AN IDEAL LEADERSHIP STYLE FOR UNIT MANAGERS IN INTENSIVE CARE UNITS OF PRIVATE HEALTH CARE INSTITUTIONS

Mariana van der Heever

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of the requirements for

the degree of

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Supervisor: Mrs A Damons

Co-Supervisor: Dr EL Stellenberg **March 2009**

DECLARATION

By submitting this thesis electronically, I declare that the entirety of the work contained therein is my own, original work, that I am the owner of the copyright thereof (unless to the extent explicitly otherwise stated) and that I have not previously in its entirety or in part submitted it for obtaining any qualification.

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ABSTRACT

The work environment in critical care units in South Africa is hampered by a profound shortage of nurses, heavy workloads, conflict, high levels of stress, lack of motivation and dissatisfaction among the staff. The task of managing a C.C.U. has therefore become a challenge. It is important that unit managers apply a leadership style that matches these challenges. The aim of this study was to investigate the ideal style of leadership.

The objectives set for the study were to identify the ideal leadership style required in the following areas:

- administrative functions
- education functions
- patient care
- research

An explorative, descriptive research design was applied, with a quantitative approach to determine the ideal leadership style for unit managers in critical care units of private health care institutions. The research sample consisted of all nurses working permanently in eleven private hospitals in the Cape Metropolitan area. A questionnaire consisting of predominantly closed questions was used for the collection of data, which was collected by the researcher in person. Ethical approval was obtained from the Committee of Human Science Research at Stellenbosch University. Permission to conduct the research was obtained from the institutions and informed consent from the participants. A pilot study was conducted to test the questionnaire at a private hospital which did not form part of the study. A 10% sample of the relevant staff, namely 27 participants were involved in this study. The validity and reliability was assured through the pilot study and the use of a statistician as well as experts in nursing and a research methodologist.

Data was tabulated and presented in histograms and frequencies. Statistical significant associations were drawn between variables, using the Chi-square test.

The Spearman rank (rho) order correlation was used to show the strength of the relationship between two continuous variables.

Findings of the study show that participatory leadership style and transformational leadership approach were valued in all four (4) of the objectives. Emphasis was placed on consultation prior to any decisions. Nurses requested an opportunity to give feedback on a regular basis regarding the unit managers conduct (Chi-square test $p = 0.025$). They also agreed that unit

managers should apply the necessary rules and procedures (Chi-square test $p = 0.016$). A huge request was made for integrity, trust, impartiality, openness, approachability and particularly honesty. The nurses also maintained that the nurse manager's behaviour should be congruent.

Furthermore, the results indicate that nurses would like to be empowered by:

- being involved in the scheduling of off-duties
- taking the lead in climate meetings
- being granted opportunities (to all categories of nurses) to attend managerial meetings.

N = 41 (48.2%) of nurses admitted that unit managers would instruct them to cope with insufficient staffing pertaining to ventilated patients, putting them under severe strain and at risk legally.

N = 39 (47%) of nurses admitted that unit managers only consider qualifications and experience in the delegation of tasks if the workload in the unit justifies it. Safe patient care is not always a priority.

N = 99 (96%) of nurses agreed that autocratic behaviour relating to task delegation exists.

Recommendations included the application of transformational leadership and participatory management. The aim to create a healthier, more favourable work environment for critical care nurses will hopefully be attained through applying the ideal leadership style and leadership approach.

OPSOMMING

Die werksverrigtinge in kritieke sorgeenhede in Suid-Afrika word deur 'n ernstige tekort aan verpleegsters, hoë werklading, konflik, spanning, min motivering en baie ontevredenheid onder verpleeglui gekortwiek. Die leiding en bestuur van 'n kritieke sorgeenheid is dus nie 'n maklike taak nie. Dit is dus belangrik dat eenheidsbestuurders 'n leierskapstyl aan die dag lê wat dié uitdagings doeltreffend aanspreek. Die doel van die studie is dus om ondersoek in te stel na die wenslike leierskapstyl vir kritieke sorgeenhede.

Die doelwitte daargestel is dus om die ideale leierskapstyl in elk van die volgende funksies te bepaal:

- administrasie
- opleiding
- pasiënte-sorg
- navorsing

Die ideale leierskapstyl vir eenheidbestuurders in kritieke sorgeenhede in

privaathospitale is bepaal deur 'n kwantitatiewe benadering met 'n beskrywende ontwerp toe te pas. Die populasie het alle kritieke sorg verpleeglui (permanent werksaam by een van elf privaathospitale in die Kaapse Metropool) ingesluit.

Instrumentasie het 'n vraelys behels (met oorwegend geslote vrae) en data is persoonlik deur die navorser ingevorder. Etiese toestemming is vanaf die Etiese Komitee van die Mediese Fakulteit te Universiteit Stellenbosch verkry asook die hoofde van die verskillende privaathospitale waar navorsing plaasgevind het.

Ingeligte toestemming is ook van elkeen van die deelnemers verkry. Ten einde die vraelys te toets, is 'n loodstudie by 'n privaathospitaal (wat nie by die studie ingesluit was nie) gedoen. Die loodstudie het N = 27 (10%) van die totale populasie behels. Die betroubaarheid en geldigheid van die studie is deur die loodstudie, die gebruik van 'n statistikus, verpleegdeskundiges en die navorser-metodoloog versterk. Data is getabuleer en in histogramme en frekwensies voorgestel. Deur die Chi-square- toets te gebruik, is statisties betekenisvolle assosiasies tussen veranderlikes bepaal. Ten einde sterkte van verhoudings tussen twee opeenvolgende veranderlikes te bepaal, is die Spearman rangordekorrelasie (rho) aangewend.

Die bevindings van die studie het getoon dat 'n deelnemende bestuurstyl en transformasie-leierskapbenadering die mees aangewese keuse vir al vier doelwitte is. Die toepassing van

veral 'n deelnemende besluitnemingsproses het groot voorrang geniet, Verpleegkundiges wil daarbenewens ook op 'n gereelde basis geleentheid hê om terugvoering oor die leierskapgedrag van die eenheidsbestuurder te gee (Chi-square toets p = 0.025). Ook verlang die deelnemers dat eenheidsbestuurders nie reëls en regulasies moet verontagsaam nie (Chi-square toets p = 0.016). 'n Ernstige versoek is gerig ten opsigte van integriteit met pertinente verwysing na eerlikheid, vertroue, onpartydigheid, deursigtigheid, toeganklikheid en dat die leier se woorde en dade moet ooreenstem.

Die resultate het verder getoon dat verpleegsters graag bemagtig wil word deur:

- betrokkenheid in die skedulering van afdienste,
- leiding in klimaatsvergaderings te wil neem,
- geleentheid te hê om bestuurvergaderings by te woon (alle kategorieë van verpleegkundiges)..

N = 39 (48.2%) van verpleegkundiges het erken dat hulle gedwonge personeeltekorte ten opsigte van geventileerde pasiënte ervaar en dus aan mediese geregtelike risiko's en onnodige druk blootgestel word.

N 39 (47%) van verpleegkundiges het erken dat eenheidsbestuuders kwalifikasies en ondervinding slegs in ag neem indien die werklading in die eenheid dit toelaat..Veilige pasiëntesorg kry dus nie altyd voorkeur nie.

N = 99 (96%) van verpleegkundiges het erken dat outokratiese gedrag (wat met werkstoewysing verband hou) wel voorkom.

'n Transformasie leierskapsbenadering en deelnemende bestuurstyl is dus aanbeveel.

Die hoop word dus uitgespreek dat deur aan die verpleegkundiges se versoeke ten opsigte van die ideale bestuursbenadering en bestuurstyl te voldoen, die werksatmosfeer binne kritieke sorgeenhede toenemend gesonder en dus aangenamer sal word.

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CHAPTER 1.
SCIENTIFIC FOUNDATION OF THE STUDY

1.1 RATIONALE

A critical care unit, abbreviated C.C.U., (also named intensive care unit, abbreviated I.C.U.) is a hospital unit where patients with life threatening conditions receive close monitoring and constant medical care (Definitions of critical care, n.d.) The nurse leader in command of a critical care unit is a unit manager. With the global nurse shortage (Simons, 2003:69), heavy workloads, high stress and conflict levels currently experienced in many C.C.U.s (Nel, 2005:95-96) the task of managing a C.C.U. has become a challenge. Through personal encounters in various C.C.U.s it was observed that a healthy atmosphere attracts staff and consequently the manager has the power to ensure that the spirit in the unit remains positive, supporting and respectful, but the converse is also true of what has been described could also be present. Through this study the researcher aims to identify the ideal leadership style and qualities required to be a successful C.C.U. manager**.**

The researcher endeavours to investigate how nurses perceive the characteristics of good leadership in critical care units and to define the leadership styles most beneficial and advantageous to critical care nurses. Booyens (2002:426) and Muller (2004:110) recommend a democratic leadership style for any clinical environment. In practice, however, either autocratic leadership behaviour or laissez-faire leadership style appears to be most prevalent, and their presence might be one of the reasons why Nel (2005:96) postulates that nurses working in C.C.U.s lack motivation and are unhappy. The characteristics of leadership currently displayed might also be a contributing factor in the high turnover of staff experienced currently in many C.C.U.s.

Zurn, Dolea and Stilwell (2005:8) state that the worldwide shortages of critical care nursing staff and the retention of practising staff have become a global concern and are reflected in studies that have been conducted to evaluate the reasons for job satisfaction, absenteeism, staff turnover and tendencies to work abroad . Unfortunately the concern to retain current practising staff is not always transparent in practice. It has been observed in practice that, rather than welcoming differing views and personalities, all too often unit managers use their power to intimidate staff members who oppose their leadership behaviour.

Instead of intimidating staff members who are seen to oppose the behaviour of unit managers, there should be a concerted attempt by unit managers to create a therapeutic atmosphere conducive to the development of healthy interpersonal relationships between all

staff members. Unit managers should attempt to involve staff democratically in the planning phase of the management process (Van der Colff, n.d.:70).This kind of transformational leadership approach contributes positively to the improvement of staff morale and work performance (Ohman, 2000:46).

The researcher, a practising critical care nurse, has personal experience of unit managers in C.C.U.s, who are either ignorant of the facilitation of participative leadership styles, or who are reluctant to apply the latter. The presence of autocratic leadership in C.C.U.s appears most obvious with issues such as the delegation of tasks and scheduling of off-duties, which may result in dissatisfaction amongst the nurses. It is clear that more frequent application of leadership behaviour that will enhance staff sustainability and create a healthy work environment is needed (Tauton, Boyle, Woods, Hansen & Bott, 1997:218). These must include participative decision making (Booyens, 2002:426) and the empowering of staff in the C.C.U. (Muller, 2004:114).

O'Brien-Pallas, Thomson, McGillis Hall, Pink, Kerr and Wang (2004:11) state that nursing staff of units with a productivity of greater than 83% are more inclined to quit nursing. Critical care nursing is more strenuous than nursing patients with less severe illnesses, therefore Nel (2005:96) and McCutcheon (2005:32) respectively recommend a nurse-patient ratio of 1:1 and 1:2 for critically ill patients. However, in practice a 1:3 ratio is becoming more common and nursing managers often argue that they were unable to find enough staff members for a shift. As a practising critical care nurse the researcher has experienced that nurses tend to avoid units with a heavy workload. Thus a ratio of 1:3 in C.C.U.s paves the way for a vicious circle of lessened retention and increased recruitment of staff. The researcher has also experienced that unit managers often tend to regard the application of a full nurse-patient ratio, as described above, as too costly.

Nel (2005:96) postulates that the heavy workload and shortages of nurses in C.C.U.s lead to intensified stress and conflict levels and that the conflict management of unit managers are not always effective (Nel, 2005:98). Kelly (2006:23) confirms the destructiveness of conflict in C.C.U.s as it leads to absenteeism, mistakes and diminishing of quality assurance. In practice, however, unit managers tend to minimize the consequences of relationship conflict through manipulation of the off-duties (the rival parties are on opposite shifts), direct confrontation and climate meetings are often avoided. Some unit managers will refer extreme conflict to the nurse manager, but will very seldom endeavour to solve the matter in the unit.

The study done by Nel (2005:99) accentuates the lack of motivation amongst critical care nursing staff which is attributed to heavy workloads, the shortage of trained critical care

nurses and little respect displayed towards them. Contributing further to the lack of motivation is the appraisal system of certain private hospitals which have traces of the transactional managerial style. The latter comprises of monetary rewards for exceptional performance but no extra bonuses for the staff members who failed to excel. The negative viewing of their performance added to mistrust, unhappiness and lack of motivation, especially where a nurse felt that she too deserved a bonus (Nel, 2005:100). It compliments Scribante's (2005) opinion at the Critical Care Refresher Course in 2005 that generous salaries is not the ultimate motivation for good performance. Motivation of the staff according to Marquis and Huston (2001:286) can be accomplished through giving recognition, challenges and trusting them with bigger responsibilities. Covey (1999:178) also emphasizes that trust is the highest form of human motivation as it encourages workers to produce high performance. However, in practice the researcher has observed that professional nurses are seldom trusted to be involved with the scheduling of off-duties or allowed to attend managerial meetings, but that these functions fluctuate mostly between the unit manager and the second in command. Instead, some unit managers tend to rely on the staff to perform those tasks, thus they themselves are not always motivated to complete, for example, the auditing of files and notification of infectious diseases.

1.2 LITERATURE REVIEW

Leadership, according to Maxwell (2001:16), is the ability to attract followers. Furthermore the author believes that leadership is synonymous with influence. One can therefore assume that a unit manager who has a beneficial positive influence to attract followers will not experience any difficulty in retaining staff.

Grossman and Valiga (2007:57), leaders in transformational leadership approach and intensive care nursing, state that good leaders are not born, but everyone has the latent ability to develop into one. Nurses were gradually trained how to nurse and they must gradually be trained how to lead.

Grossman and Valiga (2007:64) also give a dynamic description of the expectations of young graduates with regard to leadership in critical care units. They (Grossman & Valiga, 2007:57) are of the opinion that young nurses want to be guided and not managed and therefore value leaders who are receptive, positive, honest and supportive. These traits and leadership skills require practice. For those unit managers who truly want to excel and retain young nurses, it poses a challenge to attain these rare skills.

With reference to the latter and the leadership behaviour as discussed in the rationale the following leadership styles, approaches and Herzberg's two-factor theory will be explained.

Rocchiccioli and Tilbury (1999:103) and Booyens (2002:423) identify the following four leadership styles, namely autocratic, democratic, laissez-faire and bureaucratic. According to Rocchiccioli (1999:103), autocratic leaders are task-orientated and workers exposed to autocratic leaders tend to be dependent and submissive or aggressive while Booyens (2002:423) states that they also tend to be less productive when the leader is absent.

Democratic leadership style, however, enhances the facilitation of teamwork and human relationships. As both the leader and the workers are involved in making decisions, this leadership style enhances personal and professional growth as well as autonomy amongst the staff (Booyens, 2002:424).

Laissez-faire leaders, according to Marquis and Huston (2001:13) exhibit little or no control over workers and are non-directive and little or no constructive criticism is given.

Bureaucratic leaders on the other hand, feel threatened and rely on established policies and tend to use standards and policies to guide them with decision making (Booyens 2002:424).

Yoder-Wise (2005:22) identifies the following two leadership approaches namely transactional and transformational. The transactional leader monitors performance, rewards the staff members for good performance and problems are addressed as soon as they are noted. The transformational leadership approach, which is embedded in the democratic leadership style, is beneficial to clinical nursing and seeks to effect change in individuals and the organization. Workers are inspired to work towards desirable goals and are empowered. The leader sets the example and models the way. Yoder-Wise concludes that the transformational approach holds positive results for work satisfaction and inspires the staff to better performance.

The last paragraph of the rationale supports Herzberg’s two factor theory which states that workers can be motivated by the work itself. Herzberg distinguishes between motivating factors (achievement and recognition) and satisfies or hygiene factors (good salary, job security). Herzberg believed that motivating factors are present in the work and that leaders should use achievement, recognition, responsibility, advancement and status to motivate workers. A complete description of Herzberg’s two factor theory is given in chapter 2.

Only two previous studies on leadership styles in critical care units have been found. In a study done by Uliss (1991:56m) it was found that critical care nurses must be guided in a subtle manner and unit managers need to avoid an autocratic manner when dealing with staff. In the study done by Guy (1982:20) the author describes the situational leadership approach as a more suitable approach for the critical care environment.

1.3 PROBLEM STATEMENT

As explained in the rationale, ineffective leadership may lead to dissatisfaction amongst the staff, poor staff retention, resignations, an increase in staff turnover and lack of motivation of the staff.

In view of the above and the observations made by the researcher as discussed in the rationale it is critically important to investigate how intensive care nurses define the characteristics of good and effective leadership with regard to patient care, administration, education and research.

1.4. RESEARCH QUESTION

A research question refers to a statement of the relevant query that the researcher wishes to answer (Polit, Beck & Hungler, 2001:97).

The research question thus is: What is the ideal leadership style for unit managers of critical care units of private health care institutions?

1.5. GOAL

The goal of the study is to identify the ideal leadership style for unit managers in C.C.U. units in private health care institutions

1.6 OBJECTIVES

The objectives set for this study are:

- To identify the ideal leadership style required in administrative functions
- To identify the ideal leadership style required in the education functions
- To identify the ideal leadership style required in patient care
- To identify the ideal leadership style required in research

1.7 RESEARCH METHODOLOGY

1.7.1 Research design

An exploratory and descriptive non-experimental study with a quantitative approach will be applied to identify the ideal leadership style for unit managers in critical care units in private health institutions. With quantitative studies the design indicates the procedures the researcher aims to follow in order to develop accurate and interpretable information (Burns and Grove, 2006:42).

1.7.2 Population & Sampling

The population (N=287) will consist of all nurses working in the C.C.U.s of 11 (eleven) private health institutions in the Cape Metropolitan Area. Both day and night staff members will be targeted. Population refers to all elements that meet the sample criteria for inclusion in a study (Burns & Grove, 2003:491).

Table 1.1: The total population before data collection as in July 2008

Hospital	C.C.U.	Unit Managers	Nurses
1. Cape Town Medi-Clinic	1	1	n 08
2. Constantiaberg Medi-Clinic	1	1	n 21
3. Durbanville Medi-Clinic	1	1	n 37
4. Gatesville Medical Centre	1	1	n 18
5. Kingsbury Hospital	1	1	n 14
6. Kuils River Hospital	1	1	n 27
7. Panorama Medi-Clinic	4	4	n 46
8. Milnerton Medi-Clinic	1	1	n 14
9. N1 City Hospital	1	1	n 25
10. Vincent Pallotti Hospital	2	2	n 53
11. U.C.T. Private Hospital	1	1	n 09
Total Population : **(n) 15 + (n) 272 = (N) 287**	**15**	**(n) 15**	**(n) 272**

1.7.3 Criteria

1.7.3.1 Including Criteria

The following subject selection criteria were set for the purpose of this study:

- All nurses working in critical care units of 11(eleven) private hospitals in the Cape Metropolitan Area.
- All nurses must be permanently employed at one of the participating hospitals.

1.7.3.2 Excluding Criteria

- Agency staff
- Care givers

1.7.4 Pilot Study

A pilot study is a smaller version of the proposed study (Burns & Grove, 2003:42) and will be done at Kuils River Hospital consisting of 10% (n=28) of the total population (N=287). It will be conducted under similar circumstances as the actual study to determine the feasibility of

the study. It is also a means to test the instrument for ambiguity and accuracy. The participants of the pilot study will not be included in the actual study.

1.7.5 Reliability and Validity

Reliability refers to the consistency with which an instrument measures what it is supposed to measure (Burns & Grove, 2007:552). Validity is the extent to which an instrument measures what it is supposed to measure (Polit *et al.*, 2001:473). In support of the study's validity and reliability a pilot study will be done as a trial run for the measuring instrument as it is tested under similar conditions as the actual study. Experts in nursing were consulted to assist with the appropriateness of the individual questions in the questionnaire, thus helping to establish content validity for the instrument. A statistician was consulted to assist with the design of the questionnaire and will be guiding the researcher throughout the process.

1.7.6 Ethical considerations

The researcher obtained consent to conduct research from the Committee for Human Science Research of the Faculty of Health Sciences (Stellenbosch University) as well as from the heads of departments of the different private hospitals where research will be conducted. Informed written consent will be obtained from the participants. Confidentiality, anonymity and privacy concerning all information will be ensured. Each participant will be provided with a questionnaire as well as an envelope to ensure anonymity. Sealed envelopes will be handed directly to the researcher. The hospital where the researcher is currently employed will be excluded from the study.

1.7.7 Instrumentation

Instrumentation consists of a questionnaire with predominantly closed questions. The questionnaire designed was based on the literature, previous research and the researcher's clinical experience. The questionnaire is divided into various sections namely:

- **Biographical data:** age, qualifications, gender, positions held.
- **Administration**: task delegation, decision making, conflict management, amongst others.
- **Education**: staff development, role model, motivation, empowerment and others.
- **Patient care**: work ethics, professionalism, staffing, staff support and others.
- **Research**: staff participation, research data collection and others.

The open questions in the following sections: administration, education, patient care and research were structured according to a four point Likert scale, varying from strongly agree to strongly disagree.

1.7.8 Data collection.

Polit *et al.* (2001:460) describes data collection as the gathering of information needed to address a research problem. Following is the plan for data collection for this study.

Table 1.2: The plan for data collection

Hospital	First shift of week	Second shift of week
Cape Town Medi-Clinic and U.C.T. Private Hospital	**Week 1**. Monday, day shift: Issue questionnaires between 07:30-09:30. Collect questionnaires between 17:00-19:00. Monday, night shift: Issue questionnaires between 19:30- 22:00. Tuesday: 06:30 collect questionnaires from night staff	**Week 1**. Wednesday, day shift: Issue questionnaires between 07:30-09:30. Collect questionnaires between 17:00-19:00. Wednesday, night shift: Issue questionnaires between 19:30-22:00. Thursday: 06:30 collect questionnaires from night staff
Durbanville -, Panorama Medi-Clinic and Kuils River Hospital	**Week 2**. Follow plan for data collection as shown in week 1.	**Week.2.** Follow plan for data collection as shown in week 1
Constantiaberg Medi-Clinic, Gatesville Medical Centre and Kingsbury Hospital	**Week 3.** Follow plan for data collection as shown in week 1	**Week 3.** Follow plan for data collection as shown in week 1
Milnerton Medi-Clinic, N1 City Hospital and Vincent Pallotti Hospital	**Week 4.** Follow plan for data collection as shown in week 1	**Week 4**. Follow plan for data collection as shown in week 1

Questionnaires will be issued on Mondays when the first shift of the week is on duty (day and night staff). Questionnaires issued to the night staff (Monday evenings) will be collected the following morning. The second shift of the week will be targeted on Wednesdays. Questionnaires issued to night staff on Wednesday evenings will be collected the following morning.

Data collection will be done by the researcher and questionnaires will be distributed and collected personally from the participants.

Data collection will take place over a period of 4 weeks. Due to the limited number of participants (total population, N=287) and to ensure a representative sample, all nurses working in the C.C.U.s will be targeted. The off-duty roster, present in every C.C.U., will be used to ensure that all the nurses are given an opportunity to participate in this project.

1.7.9 Data analysis and interpretation

Polit *et al*. (2001:460) describes data analysis as the systematic organization and synthesis of research data, and the testing of research hypotheses using those data.

Data analysis and interpretation will be done by the researcher with the help of a statistician and a computer program, the SAS (Statistical Analysing System). Data will be tabulated and presented in histograms and frequencies. Statistical associations will be determined between the various variables using the chi-square test.

1.8 CONCEPTUAL FRAMEWORK

The conceptual framework of a study is generally implicit (Polit *et al*., 2001:147), in other words, not formally described by the researcher, but the reader will be able to identify it. Burns and Grove (2007:189), on the other hand, view a conceptual framework as a brief explanation of the theories, concepts, variables or parts of theories that will be tested by the study. For the purpose of this study the researcher will use the leadership styles, the transformational and transactional leadership approaches and Herzberg's motivational theory, as the theoretical framework of the study.

The figure 1.1 schematically illustrates the conceptual framework applied in this study. the application of the leadership styles, the transformational leadership approach and Herzberg's motivational factors in the four functions of the unit manager.

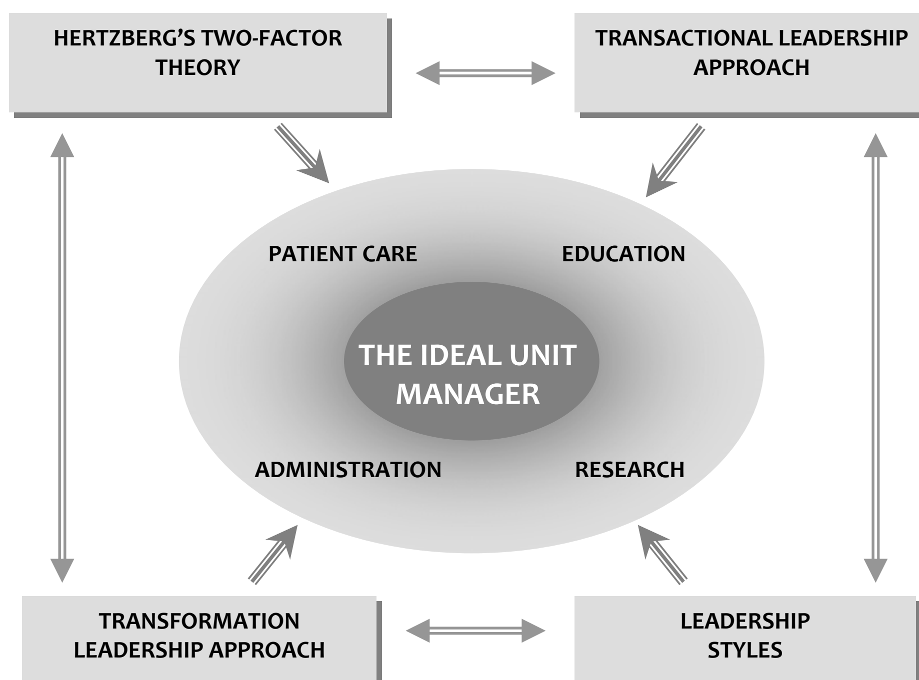

Figure 1.1: The conceptual framework

Figure 1.2 is a schematic summary of the conceptual framework for leadership in critical care units.

