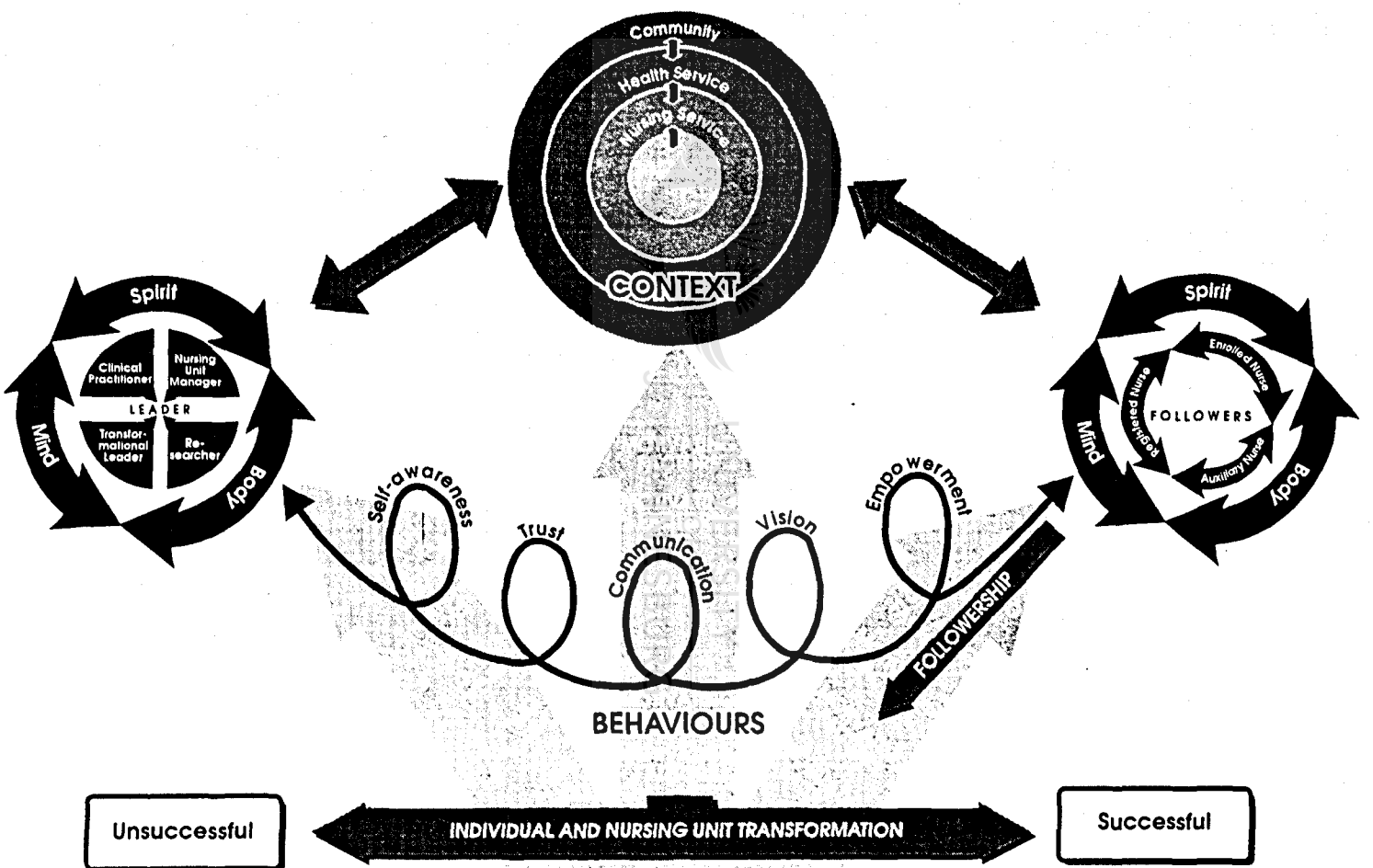


Figure 6.21: A model for transformational leadership by nursing unit managers

6.6. CONCLUSION

In this chapter the outcomes from the implementation of the model through the qualitative, descriptive case study are analysed in general and also specific for each nursing unit.

The model was evaluated through different research methods namely, feedback during the education programme (n=6); narrative sketches by leaders (n=4); cross case analysis from the case study in nursing units (n=4) and by a panel of experts (n=8). The overall feedback from the majority of the participants was that the model for transformational leadership is a comprehensive, good, stimulating and implementable model which encourages growth by leaders and followers. It was also indicated that although empowerment seems to be a new concept to some of the followers, the model in its entirety is not new or strange. Participants stated that external factors such as personnel changes, a high workload and resistance to change impacts on change. However, it is a model which provides a valuable learning opportunity to leaders and followers.

The majority of the members from the panel of experts stated that the model complied with the criteria for clarity, simplicity, generality and accessibility. Refinement and changes suggested by the members from the panel of experts were implemented. It was evident from the feedback that all the participants regarded the model as important to nursing and nursing management.

In chapter seven the evaluation of the study, recommendations for nursing unit management, nursing education and nursing research as well as final conclusions are elucidated.

CHAPTER 7

EVALUATION OF THE STUDY, CONCLUSIONS AND RECOMMENDATIONS

7.1 INTRODUCTION

It is evident that dramatic transformation is needed in the new South Africa. The RDP advocates major transformation of aspects such as meeting basic needs, developing human resources, building the economy and democratising the state and society. The National Health System (NHS) followed, which provided specific suggestions for health care in South Africa. All of these aspects necessitated major transformation in the health and the nursing service. Political, economic, social, technological and staff management changes impact on nursing management and nursing practice and therefore necessitate transformation.

Transformational leadership is needed and, as a model for transformational leadership in nursing could not be found - there was a need to develop such a model.

7.2 EVALUATION OF THE STUDY

In this study the overall aim was to describe a model, with guidelines for implementation, for transformational leadership by nursing unit managers to facilitate individual and nursing unit management.

To achieve the overall aim, objectives were formulated to:

- explore and describe a conceptual framework and a model for transformational leadership by nursing unit managers;
- operationalise this model in three steps, namely to:
  - * explore and describe an education programme for transformational leadership;
  - * implement the education programme in a nursing service and
  - * evaluate, validate and refine the described model and guidelines for implementation.

The concepts for the conceptual framework were identified through the survey list by Dickoff, et al. (1968:420) and a conceptual framework was described by means of analysis, synthesis, derivation and deductive reasoning. This conceptual framework was explored and described within the metatheoretical and theoretical assumptions of the Nursing for the Whole Person Theory.

