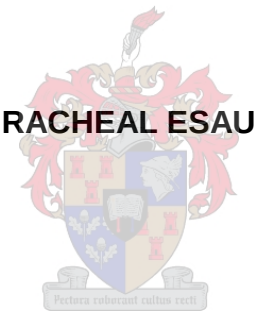
THE EXPERIENCES OF NURSE MANAGERS ON HEALTH SYSTEM BARRIERS AND ENABLERS TO THE EMPOWERMENT AND SUBSEQUENT CAREER ADVANCEMENT OF NURSES

By

RACHEAL ESAU



Thesis presented in (partial)* fulfilment of the requirements

for the degree of Master of Nursing Science

in the Faculty of Medicine and Health Sciences

Stellenbosch University

Supervisor: Dr Mariana van der Heever

Co-supervisor: Prof Anita van der Merwe

March 2023

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 sole author thereof (save to the extent explicitly otherwise stated), that reproduction and publication thereof by Stellenbosch University will not infringe any third-party rights and that I have not previously in its entirety or in part submitted it for obtaining any qualification.

Signature: ……

Date: …….

ABSTRACT

Background - Promoting nurse empowerment is a critical responsibility of a nurse manager. Accordingly, the nurse manager must use the power contained in her position to enhance worker productivity through the mobilisation of workplace resources such as information sharing, support, resources and opportunities (*structural empowerment)*. The nurse manager must also focus on cognitions of competence, impact, meaning and self-determination (*psychological empowerment*). However, nurse managers face systemic barriers in healthcare such as resource constraints, leadership incapacities, demanding workloads and political interferences that have an adverse influence on the empowerment process.

Aim - The purpose of the study was to explore the lived experiences of nurse managers on the health system barriers and enablers that influence their duties to empower and advance nursing staff.

The research objectives were:

- To gain an understanding of how the hospital's empowerment structures facilitate nursing staff empowerment and career advancement.
- To explore the nurse managers' experiences in their role of providing nurses access to power structures in the workplace.
- To get insight into the possible barriers to nurse empowerment and advancement that may exist in the hospital.

Method - A qualitative design with an interpretative phenomenological approach was employed. The study was conducted at a central public hospital in the Cape Metropole in the Western Cape province of South Africa. The sample comprised of 11 nurse managers from three tiers of nursing management employed at the study centre. Purposive sampling with maximum variation was applied to ensemble the study sample. Data analysis was done by applying Max Van Manen's interpretative phenomenological approach. Ethical approval was obtained from the Health Research Ethics Committee of Stellenbosch University and institutional permission from the study centre. Participants provided written consent to participate in the study. Data collection took format of individual virtual interviews guided by a semi-structured

interview guide and using Carl Roger's technique of reflection. Trustworthiness of the study was enhanced by applying the principles of credibility, dependability, conformability, transferability and authenticity.

Results - Four main themes with fifteen subthemes emerged from the data. The results showed that access to empowerment structures is accompanied with difficulties that have an adverse influence on the success of empowerment. Nurse managers acknowledge their responsibility towards their nurse subordinates of creating and sustaining opportunities for growth and development that will increase their chances of ascending the career ladder. However, they realised that this process is challenging and expressed a need for support to effectively discharge this responsibility. The findings also highlighted the challenges of human and budgetary constraints, demanding workloads, disengagement of staff, political and cultural issues, centralisation of power which slows down the process of empowerment. These challenges created barriers to nurse managers in the execution of their responsibility to empower the nursing staff.

Keywords - "empowerment", "nurse empowerment", "barriers to empowerment", nurse leader.

ABSTRAK

Agtergrond - Die bevordering van verpleegstersbemagtiging is 'n kritiese verantwoordelikhed van 'n verpleegbestuurder. Gevolglik moet die verpleegbestuurder die mag wat haar posisie het, gebruik om produktiwiteit in die werksplek te bevorder deur inligting oor te dra, ondersteuning en hulpbronne aan te bied en geleenthede vir groei (strukturele bemagtiging) aan verpleegpersoneel te skep. Die verpleegbestuurder moet ook fokus op persepsies van bevoegdheid, impak, betekenis en self-beslissing (sielkundige bemagtiging). In die uitvoering van hierdie taak, word die verpleegbestuurder egter deur sistemiese uitdagings soos n tekort aan hulpbronne, leierskap onbevoegdheid, veeleisende werksladings en politieke inmenging gekonfronteer, wat 'n negatiewe invloed op die bemagtigingsproses het.

Doel - Die doel van die studie was om die lewenservaringe van verpleegbestuurders aangaande obstruksies en fasiliteerders in die gesondheidssisteem wat 'n invloed het op hul taak om verpleegpersoneel te bemagtig en te bevorder, te verken.

Die navorsingsdoelwitte was:

- Om te verstaan hoe die hospitaal se bemagtigingstrukture bemagtiging en bevordering van verpleegkundiges instaat stel.
- Om die ervaringe van verpleegbestuurders in hulle rol om verpleegkundiges toegang tot magstrukture in die werksplek te bied, te verken.
- Om insig oor die bestaan van moontlike obstruksies in die bemagtiging van verpleegkundiges in die hospitaal te verkry.

Metode - 'n Kwalitatiewe ontwerp met 'n interpreterende fenomenologiese benadering was gebruik. Die studie was onderneem in 'n Suid Afrikaanse, sentrale publieke hospitaal, geleë in die Kaapse Metropool van die Wes-Kaapprovinsie. Die steekproef het uit 11 verpleegbestuurders, vanuit drie bestuursvlakke, werksaam by die studie sentrum, bestaan. Doelgerigte steekproefneming met maksimale variasie was gebruik om die steekproef te verkry. Data analise was gedoen deur Max Van Manen's interpreterende fenomenologiese benadering te gebruik. approach Etiese goedkeuring was verkry vanaf die Gesondheidsnavorsing Etiese Komitee van Stellenbosch Universiteit en instansie goedkeuring by die studie sentrum self.

Studiedeelnemers het geskrewe toestemming voorsien om aan die studue deel te neem. Dataversameling was uitgevoer deur individuele afstandsonderhoude, 'n semi-gestruktureerde onderhoudsgids en Carl Roger's se tegniek van refleksie, te gebruik. Die betroubaarheid van die studie was bevorder deur die beginsels van geloofwaardigheid, aanvaarbaarheid, ooreenstemming, oordraagbaarheid en egtheid toe te pas.

Resultate - Vier hooftemas met vyftien sub-temas het uit die data-analise voortgespruit. Die resultate dui daarop dat bemagtigingstrukture gepaard gaan met probleme wat 'n negatiewe invloed op die sukses van bematiging het. Verpleegbestuurders is bewus van hul verantwoordelikheid om geleenthede vir die groei en ontwikkeling van verpleegpersoneel te skep en te onderhou, maar erken dat vanweë die uitdagings wat daarmee gepaard gaan, hulle ondersteuning benodig om die verantwoordelikheid effektief te verrig. Die verpleegbestuurders erken ook dat hierdie geleenthede die kanse vir bevordering van verpleegpersoneel verbeter. Verder, is daar bevind dat die verpleegbestuurders uitdagings soos personeel en finansiële tekorte, veeleisende werksladings, personeel onbetrokkenheid, politieke en kulturele kwessies asook sentralisering van mag in die werksplek ervaar. Hierdie uitdagings vertraag die bemagtigingsproses en belemmer die pogings van verpleegbestuurders om hul taak effektief uit te voer.

Sleutelwoorde - "bemagtiging", "vepleegsterbemagtiging", "obstruksies tot bemagtiging", "vepleegbestuurder" of "verpleegleier".

ACKNOWLEDGEMENTS

I would like to express my sincere gratitude to:

- Our Heavenly Father – for sustaining me through a very difficult period of my life and for keeping me standing during these past three years and still now. To Him all the glory, honour and praise.
- My late husband, Elton John Julian Esau. My no.1 supporter, my soulmate, the one who encouraged me to pursue this degree. Thanks for being my guardian angel, I sincerely miss you. This one is for you, my love.
- Dr Mariana Van der Heever, my study supervisor, for never giving up on me even when I did. Thanks for your patience, encouragement and belief in my abilities even when I was at my lowest and lost all belief.
- My late sisters, Hester Mc Kenzie and Beverley Hollenbach and also Lettie May. Thanks for your unwavering support during the darkest period of my life and for encouraging me to complete my studies.
- My mother in law, Daphne Esau who prayed for me and stood by my side through it all.
- To my extended family, Mc Kenzie, Magosie, May and Esau. Thanks for praying for me.
- The URCSA Rainbow congregation, Reverand Johan Julies, choir members, for your prayers, encouragement and support.
- Mr Are van Schalkwyk whom I regard as a Godsend, for accepting the offer to do language editing on the thesis on such short notice. You have done a great job.
- Mrs Rukshana Adams, for rescuing my studies by agreeing to do technical editing at literally the last moment. You are stellar. May our Lord enlarge your territory beyond measure.
- Lyndle Jonas, a fellow student and colleague whom I've met through my studies. Lynn, you've been a tremendous source of support making sure I am not left behind.
- All the nursing and managerial staff who participated in sharing their experiences.

- Management of Dr Harry Surtie hospital, Mrs Ronel Du Preez, Dr George Isaacs and Mr Tebogo Moncho for being supportive in granting me leave whenever I needed it.

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

LIST OF APPENDICES

ABBREVIATIONS

PI - Principal investigator

EEA - Employment Equity Act, no 55 of 1998

SDA - Skills Development Act, no 97 of 1998

OSD - Occupation Specific Dispensation

HRM - Human Resource Management

HRD - Human Resource Development

WSP - Workplace skills plan (WSP)

CNTU - Clinical Nurse Training Unit

CPD - Continuous professional development (CPD)

NQF - National Qualifications Framework

OPM - Operational Nurse Manager

ANM - Assistant Nurse Manager

DNM - Deputy Nurse Manager

CEO - Chief Executive Officer

SANC - South African Nursing Council

ICN - International Council of Nurses

DPSA - Department of Public Service Administration

WCDOH - Western Cape Department of Health

PGWC - Provincial Government of the Western Cape

PA - Performance appraisal

EPMDS - Employee Performance Management and Development System

SPMS - Staff Performance Management System

IP - Interpretative phenomenology

RPL - Recognition of prior learning

NEI - Nursing Education Institute

CHAPTER 1
FOUNDATION OF THE STUDY

1.1 INTRODUCTION

Organisations consist of people originating from diverse societies who, through exposure to organisational values and norms, adopt the organisational culture that guides organisational behaviour (Mazibuko & Govender, 2017:1). Mazibuko and Govender (2017:1) stated that this form of diversity is to be coordinated to enhance employee productivity. The successful management of diversity within an organisation such as a hospital is evidenced by employees having equal access to empowerment structures in the workplace that will build capacity (Breakfast & Maart, 2019:3). The SDA, no. 97 of 1998, was promulgated to facilitate the non-discriminate improvement of skill, productivity levels, quality of lives and chances for career advancement of all public servants (Republic of South Africa, 1998). Oosthuizen, Tonelli and Mayer (2019:2) posited that workplace transformation needs to be accompanied by training and development to facilitate improved management of diversity at work. This sentiment was shared by Booysen (2007:48), who argued that successful implementation of employment equity must be accompanied by human resource development strategies and changes in the organisational culture. Training in diversity management will increase employee engagement and commitment to work goals (Joubert, 2017:367).

Empowerment refers to the ability to (i) mobilise and access social structures in the workplace such as information, support, resources and opportunities, termed *structural empowerment*, and (ii) focus on personality attributes and tendencies to enhance workers' productivity or enable them to perform their jobs, termed *psychological empowerment* (Skytt, Hagerman, Strömberg & Engström, 2015:1003).

Career advancement in nursing refers to any form of professional preferment in recognition of clinical and administrative nursing excellence (Adeniran, Bhattacharya & Adeniran, 2012:42). Adeniran *et al.* (2012:42) stated that career advancement affords the nurse opportunities to reach clinical and administrative excellence through participation in perpetual personal development exercises.

The concepts of empowerment and advancement are not interrelated. An employee may have the ability to do things (feeling empowered) but may also not be the preferred candidate for a promotion (advancement). The opposite is also true in nurse manager recruitment processes where the emphasis is on years of service (viewed as the level of expertise) and less on management knowledge and skill, thus creating a void in nurse leadership competency (Naicker & Hoque, 2017:291).

Nurse managers play a pivotal role in supporting, mentoring and role-modelling new entrants to the profession (Republic of South Africa, 2013:21). However, middle management faces several challenges that include an increase in disease burden that often exceeds the supply of nurses, complex and often outdated job agreements that lack formal authority over resources, a lack of support from executive structures, staff shortage and absenteeism, amongst others (Republic of SA, 2013:21). Human factors relating to self-motivation, intrapersonal competence and self-regulation also play a pivotal role in the nurse's ability to exploit opportunities for growth and professional ascension (Adeniran, 2012: 46). Access to empowering structures in the workplace is vital for staff development, continued growth, and career advancement (Oliver, Gallo, Griffin, White & Fitzpatrick, 2014:227).

Kanter's (1993) theory of structural empowerment underpins the study. This theory draws attention to the extent to which organisations provide workers access to support, opportunities, resources, and information (known as "power" tools) that will enable them to become efficient and effective in their jobs (Laschinger, Wong, Cummings & Grau, 204:348; Roji & Jooste; 2020:1). The derived power presents opportunities for the acquisition of knowledge, thus boosting productivity and improving chances of career mobility (Regan, Laschinger & Wong, 2015:E55).

Accordingly, the focus of the study was to explore the experiences of nurse managers on health system barriers and enablers and how these influence nurse empowerment and subsequent advancement at a tertiary hospital in the Western Cape.

1.2 BACKGROUND, RATIONALE AND PRELIMINARY LITERATURE REVIEW

1.2.1 Empowerment, equity and legislation

In the 1960s, the United States of America and parts of Western Europe faced a revolution on equal opportunity for marginalised groups which led to the promulgation of legislation aimed at managing inequalities as well as equal employment in the United States of America, parts of Western Europe and Britain in 1976 (Johnson & Parker,1987:81; Nkoma & Stewart, 2006:521; Breakfast & Maart, 2019:2). In 1995, the democratic government of South Africa also inherited a country that was burdened with disparities and racial, political, social, and economic divisions (Republic of South Africa, 1995:3). To remedy the wrongs of the apartheid regime new legislation was promulgated, which includes the Employment Equity Act, no. 55 of 1998 and the Skills Development Act, no. 97 of 1998. The Employment Equity Act (EEA) aimed to redress the past injustices of unfair discrimination and work towards a free, democratic society based on justice, non-discrimination, and equity (Zulu & Parumasur, 2009:1). In the workplace, the EEA dictates the empowerment of the previously disadvantaged by allowing them to get access to employment and career advancement. Another enabling piece of legislation is the Skills Development Act (SDA) which addresses past discriminations and exclusions through the provision of a framework for the implementation of workplace strategies to develop and improve the skills of the South African worker (Republic of South Africa, 1998). Both forms of legislation aim to provide a working environment that fosters employee growth and upward mobility. These legislative prescripts provide a guide to hospital management structures in executing their responsibility of providing equal employment opportunities to the general public and internal career ascension mobility to employees (Oosthuizen, Tonelli & Mayer, 2019:1).

Empowerment in the work context refers to the ability to derive power from structures in the workplace that will allow access to opportunities for growth, acquisition of knowledge to gain authority over work, access to resources to accomplish tasks and support from managers and peers (Kanter, 1977; Regan, Laschinger & Wong, 2015:E55). These empowerment structures will improve job performance and boost career mobility.

1.2.2 Health system barriers and nurse empowerment

The post-apartheid era harboured significant challenges for the South African government which included a health system that was facing barriers such as resource constraints, defective recruitment, and retention practices (Public Service Commission, 2016:1). Negative stereotypes attached to employment equity and affirmative action practices, cadre deployment and leadership incapacity hampering quality health care output are challenges of the post-apartheid government filtering into the public entities (Oosthuizen *et al*., 2018:2). Although employment equity and advancement practices were enforced for the sake of legal compliance, the full enactment of the legislation was lacking in the workplaces (Oosthuizen & Naidoo; 2010:2).

Nurse managers do not just have a key responsibility of providing opportunities for the empowerment of nursing staff as per their job description (DPSA - Annexure C, 2007:4), they also need to create an empowering working environment that allows nurses to develop and grow within the job (Ta'an, Alhurani, Alhalal, Al-Dwaikat & Al-Faari, 2020:635). It is against this backdrop that the study focused on the experiences of nurse managers on barriers and enablers to the empowerment and subsequent career advancement of nurses in the public health system. A special emphasis was placed on the knowledge the nurse managers have on the current empowerment structures that exist in the hospital under study and whether they facilitate nurse empowerment and advancement. At the same time, the researcher aimed to understand whether there were health system barriers to the successful empowerment and advancement of nurses in the hospital.

1.3 RATIONALE

The introduction of the EEA saw the transformation in the demographic landscape of the South African workforce by obligating employers to promote equal opportunity and fairness in employment and career advancement through abolishing discriminatory policies and practices (Joubert, 2017:367). However, the idea of employment equity and transformation in the South African labour force was met with widespread opposition forming barriers to the successful implementation thereof (Reuben & Bobat, 2014:1). Employee empowerment was hampered by realities of cadre deployment, resource constraints, lack of leadership and governance, interference in human

resource strategies, failure to meet gender and disability employment equity targets and the failure to recruit and retain critical skills (Public Service Commission, 2013:7-12) and a lack of training and development (Esterhuizen & Martins, 2008: 80). Details of these barriers are highlighted in the literature review in the next chapter.

Nursing managers have a responsibility to create a positive practice working environment for nurse subordinates through the provision of structural conditions that support nurse empowerment and advancement (Ta'an, Alhurani, Alhalal, Al-Dwaikat & Al-Faari, 2020:635). Ta'an *et al.* (2020:635) also emphasised the fact that since structural empowerment mainly involves the manipulation of administrative processes in the workplace, nurse managers can modify conditions in the workplace to facilitate the implementation of structural empowerment principles. Past literature mainly focused on situations and conditions (structures) in the workplace that may either constrain or improve nurse performances within their job categories (Orgambidez-Ramos & Borrego-Alés, 2014:29), but little emphasis was placed on what the nurse manager's level of understanding is of the concept, the role they need to play in managing the empowerment process.