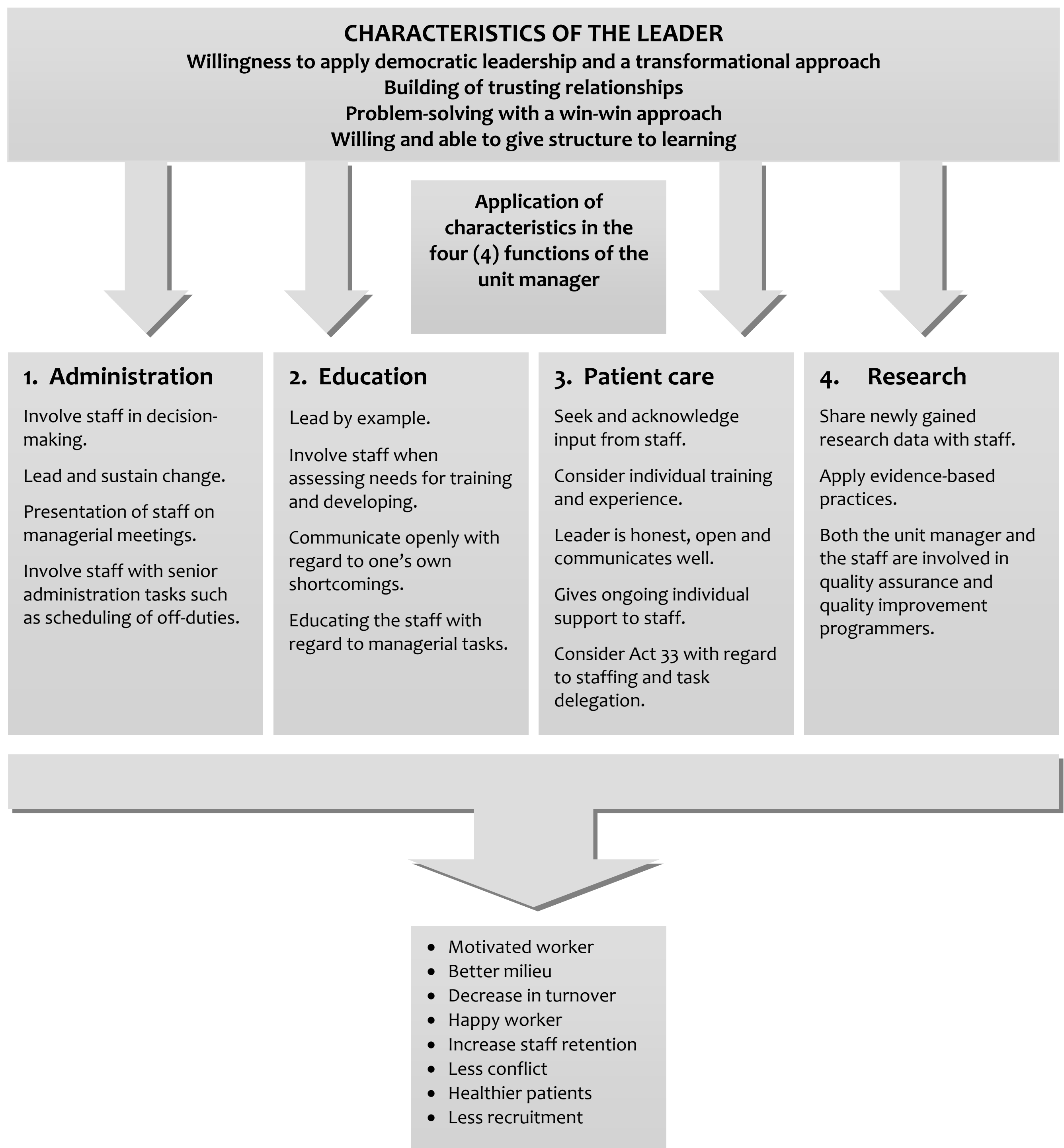

Figure 1.2: An illustration of the Conceptual Framework for Leadership in Critical Care Unit

1.9 OPERATIONAL DEFINITIONS

Critical care:

Is constant, complex, detailed health care as provided in various acute, life threatening conditions (Definitions of critical care, n.d)

Critical care unit:

Abbreviated C.C.U. A hospital unit in which special equipment and specially trained personnel are concentrated for the care of critically ill patients requiring immediate and constant monitoring and treatment. Also called an intensive care unit. Abbreviated I.C.U. (Baillière's Nurses' Dictionary, 2001:217).

Leader:

Person who demonstrates and exercises power and influence over others (Yoder-Wise, 2005:490).

Leadership:

It is a process by which one person attempts to influence others to accomplish goals (Booyens, 2002:417).

Mentor:

Individual who provides information, advice and emotional support for the protégé (Burns & Grove, 2007:448).

Motivation:

The instigation of actions based on various factors, both intrinsic and extrinsic (Yoder-Wise, 2005:491).

Recruitment of staff:

Recruitment refers to the functions that are undertaken in order to obtain enough applications for a specific position (Muller, 2004:260).

Retention of staff:

Refers to the desire of a member of the personnel to remain in the unit (Muller, 2004:268).

Turnover of staff:

The number of people entering and leaving employment (Collins Concise Thesaurus, 2003:1685).

Staffing:

The function of planning for hiring and deploying qualified personnel to meet the needs of patients for care and services (Yoder-Wise, 2005:495).

Win-win solution:

A mutual willingness between the opposing parties to seek an effective solution which will satisfy both (Booyens, 2002:535).

Workload:

The amount of work distributed to a person or unit for a given period of time (Yoder-Wise, 2005:496).

1.10 STUDY OUTLAY

Chapter 1: Scientific foundation.

Chapter 1 gives a description of the reasons which led to the research (the rationale), the problem statement, the goal and the objectives of the study, research methodology and the conceptual framework.

Chapter 2: The literature study.

In chapter 2 a literature review of the various leadership styles is described.

Chapter 3: Research Methodology.

In this chapter the research methodology applied to conduct the research is described.

Chapter 4: Data analysis and interpretation

In this chapter the results of the project are revealed, analysed and interpreted.

Chapter 5: Discussion and Recommendations.

In chapter 5, discussion and recommendations based on the scientific evidence obtained in the study are discussed.

1.11 CONCLUSION

With reference to the leadership styles and the underlying dynamics in the C.C.U., the researcher describes the rationale for the study, the goal, the objectives and the intended research methodology. The conceptual framework is illustrated and provides a deeper insight into the four functions of the unit manager. The literature review, which serves to support the rationale, will be discussed in chapter 2.

CHAPTER 2.
LITERATURE REVIEW

2.1 INTRODUCTION

Good leadership is vital in creating a healthy work environment for nurses (Bajnok, Tucker, Knights & Kumar, 2006:24). Therefore, unit managers who have the task of building a good team spirit and healthy work environment need to be educated with regard to trust, interpersonal skills and communication (Nel, 2005:99). In order to educate unit managers with regard to good leadership is of paramount importance since critical care environments are characterized by shortages of nurses and uncomfortable relationships between nurses (Alspach, 2005:11). The author furthermore accentuates the little recognition and support towards nurses, meagre communication, minimum respect for their views and that nurses are too often excluded from decision making which affects them directly. Therefore, this unsound work environment is crying out for effective leadership to transform the current situation into a more acceptable one. The question that comes to mind is what leadership behaviour is regarded as suitable for critical care units? Literature of the late 19th century (Guy, 1982:20) favoured the situational leadership approach as suitable for the C.C.U.s and regarded autocratic leadership behaviour (Uliss, 1991:56m) as detrimental to the C.C.U.s. All current literature Ohman (2000:47), Bajnok *et al.* (2006:22), Kelly (2006:27) and Botha (2008:21) affirm that transformational leadership as ideal for the C.C.U.s.

In this chapter, the focus will fall on the different definitions of leadership, the difference between leadership and management, leadership in the S.A. context and the cultural background as well as the international perspective regarding leadership. Furthermore, the role of the unit manager, critical care nurses, the critical care environment and the impact of the latter on patient care and leadership will also be discussed.

2.2 LEADERSHIP

2.2.1 Different definitions of leadership

The definition of leadership differs amongst various authors. Booyens (2002:417) views leadership as the process by which a person attempts to influence others to achieve certain goals. In the nursing field, the researcher regards effective patient care as the ultimate goal and unit managers should motivate the staff to the attainment of satisfied and healthy patients.

LaHaye (2001:8) refers to a transparent leader from a Christian viewpoint and affirms that the transparent leader is fulfilled with Christ and leads by modelling the teachings of Jesus Christ.

The author further postulates that manipulation, control and pretence will end, but a leader who possesses the characteristics of Christ will lead with excellence as Christ shines through him. Nurse leaders who display integrity, ethical behaviour and fairness show transparency (Bajnok *et al.*, 2005:33).

Furthermore Yoder-Wise (2005:2) defines leadership from a nursing perspective, regards leadership as the use of characteristics and power which positively and ethically encourages patients, families and others towards goal achievement.

Maxwell's (2001:15) business definition of leadership portrays leadership as the ability to attract followers and describes leadership by way of the following five levels: position, permission, production, development of people and personhood. Maxwell (2001:2) regards the position level as the lowest as aspects of leadership were gained by appointment. When solid interrelationships with followers exist, the leader has risen to the following level, namely permission. As soon as the successful relationship breeds positive results for the organization, the leader is said to be at the production level. People are now following the leader because of what the leader has accomplished in the organization. The fourth level is about people development. On this level, the leader is praised for his/her ability to empower others. The leader is now followed because of what he/she has accomplished for the workers. The last level is personhood. The leader is respected for good leadership and vision, hence people are attracted to what the leader symbolizes. Maxwell thus describes a leader of excellence, once that leader has won the trust of fellow workers, empowers them, breeds positive results and earns the respect of others.

2.2.2 Leadership in the South African Context

Maxwell's definition of leadership reflects on certain aspects of traditional African management values, in other words, Ubuntu. Ubuntu, a traditional African concept, has its origins in the traditional ethnic languages of Southern Africa and refers to one's humaneness to others (Hanselman, n.d.). Van der Colff (N.d.:66-69) postulates that African leadership is grounded on participation, responsibility, religious influence, shared respect and cumulative humanity.

Van der Colff (N.d.:66) states that South African leadership in the nineties was clothed in traditional Western concepts of leadership and that the current changing economy requires a more flexible style of leadership. In order to excel, the leaders now have to consider the diverse values, beliefs and backgrounds of all South Africans. Although African leadership is grounded upon participation, obligation and religious influence, it lacks transparency, leadership accountability and legitimacy.

On the other hand, Western concepts of leadership have values such as individual development, personal value commitment (e.g. a leader should model the way for the employees to become legitimate leaders) and inclusive vision (a vision grounded upon participative decision-making and is accepted by the leader and the employees). Van der Colff (N.d.:64-69) states that leaders should combine Western and African management values to establish an organizational culture that is locally and internationally beneficial (Van der Colff, n.d.:64-69).

Values inherent to African leadership such as participation and religious influence are also present in transformational leadership (recommended for the C.C.U., see 2.2.3). The transformational leader communicates a futuristic vision to followers in such a manner that both the leader and his or her followers are inspired to higher levels of motivation and humaneness. The followers trust the transformational leader and grow emotionally, spiritually and intellectually (Booyens, 2002:436). The critical care units burdened by inadequate staffing, stress and conflict can therefore benefit from the benevolence that accompanies this highly ethical leadership approach (Kelly, 2006:22, 26).

2.3 LEADERSHIP APPROACHES

2.3.1 Transformational Leadership Approach

In the light of the above, Western management values such as inclusive vision and personal value commitment are found in transformational leadership. With transformational leadership the leader uses his or her influence to attain goal achievement by changing the values, needs and ideas of the followers. The leader has a vision of what can be accomplished in the future and empowers the workers with that vision. Therefore, this leadership approach is future orientated, involves change and the empowerment of workers (Ohman, 2000:47).

However, Booyens (2002:436) identifies the following four strategies by which transformational changes can be accomplished.

- New visions need to be created by the leader in order to make nursing more meaningful and positive.
- Then follow the creation of meaningful and trusting relationships between the nurse manager and the workers, which are essential.
- The work environment should be designed with the intension of empowering staff members.
- The nurse manager can now use her own influence and character to achieve success for the company.

Furthermore, the transformational leader has a good self-image, communicates her futuristic vision effectively and is trusted by her followers to achieve the envisioned goals. Other characteristics of the transformational leader are politeness, warmth; trust in the inherent goodness of humans, versatility and by remaining an avid student. The transformational leader, who is also familiar with his or her own strengths and weaknesses, creates excellence in the company and as a result gains the respect and trust of the workers (Booyens, 2002:438).

2.3.2 Transactional Leadership Approach

The transactional leadership approach differs from the transformational leadership approach in the sense that it is concerned with everyday happenings in the work place. The leader uses a casual reward system, active management by exception and passive management by exception to bring out the best in workers. Staff members who realise set goals receive rewards in the form of a wage increase or recognition for excellent performance (Ohman, 2000:47).

Ohman (2000:48) states with active management by exception the leader does not give guidance but constant supervision takes place and on the spot corrections are implemented , if there are any deviations from the norm. Positive strengthening supplied by the leader can be adjustments, disapproval or contingent strengthening.

Passive management by exception occurs if the leader only intervenes when goals are not met. The constant supervision that is present with active management by exception is not practised.

Research done by Nel (2005:97) indicates that monetary rewards for staff members who excel may cause conflict as nurses who were excluded from the wage increase may feel de-motivated. A study done by Botha (2008:21) reveals that the application of both transformational and transactional leadership approaches could bear positive results for the changing critical care environment but that leaders need to be trained for the implementation of these approaches.

2.4 LEADERSHIP STYLES

The study is grounded in the leadership approaches that were described as well as the following different leadership styles that will now be discussed, namely autocratic, participative or democratic, laissez-faire and bureaucratic. A brief description of each style was given in Chapter 1.

2.4.1 Autocratic

The autocratic leader usually embarks on self-centredness and is mostly I-directed. The leader drives the group to achieve goals and her self-image benefits from the work accomplished. As the leader, and not the group, set the goals, his or her importance is placed in the forefront, and not necessarily that of the patients. This leadership style is not beneficial to the clinical setting as the benefits of the patients should always be a first priority (Muller, 2004:157).

Rigolosi (2005:83), on the other hand, views the autocratic leader as a strict, firm person, making one-sided decisions. Rigolosi postulates further that, although autocratic statements are usually perceived as antagonistic, it can also be kind or good depending on how they were voiced.

The autocratic leader is known by the following characteristics: strict authority over the group and motivation by coercion, downward communication, the leader alone makes decisions, and criticism tends to be vindictive (Marquis & Huston, 2001:12-13). Leaders who exercise autocratic behaviour also tend to be arrogant and exert power by withholding or issuing rewards and punishments (Theofanides & Dikatpanidou, 2006:2).

2.4.2 Democratic or Participative Leadership Style.

Different opinions with regard to democratic leadership exist. Booyens (2002:423) regards democratic leadership as synonymous to participative leadership style while Muller (2004:157) regards it as two different styles

Both Booyens (2002:423) and Marquis and Huston (2001:12-13) agree that participative leadership style holds positive results for groups who work together for long periods of time as it benefits teamwork and harmony within the groups. Since both the group and the leader make decisions, both participants are accountable for goal achievements and implementation of decisions (Booyens, 2002:423). With participative leadership, the workers also receive responsibilities but the glamour or grace of this leadership style is embedded in the fact that the workers are given a choice (Rigolosi, 2005:83). Therefore, Theofanides and Dikatpanidou (2006:2) write that workers should be consulted and participation encouraged.

Democratic leaders exhibit the following characteristics: less authority is needed, monetary rewards and recognition are used to motivate staff members, subtle guidance of staff is displayed, two-way communication between the leader and the group is present, participative decision-making is practised, emphasis is on “us” rather than the leader and constructive criticism is given (Marquis & Huston, 2001:12-13).

A group led through participative leadership style is characterized by a good team spirit, creative ideas and risks being taken. Staff members can function independently, are trusted by the leader, the work done is less efficient than that of the workers who have an autocratic leader but the workers are more motivated (Booyens, 2002:424).

2.4.3 Laissez–faire Leadership Style

The laissez-faire leader is non-directive, uninvolved, expresses little or no criticism and is unpredictable. He or she would periodically become directive and order staff to do this or the other. Staff members tend to ignore these ventures or undertakings. The laissez-faire leader is known to be permissive, relinquishes control to the group and is pre-occupied with their work (Booyens, 2002:424). Rigolosi (2005:83) views the laissez-faire leader as a person who exerts loose control over workers and indicates that the leadership style is suitable for workers who have already adjusted in the work place. Theofanides and Dikatpanidou (2006:2) regard the laissez-faire leader as someone who gives his or her followers freedom to complete their tasks and expects them to set their own goals. Furthermore the authors postulate that the laissez-faire leader should support their workers by supplying them with information.

Both Marquis and Huston (2001:13) and Booyens (2002:424) are of the opinion that this non-directed form of leadership applies to groups which are highly motivated and self directed as it enhances productivity amongst the group.

2.4.4 Bureaucratic Leadership Style

Bureaucratic leadership style is characteristic of the insecure leader who finds confidence in following rules and regulations. Furthermore, common to this leadership style, is the exercising of authority by demanding that staff follow rigid rules, has poor interpersonal communication skills, association with staff tends to be remote and decisions are made based on rules and regulations (Booyens, 2002:425). According to Muller (2004:109) senseless regulating of actions, control and task-directedness characterize the leadership style.

2.4.5 The difference between leadership and management

Leadership is the process leaders use to influence others to perform to the best of their ability. It is also the process by which one person attempts to influence others to accomplish certain goals (Booyens, 2002:417). Although the Concise Thesaurus (2003:519) states that management, administration, supervision and control are synonymous, leadership and management are two different terms. Leaders are not always good managers and managers

are not necessarily good leaders. However, leaders can learn management skills and visa versa (Jooste, 2007:26).

Kent (2005:1013), however, is of the opinion that for the two processes, leading and managing to be effective, they it need to be applied jointly and both leading and managing must be vested within the same person. Kent (2005) views the purpose of leading as the creation of direction and the developing of a mental attitude to pursue that direction. The author pictures the purpose of managing as determining the different uses of resources. Kent regards trust and good behaviour as products of leading, but considers an awareness of performance as a product of managing. Leaders use processes such as creating a vision and managing of the leader's self image in contrast to managers who use organizing, planning, controlling and co-ordinating as processes.

Jooste (2007:27) mentions the following differences between managers and leaders. Managers differ from leaders since managers apply the functions of planning, organization, staffing, directing and controlling, to maximize the output of the organization through administration processes. Leaders, on the other hand, strive to attain organizational goals through harmonious relationships with the staff. To attain this, the leader applies open communication, participative decision-making, group dynamics and strategies to bring about change. Leaders and managers tend to differ on various aspects. Managers direct and control whereas leaders are concerned with empowering of workers. People could be trained to manage, but leadership needs to be practised in order to excel. Managers need steadfastness but leaders require versatility. Managers incorporate the organization's structure and culture, but leaders look for something challenging and different. Managers adhere to the company's policy while leaders follow their sixth sense.

2.5 HERZBERG'S TWO FACTOR THEORY

Herzberg's two factor theory is included as it forms part of the conceptual framework of the study. Herzberg distinguishes between motivating factors (achievement, recognition) and satisfiers or hygiene factors (good salary, job security). Herzberg believes that motivating factors are present in the work itself and that leaders should use achievement, recognition, responsibility, advancement and status to motivate workers. Herzberg is of the opinion that a good salary is necessary as it keep workers satisfied, but that it does not inspire them to better performance. Other satisfiers identified by Herzberg is supervision, job security, positive work conditions, interpersonal relations and personal life. Herzberg further argues that leaders should apply both motivating factors and the satisfiers to ensure a motivated and satisfied workforce (Marquis & Huston, 2001:285).

2.6 CRITICAL CARE

Critical care refers to the care and treatment of critically ill patients, often in an intensive care unit (Definitions of critical care, n.d.) Leadership in critical care units could be viewed as where a unit manager (person in command of a critical care unit) uses her characteristics and power to positively and ethically influence the staff towards goal achievement (Yoder-Wise, 2005:2).

2.6.1 Critical Care Nurses and the Critical Environment

Various literature sources, Grossman & Valiga (2007:57), Simons (2003:69) and Alspach (2005:11) postulate that the shortage of specialty care nurses, low morale, increase in infectious diseases, strained relationships with colleagues and inadequate staffing are hampering critical care nursing. Alspach (2005:11) also states that this unhealthy environment adds to the staff turnover, errors and incidents that affect patients negatively and contribute to the lessened retention of current practicing staff. Simons (2003:69), however, argues that the recruitment and retention of nurses are influenced by how the nurses perceive their immediate supervisor. The latter concurs with Nel's (2005:99) view that unit managers are influential in creating a positive work environment.

In order to combat these problems many hospitals worldwide strive for Magnet Recognition. The Magnet Recognition Program (administered through the American Nurses Credential Centre) gives recognition to hospitals that provide a professional practice environment that is beneficial to patient outcomes. In order to attain Magnet Recognition, organizations need to provide evidence of flatter organizational structures, participative decision making, little use of agency personnel, higher nurse patient ratios and a decrease in turnover rates for nurses, to name a few (Burchardi, 2001).

Locally Gillespie, Kyriacos and Mayers (2006:50) state that C.C.U.s in S.A. are burdened with a vast shortage of critical care nurses and consequently heavier workloads, higher stress and conflict levels (Nel, 2005:96). Poor communication between doctors and nurses and very little team spirit contribute to the unhappy work environment that exists in many C.C.U.s (Nel, 2005:99). Scribante, Schmollgruber and Nel (2005:115) add poor senior management, lack of equipment and poor remuneration to the list of negative factors that hamper C.C.U.s and the nursing staff in S.A. No literature indicates whether the S.A. government or leading health care organizations have tried to solve these problems. Fouché (2007:54) reports that the S.A. government has tried to retain public employees (nurses) through improved remuneration called Occupation-Specific Dispensation (O.S.D.). However, the author remains sceptical since higher salaries are unaccompanied by quality assurance measures to ensure that

nurses continually improve their skills and remain competent and deserving of the more lucrative salaries. Fouché (2007:54) also contemplates the wisdom underlying the implementation of O.S.D. without quality assurance measures by citing the following: “Money cannot replace quality human care and most of all competence”.

2.7 THE CHARACTERISTICS OF A UNIT MANAGER

A study done by Boyle, Bott, Hansen, Woods and Taunton (1999:361) indicated that leadership practices that request and appreciate staff contribution, enhance a climate in which information is shared freely and participative decision making amongst the nurses is promoted, are beneficial for the retention of nurses. These practices resemble the participative leadership behaviour explained earlier.

Bajnok *et al.* (2006:23) identified the following virtues needed for effective leadership. The nurse leader should display fairness and trustworthiness by admitting mistakes openly. Furthermore, transparency and consistency is essential and the leader must keep promises. The leader needs to show respect and loyalty to all the staff by listening without judging and should always request the opinion of all involved. The nurse as a leader should be accessible to all. Communication should be honest, open and effective. Effective conflict-management should be in place. Co-operation, liaison and teamwork should be promoted. Role competence needs to be displayed. A display of love and respect for the nursing profession must prevail. The latter should be demonstrated through a commitment towards quality care, a respect for nurses, patients and communities. Nursing controversies are verbalized without fear and the leader shows support for the development of sound nursing knowledge. All these traits are positively linked to a transformational leadership approach.

2.8 THE ROLE AND FUNCTION OF A UNIT MANAGER

The role and function of the unit manager as applied in the four core functions i.e. administration, education, patient care and research.

2.8.1 Administration

The role of the unit manager with regard to administration will be discussed under the following headings, decision-making and problem solving, conflict management; performance appraisal and cost containment.

2.8.1.1 Decision making and problem solving

Decision-making and problem solving are linked with each other while effective decision-making promotes sound interpersonal functioning (Booyens, 2002:503).

Grossman & Valiga (2007:60) advises nurse managers to use the nursing process actively as a basis for problem solving, but accentuates the importance of explaining the rationale of decisions made to the staff. By explaining the latter to the staff, the unit manager demonstrates respect and ethically sound behaviour, which forms the basis for building trusting relationships (Bajnok *et al.*, 2006:33). Unit managers need to go further than effectively communicating decisions. Van der Colff (N.d.:70) advises that they should rather invest in a participative decision making style which consequently leads to greater commitment from staff members. The author believes that the informed worker is more likely to make decisions that are beneficial to both the individual and the company.

2.8.1.2 Conflict management

Marquis and Huston (2001:348) describe conflict as internal or external contention that result from different ideas, virtues or emotions. Kelly (2006:23) postulates that the tendency of intensive care nurses to handle conflict through avoidance is wrong. This strategy paves the way for a low morale amongst C.C.U. nurses and therefore nurses lack confidence when confronting people in authority. To combat the tendency to avoid conflict, managers should adopt a win-win solution, a transformational leadership approach (par. 2.2.3) and staff members need to be educated with regard to conflict management (Kelly, 2006:27). A win-win solution is seen as collaborating since the opposing parties are both inclined to strive for a solution that will satisfy both (Booyens, 2002:535).

2.8.1.3 Performance appraisal

Performance appraisal is a tool required to assess how thoroughly employees carry out their duties. Effective usage of the appraisal system could lead to an enhancement in motivation and an increase in retention and productivity (Marquis & Huston, 2001:414). For the appraisal system to be effective, unit managers should display trust, honesty and fairness prior to the actual procedure. Unit managers should take care that their own prejudices and predispositions with regard to the employer do not interfere with the evaluation of the employee. Therefore, the display of honesty and objectivity is essential. The atmosphere should be such that the employee experiences little or no intimidation and dialogue should take place (Marquis & Huston, 2001:415).

2.8.1.4 Cost Containment

Cost containment refers to successful and streamlined service delivery while producing the necessary profits for continued organizational productivity (Marquis & Huston, 2001:110). The authors also advise unit managers to communicate budgetary goals to staff members, as informed staff members are more compliant.

Health care cost can be reduced if staff members are involved in decision making with regard to identification of health care delivery (staff members have the opportunity to provide input with regard to care that is applicable). The unit manager needs to recognize the problem-solving strategies with reference to budgetary constraints and should ensure that the client's safety is not sabotaged by cost containment. Unit managers should actively involve staff members in short, long-range fiscal planning, ultimately affording staff members the opportunity to participate in cost containment by sharing their power with them. By practising power-sharing (empowerment), the unit manager paves the way to increased motivation and consequently higher performance (Marquis & Huston, 2001:112).

2.8.2 Patient care

2.8.2.1 Patient safety

Patient safety in S.A. is controlled by the S.A.N.C. and Government legislation. The S.A.N.C. is a statutory body that provides a regulatory framework for the nursing profession. The Nursing Act, Act 33 of 2005, regulates the nursing profession in S.A. Article 30 of the Act stipulates that professional nurses registered under the S.A.N.C. are able to function independently. The Act stipulates that an enrolled nurse is limited to basic nursing practice and an auxiliary nurse should carry out elementary nursing care. Article 31 of the Act (Nursing Act, 2005) stipulates that all three categories of nursing may only practise nursing if registered with the S.A.N.C. Searle (2005:131) states that nurses with lower qualifications than the professional nurse, should function under the supervision of the professional nurse. In the event where an enrolled or auxiliary nurse omits or fails to act within her scope of practice, compromising patient care, both the nurse (enrolled/auxiliary) and the professional nurse are held accountable for their actions (Searle, 2005:131). Therefore, management must link decisions about nurse staffing with the type of hospital unit, patient acuity and the scope of practice of the nurse (McCutcheon, MacPhee, Davidson, Doyle-Waters, Mason & Winslow, 2005: 1-2).

2.8.2.2 Staffing

According to Nel (2005:96), C.C.U.s in S.A. are severely understaffed. Nel (2005:96) and McCutcheon *et al.* (2005:7) respectively recommend a nurse-patient ratio of 1.1 and 1.2 for critically ill patients. McCutcheon *et al.* (2005:1) confirm the negative impact of lower staffing levels as resulting in the following: an increase in medication errors, pressure ulcers, more urinary tract infections and patient mortality. The effects on nursing staff are lower levels of job satisfaction, burnout and an increase in turnover. The effects on the patient are an increase in the length of stay and financial implications for the patient and the company at large. McCutcheon *et al.* (2005:11) confirm that good staffing initiatives should go hand in

hand with leadership and management to ensure efficiency. The authors advise that the establishing of transformational leadership practices, adequate autonomy for nurses and an increase in the use of technology will help to decrease the negative impact of nursing shortages.

2.8.3 Education.

2.8.3.1 Development and training.

This section focuses on the role of the unit manager with regard to the socialization of new staff members, in-service training, ongoing development and team building. With socialization, the new employees are introduced to the values, culture and characteristics of the organization. It serves the purpose of helping the new employee to adapt to the new environment and norms and values can be clarified. After socialization the leader appoints an experienced nurse as a mentor for the new employee. The mentor should display support to the new employee.

Bajnok *et al*. (2005:41) avers that nurse leaders should contribute technical, informational and academic infrastructure to support learning and that staff members should be granted ample access to information.

Since the leader is responsible for a competent cadre of nurses, all new equipment and procedures should be accompanied with the necessary training (Marquis & Huston, 2001:245).