Thereafter, a practice theory model for transformational leadership was derived from the conceptual framework by means of deductive reasoning. With regards to the methodological assumptions for this study, a functional reasoning approach as proposed by the Nursing Research model of Botes (1995) was utilised. Therefore, guidelines for the implementation of this model were also formulated. These guidelines were implemented as the strategies to support the behaviours of transformational leadership by nursing unit managers. In this model the structure and process of transformational leadership by nursing unit managers were described around the main concepts of transformational leadership, leader, followers, nursing unit as the context, the goal of transformational leadership, motivating forces, and the behaviours of transformational leadership (self-awareness, trust, communication, vision and empowerment).

After the description of the model, an education programme (based on the conceptual framework, model and principles of adult learning and the constructivistic learning theory) was developed and presented to nursing unit managers (n=12) in a private hospital.

A purposive sample of four nursing units was selected and the model implemented for a period of 12-14 weeks during which the model and guidelines were evaluated, validated and refined through a qualitative, descriptive case study. The model was also evaluated, validated and refined by a panel (n=8) of experts (as described in chapter two) according to the criteria of Chinn and Kramer (1991:138-139). The central theoretical statement was stated as follows: successful transformational leadership facilitates individual and nursing unit transformation or change. This central theoretical statement was supported by the case study evidence. Individual transformation was evident from the outcomes obtained from the questionnaires to the leaders and the followers (see figures 6.16; 6.17). The nursing unit transformation was evident from the nursing audit outcomes (see figure 6.18). It is therefore evident that transformational leadership facilitates individual and nursing unit transformation. It was also supported by the feedback from the narrative sketches of the leaders.

This study is unique as it is the first model for transformational leadership described within the context of nursing. In this model, leadership is not based on a list of characteristics of the leader, but on an ongoing process of behaviours (with supportive strategies) by the leader. This model is needed in the current situation in nursing where transformation is urgently needed and demanded.

The value of this model (and guidelines for implementation) is that it was implemented and evaluated, validated and refined in the practical setting of nursing units (n=4). During this implementation period it was evident that the model (and guidelines) can be effectively implemented by the nursing unit managers in the nursing units.

7.3 RESEARCH METHOD

The research method for this study is summarised in table 7.1.

Table 7.1: Research methods

Aim	Method	Strategy
Phase I: Model development		
- Explore and describe a conceptual framework and model for transformational leadership	- Theory generation • Survey list of Dickoff, et al. (1968:420) • Three-step method of Wandelt and Stewart (1975:64-69) • Definitions according to criteria by Copi and Cohen (1990:151-154) - Model development • Structure and process description	- Analysis, synthesis, derivation, deductive reasoning
Phase 2: Implementation of model		
- Explore and describe an education programme	- Theoretical development • Content of the conceptual framework and model - Didactical development • Principles of adult education Knowles (1984), Gravett (1991) • Constructivistic learning theory Klopper (1994 (c))	- Analysis, synthesis, derivation, deductive reasoning
- Evaluate, validate and refine described model	- Case study	
• explore and describe individual transformation of leaders	• Questionnaires to leaders and followers before and 12-14 weeks after the implementation of the model	- Quantification of outcomes - Presented as percentages through a bar graph - Validation by external researcher
• explore and describe nursing unit transformation	• Nursing audit through a nursing audit instrument	- Quantification of outcomes - Presented as percentages through a bar graph - Validation by external researcher
• explore and describe experience of leaders on transformational leadership	• Narrative sketches	- Content analysis according to Tesch (1991) - Description of outcome - Validation by external researcher
• collect data on the setting, interactions, participants, activities	• Direct observation by researcher	- Field notes as part of audit trail - Analysis, synthesis, inductive reasoning
• collect data on the implementation of the model	• Unstructured interviews (contact sessions) with leaders by researcher	- Field notes as part of audit trail - Analysis, synthesis, inductive reasoning
• collect data on the structure and process description of model	- Evaluation and validation of model • Model development experts (n=2) • Nursing service managers (n=2) • Nursing unit managers (n=4)	- Criteria by Chinn and Kramer (1991:138-139)

7.4 CONCLUSIONS

A conceptual framework and model, with guidelines for operationalisation, for transformational leadership were explored and described. Thereafter an education programme for transformational leadership was explored, described and implemented in a nursing service. Lastly, the model with guidelines was implemented in four nursing units.

It was clear from the evidence, the case study and the feedback from the leaders and the followers, that the implementation of transformational leadership by nursing unit managers facilitated individual and nursing unit transformation. It can therefore be concluded that the described model with guidelines should make a meaningful contribution to individual and nursing unit transformation.

The purpose of this study was not to test hypotheses. However, the following hypotheses were derived from the outcomes of the study:

- the implementation of the model for transformational leadership facilitates individual, personal and professional transformation of the leaders as well as the followers;
- the implementation of transformational leadership facilitates nursing unit transformation leading to improved quality nursing care and
- the implementation of transformational leadership facilitates quality nursing unit management.

The above-mentioned hypotheses should be tested however, and then be utilised as standards of care.

The individual transformation of the leaders was indicated by the outcome from the questionnaires (see figures 6.16; 6.17) to the leaders and the followers. The nursing unit transformation was indicated by the outcome from the nursing audit in each of the four nursing units (see figure 6.18).

7.5. RECOMMENDATIONS

7.5.1. Nursing unit management

The following recommendations are made regarding nursing unit management.

- The model should be presented as part of an inservice education programme to all nursing unit managers prior to implementation of the model in the nursing units. The education programme described for this study should be utilised for this purpose.
- The model for transformational leadership should be implemented in all nursing units to facilitate individual and nursing unit transformation.
- Transformation is advocated by the RDP in all areas of the health delivery service. It is recommended that this model be implemented to facilitate the required transformation.

7.5.2. Nursing education

The following recommendations are made regarding nursing education.

- This model should be promoted by means of publication in journals, presentations at symposia and conferences and refresher courses to already qualified nursing unit and nursing service managers.
- The model should also be promoted to nursing educators to empower them to teach this model.
- The model for transformational leadership should form part of the curriculum of the comprehensive four-year course for basic nursing students. It should also be included in all post-basic nursing courses for example courses for nursing educators and nursing managers. (This model should form part of the content of nursing unit management and leadership).

7.5.3. Nursing research

The following recommendations are made regarding further research.