1.4 RESEARCH FRAMEWORK

Nurse empowerment refers to the nurse's capacity to exercise control over the individual nursing practice by discharging nursing responsibilities in a successful manner (Rao, 2012:399). Rao (2012:399) states that empowerment exists concurrently at an individual, organisational and social level, denoting psychological power (individual level), structural power (organizational level) and social power (institutional or social level). The concept of empowerment is divided into two categories, namely psychological and structural empowerment (Ta'an *et al.*, 2020:635).

Relationship between structural and psychological empowerment

The concept of structural empowerment refers to the power that is derived from the workplace through the distribution of resources, information, access to opportunities and support that can have a notable impact on an employee's work experience, commitment and job performance (Abel & Hand, 2018:579). Psychological empowerment is essential for structural empowerment to be effective since it focuses on the nurse's intrinsic motivation to access power based on what meaning he or she

denotes to the job, the individual confidence he or she has to perform the job well, the capacity to be self-determined in practice and having a sense of purpose in the organisation, and lastly, to be able to influence organisational outcomes (Meng, Liu, Liu, Hu, Yang & Liu, 2013:305). Psychological empowerment facilitates positive attitudes that are necessary to successfully access structural empowerment tools that will improve job efficacy (Wang & Liu, 2013:289). Abel and Hand (2018:581) illustrated a concurrent relationship between psychological empowerment and structural empowerment in the workplace (Figure 1).

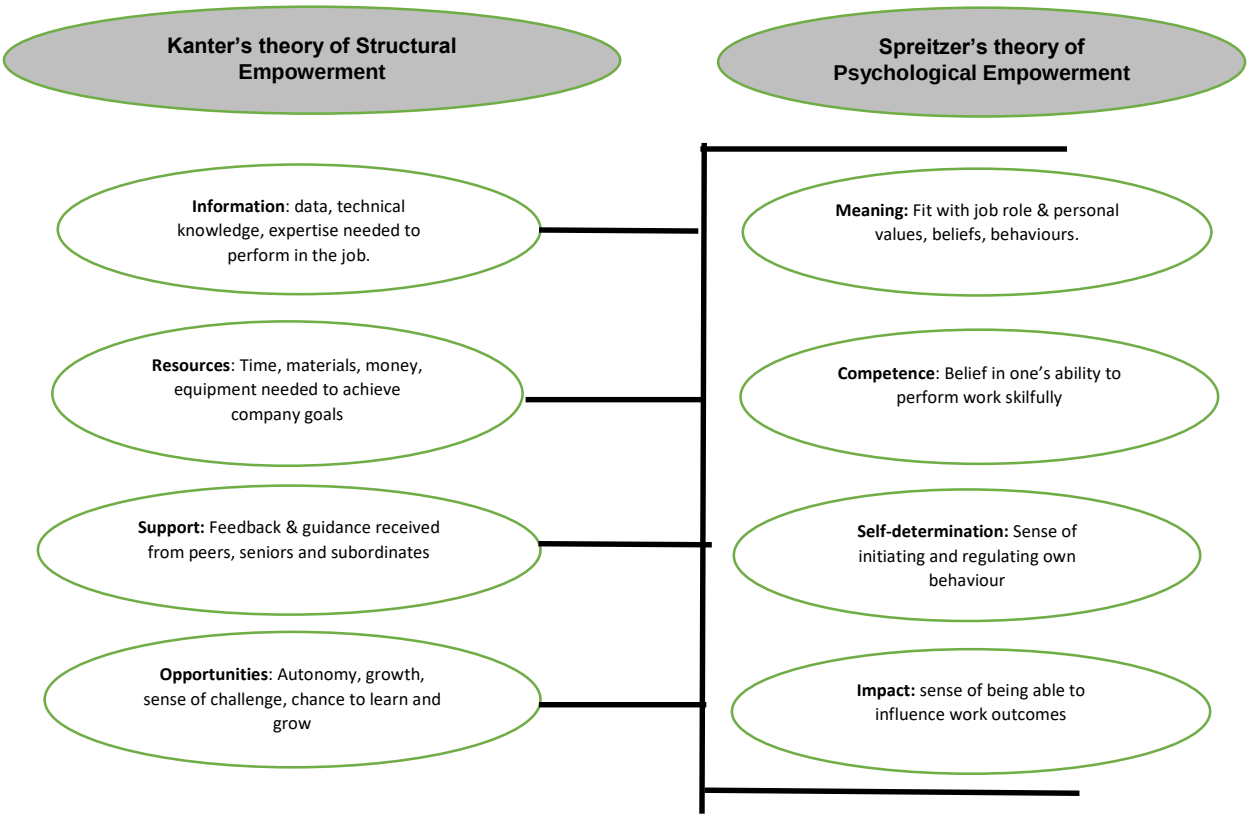


Figure 1: Relationship between psychological empowerment and structural empowerment (Abel & Hand (2018:581)

This model demonstrates that although there is no causal relationship between the two concepts, they both co-exist in the workplace to impact employees' experiences and work performances. Kanter's theory of structural empowerment is the fundamental framework for the study.

1.4.1 Kanter's theory of structural empowerment

Kanter's (1993) theory of structural empowerment holds that an employee's work performance is influenced by situations and conditions (structures) in the workplace that may either constrain or improve job performances (Orgambidez-Ramos & Borrego-Alés, 2014: 29). Accordingly, organisations should provide staff access to opportunities for growth and upward mobility and support from seniors and other colleagues through constant feedback and advice (Oliver, Gallo, Griffin, White & Fitzpatrick, 2014:227). Oliver *et al.* (2014:227) also emphasised the importance of providing employees access to information on how to acquire the knowledge and expertise to accomplish assigned tasks and lastly, providing access to time and financial and material resources to execute these responsibilities. By mastering all these empowerment structures, power is transferred to employees to improve work performance and enhance productivity (Oliver *et al*., 2014:227). Kanter emphasised the development and use of workplace structures as sources of power that are accessible through formal and informal systems in the organisation (Ali, Nageeb & Hassona, 2018:627).

The concept of power can be defined as the capacity to exert influence and motivate oneself and others towards goal-directed action (Rao, 2012: 400). A positive working environment must be able to afford employees access to both formal and informal power. Formal power is derived from the inherent characteristics of a post that allows for the use of discretion and volition to exercise delegated responsibilities (Abel & Hand, 2018: 580). Informal power is derived from interpersonal relationships and alliances with colleagues in the workplace (Oliver et al., 2014: 227). According to Kanter (1977, 1979), employees who are denied access to resources, support and information may feel destitute and low in morale whilst empowered employees are confident, thriving in the workplace and motivated to empower others (Laschinger *et al*., 2010:6). Kanter also stated that employees who perceive a workplace as supportive of worker empowerment demonstrate commitment to the realisation of company goals (Orgambidez-Ramos & Borrego-Alés, 2014:29).

Regan, Laschinger and Wong (2015:E55) view structural empowerment as those structures in the workplace that support the employee's opportunity to grow by acquiring information and knowledge that enable them to perform better. Nurse managers have an important role in providing nurse subordinates ample opportunities

to gain knowledge, known as “power tools”, that will enable them to make meaningful contributions at their work (Laschinger, Gilbert, Smith & Leslie, 2010:5). Kanter (1993) posited that a manager will increase his or her power by allowing employees access to empowerment structures that will improve their work performance and contribute positively towards company goal achievement (Ali *et al*., 2018:627). Jobs of higher ranking are high in formal power since they give access to information, support, resources, and opportunities for growth whilst informal power is transferred to those employees who build positive relations with colleagues and superiors to realise company goals (Orgambidez & Borrego-Alés, 2014:29).

1.4.2 Value of the theory

Kanter (1977) states that if an organisation is structured to provide empowerment and access to job-related empowerment opportunities, it will have a positive impact on employees and their work effectiveness. On the other hand, if the working environment is thin on empowerment opportunities it may harm the employees and their work effectiveness. The theory of structural empowerment illustrates that an organisation that employs formal and informal structures of power can create a committed workforce with increased productivity levels. When combined with information and adequate resources, these power structures will increase proficiency, self-determination, and commitment (Fragkos, Makrykosta & Frangos, 2019:941).

Figure 2 provides a graphic illustration of the impact that health system barriers and enablers have on employee empowerment in the workplace. Column A depicts the enabling organisational structures that, if present, can be employed and maximised to positively impact the nurse’s growth, motivation and job outputs. Column B illustrates Kanter’s theory of structural empowerment by depicting the key concepts underlying the theory and how they can be identified within the workplace. It demonstrates the influence these structures have on the working environment and ultimately worker performance. Column C - this diagram concerns the key concepts in Kanter’s theory of structural empowerment to demonstrate organisational factors that may cause barriers to employee empowerment.

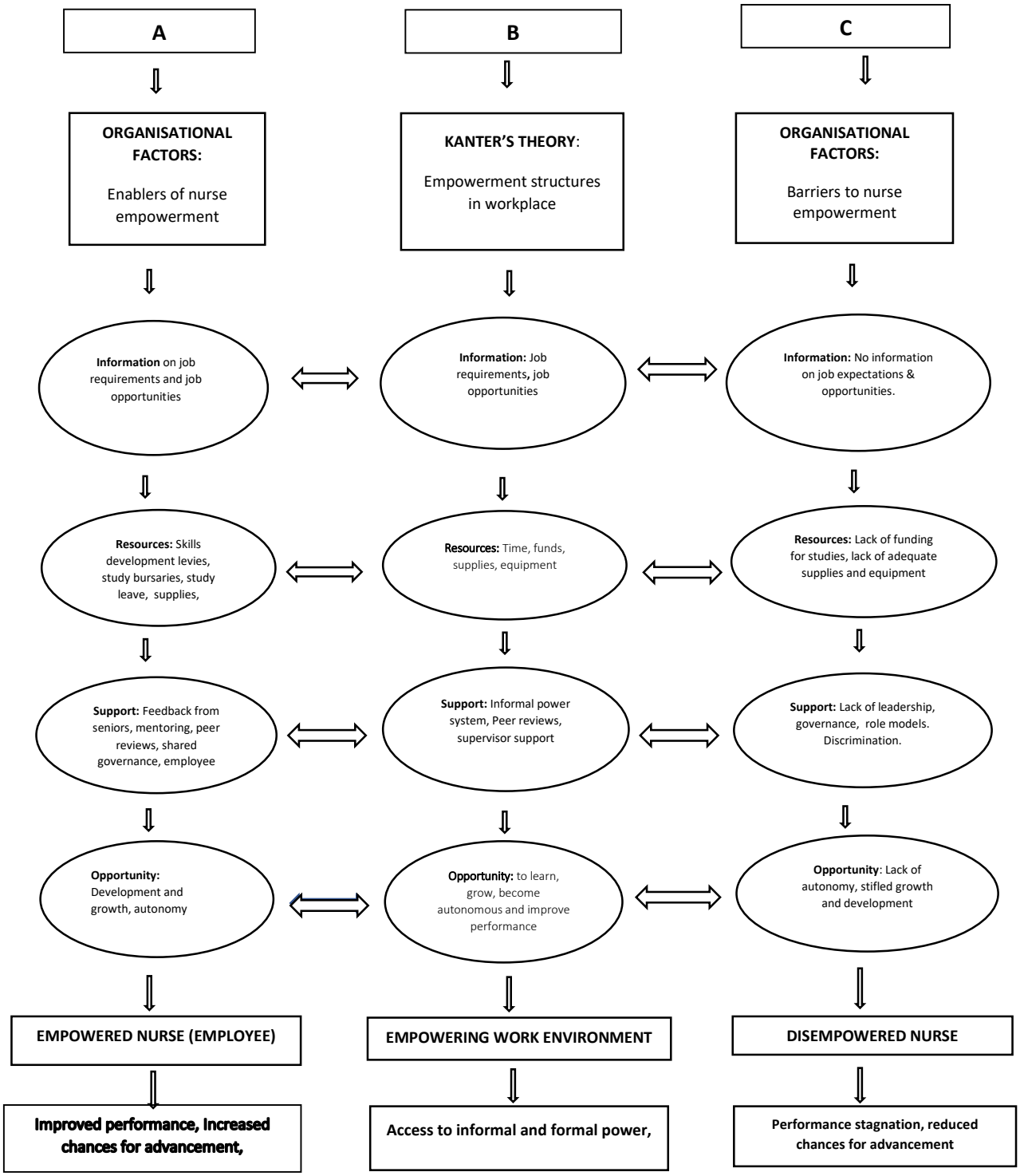


Figure 2: Conceptual map - Kanter's Theory of Structural Empowerment (Travers, Schroeder, Norful & Aliyu,2020:3) - linked with organizational factors (enablers and barriers) impacting on nurse empowerment and advancement.

1.5 PROBLEM STATEMENT

Structural empowerment refers to the degree to which the working environment supports or avails “power tools” in the form of information, resources, and learning opportunities to the employee that will allow the transfer of authority, power, and personal growth to reach professional autonomy (Roji & Jooste, 2020:2). According to Cattaneo and Chapman (2010: 647), the process of empowerment eliminates the constraints to the implementation of equity and fairness by enhancing competitiveness. In the hospital environment, nurse managers must empower nurses with the aim of ultimately advancing the careers of individual nurses.

The SA government introduced legislation such as the Skills Development Act and the Employment Equity Act to enable the empowerment and subsequent advancement of nurses. However, the nurse manager’s responsibility of facilitating structural empowerment and the subsequent advancement of nurses is seemingly influenced by systemic barriers, highlighted in the previous paragraph. It is not known what the experiences of nurse managers, employed at a central public hospital in the Western Cape, are in terms of facilitating access to empowerment structures to the nurse as well as how they manage organisational factors affecting nurse empowerment and advancement (enablers and barriers to empowerment and advancement).

1.6 RESEARCH QUESTIONS

The overarching questions that underpin the study were:

- What are the lived experiences of nurse managers on health system barriers and enablers that influence their duties to empower nursing staff in a public hospital?
- What are the lived experiences of nurse managers on health system barriers and enablers that influence the advancement of nursing staff in a public hospital?

1.7 RESEARCH AIM

The purpose of the study was to explore the lived experiences of nurse managers on the health system barriers and enablers that influence their duties to empower and advance nursing staff.

1.8 RESEARCH OBJECTIVES

- To gain an understanding of how the hospital's empowerment structures enable nursing staff empowerment and career advancement.
- To explore the nurse managers' experiences in their role of providing nurses access to power structures in the workplace.
- To get insight into the possible enablers and barriers to nurse empowerment and advancement that may exist in the hospital.

1.9 RESEARCH METHODOLOGY

This chapter contains a brief overview of the methodology and a more detailed report is presented in Chapter 3. The study adopted a qualitative design with an interpretative phenomenological approach to explore the lived experiences of nurse managers on health system barriers and enablers in nurse empowerment and subsequent advancement. Figure 3 provides a graphic illustration of the research methodology that was applied in the research.

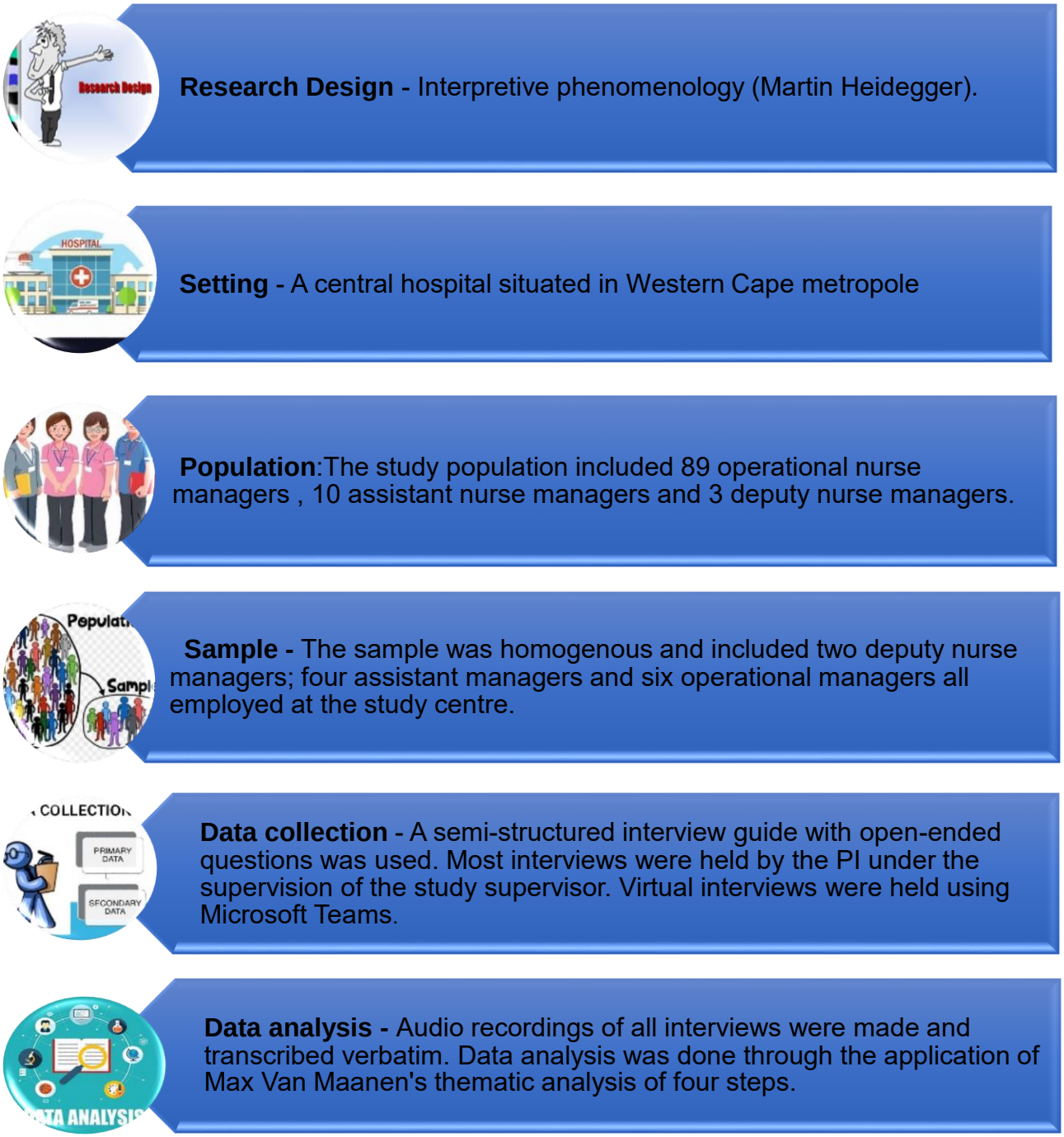


Figure 3: Graphic illustration of the research methodology that was applied in the study

1.9.1 Research design and approach

A qualitative design was used which allowed systematic exploration of the participants' experiences of a phenomenon from their perspective (Grove & Gray, 2019:59). An interpretative phenomenological approach was adopted to search beyond the subjective description or what is consciously known of the lived experience to focus

on the deeper meaning of such experiences that are sometimes not even known to the participants themselves but lies hidden in the responses they give to questions posed by the researcher during the interviews (Lopez & Willis, 2004:728).