2.8.3.2 Motivation and empowerment

At the Critical Care Refresher Course in 2005 Juan Scribante (2005) advises those who wish to create more progressiveness in C.C.U.s in S.A. to take into consideration the motivational and hygiene factors vested in Herzberg's two-factor theory, discussed earlier in the chapter (par.2.2.9). Yoder-Wise (2005:7) also states that transformational leaders use motivational factors, as explained by Herzberg, abundantly when striving to increase work performance. To attain a motivated workforce through application of this theory, both motivational and satisfying factors should be in place (Marquis & Huston, 2001:286).

Kotter of the Harvard Business School (Kotter, 2001) states that motivation of workers will not be attained by pushing them in the proper or best direction, but by satisfying the basic human desire for achievement, a sense of affinity, acknowledgement, and a feeling of being in control of one's own life. Kotter (2001) goes further and states that effective leaders acknowledge and reward success since this form of recognition creates a feeling of belonging

towards the organization. Once this feeling of belonging is created, the work becomes fundamentally motivating.

Humans are mostly driven or motivated by goals they wish to achieve. Therefore, leaders should be cognizant of the goals of each employee and must render support to the workers in attaining these goals (Marquis & Huston, 2001:292-295).

The authors offer the following guidelines by which a leader can motivate a discouraged worker. Firstly, the leader has to acknowledge the uniqueness of each employee and must demonstrate faith in each employee. The display of faith or trust by the leader exhibited towards the worker triggers a positive attitude in the worker so that the latter views him or herself as more confident. The unit manager needs to be very sensitive to the personal goals of each employee and should render the individualized support that each employee needs. The unit manager needs to be a good listener, a good role model and confidence needs to be displayed. Once motivation is created, the leader should reward it. Through rewarding the desired behaviour, the leader encourages the worker to display positive behaviour more consistently.

Empowerment is the mutual process that builds and strengthens power through collaboration and working together. This takes place when the leader shares his vision with the employee and the employee now has an opportunity to use his or her own virtues (Marquis & Huston, 2001:172). Yoder-Wise (2005:436) describes empowerment as the process by which the leader shares her power with co-workers and patients. Yoder-Wise (2005:436) further explains that collaboration is essential in the process of empowerment and that by sharing power the power base of the owner expands as the newly empowered recipient is motivated and satisfied. Empowerment, therefore, yields positive results in the workplace as it leads to an increase in job satisfaction, mental health, autonomy and control, staff motivation, respect and admiration for the leader (Bajnok *et al.*, 2005:35). The researcher illustrates in the conceptual map how empowerment of critical care nurses can be accomplished through staff participation with reference to scheduling of off-duties, presentation at managerial meetings and participative decision-making.

2.8.4 Research

2.8.4.1 Risk management and quality improvement

Booyens (2002:583) describes risk management as a tool to limit financial losses that may result from malpractice claims. Therefore a unit manager needs to be familiar with the interrelationship between risk management and quality assurance, in-service training, occupational health and safety, fire safety and security programmes. Unit managers should

ensure that staff members are familiar with routine reporting of incidents and the writing skills involved. Once the incident has been reported, the information should be used to prevent a recurrence thereof (Booyens, 2002:584-585).

Quality improvement is concerned with the monitoring, measuring and evaluating of service delivered, identifying opportunities for improvement and a mechanism that provides for remedial steps to be followed (Booyens, 2002:597). Staff members in the C.C.U. should be actively involved in the quality improvement programme and the unit manager should be a role model in accepting responsibility and accountability for actions that were taken. The unit manager needs to support and actively participate in research efforts that are related to quality improvement (Marquis & Huston, 2001:395).

2.8 SUMMARY

This chapter reflects on the conceptual framework (figure 1.1) illustrated in the first chapter. Attention was given to the role of the unit manager and applications of the different virtues of the leader. Most of the literature used favoured the transformational leadership approach as a mechanism to attain excellence when managing people.

In the following chapter, the researcher will discuss the research methodology applied to conduct the study.

CHAPTER 3.

RESEARCH METHODOLOGY

3.1 Introduction

In the preceding chapters the background and rationale of the study were described. A comprehensive literature review describing the leadership styles, approaches and a theoretical framework were presented.

The impetus of this chapter is to describe the research methodology that was applied to determine the ideal leadership style for unit managers in critical care units.

3.2 GOAL

The goal of the study was to define the ideal leadership style and characteristics for unit managers in critical care units of private health care institutions in the Cape Metropolitan Area.

3.3 OBJECTIVES

The objectives set for this study are:

- To identify the ideal leadership style required in administrative functions
- To identify the ideal leadership style required in the education functions
- To identify the ideal leadership style required in patient care
- To identify the ideal leadership style required in research

3.4 RESEARCH METHODOLOGY

3.4.1 Research design

An exploratory and descriptive non-experimental study with a quantitative approach was applied to identify the ideal leadership style for unit managers in critical care units of private health institutions.

Polit *et al*. (2001:167) describe research design as the comprehensive plan of the researcher for answering the research question or testing the research hypotheses. Research design is a blueprint for managing or supervising the study and by which command is gained over factors that might interfere with the desired outcome. With quantitative studies the design indicates the procedures the researcher aims to follow in order to develop accurate and interpretable information (Burns & Grove, 2007:42).

3.4.2 Research Question

A research question refers to a statement of the relevant query the researcher wishes to answer (Polit *et al.*, 2001:97).

Thus the research question is: What is the ideal leadership style for unit managers in critical care units in private health care institutions?

3.4.3 Population & Sampling

The population (N=287) consists of all nurses working in C.C.U.s of 11 (eleven) private health institutions in the Cape Metropolitan Area. Both day and night staff members were targeted.

Polit *et al.* (2001:467) describe population as the entire sets of individuals having some common characteristics and regards sampling as the process of selecting a portion of the population to represent the entire population (Polit *et al.*, 2001:470). In July 2008 the total number of permanent employed nurses in the eleven participating hospitals was N=287 (see table no 3.1). Excluding the nurses involved in the pilot study (N=27) only 267 nurses were available for the actual study. In September 2008 when data was collected, the total population was N=207. One of the reasons for the difference could be that the human resource officers, who mostly supplied the information, supplied the nursing posts that were available and not the occupied posts. Other reasons might be resignations, nurses on maternity leave and transfers to other hospitals or wards.

Since the population consisted of only permanently employed critical care nurses (N=287), the decision was made to target the whole population. Nursing staff of all categories, on both, day and night shifts, was targeted. The off-duty roster present in every C.C.U. was used to ensure that all the available staff members were targeted. Questionnaires were issued and collected between 2 to 26 September 2008.

Table 3.1: The total population before data collection as in July 2008

Hospital	C.C.U.	Unit Managers	Nurses
1. Cape Town Medi-Clinic	1	1	n 08
2. Constantiaberg Medi-Clinic	1	1	n 21
3. Durbanville Medi-Clinic	1	1	n 37
4. Gatesville Medical Centre	1	1	n 18
5. Kingsbury Hospital	1	1	n 14
6. Kuils River Private Hospital	1	1	n 27
7. Panorama Medi-Clinic	4	4	n 46
8. Milnerton Medi-Clinic	1	1	n 14
9. N1 City Hospital	1	1	n 25
10. Vincent Pallotti Hospital	2	2	n 53
11. U.C.T. Private Hospital	1	1	n 09
Total Population: (n) 15 + (n) 272 = (N) 287	**15**	**(n) 15**	**(n) 272**

Table 3.2: Total population involved in data collection in September 2008

Hospital	C.C.U.	Unit Managers	Nurses	Questionnaires returned	No response
1. Cape Town Medi-Clinic	1	1	n 05	05	
2. Constantiaberg Medi-Clinic	1	1	n 14	09	
3. Durbanville Medi-Clinic	1	1	n 18	14	03
4. Gatesville Medical Centre	1	1	n 12	11	
5. Kingsbury Hospital	1	1	n 16	14	02
6. Kuils River Private Hospital				**Pilot study**	
7. Panorama Medi-Clinic	4	4	n 29	27	02
8. Milnerton Medi-Clinic	1	1	n 08	07	01
9. N1 City Hospital	1	1	n 22	20	01
10. Vincent Pallotti Hospital	2	2	n 25	24	02
11. U.C.T. Private Hospital	1	1	n 06	06	
Total Population: (n)14 + (n)155 = (N) 169	**14**	**(n) 14**	**(n)155**	**137 = 88.4%**	**11 = 7.1%**

3.4.4 Criteria

3.4.4.1 Including Criteria

The following subject selection criteria were set for the purpose of this study:

- All nurses working in critical care units of 11 (eleven) private hospitals in the Cape Metropolitan Area.
- All nurses must be permanently employed at one of the participating hospitals.

3.4.4.2 Excluding Criteria

- Agency staff
- Care givers

3.4.5 Pilot Study

A pilot study was conducted in the Cape Metropolitan Area under similar circumstances as the actual study at Kuils River Private hospital in September 2008, in order to determine the feasibility of the study and consisted of 10% (n=28) of the total population (N=287). The participants of the pilot study were excluded in the actual study. A pilot study also attempts to test the instrument for ambiguity and accuracy and is a trial run, done in preparation for a major study (Polit *et al.*, 2001:467).

3.4.6 Reliability and Validity

Reliability refers to the consistency with which an instrument measures what it is supposed to measure (Burns & Grove, 2007:552). Validity is the extent to which an instrument measures what it is supposed to measure (Polit *et al.*, 2001:473). In support of the validity and reliability of the study, a pilot study took place as a trial run for the measuring instrument as it has to be tested under similar conditions as the actual study. Experts in nursing were consulted to assist with the appropriateness of the individual questions in the questionnaire, thus helping to establish content validity for the instrument. A statistician was consulted to assist with the design of the questionnaire guided the researcher throughout the process.

3.4.7 Ethical considerations

The researcher obtained consent to conduct research from the Committee for Human Science Research of the Faculty of Health Sciences, Stellenbosch University as well as head of departments of the different private hospitals where research was conducted. Informed written consent were obtained from the participants. Confidentiality, anonymity and privacy concerning all information was ensured. To ensure anonymity, each participant was provided with a questionnaire and an envelope. Participants were advised to place the questionnaire into the envelope provided after completion. Sealed envelopes were handed directly to the researcher. The hospital where the researcher is currently employed was excluded from the study.

3.4.8 Instrumentation

Instrumentation consists of a questionnaire with predominantly closed questions. The design of the questionnaire is based on the literature, previous research and the researcher's clinical experience. The questionnaire is divided into various sections namely biographical,

administration, education, patient care and research. The open questions in the following sections: administration, education, patient care and research were structured according to a four point Likert scale, varying from strongly agree to strongly disagree.

3.4.9 Data collection

The original plan for data collection was discussed and illustrated in chapter one. Since the required consent from some of the different hospitals were granted very leisurely and others very speedily and the days the hospitals regarded as fit for data collection clashed with the original plan, the plan had to be adjusted. Data collection started on 6 September 2008 at the Panorama Medi-Clinic and ended on 26 September 2008 at Kingsbury Hospital. Of the N = 155 questionnaires issued, only N = 137 (88.4%) were returned and N = 11 (7.1%) without any response.

Table 3.3: The original plan for data collection

Hospital	First shift of week	Second shift of week
Cape Town Medi-Clinic and U.C.T. Private Hospital	**Week 1**. Monday, day shift: Issue questionnaires between 07:30-09:30. Collect questionnaires between 17:00-19:00. Monday, night shift: Issue questionnaires between 19:30- 22:00. Tuesday: 06:30 collect questionnaires from night staff	**Week 1**. Wednesday, day shift: Issue questionnaires between 07:30-09:30. Collect questionnaires between 17:00-19:00. Wednesday, night shift: Issue questionnaires between 19:30-22:00. Thursday: 06:30 collect questionnaires from night staff
Durbanville -, Panorama Medi-Clinic and Kuils River Hospital	**Week 2**. Follow plan for data collection as in week 1.	**Week.2**. Follow plan for data collection as in week 1
Constantiaberg Medi-Clinic, Gatesville Medical Centre and Kingsbury Hospital	**Week 3**. Follow plan for data collection as in week 1	**Week 3.** Follow plan for data collection as in week 1
Milnerton Medi-Clinic, N1 City Hospital and Vincent Pallotti Hospital	**Week 4.** Follow plan for data collection as in week 1	**Week 4.** Follow plan for data collection as in week 1

Table 3.4: Revised plan for data collection.

Hospital	First shift	Second shift
Panorama Medi-Clinic	06/09/2008 Saturday. Day shift: Issue questionnaires between 07:30-09:30. Collect questionnaires between 17:00-19:00. Night shift: Issue questionnaires between 19:30- 22:00. 06:30 collect questionnaires from night staff.	08/09/2008 Monday, Day shift: Issue questionnaires between 07:30-09:30. Collect questionnaires between 17:00-19:00. Night shift: Issue questionnaires between 19:30-22:00. 06:30 collect questionnaires from night staff.
Durbanville Medi-Clinic	09/09/2008. Follow plan for data collection as above	10/09/2008. Follow plan for data collection as above
Constantiaberg Medi-Clinic, Milnerton Medi-Clinic and U.C.T. Private Hospital	11/09/2008. Follow plan for data collection as above	12/09/2008. Follow plan for data collection as above
Cape Town Medi-Clinic	16/06/2008. Follow plan for data collection as above	17/09/2008. Follow plan for data collection as above
Gatesville Medical Centre, N1 City Hospital and Vincent Pallotti Hospital	20/09/2008. Follow plan for data collection as above	22/09/2008. Follow plan for data collection as above
Kingsbury Hospital	25/09/2008. Follow plan for data collection as above	26/09/2008. Follow plan for data collection as above

3.4.10 Data analysis and interpretation

The data was analysed and interpreted by the researcher with the help of a statistician and a computer program, the S.A.S. (Statistical Analysing System). The data was tabulated, presented in histograms and frequencies. Statistical associations were determined between the various variables using the chi-square test.

3.5 LIMITATIONS

The study was conducted in eleven private hospitals in the Cape Metropolitan Area. The public sector was excluded from the study.

The initial purpose of this study was to identify leadership styles prevalent in C.C.U.s. Because of exploratory undertones of the questionnaire and the possibility of subjectivity, the study was not approved by the Committee of Human Science Research at Stellenbosch University. The researcher was advised to consider the current title, “An ideal leadership style for unit managers in C.C.U.s.” The Committee of Human Science Research advised a change of focus for the study, i.e., to determine the ideal leadership style instead of investigating current leadership styles. The researcher is of the opinion that the current title does not address leadership misconduct.

Most unit managers at the participating hospitals remained indifferent towards the project and walked away while the researcher addressed the staff with regard to the project. Only four unit managers participated in the project.

3.6 DELAYS IN THE COMPLETIONS

As critical care units were very busy it was impossible for the researcher to wait for the nurses to complete the questionnaires. The researcher had to visit each hospital three times daily during the period of data collection. Eleven N = 11 (7.1%) questionnaires were returned without any response.

3.7 LAYOUT OF QUESTIONNAIRE

The questionnaire consisted of five sections: biographical data, administration, education, patient care and research.

Section A - Biographical data

Questions 1 and **2** relate to the age and gender of the participants. Questions **3-7** are concerned with the basic qualifications, year of achievement and years of C.C.U. experience. The rest of the questions (**questions 3 – 6** and **8)** relate to management training and experience. **Question 7** has been omitted since it is repetition of question 1.

All these questions provide information which will assist in determining the strengths of the critical care work force.

Section B - Administration

In Section B, the ideal leadership style with regard to the following variables **(questions 15 - 24)** were determined: decision making, task delegation, problem solving, conflict management, performance appraisal and planning.

Section B consists of twelve questions that relate to the administrative tasks of the unit manager. Each of the first ten questions was coupled with certain scenarios. Each scenario presents a variable and is coupled with four to five options. Each option presents a certain leadership style. Participants were asked to indicate whether they agree, strongly agree, disagree or strongly disagree with the different options. By completing the questionnaire, the participants indicated how they thought or believe an ideal unit manager should behave. **Questions 25 and 26** are open questions concerned with management approaches and a healthy work environment.

Section C - Education

This section is concerned with leadership behaviour that is beneficial for education and training in the critical care setting. The ideal leadership response with regard to the following variables (**questions 28 - 33**) was determined: training, role model, staff participation, staff development, motivation and empowerment.

Section D – Patient care

Section D consists of seven questions that relate to patient care. In this section the ideal leadership response with regard to the following variables **(questions 34 – 36, 41,**) were determined: work ethics, professionalism, organizational climate and record keeping. To gain insight into leadership behaviour the other four questions **(questions 37 - 40)** were also coupled with scenarios but participants were asked to indicate how most unit managers generally handle certain situations, thus a clearer picture of what is going on in the workplace.

Section E - Research

This section consists of five questions, **questions 42-45. Questions 42-44** are concerned with research as it is generally practised in the critical care setting and respondents were asked to indicate the ideal response for a unit manager in each of the scenarios presented. In **question 45** the respondents were asked to indicate whether unit managers normally implement evidence based guidelines.

3.8 CONCLUSION

In chapter 3, the researcher described the research methodology related to the project. The different steps of the methodology and limitations concerned with the project were described. The procedures involving data analysis and interpretation will be discussed in the later chapter.

CHAPTER 4.
ANALYSIS AND INTERPRETATION OF RESEARCH FINDINGS

4.1 INTRODUCTION

In this chapter, the results of the research study will be presented and interpreted. The data is predominantly quantitative.

4.2 DESCRIPTION OF STATISTICAL ANALYSIS

The data is presented in the form of frequency distribution tables (one-way and two-way). Histogram charts were created from the frequency distribution tables. A follow up confirmatory analysis to test for equality of proportions across the levels of the variables was carried out using the chi-squared test (one-way tables). The chi-squared test for independence was also used to test for associations between demographic variables and the responses to the questions on the views of the nurses working in C.C.U., in relation to the types of leadership (two-way tables). Due to sparseness of the contingency tables for the two-way cross classifications between demographic data and responses to the questions under study, the responses were collapsed to represent agreement and disagreement only.

The chi-squared tests for suitability of fit show that the responses were not equally distributed across the categories of the variables all inclusively (one-way frequency distributions). Only some selected variables had statistically significant associations with the demographic variables.

The Chi-square test, a test for significance, is used to quantify the degree to which chance variability may account for the results observed in any individual study.

The p-value is the measure reported from all tests of statistical significance. It is defined as the probability that an effect, at least as extreme as that observed in a particular study, could have occurred by chance alone. If the p-value is greater than 0.05 by convention, the chance cannot be excluded as a likely explanation and the findings are stated as not statistically significant at that level (Burns & Grove, 2003:328-331). Therefore the 95% confidence interval will be applied to determine whether there is an association between variables. The Spearman rank (rho) order correlation was used to show the strength of the relationship between two continuous variables. Spearman rank order correlation shows the strength of the relationship

- between two continuous variables. It is suitable for use if it cannot be assumed

- that the variables are more or less normally distributed. The rho value indicates
- the strength of the correlation. A rho of -1 is a perfect negative correlation,
- a rho of 1 is a perfect positive correlation, and a rho of 0 means there is no
- correlation. The p value indicates whether the correlation is statistically significant.
- Given a large enough sample size (n), even a very weak correlation can be
- statistically significant, and given a small enough sample size even a very
- strong correlation may not be statistically significant (Blanche & Durrheim, 2001). In this study, according to the Spearman rank order, it was identified that the correlations between age (dependant variable) and the independent variables (e.g. B48, B50) are weak correlations, only 5 of which being significant (B56, B73, C98, C101, C105).

4.3 SECTION A: BIOGRAPHICAL INFORMATION

Section A of this chapter is concerned with the biographical data of the respondents: i.e. gender, age, years in C.C.U.s, qualifications and positions held.

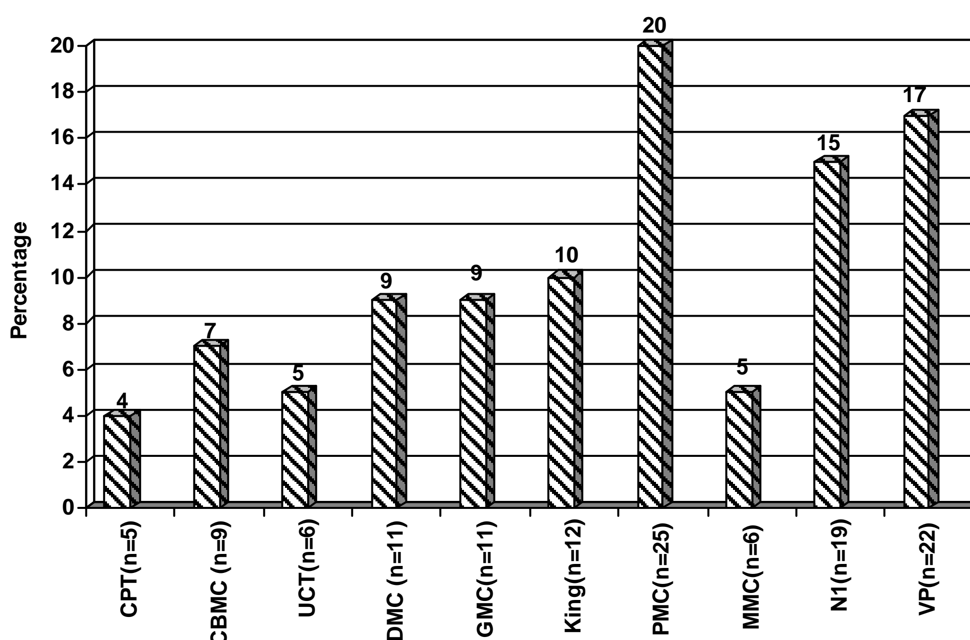

Figure 4.1: Showing participants from the various private hospitals (N=126)

The project was conducted in the Cape Metropolitan Area. Figure 4.1 shows the distribution of the various hospitals from which the sample of participants was drawn from. The majority of participants N=25 (20%) were from Panorama Hospital and the minority N=5 (4%) from Cape Town Medi-Clinic. Participants were from ten (10) private hospitals in the Cape Metropolitan Area.

QUESTION 1: GENDER

This distribution shows the dominance of females in the profession. Table 4.1 shows that the majority of participants were females N=116. Kelly (2006:27) has acknowledged the female dominance in the nursing profession.

Table 4.1: Gender (N=125)

SAMPLE		
Gender	**N**	**%**
Female	116	93
Male	09	07
TOTAL	**125**	**100**

QUESTION 2: AGE (N=123)

Table 4.2 shows the age range of the participants. The majority of participants, N=75 (61%) were between 40 and 50 years of age.

As shown in Table 4.2, the workforce shows signs of ageing in the Cape Metropolitan Area of the Western Cape. N=75 (61%) of the nursing workforce is older than 40 years of age.

The Position Statement of the American Association of Colleges of Nursing (2001) confirms that since fewer nurses are entering the nursing workforce, the current nursing population is ageing.

Table 4.2: Age (N=123)

Age range	N	%
20 -29	22	18
30-39	26	21
40 – 49	48	39
> 50	27	22
TOTAL	**123**	**100**

QUESTION 3: QUALIFICATIONS (N=123)

N=95(77%) of the respondents were professional nurses and only N=29(23%) consisted of non-professional nurses. Since the majority of respondents consisted of nurses with standard training, the assumption is that their opinions reflect reasonable insight into leadership activities.

Table 4.3: Qualifications (N=124)

Qualifications	N	%
Professional nurse	95	77
Enrolled nurse	21	17
Auxiliary nurse	08	06
TOTAL	**124**	**100**

QUESTION 4: YEAR OF ACHIEVEMENT (N=124)

Most of the respondents N = 64 (52%) according to Table 4.4 received training during the period from 1981 to 2000 and N = 36 (29%) were trained between 2001 and 2007.

Table 4.4: Year of Achievement (N=124)

Year of achievement	N	%
1970-1980	19	15
1981-2000	64	52
2001-2007	36	29
Other	05	04
TOTAL	**124**	**100**

QUESTION 5: POST BASIC QUALIFICATIONS

Table 4.5 illustrates that only N = 46 (37%) of the respondents are trained critical care nurses. The number corresponds well with a study done by Gillespie *et al.* (2006:50) to determine the critical care workforce in the Western Cape. It was identified in their study that only 38.1% of the respondents were found to be trained critical care nurses. The results emphasize the need for more trained staff.

Only N = 4 (3%) of the respondents were in possession of a post basic qualification in nursing administration.

Table 4.5: Post Basic Qualifications

Post basic qualification	N	%
Critical care	46	37
Education	16	13
Admin	04	03
Other	12	10
TOTAL	**78**	**63%**

QUESTION 6: YEAR OF ACHIEVING POST BASIC QUALIFICATION (N=64)

Table 4.6 shows that the majority of post-basic qualifications were obtained during the 1980s and 1990s N = 30 (47%) and fewer after the year 2000 N = 24 (38%).

Table 4.6: Post Basic Qualifications (N=64)

Year of achieving post basic qualification	N	%
1970-1980	07	11
1981-2000	30	47
2001-2007	24	38
Other	03	05
TOTAL	**64**	**100%**

QUESTION 7: YEARS IN CCU (N=126)

Most of the respondents N = 70 (56%) had been working in C.C.U. for more than 7 years. The latter shows a well-experienced workforce. N = 56 (44%) have less than 7 years of C.C.U. experience.

Table 4.7: Years in CCU (N=126)

Years in CCU	N	%
<1 year	13	10
1-3 years	22	17
4-5 years	08	06
6-7 years	13	10
>7 years	70	56
Total	**126**	**100**

QUESTION 8: NURSING MANAGEMENT TRAINING DURING THE LAST 5 YEARS (N=121)

According to Table 4.8 only N = 27 (22%) of the respondents had received management training during the last 5 years while N = 94 (78%) had received no training. Table 4.5 indicates that only N = 4 (3%) of the respondents were in possession of a management qualification.

Table 4.8: Nursing management training during the last 5 years (N=121)

Management training	N	%
Yes	27	22
No	94	78
TOTAL	**121**	**100**

QUESTION 9: IN-SERVICE MANAGEMENT TRAINING DURING THE LAST 5 YEARS (N=119)

Table 4.9. shows that only N = 37 (31%) of respondents had received in-service management training during the last 5 years whilst N = 82 (69%) had received no in-service management training.

Table 4.9: In-service management training

In-service management training	N	%
Yes	37	31
No	82	69
TOTAL	**119**	**100**

QUESTION 10: THE POSITION OF A UNIT MANAGER (N=120)

Table 4.10. shows that N = 18 (15%) of respondents had held the position of a unit manager and N = 102 (85%) had not held such a position. A statistical significant association was identified between hospital type and respondents who had held the position of a unit manager in a C.C.U. (Chi-square test p=0.050).

Table 4.10: Position of a unit manager (N=120)

Position of a unit manager	N	%
Yes	18	15
No	102	85
TOTAL	**120**	**100**

QUESTION 11: YEARS AS A UNIT MANAGER (N=17)

Table 4.11 shows that N = 5 (25%) of respondents were in a position as unit manager for more than 7 years and that N = 6 (30%) were in a unit manager position for less than a year.

Table 4.11: Years as a unit manager (N=17)

Years as a unit manager	N	%
<1 year	6	30
1-3 years	2	10
4-5 years	4	20
6-7 years	3	15
>7 years	5	25
TOTAL	**20**	**100**

QUESTION 12: RESPONDENTS AS A SHIFT LEADER (N=90)

Table 4.12.1 shows N =66 (73%) of the respondents as shift leaders and N = 24 (27%)as having not held the position. The results indicate that the majority of professional nurses in C.C.U.s were exposed to leadership practices.

Table 4.12: Respondents as a shift leader (N=90)

Respondents as a shift leader	N	%
Yes	66	73
No	24	27
TOTAL	**90**	**100**

QUESTION 13: YEARS AS A SHIFT LEADER (N=67)

Table 4.13 shows that N = 22 (33%) of the respondents were shift leaders for more than 10 years and N = 7 (10%) were in the position for between 8 and 10 years. The results also show that N = 17 (25%) of respondents were in the position for less than 2 years.