- This qualitative, descriptive case study only included four nursing units in a private hospital. This model should be evaluated, validated and refined further through extensive qualitative, descriptive, case studies to provide more supporting evidence. More nursing units in a variety of settings should be included.
- The instruments developed or utilised during this study (questionnaires, and a nursing audit instrument) should be subjected to the determination of statistical validity and reliability.
- An instrument, with specific empirical indicators, should also be developed to identify and measure quality nursing unit management.
- During the exploration and description of the model, theoretical statements were generated from the conceptual framework by means of deductive reasoning. Each of these theoretical statements can also be regarded as an hypothesis and be tested.
- The hypotheses stated earlier in this chapter should be tested through further research.
- This is a practice theory model designed specifically for transformational leadership by nursing unit managers, but the transferability of this model should be tested for other nursing disciplines (such as nursing education) and also for other health-related disciplines.

7.6 CONCLUDING STATEMENTS

In this final chapter, the study was evaluated, conclusions and recommendations were made for nursing unit management, nursing education and nursing research.

The overall aim of this study was to describe a model, with guidelines for implementation, for transformational leadership by nursing unit managers to facilitate individual and nursing unit transformation. This aim was attained in this study. The described model (with guidelines) was also implemented and thereafter evaluated, validated and refined in four nursing units through a qualitative, descriptive case study and a panel of experts. The central theoretical statement for this study was also supported.

The outcomes of the case study and the evaluation by the panel of experts proved conclusively to the researcher that this model is functional and implementable.

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ANNEXURE A

OVERVIEW

TOPIC: TRANSFORMATIONAL LEADERSHIP BY NURSING UNIT MANAGERS

INSTITUTION: RAND AFRIKAANS UNIVERSITY

RESEARCHER: MARITA NAUDÉ

B.Cur; Diploma advanced nursing;
M.Cur (cum laude)
Registered nurse, midwife, psychiatric nurse,
community nurse, nursing educator, nursing manager

Telephone: 012-529-4774 (office)
012-529-4664 (leave a message)
011-457-1111 code 664 (pager)

STUDY LEADER: PROF ME MULLER

AIM OF STUDY:

The overall aim of this study is to describe a model, and guidelines for implementation of this model, for transformational leadership by nursing unit managers to facilitate individual and nursing unit transformation or change.

To achieve this overall purpose the following objectives are formulated:

- to explore and describe a conceptual framework and a model for transformational leadership by nursing unit managers;
- to operationalise the model in three steps, namely:
  - * explore and describe an education programme for transformational leadership by nursing unit managers;
  - * implement this education programme in a nursing unit and
  - * evaluate, validate and refine the described model and guidelines.

EDUCATION PROGRAMME

AIM OF THIS PROGRAMME

The overall aim of this programme is to:

- develop transformational leadership in nursing unit managers to empower them to practice transformational leadership to facilitate individual and nursing unit transformation.

DURATION, SCHEDULING AND PRESENTATION OF THE PROGRAMME

The education programme is presented in three sessions. A specific date for each session is selected in collaboration with the nursing service managers and the nursing unit managers involved. The programme is presented and evaluated by the researcher.

EVALUATION

The acquisition of knowledge and skills are evaluated on a continuous basis through interaction and feedback between the participants and the researcher.

STRUCTURE AND CONTENT OF THE PROGRAMME

The programme is presented by means of introductory lectures by the researcher, small-group discussions and individual self-study sessions. The research acts as a facilitator in all the sessions. A study guide (divided into modules) is used as a teaching aid. All study material is supplied by the researcher. The content of the programme is listed in table 1.

Table 1: Content for studyguide

Module	Topic
Module 1	Model for transformational leadership
Module 2	Self-awareness
Module 3	Trust
Module 4	Communication
Module 5	Vision
Module 6	Empowerment

IMPLEMENTATION OF TRANSFORMATIONAL LEADERSHIP

Selection of nursing units

Four nursing units are selected for the implementation of transformational leadership. These nursing units are selected in collaboration with the nursing service managers and according to pre-formulated criteria.

Implementation

The behaviours and strategies of transformational leadership (as learned through the education programme) are implemented in the selected nursing units by the nursing unit managers over a period of 12-14 weeks. The researcher acts as a facilitator and mentor to provide guidance and support to the nursing unit managers as transformational leaders.

The evaluation of transformational leadership is done according to a qualitative, descriptive case study strategy by means of questionnaires, narrative sketches, a nursing audit instrument, direct observation and unstructured interviews.

ANNEXURE B

CONSENT FROM PARTICIPANTS

Dear participant

I am conducting a research study to comply with the requirements for the D.Cur degree from the Rand Afrikaans University. I need your participation as the aim of this study is to develop a model for transformational leadership by the nursing unit manager. Your input is therefore of the utmost importance.

Your participation includes the following aspects:

- attending an educational programme for transformational leadership. This involves three lectures / discussion group sessions;
- implementing the knowledge on transformational leadership that you have gained in the education programme in your nursing unit;
- evaluating the change in your nursing unit by means of questionnaires, nursing audit tools and narrative sketches after a period of 12-14 weeks of implementation and
- participating in unstructured interviews.

Your anonymity is guaranteed as neither your name, or that of your nursing unit or institution are mentioned anywhere and all raw material is destroyed after validation by an external consultant and after completion of the study.

You receive no remuneration for participation in this study, but I believe that your participation will be of value to you and your nursing unit.

Your participation is voluntary.

The researcher acts as a mentor and facilitator to provide support and clarification. I can be contacted at the following telephone numbers:

(012) 529-4774 (office)
(012) 529-4664 (leave a message)
(011) 457-1111 (paging code 664)

Thank you

Marita Naudé (ms)

CONSENT

I _____ agree to participate in the study and understand the above-mentioned information.

_____ _____

Participant's signature **Researcher's signature**

_____

Date

TOESTEMMING VANAF DIE DEELNEMERS

Geagte deelnemer

Ek is tans besig met 'n navorsing studie om te voldoen aan die vereistes vir die D.Cur graad aan die Randse Afrikaanse Universiteit. Ek benodig u deelname aangesien die doel is om 'n model vir omvormingsleierskap deur die verpleegseenheidsbestuurder te beskryf. U bydrae is dus van die uiterste belang.

U deelname behels die volgende :

- bywoning van 'n onderrigprogram vir omvormingsleierskap deur die verpleegseenheidsbestuurder. Hierdie kursus word in drie sessies aangebied;
- implementering van die kennis oor omvormingsleierskap wat u gedurende die onderrigprogram verkry het in u verpleegeenheid;
- evaluering van die verandering in u verpleegeenheid deur middel van vraelyste, verpleegauditering instrumente en spontane sketse. Evaluering vind plaas na 12-14 weke vanaf die datum van implementering en
- deelneming aan ongestruktureerde onderhoude.