1.9.2 Study setting and population

The study was conducted in a central hospital situated in the Cape Metropole of the Western Cape province of South Africa. The study population included 89 Operational Nurse Managers,10 Assistant Nurse Managers and three Deputy Nurse Managers from the nursing management corps employed permanently in the study centre.

1.9.3 Sampling

Purposive sampling with maximum variation was applied by intentionally selecting nurse managers from various levels of the nurse hierarchy. Accordingly, six operational managers, four assistant nurse managers and two deputy nurse managers were included in the study.

1.9.4 Exclusion criteria

Nurse managers who were on leave during the period of data collection were excluded from the project.

1.9.5 Data collection tool

Interviews were conducted using a semi-structured interview guide with open-ended questions. The guide was based on the research framework and aimed at addressing the research objectives.

1.9.6 Pilot interview

The pilot interview was held with an Operational Manager from the study centre.

1.10 DATA COLLECTION

Virtual interviews were held with all participants via Microsoft Teams by the principal investigator (PI) and the study supervisor who monitored the data collection process.

1.10.1 Trustworthiness

The quality of the study was evaluated according to Guba and Lincoln's (1985, 1989, 1994) criteria of trustworthiness, namely credibility, dependability, conformability, transferability and authenticity (Polit & Beck, 2014: 323).

1.11 ETHICAL CONSIDERATIONS

1.11.1 Ethical clearance

Ethical clearance was issued by the Health Research Ethics Committee of Stellenbosch University on 6 January 2022. Institutional consent was received on 9 May 2022. Each participant submitted signed consent forms for their voluntary participation and recording before the conduct of the interviews. Anonymity and confidentiality were assured by omitting the name of the participant and the study centre on all consent forms. Only the PI, study supervisor and the participant attended virtual interviews. All documentation, audio recordings and transcripts of the recordings were managed by the PI only. The name of the study setting was omitted from all documents. The recording, transcribing and coding of transcriptions were done by the PI. Autonomy and respect were upheld by the researcher who made full disclosure of the research study, the possible risks, and benefits to enable the participants to make an informed decision. The principle of self-determination was adhered to by informing the participants that their participation is voluntary and that they could withdraw from it at any stage if they so wished without fear of intimidation.

1.11.2 Conflict of interest

The PI was also previously employed at the study centre as a professional nurse from January 1995 until May 2005. Since 2005 and the time of data collection (2022), the PI had no ties with the study centre.

The PI is an advocate for nurse empowerment and have been actively involved in encouraging colleagues on developing themselves. She started her career in the post-apartheid era and was afforded the opportunities to ascend the career ladder in relatively short period. The PI observed oppression of nurses by medical doctors and other health professionals within the health care context. The disconcerting part is that nurses seemingly submitted to the existing oppression and has therefore taken a back seat in decision-making processes both at operational and strategic level. This demeanour is evident from nurses at the bedside as well as ward managers (OPM’s), hence the urgency behind the research.

1.12 OPERATIONAL DEFINITIONS

A nurse manager is a professional nurse with an R425 basic qualification with at least seven or more years of appropriate experience after registration as a nurse (DPSA, Occupation Specific Dispensation (OSD) for Professional Nurses, 2007: 18). The nurse manager is responsible for ensuring the delivery of quality nursing care in a unit, medical discipline (area) or hospital depending on the level of appointment within the four tiers of nursing management.

Employment equity refers to the principle of availing job opportunities or advantages to people who were previously disadvantaged and discriminated against because of their race, sex, physical appearance and more (Cambridge Business English Dictionary, 2021).

Career advancement is defined as the promotion or elevation to a higher rank (Merriam-Webster Dictionary, 2021). In the context of this study, career advancement in nursing refers to any form of professional preferment in recognition of clinical and administrative nursing excellence (Adeniran, Bhattacharya & Adeniran, 2012: 42).

Empowerment refers to the ability to (i) mobilise and access social structures in the workplace such as information, support, resources and opportunities, termed *structural empowerment*, and (ii) focus on personality attributes and tendencies to enhance workers' productivity or enabling them to perform their jobs, termed *psychological empowerment* (Skytt, Hagerman, Strömberg & Engström, 2015: 1003).

Empowerment refers to the mobilisation of workplace structures such as support, opportunities, resources, and information (known as "power" tools) to derive power (structural empowerment) (Laschinger, Wong, Cummings & Grau, 204:348; Roji & Jooste; 2020:1) as well as the intrinsic motivation to derive power from cognitions of meaning, competence, impact, and self-determination (psychological empowerment) (Li *et al*., 2018:1266).

1.13 CHAPTER OUTLINE

Chapter 1: Foundation of the study

Chapter 2: Literature review

Chapter 3: Research methodology

Chapter 4: Results

Chapter 5: Discussion, conclusions and recommendations

1.14 SIGNIFICANCE OF THE STUDY

The study findings provided information on barriers and enables the empowerment of nurses in a public hospital setting. The findings place renewed emphasis on the creation of a stimulating work environment where empowerment structures are in place to enhance the growth and development of nurses. Hopefully, nurse managers will better understand their role in providing their nurse subordinates access to these power structures to enable them to gain autonomy and enhance their chances for advancement in the organisation.

1.15 SUMMARY

The South African health system is burdened with the realities of cadre deployment, lack of proper leadership and governance and unfair human resource practices that may impact fair practices of staff empowerment, career advancement and appointment of nurses. There appears to be a tendency amongst most South African employers in health care to not adhere to prominent acts and legal guidelines that are aimed at redressing these barriers. Failure to implement legal enablers in the form of legislation such as the Employment Equity Act, no 55 of 1998 and the Skills Development Act, no 97 of 1998 may undermine staff commitment and motivation to raise their productivity levels and contribute positively towards the attainment of organisational goals. This study will adopt a qualitative phenomenological approach to explore the experiences of nurse managers on the barriers and facilitators of employment, career advancement and empowerment of nurses in a public hospital situated in the Western Cape.

The literature review in the next chapter seek to explore existing knowledge on the phenomenon under study to either identify gaps, build on the existing knowledge and eventually create a general image and understanding of the phenomenon under study.

.

CHAPTER 2
LITERATURE REVIEW

2.1 INTRODUCTION

Chapter 1 contains a synopsis of the research study inclusive of an introduction, a preliminary literature review, summarised information on research methodology and lastly a summary. Chapter 2 includes a synthesis of written information on the phenomenon under study by reviewing the existing literature and textbooks on this phenomenon.

The literature review is a concise written product that represents the author's comprehension of available subject matter on a chosen topic following a systematic analysis of research and non-research knowledge sourced from an array of search engines (Machi & McEvoy, 2016:1). Reviewing the literature when undertaking a research study provides the researcher with the opportunity to peruse the existing literature to become familiar with the available body of knowledge in interest (Kumar, 2011:47). Kumar (2011:46) postulated that the literature review has a multi-faceted role in the research process in that it provides a theoretical background to the study; it helps to establish the link between the known and the unknown in terms of the body of knowledge on the research problem. Furthermore, an objective literature review provides clarity and brings focus to the research problem by placing the study in context with the available body of knowledge (Brink, Van der Walt & Van Rensburg, 2006:68), thus enhancing the significance of the intended research study. Various search engines were used to source and review literature on health system barriers and enablers to nurse empowerment and advancement with a focus on how nurse managers experience it.

The research design in this study is a qualitative phenomenology that is built on a naturalistic paradigm. The naturalistic paradigm adopts the assumption that there are existing realities on a phenomenon originating from the experiences of those who live with this phenomenon (Ryan, Coughlan & Cronin, 2007:738). Ryan *et al*. (2007:738) postulate that the literature review in qualitative research focuses on giving an objective account of these emerging themes that may inform the choice of a conceptual framework for the intended research study.

2.2 SELECTING AND REVIEWING THE LITERATURE

The principal investigator performed an updated search of the following electronic databases from 2007 to 2022: CINAHL, Sabinet, Wiley online learners, EBSCO host, Gale Academic online and Google Scholar (for other free access articles), e-journals, textbooks, relevant electronic journals and acts. Articles were also sourced from the reference lists found in the articles. Textbooks that were used to include grey literature authored by Brink *et al*. (2006), Polit and Beck (2010) and Huber (2010). The literature that was included in the search was mainly published between May 2010 and May 2022 except for seminal information from authors like Kanter (1995) and Laschinger (2007). All literature was mainly written in English. The keywords that were used included “empowerment”, “nurse empowerment”, “barriers to empowerment”, “organisational climate and culture”, “shared governance”, and “continued professional development”. Both quantitative and qualitative studies involving nurse empowerment, barriers and enablers of nurse empowerment, structural empowerment, factors influencing structural empowerment and related topics were sourced from databases and included. Since the focus of the study was on nurse managers’ experiences with health system barriers and enablers on empowerment and subsequent advancement, the literature search had to be extended to also include keywords like “health system barriers” and “enablers”, “nurse leadership”, “recruitment and selection processes”. Most articles that were used were published from 2010 to 2022.

The literature review is presented in the following format:

- Factors influencing empowerment
- Enablers of empowerment
- Barriers to empowerment
- Role of nurse managers in empowerment

2.3 FACTORS INFLUENCING EMPOWERMENT

Empowerment defined refers to the ability to (i) mobilise and access social structures in the workplace such as information, support, resources and opportunities, termed *structural empowerment* and (ii) focus on personality attributes and tendencies to enhance workers’ productivity or enabling them to perform their jobs, termed *psychological empowerment* (Skytt, Hagerman, Strömberg & Engström, 2015:1003).

Empowerment can be regarded as a concept, a process and a result with the focus being on enhancing individual capacity to promote the recognition and acquisition of power that is inherent in employment structures (Halvorsen, Dihle, Hansen, Nordhaug, Jerpseth, Tveiten, Joranger & Knutsen, 2020:1264).

The following three paragraphs focus on the two types of empowerment and the concept of power as defined in literature followed by an analysis of the factors that influence empowerment.

2.3.1 Structural empowerment

Structural empowerment speaks to job-related resources that address the basic needs of the employee, thus rendering them fulfilled, motivated and active in their jobs (Balay-odao, Cruz, Alquwez, Al Otaibi, Al Thobaity, Alotaibi, Valencia & Danglipen, 2021:502). At an organisational level, these job resources are inclusive of the formal job requirements, informal work relationships, organisational mobility and the availability of opportunities for personal growth that impacts job accomplishment as well as the degree to which an employee perceives empowerment (Orgambidez-Ramos & Borrego-Aléz, 2014:30). Structural empowerment as a managerial expression describes a management-initiated organisational culture of order and structure created by the development of policies that will address the issue of access to power that will boost efficiency in service delivery (Bish, Kenny & Nay, 2012:3)

A large body of nurse research on empowerment is based on structural empowerment (Woodward, 2019: 138), with a focus on the quality of nurse managers' support to employees in accessing empowering structures in the workplace (Roji & Jooste, 2020), nurse managers' perceptions of empowerment (Bish *et al*., 2012; Regan & Rodriguez, 2011) and the reflections of first-line manager's on their staff's access to empowerment structures in the workplace (Skytt *et al*., 2014). Literature showed that structural empowerment factors such as access to information, support, resources needed to do the job, and opportunities to learn and grow, in the workplace outweigh the importance of personal attributes and social experiences in employee development and productivity (Trus, Razbadauskos, Doran, & Suominen, 2012:413). A Korean study premised on Kanter's theory of structural empowerment highlighted the significance of providing access to power structures such as shared governance and participative decision-making in establishing autonomy and job satisfaction (Choi

& Kim, 2019:1671). Skytt *et al*. (2014:1004) suggested that access to these power structures in the workplace is a management responsibility since the nurse manager has the mandate to create an empowering environment.

2.3.1.1 Elements of structural empowerment

Structural empowerment is a social structure that incorporates four dimensions of access in the workplace that allow employees to reach work goals. As postulated by the structural empowerment theory, a workplace needs to ensure that employees have access to various structures in the workplace that will transfer power and autonomy. Therefore, access to opportunity, resources, information and support are essential features of a highly empowered workplace. Access to opportunities involves information on the acquisition of knowledge and skills through training and development, chances for career growth, and creating a challenging work environment that enables professional growth (Balay-odao *et al*., 2021:502). Information sharing is vital to inculcate a sense of purpose and value in the employee, thus enabling them to meet job expectations and ultimately contribute towards the achievement of organisational goals (Orgambidez- Ramos & Borrego-Aléz, 2014:29). Access to support refers to the feedback, guidance, and direction one receives from management, subordinates and colleagues that influence independent decision-making and adaptability to change (Skytt *et al*., 2015:1004). Finally, support from management and peers in terms of constant feedback and guidance is essential to denote value, appreciation and worth to employees (Orgambidez - Ramos & Borrego-Aléz, 2014:29).

2.3.2 Psychological empowerment

Spreitzer (1995) defined psychological empowerment as the psychological perception of or attitude of employees towards their work and their organisational roles (Spreitzer, 1995 & Li *et al*., 2018: 1266), that finds expression through four cognitive experiences, the sense of competence, impact, meaning and self-determination (Rao, 2012:400). Psychological empowerment theory holds that empowered employees have an intrinsic motivation to access power (Spreitzer, 1995; Zhou & Chen, 2021:3) based on what meaning he or she denotes to the job, the individual competence related to the level of confidence he or she has to perform the job well, the capacity to take control over one's work (self-determination) and having a sense of purpose in the organisation and lastly, to be able to influence organisational outcomes (Meng, Liu, Liu, Hu, Yang

& Liu, 2013:305). Therefore, psychological empowerment is an active process that enables an employee to continuously remodel his or her job function and context (Spreitzer, 1995:1444; Sparks, 2012:453).

Psychological empowerment (PE) precedes structural empowerment (SE) because SE can only take effect when employees feel motivated and confident in their abilities (Li, Shi, Li, Xing, Wang, Ying, Zhang & Sun, 2018:1263). The difference between structural empowerment (SE) and psychological empowerment (PE) lies in the fact that SE focuses on organisational empowerment structures of opportunities, information, resources and support as sources of power, whereas PE focuses on cognitions of meaning, competence, impact and self-determination as fundamental sources of power to gain control over job responsibilities (Li *et al*., 2018:1266). Therefore, psychological empowerment facilitates positive attitudes that are necessary to successfully access structural empowerment tools that will improve job efficacy (Wang & Liu, 2013:289).

2.3.3 Social empowerment

Social empowerment refers to the process of liberating a person from historical oppression in the workplace that interferes with his or her ability to gain control over his or her work (Rao, 2012:399). In the context of nursing, social empowerment refers to the liberation of nurses from institutional oppression and hegemonic forces that impose the stance of the medical discipline (historically regarded as the dominant occupational class) upon nurses (Roa, 2012:399).

An integrative review of literature that was done in Philadelphia revealed that the empowerment process occurs contemporaneously at an individual, organisational and social level, denoting psychological power (individual level), structural power (organisational level) and social power (institutional or social level) (Rao, 2012:399). A socially empowered nurse takes control over practice and expresses his or her worth in health care by negating the perception of being predominantly clinical and starting to participate in health strategic planning structures (Casey *et al*., 2010; Roa, 2012:399). Both social empowerment and structural empowerment refer to the value of the quality of social interactions on an employee's autonomy, power and impact (Halvorsen *et al*., 2020:1264). However, this study is premised on Kanter's (1995)

theory of structural empowerment, not undermining the fact that other individual or psychological factors also influence worker performance and commitment.

2.3.4 Power

Empowerment is premised on the notion of "power" which from a structural empowerment viewpoint refers to having information, managerial support, resources and opportunities for growth in the workplace (Roji & Jooste, 2020:2). According to Kanter (1977), power is gained when employees have access to workplace empowerment structures. The power that is acquired enables the employee to mobilise resources and reach performance targets (Kanter, 1977; Amor, Vásquez, Faíña, 2018:2). Rao (2012:400) describes "power" as the ability to exert influence on others that will move them towards action in pursuit of common organisational goals. Structural empowerment specifically speaks to the inherent power that's incorporated in job resources and how this impacts workers' performance (Woodward, 2019:138). Alternately, the theorists of psychological empowerment view "power" as the employee's ability to display confidence, make meaningful contributions to organisational goals, be self-determined and make an impact in the organisation (Al-Niarat & Abumoghli, 2019:1241). The literature reviewed by Rao (2012:401) holds the view that empowerment will be realised through the mobilisation of power, meaning that empowerment cannot happen without the transfer of power, but power can be without empowerment since power can exist on a formal (imbedded in positional rankings) and informal level (quality of interpersonal relationships).

Kanter (1977, 1993) stated that the empowerment of employees and managers is not determined by personal attributes or the quality of workplace relationships but rather by the ranking of their jobs within the organisational structure (Tyagu & Shah, 2018:367). A qualitative Australian study had similar results in pointing out the influence that job ranking has on a nurse manager's degree of power and autonomy (Hughes, Carryer & White, 2015:2). This inexplicably means that the higher the job ranking, the greater the level of power and the responsibility to enable employee growth and expansion of individual abilities through creating an empowering climate in the workplace.

Rao (2012:399) used an illustration (Figure 4) to demonstrate how employee and managerial efforts to mobilise power can impact better personal output and organisational outcomes.