A statistical significant association was identified between hospital type and the number of years the respondents had acted as shift leaders in a C.C.U. (Chi-square test p=0.047).

Table 4.13: Years as a shift leader (N=67)

Years as a shift leader	N	%
<2 year	17	25
3-4 years	10	15
5-7 years	11	16
8-10 years	07	10
>10 years	22	33
TOTAL	**67**	**100**

4.4 SECTION B - ADMINISTRATION

Leadership behaviour that applies to administration tasks such as problem solving, conflict management, decision making and health economics is described in Section B.

QUESTION 15: DECISION MAKING B48, B49, B50, B51

"If structural changes are planned for the unit, for example, new built-in cupboards or new waiting room chairs, the unit managers should…"

Table 4.14 shows 4 variables (B48-B51) and 4 options regarding decision making. .

The results obtained for variable B48 show that the majority 106 (93%) of participants agreed that the staff should be consulted when decisions are made. A further analysis showed that N = 83 (93.3%) of the professional nurses (PN) and N = 23 (92%) of the non-professionals agreed.

The results obtained are supported by Alspach (2005:12): that nurses should be included in decision-making policies and organisational operations.

The results obtained for variable B49 show that the majority 80 (92%) of participants disagreed that the staff should hand the task over to the matron when decisions are made. A further analysis shows that N =65 (94.2%) of the professional nurses (PN) and 15 (83.3%) of the non-professionals disagreed.

The results obtained accentuate the need for participatory management style.

The results obtained for variable B50 show that the majority 60 (87%) of participants disagreed that the unit manager should have sole decision-making power. A further analysis shows that N = 60 (87%) of the professional nurses (PN) and N =15 (79%) of the non-professionals disagreed. This results show that nurses are not in favour of autocratic leadership. Muller (2004:157) also advises nurse leaders not to practice autocratic leadership.

The results obtained for variable B51 show that the majority N = 79 (87.8%) of participants agreed that the unit manager should communicate the rules, procedures and budget. A further analysis shows that N = 61 (87.1%) of the professional nurses (PN) and N = 18(90%) of non-professionals agreed. This shows that nurses are not in favour of bureaucratic leadership styles but prefer open and honest communication, which forms part of the transformational leadership approach (Bajnok *et al.*, 2006:33).

Table 4.14: Decision-Making

		PN	**Non-Professional**
B48	…**obtain the staff's input**.		
	Agree: N=106 (93%)	N=83(93.3%)	N=23(92%)
	Disagree: N=8 (7%)	N=6(6.7%)	N=2(8%)
	TOTAL: N =114	**N=89**	**N=25**
B49	…**hand the task over to the matron**.		
	Agree: N=7(8%)	N=4(5.8%)	N=3(16.7%)
	Disagree: N=80(92%)	N=65(94.2%)	N=15(83.3%)
	TOTAL: N=87	**N=69**	**N=18**
B50	…**decide what is needed and choose it all by herself.**		
	Agree: N=13 (14.8%)	N=9(13%)	N=4(21%)
	Disagree: N=75 (85.2%)	N=60(87%)	N=15(79%)
	TOTAL: N= 88	**N=69**	**N=19**
B51	…**emphasize the budget, the rules and the procedures involved**.		
	Agree: N=79(87.8%)	N=61(87.1%)	N=18(90%)
	Disagree: N=11(12.2%)	N=9(12.9%)	N=2(10%)
	TOTAL: N=90	**N=70**	**N=20**

QUESTION 16: TASK DELEGATION B52, B53, B54, B55

"When the daily delegation of tasks takes place, a unit manager should…"

Table 4.15 shows the results obtained for variable B52 indicating that the majority N = 98 (88.3%) of participants agreed that the unit manager should encourage the staff's input and opinions before delegating tasks. A statistical significant association was identified between both professional and non-professional nurses and that managers should welcome the staff's input and opinions before delegating tasks (Chi-square test p = 0.006). These results show that nurses value consultation in the work place and therefore prefer participatory management.

Table 4.15 shows the results obtained for variable B53 indicating that the majority N = 76 (89.4%) of participants disagreed that tasks be delegated without considering the staff's opinion. A statistical significant association was identified between both professional and non-professional nurses and that tasks should be delegated without considering the staff's opinion

(Chi-square test p = 0.03). As described in B52 the results show that nurses prefer to be consulted in the work place and therefore chose participatory management.

Table 4.15 shows the results obtained for variable B54 indicating that the majority N = 54 (64.3%) of participants disagreed that task delegation be transferred to the second in command. A further analysis shows that N = 42 (63.6%) of the professional nurses (PN) and N = 12 (66.7%) of non-professionals disagreed. As described in B52 the results show that nurses prefer to be consulted in the work place and therefore prefer participatory management.

Table 4.15 shows the results obtained for variable B55 indicating that the majority N = 81 (84.4%) of participants agreed that unit managers should consider rules and regulations when task delegation takes place. A further analysis shows that N = 63 (82.9%) of the professional nurses (PN) and N = 18 (90%) of non-professionals agreed. A statistically significant association was identified between years of experience and delegation of tasks according to the rules and regulations (Chi-square test p = 0.016).

Table 4.15: Task delegation

		PN	**Non-Professional**
B52	…welcome the staff 's input and opinions before delegating tasks		
	Agree: N=98 (88.3%)	N=72(84.7%)	N=26(100%)
	Disagree: N=13 (11.7%)	N=13(15.3%)	N=0(0%)
	TOTAL: N =111	**N=85**	**N=26**
B53	…delegate tasks without considering the staff's opinion		
	Agree: N=9(10.6%)	N=9(13.4%)	N=0(0%)
	Disagree: N=76(89.4%)	N=58(86.6%)	N=18(100%)
	TOTAL: N=85	**N=67**	**N=18**
B54	…transfer delegation of tasks to the second in command.		
	Agree: N=30 (35.7%)	N=24(36.4%)	N=6(33.3%)
	Disagree: N=54 (64.3%)	N=42(63.6%)	N=12(66.7%)
	TOTAL: N= 84	**N=66**	**N=18**
B55	…delegate tasks according to the rules and regulations		
	Agree: N=81(84.4%)	N=63(82.9%)	N=18(90%)
	Disagree: N=15(15.6%)	N=13(17.1%)	N=2(10%)
	TOTAL: N=96	**N=76**	**N=20**

QUESTION 17: PROBLEM SOLVING B56, B57, B58, B59

"You have lodged a complaint with the unit manager (um), e.g. you feel that you have been assigned to nurse very sick patients often while other nurses are only assigned to patients who are less seriously afflicted. What is the ideal response from your unit manager (i.e. a response that you would prefer)?"

Table 4.16 shows the results obtained for variable B56. The majority N = 101 (93.5%) of participants agreed that the unit manager should investigate the complaint and give honest and objective feedback. A further analysis shows that N = 80 (95.2%) of the professional nurses (PN) and N = 21 (87.5%) of non-professionals agreed. A Spearman test identified a correlation with significance between age and the unit manager investigating the complaint and giving honest and objective feedback (rho = -0.01; p=0.02). These results show that the nurses prefer unit managers to display integrity and fairness in the work place. These attributes are grounded in the transformational leadership approach (Bajnok *et al*., 2006:33).

Table 4.16 shows the results obtained for variable B57. The majority N = 43 (51.2%) of participants agreed that the unit manager should give a meaningful explanation for her actions. A further analysis shows that N = 34 (50.7%) of the professional nurses (PN) and N = 9 (52.9%) of non-professionals agreed. The results indicate that nurses value assertiveness and effective communication from unit managers. These traits are important for conflict management (Kelly, 2006:27) and are also grounded in the transformational leadership approach (Bajnok *et al*., 2006:33).

Table 4.16 shows the results obtained for variable B58. The majority N = 55 (64%) of participants agreed that the unit manager's actions could be attributed to the heavy workload in C.C.U.s (Simons, 2003:69). A further analysis shows that N=44 (63.8%) of the professional nurses (PN) and N=11 (64.7%) of non-professionals agreed. A statistically significant association was identified between years of experience in the CCU and the unit manager justifying her decision based on the current workload (Chi-square test p = 0.098).

Table 4.16 shows the results obtained for variable B59. The majority N=62 (69.7%) of participants agreed that the unit manager should apologise and admit the lack of thoroughness on her part. A further analysis shows that N=49 (68.1%) of the professional nurses (PN) and N=13 (76.5%) of non-professionals agreed. As described in B52 the results show that nurses do not approve of laissez-faire behaviour but prefer participatory management.

Table 4.16: Problem solving

		PN	**Non-Professional**
B56	The unit manager investigates the complaint and gives honest and objective feedback.		
	Agree: N =101 (93.5%)	N = 80 (95.2%)	N =21 (87.5%)
	Disagree: N = 7 (6.5%)	N = 4 (4.8%)	N = 3 (12.5%)
	TOTAL: N = 108	**N = 84**	**N = 24**
B57	She gives her reasons and asks you to continue with your work.		
	Agree: N=43 (51.2%)	N=34 (50.7%)	N=9 (52.9%)
	Disagree: N=41 (48.8%)	N=33(49.3%)	N=8 (47.1%)
	TOTAL: N=84	**N=43**	**N=17**
B58	She justifies her decision based on the current workload.		
	Agree: N=55 (64%)	N=44 (63.8%)	N=11 (64.7%)
	Disagree: N=31 (36%)	N=25 (36.2%)	N=6 (35.3%)
	TOTAL: N= 86	**N=69**	**N=17**
B59	She apologizes and acknowledges that she was not aware of it.		
	Agree: N=62 (69.7%)	N=49 (68.1%)	N=13 (76.5%)
	Disagree: N=27 (30.3%)	N=23 (31.9%)	N= 4(23.5%)
	TOTAL: N=89	**N=72**	**N=17**

QUESTION 18: CONFLICT MANAGEMENT B60, B61, B62, B63

"When dealing with disputes the unit manager needs to apply certain rules and procedures. Two or more persons have a dispute and one of them complains to the unit manager."

Table 4.17 shows the results obtained for variable B60. The majority N = 109 (94%) of participants agreed that the unit manager must support conflict management objectively and encourage the rival parties to talk to each other. Marquis and Huston (2001:357) also advise managers to encourage those involved to try to solve the problem themselves. A further analysis shows that N = 86 (93.5%) of the professional nurses (PN) and N = 23 (95.8%) of non-professionals agreed. As described in B52 the results show that nurses do not approve of 'laissez- faire' behaviour but prefer participatory management.

Table 4.17 shows the results obtained for variable B61. The majority N=58(71.6%) of participants disagreed that the unit manager should be the only person to decide on who is

right or wrong where conflict is concerned. A further analysis shows that N = 49 (75.4%) of the professional nurses (PN) and N = 9 (56.3%) of non-professionals disagreed. The results show that nurses do not approve of autocratic behaviour but prefer to be involved in decision-making that affects them. Kelly (2006:26) confirms that collaboration, i.e. a win-win solution and a transformational approach is desirable for conflict management.

Table 4.17 shows the results obtained for variable B62. The majority of participants N = 66 (80.5%) disagreed that the unit manager should refer the matter to the matron. A statistically significant association was also identified between years of experience in the C.C.U. and the unit manager referring the matter to the matron (Chi-square test p = 0.080). A further analysis shows that N = 86 (93.5%) of the professional nurses (PN) and N = 23 (95.8%) of non-professionals disagreed. The results demonstrate that nurses do not approve of laissez-faire behaviour but prefer participatory leadership.

Table 4.17 shows the results obtained for variable B63. The majority N=60 (71.4%) of participants disagreed on the option of avoidance as a solution to conflict. A further analysis shows that N=47 (71.2%) of the professional nurses (PN) and N=13 (72.2%) of non-professionals disagreed. The results affirm that nurses do not approve of laissez-faire behaviour. Booyens (2002:425) confirms that this non-directive leadership style paves the way for higher levels of frustration.

Table 4.17: Conflict Management

		PN	**Non-Professional**
B60	The unit manager assesses the situation and encourages them to speak honestly and openly to each other.		
	Agree: N=109 (94%)	N=86 (93.5%)	N=23 (95.8%)
	Disagree: N=7 (6%)	N=6 (6.5%)	N=1 (4.2%)
	TOTAL: N =116	**N=92**	**N=24**
B61	She decides who is to blame and responds accordingly.		
	Agree: N=23 (28.4%)	N=16 (24.6%)	N=7 (43.7%)
	Disagree: N=58(71.6%)	N=49(75.4%)	N=9 (56.3%)
	TOTAL: N=81	**N=65**	**N=16**
B62	The unit manager refers the dispute to the matron.		
	Agree: N=16 (19.5%)	N= 10(15.4%)	N=6 (35.3%)
	Disagree: N=66 (80.5%)	N= 55(84.6%)	N=11 (64.7%)
	TOTAL: N= 82	**N=65**	**N=17**
B63	She changes the off-duty roster so that those involved have little or no contact with each other.		
	Agree: N=24 (28.6%)	N=19 (28.8%)	N= 5(27.8%)

	Disagree: N=60 (71.4%)	N=47 (71.2%)	N=13 (72.2%)
	TOTAL: N=84	**N=66**	**N=18**

QUESTION 19: PLANNING B64, B65, B66, B67

"How often should climate meetings be held?"

Table 14.18 show the results obtained for variables B64-B67

B64. The majority of nurses N=89 (72%) agreed that climate meetings should be held whenever necessary. The latter is congruent to Kelly's (2006:27) recommendation that nurses must embrace conflict constructively.

B65. Since only N = 27 (22%) of the respondents agreed that climate meetings should take place every 6 months, it is clear that nurses do not opt for avoidance as means to resolve conflict and therefore do not approve of laissez-faire leadership.

B66. Only N = 3 (2%) of the participants preferred climate meetings to be held in crisis situations. If climate meetings were only to be held in desperate times, it would indicate that prior incidents leading to the current situation had been ignored. The latter emphasizes the error of avoiding climate meetings and therefore laissez-faire leadership with regard to conflict. A holistically viewing of the results of question 18 and 19 indicates the nurses' preference for openness and honesty where conflict management is concerned. Openness and honesty are based in the transformational leadership approach which Kelly (2006:27) regards as highly ethical and suitable for the critical care setting.

B67. Only N = 4 (3%) of the participants were not in favour of climate meetings.

Table 4.18: Planning

B64	Whenever necessary.	N= 89(72%)
B65	Every 6 months.	N=27(22%)
B66	Only when conflict situations become untenable.	N=3(2%)
B67	Never.	N=4(3%)
	TOTAL: N=	**N=123 (100%)**

QUESTION 20: HEALTH ECONOMICS B68, B69, B70, B71.

"Staff should be involved in cost containment and cost awareness measures. When there is a problem with stock not being charged, the unit manager should …"

Table 4.19 shows the results obtained for variable B68. The majority N =107 (99%) of participants agreed that the unit manager should involve the staff when seeking solutions with regard to cost containment. A further analysis shows that N = 86 (100%) of the professional nurses (PN) and N = 21 (95.5%) of non-professionals agreed. A statistical significant association was identified between both professional and non-professional nurses and the proposal that managers should seek the staff input and opinions related to cost containment (Chi-square test p = 0.072). The results affirm that nurses prefer participatory leadership as explained in B52.

Table 4.19 shows the results obtained for variable B69. The majority N =48 (56.5%) of participants disagreed that the unit manager should decrease ward stock and inform staff to order what each patient requires. A further analysis shows that

N = 40 (58.8%) of the professional nurses (PN) and N = 8 (47.1%) of non-professionals agreed. The results affirm that nurses prefer participatory leadership as explained in B52.

Table 4.19 shows the results obtained for variable B70. The majority N =42 (53.2%) of participants agreed that the unit manager should approach the secretary for assistance to help solve the problem. A further analysis shows that

N = 33 (51.6%) of the professional nurses (PN) and N = 9 (60%) of non-professionals agreed. The results affirm that nurses need support since the workload in the critical care setting is intense (Simons, 2003:69).

Table 4.19 shows the results obtained for variable B71. The majority N =78 (88.6%) of participants agreed that the unit manager should present a lecture on how to order and charge stock. A further analysis shows that N=62 (88.6%) of the professional nurses (PN) and N=16 (88.9%) of non-professionals agreed. The results affirm that nurses prefer unit managers who communicate well and offer structured learning (Grossman & Valiga, 2007:64).

Table 4.19: Health Economics

		PN	Non-Professional
B68	… have a meeting with the staff where she explains the losses and asks them for possible solutions.		
	Agree: N=107 (99%)	N=86 (100%)	N=21 (95.5%)
	Disagree: N=1 (1%)	N=0 (0%)	N= (4.5%)
	TOTAL: N =108	**N=86**	**N=22**
B69	… decrease ward stock and inform staff to order what each patient requires.		
	Agree: N=37 (43.5%)	N=28 (41.2%)	N=9 (52.9%)
	Disagree: N=48 (56.5%)	N=40(58.8%)	N=8 (47.1%)
	TOTAL: N=85	**N=68**	**N=17**
B70	…. ask the secretary to help solve the problem.		
	Agree: N=42 (53.2%)	N=33 (51.6%)	N=9 (60%)
	Disagree: N=37 (46.8%)	N=31 (48.4%)	N=6 (40%)
	TOTAL: N= 79	**N=64**	**N=15**
B71	… present a lecture on how to order and charge stock.		
	Agree: N=78 (88.6%)	N=62 (88.6%)	N=16 (88.9%)
	Disagree: N=10 (11.4%)	N= 8(11.4%)	N=2 (11.1%)
	TOTAL: N=88	**N=70**	**N=18**

QUESTION 21: PERFORMANCE APPRAISAL. B72, B73, B74, B75, B76.

"How should performance appraisal be applied?"

Table 4.20 shows the results obtained for variable B72. The majority N =109 (95.6%) of participants agreed that performance appraisal should be accompanied with dialogue between the unit manager and the staff member. A further analysis shows that N = 86 (95.6%) of the professional nurses (PN) and N = 23 (95.8%) of non-professionals agreed. A statistical significant correlation was identified between years of experience in the C.C.U. and the proposal that performance appraisal should be accompanied with dialogue between the unit manager and the staff member (Chi- square test p = 0.098). The results relate to Muller's (2004:299) opinion that performance appraisal should be coupled with an interview. Since workers must be involved in goal setting (Marquis & Huston, 2001:416) the results support a preference towards participatory leadership.

Table 4.20 shows the results obtained for variable B73. The majority N=69 (86.3%) of participants agreed to an opportunity to give feedback that relating to the unit managers' conduct. A further analysis shows that N=62 (88.6%) of the professional nurses (PN) and N=16 (88.9%) of non-professionals agreed. A statistical significant association was identified between both professional and non-professional nurses and an opportunity to give feedback that regarding the unit managers conduct (Chi-square test p = 0.025). A Spearman test identified a correlation with significance between age and that the staff should get an opportunity to give feedback regarding the unit manager’s conduct (rho = -0.01; p=0.02). The results affirm that nurses prefer a unit manager who communicates well, provides accountability and acknowledges his/her mistakes. These traits are present in the transformational leadership approach (Bajnok *et al.*, 2006:33).

Table 4.20 shows the results obtained for variable B74. The majority N = 74 (93.7%) of participants disagreed that performance appraisal should comprise of only a written form and no dialogue. A further analysis shows that N = 59 (93.6%) of the professional nurses (PN) and N = 15 (93.7%) of non-professionals disagreed. The results affirm that nurses prefer participatory leadership as explained in B52.

Table 4.20 shows the results obtained for variable B75. The majority N=72 (91.1%) of participants disagreed that performance appraisal should not take place. A further analysis shows that N = 56 (88.9%) of the professional nurses (PN) and N =14 (87.5%) of non-professionals disagreed. The results affirm that nurses prefer participatory leadership as explained in B52 instead of laissez-faire leadership.

Table 4.20 shows the results obtained for variable B76. The majority N=68 (87.2%) of participants disagreed that performance appraisal should only take place once the unit manager had completed her administrative functions. A further analysis shows that N = 58 (92.06%) of the professional nurses (PN) and N=12 (80%) of non-professionals disagreed. A statistical significant correlation was identified between years of experience in the C.C.U. and the proposal that performance appraisal should only take place once the unit manager had completed her administrative functions (Chi- square test p = 0.044). The results affirm that nurses prefer participatory leadership as explained in B52 instead of bureaucratic leadership.

Table 4.20: Performance Appraisal.

		PN	Non-Professional
B72	By means of a conversation between the unit manager and the staff member.		
	Agree: N=109 (95.6%)	N= 86 (95.6%)	N= 23(95.8%)
	Disagree: N= 5(4.4%)	N= 4(4.4%)	N= 1 (4.2%)
	TOTAL: N =114	**N= 90**	**N= 24**
B73	The staff gets an opportunity to give feedback that applies to the unit manager's conduct.		
	Agree: N=69 (86.3%)	N=54 (83.1%)	N= 15 (100%)
	Disagree: N=11 (13.7%)	N=11 (16.9%)	N= 0 (0%)
	TOTAL: N=80	**N=65**	**N= 15**
B74	The unit manager hands out a form with a given score which indicates what you are worth and asks you to sign it without discussing it.		
	Agree: N= 5 (6.3%)	N= 4 (6.4%)	N= 1 (6.3%)
	Disagree: N=74 (93.7%)	N= 59 (93.6%)	N= 15 (93.7%)
	TOTAL N= 79	**N= 63**	**N= 16**
B75	Performance appraisal does not take place.		
	Agree: N=7 (8.9%)	N=5 (7.9%)	N=2 (12.5%)
	Disagree: N=72 (91.1%)	N= 58 (92.06%)	N=14 (87.5%)
	TOTAL: N=79	**N=63**	**N=16**
B76	The unit manager is a very busy administrator and performance appraisal only takes place when her schedule allows it.		
	Agree: N=10 (12.8%)	N=7 (11.1%)	N= 3 (20%)
	Disagree: N=68 (87.2%)	N= 56 (88.9%)	N=12 (80%)
	TOTAL: N=78	**N=63**	**N=15**

QUESTION 22: ASSESSMENT OF WORK PERFORMANCE. B77, B78, B79, B80

"Performance appraisal takes place annually between you and the unit manager. What would be the ideal atmosphere that should prevail during the conversation?"

Table 4.21 shows the results obtained for variable B77. The majority N= 119 (99.2%) of participants agreed that the atmosphere during performance appraisal should be honest and open. A further analysis shows that N = 58 (92.06%) of the professional nurses (PN) and N=12 (80%) of non-professionals agreed. The results affirm that nurses prefer participatory leadership as explained in B52.

Table 4.21 shows the results obtained for variable B78. The majority N = 73 (96%) of participants disagreed that the atmosphere during performance appraisal should be vague, superficial and non-directive. A further analysis shows that N = 61 (96.8%) of the professional nurses (PN) and N=12 (92.3%) of non-professionals disagreed. The results affirm that nurses do not prefer laissez-faire leadership.

Table 4.21 shows the results obtained for variable B79. The majority N = 72 (91.1%) of participants disagreed that the atmosphere during performance appraisal should be tense and somewhat scary. A further analysis shows that N = 58 (89.2. %) of the professional nurses (PN) and N=14 (100%) of non-professionals disagreed. A statistical significant association was identified between both professional and non-professional nurses and that the atmosphere during performance appraisal should be tense and somewhat scary (Chi-square test p = 0.090).The results affirm that nurses do not prefer autocratic leadership.

Table 4.21 shows the results obtained for variable B80. The majority N = 54 (70.1%) of participants disagreed that the atmosphere during performance appraisal should be nonchalant or somewhat irritating. A further analysis shows that N = 44 (69.8%) of the professional nurses (PN) and N=10 (71.4%) of non-professionals disagreed. The results affirm that nurses do not prefer bureaucratic leadership.

Table 4.21: Assessment of work performance

		PN	**Non-Professional**
B77	Honest and frank (open).		
	Agree: N=119 (99.2%)	N=92 (98.9%)	N=27 (100%)
	Disagree: N=1 (0.8%)	N=1 (1.1%)	N=0 (0%)
	TOTAL: N=120	**N=93**	**N=27**
B78	Vague, superficial and non-directive.		
	Agree: N=3 (4%)	N=2 (3.2%)	N=1 (7.7%)
	Disagree: N=73 (96%)	N=61 (96.8%)	N=12 (92.3%)
	TOTAL: N=76	**N=63**	**N=13**
B79	Tense, as you do not feel bold enough to speak or ask questions.		
	Agree: N=7 (8.9%)	N=7 (10.8%)	N=0 (0%)
	Disagree: N=72 (91.1%)	N=58 (89.2%)	N=14 (100%)
	TOTAL: N= 79	**N=65**	**N=14**
B80	This is just another procedure that need to be conducted.		
	Agree: N=23 (29.9%)	N=19 (30.2%)	N=4 (28.5%)
	Disagree: N=54 (70.1%)	N=44 (69.8%)	N=10 (71.4%)
	TOTAL: N=77	**N=63**	**N=14**

QUESTION 23*:* MANAGEMENT APPROACH B81, B82, B83, B84

"An ideal management approach in intensive care units should be…."

Table 4.22 shows the results obtained for variable B81. The majority N = 73 (93.6%) of participants disagreed to leadership behaviour that does not consider the staff's opinion. A further analysis shows that N = 60 (95.2%) of the professional nurses (PN) and N = 13 (86.7%) of non-professionals disagreed. The results affirm that nurses do not prefer autocratic leadership.

Table 4.22 shows the results obtained for variable B82. The majority N = 69 (90.8%) of participants disagreed to leadership behaviour where decisions are made, based on norms and standards, without consulting the staff. A further analysis shows that N = 58 (92%) of the professional nurses (PN) and N =11 (84.6%) of non-professionals disagreed. The results affirm that nurses do not prefer bureaucratic leadership.

Table 4.22 shows the results obtained for variable B83. The majority N = 73 (96%) of participants disagreed to leadership behaviour where control is given to the group and the unit manager provides little or no direction. A further analysis shows that N = 60 (96.8%) of

the professional nurses (PN) and N =13 (92.9%) of non-professionals disagreed. The results affirm that nurses do not prefer laissez-faire leadership.

Table 4.22 shows the results obtained for variable B84. The majority N = 121 (99.2%) of participants agreed to a leadership approach where the staff are involved in decision making and it is honest and open. A further analysis shows that N = 93 (98.9%) of the professional nurses (PN) and N = 28 (100%) of non-professionals agreed. The results affirm the nurses' preference to participatory leadership and a transformational approach (see B56).

Table 4.22: Management approach

		PN	**Non-Professional**
B81	…where the leader makes decisions without consulting the staff.		
	Agree: N=5 (6.4%)	N=3 (4.8%)	N=2 (13.3%)
	Disagree: N=73 (93.6%)	N=60 (95.2%)	N=13(86.7%)
	TOTAL: N =78	**N=63**	**N=15**
B82	…where decisions are made, based strictly on norms and standards, without consulting staff.		
	Agree: N=7 (9.2%)	N=5 (8%)	N=2 (15.4%)
	Disagree: N=69 (90.8%)	N=58 (92%)	N=11 (84.6%)
	TOTAL: N=76	**N=63**	**N=13**
B83	…where control is given to the group and the unit manager provides little or no direction.		
	Agree: N=3 (4%)	N=2 (3.2%)	N=1 (7.1%)
	Disagree: N=73 (96%)	N=60 (96.8%)	N=13 (92.9%)
	TOTAL: N=76	**N=62**	**N=14**
B84	…where the staff are involved in decision-making and it is honest and open.		
	Agree: N=121 (99.2%)	N=93 (98.9%)	N=28 (100%)
	Disagree: N=1 (0.8%)	N=1 (1.1%)	N=0 (0%)
	TOTAL: N=122	**N=94**	**N=28**

QUESTION 24: WORK ENVIRONMENT. B85, B86

"Does a unit manager's actions and presence contribute to a healthy work environment?"

B85 – B86 The majority N = 107 (90%) of participants agreed that a unit manager's presence and actions contribute to a healthy work environment. The results confirm that the participants value the presence of a leader.