U anonomiteit word gewaarborg aangesien u naam, of die naam van die verpleegeenheid of die instansie nie gemeld word nie. Alle rou data word ook vernietig na analise en verfikasie deur 'n eksterne kodeerder en na voltooiing van die studie.

U ontvang geen vergoeding vir deelname aan hierdie projek nie, maar ek glo dat u deelname vir u en die verpleegeenheid van waarde sal wees.

U deelname aan die projek is vrywillig.

Die navorser tree as mentor en fasiliteerder op om ondersteuning en uitklaring te verleen en kan by die volgende telefoonnommers gekontak word:

(012) 529-4774 (kantoor)
(012) 529-4664 (laat 'n boodskap)
(011) 457-1111 (roepstel kode 664)

Baie dankie

Marita Naudé (me)

TOESTEMMING

Ek _____ stem in tot deelname aan die studie en verstaan die bovermelde inligting.

_____ _____

Deelnemer se handtekening **Navorser se handtekening**

_____

Datum

ANNEXURE C

LEARNING PACKAGE

TRANSFORMATIONAL LEADERSHIP BY NURSING

UNIT MANAGERS

Compiled by: Marita Naudé

January 1994

INTRODUCTION

Welcome to the education programme for transformational leadership by nursing unit managers. In this learning package an overview of the proposed model is given. The specific behaviours and strategies to be implemented by the nursing unit manager (as transformational leader) are discussed in detail.

This learning package is divided into modules with learning objectives, practical exercises and references to be utilised. All lecture material is supplied by the researcher. Lecture material is presented by means of introductory lectures, small-group discussions and practical exercises. The acquisition of knowledge and skills is evaluated on a continuous basis through interaction and feedback between the participant and the researcher.

Aim of this education programme

The overall aim of this programme is to:

- develop transformational leadership in nursing unit managers to enable the nursing unit manager to practice transformational leadership in the nursing unit to facilitate individual and nursing unit transformation.

MODULE 1: MODEL FOR TRANSFORMATIONAL LEADERSHIP BY NURSING UNIT MANAGERS

Learning objectives

1. Define the following concepts:
   - 1.1 leader
   - 1.2 leadership
   - 1.3 transformational leadership
   - 1.4 follower
   - 1.5 followership
   - 1.6 behaviour
   - 1.7 strategy

2. Discuss the model for transformational leadership by nursing unit managers

References

1. Articles related to leadership
2. Lecture material

MODULE 2: SELF-AWARENESS

Learning objectives

1. Define "self-awareness"
2. Discuss the strategies that the nursing unit manager should implement to develop her own self-awareness
3. Participate in the individual and/or group exercises as provided

Exercises

1. Write down 10 of your positive characteristics
2. Air balloon exercise

References

1. Lecture material

MODULE 3: TRUST

Learning objectives

1. Define the concept "trust"
2. Discuss the strategies that the nursing unit manager should implement to enhance trust
3. Participate in the individual/group exercises

Exercises

1. Blindfold leading

References

1. Lecture material

MODULE 4: COMMUNICATION

Learning objectives

1. Define "communication"
2. Discuss the communication process
3. Discuss the stumbling blocks in communication.
4. Discuss how the nursing unit manager can overcome these stumbling blocks
5. Discuss the strategies that the leader can utilise for effective verbal communication
6. Describe the strategies for written communication
7. Differentiate between:
   - 7.1 selective listening
   - 7.2 empathetic listening
8. Discuss the strategies for effective listening
9. Discuss the strategies for effective reading
10. Participate in the individual/group exercises

Exercises for:

1. Perception
2. Verbal communication
3. Non-verbal communication
4. Listening

References

1. Articles related to communication
2. Lecture material

MODULE 5: VISION

Learning objectives

1. Define "vision"
2. Discuss the purpose of the vision
3. Discuss the strategies that the nursing unit manager should implement to create, explain and implement the vision
4. Participate in the individual/group exercises provided

Exercises

1. Formulate your own personal vision
2. Formulate a vision for your nursing unit

References

1. Examples of mission statements
2. Articles related to mission statements and philosophies
3. Lecture material

MODULE 6: EMPOWERMENT

Learning objectives

1. Define "empowerment"
2. Describe the empowerment process
3. Discuss the strategies that the nursing unit manager should implement to encourage empowerment
4. Participate in the individual/group exercises

Exercises

1. Moon landing

References

1. Articles related to empowerment
2. Lecture material

ANNEXURE D

QUESTIONNAIRE TO LEADERS

Dear Participant

The aim of this questionnaire is to determine to which degree you as a leader utilise the strategies for the desired behavious of transformational leadership.

INSTRUCTIONS

1. Please complete the included questionnaire by making a X in the applicable column. Answer all questions.

2. Be open, honest and objectives in your answers as your answers determine the results of this study and also the recommendations resulting from this study.

3. Your anonymity is guaranteed as your name and the name of the nursing unit/institution appears nowhere on the questionnaire.

4. The results of this study should be available towards the end of 1995.

5. The following scale applies throughout:
   - 4: Always
   - 3: Mostly
   - 2: Often
   - 1: Never

Thank you very much for your valuable input into this study. It is really appreciated.

Marita Naudé

STRATEGIES FOR INCREASED SELF-AWARENESS

Please indicate the degree to which you as a person:

	4	3	2	1	OFFICE
1. acknowledges your own strengths and limitations					
2. accepts the limitations or change the behaviours that support these limitations.					
3. is aware of your own identity, acts, feelings and motives					
4. gains knowledge on your body and physical potential					
5. acknowledges your spiritual needs					
6. acknowledges your inter-actions with the followers and the external environment (nursing unit)					
7. listens to yourself by allowing yourself to experience genuine emotions.					
8. listens to and learn from others by active listening and openness to the feedback from other people.					
9. exercises self-disclosure by revealing/sharing perpectives with other.					
10. enlarges your experiences by engaging in unfamiliar/new activities.					
11. develops a commitment to continual personal and professional learning and development.					

STRATEGIES FOR BUILDING TRUST

Please indicate the degree to which you as a person/leader.

	4	3	2	1	OFFICE
1. is reliable					
2. is consistant					
3. is honest/always tell truth					
4. sets high personal and professional standards					
5. acknowledges the followers' knowledge, skill and experience					
6. gives honest feedback to followers in a sensitive manner					
7. acknowledges and value effort from the followers					
8. keeps your commitments					
9. encourages new projects / risk taking					
10. is kind					
11. encourages creativity					
12. clarifies expectations					
13. apologises for mistakes					
14. is personally and professionally accountable					
15. demonstrates commitment to the followers and the nursing unit					
16. spends time with the followers to build contact					
17. keeps personal information of any follower confidential					
18. respects each follower as an individual.					
19. creates an environment of caring					

EFFECTIVE COMMUNICATION

Please indicate the degree to which you as a leader.