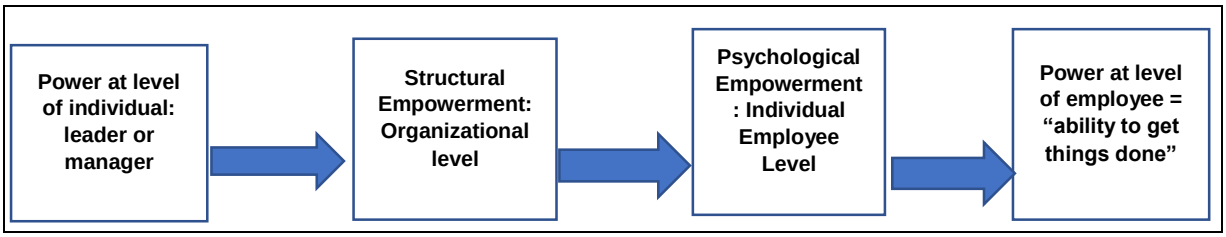


Figure 4: Mobilisation of Power within an organisation (Ellefson & Hamilton, 2000; Kanter, 1977; Spreitzer, 1995; Spreitzer *et al*., 1997; Laschinger *et al*., 2006)

Figure 4 illustrates how individual empowerment is achieved by the nurse exerting control over the nursing practice by recognising the power that lies within his or her job, exploiting available empowerment structures in the workplace and being motivated to excel (Rao, 2012:399).

2.3.5 Empowerment and career advancement

Career advancement in nursing refers to any form of professional preferment in recognition of clinical and administrative nursing excellence (Adeniran, Bhattacharya & Adeniran, 2012:42). In nursing, career advancement takes the form of a formal structure that provides nurses with the opportunities to increase their capacity and enhance their abilities to be promoted (Sheikhi, Khoshknab, Mohammadi & Oskouie, 2016:2). Participants in a qualitative study that was aimed at exploring the role of the working environment in a nurse's career progression, described the concept of career advancement as a form of professional promotion that holds a change in roles, power and financial benefits (Sheikhi *et al*., 2016:2).

A quantitative study that was done in hospitals in Tianjin, China, demonstrated a positive relationship between structural empowerment and career advancement (Dan, Xu, Liu, Hou, Lui & Bachelor, 2018:1). The nature of this relationship refers to the employee's ability to access formal power, opportunities and resources that motivate the employee towards efficiency in skill which, in turn, promotes the chances of career advancement (Dan *et al*., 2018:1). This finding is supported by the results from a Finnish quantitative study which determined that the employee's ability to master structural empowerment structures enhances his or her self-determination to attain

career goals (Dan *et al*., 2018:3). Sheikhi *et al*. (2016:5) stated in their qualitative study that the participants experienced challenges such as high service demands, staff shortages, a lack of access to education and inadequate promotional opportunities that slowed nurse advancement. Therefore, standardised career advancement structures are needed to promote professional growth (Sheikhi *et al*., 2016:5).

The concepts of empowerment and advancement are not interrelated which means that an employee may have the ability to do things (feeling empowered) but may also not be the preferred candidate for a promotion (advancement).

2.4 ENABLERS OF EMPOWERMENT

2.4.1 Legislation as an enabler

Post-apartheid, the South African government inherited a public service characterised by various forms of discrimination based on race, gender, social standing, and physical ability, denying members of disadvantaged groups from accessing managerial positions (Milne, 2009:970). Milne (2009:971) sketched a dire situation of inequalities where organisational profiles reflected a situation of a predominantly Black workforce and an overrepresentation of White males employed at management levels urging the need for restructuring. To address these past inequities, the South African government introduced legislation to support the general public in accessing the job market, equal opportunities for upward mobility in the workplace and access to empowering structures in the workplace.

The Employment Equity Act (EEA), no. 55 of 1998 seeks to deracialise employment and create equal opportunities for employment of individuals from diverse ethnic descent (Oosthuizen, Tonelli & Mayer, 2019:1). Furthermore, section 20 of the EEA obligates each state enterprise to develop an Equity Plan stating numerical targets for employment of persons from each racial and gender group to mirror the demographics of the South African society (Republic of South Africa, 1998). Employers are obligated to submit annual reports on their progress in terms of employment equity to the Department of Public Service Administration (DPSA).

The Skills Development Act (SDA), no. 97 of 1998, was promulgated to enable managers to provide employees access to empowerment structures (access to information, resources, support training and development opportunities) that will

facilitate the non-discriminate improvement of skill and productivity levels to improve individual work performance, quality of lives and chances for career advancement of all public servants (Republic of South Africa, 1998).

2.4.2 Organisational systems

Coupled with the legislative prescripts on mandatory employee empowerment is the management's obligation to create an enabling workplace where employees have access to power structures such as opportunities and support that will foster employee growth and development in knowledge and skill. Such systems include the creation of a culture of shared governance as a critical propeller of staff empowerment and continuous nurse development and training.

2.4.2.1 Human Resource Development (HRD) processes

Human resource development defined, refers to all programmes that will enhance the skills, knowledge and abilities of employees to maximise their potential and improve the productivity of the organisation (Alhalboosi, 2018:3). The EEA and SDA posed employers with a double challenge of having to develop its human capacity to a point of being competitive in the global economy whilst still enforcing workplace transformation to redress past inequalities based on a rights-based democracy (Breakfast & Maart, 2019:3). The discourse on HRD was further supported by the introduction of the employee performance management and development system (EPMDS) by the South African Department of Public Service Administration (DPSA) in April 2007, to improve productivity in the workplace as a vital aspect of economic development in the country (Hendricks & Matsiliza, 2015:125).

The performance appraisal or employee performance management and development system (EPMDS) as it is currently known in the South African context is a human resource management system that focuses on the effectiveness and efficiency of employee performance (Agarwhal & Thakur, 2013:617). The PA process has a dual purpose in that it firstly, enables the manager to get insight into the employees' perceptions of their jobs, the values and interests they attach to their jobs and what motivates them (Huber, 2017:401). Secondly, PA creates a platform for employees to communicate their job expectations and development needs (Agarwal & Thakur, 2013:617). The expression of these developmental needs informs the introduction of structural empowerment structures (information, opportunities, resources and support)

by the manager, which will improve knowledge and skill and ultimately enhance employee and organisational efficiency (Huber, 2017:402).

Hendricks and Matsiliza (2015:125) staged a qualitative research project that included employees of the South African Department of Land Reform and Rural Development to explore the level of understanding of the EPMDS among them. This study exposed a lack of understanding amongst both operational workers and managers on the EPMDS policy which translated into poor compliance and a lack of commitment to proper implementation of the policy (Hendricks & Matsiliza, 2015:128). An Asian quantitative descriptive study investigated the impact of PA on motivation and job performance in the government sector (Al-Jedaia & Mehrez, 2020:2081). The findings revealed that opportunities for training and development, recognition and rewards, referred to as outcomes of successful PA in the study, enhanced employee motivation and improved job performance (Al-Jedaia & Mehrez, 2020:2085).

2.4.2.2 Recruitment and selection of nurses

In the nursing profession, entry and promotional appointments in the South African public service are prescribed by the Occupation-Specific Dispensation (OSD) (Republic of South Africa, 2007). One of the many reasons that underlined the introduction of OSD was to attract and retain health professionals, like nurses, in the public service by offering competitive salary packages that are aligned with the competencies and experience levels of health professionals (George & Rhodes, 2012:2). The OSD does not only represent a graded salary structure but provides opportunities for career mobility based on competencies, performance and experiences (Republic of South Africa, 2007:2).

The appointment of nurses into new positions follows the normal human resource (HR) recruitment processes except for those nurses who are eligible for grade progression within their current occupational stream. Grade progression refers to the upward movement of salary levels from a lower grade (salary level) to a higher grade (salary level) attached to all posts in the public service (Republic of South Africa, 2012:3). Translational appointments between nurse categories and operational streams (general and speciality) require the mandatory completion of a post- or undergraduate qualification and a formal recruitment and selection process. Advancement to managerial level posts follows the recruitment and selection route where candidates compete in the open market for such positions. Hospital management teams have the

prerogative of compiling job requirements in addition to the baseline requirements contained in the Occupation-Specific Dispensation (OSD) guidelines for the various categories of nurses (Republic of South Africa, 2007).

The OSD system for nurses motivates nurses to engage in empowerment structures to improve a skill that provides access to opportunities for professional advancement and better remuneration packages. A South African mixed-method study demonstrated mixed experiences amongst participants where senior officials concurred on the positive aspects of OSD being a successful recruitment and retention strategy for specialist nurse professionals specifically, whilst the other participants relayed experiences of feeling distressed and perceiving a conflict between staff following the introduction of OSD (Motsosi & Rispel, 2012:141).

2.4.2.3 Culture of shared governance

Shared governance is viewed as a vital precedent of empowerment and the building of structures that encourage the inclusion of nurses in decision-making towards reaching autonomy and efficiency in nursing practice (Khraisat, Al-awamreh, Hamdan, AL-Bashtawy, Al khawaldeh, Alqudah, Qaddumi & Haliq, 2020:348). Central to shared governance are the concepts of input - from nurses and the leadership, process - denoting the fluidity of shared governance and outcome - that refers to the impact it has on the individual, unit and organisational level (Choi & Kim, 2019: 1665).

Shared governance requires a change in the nurse manager's leadership style from being despotic to involving nurses in decision-making processes and being operational to mentor nurses' practice (Ott & Ross, 2014:763). The transition of autocratic nurse managers to being facilitators of participative decision-making is critical in shared governance (Ott & Ross, 2014:763). A descriptive correlation study conducted in Saudi found that a supportive work culture and climate where nurses feel valued will enhance nursing leadership behaviour and promote organisational commitment amongst nurses (Abd-El Aliem & Abou Hashish, 2021:273).

Implementing shared governance in the workplace is a method of transferring power to the nurse that will enable autonomy in decision-making and clinical practice (Huber, 2017:426)

2.5 BARRIERS TO NURSE EMPOWERMENT

Enablers in the form of available legislation and information do exist in the workplace but are often not implemented due to other challenges. These barriers include the lack of implementation of legislative prescripts such as the Employment Equity Act (EEA), no 55 of 1998, and the Skills Development Act (SDA), constraints in resources, cadre deployment leading to poor governance and leadership (Tshishonga, 2014:891), and defective human resource processes which may lead to irregular appointments (Public Service Commission, 2016:1).

2.5.1 Barriers to the successful implementation of Employment Equity

The available literature on employment equity highlighted different views on the efficacy and progress of transformation in South African organisations. In a South African study done by Oosthuizen and Naidoo (2010:2), they found that although the enforcement of the Employment Equity Act, no.55 of 1998, led to the empowerment of the previously disadvantaged, the process is viewed negatively as a slow exercise of legal compliance. Esterhuizen and Martins (2008:66) identified different perceptions of the fairness of employment equity along racial, gender, age, and post levels. This study emphasised unfair human resource practices, lack of training and development, and lack of acknowledgement and communication of employment equity as barriers to the successful implementation of employment equity (Esterhuizen & Martins, 2008:80).

Oosthuizen and Naidoo (2010:8) contributed to the equity discourse by stating that both white and black respondents in their study shared the opinion that Employment Equity is inconsistently applied and detached from skills development strategies. Esterhuizen and Martins (2008:68) posited that employment equity and related measures such as affirmative action cannot ensure successful transformation unless the importance of skill, employee engagement and empowerment, change in organisational culture and abolishment of negative perceptions and stereotypes are attended to. Zulu and Parumasur (2009:8) concluded in their study report that despite the progress in transformation, the South African government made little progress in empowering and developing employees to assume their roles in the labour market. They propagate that the engagement and empowerment of employees ensure employee commitment towards the achievement of successful workplace transformation (Zulu & Parumasur, 2009:8). Through such findings, an inference on

the positive relationship between the empowerment of staff and successful transformation can be drawn.

Motaung, Bussin and Joseph (2017:7) added to the gender debate by highlighting patriarchal dominance and male supremacy, fostered by societal systems assigning privilege and advantage to men, as barriers to employment equity and career advancement for especially black women within managerial ranks in the labour market.

Implementing employment equity proves to be quite challenging to employers but is possible when management is committed to the vision of fairness and equal opportunity as well as displaying the necessary skill to design and lead such processes within the organisation (Oosthuizen & Naidoo, 2010:2).

2.5.2 Lack of nurse leadership and governance

Leadership defined, refers to the process whereby an individual enlists a group of people to work together towards a common goal (Weiss & Tappen, 2015:4). Leadership styles can influence the quality of teamwork and boost the achievement of goals (Manning, 2016; Abd-Ehl Aliem & Abou Hashish, 2021:273).

The complex nature of South African health care demands highly skilled managers who can develop a health care system that is responsive to the population's health needs (Republic of South Africa, 2019:2). A responsive health service is needed to mitigate the ill public perception regarding the quality of South African public health care services as portrayed by the media (Govender, Gerwel, Proches & Kader, 2018:158). A mixed-method study completed in Durban, South Africa, identified communication breakdown, poor governance, and lack of managerial skills as leadership shortcomings that can be addressed through the introduction of capacity-building empowerment structures in the workplace (Govender *et al*., 2018:165). In support of the previous finding of the study were the importance of shared governance, participative decision-making, open communication and a supportive and empowering work environment in boosting leadership efficiency, promoting positive work relations and realising the attainment of organisational goals (Abou Hashish, 2020; Abou Hashish & Fargally, 2018; Kowalski *et al*., 2020; Abd-Ehl Aliem & Abou Hashish, 2021:279).

The findings in a Sub-Saharan cross-sectional study revealed bad leadership styles as a precedent to lack of psychological empowerment of employees and poor job performance (Ofei, Paarima, Barnes & Pofu, 2022:8). On the other hand, results from a quantitative study conducted in Saudi Arabia showed that a transformational nurse leadership style and a supportive working environment support employee empowerment (Abd-Ehl Aliem & Abou Hashish, 2021:273).

2.5.3 Corruption in human resource recruitment and retention processes

Corruption in human resource practices ranged from non-compliance to policies by appointing or advancing a person without subjecting him/her to an interviewing process; appointing or advancing an unsuitable applicant and selection panels failing to abdicate their responsibility of recommending the best candidate (Public Service Commission, 2019). Political interferences in human resource practices presented in the form of patronage (exchanging political support for jobs), politicisation (changing basic job requirements to fit deployment candidate's abilities), nepotism (exploiting a position of authority by approving the unauthorised appointment of relatives) and cronyism (appointment of friends and relatives without consideration of qualifications) (Kirya, 2020:3-4). The findings from a mixed-method study conducted in two South African provinces showed that political interference is prevalent in South African hospitals whereby hospitals were coerced into appointing or promoting candidates who had political alliances (van der Heever, van der Merwe, 2018:253).

2.5.4 Introduction of cadre deployment

The introduction of the Cadre Deployment policy by the South African ruling party was meant to expedite service delivery through the centralisation of democratic powers (Tshishonga, 2014:893). The reality of Cadre Deployment, generally known as "political appointments", in public service cannot be ignored. In an article written by Shava and Chamisa (2018:3) on the impact of cadre deployment on performance management, they stated that political appointments were done to safeguard the ruling party from possible sabotage from opposition parties. They also affirmed the fact that it was often the case of officials being deployed into positions that they are not qualified for (Shava & Chamisa, 2018:3). These "cadres" are party loyalists and are strategically placed to implement governmental policies and imperatives. This type of appointment led to inefficiencies in the management of public entities (Tshihonga, 2014:891). This brings us to the issue of the basic requirements of the post and the function of interview

panels in selecting candidates who meet these criteria. The only logical explanation to render such recruitment practices fair was to amend these inherent job requirements to suit the preferred candidate. Zulu (2013) was quoted in an article written by Thsihonga (2014:900) in stating that the practice of cadre deployment poses a threat to service delivery and at the same time makes room for rampant corruption simply because “cadres” who are not qualified for the positions they occupy, are entrusted with power.

Shava and Chamisa (2018:1) conducted a study in South Africa on the effects of the Cadre Deployment policy on service delivery within local government. The results of this study confirmed that the implementation of this policy led to the emergence of other problems such as corruption, poor supply chain management systems, wasteful expenditure and resultant deterioration in the performance of many municipalities due to poor management capacity. (Shava & Chamisa, 2018:1). The study also highlighted the notion of incompetent people being placed in strategic positions across influential government sectors to protect the interests of the ruling party. Wolvaardt *et al.* (2013:89) also gave their inputs on the high turnover rate in senior management as being one of the leading causes of inconsistencies in leadership style and a collapse of services. Managers who were appointed under the Cadre Deployment policy also brought another challenge of being difficult to manage especially if found incompetent or failing to perform (Wolvaardt, 2013:89).

Shava and Chamisa (2018:1) stated that cadre deployment undermined good leadership and governance by overlooking merit and skill and rewarding loyalty to party ideologies. These authors dubbed cadre deployment as a form of political patronage using government positions to promote party mandates (Shava & Chamisa, 2018:1). Cadre deployment undermines the fairness and credibility of recruitment and selection practices by enforcing the appointment and advancement of preselected candidates in senior positions who are generally perceived as inappropriately qualified to execute their delegated authority and responsibilities (Public Service Commission, 2013:7).

2.5.5 Human and financial resource constraints

2.5.5.1 Human resource constraints

Training output reports from the South African Nursing Council (2019) showed a total number of 3 563 newly qualified professional nurses with a countrywide nurse: patient ratio of 1:363 (estimated for professional nurses) (SANC, 2019). The absence of national nurse: patient ratios impede effective planning and supply of nursing staff concerning staffing and skill mix needed for quality nursing care delivery (Western Cape Department of Health - WCDOH, 2017:9). The same document reports an increase in the number of nurses trained in basic and post-basic courses, but the human resource crisis still prevailed in the clinical field (WCDOH, 2017:6).

The introduction of compulsory community service in 1998 saw the deployment of newly qualified doctors and later nurses, in 2015, to rural and underprivileged health services. The initiative had two objectives firstly ensuring the improvement in health services, with a focus on rural health care and secondly, to provide young health professionals with an environment to test and enhance their newly acquired knowledge as well as master the skill of critical thinking that will boost their growth within their chosen occupational field (Reid, 2018:46).