Table 4.23: Work Environment.

B85/86	Yes or no?		
	Yes: N=107 (89.9%)	N=84 (92.3%)	N=23 (82.1%)
	No: N=12 (10.1%)	N=7 (7.7%)	N= 5 (17.9%)
	TOTAL: N=119	**N=91**	**N=28**

QUESTION 25:

"If the answer to question 24 is no, please elaborate."

Only 10 participants responded to this question. The most general complaint regarding unit managers was their favouritism of certain staff members. Other complaints were: tactlessness; non-recognition of overtime; unit managers not distancing themselves from inter-staff problems; intimidating behaviour; using her power against the staff; autocratic conduct; favouritism of the patients of certain doctors was also mentioned.

QUESTION 26:

"Give suggestions how unit manager's behaviour can lead to the improvement of the working environment in I.C.U."

The following themes were identified: integrity, presence and accessibility, professionalism, conflict and problem solving, patient care and staffing, training, personnel management.

Table 4.24

Theme	Leadership Behaviour	Request
Integrity	impartiality, no favouritism	16
	trust	10
	honesty	07
	refrain from gossip	06
	consistency	04
	transparency	01
Presence and accessibility	approachability and openness	15
	be attentive and a good listener	05
	staff support when unit is busy	09
	friendliness	05

	be visible	03
	available for suggestions	03
	be less of an administrator	01
	no “I am the manager” attitude	01
	refrain from autocratic behaviour	01
Professionalism	effective communication	06
	professional conduct	05
	be a role mode	06
	positive attitude	05
	keep professional distance from staff	02
	not to be moody	02
	disciplined, punctual	01
	do not shout, avoid loudness	01
	be effective, committed and knowledgeable	06
	stability	01
	confidence	01
	presentable	01
Conflict and problem solving	problem solving will be easier if unit manager is more visible and approachable	01
	start problem solving as soon as possible	01
	be objective and neutral	01
	try and solve problems on unit level	01
	confront staff members who do not bring their side	01
	include those involved	01
Patient care, staffing	be patient-orientated and involved	12
	be flexible	03
	be assertive	02
	address staff shortages	01
	be a team player	01
	patient care should be her first priority	01
Training	provide training where necessary	01
	offer structured learning	01
	address shortcomings whether training or quality	01
Personnel Management	ongoing supervision of staff where tasks are concerned	01
	feedback on problems that unit manager had to address	02
	practice participative decision making	09
	provide opportunity for staff members to give input	02
	provide set standards and achieve goals	02
	outside of work team building sessions	01
	delegate clinical work	02
	involve staff with regard to meetings	01
	create a secure environment	01
	be an advocate for the staff	06
	do not isolate yourself	01
	better awareness of staff, be sensitive to their feelings	01
	if the unit manager disagrees with management, she should confront them	01

	employ the correct category of staff, and ensure assistance that is competent and professional	01
	unit manager needs to have a qualification in nursing administration	01

QUESTION 27: QUALITY CONTROL. B87, B88, B89, B90.

"Quality assurance and quality improvement are closely linked. Should unit managers ..."

Table 4.25 shows the results obtained for variable B87. The majority N = 111 (98.2%) of participants agreed that unit managers should be involved with the auditing of files and provide the staff with feedback. A further analysis shows that 83 (97.6%) of the professional nurses (PN) and N = 28 (100%) of non-professionals agreed. The results affirm that nurses prefer participatory leadership

Table 4.25 shows the results obtained for variable B88. The majority N = 74 (97.4%) of participants disagreed that unit managers should delegate quality assurance tasks and not give any feedback to the staff. A further analysis shows that N = 59 (98.36%) of the professional nurses (PN) and N =15 (93.7%) of non-professionals disagreed. A statistical significant association was identified between years of experience in the C.C.U. and that unit managers should delegate quality assurance tasks and not give any feedback to the staff (Chi-square test p = 0.058). The results affirm that nurses prefer participatory leadership and reject autocratic behaviour.

Table 4.25 shows the results obtained for variable B89. The majority N = 76 (89.4%) of participants agreed that unit managers should follow company policy with regard to the auditing of files. A further analysis shows that N = 62 (91.2%) of the professional nurses (PN) and N = 14 (82.3%) of non-professionals agreed. Holistically viewed, the results show that nurses acknowledge the underlying rules and regulations that guide their profession, but prefer to be consulted in the work place.

Table 4.25 shows the results obtained for variable B90. The majority N = 75 (97.4%) of participants disagreed that unit managers should audit the files themselves and not take responsibility for shortcomings detected. A further analysis shows that N = 60 (96.8%) of the professional nurses (PN) and N =15 (100%) of non-professionals disagreed. A statistical significant association was identified between years of experience in the C.C.U. and that unit managers should audit the files themselves and not take responsibility for shortcomings detected (Chi-square test p = 0.046). The results reiterate that nurses prefer participatory leadership and reject laissez-faire behaviour.

Table 4.25: Quality Control

		PN	**Non-Professional**
B87	…be involved with the staff when auditing files and giving feedback to the staff?		
	Agree: N=111 (98.2%)	N=83 (97.6%)	N=28 (100%)
	Disagree: N=2 (1.8%)	N=2 (2.4%)	N=0 (0%)
	TOTAL: N =113	**N=85**	**N=28**
B88	…delegate quality assurance tasks to staff members and not give any feedback?		
	Agree: N=2 (2.6%)	N=1 (1.7%)	N=1 (6.3%)
	Disagree: N=74 (97.4%)	N=59 (98.36%)	N=15 (93.7%)
	TOTAL: N=76	**N=60**	**N=16**
B89	…follow company policy with regard to the auditing of files?		
	Agree: N=76 (89.4%)	N=62 (91.2%)	N=14 (82.3%)
	Disagree: N=9 (10.6%)	N=6 (8.8%)	N=3 (17.7%)
	TOTAL N=85	**N=68**	**N=17**
B90	…audit the files themselves but not take responsibility for shortcomings detected?		
	Agree: N=2 (2.6%)	N=2 (3.2%)	N=0 (0%)
	Disagree: N=75 (97.4%)	N=60 (96.8%)	N=15 (100%)
	TOTAL: N=77	**N=62**	**N=15**

4.5 SECTION C – EDUCATION:

This section is concerned with leadership behaviour, which is beneficial for education in a C.C.U.

QUESTION 28: TRAINING AND DEVELOPMENT. C91, C92, C93, C94.

"The unit manager needs to educate and motivate staff. How should a unit manager approach in-service training?"

Table 4.26 shows the results obtained for variable C91. The majority N = 100 (96.2%) of participants agreed that unit managers should involve staff in assessing needs and plan concertedly to address those needs. A further analysis shows that N = 77 (95.1%) of the professional nurses (PN) and N = 23 (100%) of non-professionals agreed. The results show the nurses' preference to consultation in the work place and therefore their preference for participatory leadership.

Table 4.26 shows the results obtained for variable C92. The majority N = 54 (67.5%) of participants agreed that unit managers should ask the training & development consultant to

assess the needs. A further analysis shows that N=40 (62.5%) of the professional nurses (PN) and N = 14 (87.5%) of non-professionals agreed. A statistical significant association was identified between both professional and non-professional nurses and that unit managers should ask the training and development consultant to assess the needs (Chi-square test p = 0.041). The results show the nurses' preference to consultation in the work place and therefore their preference for participatory leadership and support in training and development

Table 4.26 shows the results obtained for variable C93. The majority N=44 (57.1%) of participants agreed that unit managers should attach notifications of in-service training sessions on the notice board and leave it for the individual to decide whether he/she wants to attend. A further analysis shows that N = 34 (55.8%) of the professional nurses (PN) and N=10 (62.5%) of non-professionals agreed. The results again show the preference to consultation in the work place and therefore the preference for participatory leadership and support in training and development.

Table 4.26 shows the results obtained for variable C94. The majority N = 47 (56.6%) of participants agreed that unit managers may delegate staff to attend certain lectures and inform them that the lectures are compulsory. A further analysis shows that N =31 (49.2%) of the professional nurses (PN) and N =16 (80%) of non-professionals agreed. A statistical significant association was identified between both professional and non-professional nurses and that unit managers may delegate staff to attend certain lectures and inform them that the lectures are compulsory (Chi-square test p = 0.0123). The results again show the preference to consultation in the work place and therefore the preference for participatory leadership and support in training and development.

Table 4.26: Training and Development.

		Professional Nurse	Non-Professional
C91	She involves staff in assessing needs and plans concertedly to address those needs.		
	Agree: N = 100 (96.2%)	N = 77 (95.1%)	N = 23 (100%)
	Disagree: N = 4 (3.8%)	N = 4 (4.9%)	N = 0 (0%)
	TOTAL: N = 104	**N = 81**	**N = 23**
C92	She asks the training & development consultant to assess the needs.		
	Agree: N = 54 (67.5%)	N = 40 (62.5%)	N =14 (87.5%)
	Disagree: N = 26 (32.5%)	N = 24 (37.5%)	N = 2 (12.5%)
	TOTAL: N = 80	**N = 64**	**N = 16**
C93	She attaches notifications of in-service training sessions on the board and leaves it for the individual to decide.		
	Agree: N = 44 (57.1%)	N = 34 (55.8%)	N = 10 (62.5%)
	Disagree: N = 33 (42.9)	N = 27 (44.2%)	N = 6 (37.5%)
	TOTAL: N = 77	**N = 61**	**N = 16**
C94	She delegates staff to attend certain lectures and informs them these are compulsory.		
	Agree: N = 47 (56.6%)	N = 31 (49.2%)	N =16 (80%)
	Disagree: N = 36 (43.4%)	N = 32 (50.8%)	N = 4 (20%)
	TOTAL: N = 83	**N = 63**	**N = 20**

QUESTION 29: ROLE MODEL C95, C96, C97, C98, C99.

"How should a unit manager approach compulsory in-service training, for e.g. Advanced Life Support and Basic Life Support?"

Table 4.27 shows the results obtained for variable C95. The majority N=86 (94.5%) of participants agreed that unit managers should set the example and attend both courses. A further analysis shows that N = 67 (93%) of the professional nurses (PN) and N =19 (100%) of non-professionals agreed. The results show that nurses want unit managers to be role models.. Van der Colff (n.d.66) is of the opinion that leaders will gain legitimacy by being role models for their followers through their actions. A leader who is admired as a role model has the respect and trust of the followers. All these qualities are present in the transformational leadership approach (Ohman, 2000:47).

Table 4.27 shows the results obtained for variable C96. The majority N = 97 (95.1%) of participants agreed that unit managers should explain the necessity of the courses, show the staff the off-duty roster and ask them which dates suit them best. A further analysis shows that N = 74 (93.7%) of the professional nurses (PN) and N = 23 (100%) of non-professionals agreed. The results show that nurses prefer consultation in the work place and therefore prefer participatory leadership and support that relates to training.

Table 4.27 shows the results obtained for variable C97. The majority N = 62 (79.5%) of participants disagreed that unit managers should inform the staff that attendance is compulsory and set dates for each course without any input from the staff members. A further analysis shows that N = 48 (77.4%) of the professional nurses (PN) and N = 14 (87.5%) of non-professionals disagreed. The results support consultation in the work place and therefore a preference to participatory leadership over autocratic leadership.

Table 4.27 shows the results obtained for variable C98. The majority N = 53 (68%) of participants disagreed that unit managers should send the staff on training only when the workload in the unit justified it. A further analysis shows that N = 45 (72.6%) of the professional nurses (PN) and N=8 (50%)of non-professionals disagreed. A statistical significant association was identified between the both the professional and non-professional nurses and that unit managers should send the staff on training only when the workload in the unit justified it (Chi-square test p=0.092). A Spearman test identified a correlation with significance between age and that the unit manager sends staff on training only when the workload in the unit justifies it. (rho = -0.15; p = 0.02). The results show that nurses prefer a proactive and participatory approach, which signifies transformational leadership (Bajnok *et al.*, 2006:23).

Table 4.27 shows the results obtained for variable C99. The majority N = 71 (94.7%) of participants disagreed that unit managers should allow the training centre to recruit staff to attend. A further analysis shows that N =58 (96.7%) of the professional nurses (PN) and N =13 (86.7%) of non-professionals disagreed. The results show that nurses do not value laissez-faire leadership.

Table 4.27: Role Model

		PN	**Non-Professional**
C95	She sets the example by attending both courses.		
	Agree: N = 86 (94.5%)	N = 67 (93%)	N = 19 (100%)
	Disagree: N = 5 (5.5%)	N = 5 (7%)	N = 0 (0%)
	TOTAL: N = 91	**N = 72**	**N = 19**
C96	She explains the necessity of the courses shows them the off-duty roster and asks them which dates suit them best.		
	Agree: N = 97 (95.1%)	N = 74 (93.7%)	N = 23 (100%)
	Disagree: N = 5 (4.9%)	N = 5 (6.3%)	N = 0 (0%)
	TOTAL: N = 102	**N = 79**	**N = 23**
C97	She informs the staff that attendance is compulsory and sets dates for each course without any input from the staff members.		
	Agree: N = 16 (20.5%)	N = 14(22.6%)	N = 2 (12.5%)
	Disagree: N = 62 (79.5%)	N = 48 (77.4%)	N = 14 (87.5%)
	TOTAL: N = 78	**N = 62**	**N = 16**
C98	She sends the staff on training only when the workload in the unit justifies it.		
	Agree: N = 25 (32%)	N =17 (27.4%)	N = 8 (50%)
	Disagree: N = 53 (68%)	N = 45 (72.6%)	N = 8 (50%)
	TOTAL: N = 78	**N = 62**	**N = 16**
C99	She leaves it up to the training centre to recruit staff to attend.		
	Agree: N = 4 (5.3%)	N = 2 (3.3%)	N = 2 (13.3%)
	Disagree: N = 71 (94.7%)	N = 58 (96.7%)	N = 13 (86.7%)
	TOTAL: N = 75	**N = 60**	**N = 15**

QUESTION 30: STAFF PARTICIPATION C100, C101, C102, C103.

"Orientation is the personalized training of the individual employee. A new professional nurse has been appointed – how should a unit manager establish a mentor-mentored relationship?"

Table 4.28 shows the results obtained for variable C100. The majority N = 60 (58.3%) of participants agreed that unit managers should introduce a new staff member to possible

mentors and ask her to select her own mentor. A further analysis shows that N = 41 (52.6%) of the professional nurses (PN) and N =19 (76%) of non-professionals agreed. A statistical significant association was identified between both professional and non-professional nurses and that unit managers should introduce a new staff member to possible mentors and ask her to select her own mentor (Chi-square test p = 0.034). The results show that nurses prefer consultation in the work place and therefore prefer participatory leadership.

Table 4.28 shows the results obtained for variable C101. The majority N = 71 (82.6%) of participants agreed that unit managers should inform them that they would evaluate the outcomes within a certain period. A further analysis shows that N = 58 (82.9%) of the professional nurses (PN) and N=13 (81.3%)

- of non-professionals agreed. A Spearman test identified a correlation with significance between age and that the unit manager informs the staff that she will evaluate the outcomes within a certain period (rho = -0.15; p = 0.02). The results show that nurses prefer a goal directing approach with regard to mentoring. The latter is congruent with Grossman & Valiga's (2007:64) findings that nurses value leaders who provide structure to learning.

Table 4.28 shows the results obtained for variable C102. The majority N = 74 (94.9%) of participants disagreed that unit managers should appoint a mentor to the new staff member and not follow-up on the results. A further analysis show that N = 60 (96.8%) of the professional nurses (PN) and N = 14 (87.5%) of non-professionals disagreed. A statistical significant association was identified between years of experience in the C.C.U. and that unit managers should appoint a mentor to the new staff member and not follow-up on the results (Chi-square test p = 0.023). The results show that nurses do not prefer a laissez-faire approach with regard to mentoring.

Table 4.28 shows the results obtained for variable C103. The majority N = 72 (96%) of participants disagreed that the mentor should not be on the same shift as the mentored if her expertise is needed on the other shift. A further analysis show that N = 59 (98.3%) of the professional nurses (PN) and N = 13 (86.7%) of non-professionals disagreed. A statistical significant association was identified between both professional and non-professional nurses and the proposal that the mentor should not be on the same shift as the mentored if her expertise is needed on the other shift (Chi-square test p = 0.071). The results show that nurses do not prefer a bureaucratic approach with regard to mentoring.

Table 4.28: Staff Participation.

		PN	**Non-Professional**
C100	She introduces a new staff member to possible mentors and asks her to select her own mentor.		
	Agree: N = 60 (58.3%)	N = 41 (52.6%)	N =19 (76%)
	Disagree: N = 43 (41.7%)	N = 37 (47.4%)	N = 6 (24%)
	TOTAL: N = 103	**N = 78**	**N = 25**
C101	She informs them that she will evaluate the outcomes within a certain period.		
	Agree: N = 71 (82.6%)	N = 58 (82.9%)	N = 13 (81.3%)
	Disagree: N = 15 (17.4%)	N = 12 (17.1%)	N = 3 (18.7%)
	TOTAL: N = 86	**N = 70**	**N = 16**
C102	She appoints a mentor to the mentored but does not follow-up on the results.		
	Agree: N = 4 (5.1%)	N = 2 (3.2%)	N = 2 (12.5%)
	Disagree: N = 74 (94.9%)	N = 60 (96.8%)	N = 14 (87.5%)
	TOTAL: N = 78	**N = 62**	**N = 16**
C103	The mentor is not on the same shift as the mentored because her expertise is needed on the other shift		
	Agree: N = 3 (4%)	N = 1 (1.7%)	N = 2 (13.3%)
	Disagree: N =72 (96%)	N = 59 (98.3%)	N = 13 (86.7%)
	TOTAL: N = 75	**N = 60**	**N = 15**

QUESTION 31: STAFF DEVELOPMENT C104, C105, C106, C107.

"Unit managers need to educate staff with regard to scheduling of off-duties. The scheduling of off-duties within a unit should be the function of..."

Table 4.29 shows the results obtained for variable C104. The majority N=52 (63.4%) of participants disagreed that the scheduling of off-duties within a unit should be the function of only the unit manager. A further analysis shows that N=44 (66.7%) of the professional nurses (PN) and N= 8(0%) of non-professionals disagreed. The results show that nurses do not prefer an autocratic approach with regard to scheduling of off-duties.

Table 4.29 shows the results obtained for variable C105. The majority N = 63 (68.5%) of participants agreed that each professional nurse should get a chance to be involved with the scheduling of off-duties. A further analysis shows that N = 49 (68.1%) of the professional

nurses (PN) and N = 14 (70%) of non-professionals agreed. A statistical significant association was identified between years of experience in the C.C.U. and that each professional nurse should get a chance to be involved with the scheduling of off-duties (Chi-square test p = 0.041). A Spearman test identified a correlation with significance between age and that each professional nurse should get a chance to be involved with the scheduling of off-duties (rho = -0.15; p = 0.02). The results show that nurses prefer participatory leadership with regard to scheduling of off-duties.

Table 4.29 shows the results obtained for variable C106. The majority N=51 (64.6%) of participants agreed that the professional nurse, second-in-command, should be involved with the scheduling of off-duties. A further analysis shows that N=41 (65.1%) of the professional nurses (PN) and N=10 (62.5%) of non-professionals agreed. The results show that nurses prefer participatory leadership.

Table 4.29 shows the results obtained for variable C107. The majority N = 47 (56%) of participants disagreed that the scheduling of off-duties be regarded as a managerial function and should only be done by the unit manager. A further analysis shows that N=37 (55.2%) of the professional nurses (PN) and N=10 (58.8%) of non-professionals disagreed. The results show that nurses prefer participatory leadership and reject autocratic leadership.

Table 4.29: Staff Development

		PN	**Non-Professional**
C104	…only the unit manager.		
	Agree: N=30 (36.6%)	N=22 (33.3%)	N=8 (50%)
	Disagree: N=52 (63.4%)	N=44 (66.7%)	N=8 (50%)
	TOTAL: N =82	**N=66**	**N=16**
C105	…each professional nurse gets a chance to be involved.		
	Agree: N=63 (68.5%)	N=49 (68.1%)	N=14 (70%)
	Disagree: N=29 (31.5%)	N=23 (31.9%)	N=6 (30%)
	TOTAL: N=92	**N=72**	**N=20**
C106	…the professional nurse - second in command.		
	Agree: N=51 (64.6%)	N=41 (65.1%)	N=10 (62.5%)
	Disagree: N=28 (35.4%)	N=22 (34.9%)	N=6 (37.5%)
	TOTAL: N: 79	**N=63**	**N=16**
C107	…is regarded as a managerial function and must be done by the unit manager.		
	Agree: N=37 (44%)	N=30 (44.8%)	N=7 (41.2%)
	Disagree: N=47 (56%)	N=37 (55.2%)	N=10 (58.8%)
	TOTAL: N=84	**N=67**	**N=17**

QUESTION 32: MOTIVATION AND EMPOWERMENT C108, C109, C110, C111, C112

"Unit managers are involved in the motivation and development of staff. When having a climate meeting, who should chair the meeting?"

Table 4.30 shows the results obtained for variable C108. The majority N = 62 (68.2%) of participants agreed that unit managers should always chair meetings

A further analysis shows that N = 46 (66.7%) of the professional nurses (PN) and N = 16 (72.7%) of non-professionals agreed. The results show that nurses prefer firm leadership with regard to climate meetings.

Table 4.30 shows the results obtained for variable C109. The majority N = 54 (61.4%) of participants agreed that each professional nurse should get a chance to chair the meeting. A further analysis show that N = 41 (58.6%) of the professional nurses (PN) and N = 13 (72.2%) of non-professionals agreed. The results accentuate the nurses' preference for participatory leadership and empowerment.

Table 4.30 shows the results obtained for variable C110. The majority N=38 (50.7%) of participants disagreed to it being regarded as a managerial function and to meetings being chaired only by the unit manager. A further analysis shows that N=28 (46.7%) of the professional nurses (PN) and N=10 (66.7%) of non-professionals disagreed. The results accentuate the nurse's preference for participatory leadership and empowerment.

Table 4.30 shows the results obtained for variable C111. The majority N = 43 (58.1%) of participants disagreed that the second-in-command of the unit should chair the meetings. A further analysis shows that N = 34 (57.6%) of the professional nurses (PN) and N = 9 (60%) of non-professionals disagreed. The results accentuate the nurse's preference for participatory leadership and empowerment.

Table 4.30 shows the results obtained for variable C112. The majority N=56 (71.8%) of participants disagreed that climate meetings should not take place. A statistical significant association was identified between years of experience in the C.C.U. and that climate meetings should not take place (Chi-square test p = 0.086). The results indicate that nurses do not value laissez-faire leadership.

Table 4.30: Motivation and Empowerment.

		PN	**Non-Professional**
C108	The unit manager always chairs the meetings.		
	Agree: N=62 (68.1%)	N=46 (66.7%)	N=16 (72.7%)
	Disagree: N=29 (31.9%)	N=23 (33.3%)	N=6 (27.3%)
	TOTAL: N =91	**N=69**	**N=22**
C109	Each professional nurse gets a chance to chair the meeting.		
	Agree: N=54 (61.4%)	N=41 (58.6%)	N=13 (72.2%)
	Disagree: N=34 (38.6%)	N=29 (41.4%)	N=5 (27.8%)
	TOTAL: N=88	**N=70**	**N=18**
C110	It is regarded as a managerial function and should be chaired by the unit manager.		
	Agree: N=37 (49.3%)	N=32 (53.3%)	N=5 (33.3%)
	Disagree: N=38 (50.7%)	N=28 (46.7%)	N=10 (66.7%)
	TOTAL: N=75	**N=60**	**N=15**
C111	The second in command of the unit chairs the meetings.		
	Agree: N=31 (41.9%)	N=25 (42.4%)	N=6 (40%)
	Disagree: N=43 (58.1%)	N=34 (57.6%)	N=9 (60%)
	TOTAL: N=74	**N=59**	**N=15**
C112	Climate meetings do not take place.		
	Agree: N=22 (28.2%)	N=14 (24.1%)	N=8 (40%)
	Disagree: N=56 (71.8%)	N=44 (75.9%)	N=12 (60%)
	TOTAL: N=78	**N=58**	**N=20**

QUESTION 33: MOTIVATION AND EMPOWERMENT C113, C114, C115, C116

Motivation and Empowerment.

"Unit managers need to empower staff. Therefore, managerial meetings need only be…"

Table 4.31 shows the results obtained for variable C113. The majority N = 45 (53%) of participants disagreed that only the unit manager should attend managerial meetings. A further analysis shows that N=34 (52.3%) of the professional nurses (PN) and N = 11 (55%) of non-professionals disagreed. A statistical significant association was identified between

years of experience in the C.C.U. and that only the unit manager should attend managerial meetings (Chi-square test p = 0.088). The results accentuate the nurse's preference for participatory leadership and empowerment.

Table 4.31 shows the results obtained for variable C114. The majority N = 55 (67%) of participants agreed that managerial meetings should be attended by the unit manager and the professional nurse second-in-command. A further analysis shows that N = 44 (67.7%) of the professional nurses (PN) and N = 11 (64.7%) of non-professionals agreed. The results show recognition of hierarchical figures / structures and therefore support bureaucratic leadership.

Table 4.31 shows the results obtained for variable C115. The majority N=74 (79.6%) of participants agreed that managerial meetings should be attended by each professional nurse in the unit, on a rotational basis. A further analysis shows that N=58 (78.4%) of the professional nurses (PN) and N=16 (84.2%) of non-professionals agreed. The results outscore the response to variable 114 and show a definite swing towards participatory leadership and empowerment.

Table 4.31 shows the results obtained for variable C116. The majority N=47 (60.3%) of participants agreed that managerial meetings should be attended by those who wish to attend. A further analysis shows that N=33 (54.1%) of the professional nurses (PN) and N=14 (82.4%) of non-professionals agreed. A statistical significant association was identified between both professional and non-professional nurses and that managerial meetings should be attended by those who wish to attend (Chi-square test p = 0.028). The results are a definite indication towards participatory leadership and empowerment.

Table 4.31: Motivation and Empowerment

		PN	**Non-Professional**
C113	…attended by the unit manager.		
	Agree: N=40 (47%)	N=31 (47.7%)	N=9 (45%)
	Disagree: N=45 (53%)	N=34 (52.3%)	N=11 (55%)
	TOTAL: N =85	**N=65**	**N=20**
C114	…attended by the unit manager and the professional nurse second in command.		
	Agree: N=55 (67%)	N=44 (67.7%)	N=11 (64.7%)
	Disagree: N=27 (33%)	N=21 (32.3%)	N=6 (35.3%)
	TOTAL: N=82	**N=65**	**N=17**
C115	…attended by each professional nurse in the unit on a rotational basis.		
	Agree: N=74 (79.6%)	N=58 (78.4%)	N=16 (84.2%)
	Disagree: N=19 (20.4%)	N=16 (21.6%)	N=3 (15.8%)
	TOTAL: N=93	**N=74**	**N=19**
C116	…attended by those who wish to attend.		
	Agree: N=47 (60.3%)	N=33 (54.1%)	N=14 (82.4%)
	Disagree: N=31 (39.7%)	N=28 (45.9%)	N=3 (17.6%)
	TOTAL: N=78	**N=61**	**N=17**

4.6 SECTION D - PATIENT CARE:

Questions 34-36 refers to the ideal leadership behaviour that applies to patient care. In questions 37-40 the respondents were asked to indicate their general observations of leadership behaviour as it currently exists.

QUESTION 34: WORK ETHICS D117, D118, D119, D120

"There is a vacancy for a senior position in the unit. A unit manager should …"

Table 4.32 shows the results obtained for variable D117. The majority N =111 (97.4%) of participants agreed that the unit manager should inform all staff members who qualify and motivate them to apply. A further analysis shows that N = 84 (97.7%) of the professional nurses (PN) and N = 27 (96.4%) of non-professionals agreed. A statistical significant association was identified between years of experience in the C.C.U. and that the unit manager should inform all staff members who qualify and motivate them to apply (Chi-square

test p = 0.055). The results reveal a preference towards honesty, openness and empowerment, all of which are characteristics of transformational leadership (Kelly, 2006:26).