EFFECTIVE LISTENING	4	3	2	1	OFFICE
1. avoids false listening / selective listening					
2. limits external disturbances such as noise, distrubances					
3. listens in a non-judgemental manner					
4. establishes good rapport					
5. uses empathy					
6. clarifies unclear messages through asking questions and verifying facts					
7. is patient and allows enough time to the follower to express words and feelings					
8. keeps cool and calm					
9. is alert and attentive by showing interest in the person who is speaking and in the subject that is addressed					
10. regularly summarises what you are hearing and clarifies the content with the follower.					
EFFECTIVE VERBAL COMMUNICATION	4	3	2	1	OFFICE
11. avoids stumbling blocks in verbal communication like: - unclear/double/vague messages					
12. - quick thought processes (thinking on behalf of the other person)					
EFFECTIVE VERBAL COMMUNICATION	4	3	2	1	OFFICE
13. analyses and improve on the quality your voice: - talks loud enough but does not shout					
14. - talks with enthusiasm					
15. - pronounces words clearly and correctly					
16. avoids mannerisms like: "um; ok; you know."					

17. controls the tempo of your speech					
18. maintains eye contact with the person you are speaking to					
19. uses pauses effectively while speaking					
20. uses silences effectively					
EFFECTIVE VERBAL COMMUNICATION When writing documents (memoranda, reports) I implement the following strategies:	4	3	2	1	OFFICE
21. all the facts, statistics and statements should be accurate					
22. when using quotations, they should be accurate and applicable					
23. use short sentences and paragraphs but give enough detail to be understandable					
24. do not use abbreviations					
25. give attention to the technical detail of a document					
26. am exact with statistical data for example 25,7% and not more or less than 25%					
27. order information logically and systemactically					
28. proofread all documentation					
EFFECTIVE WRITTEN COMMUNICATION When writing documents (memoranda, reports) I implement the following strategies:	4	3	2	1	OFFICE
29.. write in the third person for example "the writer/the researcher" and not "I"					
30. use scientific language/medical terminology when writing to another professional person or medical professional					
31. am polite and tactful					
32. do not generalise by using "sometimes, all" but use objective data to support statements					
EFFECTIVE READING When reading a document I use the following strategies:	4	3	2	1	OFFICE
33. skimming - quick review of a source to gain an overview of the content					

34. comprehending-read the entire source carefully to understand the major concepts and the logical flow of ideas					
35. analysis - dividing the content into parts to be examined in-depth					
36. synthesis - cluster idea together to form a new meaningful whole					

DEVELOPING THE VISION FOR THE NURSING UNIT

To develop the vision for the nursing unit, I:

	4	3	2	1	OFFICE
1. use an interactive process between the leader and the follower					
2. create a vision that is clear and concise					
3. include workable solutions to significant problems					
4. emphasise priorities and common goals					
5. include the individual's and the nursing unit's aspirations					
6. create sufficient purpose to the follower to rise above self-interest and work wogether as a team					
7. explain vision so that it becomes clear and understable					
8. use written/verbal format to explain the vision					
9. encourage support and commitment to the vision					
10. integrate the vision into every aspect of the nursing unit management					

EMPOWERMENT

For empowerment I implement the following strategies:

	4	3	2	1	OFFICE
1. as self-empowered					
2. invest power in and shares power with the followers by utilising participative management					
3. delegate responsibilities to the followers					
4. decentralise decision-making					
5. enhance feeling of self-efficiency					
6. develop motivated and competent followers who use authority and responsibility					
7. create an environment where the followers can utilise their unique knowledge, skill, experience and creativity to the fullest					
8. focus on the individual needs of the follower and encourage self-responsibility by altering self-limiting beliefs					
9. create a paradigm shift by moving from nursing unit domination to personal participation and partnership					
10. develop a shared vision					
11. educate followers on this shared vision and the purpose ("why") of the nursing unit					
12. demonstrate commitment to empowerment ("walk the talk")					
13. encourage open communication systems					
14. set goals that are meaningful and inspirational to he followers					
15. encourage self-expression and self-growth					

ANNEXURE E

QUESTIONNAIRE TO FOLLOWERS

Dear Participant

The aim of this questionnaire is to determine to which degree your leader utilises the strategies for the desired behavious of transformational leadership.

INSTRUCTIONS

1. Please complete the included questionnaire by making a X in the applicable column. Answer all questions.

2. Be open, honest and objective in your answers as your answers determine the results of this study and also the recommendations resulting from this study.

3. Your anonymity is guaranteed as your name and the name of the nursing unit/institution appears nowhere on the questionnaire.

4. The results of this study should be available towards the end of 1995.

5. The following scale applies throughout:
   - 4: Always
   - 3: Mostly
   - 2: Often
   - 1: Never

Thank you very much for your valuable input into this study. It is really appreciated.

Marita Naudé

STRATEGIES FOR INCREASED SELF-AWARENESS

Please indicate the degree to which the leader in your nursing unit encourages you to:

	4	3	2	1	OFFICE
1. acknowledge your own strengths and limitations					
2. accept the limitations or change the behaviours that support these limitations.					
3. be aware and conscious of your own identity, acts, thoughts feelings and motives					
4. listen to and learn from others by active listening and openness to the feedback from other people					
5. exercise self-disclosure by revealing/sharing perpectives with other					
6. enlarge your experiences by engaging in unfamiliar/new activities					
7. develop a commitment to continual personal and professional learning and development.					