The nursing shortage moved employers to restructure the support of nurse empowerment through the provision of opportunities for nurses to enhance and address competency shortfalls and achieve organisational goals (Graebe & Cosme, 2022:246). Nursing shortages create a challenge for nurse managers in releasing nurses to attend training sessions. This reality led the PGWC to institute the practice of appointing nurses on a one-year contract to replace those nurses who were selected for further training (PGWC, 2020:12). The findings of an integrative review on the impact of nurse supply on access to opportunities for continued professional development indicated that nurses were unable to attend such sessions due to staff shortage and the non-availability of relief staff (Coventry, Maslin-Prothero & Smith, 2015:1). This explains a common phenomenon in nursing where the delivery of patient care takes precedence over employee development.

2.5.5.2 Constraints in financial support

In an article authored by Gaede and Versteeg (2011:103) and published in the *South African Health Review*, they mentioned existing studies which found that national public health care fund allocation to provinces with a greater burden of disease, the

largest population in size, decreased health capacity and with a lack in economic resources, is the smallest. On the flip side of the coin, it is noted that provinces with more hospitals and more doctors receive bigger funding. The rationale provided for this inequity was that these provinces have a better capacity to spend allocated funds and to maintain quality levels of care (Gaede & Versteeg, 2011:103).

Other criteria for health care financing are efficiency indicators such as cost per patient per day equivalent. The use of such indicators as criteria for fund allocation is heavily criticised by Gaede and Versteeg (2011:103) since the efficiency of service delivery is dependent on the availability of basic resources and not judged by the rate of the service utilised.

2.6 THE ROLE OF THE NURSE MANAGER IN NURSE EMPOWERMENT

Creating an empowered team is a key performance indicator in the job description of nurse managers. The enactment of such has a meaningful influence on staff morale, productivity, staff retention and associated costs, patient care, quality, and patient safety (Linen & Rowley, 2014:46).

A nurse manager's power and status are determined by his or her structural position within the organisation which lends him or her the opportunity to progress and foster action within the work environment (Hughes, Carryer & White, 2015:5). Hughes *et al.* (2015:5) also stated that the nurse manager with high opportunity displays a positive sense of belonging within the executive management group which gives him or her the freedom to act and drive to effect change within the working environment. Since structural empowerment mainly involves the manipulation of administrative processes within the workplace, nurse managers can modify conditions in the workplace to facilitate the implementation of structural empowerment principles (Ta'an *et al*., 2020:635). Being an empowered nurse manager is infectious in that it rubs off onto the nurse subordinates resulting in the creation of an empowering work environment characterised by excellence.

Bish *et al*. (2012:7) tested nurse leaders' perception of structural empowerment in a quantitative, descriptive, non-experimental study conducted in Australia, and found that nurse leaders, although perceived as being moderately empowered, expressed a need for theory development to support and guide future nurse leaders in empowering

staff. On the other hand, continued staff empowerment must be adopted as a strategic imperative by an organisation to secure managerial support (Skytt *et al*., 2014:1009). Research also proved that a combination of access to organisational empowerment structures and positive psychological attributes influence the empowerment process (Sparks, 2012:452).

2.6.1 Having the power to empower

Nurse managers have a critical role in managing patient units in a health system that is characterised by resource constraints amidst increasing demand for health care services. This reality accentuates the importance of nurse managers having the authority and power to lead (Trus, Martinkenas & Suominen, 2017:337). Trus *et al*. (2017:337) define nursing power as the "power to", referring to the ability to be efficient and autonomous in the job, and the "power over", referring to the ability to influence others by role modelling competence and efficiency in the job. Hughes *et al*. (2015:6) stated that power and authority are invested within a job function and that this ability to mobilise resources is determined by the positioning of the post within the organisational structure. This means that the higher the placement of a position within the organisational structure, the greater the institutional regard and value and the higher the ability to influence policy and affect change within an organisation.

However, a qualitative study performed in New Zealand explored the views of nurse managers and hospital Chief Executive Officers on the structural positioning of nurse leaders in the hospital organisational structure. This study proved that nurse managers who felt excluded from executive management processes experience low levels of power and vice versa (Hughes *et al*., 2015:6). The same study also highlighted that nurse managers experience discrimination and oppression in the workplace stemming from executive management's low regard for their intellectual capacity (Hughes *et al.,* 2016:6) The institutional oppression was fuelled by hospital executive structures who upheld a power differential between medical doctors and nurses that finds expression in the difference in hierarchical placement of these two occupational classes within the organisational structure (Woodward, 2020:137).

The findings of a descriptive cross-sectional study done in West Iran showed low levels of power among nurse managers. The low levels of power were ascribed to the unfair centralisation of power in the top hierarchy of management which harms the

nurses' motivational levels (Gholami, Saki & Pour, 2019:1020-1021). Situations like these can be mitigated through a focus on the empowerment of nurse managers that will transfer the power to this cadre of nurses to become visible and vociferous within organisational executive structures and ultimately contribute to change (Woodward, 2020:137).

2.6.2 Creating an empowering work culture and climate

According to the International Council of Nurses (ICN), positive practice environments allude to settings that stimulate staff to pursue excellence and improve productivity at the individual and organisational levels (International Council of Nurses *et al*., Republic of South Africa, 2020:6). Nursing managers have a responsibility to create a positive practice working environment through the provision of structural conditions that support nurse empowerment and advancement (Ta'an, Alhurani, Alhalal, Al-Dwaikat & Al-Faari, 2020:635). Thus, the role of a nurse manager changed from focusing on managing operations within the clinical setting to creating an environment that fosters employee growth and freedom to contribute positively towards efficiency and the realisation of company goals. A workplace that supports the autonomous functioning of the employee and meaningful intra- and inter-professional collaboration promotes employee commitment and trust (Dahinten *et al*., 2016; Gholami, Saki & Pour, 2019:1021). The creation of access to opportunities for career advancement and the cultivation of a culture of continuous learning aid nurse recruitment and retention and eliminate barriers to career advancement (Graebe & Cosme, 2022:246).

Organisational culture defined, refers to the code of conduct that guides employees in the way they perform their functions, whilst organisational climate refers to the shared perception of the social and psychological impact that the organisation has on the employee's work life (Aarons *et al*., 2012; Glisson, Green & Williams, 2012; Glisson & Williams, 2015; Trus *et al*., 2018:55). Organisational culture and climate are key features of a successful organisation as it is associated with organisational efficiency and improved performance (Clark, Belcheir, Strohfus & Springer, 2012; Glisson, 2015; Trus *et al*., 2018:54). The process of building an empowered workplace requires structure, industrious planning and decision making and a total overhaul of the quality of employee-manager engagements (Ott & Ross, 2014:762). In an empowering organisational climate and culture, both structural and psychological empowerment come to effect as nurses will have access to empowering structures whilst also feeling

motivated and experiencing confidence and trust in the organisation (Trus *et al*., 2018:55).

The findings of an integrative review done by Coventry *et al*. (2015:2724) revealed that there is a positive relationship between Continuous Professional Development (CPD) opportunities, organisational culture and leadership denoting that access to professional development opportunities is a trademark of a working environment that adopted a culture of learning and is supported by management.

2.6.3 Adopt an empowering leadership style

The definition of "leadership" speaks about a process where the leader influences others/ followers towards the realisation of shared goals. The leader influences his or her followers by implementing leadership styles that adapt to a different context (Manning, 2016; Abd El Aliem & Abou Hashish, 2021:273). Leaders mediate with followers on issues such as the availability of resources, facilitate access to opportunities and support efforts towards the attainment of organisational goals (Bamford-Wade & Spence, 2012:191). Leaders also operate within a team context when seeking solutions to challenges (Connolly, Jacobs & Scott, 2018:882).

The position of the nurse manager is accompanied by a certain degree of power and influence that can be transferred to the subordinates accentuating the fact that the behaviours and demeanour of nurse managers impact every nursing subordinate within the team and can become characteristic of the team as a whole (Ott & Ross, 2014:761). It is important to note that the nurse manager's perception of his or her degree of power within the workplace underscores his or her ability to display good leadership skills and influence other nurses' (Connolly, Jacobs & Scott, 2018:883). A common realisation within the nurse leadership discourse is the fact that the traditional despotic leadership style of nursing must be replaced by a focus on empowerment, governance, and participative decision-making (Ott & Ross, 2014:761).

The transformational leadership style supports the concept of structural empowerment by denoting value to shared governance, participative decision-making, and staff motivation as antecedents of power in a workplace (Amor *et al*., 2019:2). According to Bass (1995), a transformational leader inspires the employee to continue professional growth and transcend restrictions in the job description (Amor *et al.,* 2019:2). The findings of quantitative research conducted in Spain emphasised the importance of a

transformational leadership style in the creation of an empowering working environment (Amor *et al.*, 2019:8).

2.6.4 Creating access to power and opportunities

Access to opportunities is regarded as a workplace empowerment structure that speaks to the sharing of information regarding available avenues to develop new skills and knowledge and the recognition of empowering working environments that is crucial for professional growth (Balay-odao, 2021:502). The multitude of literature on structural empowerment is vocal on the nurse manager's responsibility of creating opportunities for the learning and growth of nurse subordinates. These opportunities include access to challenging work, rewards and professional development (Laschinger *et al*., 2012:879). The ability to enable employee growth is inherent in managerial positions as these positions contain formal and informal power that allows the incumbent the autonomy and confidence to act as well as to draw from the richness of manager-staff and manager-peer relations within the organisation (Albasal *et al*., 2022:625).

There are many ways to promote the nurses' ability; and continuous professional development (CPD) has been considered one of the important approaches to helping them maintain skills and motivation for work to provide patients with safe care (Yu, Huang & Liu, 2022:1). CPD points to a process of continuous, life-long training and development of health professionals to capacitate them with critical job knowledge and skill to reach and maintain competence and professional excellence (Mandlenkosi, Silén & McGrath, 2021:2). Considering the critical importance of CPD for nurses, nurse managers should ensure that access to such opportunities is realistic and achievable (Mandlenkosi *et al*., 2021:1).

2.6.5 Supporting growth and development

The nurse manager must facilitate access to support by providing feedback and direction to nurses on work performance which will allow them to become self-reliant (Albasal *et al*., 2022:625) and engage in autonomous functioning, discretionary decision-making, ingenuity, and remodelling (Skytt *et al*., 2015:1004). Continued nurse development is vital to assist nurses in remaining abreast of all developments within the field. However, the differences in age and intrinsic motivation tend to determine their perception of the value of investing in continuing professional

development (Yu *et al.*, 2022:6). It is, for this reason, that nurse managers should recognise and consider the nurse's situation and unique training needs and then provide support for them to access such CPD opportunities (Yu *et al*., 2022:6). Management support and commitment to CPD of staff can be perceived as an affirmation of the value of the staff (Mlambo *et al*., 2021:7).

2.6.6 Enable access to information and resources

Access to information, according to Kanter's (1977) structural empowerment theory, means having knowledge and skills that are necessary to perform effectively in an appointed position (Albasal *et al*., 2022:625). Having information on organisational policies, goals and strategic planning bestows a sense of value and purpose on an employee resulting in a renewed commitment to contribute toward the actualisation of organisational goals (Laschinger *et al*., 2012:879). Literature on structural empowerment refers to access to resources as the ability of staff to access funds, materials and supplies necessary to perform the job and contribute towards the realisation of company ideals (Laschinger *et al*., 2012:879). Hughes *et al*. (2015:6) posited that the hierarchical placement of nurse managers determines their level of power and authority. This autonomy and power enable them to influence the mobilisation of resources. Therefore, nurse managers must use the power that's invested within their positions to ensure that nurses have access to all the empowerment structures that will ensure efficiency within the organisation.

2.7 SUMMARY

The South African government promulgated the Employment Equity Act and the Skills Development Act to eliminate the historical discrimination of accessibility in opportunities for employment and empowerment for the previously disadvantaged. However, the realities of health systemic challenges of resource constraints, ineffective leadership and governance, and defective human resource management processes, to name a few, hampered the realisation of employment equity, employee empowerment and career advancement.

The successful empowerment of employees depends on the availability of workplace structures of information sharing, resources of time, human capital and finances, opportunities for growth and support from seniors and peers. These empowerment structures lend power to the employees to reach autonomy in practice and enhance

productivity. The nurse manager has a mandate of facilitating access to these structures. This responsibility proves to be difficult when they lack the power to empower. The complexity of health care services coupled with the increasing demand for health care requires resilient, skilled nurse leadership to direct the majority of health human resources towards increased productivity and the realisation of organisational outcomes.

The next chapter includes detail on the research process as it unfolded during this study.

CHAPTER 3
RESEARCH METHODOLOGY

3.1 INTRODUCTION

Chapter 1 contains an overview of the scientific foundation of the study, i.e. the background, rationale, and a summary of the research methodology. Chapter 2 comprises a synthesis of the literature underlying the phenomenon under study. In this chapter, an in-depth discussion is presented of the research methodology that was applied in the study.

3.2 RESEARCH AIM

The purpose of the study was to explore the lived experiences of nurse managers on the health system barriers and enablers that influence their duties to empower and advance nursing staff.

3.3 RESEARCH OBJECTIVES

The objectives were:

- To gain an understanding of how the hospital's empowerment structures enable nursing staff empowerment and career advancement;
- To explore the nurse managers' experiences in their role of providing nurses access to power structures in the workplace; and
- To get insight into the possible barriers and enablers to nurse empowerment and advancement that may exist in the hospital.

3.4 RESEARCH METHODOLOGY

3.4.1 Research design

The research adopted a qualitative design as it allows for a systematic exploration of the participant's experiences of a phenomenon from their perspective (Grove & Gray, 2019:59). Qualitative research designs focus on people's written or spoken word and observed behaviour to comprehend that which is hidden in the lived experiences of the research participants within a given context (Taylor, Bogdan & DeVault, 2016:21). The progression of the research process starts with the posing of questions or observation of procedures, followed by data collection that is done within a natural

setting by the principal investigator (PI) and lastly, the inductive analysis of data starting from a sequential building of themes towards deductive analysis through the interpretation of all the essences related to the phenomenon under study (Creswell & Creswell, 2018:43).

Creswell and Creswell (2018:301) highlighted the characteristics of qualitative research designs as applied to this study.

(i) Throughout the research inquiry, the core focus was on finding information on the underlined **meaning or essence of the lived experiences that the participants have** of a phenomenon.

(ii) Data collection was done within a **natural setting**, meaning the context in which the participants have their experiences or where the phenomenon exists which in this instance is the identified study centre.

(iii) The **active involvement of the PI** was compulsory throughout the data collection and analysis phases.

(iv) Virtual **semi-structured interviews were used to collect data**. Probing was mainly applied to elicit rich responses from the participants.

(v) Throughout the research process, there was room for **flexibility and fluidity** as the initial plan of data collection was changed to adjust to the realities of the participants. Interview questions were adjusted following probing into responses that allow for a deeper search to elicit richer meanings.

(vi) **Inductive and deductive analysis** was applied, as discussed in the preceding paragraph.

3.4.2 Research approach

The research approach or tradition used in this study is phenomenology which stems from the discipline of philosophy (Polit & Beck, 2010:263). Phenomenological studies investigate lived experiences by analysing the information shared by those who are in the situations. Phenomenologists apply the concept of *being in the world* as a recognition of the physical interaction between the world and the person (Polit & Beck, 2010:263). The value of phenomenological research lies within the ability of the PI to not only understand the people's experiences but what meaning lies behind those experiences (De Chesnay, 2015:25). Two phenomenological approaches are mainly

applied in qualitative health care research, namely interpretative (hermeneutic) and descriptive (eidetic) phenomenology (Lopez & Willis, 2004:727).

An interpretative phenomenological approach was implemented during this study to look beyond the subjective description or what is consciously known of the lived experience to focus on the deeper meaning of such experiences that are sometimes not even known to the participants themselves but lie hidden in the responses they give to questions posed by the researcher during the interviews (Lopez & Willis, 2004:728). Interpretative phenomenology (IP), also referred to as hermeneutics, is founded on the philosophical contributions of Martin Heidegger (1889-1976), Hans-Georg Gadamer and other philosophers who improved on the theory of Husserl by valuing the ontological meaning of a person's existence and hermeneutics (Pietkiewitz & Smith, 2014:8). Hermeneutics derived from the Greek word "to interpret" or "clarify" refers to the ability of the researcher to emphatically immerse into the responses and use his or her prior knowledge on the subject to add meaning to it (Pietkiewitz & Smith, 2014:8). During data collection, the PI acknowledge the role his or her socio-cultural backgrounds and past experiences are playing in shaping his or her deductive reasoning and interpretation of the participants' responses (Creswell & Creswell, 2018: 49). This explains why the PI does not bracket preconceived ideas on the phenomenon under study. Furthermore, hermeneutics prescribes a prior understanding of the phenomenon under study on the part of the researcher and the application of reflective listening skills during the interview process (Polit & Beck, 2010:269).

In hermeneutics, the emphasis is placed on essences and exposition by using lived experiences as a means of arriving at a richer understanding of the social, cultural, political, or historical context in which the person's experiences occur (Polit & Beck, 2010:263).

In interpretative phenomenology, Martin Heidegger does not value epistemology but views ontology as important - thus focusing on the science of the being/the true reality. He studies the concept of being in the world rather than knowing the world. In so doing, the core of hermeneutic philosophy moves beyond just describing the concepts related to an experience to searching for meaning embedded in everyday interactions (Reiners, 2012:1). De Chesnay (2015:5) states that the philosophy of hermeneutics

supports the notion that the essence of human understanding of “being in the world” is a result of how human beings interpret or add meaning to their experiences in the world.

Central terms to the thought of Heidegger's theory are the *lifeworld* referring to the fact that a person’s experiences are influenced by the world and *being in the world* emphasises the reality that the person is an invariable part of the world and can therefore not detach him- or herself from it (Lopez & Willis, 2004:724). Heidegger studied the concept of being in the world rather than knowing the world. In so doing, the core of hermeneutic philosophy moves beyond just describing the concepts related to an experience to searching for meaning embedded in everyday interactions (Reiners, 2012:1). Lopez and Willis (2004:729) stated that when using interpretative phenomenology, the researcher’s preconceived ideas and knowledge of the phenomenon under study are not bracketed but used to guide the interpretation of the participants’ responses (Lopez & Willis, 2004:729).