Table 4.32 shows the results obtained for variable D118. The majority N =72 (93.5%) of participants disagreed that the unit manager should not mention it. A further analysis show that N = 57 (93.4%) of the professional nurses (PN) and N = 15 (93.7%) of non-professionals disagreed. A statistical significant association was identified between years of experience in the C.C.U. and that the unit manager should not mention it (Chi-square test p = 0.055). The results reveal a preference towards honesty, openness and empowerment, all of which are characteristics of transformational leadership (Kelly, 2006:26).

Table 4.32 shows the results obtained for variable D119. The majority N = 69 (90.8%) of participants disagreed that the unit manager should inform only certain staff members and motivate only those who wish to apply. A further analysis shows that N =53 (89.8%) of the professional nurses (PN) and N =16 (94.1%) of non-professionals disagreed. The results reveal a preference towards honesty, openness and empowerment, as described above in variable D119.

Table 4.32 shows the results obtained for variable D120. The majority N = 65 (82.3%) of participants agreed that the unit manager should emphasize the requirements for the position as well as the procedures. A further analysis shows that N = 52 (81.3%) of the professional nurses (PN) and N =13 (86.7%) of non-professionals agreed. The results reveal a preference towards honesty, openness, empowerment and effective communication. These attributes form part of the transformational leadership approach (Bajnok *et al.*, 2006:33).

Table 4.32: Work Ethics

		PN	**Non-Professional**
D117	…inform all staff who qualify and motivate them to apply.		
	Agree: N =111 (97.4%)	N=84 (97.7%)	N=27 (96.4%)
	Disagree: N=3 (2.6%)	N =2 (2.3%)	N = 1 (3.6%)
	TOTAL: N =114	**N =86**	**N =28**
D118	…not mention it.		
	Agree: N =5 (6.5%)	N =4 (6.6%)	N=1 (6.3%)
	Disagree: N =72 (93.5%)	N =57 (93.4%)	N=15 (93.7%)
	TOTAL: N =77	**N =61**	**N =16**
D119	…inform only certain staff members and motivate only those who wish to apply.		
	Agree: N=7 (9.2%)	N =6 (10.2%)	N =1 (5.9%)
	Disagree: N =69 (90.8%)	N =53 (89.8%)	N =16 (94.1%)
	TOTAL: N = 76	**N =59**	**N =17**
D120	…emphasize the requirements for the position as well as the procedures.		
	Agree: N =65 (82.3%)	N =52 (81.3%)	N =13 (86.7%)
	Disagree: N =14 (17.7%)	N =12 (18.7%)	N =2 (13.3%)
	TOTAL: N =79	**N =64**	**N =15**

QUESTION 35: PROFESSIONALISM. D121, D122, D123, D124

"A unit manager acted inappropriately as a leader. Should the unit manager …"

Table 4.33 shows the results obtained for variable D121. The majority N = 111 (95.7%) of participants agreed that the unit manager should admit inappropriate conduct openly and apologize. A further analysis shows that N =85 (95.5%) of the professional nurses (PN) and N =26 (96.3%) of non-professionals agreed. A statistical significant association was identified between years of experience in the C.C.U. and that the unit manager should admit inappropriate conduct openly and apologize (Chi-square test p = 0.013). The results reveal a preference towards honesty, openness and integrity. These attributes form part of the transformational leadership approach (Bajnok *et al.*, 2006:33).

Table 4.33 shows the results obtained for variable D122. The majority N = 72 (96%) of participants disagreed that the unit manager should ignore inappropriate conduct and refuse to discuss it. A further analysis shows that N =85 (95.5%) of the professional nurses (PN) and

N=16 (100%) of non-professionals disagreed. The results reveal a preference towards honesty, openness and integrity. These attributes form part of the transformational leadership approach (Bajnok *et al.*, 2006:33).

Table 4.33 shows the results obtained for variable D123. The majority N = 69 (92%) of participants disagreed that the unit manager should try to shift the blame by blaming the rule or the procedure involved. A further analysis shows that N = 55 (93.2%) of the professional nurses (PN) and N =14 (87.5%) of non-professionals disagreed. The results reveal a preference towards honesty, openness and integrity as in D22.

Table 4.33 shows the results obtained for variable D124. The majority N = 68 (89.5%) of participants disagreed that the unit manager should justify her actions without admitting that she is to blame. A statistical significant association was identified between years of experience in the C.C.U. and that the unit manager should justify her actions without admitting that she is to blame (Chi-square test p = 0.038). A further analysis shows that N =54 (90%) of the professional nurses (PN) and N =14 (87.5%) of non-professionals disagreed. The results reveal a preference towards honesty, openness and integrity as in D22.

Table 4.33: Professionalism

		PN	Non-Professional
D121	…admit it openly and apologizes?		
	Agree: N =111 (95.7%)	N =85 (95.5%)	N =26 (96.3%)
	Disagree: N =5 (4.3%)	N =4 (4.5%)	N =1 (3.7%)
	TOTAL: N =116	**N =89**	**N =27**
D122	…ignore it and refuse to discuss it?		
	Agree: N =3 (4%)	N =3 (5%)	N=0 (0%)
	Disagree: N =72 (96%)	N =56 (95%)	N=16 (100%)
	TOTAL: N =75	**N =59**	**N =16**
D123	…try to shift the blame by blaming the rule or the procedure involved?		
	Agree: N=6 (8%)	N =4 (6.8%)	N =2 (12.5%)
	Disagree: N =69 (92%)	N =55 (93.2%)	N =14 (87.5%)
	TOTAL: N = 75	**N =59**	**N =16**
D124	…justify her actions without admitting that she is to blame?		
	Agree: N =8 (10.5%)	N =6 (10%)	N =2 (12.5%)
	Disagree: N =68 (89.5%)	N =54 (90%)	N =14 (87.5%)
	TOTAL: N =76	**N =60**	**N =16**

QUESTION 36: ORGANIZATIONAL CLIMATE. D125, D126, D127, D128

"The ideal atmosphere in an I.C.U. should be …"

Table 4.34 shows the results obtained for variable D125. The majority N =118 (99%) of participants favoured a healthy, trustworthy and supportive work climate. A further analysis shows that N = 89 (98.9%) of the professional nurses (PN) and N = 29 (100%) of non-professionals agreed. The results reveal a preference towards honesty, openness and integrity as in D22.

Table 4.34 shows the results obtained for variable D126. The majority of participants N =62 (81.6%) favoured a manageable work climate. A further analysis shows that N =49 (81.7%) of the professional nurses (PN) and N=13 (81.3%) of non-professionals agreed. The results show that nurses prefer participatory leadership since the latter has proven to be suitable for workers who need to work as a team, as in nursing (Booyens, 2002:242).

Table 4.34 shows the results obtained for variable D127. The majority of participants N =69 (93.2%) disapproved of a stressful work climate. A further analysis shows that N =54 (93.1%) of the professional nurses (PN) and N =15 (93.7%) of non-professionals disagreed. The results show that nurses prefer participatory leadership as stated in D126.

Table 4.34 shows the results obtained for variable D128. The majority of participants N = 66 (95.7%) disfavoured a work climate that is frustrating and demoralizing. A further analysis shows that N = 52 (96.3%) of the professional nurses (PN) and N =14 (93.3%) of non-professionals disagreed. A statistical significant association was identified between years of experience in the C.C.U. and a work climate that is frustrating and demoralizing (Chi-square test p = 0.044). The results show that nurses prefer participatory leadership as stated in D126.

Table 4.34: Organizational Climate

		PN	Non-Professional
D125	…healthy, trustworthy and supportive.		
	Agree: N =118 (99%)	N =89 (98.9%)	N =29 (100%)
	Disagree: N =1 (1%)	N =1 (1.1%)	N =0 (0%)
	TOTAL: N =119	**N =90**	**N =29**
D126	…manageable.		
	Agree: N =62 (81.6%)	N =49 (81.7%)	N=13 (81.3%)
	Disagree: N =14 (18.4%)	N =11 (18.3%)	N=3 (18.7%)
	TOTAL: N =76	**N =60**	**N =16**
D127	…stressful.		
	Agree: N=5 (6.8%)	N =4 (6.9%)	N =1 (6.3%)
	Disagree: N =69 (93.2%)	N =54 (93.1%)	N =15 (93.7%)
	TOTAL: N = 74	**N =58**	**N =16**
D128	…frustrating and demoralizing.		
	Agree: N =3 (4.3%)	N =2 (3.7%)	N =1 (6.7%)
	Disagree: N =66 (95.7%)	N =52 (96.3%)	N =14 (93.3%)
	TOTAL: N=69	**N =54**	**N =15**

QUESTION 37: COMMUNICATION. D129, D130, D131, D132

"Communication with a unit manager with regard to patient care is usually..."

Table 4.35 shows the results obtained for variable D129. The majority of participants N = 99 (90.8%) revealed that communication with unit managers is usually honest and open. A further analysis shows that N =75 (91.5%) of the professional nurses (PN) and N = 24 (88.9%) of non-professionals agreed, however N =10 (9.2%) disagreed. The results show that the majority of nurses experience little difficulty with regard to communication with unit managers in the work place.

Table 4.35 shows the results obtained for variable D130. The majority of participants N = 58 (76.3%) disagreed that communication with unit managers is minimal since they should listen to and obey her as she is in command. A further analysis shows that N = 47 (78.3%) of the professional nurses (PN) and N=11 (68.7%) of non-professionals disagreed. However, the results show that N =18 (23.7%) of the participants do experience autocratic behaviour in the workplace.

Table 4.35 shows the results obtained for variable D131. The majority of participants N = 47 (58.7%) disagreed that communication with unit managers is via the second-in-command or the shift leader. A further analysis shows that N = 39 (62.9%) of the professional nurses (PN) and N = 8 (44.4%) of non-professionals disagreed. The results show that N = 33 (41.3%) of the participants do experience laissez-faire leadership in the workplace.

Table 4.35 shows the results obtained for variable D132. The majority of participants N = 56 (72.7%) disagreed that communication with unit managers is minimal owing to administration duties being her first priority. A further analysis shows that N = 45 (73.8%) of the professional nurses (PN) and N =11 (68.7%) of non-professionals disagreed. The results show that N = 21 (27.3%) of the participants do experience some form of bureaucratic leadership in the workplace.

Table 4.35: Communication

		PN	Non-Professional
D129	…easy, open and honest.		
	Agree: N = 99 (90.8%)	N = 75 (91.5%)	N =24 (88.9%)
	Disagree: N =10 (9.2%)	N = 7 (8.5%)	N = 3 (11.1%)
	TOTAL: N =109	**N =82**	**N =27**
D130	…minimal since we are to listen and obey as she is in command.		
	Agree: N =18 (23.7%)	N =13 (21.7%)	N = 5 (31.3%)
	Disagree: N =58 (76.3%)	N =47 (78.3%)	N =11 (68.7%)
	TOTAL: N =76	**N =60**	**N =16**
D131	…via the second in command or the shift leader.		
	Agree: N =33 (41.3%)	N = 23 (37.1%)	N =10 (55.6%)
	Disagree: N = 47 (58.7%)	N =39 (62.9%)	N = 8 (44.4%)
	TOTAL: N = 80	**N = 62**	**N =1 8**
D132	…minimal because her administration duties are her first priority.		
	Agree: N =21 (27.3%)	N =16 (26.2%)	N = 5 (31.3%)
	Disagree: N=56 (72.7%)	N = 45 (73.8%)	N =11 (68.7%)
	TOTAL: N=77	**N= 61**	**N=16**

QUESTION 38: STAFFING. D133, D134, D135, D136, D137

"The recommended nurse-patient ratio for ventilated patients is 1:1. The I.C.U. suddenly becomes very busy and the nurse patient ratio has shifted. You now have two patients, one of whom is on a ventilator. The unit manager …"

Table 14.36 shows the results obtained for variable D133. The majority of participants N = 55 (65.5%) disagreed that unit managers seem unconcerned and leave at 16:00. A further analysis shows that N = 44 (66.7%) of the professional nurses (PN) and N =11 (61.1%) of non-professionals disagreed. N = 29 (34.5%) of the participants revealed that unit managers do go home knowing that staffing relating to ventilated patients, does not meet the prescribed measures, being a nurse-patient ratio of 1:1 (Nel, 2005:96). The latter proves that an element of laissez-faire leadership exists.

Table 14.36 shows the results obtained for variable D134. The majority of participants N = 44 (51.8%) disagreed that unit managers would tell them to cope, as it would be impossible to find extra staff. A further analysis shows that N = 36 (53.7%) of the professional nurses (PN) and N = 8 (44.4%) of non-professionals disagreed. N = 41 (48.2%) of the participants revealed that unit managers would tell them to cope and would say that they could not find extra staff, knowing that staffing of ventilated patients was not meeting the prescribed measures (a nurse-patient ratio of 1:1 (Nel, 2005:96)). The results prove that autocratic behaviour with regard to staffing exists.

Table 14.36 shows the results obtained for variable D135. The majority of participants N = 64 (71.1%) agreed that unit managers would take over the non-ventilated patient, change their shift and work until 19:00. A further analysis shows that N = 50 (70.4%) of the professional nurses (PN) and N = 14 (73.7%) of non-professionals agreed. N = 26 (28.9%) of the participants disagreed that the unit manager usually changes her shift and offers the necessary support. The results reveal that an element of laissez-faire leadership exists.

Table 14.36 shows the results obtained for variable D136. The majority of participants N = 86 (91.5%) agreed that unit managers would do their utmost to find extra staff. A further analysis shows that N = 68 (93.1%) of the professional nurses (PN) and N =18 (85.7%) of non-professionals agreed. N = 26 (28.9%) of the participants disagreed that the unit manager usually does her best to find extra staff. The results reveal that an element of laissez-faire leadership exists.

Table 14.36 shows the results obtained for variable D137. The majority of participants N = 63 (85.1%) disagreed that unit managers would tell them that it is costly to get agency staff

for the rest of the day. A further analysis shows that N = 50 (86.2%) of the professional nurses (PN) and N = 13 (81.3%) of non-professionals disagreed. N = 11 (14.9%) of the participants agreed that the unit manager would tell them that it is costly to get agency staff for the rest of the day. The results reveal that an element of bureaucracy with regard to staffing exists.

Table 4.36: Staffing

		PN	Non-Professional
D133	…seems unconcerned and leaves at 16:00.		
	Agree: N = 29 (34.5%)	N = 22 (33.3%)	N = 7 (38.9%)
	Disagree: N = 55 (65.5%)	N = 44 (66.7%)	N = 11 (61.1%)
	TOTAL: N = 84	**N = 66**	**N = 18**
D134	…tells you to cope, as it is impossible to find extra staff at this stage.		
	Agree: N = 41 (48.2%)	N = 31 (46.3%)	N = 10 (55.6%)
	Disagree: N = 44 (51.8%)	N = 36 (53.7%)	N = 8 (44.4%)
	TOTAL: N = 85	**N = 67**	**N = 18**
D135	…takes over the non-ventilated patient, changes her shift and works until 19:00.		
	Agree: N = 64 (71.1%)	N = 50 (70.4%)	N =14 (73.7%)
	Disagree: N = 26 (28.9%)	N = 21 (29.6%)	N =5 (26.3%)
	TOTAL: N = 90	**N = 71**	**N = 19**
D136	…does her utmost to find extra staff.		
	Agree: N = 86 (91.5%)	N = 68 (93.1%)	N =18 (85.7%)
	Disagree: N = 8 (8.5%)	N = 5 (6.9%)	N = 3 (14.3%)
	TOTAL: N = 94	**N = 73**	**N = 21**
D137	…tells you it is costly to get agency staff for the rest of the day and that the budget for agency staff is almost depleted.		
	Agree: N =11 (14.9%)	N = 8 (13.8%)	N = 3 (18.7%)
	Disagree: N = 63 (85.1%)	N = 50 (86.2%)	N = 13 (81.3%)
	TOTAL: N = 74	**N = 58**	**N = 16**

QUESTION 39: WHEN DELEGATING TASKS, DO UNIT MANAGERS CONSIDER QUALIFICATIONS AND EXPERIENCE? D138, D139, D140, D141

"When delegating tasks, do unit managers consider qualifications and experience?"

Table 14.37 shows the results obtained for variable D138. The majority of participants N = 44 (53%) agreed that unit managers consider qualifications and experience only when the workload justifies it. A further analysis shows that N = 34 (53.1%) of the professional nurses (PN) and N =10 (52.6%) of non-professionals agreed. N = 39 (47%) of the participants disagreed that the unit manager considers qualifications and experience only when the workload justifies it. Galley and O'Riordan (2003:7) point out that decisions that relate to the safety and staffing of patients should primarily be based on the needs of the patients. Therefore, the results reveal that an element of laissez-faire leadership with regard to the safety of patients exists.

Table 14.37 shows the results obtained for variable D139. The majority of participants N = 64 (82%) disagreed that unit managers would ignore qualifications and experience with regard to staffing. A further analysis shows that N = 50 (82%) of the professional nurses (PN) and N = 14 (82.4%) of non-professionals disagreed. N = 14 (18%) of the participants agreed that the unit manager ignores qualifications and experience with regard to staffing. A statistical significant association was identified between years of experience in the C.C.U. and that unit managers would ignore qualifications and experience with regard to staffing (Chi-square test p = 0.030). The results, N = 14 (18%) although small, reveal that an element of laissez-faire leadership with regard to patient safety exists.

Table 14.37 shows the results obtained for variable D140. The majority N = 77 (85.6%) of participants agreed that unit managers always consider qualifications and experience with regard to staffing. A further analysis shows that N = 62 (88.6%) of the professional nurses (PN) and N = 15 (75%) of non-professionals agreed. N = 13 (14.4%) of the participants disagreed that unit managers always considered qualifications and experience with regard to staffing. A statistical significant association was identified between years of experience in the C.C.U. and that unit managers always consider qualifications and experience with regard to staffing. (Chi-square test p = 0.043). The results, although small, N = 13 (14.4%) reveal that an element of laissez-faire leadership with regard to patient safety exists.

Table 14.37 shows the results obtained for variable D141. The majority N = 89 (90%) of participants agreed that unit managers do what they think is best in any particular situations regarding staffing. A further analysis shows that N = 69 (89.6%) of the professional nurses (PN) and N = 20 (90.9%) of non-professionals agreed. N = 10 (10%) of the participants

disagreed that unit managers always do what they think is best in any particular situations regarding staffing. A statistical significant association was identified between years of experience in the C.C.U. and that unit managers do what they think is best in situations regarding staffing (Chi-square test p = 0.081). The results reveal that autocratic leadership with regard to staffing exists.

Table 4.37: Staffing

		PN	Non-Professional
D138	Only when the workload justifies it.		
	Agree: N = 44 (53%)	N = 34 (53.1%)	N = 10 (52.6%)
	Disagree: N = 39 (47%)	N = 30 (46.9%)	N = 9 (47.4%)
	TOTAL: N = 83	**N = 64**	**N = 19**
D139	She ignores it.		
	Agree: N = 14 (18%)	N =11 (18%)	N = 3 (17.6%)
	Disagree: N = 64 (82%)	N = 50 (82%)	N = 14 (82.4%)
	TOTAL: N = 78	**N = 61**	**N = 17**
D140	She always considers it.		
	Agree: N = 77 (85.6%)	N = 62 (88.6%)	N = 15 (75%)
	Disagree: N = 13 (14.4%)	N = 8 (11.4%)	N = 5 (25%)
	TOTAL: N = 90	**N = 70**	**N = 20**
D141	She does what she thinks is the best option in a particular situation.		
	Agree: N = 89 (90%)	N = 69 (89.6%)	N = 20 (90.9%)
	Disagree: N = 10 (10%)	N = 8 (10.4%)	N = 2 (9.1%)
	TOTAL: N = 99	**N = 77**	**N = 22**

QUESTION 40: STAFF SUPPORT. D142, D143, D145, D146

"You are assigned to two patients of whom one is very confused and aggressive and the other very unstable. You ask the unit manager for help. How does a C.C.U. manager mostly respond?"

Table 14.38 shows the results obtained for variable D142. The majority of participants N = 57 (73%) disagreed that unit managers would instruct them to be more organized and work more speedily. A further analysis shows that N = 44 (72.1%) of the professional nurses (PN) and N =13 (76.5%) of the non-professionals disagreed. Since N = 21 (27%) of the

participants agreed that the unit manager would instruct them to be more organized and work more speedily, the results, although small, reveal that an element of laissez-faire leadership with regard to staff support exists.

Table 14.38 shows the results obtained for variable D143. The majority of participants N = 58 (72.5%) disagreed that unit managers would explain the ratio for non-ventilated patients and instruct them to cope on their own. A further analysis shows that N = 44 (69.8%) of the professional nurses (PN) and N = 14 (82.4%) of the non-professionals disagreed. Since N = 22 (27.5%) of the participants agreed that the unit manager would explain the ratio for non-ventilated patients and instruct them to cope on their own, the results, although small, reveal that an element of autocratic conduct with regard to staff support exists.

Table 14.38 shows the results obtained for variable D145. The majority of participants N = 86 (81.9%) agreed that the unit manager would offer assistance until the patients were more stable. .A further analysis shows that N = 64 (80%) of the professional nurses (PN) and N =22 (88%) of the non-professionals agreed. Since

N =19 (18.1%) of the participants disagreed that the unit manager would offer assistance until the patients were more stable, the results, although small, reveal that an element of autocratic conduct with regard to staff support exists.

Table 14.38 shows the results obtained for variable D146. The majority of participants N = 67 (84.8%) disagreed that unit managers would ignore their plea for assistance. A further analysis show that N = 54 (85.7%) of the professional nurses (PN) and N =13 (81.3%) of the non-professionals disagreed. A statistical significant association was identified between years of experience in the C.C.U. and that unit managers would ignore their plea for assistance (Chi-square test p = 0.019). Since N =12(15.2%) of the participants agreed that the unit manager would ignore their plea for assistance, the results, although small, reveal that an element of autocratic conduct with regard to staff support exists.

Table 4.38: Staff Support

		PN	**Non-Professional**
D142	She instructs you to organize yourself and work more speedily.		
	Agree: N = 21 (27%)	N =17 (27.9%)	N = 4 (23.5%)
	Disagree: N = 57 (73%)	N = 44 (72.1%)	N =13 (76.5%)
	TOTAL: N = 78	**N =61**	**N =17**
D143	She explains the ratio for non-ventilated patients and instructs you to cope on your own.		
	Agree: N = 22 (27.5%)	N =19 (30.2%)	N = 3 (17.6%)
	Disagree: N = 58 (72.5%)	N = 44 (69.8%)	N=14 (82.4%)
	TOTAL: N = 80	**N = 63**	**N = 17**
D145	She offers her assistance until the patients are more stable.		
	Agree: N = 86 (81.9%)	N = 64 (80%)	N = 22 (88%)
	Disagree: N =19 (18.1%)	N = 16 (20%)	N = 3 (12%)
	TOTAL: N = 105	**N = 80**	**N = 25**
D146	She ignores your plea for assistance.		
	Agree: N =12 (15.2%)	N = 9 (14.3%)	N = 3 (18.7%)
	Disagree: N = 67 (84.8%)	N = 54 (85.7%)	N =13 (81.3%)
	TOTAL: N = 79	**N = 63**	**N = 16**

QUESTION 41: RECORD KEEPING. D147, D148, D149, D150

"A problem arises because of poor record keeping. How should an I.C.U. manager respond?"

Table 4.39 shows the results obtained for variable D147. The majority of participants N = 74 (84.1%) agreed that the unit manager should give a lecture on record keeping. A further analysis shows that N = 54 (81.8%) of the professional nurses (PN) and N = 20 (90.9%) of non-professionals agreed. The results show that nurses value training.

Table 4.39 shows the results obtained for variable D148. The majority of participants N = 99 (96.1) agreed that the unit manager should approach those involved, ask them what went wrong and guide them through the correct procedure. A further analysis shows that N = 75 (94.9%) of the professional nurses (PN) and N = 24 (100%) of non-professionals agreed. The results show that nurses value training and participatory leadership.

Table 4.39 shows the results obtained for variable D149. The majority of participants N = 44 (55.7%) disagreed that the unit manager should reprimand them and warn them not to repeat the same mistakes. A further analysis shows that N = 34 (54%) of the professional nurses (PN) and N =10 (62.5%) of non-professionals disagreed. The results show that nurses value participatory leadership and disapprove of autocratic leadership.

Table 4.39 shows the results obtained for variable D150. The majority of participants N = 68 (89.5%) disagreed that the unit manager should be unaware of the situation. A further analysis shows that N = 54 (88.5%) of the professional nurses (PN) and N = 14 (93.3%) of non-professionals disagreed. A statistical significant association was identified between years of experience in the C.C.U. and that the unit manager should be unaware of poor record keeping (Chi-square test p = 0.013). The results show that nurses value participatory leadership and reject laissez-faire leadership.

Table 4.39: Record Keeping

		PN	**Non-Professional**
D147	She gives a lecture on record keeping.		
	Agree: N = 74 (84.1%)	N = 54 (81.8%)	N = 20 (90.9%)
	Disagree: N =14 (15.9%)	N = 12 (18.2%)	N = 2 (9.1%)
	TOTAL: N = 88	**N = 66**	**N = 22**
D148	She approaches those involved, asks them what went wrong and guides them through the correct procedure.		
	Agree: N = 99 (96.1%)	N =75 (94.9%)	N = 24 (100%)
	Disagree: N = 4 (3.9%)	N = 4 (5.1%)	N = 0 (0%)
	TOTAL: N =103	**N =79**	**N =24**
D149	She reprimands them and warns them not to repeat the same mistakes.		
	Agree: N = 35 (44.3%)	N = 29 (46%)	N = 6 (37.5%)
	Disagree: N = 44 (55.7%)	N = 34 (54%)	N = 10 (62.5%)
	TOTAL: N = 79	**N = 63**	**N = 16**
D150	She is not aware of the situation.		
	Agree: N = 8 (10.5%)	N = 7 (11.5%)	N = 1 (6.7%)
	Disagree: N = 68 (89.5%)	N = 54 (88.5%)	N = 14 (93.3%)
	TOTAL: N = 76	**N = 61**	**N = 15**

4.7 SECTION E - RESEARCH

Section E refers to how nurses believe the ideal unit manager should approach issues with regard to research.

QUESTION 42: STAFF PARTICIPATION E151, E152, E153, E154

"Research forms part of the nurse's daily duties. How should a unit manager respond when investigating any recurrence of infections?"

Table 4.40 shows the results obtained for variable E151. The majority of participants N = 67 (83.7%) disagreed that the unit manager should not investigate the tendency, but should assume that carelessness of staff members is to blame and therefore enhance infection control measures. A further analysis shows that N = 52 (82.5% of the professional nurses (PN) and N =15 (88.2%) of non-professionals disagreed. A statistical significant correlation was identified between years of experience in the C.C.U. and that the unit manager should not investigate the tendency, but should assume that carelessness of staff members is to blame and therefore enhance infection control measures (Chi-square test p = 0.047). The results show that nurses value participatory leadership and reject autocratic leadership.

Table 4.40 shows the results obtained for variable E152. The majority of participants N = 99 (94.3%) agreed that the unit manager should investigate the problem, inform staff members of the problem and her findings, and ask them for suggestions on how to combat the problem. A further analysis shows that N = 76 (93.8%) of the professional nurses (PN) and N = 23 (95.8%) of non-professionals agreed. The results show that nurses value participatory leadership.

Table 4.40 shows the results obtained for variable E153. The majority of participants N = 70 (85.4%) agreed that the unit manager should ask the risk manager to give a lecture on infection control. A further analysis shows that N = 54 (84.4%) of the professional nurses (PN) and N = 16 (88.9%) of non-professionals agreed. The results show that nurses value training.