STRATEGIES FOR BUILDING TRUST

Please indicate the degree to which the leader in your nursing unit:

	4	3	2	1	OFFICE
1. is reliable					
2. is consistant					
3. is honest/always tell truth					
4. sets high personal and professional standards					
5. acknowledges the followers' knowledge, skill and experience					
6. gives honest feedback to followers in a sensitive manner					
7. acknowledges and value imput and effort from the followers					
8. keeps to your commitments					
9. encourages new projects / risk taking					
10. is kind					
11. encourages creativity					
12. attends to the little things					
13. clarifies expectations					
14. apologises for mistakes					
15. is personally and professionally accountable					
16. demonstrates commitment to the followers and the nursing unit					
17. spends time with the followers to build contact					
18. keeps personal information of any follower confidential					
19. respects each follower as an individual					
20. creates an environment of caring					

EFFECTIVE COMMUNICATION

Please indicate the degree to which the leader in your nursing unit:

EFFECTIVE LISTENING	4	3	2	1	OFFICE
1. avoids false listening / selective listening					
2. limits external disturbances such as noise, distrubances					
3. listens in a non-judgemental manner					
4. establishes good rapport					
5. uses empathy					
6. clarifies unclear messages through asking questions and verifying facts					
7. is patient and allows enough time to the follower to express words and feelings					
8. keeps cool and calm					
9. is alert and attentive by showing interest in the person who is speaking and in the subject that is addressed					
10. regularly summarises what you are hearing and clarifies the content with the follower.					
EFFECTIVE VERBAL COMMUNICATION	4	3	2	1	OFFICE
11. avoids stumbling blocks in verbal communication like: - unclear/double/vague messages					
12. - quick thought processes (thinking on behalf of the other person)					
13. analyses and improve on the quality your voice: - talks loud enough but does not shout					
14. - talks with enthusiasm					
15. - pronounces words clearly and correctly					
16. avoids mannerisms like: "um; ok; you know."					

17. controls the tempo of your speech					
18. maintain eye contact with the person you are speaking to					
19. uses pauses effectively while speaking					
EFFECTIVE WRITTEN COMMUNICATION When writing documents (memoranda, reports) the leader implements the following strategies:	4	3	2	1	OFFICE
20 all the facts, statistics and statements should be accurate					
21. when using quotations, they should be accurate and applicable					
22. use short sentences and paragraphs but give enough detail to be understandable					
23. do not use abbreviations					
24. give attention to the technical detail of a document					
25. is exact with statistical data for example 25,7% and not more or less than 25%					
26. orders information logically and systemactically					
27. proofread all documentation					
28. writes in the third person for example "the writer/the researcher" and not "I"					
29. use scientific language/medical terminology when writing to another professional person or medical professional					
30. is polite and tactful					
31. does not generalise by using "sometimes, all" but use objective data to support statements					

DEVELOPING THE VISION FOR THE NURSING UNIT

To develop the vision for the nursing unit, the leader in the nursing unit:

	4	3	2	1	OFFICE
1. interacts with the follower when creating the vision					
2. creates a vision that is clear and concise					
3. includes workable solutions to significant problems					
4. emphasises priorities and common goals					
5. includes the individual's and the nursing unit's aspirations					
6. createssufficient purpose to the follower to rise above self-interest and work together as a team					
7. explains vision so that it becomes clear and understable					
8. uses written/verbal format to explain the vision					
9. encourages support and commitment to the vision					
10. integrates the vision into every aspect of the nursing unit management					

EMPOWERMENT

For empowerment I implement the following strategies:

	4	3	2	1	OFFICE
1. is self-empowered					
2. invests power in and shares power with the followers by utilising participative management					
3. delegates responsibilities to the followers					
4. decentralises decision-making					
5. enhances feeling of self-efficiency					
6. develops motivated and competent followers who use authority and responsibility					
7. creates an environment where the followers can utilise their unique knowledge, skill, experience and creativity to the fullest					
8. focuses on the individual needs of the follower and encourage self-responsibility by altering self-limiting beliefs					
9. creates a paradigm shift by moving from nursing unit domination to personal participation and partnership					
10. develops a shared vision					
11. educates followers on this shared vision and the purpose ("why") of the nursing unit					
12. demonstrates commitment to empowerment ("walk the talk")					
13. encourages open communication systems					
14. sets goals that are meaningful and inspirational to he followers					
15. encourages self-expression and self-growth					

ANNEXURE F

PROTOCOL FOR DATA COLLECTION QUESTIONNAIRES TO LEADERS

(Data-collection is done by the researcher)

1. Allow the participants to gather in the prepared venue and to be seated comfortably.

2. Questionnaires before implementation of model:

   These questionnaires are coded (A,B,C, etcetera).

   Request the participants to select and fill in one questionnaire.

   The participant must remember his/her code as this code should again be used on the questionnaire to be filled in 12-14 weeks after the implementation of transformational leadership in the nursing unit.

   Questionnaires after implementation of model:

   These questionnaires are uncoded. Request the participant to write the same code that was written on the "before" questionnaire on this questionnaire.

3. Request the participants not to write their name, the name of their nursing unit or any identifying detail on the questionnaire.

4. Inform the participants that no discussion on the content of the questionnaire is allowed, as the researcher needs the unique and individual response from each participant.

5. Allow each participant to complete the questionnaires at their own pace.

6. Write down field notes on the prevailing circumstances during this data-collection session.

7. After completion, the participants place the questionnaires in a box.

8. After collection of all questionnaires, the researcher seals the box.

ANNEXURE G

PROTOCOL FOR DATA COLLECTION QUESTIONNAIRES T0 FOLLOWERS

(Data-collection is done by the leaders)

1. Please hand the enclosed questionnaires to ten of your followers. Please start with the most senior person.

2. Questionnaires before implementation of model:

   These questionnaires are coded. Ask each follower to select a questionnaire; complete it and seal it in the provided envelope and hand to the leader. Each follower should remember his/her code, as this code should be used on the questionnaire to be filled in 12-14 weeks after the implementation of the model in the unit.

   Questionnaires after implementation of model:

   These questionnaires are uncoded. Request the participant to write the same code that was written on the "before" questionnaire on this questionnaire.

3. Request the participant not to write his/her name, the name of his/her nursing unit or any identifying detail on the questionnaire.

4. Please keep a list of names of the participants. However, your list may not include the codes of participants.

5. Inform the participants that no discussion on the content of the questionnaire is allowed, as the researcher needs the unique and individual response from each participant.

6. Collect all the completed questionnaires and keep in a safe place. Please contact the researcher when all the completed questionnaire are collected.

ANNEXURE H

PROTOCOL FOR DATA ANALYSIS QUESTIONNAIRES

(Data-analysis is done by the researcher)

1. Open the sealed box/sealed envelopes.

2. Check each questionnaire for completeness.

3. Quantify the responses for each behaviour (self-awareness, trust, communication, vision, empowerment).

4. When a question is unanswered (left blank), ignore this question and change the total for this behaviour accordingly.

5. Determine the average for the whole questionnaire.

6. Reseal the questionnaires in the prepared envelopes (Nursing unit A, B, C, D).

7. Hand to the external coder.

ANNEXURE I

PROTOCOL FOR EXTERNAL CONTROLLER REGARDING THE QUESTIONNAIRES

1. Open the sealed envelopes.

2. Ignore the questionnaires marked: "Spoiled questionnaire." Work on the remaining questionnaires.

3. Check the quantification of the responses for each behaviour (self-awareness, trust, communication, vision, empowerment).