3.4.3 The research paradigm

A paradigm has four major components in metaphysics, these are methodology, quality, and ethics that determine the unfolding of the research process (Kafle, 2011:193). Kafle (2011:193) stated that the researcher’s decision concerning the adoption of a particular research method is influenced by his/her position on epistemological and ontological foundations. Whilst ontology refers to the study of the being (Cohen, 2000; Kafle, 2011:193), the term “epistemology” refers to the nature of the relationship between the knower and what is to be known (Laverty, 2003:12).

Phenomenological research falls within the naturalistic paradigm that holds the view of reality being fluid and based on subjective individual experiences (Reiners, 2012:1). The naturalistic paradigm, also called the constructivist paradigm, emerged as an opposing movement to the paradigm of positivism by authors such as Weber and Kant (Polit & Beck, 2010:16). Polit and Beck (2010:16) postulate that naturalistic inquiries hold the view of reality existing within a context and consist of the amalgamation of experiences of those who co-exist within the given context. The application of IP was deemed suitable to the study in question as it allows the PI to compare personal experiences against those of the research participants to enhance understanding of the phenomenon under study.

3.4.4 Study setting

A characteristic of qualitative research is that data collection occurs within a natural setting or the real world, referring to the context in which the participants have the experiences (Polit & Beck, 2010:261). The setting for this study was a central public hospital based in the Cape Metropole in the Western Cape province. The hospital is surrounded by a predominantly middle class Coloured population and on the other side a historically middle-class white community. The hospital also provides tertiary services to other communities in Eastern Sub-district such as Khayelitsha, a historically Black community, who have to travel 25- 3- minutes to access the service. The hospital serves a population of over 3.4 million people from the Northern Metro sub-districts, Khayelitsha - north of Spine Road, Eastern Tygerberg, the West Coast, Cape Winelands and Overberg rural districts. It recorded annual patient statistics of 107 215 patient admissions, 492 670 outpatient visits and 30 784 operations with an average bed utilisation rate of 87%.

The selection of a study setting was premised on the fact that the study population was larger in numbers which would increase the probability of finding suitable participants for the study. The PI also presumed that empowerment structures in central hospitals are established which will allow nurse managers to provide rich information on the phenomenon under study.

3.4.5 Study Population

The population for this study were nurse managers from only three tiers of nursing management employed at the study centre. The study population includes 89 operational nurse managers (Operational Manager (1st tier - the person managing the unit/ward), 10 assistant nurse managers (Assistant Nurse Manager) (2nd tier - the person who manages a group of wards or a complete discipline, e.g. all the surgical wards) and the deputy nurse managers (Deputy Nurse Manager) that concerns the 3rd managerial tier - managing clusters of medical disciplines (Tygerberg Hospital, 2016). The position of a nursing director in public service represents the fourth tier of the nursing management team. The nursing director was excluded from the study since the nature of the job is strategic and less operational.

3.4.6 Sampling

Interpretative phenomenology is concerned with getting rich descriptions of participant experiences, hence the reason why the sample in this study is rather small to allow for timeous and in-depth exploration, interpretation, and analysis of data (Pietkiewicz & Smith, 2014:9). Quality in a phenomenological hermeneutic analysis is attained through good, in-depth narrations during interviews that support the decision to involve only those participants to whom the phenomenon has relevance and those who are willing to tell their stories (Lindseth & Norberg, 2004; De Chesnay, 2014:160).

A purposive sampling technique was applied in selecting the study sample to ensemble a homogenous group of participants to whom the research problem has relevance and significance (Pietkiewicz & Smith, 2014:9). Written consent was requested from the South African National Health Research Database (NHRD) who referred the matter to the Research Unit at the study centre, hence the issuing of a letter of permission from the Research Unit at the study centre. A letter was drafted to the Director of Nursing to request approval to commence with sampling and data collection. The PI was referred to the Clinical Training Unit which appointed a Clinical Facilitator to assist with the sampling process. Nurse managers who were appointed within the position for a period longer than 12 months were eligible to participate in the study. The request was made to the Clinical facilitator for the recruitment of two Deputy Nurse Managers, four Assistant Nurse Managers and six Operational Managers of different gender and race. The clinical facilitator initially recruited participants and provided contact details with their consent. The PI also approached potential participants who are employed in the study centre for participation in the study. All the prospective participants received a narrative email message that provided a short introduction to the research study with a copy of the informed consent form as an attachment. Willing participants returned signed informed consent via email and agreed to suitable dates and timeslots for interviews. Interviews were set up by the PI using the Microsoft Windows Teams application. The initial recruitment drive included a sample comprising one Deputy Nurse Manager, four Assistant Nurse Manager and six Operational Nurse Managers who consented to participate in the research project. One Assistant Nurse Manager and one Operational Nurse Manager had to be replaced due to the voluntary withdrawal of two initial participants. Ethnic and gender classification of the sample included, two African Blacks (one female and one male);

one White female; eight Coloureds (two males and six females). The additional interviews brought no new insights which deemed the sample to be adequate since all themes referring to the enactment of empowerment, power to empower, barriers to empowerment and political interferences were saturated (Creswell & Creswell, 2018: 308). All interviews were held in the privacy of the work setting of the PI and participants.

3.5 DATA COLLECTION TOOL

Semi-structured interviews were held using an interview guide with broad open-ended questions which the participants had to answer. The interview guide (Addendum A) had three questions that were posed to elicit responses on the experiences of nurse managers on barriers and enablers to empowerment and subsequent advancement of nurses they supervise. Probes were used to explore interesting points thus resulting in richer responses from the participants. The PI and participants had an open dialogue wherein participants were encouraged to talk freely and openly without fear or blame.

3.6 PILOT INTERVIEW

A pilot interview serves as a test run to test the suitability of the interview guide. Performing a pilot interview allows for the identification of problems with question design and sequencing, recording procedure, and time allocation for interviews (Gray, *et al.,* 2017:405). The PI was coached by the study supervisor on the technique of reflective interviewing before completing the pilot interview. The interview guide that was used proved to be understandable with a lot of emphasis placed on the experiences of the participants. The pilot interview was held with one Operational Manager. The questions were clear as the participant understood them and related her experiences. However, the PI at times was unsure of exactly when to probe. Accordingly, the PI practised her interviewing skills with the supervisor before commencing the interviews for the main study. Since the data achieved during the pilot related to the study objectives, the data collected was included in the study.

3.7 DATA COLLECTION

The goal of the research is to rely as much as possible on the participants' views of the situation being studied, hence the posing of broad, open-ended questions that

allowed the participants to express them freely with the PI listening attentively to the respondents' narrations of their experiences of a phenomenon in a certain life setting (Creswell & Creswell, 2018: 48).

3.7.1 Preparation for data collection

3.7.1.1 Setting up of the interviews

Virtual interviews were conducted with all participants using the Microsoft Teams application since the PI resides in Upington. Participants had the freedom to select a convenient time and date for the interviews which were followed by an electronic invite from the PI.

3.7.1.2 The interview technique used

The interviews were conducted using the reflective technique of interviewing introduced by Carl Rogers in psychotherapy (1945). This technique is a form of in-depth interviewing using open-ended, broad questions to guide the participants in giving free accounts of their experiences on the topic under study (McGehee, 2012:380). Instead of just giving descriptive narratives of their experiences, respondents could talk about the essence of the phenomenon and their lived events without any judgement from the researcher (Pessoa, Harper, Santos & Da Silva Gracino, 2019:3).

When reflecting, the researcher applied the skill of active listening and echoing the crux of the participant's narratives to demonstrate her understanding of the essence of the responses. The echoing of the participant's responses was meant to probe for clarification, invite elaboration or changes to allow participants the opportunity to rethink the initial message (whether they indeed meant what they said) and agreement or affirmation from the participants (Ryan, Coughlan & Cronin, 2009:311). Carl Rogers, the founder of the reflective interviewing technique, felt it necessary that an interviewer must be in touch with his/her feelings and views on the topic under study (genuineness) and attempt to view the world from the participants' perspective (empathy) and regard participants' views as valuable (respect) (Boeree, 2006).

The PI had practical training in this technique in the first year of her studies as well as a short repetition with the supervisor using the Windows Teams application during June 2022. Typically, the reflective interview technique is posing an open-ended question like, *"Tell us more about your experiences of how you ensure the*

empowerment of those nurses you supervise". Depending on the responses that were given, probes were used to elicit deeper responses, instead of just merely following the interview guide in posing follow-up questions as stated. The use of probes allowed clarification of essences and the establishment of a rapport between the PI and participant, demonstrating a true interest in understanding the participants' experiences (Brink, 2006:152). Another strategy that was employed during the data collection process was intuition referring to the PI's immersion into the phenomenon under study to develop total comprehension (Brink, 2006:114). An audio recording with automatic initial transcriptions was done for each interview.

3.7.2 Collecting the data

Following the receipt of institutional permission to do data collection at the study centre on 9 May 2022, participants were recruited with the assistance of the staff in the Clinical Training Unit based in the study centre. Data collection commenced on 18 July and was extended until 16 September 2022 with virtual interviews that were scheduled through Microsoft Teams. The application enabled the recording and automatic transcription of all responses. The interviews lasted for 60 to 90 minutes and were mainly conducted in English with some participants reverting to Afrikaans to express themselves better on certain topics under discussion.

3.7.3 Data Management

Data management involves the process of reducing large portions of data to smaller manageable segments (Polit & Beck, 2010: 469). Data management started with the transcription of recorded interviews in their original version capturing the participants' own words and nuances (Grove & Gray, 2019: 84). Each transcription was reviewed by the PI by repeatedly listening to the interviews to ensure that all details were captured. A master with all real names were compiled, but pseudonyms were assigned to each participant on the transcribed responses. All the data was stored in a separate file on the PI's personal computer that is password protected and only known to the PI.

3.8 DATA ANALYSIS

Data analysis follows the collection process. In interpretative phenomenology, the analysis process is informed by hermeneutics (the theory of interpretation) assuming that the participants' responses represent their efforts of interpreting and trying to

make sense of their experiences in life, whilst the researcher employs the same technique of interpretation and making sense, but does so methodically and consciously (Smith *et al.,* 2009:3; Rodham, Fox & Doran, 2015:3).

The analysis process started with the repeated reading of transcripts and comparing them with the recorded responses and reflective notes that were made during the interview process. Moving back and forth between the transcripts, actual recordings and the reflective notes is named the hermeneutic cycle which demonstrates how the PI moves between parts of a phenomenon to build towards the whole (gaining a common understanding of the underlined phenomenon). These notes and transcripts formulate meaningful statements or themes that explain the essence of the phenomenon (Pietkiewicz & Smith, 2014:12).

Data analysis was done by adopting Van Manen's interpretative phenomenological approach. Van Manen (1942) is a Canadian-born philosopher who designed this approach for data analysis in an attempt to explore the participants' experience without bracketing or suspending the researcher's knowledge or understanding of the experience (Ritruecahi *et al.,* 2018:42). According to Van Manen, interpretative phenomenology refers to the conscious experiences of the research participants of a situation or event (phenomenon) and how they interpret the life they live and the experiences (hermeneutics) they have of this situation or event (Alase, 2017:10). Van Manen held the view that thematic descriptions of participant experiences can be isolated by either adopting a holistic, selective or detailed approach (Polit & Beck, 2010:475). The selective approach was adopted by highlighting statements from the transcripts that were viewed as important to the experience under study to formulate themes which became the focal point for reflection and interpretation (Polit & Beck, 2010:475).

Van Manen's thematic analysis is a four-step process aimed at exploring and gaining a deeper understanding of the meaning of the participants' experiences (Ritruecahi, *et al.*, 2018:42). These steps are explained as follows:

Step 1: Uncovering thematic concepts - the PI engaged with the transcripts by repeatedly reading them and comparing them with the recordings until an accurate version of the transcription was established. Areas for clarification and further exploration were identified. The repetitive reading allowed the PI to immerse into the

life world of the participant to gain deeper meaning and understanding of the experiences they narrated.

Step 2: Isolating thematic statements - The PI once more read through the transcripts, listened to the data recordings and reflected on them. The data was organised into codes/labelled to facilitate the building of themes. These codes were used to develop thematic statements by moving back and forth between the code, the theme and the data to capture the essence of the participants' experience and arrive at possible answers to the research questions (Creswell & Creswell, 2018:301).

Step 3: Composing linguistic transformations - At this stage, the PI changed thematic statements into paragraphs that clearly outline the underlined essence related to the phenomenon under study. This process was done with the assistance of the study supervisor. Themes were rewritten and rechecked against the narratives of the participants on the transcripts.

Step 4: Gleaning thematic descriptions - Descriptive explanations of the themes were formulated whilst still maintaining the essence of the phenomenon under study. Selective portions of the transcripts were grouped to substantiate the themes that were formulated (Ritruecahi *et al.,* 2018:42).

3.9 RIGOUR OF THE STUDY

Rigour refers to the quality of the research project concerning the accuracy and thoroughness applied throughout the research project. The quality of the study was evaluated by using the criteria of trustworthiness named credibility, dependability, conformability, transferability and authenticity, as proposed by Guba and Lincoln (1985, 1989, 1994) (Polit & Beck, 2014: 323). An explanation of each is provided coupled with strategies of how it was maintained throughout the study.

3.9.1 Credibility

Credibility refers to the aspect of the believability of the data collected and the interpretation thereof. In qualitative research, the PI has the responsibility of assuring confidence in the data that was collected (Polit & Beck, 2010:492). Several strategies can be employed to establish credibility in the research process. Member checking is such a strategy that was applied using the technique of summarising and reflection by echoing the participants' responses to ensure that both have the same understanding

of the responses given. Peer debriefing was done after each interview by the research supervisor to critique the interview, thus ensuring external validation of the study (Polit & Beck, 2014:330). The interview sessions lasted more than 60 minutes to allow for an in-depth understanding of the participant's responses (Polit & Beck, 2010:495). Participants were issued with the transcripts of the interview sessions to authenticate them.

3.9.2 Transferability

Transferability is parallel with the term "generalisability" and refers to the applicability of research findings of a particular study to other settings or groups (Polit & Beck, 2010:492). Transferability of research findings was assured through a detailed descriptive report on the research process, the method of data collection and analysis and the findings (Polit & Beck, 2010:493). Sampling and interviewing continued until no new information emerged. Furthermore, the truth value of the study is enhanced by using a conceptual framework to guide the research methodology applied in the study as well as providing a framework for data analysis and reporting on the findings (Lopez & Willis, 2008:730).

3.9.3 Dependability

Dependability refers to the reliability of data over time and circumstances, thus demonstrating that a repeat of the study with the same participants within the same context will yield the same results (Polit & Beck, 2010:492). The conduct of audit trials by the designated supervisor and additional credible researchers can verify the dependability of the research study by evaluating each step of the research process, which includes data analysis, for accuracy (Ravers *et al*., 2020:4). The same interview guide was used for each participant although probes differed. A detailed report of the research methodology and process is included in the research report.

3.9.4 Confirmability

Confirmability refers to the alignment or congruence between the findings of the study and the raw data, e.g. the recordings (Polit & Beck, 2014:429). Accordingly, the researcher and supervisor assure the confirmability of the study findings by reviewing the transcripts and actual audio recordings of the interviews together with field notes to ascertain that they correlate and are congruent. Confirmability was strengthened

through the application of a hermeneutic analysis method, i.e. repeated references between the recorded responses, transcripts, reflective notes, and themes.

3.10 ETHICAL CONSIDERATIONS

Protecting the rights of the participants and society at large is a cornerstone for the enforcement of an ethical code for health care research (Polit & Beck, 2014:177). The study adhered to the three broad ethical principles of beneficence, respect for human dignity and justice, as articulated in the Belmont Report (1978) (Polit & Beck, 2010:119).

3.10.1 Ethical clearance

Ethical clearance for the study was received from the Health Research Ethics Committee of Stellenbosch University following the submission of the research proposal on 1 January 2022. The study was then registered on the National Health Research Database, followed by institutional approval for the use of the study centre that was granted by the Western Cape Department of Health on 9 May 2022. Written permission to commence sampling was submitted to the Nursing Director's office on 30 May 2022.

3.10.2 Beneficence - minimising harm

Beneficence is one of the primary ethical principles of the Belmont Report (1978) that obligates the PI to ensure that the research project holds maximum benefits and very little harm to the participant. The study had a low risk of possible harm. Talking about issues of empowerment and barriers to the realisation thereof could be distressing for some participants, hence the insistence of the PI to start all the interviews by reassuring the participants that it is not a form of interrogation or fault-finding project, but a mere search for information to write a research report. During the interviews, issues related to leader autocracy and lack of decision-making power were apparent, but participants were allowed to express themselves freely without becoming distressed. No signs of psychological distress or scarring were evident during all the interviews.

There was a plan to refer those participants who would become emotionally distraught to the Employee Health and Wellness centre situated in the hospital (ICAS). This service has psychologists and other health professionals on staff. The referral would

be facilitated through the Clinical Training Unit which was assigned as the official liaison office between the PI, participants and the Nursing Director.

3.10.3 Respect for human dignity

Respect for human dignity is the second broad principle in the Belmont Report (1978) and refers to the right to self-determination and respect (Polit & Beck, 2010:122). Self-determination or autonomy refers to the participant's right to make decisions voluntarily and independently. The ethical principles of autonomy and respect for persons were adhered to by including full disclosure of the research study, the possible risks, and benefits on the written consent form to enable the participants to make an informed decision on their participation in the study. Consent forms were signed for voluntary participation and recording of responses at leisure and under no duress. Participants also had the right to withdraw from the study at any stage if they so wish without fear of intimidation.

3.10.4 Justice

Justice is the third principle from the Belmont Report (1978) that speaks to the participant's right to fair treatment and privacy (Polit & Beck, 2010:124). The sample selection was fair according to a predetermined criterion. All participants received an electronic instant cash voucher in the amount of R200 for participation in the research. Consent forms, data recordings and transcripts of interviews were only managed by the PI. Each transcript, recording and consent form were identified with a number that was issued to each participant. The name of the study setting did not reflect on any documents and is not mentioned in any reports on the research outcomes.

The English language was the medium of communication throughout the entire research process as it is the language commonly used as a teaching medium in the Western Cape.