Table 4.40 shows the results obtained for variable E154. The majority of participants N = 74 (91.4%) agreed that the unit manager should ensure that all the administrative details with regard to infection control are in place. A further analysis shows that N = 62 (93.9%) of the professional nurses (PN) and N = 12 (80%) of non-professionals agreed. The results show that nurses value the accuracy of administration with regard to infection control.

Table 4.40: Staff Participation

		PN	Non-Professional
E151	She does not investigate the tendency, but assumes that carelessness of staff members is to blame and enhances infection control measures.		
	Agree: N = 13 (16.3%)	N =11 (17.5%)	N = 2 (11.8%)
	Disagree: N = 67 (83.7%)	N = 52 (82.5%)	N =15 (88.2%)
	TOTAL: N = 80	**N = 63**	**N = 17**
E152	She investigates the problem, informs staff members of the problem, her findings and asks them for suggestions on how to combat the problem.		
	Agree: N = 99 (94.3%)	N = 76 (93.8%)	N = 23 (95.8%)
	Disagree: N = 6 (5.7%)	N = 5 (6.2%)	N =1 (4.2%)
	TOTAL: N = 105	**N = 81**	**N = 24**
E153	She asks the risk manager to give a lecture on infection control.		
	Agree: N = 70 (85.4%)	N = 54 (84.4%)	N =16 (88.9%)
	Disagree: N =12 (14.6%)	N =10 (15.6%)	N = 2 (11.1%)
	TOTAL: N = 82	**N =64**	**N = 18**
E154	She ensures that all the administrative detail with regard to infection control is in place.		
	Agree: N = 74 (91.4%)	N = 62 (93.9%)	N =12 (80%)
	Disagree: N = 7 (8.6%)	N = 4 (6.1%)	N = 3 (20%)
	TOTAL: N = 81	**N = 66**	**N = 15**

QUESTION 43: RESEARCH DATA COLLECTION. E155, E156, E157, E158

"Each nurse has a duty to collect and store research data e.g. record keeping. How should the unit manager deal with research data? The unit manager…"

Table 4.41 shows the results obtained for variable E155. The majority of participants N = 85 (90.4%) agreed that the unit manager is accurate as far as such data is concerned. A further analysis shows that N = 66 (90.4%) of the professional nurses (PN) and N = 19 (90.5%) =of non-professionals agreed. The results show that nurses have faith in the accuracy of unit managers with regard to administration.

Table 4.41 shows the results obtained for variable E156. The majority of participants N = 65 (83.3) disagreed that the unit manager has no idea as to how such data is stored. A further analysis shows that N = 50 (80.6%) of the professional nurses (PN) and N =15

(93.7%) of non-professionals disagreed. A statistical significant association was identified between years of experience in the C.C.U. and that the unit manager has no idea as to how such data is stored (Chi-square test p = 0.013). The results show that nurses trust the bureaucratic side of unit managers with regard to research.

Table 4.41 shows the results obtained for variable E157. The majority of participants N = 80 (84.2%) agreed that the unit manager should involve the nursing staff with the storage of such data. A further analysis shows that N = 63 (85.1%) of the professional nurses (PN) and N = 17 (80.9%) of non-professionals agreed. The results show that nurses value participatory leadership.

Table 4.41 shows the results obtained for variable E158. The majority of participants N = 72 (90%) disagreed that the unit manager should force staff to store such data while she herself is not involved. A further analysis shows that N = 55 (88.7%) of the professional nurses (PN) and N =17 (94.4%) of non-professionals disagreed. A statistical significant association was identified between years of experience in the C.C.U. and that the unit manager should force staff to store such data while she herself is not involved. (Chi-square test p = 0.037). The results show that nurses value participatory leadership.

Table 4.41: Research Data Collection

		PN	**Non-Professional**
E155	… is accurate as far as such data is concerned.		
	Agree: N = 85 (90.4%)	N = 66 (90.4%)	N = 19 (90.5%)
	Disagree: N = 9 (9.6%)	N = 7 (9.6%)	N = 2 (9.5%)
	TOTAL: N = 94	**N = 73**	**N = 21**
E156	… has no idea as to how such data is stored.		
	Agree: N =13 (16.7%)	N = 12 (19.4%)	N = 1 (6.3%)
	Disagree: N = 65 (83.3%)	N = 50 (80.6%)	N = 15 (93.7%)
	TOTAL: N = 78	**N = 62**	**N = 16**
E157	… involves the nursing staff with the storage of such data.		
	Agree: N = 80 (84.2%)	N = 63 (85.1%)	N = 17 (80.9%)
	Disagree: N =15 (15.8%)	N = 11 (14.9%)	N = 4 (19.1%)
	TOTAL: N = 95	**N = 74**	**N = 21**
E158	… forces staff to store such data, but she herself is not involved.		
	Agree: N = 8 (10%)	N = 7 (11.3%)	N = 1 (5.6%)
	Disagree: N = 72 (90%)	N = 55 (88.7%)	N =17 (94.4%)
	TOTAL: N = 80	**N = 62**	**N = 18**

QUESTION 44: RESEARCH INPUT. E159, E160, E161, E162

"It is important for nurses to give their input where research is concerned. Therefore, the unit manager should…"

Table 4.42 shows the results obtained for variable E159. The majority of participants N =115 (98.3%) agreed that the unit manager should encourage the staff to give their input when completing research questionnaires. A further analysis shows that N = 87 (97.7%) of the professional nurses (PN) and N = 28 (100%) of non-professionals agreed. The results show that nurses value participatory leadership.

Table 4.42 shows the results obtained for variable E160. The majority of participants N = 73 (93.6%) disagreed that the unit manager should ignore questionnaires. A further analysis shows that N =56 (91.8%) of the professional nurses (PN) and N = 17 (100%) of non-professionals disagreed. A statistical significant association was identified between years of experience in the C.C.U. and that the unit manager should ignore questionnaires (Chi-square test p = 0.010). The results show that nurses do not value laissez-faire leadership.

Table 4.42 shows the results obtained for variable E161. The majority of participants disagreed N =72 (93.5%) disagreed that the unit manager should force the staff to complete the questionnaires. A further analysis shows that N =56 (93.3%) of the professional nurses (PN) and N =16 (94.1%) of non-professionals disagreed. The results show that nurses prefer participatory leadership over autocratic leadership.

Table 4.42 shows the results obtained for variable E162. N = 41 (54.7%) agrees that the unit manager should ask the staff to complete the questionnaires once their work is done. A further analysis shows that N = 35 (59.3%) of the professional nurses (PN) and N = 6 (37.5%) of non-professionals agreed. The results show that nurses regard patient care as their first priority.

Table 4.42: Research Input

		PN	**Non-Professional**
E159	…encourage the staff to give their input when completing research questionnaires.		
	Agree: N = 115 (98.3%)	N = 87 (97.7%)	N = 28 (100%)
	Disagree: N = 2 (1.7%)	N = 2 (2.3%)	N = 0 (0%)
	TOTAL: N = 117	**N = 89**	**N = 28**
E160	…ignore questionnaires.		
	Agree: N = 5 (6.4%)	N = 5 (8.2%)	N = 0 (0%)
	Disagree: N = 73 (93.6%)	N = 56 (91.8%)	N = 17 (100%)
	TOTAL: N = 78	**N = 61**	**N = 17**
E161	…force the staff to complete the questionnaires.		
	Agree: N = 5 (6.5%)	N = 4 (6.7%)	N = 1 (5.9%)
	Disagree: N = 72 (93.5%)	N = 56 (93.3%)	N = 16 (94.1%)
	TOTAL: N = 77	**N = 60**	**N = 17**
E162	…ask the staff only to complete the questionnaire once their work is done.		
	Agree: N = 41 (54.7%)	N = 35 (59.3%)	N = 6 (37.5%)
	Disagree: N = 34 (45.3%)	N = 24 (40.7%)	N =10 (62.5%)
	TOTAL: N = 75	**N = 59**	**N = 16**

QUESTION 45: RESEARCH OUTPUT. E163 – E164

"Do unit managers normally implement evidence-based guidelines? For example, research done in 2007 proved that the incidence of ventilated acquired pneumonia is less frequent in ventilated patients who received 4 hourly mouth care than in patients who received 8 hourly mouth care. Would unit managers who know about the results implement measures to ensure that all ventilated patients in their care receive 4 hourly mouth care?"

E163 – E164 The majority N = 80 (67.2%) of participants agreed that a unit manager will implement evidence-based guidelines. A further analysis shows that N = 62 (67.4%) of the professional nurses (PN) and N =18 (66.7%) of non-professionals agreed. A statistical significant association was identified between years of experience in the C.C.U. and that a unit manager will implement evidence-based guidelines (Chi-square test p = 0.051). The results show that nurses are aware of the value or importance of research.

Table 4.43: Research Output.

		Professional nurse	Non-professional
E163	Yes: N = 80 (67.2%)	N = 62 (67.4%)	N = 18 (66.7%)
E164	No: N = 39 (32.8%)	N = 30 (32.6%)	N = 9 (33.3%)
	TOTAL: N =119	**N = 92**	**N = 27**

4.8 DISCUSSION

4.8.1 Section A

The information gained in Section A shows that the majority of participants were females N = 116 (93%) of which N = 75 (61%) were older than 40 years. Most of the respondents were professional nurses N = 95 (77%) and N = 64 (52%) of the respondents received their training during 1980 and 2000. Only N = 46 (37%) of the respondents were trained critical care nurses and N = 70 (56%) of the respondents have been working in C.C.U.s for more than seven years. Only N = 4 (3%) have received nursing management training during the last 5 years. A mere N = 18 (15%) of the respondents had held the position of a unit manager and N = 66 (73%) has acted in the position as a shift leader.

4.8.2 Section B

The options that relate to the rules and procedures underlying the nursing profession were well accepted, but were outshone by the value placed on the participatory responses. Therefore, the results prove that nurses primarily prefer participatory leadership, but in a lesser sense, show an affinity towards the bureaucratic past of the profession. The results are confirmed by Grossman & Valiga’s (2007:64) writing that the bureaucratic attitude in nursing is declining.

The results with regard to questions B18 and B19 show that nurses value integrity and can therefore benefit from the transformational leadership approach which is highly ethical (Kelly, 2006:27).

The response to question B26, which indicates the need for impartiality (16 requests), approachability (15 requests), trust (10 requests) and staff support (9 requests) also emphasizes the need for a leadership approach that is highly ethical.

It is quite clear from the results in Section B that nurses value a participatory leadership style and a transformational leadership approach.

4.8.3 Section C

The general choice made by the respondents with regard to education (Section C) is participatory management. However, the results of C101 indicate that nurses prefer a more purposeful or rather firm approach with regard to the mentored relationship. The same applies to climate meetings where the respondents placed emphasis on the unit manager as a leader but preferred participatory leadership behaviour. The reasons might be that leadership with regard to conflict and mentoring are currently in arrears.

4.8.4 Section D

The results of questions 34-36 (Section D) show that nurses prefer participatory leadership and a transformational approach. The results of D130 reveal that the majority of respondents experience honesty and openness in the workplace. However, the latter is in contrast to the huge request for honesty, trust, openness and approachability as shown in the results to question 26. The reason might be that the respondents did not read the instructions in the questionnaire thoroughly and that they assumed that they had to indicate the ideal response for a unit manager, which was the case with most of the questions. Nonetheless, the results of D131 indicate that 43% of the respondents experience laissez-faire leadership with regard to communication in the workplace. The results of D132 show that 27% of the participants are confronted with bureaucratic behaviour that relates to communication in the workplace. The results of D134 reveal that 48.2% of the respondents are exposed to situations where they are forced to nurse a ventilated patient as well as another patient. The latter shows an autocratic response to staffing that relates to serious ill patients and therefore a red light with regard to patient safety.

Another disturbing response is that 47% of the respondents in D138 acknowledged that unit managers only considered qualifications and experience when the workload justifies it. The results indicate that patient safety and safe nursing practice are not always considered the unit manager’s first priority.

4.8.5 Section E

The results in Section E show that nurses prefer a participatory approach with regard to research and that they trust unit managers with regard to accuracy of research data and the implementation of evidence-based practice guidelines.

4.9 SUMMARY

The objectives set for this study were:

- To identify the ideal leadership style required in administrative functions
- To identify the ideal leadership style required in the education function
- To identify the ideal leadership style required in patient care
- To identify the ideal leadership style required in research.

The following four paragraphs summarise the findings of the study with regard to each of the above mentioned objectives.

Section B consists of questions that relate to the administration functions of the unit manager. The results of the eleven closed questions reveal that nurses in the critical care setting prefer participatory leadership and a transformational leadership approach with regard to the administrative function of the unit manager. The statistical significant associations found in B52, B53, B62, B68, B72, B73 and B90 accentuate the respondents' preference for participatory leadership. The answers to the open questions (25-26) show a huge demand for impartiality, trust, openness, approachability and staff support, of which all are present in the transformational leadership approach.

The six questions in Section C relate to the education function of the unit manager. The results of these questions reveal (C95) that the respondents prefer the unit manager to be a role model with regard to training. The choices made in C101 reveal that the nurses value a purposeful approach in training and that they want to be involved in the scheduling of off-duties (C105). The results in C115 also indicate that nurses prefer to attend managerial meetings. These findings confirm that nurses in the critical care environment prefer participative management with regard to education.

The questions in Section D are concerned with patient care and the results of D117, D118, D121 – 124 and D125 show that nurses prefer honesty, openness, empowerment and effective communication where patient care is concerned. Since all these traits are present in the transformational leadership approach it is obvious that nurses prefer the latter in patient care.

The results of Section E indicate that the respondents prefer participatory leadership with regard to research. E152 which represents the participative leadership option of question 42 received a yes vote N = 99 (94.3%). The participative management options of questions 43 - 44, were also favourably received by the respondents.

Since all four of the objectives are met, the answer to the research question of this study: "What is the ideal leadership style for unit managers in C.C.U.s of private health care

institutions?” has been identified. Nurses in C.C.U.s prefer participatory and highly ethical leadership behaviour, both of which are present in the transformational leadership approach.

In the next chapter, chapter 5, conclusions will be drawn and recommendations will be made with regard to the implementation of an ethical sound leadership style in C.C.U.

CHAPTER 5.
DISCUSSIONS AND RECOMMENDATIONS

5.1 INTRODUCTION

In the previous chapters the researcher defined the reasons for this project, presented an in depth literature review and described the research methodology applied to the project and the data analysis. In this chapter the researcher presents conclusions on the findings and detailed recommendations are proposed.

5.2 CONCLUSIONS

The objectives set for this study were to determine the characteristics and styles of leadership beneficial to intensive care units with regard to: administration, patient care, education and research. These form the core functions of the unit manager.

5.2.1 Objective 1: Administration

The first objective of the study was to determine the ideal leadership style with regard to the administrative function of the unit manager. Section B of the questionnaire referred to the administrative function of the unit manager and the ideal leadership response with regard to the following variables was determined: decision -making, task delegation, problem solving, conflict management, cost containment, performance appraisal, work environment and quality control.

With reference to task delegation (**B48-B51**) and decision-making (**B52-B55**) the nurses valued participatory leadership. A statistical significant association (**B53**) was identified between both professional and non professional nurses and that unit managers should not delegate tasks without consulting the staff (Chi-square test $p = 0.03$). A statistical significant association was identified between both professional and non professional nurses (**B52**) and that unit managers should welcome the input of the staff before task delegation takes place (Chi-square test $p = 0.06$). **B55** showed a statistical significant association between years in C.C.U. and that unit managers should consider rules and regulations when delegating tasks (Chi-square test $p = 0.016$). The results indicate that nurses prefer a participatory leadership style but acknowledge the underlying rules and regulations that guide nursing practice, since they will be held accountable for their actions, as supported by Muller (2004:59).

With regard to problem solving (**B56-B59**) the nurses opted for honesty, fairness, objectivity and assertiveness, all of which are characteristics of the transformational leadership approach as described by Bajnok *et al*. (2006:33).

The data obtained in (**B60-B67**) showed that nurses disapproved of 'laissez-faire' and autocratic leadership during conflict management. A statistical significant association was identified between years in C.C.U. and that conflict should be referred to the nursing service manager (**B62**). The nurses disapproved of the latter. The results showed that nurses value honesty, objectivity, assistance and a speedy response from unit managers with regard to conflict management.

With reference to health economics (**B68-B71**), the nurses rejected autocratic options but agreed to participatory conduct, secretarial assistance and training where necessary. A statistical significant association (Chi-square test p = 0.072) was identified between both professional nurses and non-professional nurses and that unit managers should seek the input of the staff when trying to solve problems related to cost containment.

Question 21 (**B72-B80**) referred to performance appraisal. **B72** shows a statistical significant association (Chi-square test p = 0.098) between years in C.C.U. and that performance appraisal should be coupled with dialogue between the unit manager and the staff member. A statistical significant association (Chi-square test p = 0.025) was identified between both professional and non-professional nurses and that staff should have an opportunity to give feedback regarding the unit managers behaviour (**B73**). With regard to performance appraisal, the nurses preferred honesty, openness, effective communication, participatory conduct and that unit managers should acknowledge their mistakes and provide explanations.

The results of **B81-B84**, in which the respondents had to decide on the ideal management style, it was, again confirmed that nurses value participatory leadership. In question 24, N = 107 (89.9%) of the respondents confirmed that a unit manager's presence and actions contribute to a healthy work environment.

The respondents (question 25) who regarded the unit manager’s actions and presence as negative to the work environment in the C.C.U. attribute their opinion to unit managers who favour certain staff members and the patients of certain doctors. These unit managers are perceived to have an autocratic way of conduct and do not distance themselves from inter-staff problems.

On suggestions as to how the unit manager’s behaviour can contribute to a healthy work environment (question 26), the respondents largely requested impartiality, trust, honesty, openness, approachability and support when the unit is busy. All these reflect a need for integrity in leadership.

It is identified that, with regard to quality control (**B87-B90**), the respondents favoured participatory leadership and gave credit to the policies that accompany quality control.

The results obtained proved that nurses prefer participatory leadership in almost every sphere of administration. However, in three of the eleven questions, the options that signify bureaucratic leadership and relate to rules, procedures and policies underlying the profession, were well accepted but did not overcast the value placed on the participatory response.

5.2.2 Objective 2: Education

The second objective of the study was to determine the ideal leadership style required, with reference to the education function of the unit manager. The ideal leadership response with regard to the following variables regarding education was determined: training and development, role model behaviour, staff participation, staff development, motivation and empowerment.

With reference to (**C91**) training and development, the nurses showed a clear preference for participatory leadership N = 100 (96.2%). A statistical significant association (Chi-square test p=0.041) was identified between both professional nurses and non professional nurses and that the unit manager should ask the training and development consultant for support pertaining to training (**C92**). The results with regard to this variable showed that nurses value participatory conduct and support with training.

The outcome of question 29 (**C96**) confirmed that nurses prefer participatory leadership since N = 97 (95.1%) of the respondents agreed to a participatory approach in compulsory in-service training.

With reference to question 30 (**C100**), the majority agreed to a participatory approach in the mentored relationship N = 60 (58.3%). However, N = 71 (82.6%) of the respondents agreed to a definite time limit in evaluating the outcome of the mentorship. The latter affirms that nurses prefer leaders to give structure to learning as substantiated by Grossman (2007:64).

The results of **C105** (question 31) showed that nurses wish to be involved in the scheduling of off-duties. A statistical significant association (Chi-square test p=0.041) was identified between years in C.C.U. and that each professional nurse should have a chance to be involved in the scheduling of off-duties.

The results obtained in question 32 (**C109**) indicate the majority of respondents agreed that each nurse should have a chance in leading climate meetings.

The outcome of question 33 confirms that the nurses desire to be present at managerial meetings enabling them to feel more empowered. The results obtained with reference to **C115** showed that N = 74 (79.6%) of the nurses agreed that each professional nurse should have a chance to attend managerial meetings. In **C116** a statistical significant association was identified between years in C.C.U. and that managerial meetings should be attended by all who wish to attend.

The outcomes of Section C confirm that participatory leadership is ideal for education in C.C.U.s

5.2.3 Objective 3: Patient Care

The third objective of the study was to determine the ideal leadership approach required in patient care. With the purpose of obtaining the objective, the ideal leadership approach relating to the following variables was investigated: work ethics, professionalism, organizational climate, communication, staffing, staff support and whether unit managers consider qualifications and experience when delegating tasks.

The outcome of question 34 (**D117**) referring to work ethics, showed that nurses favour openness, honesty and empowerment. A statistical significant association was identified between years in C.C.U. (Chi-square test p = 0.055) and that unit managers should inform and motivate all relevant staff members with regard to senior positions.

The results of question 35 (**D121**) showed a statistical significant association between years of experience in C.C.U. and that the unit manager should admit inappropriate conduct and apologize (Chi-square test p = 0.013). The respondents' preference for openness, honesty and integrity is obvious.

The response to **D125** reveals the nurses N = 118 (99%) prefer a healthy, trustworthy and supportive organizational climate.

N = 99 (90.8%) of the respondents in **D129** of question 37 revealed that communication with unit managers is usually honest and open. The latter is in contrast to the huge request for approachability and openness as revealed in question **26**. The findings obtained in **D131** show that N = 33 (41.3%) of the respondents experience a laissez-faire attitude or conduct with regard to communication in the work place.

The response to **D133** in question 38 reveals that N = 29 (34.5%) of nurses experience a laissez-faire attitude from unit managers regarding staffing of ventilated patients. The results of **D134** show that N = 41 (48.2%) of the respondents are exposed to autocratic leadership

relating to staffing of ventilated patients, since unit managers would tell them to cope although staffing is insufficient.

The results of **D138** N = 39 (47%) in question 39 show that unit mangers only consider qualifications and experience when delegating tasks if the workload in the unit justifies it. The latter shows an element of laissez-faire leadership with regard to task delegation. The response to **D141** shows that a statistical significant association was identified between years of experience in C.C.U. (Chi-square test p = 0.081) and that unit managers would do what they thought best in a particular situation. N = 99 (96.1%) of the participants agreed to the latter. The results verify an autocratic conduct that relates to task delegation.

The results of question 40 **D145** show that unit managers in general are supportive in patient care.

The outcome of **D148** N = 99 (96.1%) validates that nurses prefer participatory conduct with reference to the record keeping function of nurses.

The results of questions 37-40 verify that autocratic and laissez-faire leadership exist in C.C.U.s. The outcome of questions 34-36 and 41 accentuate the nurses' desire for participatory and highly ethical leadership conduct. The results prove that nurses prefer participatory and transformational conduct in patient care.

5.4.4 Objective 4: Research

The fourth objective of the study was to determine the ideal leadership style required for research. The ideal leadership conduct relating to the following variables was determined: staff participation, research data collection, research input and output.

The results of questions 42 (**E152**), 43(**E157**) and 44(**E159**) showed that nurses prefer participatory leadership with regard to research.

5.3 RECOMMENDATIONS

The results show that nurses prefer participatory leadership practices and a transformational leadership approach. All recommendations are therefore based on the scientific evidence obtained in this study regarding the latter. The benefits of these leadership practices and thus the results are supported by literature.

Jooste (2007:8-10) postulates that the changing health care environment requires a new approach to leadership. Health care in South Africa is faced with a number of challenges such as: financial constraints; the National Patients Rights Charter of South Africa;

bureaucratic practices; legislation, for example, a new Nursing Act in the process of implementation; and labour issues. .

Consequently, to accommodate these challenges, the researcher recommends a transformational leadership approach in nursing, with specific reference to C.C.U., the research environment under study. Nurse leaders should be less static, more flexible and more open-minded. They should have fewer boundaries, promote collaboration and a team approach in the workplace. Furthermore, nurse leaders should be encouraged to be involved in direct patient care and in so doing, support and empower the workers. In addition, they should be creative in decision-making and recruit talented new staff from all ages, ethnic backgrounds and work experiences. Consequently, this will result in increased team cohesiveness and success overall.

Nurse leaders who wish to transform the working environments of nurses will have to implement fundamental transformational leadership practices such as the building of trusting relationships. Nurse leaders need to create an empowering work environment allowing access to information, support and opportunities for nurses. It is essential for nurse leaders to create an environment that supports knowledge development and training. In addition, it is fundamental for nurse leaders to initiate and sustain change, namely to adopt a proactive and participatory approach for implementing change. Ultimately the leaders in nursing should balance competing values and priorities by advocating and mobilizing the required nursing resources, thus ensuring quality patient care, as supported by Bajnok *et al*. (2006:23).

5.3.1 Administration

5.3.1.1 Decision making, task delegation, planning and problem-solving

The results concerning decision-making, task delegation, planning and problem-solving indicated that nurses prefer participatory leadership practices with regard to these variables. Therefore, unit managers need to supply the staff with the necessary information to make informed decisions and to be committed partners. Staff inclusion in decision-making should be a standard operating practice as supported by Alpach (2005:12). Decentralization, which allows for the transfer of decision making to unit level, needs to be implemented as supported by Muller, Bezuidenhout and Jooste (2006:64). Unit managers should educate staff members with regard to collaboration, effective communication, demonstrating mutual respect, professional competence and integrity when dealing with the above mentioned variables, as supported by Alpach (2005:12). Furthermore, unit managers should link decisions relating to task delegation to the scope of practice of the individual employee as substantiated by McCutcheon *et al*. (2005:1-2).

5.3.1.2 Conflict management

The results regarding conflict management showed that nurses value participatory conduct, a speedy response and integrity.

As substantiated by Kelly (2006:27), the unit manager should allow the staff to engage in conflict assertively, yet respectfully. Nurses should be trained in emotional intelligence in order to deal with conflict more effectively. Critical care nurses need to embrace independence and increased accountability in the work environment since it will help them to think more critically and analytically. This will result in successful conflict resolution. The adoption of the highly ethical transformational approach and a win-win solution are essential for effective conflict management.

5.3.1.3. Performance appraisal

The results N=69 (86.3%) show that nurses would like to have an opportunity to give feedback regarding the unit managers' conduct. It is therefore essential that nurse leaders provide such an opportunities on a regular basis. The results obtained relating to performance appraisal indicated that nurses value integrity, openness and honesty. Considering the findings of this study, the researcher recommends that unit managers adopt such virtues throughout their leadership in the work environment. It is expected that unit managers should display trust, honesty and fairness prior to the actual procedure in order for any appraisal system to be effective. This is substantiated in the relevant literature (Marquis & Huston, 2001:415).

5.3.1.4 Health economics and quality control

The results show that nurses value participatory leadership practices in both health economics and quality control. Therefore, the unit manager needs to conduct meetings with immediate subordinates to gain their input in decisions, plans, task distribution and problem solving. By including the subordinates in these tasks, the unit manager helps to fulfill the human need for self-expression and achievement, as supported in the literature (Muller *et al.*, 2006:289).

5.3.1.5 Management approach and improvement of the work environment

The outcome of question 23 (ideal management approach) and questions 24-26 (the improvement of the work environment) indicated that nurses prefer participatory and transformational leadership practices. A thorough discussion of both participatory and transformational leadership practices was presented in chapter 2. The findings of the study support the establishment of a healthy work environment for nurses. Nurse leaders must fully

embrace the importance of a healthy work environment and be actively involved in sustaining and developing of such an environment. It is imperative that nurses need to be as efficient in communication as they are in the clinical practice. They should constantly seek and nurture true collaboration. The staff should be valued and dedicated partners in establishing policies and directing and evaluating clinical care. Fundamental to these recommendations is appropriate staffing since staffing must ensure the effective pairing between patient needs and nurse competencies. Both management and nursing staff should engage in meaningful recognition of the value that each contributes to the organization, as supported by Alspach (2005:12).

The outcome of question 26 signifies an outcry for integrity. Integrity is grounded in the transformational approach (see chapter 2). Jooste (2007:14) postulates that leaders must "shift the focus from narrow self-interest to concern for good of the whole". It is strongly recommended that integrity forms the basis of nurse leadership. True or genuine leadership is therefore required in the working environment.