4. When a question is unanswered (left blank), ignore this question and change the total for this behaviour accordingly.

5. Determine the average for the whole questionnaire.

6. Reseal the questionnaires in the prepared envelopes (Nursing unit A, B, C, D).

7. Hand back to the researcher.

ANNEXURE J

PROTOCOL FOR DATA COLLECTION
NARRATIVE SKETCHES

(Data-collection is done by the researcher)

1. Allow the participants to gather in the pre-prepared venue and to be seated comfortably.

2. Hand a blank page and a pen to each participant.

3. Request the participants not to write their name, the name of their nursing unit or any identifying detail on the blank page.

4. Pose the following research question to the participants: "Please describe your experience on the implementation of transformational leadership in the nursing unit."

5. Inform the participants that no discussion on the research question is allowed, as the researcher needs the unique and individual response from each participant.

6. Allow each participant to complete the narrative sketch at his/her own pace.

7. Write down field notes on the prevailing circumstances during this data-collection session.

8. Collect the sketches as each participant completes it.

9. Place the completed sketches in the prepared envelope and seal.

10. Duplicate (photocopy) the narrative sketches, seal in the provided envelope and hand over to the independent coder.

ANNEXURE K

PROTOCOL FOR DATA ANALYSIS
NARRATIVE SKETCHES

(Data-analysis is done by the researcher and an independent, external coder.)

1. Open the sealed envelopes.

2. The analysis of the narrative sketches is based on guidelines/steps proposed by Tesch (1990) in Cresswell (1994:142-145).

3. The following steps are used:

   3.1 Read through all the narrative sketches to get a sense of the whole.

   3.2 Read through each narrative sketch carefully and concentrate on the topics/issues/thoughts/feelings mentioned by the participant. List these aspects on a separate page.

   3.3 Cluster similar aspects together in categories, trying to devise the minimum number of sensible categories.

   3.4 Assign codes to each category.

   3.5 Read through each narrative sketch and code the data according to the selected categories.

4. Reseal the narrative sketches in the prepared envelopes.

5. Attend the consensus discussion as according to the planned date.

ANNEXURE L

PROTOCOL FOR DATA COLLECTION
DIRECT OBSERVATION AND CONTACT SESSIONS

(Data-collection is done by the researcher)

1. Set a date (in interaction with the leader) for a contact session.

2. During the contact session:

   2.1 Collect data on the setting, participants, activities and interactions.

   2.2 Collect data on the implementation of the model.

   2.3 Work on the objectives, strategies and actions planned for the nursing unit.

3. Keep detailed field notes of the contact session.

4. Seal field notes and other material received in the prepared envelopes (Nursing unit A, B, C, D).

ANNEXURE M

PROTOCOL FOR DATA ANALYSIS DIRECT OBSERVATION AND CONTACT SESSIONS

(Data-analysis is done by the researcher)

1. Analyse the data for each nursing unit individually.

2. Analyse data as soon as possible after collection.

3. Open the sealed envelopes.

4. Read through the field notes and the written material received.

5. Cluster (group) similar aspects/ideas/thoughts together and analyse.

6. Support analysis with direct quotations from the field notes for example comments by the leader.

7. Reseal field notes and other material.

ANNEXURE N

PROTOCOL FOR NURSING AUDIT

These nursing audits are conducted by the nursing audit committee of this nursing service. The nursing audit committee consists of members including the following:

- two nursing service managers;
- one clinical lecturer and
- rotating nursing unit managers.

1. Select four to eight files from each nursing unit.

2. Read the whole document and identify stort-comings by comparing flowcharts, assessment charts and laboratory reports.

3. Assess the continuity of nursing care provided.

4. Assess legal aspects such as legible handwriting, signatures, dates and times of recorded information and the methods used to cancel incorrect entries in a patient's document.

5. Provide a written report as feedback to the specific nursing units.

GESONDHEIDSORG - PASIËNT DOKUMENTASIE : VERPLEEGAUDIT

DATUM	
HOSPITAAL	
PASIËNT NAAM	
PASIËNT NOMMER	
OPNAME DATUM	
SAAL	
AUDIT GEDOEN DEUR :	

METINGSINSTRUMENT					
V=	VOLLEDIG	2	O =	ONVOLLEDIG	1
A=	AFWESIG	0	NVT =	NIE VAN TOEPASSING	

FORMULE
% = AANTAL PUNTE X 100 TOTALE ITEMS 1 GEOUDIT X 2

AFDELING		
A: VERPLEEGBERAMING & DIAGNOSE	MOONTLIKE	PUNTE
B: VERPLEEGBEPLANNING & TUSSENTREDE		
C: VERPLEEGEVALUERING		
TOTAAL	=	%

A.	VERPLEEGBERAMING & DIAGNOSE	V 2	O 1	A 0	NVT
1.	VITALE INLIGTING				
1.1	Bio-grafiese				
1.2	Huistaal				
1.3	Dokter in kennis gestel en tyd				
1.4	Nood kommunikasie				
1.5	Opname diagnose				
1.6	Wyse van opname				
1.7	Normale daaglikse leefgewoontes voor huidige siekte				
1.8	Huidige leefsituasie/Gemeenskap steunstelsels				
1.9	Prostese				
1.10	Vorige/familie/huidige geskiedenis van belang				
1.11	Medikasie ingebring deur pasiënt				
1.12	Allergiee				
1.13	Huidige pasiënt probleme wat verpleegkundige bystand benodig				
1.14	Pasiënt onderrig afdeling: Spesifieke gesondheidsorg instruksies ter voorbereiding vir ontslag				
1.15	Pasiënt/ouer orientasie				
1.16	Identifikasie bande				
1.17	Hantering van waardevolle artikels/klere/vuurwapens				
1.18	Vitale tekens				
1.19	Gespesialiseerde/hoë risiko beraming (bv.veiligheid infeksies/immuun onderdrukte faktore/ander				
1.20	Urienanalise				