3.11 SIGNIFICANCE OF THE STUDY

The study sought to explore the experiences of nurse managers on the barriers and enablers to the empowerment and subsequent advancement of nurses. Nurse managers are leaders to lower categories of nurses who, by their positions, have the power to play a meaningful role in the empowerment and subsequent advancement

of nurses. According to Trus *et al*. (2017:337), nurse managers have the power to be efficient and autonomous in their jobs as well as the power to influence others by setting an example of confidence and efficiency. Nursing managers have a responsibility to create a positive practice working environment through the provision of structural conditions that support nurse empowerment and advancement (Ta'an, Alhurani, Alhalal, Al-Dwaikat & Al-Faari, 2020:635). Leaders mediate with followers on issues such as the availability of resources, facilitate access to opportunities and support efforts towards the attainment of organisational goals (Bamford-Wade & Spence, 2012:191). The findings from a South African study indicated that good governance, excellent managerial skills and effective communication skills are the skills that are lacking in South African leaders (Govender *et al*., 2018:165). Legislative frameworks such as the EEA and SDA are promulgated to enable empowerment in the workplace but are often not implemented correctly due to challenges such as resource constraints and cadre deployment, leading to poor governance and leadership (Tshishonga, 2014:891).

The PI could not find previous studies on barriers to the empowerment and advancement of nurses that were conducted in the Western Cape province in South Africa. The study findings can contribute towards changes in institutional empowerment policies as well as being incorporated into nurse management training both on a formal and informal platform. Knowing the enablers and barriers that influence the empowerment process can allow the nurse manager to be better equipped in managing them and mitigating adverse outcomes.

3.12 SUMMARY

The study adopted a qualitative design with an interpretative phenomenological approach. The objectives of the study were threefold. Firstly, the study endeavoured to gain an understanding of how the hospital's empowerment structures facilitate nursing staff empowerment and career advancement. Secondly, the emphasis was on exploring the experiences of nurse managers in their role of providing nurses access to power structures in the workplace and lastly, to get insight into the possible barriers to nurse empowerment and advancement that may exist in the hospital.

This chapter included a detailed discussion of the research methodology that was adopted. The study centre was a central public hospital in the Cape Metropole in the Western Cape. The study population was nurse managers from the three tiers of nurse management from which a sample comprising six Operational Managers, four Assistant Nurse Managers and one Deputy Nurse Manager was selected to participate. Sample selection was done by both the PI and a Clinical Training Facilitator that was assigned by the office of the Nursing Director. Data collection took the form of virtual interviews with all 11 participants using Microsoft Teams and an interview guide containing three open-ended questions and relevant probes. Van Manen's (1942) four-step process of thematic analysis was applied during the analysis of the data. The three broad ethical principles of beneficence, respect for human dignity and justice were applied throughout the research process.

In the next chapter, the findings of the data analysis are discussed.

CHAPTER 4
FINDINGS AND INTERPRETATION

4.1 INTRODUCTION

The previous chapters respectively concern an overview of the study, a detailed synthesis of all available literature on the phenomenon under study and a discussion of the research methodology that was adopted throughout the study. This chapter contains a presentation of the data that were collected during the semi-structured virtual interviews. The data were analysed according to the method proposed by Max van Maanen. This process is explained in Chapter 3, but in summary, included the following steps.

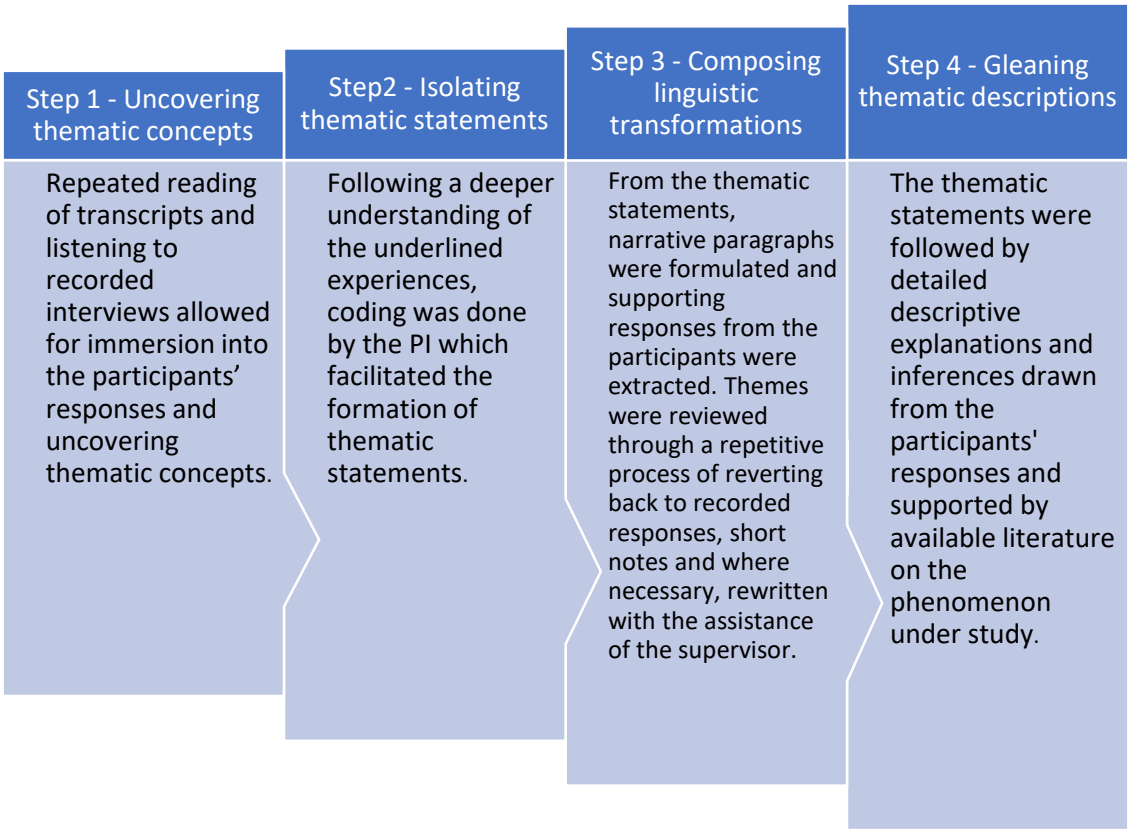


Figure 5: Process flow in Max van Maanen's process of data analysis

The discussion of the findings commences with a presentation of the demographic data of the participants followed by the themes and subthemes that emerged from the data.

To conform to the principle of confidentiality and privacy, the transcripts and consent forms of each participant were identified in numerical terms e.g., “Participant 1”. All findings were supported by verbatim quotes from participants. For ease of reference, the word junior manager refers to the operational manager (OPM, official job title); middle-level manager refers to the assistant nurse manager (ANM) and the senior manager refers to the Deputy Nurse Manager (DNM).

4.2 SECTION A: BIOGRAPHICAL DATA

A total of 11 managers were interviewed which included three males and nine females. In terms of race, the participants comprised of one White, three Africans, and seven Coloureds. The difference in nurse management ranks included one Deputy Nurse Manager, four Assistant Nurse Managers and six Operational Nurse Managers. All participants were appointed for more than 12 months in their respective positions. With the exclusion of the Deputy Nurse Manager, all other managers were appointed between October 2019 and June 2021, a period of fewer than five years, thus rendering them as being relatively new in their appointed positions.

4.3 SECTION B: THEMES EMERGING FROM THE INTERVIEWS

Four themes and 17 subthemes emerged from the data. The themes and subthemes are displayed in Table 4.1.

The interpretative phenomenological approach allows for the expression of the PI’s preconceived ideas on the phenomenon under study and related essences. The discussion on the findings per theme is preceded by a statement on these preconceived ideas followed by a narrative on the findings and relevant quotes from the transcriptions of the interview recordings that were made.

Table 4.1 - The themes and subthemes that emerged from the data

Themes	Sub-themes
Enactment of Empowerment	Significance of empowerment
	Opportunities for development
	Structures of support
	Information sharing
	Access to resources
Power to empower	Training of managers in their roles
	Decision-making powers
	Shared governance
	Performance appraisal
Barriers to empowerment	Resource constraints
	Autocratic leadership
	Staff attitudes towards empowerment
	Changes in nursing curriculum
	Generational diversity
Political factors	Prejudice in the workplace
	Politics in hospital funding
	Cultural issues

4.3.1 Theme 1: Enactment of empowerment

Preconceived ideas from the PI: *All nurse managers are aware of the empowerment structures that exist in the workplace and acknowledge their responsibilities towards their subordinates in terms of enabling empowerment. Nurse managers are also familiar with the vital role that staff empowerment plays towards employee productivity and the realisation of organisational goals.*

4.3.1.1 Sub-theme 1: Significance of empowerment

The participants accentuated the importance of providing their staff access to empowering structures which included applying for formal nurse training and attending generic and external short training sessions. They demonstrated their determination in ensuring that their staff members have the necessary information on available internal and external training and assisting them in accessing those. A middle-level

manager (Assistant Nurse Manager) stated that nurse empowerment is necessary to enhance a nurse's knowledge and skills. By enhancing job knowledge and skills, a nurse's job performance improves, which translates into improved patient care. This fact fuels their continued motivation and insistence on nursing staff to make use of available training opportunities where and whenever possible.

> *"There is always learning opportunities for us as nurses and one have to use the platform. And in order for them to become a better nurse, they will be, they will also be able to treat their patients because if they are exposed to more knowledge and to become a better nurse, there is so much out there and we as nurses, as assistant managers, we have to keep our ear on the floor to see what is there we can do for our, for our staff."* (Participant 9, female, middle-level manager).

A junior manager (Operational Manager) emphasised the fact that continuous staff development and training is important for personal and professional growth and also to remain abreast of the latest developments in nursing. To participate in continuous learning, the nurse managers introduced ward-based training sessions that are either based on the subject matter or other health-related topics. The principle of peer learning is applied in the nursing units with all categories of staff taking part in presenting training.

> *"They can just be nurses like enrolled nursing assistants that have a very a lot of experience. So I used them to be the ones that will be mentoring and also showing the ropes to the new ones that comes. So, when it comes to orientation of staff, those are the things that I don't really worry myself a lot about. They are the things that I give to them because I know that this is, this is, they orientated me, so I trust them fully with that. So that is where they take charge of that. They know, sometimes they don't, sometimes even new person comes in and I'm busy with something, someone take that person and they go on with that person and orientate them."* (Participant 6, female, junior manager).

Junior managers emphasised the importance of nurses being psychologically empowered to be able to recognise and explore structural empowerment opportunities for personal growth. The nurses in the units had to be motivated by their managers first before they could meaningfully participate in the empowerment process. One junior manager used her personal story to motivate the staff whilst another junior manager relied on building self-belief amongst the nurses to move them to participate

in empowerment initiatives in the hospital. Responses from two middle-level managers referred to the psychological benefits empowerment holds. One middle-level manager shared the experiences of nurses who attended training presented by Metropolitan that left them feeling rejuvenated and relaxed. At these places of training, the staff members were exposed to other individuals and could start to network to build new relations with their peers from other units. A senior nurse manager (Deputy Nurse Manager) also mentioned how on-the-spot teaching efforts affected the morale and confidence of the staff.

> *"You, you will gain something by coming to listen to, to train, to give your input, and you, you maybe some of them don't see it, but I it's already a stress reliever… Getting away, getting your, you a fresher view. You don't even need to talk sometimes just on…on patient care, that's maybe the, the last thing for some of them at that moment to give them a lecture on. We had quite a few Metropolitan sessions, which isn't part of the training unit sessions. The feedback that we got was people are sometimes just want to get away from the floor, see each other in a different light. Specifically, if, if you have different staff together. And then they leave there with new vigour..."* (Participant 5, female, middle-level manager).

A middle-level manager stated that junior managers must be exposed to a higher level of information and skills to allow them to ascend in their careers. The senior nurse manager indicated that they prioritise the training of the nurses who are placed in speciality units to meet the demand. This decision implies that more professional nurses will have the opportunity to acquire a higher qualification which will put them in the speciality stream of nursing. According to OSD, the successful completion of a speciality post-basic course leads to translational promotion in rank and salary. A junior manager added to the empowerment discourse stating that she would engage with her staff to make them aware of the benefits of self-actualisation, personal and professional growth and career advancement.

> *"I don't force anyone. It's OK. No problem, you know, because at the end of the day, it's not something that you are suppose it's all about you as a person, how far do I want to go? Where do I see myself in five years? I would also want to be an OPM. So for me to learn some of these things, you are also learning some, taking responsibility, taking charge. So when you get to that level, you are already mature*

and then you can be able to get to where you want to be." (Participant 6, female, junior manager).

4.3.1.2 Sub-theme 2: Opportunities for development

The hospital provides nurses with opportunities to access training and development through formal and informal training structures. The formal training is mandated and funded by the Western Cape Department of Health and the informal training is a hospital-based initiative. The formal and informal training (both from internal and external providers) are coordinated by the Clinical Training Facilitators that are stationed in the Clinical Nurse Training Unit. The formal training programme is done at the Nurse Education Institutes. The Clinical Nurse Training Unit liaises with the NEIs on any matters that are related to student training.

Formal training structures - The participants indicated that access to the formal training opportunities is subjected to a strict selection process according to predetermined criteria, hence the staging of mandatory processes of selection and adjudication of prospective students at the hospital level. Nominations and motivations from managers of prospective candidates are received from all the wards and discussed in the adjudication meetings. A junior manager alluded to the fact that the process of nominating prospective students at the unit level is open and transparent meaning that all staff members can apply. However, the number of nominees per unit is restricted. The same manager provided further information on how the selection and adjudication process unfolds at the hospital level. She indicated that the nominees from the unit level enter the pool of prospective candidates from the department. These candidates are scrutinised at the adjudication meetings according to the predetermined criteria that are stipulated in the hospital and provincial study by assignment policy. A junior manager indicated that the principle of anonymity is applied during the adjudication process to eliminate any form of bias. The hospital stages the first round of adjudication followed by the submission of selected candidates to the head office where final adjudication takes place.

"… the way it works here we get all the study leaves. All the operational managers get the study leave forms in. And everybody that wants to study I, the way I worked is I gave everybody that wants to study, I gave a form, I didn't pick this one and that one. So what we end up doing is we get all the study forms. Then we set as a module. To

> *see because then they will say they will. Can we send, two enrolled nurses to study for R171, three RPN' for ICU, two for, for administration. So then we'll have to sit with all of that and go through the criteria and to see who qualified because they said there's a certain paper we have to, to rate the people. So you must fall in a certain percentage to even go, go be considered for the shortlisting."* (Participant 10, female, junior manager).

A junior manager indicated that the criteria included aspects such as years of service in the unit, employee attendance record, number of times the nurse applied, compliance in terms of NQF level, and compliance in terms of subjects and grades. The selection criteria did not include the recognition of prior learning (RPL) which posed a problem since the hospital had fewer professional nurses with a basic degree qualification that could qualify. Despite this, the senior nurse manager still motivated nurses to proceed in applying to the NEI and transferred the responsibility of deciding on the nurse's fate to the NEI.

> *"Due to the fact that the NQF level of people was taken into consideration, so people with a lot of interest to go and do these advanced training have a little bit of a setback and we are waiting on the recognition of prior learning to…to prioritize these people because at the moment we do not have a lot of people who did the basic training at a degree in the basic training. Most of the people that are currently here have got a diploma. But nevertheless, if we don't approve their application due to the NQF level or whatever the case might be, we motivate them to apply at the universities and at the university from their side decide no you, you, you are not approved.*" (Participant 3, male, senior manager).

Informal training structure - Based on the responses from the participants, the informal training structure at the hospital seems to be well established and has an annual training programme that is communicated to all the staff at the hospital. The content for these training sessions are informed by the training needs that were communicated through the performance appraisal system. The clinical nurse training unit staff compile the annual internal or generic training programme in the hospital and communicate such information to the managers. A junior manager deemed these sessions to be appropriate and accessible to all nurses.

> *"We do have now proper structures now and they are accessible to nursing categories especially our training unit for example we have a new head of training, you can see now they're more active now. They always disperse information regarding to what's new topics for the month and so forth. We have new appointees now, so everybody has brought in new ways of, of making sure that nurses get trained, you know I can really say the structures are quite accessible now and, and quite, quite appropriate also."* (Participant 1, male, junior manager).

Some managers pointed out that informal training involves more than just sitting down at an in-service training session. The managers employ various methods of developing their staff and expanding their knowledge. A senior manager mentioned that routine ward activities can also be educational for nurses. Another middle-level manager referred to the introduction of ward-based training which includes product training that is presented by either the CNTU staff or representatives from medical companies. A junior manager referred to the use of social media and other platforms to share educational material with the nurses that they can engage with in their own time. The older method of compiling a monthly ward training plan and recording it on the training record is still applied by most managers. Some managers referred to on-the-spot teachings during their monitoring rounds in their units.

> *"I would normally download a video or something and then we share on the Internet and then whatever that is out there, circulars and all of that. I also print them out and then we read. I prefer like for us to sit here and we read it out because sometimes you give people and then they don't go and read and then they miss the certain kind of information."* (Participant 10, female, junior manager).

Participants reported that the CNTU communicated different nurse training dates for the various clinical departments. Several managers told the principal investigator that they are experiencing problems with the days and times of these planned pieces of training, but have not been able to address such issues with the CNTU. There is a perception that the logistics around the planning of training interventions in the hospital are done by the CNTU staff solely without inputs from the managers in the clinical units. According to the nurse managers, exclusion from the planning of training dates contributes to the non-attendance of in-service training sessions. A process of consultation between the clinical training unit and the nursing units is deemed

necessary to improve staff attendance amidst the human resource challenges and service demands that all units are faced with.

> *"I said to my colleagues and I just speak to the training department to maybe alter the times over the training and they also have their stuff that they must do in the morning … because I really want the staff to go to this training."* (Participant 10, female, junior manager).

Throughout the interviews, the participants bore testimony to the existence of a well-established structure for formal and informal training that is appropriate and accessible to nurses in the hospital. However, there was a sentiment shared by two higher-ranking nurse managers that the training provided by the CNTU does not meet the needs of operational managers. Therefore, both of these managers arranged other informal training sessions exclusively for operational managers. Although only one of these programmes was approved by top management, such interventions indicate that senior nurse managers have the power to initiate informal training where they see the need.

> *"The, the operational manager wanted to know, how do I handle union representatives, if they come into my office. That was the need. So we ask our Labour Relations department to give specific training within their training programme to our operational managers. Uh, you know to make them ready for when the Union members will come to their office."* (Participant 3, male, senior manager).