The results of question 26 showed a need for unit managers to be supportive with regard to patient care. The researcher recommends that unit managers need to be actively involved in patient care be it directly or indirectly. The unit manager should delegate administrative tasks appropriately, considering prior consultation and coaching, so that she herself is available for patient care. Furthermore, unit managers should be available to relieve the staff for tea and lunch breaks. The latter should be a priority and they should be self-disciplined in this regard. To promote empowerment of staff, unit managers should grant staff opportunities to attend managerial meetings. Prior arrangements to relieve the staff from direct patient care to attend these meetings should be made with the staff. Unit managers should take over direct patient care from a staff member at least once a week so that one of the staff members may attend managerial meetings. Continuity of care and empowerment of staff will therefore be ensured.

It is also expected of unit managers to ensure that continuous professional development regarding good leadership practices occurs. Aspects relating to participative management, shared governance, empowerment, staff development and motivation are some issues that require continuous updating.

5.3.2 Education

5.3.2.1 Training and development, role models and staff participation

The results obtained regarding training and development, role model and staff participation show that nurses prefer participatory and transformational leadership practices (questions 28-30). Therefore, the recommendations as described in paragraph 5.3.1.5 under the heading,

"Management approach and improvement of the work environment", are also applicable to this section.

5.3.2.2 Staff development, motivation and empowerment

The results with regard to staff development, motivation and empowerment (questions 31-33) indicate the following:

- Nurses would like to be involved in the scheduling of off-duties.
- Nurses would like to take the lead in climate meetings.
- All categories of nurses would like to attend managerial meetings.

The results signify a need for empowerment. It is therefore recommended that nurse leaders should implement management structures which will contribute to the empowerment of the staff. Examples include decentralized management, less bureaucracy, improved communication and opportunities for professional development. Unit managers should actively practice power sharing with even the lowest possible level in the unit. In this manner, for example, all categories of nurses would have an opportunity to attend managerial meetings. It is of paramount importance that unit managers practice participative decision making in the empowering of the nurses. Participative decision-making results in a positive work environment, improved team spirit and effective conflict management. Furthermore, unit managers should introduce motivation and reward strategies that would contribute to high performance. Nurse leaders must also take cognizance of the fact that leaders who empower others, are professional role models, they display fairness and reason, they value their staff, they promote two-way communication and exhibit trustworthiness through honest interactions, as supported by Muller *et al.* (2006:408).

5.3.3 Patient care

5.3.3.1 Work ethics, organizational climate, record keeping and professionalism.

The results with reference to work ethics, organizational climate, record keeping and professionalism (questions 34-36 & 41) show a preference for ethical behaviour, honesty, openness and integrity. The researcher recommends that unit managers should be aware of their own value system, religious and cultural beliefs, and be of ethically sound behaviour.

Honesty is a quality of integrity, and the nurse manager should display congruent behaviour in this respect at all times. Integrity is more than just being honest. Covey (1999:195) defines integrity as "conforming reality to our words." Since the results of this study indicated a profound request for integrity, the researcher recommends that every unit manager or nurse leader should incorporate or practice the basic principles underlying integrity. Nurse leaders

need to display loyalty to staff members in their absence and by doing that, they will gain the trust of those who are present. An example of such loyalty is to refrain from discussing staff members in their absence.

5.3.3.2 Communication, staffing, staff support and task delegation

The results with reference to communication, staffing, staff support and task delegation (questions 37-40) reveal that the respondents are at risk to litigation due to a high demand for patient care with minimum staff. This is illustrated in instances where the nurse is forced to attend to a ventilated patient and another patient simultaneously. The latter shows an autocratic response to staffing that relates to critically ill patients and therefore compromises the patient’s safety. The results shows that unit managers only consider qualifications and experience when the workload justifies it as illustrated when caregivers are utilized in critical care units. The results indicate that patient safety and safe nursing practices are not always considered as the unit manager’s first priority. Good staffing initiatives will only be effective and efficient if they are supported by management. The unit managers should link decisions concerned with staffing to the type of hospital unit, patient acuity and the scope of practice of the nurse, as supported by McCutcheon *et al.* (2005: 1-2,11). It is therefore strongly recommended that hospitals in South Africa are accredited by Magnet Recognition (see 2.6.1).

5.3.4 Research

5.3.4.1 Staff participation, data collection and research input.

The results obtained regarding staff participation, data collection and research input (questions 42-44) indicated that nurses prefer participatory leadership with regard to research. The researcher recommends that the basic principles underlying participative leadership be applied as described in 5.3.1.1 and 5.3.2.2.

5.4 SUMMARY

In this chapter the researcher described the recommendations based on the findings of the research objectives defined for this study as well as the relevant literature.

5.5 CONCLUSION

Transformational leadership and participatory management styles have clearly been shown as the ideal leadership styles for critical care units. As described by Drucker (1990:14) “The leader who work most efficiently never say 'I'. They don’t think 'I'. They think 'we', they think 'team'. They understand the job is to make the team function. They accept responsibility and

don’t sidestep it, but 'we' get the credit… This is what creates trust, what enables you to get the task done.”

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APPENDICES

Appendix A: Participant consent forms

PARTICIPANT INFORMATION LEAFLET AND CONSENT FORM

TITLE OF THE RESEARCH PROJECT: An ideal leadership style for unit managers in intensive care units of private health care institutions.

REFERENCE NUMBER: 12300349

PRINCIPAL INVESTIGATOR: Mariana van der Heever

ADDRESS: 21 Gardenia Road, Durbanville

CONTACT NUMBER: 0729041574

You are invited to partake in a research project. Please take some time to read the information presented here, which will explain the details of this project. Please ask the researcher any questions about any part of this project that you do not fully understand. Your participation is **entirely voluntary** and you are free to decline to participate.

This study has been approved by the **Committee for Human Research at Stellenbosch University** and will be conducted according to the ethical guidelines and principles of the international Declaration of Helsinki, South African Guidelines for Good Clinical Practice and the Medical Research Council (MRC) Ethical Guidelines for Research.

What is this research study all about?

The study will be conducted in 11 private health care institutions in the Cape Metropolitan Area. All the ICU nurses (of all categories) in the 11 health care institutions will be recruited. The total number of participants involved are 287.

The researcher is of the opinion that a unit manager has a core function in creating a healthy work environment and team spirit. The researcher wishes to determine the leadership style(s) most beneficial to critical care units. In the end, the researcher will endeavour to answer the following question: that a specific leadership behaviour exposed by unit managers contribute to a healthy work environment; to the empowerment of nurses; to good and efficient patient care; to work satisfaction; to the development, training and the retention of nurses.

Written consent will be obtained from each participant ensuring the confidentiality, anonymity and privacy concerning all information. Each nurse will then be provided with a questionnaire (and a matching envelope) to be completed by them. The researcher will issue and collect all the questionnaires. Please hand your completed questionnaire to no one but the researcher.

Why have you been invited to participate?

The researcher values the honest response of all critical care nurses. Without the response of critical nurses, this project is worthless.

What will your responsibilities be?

Each participant needs to complete the supplied questionnaire by answering **all** the questions, Place the completed questionnaire in the envelope provided and seal the envelope. Return the sealed envelope to the researcher.

Will you benefit from taking part in this research?

All nurses working in critical care units will benefit. The results of the research will be published and made available to the nursing fraternity.

Are there in risks involved in your taking part in this research?

No risks have been identified. All information will be treated with the necessary confidentiality, anonymity and privacy.

If you do not agree to take part, what alternatives do you have?

Participation is voluntary, but the researcher will appreciate the input of all nurses.

Will you be paid to take part in this study and are there any costs involved?

No, you will not be paid to take part in the study. Participation is on a voluntary basis.

Is there any thing else that you should know or do?

Please complete the whole questionnaire.

You can contact Mariana at on her cell 072 9041574 if you have any further queries.

You can contact the Committee for Human Research at 021-938 9207 if you have any concerns or complaints concerning the study.

You will receive a copy of this information and consent form for your own records.

Declaration by participant

By signing below, I …………………………………..…………. agree to take part in the research study entitled “An ideal leadership style for unit managers in intensive care units of private health care institutions”.

I declare that:

- I have read this information and consent form and it is written in a language with which I am fluent and comfortable.
- I have had a chance to ask questions and all my questions have been adequately answered.
- I understand that taking part in this study is **voluntary** and I have not been pressurised to take part.

Signed at (*place*) ....…......……………….. on (*date*) …………...……….. 2008.

....	....
Signature of participant	**Signature of witness**

Declaration by researcher

I Mariana van der Heever declare that:

- I explained the information in this document to …………………………………..
- I encouraged him/her to ask questions and took adequate time to answer them.
- I am satisfied that he/she adequately understands all aspects of the research, as discussed above
- I did/did not use a translator.

Signed at (*place*) ....…......……………….. on (*date*) …………...……….. 2008.

....	....
Signature of researcher	**Signature of witness**

Appendix B: Research questionnaire

QUESTIONNAIRE NURSING STAFF

Title
An ideal leadership style for unit managers in intensive care units of private health care institutions.

Instructions:

The following questionnaire was designed to be completed by nurses working in intensive care units(I.C.U.) of private hospitals. Please respond to all the questions that apply.
Choose the correct response by placing a cross **(X)** next to the appropriate questions below.
Where appropriate indicate or add your comment.
Principles of confidentiality and anonymity will be maintained.

SECTION A - BIOGRAPHIC DATA

1. Indicate your age group.

1	20 to 29 years	
2	30 to 39 years	
3	40 to 49 years	
4	more than 50 years	

2. Indicate your gender

5	Male	
6	Female	

3) Indicate your basic qualifications.

7	Professional nurse	
8	enrolled nursing	
9	auxiliary nursing	

4) Indicate the year of achievement.

10	1970-1980	
11	1981-2000	
12	2001-2007	
13	Other Please specify	

5) Indicate post basic qualifications.

14	nursing education	

15	nursing administration	
16	critical care nursing	
17	other (please specify)	

6) Indicate year of achievement.

18	1970-1980	
19	1981-2000	
20	2001-2007	
21	Other Please specify	

7) Indicate your age group.

21	20 to 29 years	
22	30 to 39 years	
23	40 to 49 years	
24	more than 50 years	

8) Indicate how long you have been working in I.C.U.

25	less than 1 year	
26	>1 years ≤ 3	
27	>3 years ≤ 5	
28	>5 years ≤ 7	
29	more than 7 years	

9) Have you received nursing management training during the last 5 years?

30	Yes	
31	No	

10) Have you received in-service nursing management training during the last 3 years?

32	Yes	
33	No	

11) Have you ever held the position of unit manager in an I.C.U.?

34	Yes	
35	No	

12) If your answer to question 11 is "Yes", indicate the number of years.

36	less than 1 year	
37	>1 year ≤ 3 years	
38	>3 years ≤ 5 years	
39	>5 years ≤ 7 years	
40	more than 7 years	

13) Have you ever been a shift leader in an I.C.U.?

41	Yes	
42	No	

14) If your answer to question 13 is "Yes", indicate the number of years.

43	less than 2 year	
44	>2 years ≤ 4	
45	>5 years ≤ 7	
46	>8 years ≤ 10	
47	more than 10 years	

<u>SECTION B – ADMINISTRATION</u>:

Choose what you think is the most appropriate response for an intensive care unit (I.C.U.) manager in each of the following scenarios by placing a cross (X) next to the appropriate space below.

Please note: in questions 24-26, 37-40 and 45 the respondents are asked to comment on their general impressions regarding unit managers in intensive care units.

15) Decision making.
If structural changes are planned for the I.C.U., for example, new built-in cupboards or the waiting room needs new chairs, the unit manager should…

		Agree	Strongly Agree	Disagree	Strongly Disagree
48	…inform the staff, show them the catalogue and ask them to list their ideas and preferences.				
49	…hand the task over to the nursing service manager.				

50	…decide what is needed and choose it all by her self.				
51	…emphasize the limitation of the budget, the rules and procedures they need to follow in order to get what they need.				

16) Task delegation.
When the daily delegation of tasks takes place, a unit manager should…

		Agree	Strongly Agree	Disagree	Strongly Disagree
52	…welcome the staff's input and opinions before delegating tasks.				
53	…delegate tasks without considering the staff's opinion.				
54	…transfer delegation of tasks to the second in command.				
55	…delegate tasks according to the rules and regulations.				

17) Problem solving.
You have lodged a complaint with the unit manager, e.g. you feel that you have been assigned to nurse very sick patients often while other nurses are only assigned to patients who are less seriously afflicted. What is the ideal response from your unit manager (i.e. a response that you would prefer)?

		Agree	Strongly Agree	Disagree	Strongly Disagree
56	She investigates the complaint and gives honest and objective feedback.				
57	She gives her reasons and asks you to continue with your work.				
58	She justifies her decision based on the current workload.				
59	She would apologize for her decisions and acknowledge that she was not aware of it.				

18) Conflict management.
When dealing with disputes the unit manager needs to apply certain rules and procedures. Two or more persons have a dispute and one of them complains to the unit manager.

		Agree	Strongly Agree	Disagree	Strongly Disagree
60	The unit manager assesses the situation and encourages them to speak honestly and openly to each other.				
61	She decides who is to blame and responds accordingly.				
62	The unit manager refers the dispute to the nursing service manager.				
63	She changes the off-duty roster so that those involved have little or no contact with each other.				

19) Planning.
How often should climate meetings be held?

64	Whenever necessary.	
65	Every 6 months.	
66	Only when conflict situations become untenable.	
67	Never.	

20) Health economics.
Staff should be involved in cost containment and cost awareness measures. When there is a problem with stock not being charged, the unit manager should …

		Agree	Strongly Agree	Disagree	Strongly Disagree
68	…have a meeting with the staff where she explains the losses and asks them for possible solutions.				
69	…decrease ward stock and inform staff to order what each patient requires.				
70	…ask the secretary to help solve the problem.				
71	…present a lecture on how to order and charge stock.				

21) Application of performance appraisal.
How should performance appraisal be applied ?

		Agree	Strongly Agree	Disagree	Strongly Disagree
72	By means of a conversation between the unit manager and the staff member.				
73	The staff gets an opportunity to give feedback that applies to the unit manager's conduct.				
74	The unit manager hands out a form with a given score and indicates that that is what you are worth and asks you to sign it without discussing it.				
75	Performance appraisal does not take place.				
76	The unit manager is a very busy administrator and performance appraisal only takes place when her schedule allows it.				

22) Assessment of work performance.
Performance appraisal takes place annually between you and the unit manager. What would be the ideal atmosphere that should prevail during the conversation?

		Agree	Strongly Agree	Disagree	Strongly Disagree
77	Honest and frank (open).				
78	Vague, superficial and non-directive.				
79	Tense, as you do not feel bold enough to speak or ask questions.				
80	This is just another procedure that needs to be conducted .				

23) Management approach.
An ideal management approach in intensive care units should be…

		Agree	Strongly Agree	Disagree	Strongly Disagree
81	…where the leader make decisions without consulting the staff.				
82	…where decisions are made, based strictly on norms and standards, without consulting				

	staff.				
83	…where control is given to the group and the unit manager provides little or no direction.				
84	…where the staff is involved in decision-making and it is honest and open.				

Questions 24-26: indicate your general impressions with regard to unit managers in I.C.Us.
Indicate your response in the space below with a cross (x).

24) Work environment.
Does a unit manager's actions and presence contribute to a healthy work environment?

85	Yes.	
86	No.	

25) If the answer is no, please elaborate.

……………………………………………………………………………………………………

……………………………………………………………………………………………………

26) Give suggestions how unit manager's behavior can lead to the improvement of the working environment in I.C.U.

………………………………………………………………………………………………………
………..

………………………………………………………………………………………………………
………..

Continue completing the questionnaire by choosing the most appropriate response for an I.C.U. manager in each of the following situations.

27) Quality control.
Quality assurance and quality improvement are closely linked.
Should unit managers ...

		Agree	Strongly Agree	Disagree	Strongly Disagree
87	…be involved with the staff when auditing files and giving feedback to the staff?				
88	…delegate quality assurance tasks to staff members and not give any feedback?				
89	…follow company policy with regard to the auditing of files?				
90	…audit the files themselves but not take responsibility for shortcomings detected?				

<u>SECTION C - EDUCATION</u>:
Choose the most appropriate response for an I.C.U. unit manager in each of the following situations.

28) Training and development.
The unit manager needs to educate and motivate staff. How should a unit manager approach in-service training?

		Agree	Strongly Agree	Disagree	Strongly Disagree
91	She involves staff in assessing needs and plans concertedly to address those needs.				
92	She asks the training & development consultant to assess the needs.				
93	She attaches notifications of in-service training sessions on the board and leaves it for the individual to decide.				
94	She delegates staff to attend certain lectures and informs them these are compulsory.				

29) Role model.
How should a unit manager approach compulsory in-service training, for example Advanced Life Support and Basic Life Support?

		Agree	Strongly Agree	Disagree	Strongly Disagree
95	She sets the example by attending both courses.				
96	She explains the necessity of the courses, shows them the off-duty roster and asks them which dates suit them best.				
97	She informs the staff that attendance is compulsory and sets dates for each course without any input from the staff members.				
98	She sends the staff on training only when the workload in the unit justifies it.				
99	She leaves it up to the training centre to recruit staff to attend.				

30) Staff participation.
Orientation is the personalized training of the individual employee. A new professional nurse has been appointed – how should a unit manager establish a mentor-mentored relationship?

		Agree	Strongly Agree	Disagree	Strongly Disagree
100	She introduces a new staff member to possible mentors and asks her to select her own mentor.				
101	She informs them that she will evaluate the outcomes within a certain period of time.				
102	She appoints a mentor to the mentored but does not follow-up on the results.				
103	The mentor is not on the same shift as the mentored because her expertise is needed on the other shift				

31) Staff development.
Unit managers need to educate staff with regard to scheduling of off-duties. The scheduling of off-duties within a unit should be the function of...

		Agree	Strongly Agree	Disagree	Strongly Disagree
104	…only the unit manager.				
105	…each professional nurse gets a chance to be involved.				
106	…the professional nurse - second in command.				
107	…is regarded as a managerial function and must be done by the unit manager.				

32) Motivation and empowerment.
Unit managers are involved in the motivation and development of staff. When having a climate meeting, who should chair the meeting?

		Agree	Strongly Agree	Disagree	Strongly Disagree
108	The unit manager always chairs the meetings.				
109	Each professional nurse gets a chance to chair the meeting.				
110	It is regarded as a managerial function and should be chaired by the unit manager.				
111	The second in command of the unit chairs the meetings.				
112	Climate meetings do not take place.				

33) Motivation and empowerment.
Unit managers need to empower staff. Therefore managerial meetings need only be…

		Agree	Strongly Agree	Disagree	Strongly Disagree
113	…attended by the unit manager.				
114	…attended by the unit manager and the professional nurse second in command.				
115	…attended by each professional nurse in the unit on a rotational basis.				
116	…attended by those who wish to attend.				

<u>SECTION D - PATIENT CARE</u>:
Choose the most appropriate response for an I.C.U. unit manager in each of the following situations.

34) Work ethics.
There is a vacancy for a senior position in the unit. A unit manager should …

		Agree	Strongly Agree	Disagree	Strongly Disagree
117	…inform all staff who qualify and motivate them to apply.				
118	…not mention it.				
119	…inform only certain staff members and motivate only those who wish to apply.				
120	…emphasize the requirements for the position as well as the procedures.				

35) Professionalism.
A unit manager acted inappropriately as a leader. Should the unit manager …

		Agree	Strongly Agree	Disagree	Strongly Disagree
121	…admit it openly and apologizes?				
122	…ignore it and refuse to discuss it?				

123	…try to shift the blame by blaming the rule or the procedure involved?				
124	…justify her actions without admitting that she is to blame?				

36) Organizational climate.
The ideal atmosphere in an I.C.U. should be …

		Agree	Strongly Agree	Disagree	Strongly Disagree
125	…healthy, trustworthy and supportive.				
126	…manageable.				
127	…stressful.				
128	…frustrating and demoralizing.				

Questions 37-40: indicate your general impressions with regard to unit managers in I.C.U.

37) Communication.
Communication with a unit manager with regard to patient care is usually ...

		Agree	Strongly Agree	Disagree	Strongly Disagree
129	…easy, open and honest.				
130	…minimal since we are to listen and obey as she is in command.				
131	…via the second in command or the shift leader.				
132	…minimal because her administration duties is her first priority.				

38) Staffing.
The recommended nurse-patient ratio for ventilated patients is 1:1. The I.C.U. suddenly becomes very busy and the nurse patient ratio has shifted. You now have two patients of whom one is on a ventilator. The unit manager …

		Agree	Strongly Agree	Disagree	Strongly Disagree
133	…seems unconcerned and leaves at 16:00.				
134	…tells you to cope as it is impossible to find extra staff at this stage.				
135	…takes over the non-ventilated patient, changes her shift and works until 19:00.				
136	…does her utmost to find extra staff.				
137	…tells you it is costly to get agency staff for the rest of the day and that the budget for agency staff is almost depleted.				

39) When delegating tasks, do unit managers consider qualifications and experience?

		Agree	Strongly Agree	Disagree	Strongly Disagree
138	Only when the workload justifies it.				
139	She ignores it.				
140	She always takes it into consideration.				
141	She does what she thinks is the best option in a particular situation.				

40) Staff support.
You are assigned to two patients of whom one is very confused and aggressive and the other very unstable. You ask the unit manager for help. How does an I.C.U. manager mostly respond?

		Agree	Strongly Agree	Disagree	Strongly Disagree
142	She instructs you to organize yourself and work more speedily.				
143	She explains the ratio for non-ventilated patients and instructs you to cope on your own.				
145	She offers her assistance until the patients are more stable.				
146	She ignores your plea for assistance.				

Choose the most appropriate response for an I.C.U. manager in the following situation.

41) Record keeping.
A problem arises because of poor recordkeeping. How should an I.C.U. manager respond?

		Agree	Strongly Agree	Disagree	Strongly Disagree
147	She gives a lecture on recordkeeping.				
148	She approaches those involved, asks them what went wrong and guides them through the correct procedure.				
149	She reprimands them and warns them not to repeat the same mistakes.				
150	She is not aware of the situation.				

SECTION E – RESEARCH:
Choose the most appropriate response for an I.C.U. manager in each of the following situations.

42) Staff participation.
Research forms part of the nurse's daily duties. How should a unit manager respond when investigating any recurrence of infections?

		Agree	Strongly Agree	Disagree	Strongly Disagree
151	She does not investigate the tendency, but assumes that carelessness of staff members is to blame and enhances infection control measures.				
152	She investigates the problem, informs staff members of the problem, her findings and asks them for suggestions on how to combat the problem.				
153	She asks the risk manager to give a lecture on infection control.				
154	She ensures that all the administrative detail with regard to infection control is in place.				

43) Research data collection.
Each nurse has a duty to collect and store research data e.g. record keeping. How should the unit manager deal with research data? The unit manager…

		Agree	Strongly Agree	Disagree	Strongly Disagree
155	… is accurate as far as such data is concerned.				
156	… has no idea as to how such data is stored.				
157	… involves the nursing staff with the storage of such data.				
158	… forces staff to store such data, but she herself is not involved.				

44) Research input.
It is important for nurses to give their input where research is concerned. Therefore the unit manager should…

		Agree	Strongly Agree	Disagree	Strongly Disagree
159	…encourage the staff to give their input when completing research questionnaires.				
160	…ignore questionnaires.				
161	…force the staff to complete the questionnaires.				
162	…ask the staff only to complete the questionnaire once their work is done.				

Question 45 – indicate your general impression with regard to unit managers in I.C.U.

45) Research output.
Do unit managers normally implement evidence-based guidelines? For example, research done in 2007 proved that the incidence of ventilated acquired pneumonia is less frequent in ventilated patients who received 4 hourly mouth care than in patients who received 8 hourly mouth care.
Would unit managers who know about the results implement measures to ensure that all ventilated patients in their care receive 4 hourly mouth care?

163	Yes	
164	No	

Thank you for your participation.

Researcher: M. M. van der Heever

Supervisor: Mrs. A. Damons **Co-supervisor:** Dr. EL Stellenberg

Appendix C: Organisational consent form

Dear Mariana

As per our telephonic conversation this morning,you may do your research at our Icu. Please ask for Mrs Dalvie or Bloem at reception.
As mentioned in our conversation that you sign a letter of nondisclosure which I Will forward to you.

If you have any further queries or comments please do not hesitate to contact me.

Kind Regards

Ms. Mastura Johnson
****
Hospital Manager - Gatesville Medical Centre
Melomed Hospital Holdings Ltd.
Tel: +27 21 699 0950
Fax: +27 21 699 1023
Cell: +27 82 820 5331
Email: Johnson@melomed.co.za
****

Hello

Your request to do research has been granted on condition that we receive copies of the findings on completion.

Please can you let us know when exactly you will be visiting our hospital?

Regards.

Lettie Blom
Nursing Manager
N1 CITY HOSPITAL
Netcare Limited
Louwtjie Rothman Street
Goodwood
7460

Hi Mariana,
Dit is n baie goeie vraelys en ons gee graag toestemming vir die navorsings projek. Sal jy my weer kontak om die proses te bespreek asb.

Alta Dorse
Nursing Manager

Tel: + 27 21 506 5158
Fax: + 27 21 506 5187
Mobile: + 27 82 461 6988
Email: alta.dorse@lifehealthcare.co.za
Website: www.lifehealthcare.co.za

Appendix D: Ethical approval

15 August 2008

Ms M van der Heever
Dept of Nursing

UNIVERSITEIT•STELLENBOSCH•UNIVERSITY
jou kennisvennoot • your knowledge partner

Dear Ms Van der Heever

RESEARCH PROJECT: **"An investigation into leadership styles in critical care units in private health care institutions in the Northern suburbs of the Cape Metropolitan Area."**

PROJECT NUMBER : N08/05/155

A review panel of the Committee for Human Research considered your application for the registration and approval of the abovementioned project. The panel referred the project back to you awaiting further information that was required.
This information was supplied and the project was provisionally approved on 13 August 2008 **for a period of one year from this date**. You may start with the project, but this approval will however be submitted at the next meeting of the Committee for Human Research for ratification, after which we will contact you again.

Notwithstanding this approval, the Committee can request that work on this project be halted temporarily in anticipation of more information that they might deem necessary to make their final decision.
Please quote the above-mentioned project number in ALL future correspondence.

Please note that a progress report (obtainable on the website of our Division) should be submitted to the Committee before the year has expired. The Committee will then consider the continuation of the project for a further year (if necessary). Annually a number of projects may be selected randomly and subjected to an external audit.
Translations of the consent document in the languages applicable to the study participants, should be submitted.
Federal Wide Assurance Number: 00001372
Institutional Review Board (IRB) Number: IRB0005239
The Committee for Human Research complies with the SA National Health Act No.61 2003 as it pertains to health research and the United States Code of Federal Regulations Title 45 Part 46. This committee abides by the ethical norms and principles for research, established by the Declaration of Helsinki, the South African Medical Research Council Guidelines as well as the Guidelines for Ethical Research: Principles Structures and Processes 2004 (Department of Health).

Kind regards

Pp
Prof P.J.T de Villiers
Chairperson: Committee for Human Research
RESEARCH DEVELOPMENT AND SUPPORT (TYGERBERG)
Tel: +27 21 938 9207 / E-mail: mertrude@sun.ac.za
Approval Date: 13 August 2008 **Expiry Date: 13 August 2009**

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Fakulteit Gesondheidswetenskappe • Faculty of Health Sciences

Verbind tot Optimale Gesondheid • Committed to Optimal Health
Afdeling Navorsingsontwikkeling en -steun • Research Development and Support Division
Posbus/PO Box 19063 • Tygerberg 7505 • Suid-Afrika/South Africa
Tel: +27 21 938 9677 • Faks/Fax: +27 21 931 3352
E-pos/E-mail: rdsdinfo@sun.ac.za