B.	VERPLEEGBEPLANNING EN TUSSENTREDE	V 2	O 1	A 0	NVT
1.	VERPLEEGBEPLANNING				
1.1	Toepaslike standaard plan(ne) geselekteer/sorgplan inisieer				
1.2	Probleme oorgedra vanaf beramingsinligting				
1.3	Standaard plan(ne) toepaslik aangepas				
1.4	Toepaslike probeem(e)/behoeftes gelys				
1.5	Verwagte uitkoms gedokumenteer				
1.6	Beplande verpleegtussentredes gestipuleer				
1.7	Spesifieke behandeling/prosedures				
1.8	Probleem(e)/behoeftes hanteer/opgelos gedokumenteer				
2.	VERPLEEGTUSSENTREDES				
2.1	Pasiënt vorderingsverslag korreleer metsorgplan				
2.2	Relevante/volledige verslagstaat				
2.3	Toepaslike vitale tekens gemonitor				
2.4	Toepaslike verpleegprosedures uitgevoer				
2.5	Bloed/bloedprodukte oortappings volledig gedokumenteer				
2.6	Toepaslike optrede op laboratorium uitslae				
2.7	Higiëne : Fisiese gemak en gerusstelling				
2.8	Voeding : Fasilitering en instandhouding				
2.9	Vloeistof balans: Elektroliete en suurbasis balans: toesighouding en instandhouding				
2.10	Uitskeiding : toesighouding en instandhouding				
2.11	Voorkoming van siekte : bevordering van gesondheid; onderrig; verwysing				
2.12	Fasilitering van liggaam meganisme: (ambulansie/posisionering)				
2.13	Instandhouding van vel en sensoriese funksies				
2.14	Fasilitering van kommunikasie				
2.15	Spesiale sorg: wonde, dreineringsbuise, suurstof ensovoorts				
2.16	Pyn kontrole				
2.17	Voorbereiding van diagnostiese prosedures/optrede				
2.18	Uitdeel van medikasie/behandeling voorgeskryf/reaksies gemonitor en gekaart/weiering van medikasie gedokumenteer				

ANNEXURE O

3.	PERI-OPERATIEWE VERPLEGING (CHIRURGIESE PASIËNTE ALLEENLIK)	V 2	O 1	A 0	NVT
3.1	Vorige siekte geskiedenis				
3.2	Mediese geskiedenis van familie				
3.3	Medikasie				
3.4	Chirurgiese rekords				
3.5	Ingeligte toestemming				
3.6	Identifikasie				
3.7	Pre-operatiewe voorbereiding/kontrolelys (Saal)				
3.8	Pre-operatiewe voorbereiding/kontrolelys (Teater)				
3.9	Vitale tekens gerekordeer				
3.10	Spesifieke voorbereiding				
3.11	Pre-medikasie toegedien				
3.12	Allergies gerekordeer				
3.13	Gesien deur narkotiseur				
3.14	Aard van operasie				
3.15	Chirurg(e)				
3.16	Duur van operasie				
3.17	Intra-operatiewe komplikasies				
3.18	Narkose/bloed/IV-vog/medikasie				
3.19	Velvoorbereiding				
3.20	Depper/naalde en instrumente telling				
3.21	Pak steriliteit				
3.22	Hegtings materiaal en finale verband				
3.23	Dreineringsbuise/prostese/inplantings				
3.24	Posisie, diatermie, toerniket				
3.25	X-strale				
3.26	Monsters				
3.27	Pasiënt ontslaan uit teater Herstelkamer				
3.28	Toepaslike vitale tekens/tyd van aankoms				
3.29	Lugweë				
3.30	Toestand van vel				
3.31	IV-terapie/medikasie				
3.32	Komplikasies				
3.33	Herstelkamer/tyd met ontslag/Handtekening(e) van verpleegpersoneel				
4.	KOÖRDINERING VAN VERPLEEGSORG				
4.1	Multi-professionele span besoeke gerekordeer				
4.2	Verslag reflekteer koördinering van pasiëntsorg				

5.	PASIËNTONTSLAG/OORPLASINGSDOKUMENT	V 2	O 1	A 0	NVT
5.1	Datum/tyd				
5.2	G/V magtiging				
5.3	Geneesheer magtiging/handtekening				
5.4	Finale mediese diagnose				
5.5	Opvolg afsprake/behandeling				
5.6	Familie in kennis gestel				
5.7	Vervoer gereël				
5.8	Na-ontslag medikasie/TTO's oorhandig en gebruik verduidelik				
5.9	Waardevolle artikels volgens direktief voorskrifte hanteer				
5.10	X-strale				
5.11	Pasiënt vergesel/nie vergesel na ontvang				
5.12	Spesifieke gesondheidsorg instruksies met ontslag				
5.13	Toestand met ontslag/oorplasing				
5.14	Interne hospitaaloorplasingsverslag				
5.15	Weier hospitaal behandeling (RHT)				
5.16	Dros verslag				
5.17	Afsterwe verslag voltooi				
5.18	Hoë risiko pasiënt oorhandig aan 'n verantwoordelike persoon				
5.19	Oorplasing na 'n ander hospitaal				

C.	VERPLEEGEVALUERING	V 2	O 1	A 0	NVT
1.	EVALUERING				
1.1	Verandering in toestand van pasiënt gerekordeer				
1.2	Uitkoms van behandeling/medikasie				
1.3	Verwagte uitkoms bereik				
1.4	Bewyse van kontinuiteit van *sorg*				
1.5	Bewyse van gesondheidsonderrig gegee				
1.6	Bewyse van vordering in verpleegplan				
2.	WETLIKE ASPEKTE				
2.1	Datums gerekordeer				
2.2	Tye				
2.3	Handtekeninge en range (verpleging) gerekordeer				
2.4	Inskrywings wettig				
2.5	Veranderinge (*wysigings*) geteken				
2.6	Afkortings nie gebruik nie				
2.7	Bladsye genommer				
2.8	Voorskrifte: Voldoen aan wetlike vereistes				

ANNEXURE P

CHAIN OF EVIDENCE

(The following instruments from all the participating nursing units are available from the researcher as the chain of evidence).

1. Signed consent from the participants.

2. Questionnaires of leaders.

3. Questionnaires of followers.

4. Nursing audit outcome and reports.

5. Feedback (written, statistics and graphs) from the leaders regarding the attainment of the formuled objectives.

6. The continuous feedback (verbal, written, faxed) from the leaders regarding the implementation of the model.

7. Feedback regarding the model from the leaders who attended the education programme

8. Evaluation of the model by the panel of experts.

10. Narrative sketches by the leaders.

ANNEXURE Q

TIMETABLE

The direct observation sessions and the unstructured interviews were conducted on the dates indicated by the following timetable.

Nursing Unit	Session 1	Session 2	Session 3	Session 4	Session 5	Session 6	Session 7
A	11/04	25/04	5/05	22/05	7/06	26/06	11/07
B	5/05	22/05	7/06	11/07	18/07	25/07	15/08
C	11/04	25/04	5/05	22/05	7/06	26/06	21/07
D	11/04	22/05	7/06	5/07	11/07	25/07	15/08