4.3.1.3 Sub-theme 3: Structures of support

All participants made a convincing argument on the support they provide to the nursing staff in terms of accessing empowerment structures in the workplace. This is evident from the active encouragement they gave to the staff to utilise training and development opportunities, approving study leave for nurses, giving written motivations for staff to enter formal nurse training programmes and scheduling staff to attend training internally as well as externally. A senior nurse manager alluded to an incident of having to request funding for unit management training from an external provider that would assist operational managers to understand their roles.

> *"We had, a we had a challenge with newly appointed operational managers. And we were looking for a course that specifically curtailed, not a course that, not a nursing*

> *management course, but a course that can help the operational manager to be super functional within her department. And we had a…a…an agreement with some institution who had it, was a private institution. They had their operational managers trained in certain things."* (Participant 3, male, senior manager).

The participants lend their support to the staff by physically engaging in clinical work. Several nurse managers voiced their support to nurses in terms of working in the units when there are shortages of professional nurses. They will then physically do clinical nursing to support the staff in executing their daily responsibilities. Often, they would have to attend to their normal duties as well whilst being allocated to the floor. Others had routine rounds in their units where they would support staff in executing their tasks and even do on-the-spot teaching.

> *"And I also do my regular visits inside theatre, just in the morning to see, Is everything OK? Assist with opening packs. Help the scrub sister put the patient on the table. This is also part of training. See if the sister knows the instruments. See how can I assist?"* (Participant 9, female, middle-level manager).

One middle-level nurse manager acknowledged that the nurses are working under very difficult circumstances that often leave them feeling demoralised. They end up being demotivated and not very keen on participating in any empowerment activity. The manager stated that the CEO of the hospital communicated the strategic plan for strengthening the workforce. This nurse manager lends her support to the nurses by emphasising that the strengthening of the staff should be geared towards the nurse (carer) and not merely increasing the staff complement in numbers. Realising the reality of budgetary restrictions, she suggested the introduction of a reward system and regular debriefing sessions to allow staff to offload and release stress. A middle-level manager from another clinical area reported that she engages in informal small-talking sessions with nurses where they are allowed to voice their feelings. Such initiatives create a perception that the nurse manager cares and values them in the workplace.

> *"I want the staff to engage and to get the lighter part of, of working is not just working, even if it is just debriefing sessions … in the beginning of the year, the CEO said, he want to strengthen the workforce so. I mean, strengthening the workforce does not just mean if we do it in numbers. We we want to, for me to strengthen the workforce is to*

strengthen the person in himself, with a feeling I'm wanted here. You, you are valued. It's not just working a 12 hour shift without. Getting a recognition other than tiredness … Staff do get demoralized. They not motivated at times because it doesn't seem like there's more than, than work inside here for them." (Participant 5, female, middle-level manager).

4.3.1.4 Sub-theme 4: Information sharing

Participants highlighted that sharing information with their staff ensures purposeful cooperation towards the attainment of organisational goals. Having the required knowledge of their job requirements and the hospital's strategic objectives will assist them to identify their roles in the hospital. Some nurse managers used conventional means of disseminating information on notice boards and in communication books, while others opted for the use of social media through WhatsApp groups and emails. The middle-level and senior manager indicated that they would attend unit or departmental meetings or talk with the nurses at the bed side as a control measure to ascertain whether information was filtered to all target groups.

> *"… all the communication that comes from management level. I have to escalate down to the officers working with me on ward level. Uh, I'm so it comes like e-mail to me and via a communique. So then I have to distribute it and inform everybody."* (Participant 4, female, junior manager).

A middle-level manager alluded to the role generational differences play in the receptivity and processing of information. She alluded to the fact that older staff members are selective in listening and only hear what they want to hear. The younger generation needed to receive more detail in the message they receive to move them to action. Therefore, as a nurse manager, one had to be aware of the generational age of the audience the information is targeting to adjust the method of information sharing accordingly.

> *"Where you go with your information that needs to be shared, your older generation is very much you know. It's there, they've done it. They've gone through it. Your younger generations. They they want the information … So you have them stuck in their roles for quite a time. So first of all, they think they know everything. When you want to share information with them, they kind of decide, OK, this is relevant or not relevant."* (Participant 11, female, middle-level manager).

4.3.1.5 Sub-theme 5: Access to resources

Availability of material resources: The participants indicated that the change in formal nurse training brought a new set of admission requirements with a change in the application process from manual to electronic. Prospective students were required to apply online using basic computer skills that were absent among older employees. Another important factor is that since the Covid pandemic, virtual training became a phenomenon and is still prevalent nowadays. The nurse managers mentioned the fact that the hospital has limited computers available for staff members to utilise for these purposes. A middle-level nurse manager mentioned the existence of an HR training facility within the hospital that has computers installed but is off-limits for staff to use for anything other than training.

> *"… now after Covid, everything is back on track. It's nice and so, but some of the, the in-service training and formal training is online. And some nurses really struggle to do it online because they're not computer literate."* (Participant 8, female, junior manager).

The reality of increased reliance on virtual training required a certain level of computer literacy from all prospective users. The participants indicated that not all staff are computer literate and need assistance to navigate the device to either access training opportunities, communicating with staff via emails or applying for admission to NEI's for formal nurse training. One junior manager opted to give informal training on the use of the computer at unit level to her staff, although not all the staff obliged. It was for this purpose that the Clinical Nurse Training unit was motivated to establish a computer laboratory with internet connectivity that would allow nurses access to virtual training, apply online for admission to training courses as well as access information on the global information network.

> *"The training unit don't have yet PC's resources available that they have been asking for quite a few a long time now from Finance department. They have a specific room available. It will be like a training hub, next to the training unit where they have the skills lab, but specifically a computer setup. Designed with the latest technology and Internet access, which is the most important to have. That is also what, what they had on their plans, but currently this year they didn't succeed in yet getting the…their resources."* (Participant 5, female, middle-level manager).

Availability of time: The participants indicated that all units receive training programmes from the CNTU with information on the training topics for the month, the date and time schedules as well as the target audience. Nurse managers must only plan their ward activities in such a manner that they ensure that they avail staff to attend these sessions. The same applied to short external training courses that would require staff to be nominated by their managers and approved by the middle-level managers. The time spent at these training sessions is regarded as official working time meaning that the staff do not owe the employer any working hours nor do they have to take annual leave to attend training.

> *"So, ideally when the training when the training roster go out to the area. You would expect that because off duties are planned ahead and we all know where planning started starts with your total available resources. Everyone don't go the same time on leave and that's why you you must have you. You should have planned before the time."* (Participant 5, female, middle-level manager).

Availability of human resources: The operational manager has the responsibility to indicate the availability of nursing staff to attend either internal or external training sessions. Attendance of any training session is regarded as official working hours. Relief staff are appointed on contract during the absence of all full-time nursing students from their points of service. However, extra nursing staff are not booked to replace nurses who are scheduled to be away from the unit for short courses or attending the generic in-service training sessions.

> *"We do regular in-service training in the unit and. Usually when there are generic training day in the advisor, I asked if usually it's the unit can be very busy. So sometimes I can't send anybody due to operational needs and sometimes I can send two people for the for the hospitals in service training. But other than that I motivate staff."* (Participant 10, female, junior manager).

Availability of funds: According to the participants, the formal training of nurses is funded by the provincial health department that, based on available funding, decides on the number of prospective students that can be funded for further training per health establishment. The allocations for prospective students are made per nurse training programme. All health establishments are compelled to select only the number of students as predicated in their allocation. The Provincial department also avails

funding to appoint relief staff on contract to replace those nurses that are on full-time training.

> *"I know last year only one candidate was allowed to, to go for or was approved to go and study due to financial reasons, they say. So, for instance, they were 500. If you can imagine for [name of study centre removed], but only one was approved to go due to financial constraints, they said."* (Participant 8, female, junior manager).

The hospital has a functional skills committee that makes final decisions on requests for funding external training which excludes the formal nurse training that is offered by Nursing Educational Institutions (NEIs). Some participants were able to access such funding following a formal process of application to the skills committee and the attachment of a detailed motivation. Such requests must first be recommended and approved within the department before they can be presented to the skills committee for approval of funding.

> *"We have got a skills development plan which are drawn up where we have a meeting or request a training need from all staff working in the department and from that motivation, HRD would know what is the main priorities and would negotiate that people have that specific training according to the budget that have been allocated."* (Participant 3, male, senior manager)

4.3.2 Theme 2: Power to empower

Preconceived ideas of PI: *Nurse managers are not properly trained to efficiently execute their responsibilities regarding staff empowerment. The hospital has a rigid nursing hierarchy that clings to power and allows little flexibility for independent decision-making or display of power by lower-level nurse managers on issues of empowerment.*

Nurse managers have the responsibility of managing operations in clinical units, thus explaining the requirement of autonomous decision-making, having and executing the power to lead others.

4.3.2.1 Sub-theme 1: Training of managers in their roles

Junior managers from the same discipline expressed the fact that they were not oriented or had a mentor assigned to them since their appointment, whilst their peers from other disciplines had mentors and undergone orientation. The lack of orientation

had the managers make use of peer learning to gain a level of efficiency in their daily operations.

> *"When I started as the as the operational manager, there wasn't even orientation given to me, I had to ask around and am I depended very much on. We didn't have an area manager. Also, at the time it was just somebody that stood in so I had to rely on her to, to help me through. She was also quite busy getting to know that the work that she must do being a stand in area manager. So it was a difficult year."* (Participant 7, female, junior manager).

A senior manager stated that top management acknowledged the shortcomings in the leadership skills of newly appointed operational managers, hence the investment in training initiatives to address the shortcomings. Requests for training in unit management and management of discipline were tabled to the Head of Nursing and approved. The approved request was submitted to HRD for presentation at the Workplace Skills Committee where approval of funding was done. The training sessions were conducted by an external service provider in the hospital.

> *"... we could have seen that the younger operational managers are not so exposed to what the experience operational managers were exposed to….and we were looking for a course that specifically curtailed, not a course that not a nursing management course, but of course that can help the operational manager to be super functional within her department. We had an agreement with some institution who had it was a private institution."* (Participant 3, male, senior manager).

One junior manager related an experience with a junior professional nurse who was insubordinate and insolent. She communicated a need for guidance in the management of the situation to her immediate supervisor who could not assist her in this regard. The senior managers observed the shortcomings and liaised with the Labour relations department to conduct training sessions with the nurse managers on the management of labour unions.

> *"The, the operational manager wanted to know, how do I handle union representatives, if they come into my office? That was the need. So we ask our Labour Relations department to give specific training within their training program to our operational managers." (*Participant 3, male, senior manager).

Another middle-level manager indicated that she encountered a problem with a junior nurse manager who expressed his difficulty in implementing discipline in his

unit. She indicated that the nurse managers had training on the management of discipline in the workplace shortly before this incident. She resolved to mentoring the nurse manager individually to ensure his development in this regard.

> *"You I had actually challenge a few months ago. Where you the person was send for different managerial courses. He doesn't like to be in uncomfortable positions. I send him for the formal courses. All the formal courses were done successfully, but now we have this one-on-one sessions with dealing now and and it's like you I had to dissect now." (*Participant 5, female, middle-level manager).

The need for training on the NQF alignment of the new nursing curriculum and the implementation of the study policy came through quite strongly from some junior managers. Even the senior manager stated that they were not fully ready for this process at the time. Updated knowledge of the study policy and the admission requirements to formal nurse training programmes is vital for the first-line managers as they are expected to support and guide the nurses through the application process. Wrong interpretation of the policy may cause nurses to miss out on opportunities to advance their careers. Such an outcome can adversely affect manager and staff relations and have staff morale plummeting/decreasing.

> *"I suggested to my colleagues that we must really, before we do the, the study leave applications and stuff like that before we can even train our staff, we must go for a workshop or something like that, or even the training unit can help us with that. To explain exactly what is expected of the applicants and that will give the the applicants a chance to meet the necessary requirements".* (Participant 8, female, junior manager).

4.3.2.2 Sub-theme 2: Decision-making powers

The junior manager or operational manager has the direct responsibility of managing the nursing unit or ward. Their responsibilities and authority are restricted to the single unit or ward. The operational manager can make decisions on the ward or unit operations without needing approval from the next level of management. The middle-level manager is the immediate supervisor of the junior or operational nurse manager who is responsible for the delivery of nursing service within the discipline or area (Emergency Services or Internal Medicine, etc.). There are three to four wards or units falling within a discipline that the middle-level or assistant nurse manager supervises. The next level of management is the senior-level manager or Deputy Manager of

Nursing (DMN) who is the immediate deputy of the Director of Nursing. The DMN manages a group of disciplines or areas as per hospital policy. Decisions made at the level of an AMN must be approved by the DNM especially if there are finances involved. Any other operational decisions such as staff rotations are made by the manager him/herself. Throughout the interviews, the participants emphasised the fact that they have very little power. It was clear that junior managers have no power to manage the budget of their units. Approvals for overtime utilisation are done by the senior manager but operational managers must monitor the unit's expenditure and report on over- or under-expenditure. This reality was evident in the disapproval of a middle-level manager's request for junior managers to attend training. The participants also mentioned that feedback from the senior and top nursing officials on the outcome of tabled requests was very vague.

> *"To be honest, we have not much power but sometimes I will stand up for my staff, forcing them to, to, to send me additional stuff. Like we not, we have so many restrictions like we can just make a decision. We must run it by our area manager of nursing, you understand, which is not a problem. It's just sometimes it feels like we're not recognized. Sometimes I just feel. I want to make a decision. It's, it's actually a simple thing, but now it's becoming a frustration because I'm as a running through a lot of people just to get approval."* (Participant 5, female, junior manager).

Despite the expression of feelings of powerlessness by some participants, there was still a middle-level manager who acknowledged that she can use her positional power to influence the empowerment of the nurse subordinates. She maintained this positive spirit even though her request to empower the professional nurses in her unit was disapproved. She showed real determination to continue motivating her staff and ensuring that they are developed by advocating for them at the top management level. This feeling was echoed by another middle-level manager who felt that despite the reality of demanding workloads and staff shortages, nurse managers must still motivate and advocate for their staff to gain access to training and development.

> *"I use it (positional power) to the maximum ability that I have. Where it is whether it is emails to my deputy and sometimes my senior nurse manager where I will motivate and illustrate to them what are the needs at the current moment of my staff. You know, uh nursing is very broad and you cannot stagnate. There is always learning*

opportunities for us as nurses and one have to use the platform to look at our individual nursing staff?" (Participant 9, female, middle-level manager).

4.3.2.3 Sub-theme 3: Shared governance

There was a deliberate move from some nurse managers to empowerment professional nurses who they oversee. Almost all the nurse managers alluded to the allocation of administrative tasks to nurse professionals with and without their input. The participants' responses on the issue created a general sense of nurse professionals not being very eager to execute these delegated responsibilities especially when they were not consulted in the compilation of that delegation list.

*"I know the one sister told me but sister, you always just deciding for us to do what to win. Win. Can we as a team decide for ourselves? Do you understand? And yeah, I actually understand that. But I said if I leave it to you guys will never do it. So me just be the one, but I do allow them. To decide for themselves. But I do get a lot of negativity there though." (*Participant 5, female, junior manager).

The nurse managers voiced their trust in especially the more senior nurses in relieving them in their absence. With this decision came a willingness to relinquish decision-making powers and allow the relief manager the opportunity to be autonomous and act accordingly. Sharing decision-making, implying autonomy is a powerful empowerment structure. However, it was mentioned that the relief staff are not freed from their primary responsibility whilst relieving the nurse manager. This practice deprives them of exposure of any significance, as is often the case, the added responsibility will receive less attention and dedication.

"So for instance, when I am going on leave, I need to open up to stand in for me now. They are taking over your role, but they're expected still to continue with their operational duties … they do stand in for you, but they are also overburdened with their other responsibilities that it's not really a learning opportunity for them to grow." (Participant 11, female, middle-level manager).

4.3.2.4 Sub-theme 4: Performance appraisal

When asked about the performance appraisal (PA) system, the participants indicated that the system is now done electronically, but only nurse managers and professional nurses were trained to use the system at the time that the study was conducted. Performance assessment of nurses are done bi-annually. The process starts off with

nurses using either a prescribed template or electronic template to perform self-assessment and rate themselves on the key responsibilities contained in their job descriptions. The employee self-assessment must be followed by the performance review in the form of a dialogue between the manager and the employee. The two parties discuss the rates given by the staff members as compared to the manager's observations. At the end of the dialogue, the parties agree on a rating for the nurse for each key responsibility. The interview or performance appraisal review is critical, but the findings state that the interview dialogue seldom occurs in the hospital.

The findings elucidate a reality of nursing staff not fully understanding the Staff Performance Management System, a notion that was shared by one junior nurse manager who felt that it should be changed because it was regarded as a monetary reward system for nurses. The junior manager used a personal example in demonstrating that individual performance is not considered during the recommendation and moderation of SPMS documents. Another participant stated that professional nurses are still not very forthcoming with the process of evaluating their immediate subordinates and often leave that responsibility to the junior manager.

> *"I am a firm believer of direct communication with my unit managers to have one-on-one communication with their staff if, if we have to do our performance appraisal on a yearly, quarterly basis, have those discussions and also to implement certain mechanisms for for our staff to uplift themselves to become better nurses at the end of the day." (*Participant 9, female, middle-level manager).

Despite the reports of an improvement in using the system electronically, the participants mentioned a hesitancy from professional nurses to evaluate the performance of their subordinates. A junior manager indicated that during the introduction of the electronic system, nurses were trained on the staff performance and management system by an HR official. However, there are still claims from staff of still not understanding the system.

> *"I usually what I'm telling them is don't see performance appraisal as something negative. And did you have a poor performance? You must be all me. What I can do to make it better for you if you are struggling with something just the I mean we can work together to see where we can improve your shortcomings."* (Participant 10, female, junior manager).

4.3.3 Theme 3: Barriers to empowerment

Preconceived ideas of PI**:** *Nurse empowerment is hampered by systemic issues like staff shortages, budget constraints, lack of leadership and governance, political interferences and discrimination in the workplace.*

4.3.3.1 Sub-theme 1: Resource constraints

Shortage of nurses: The relativity of the shortages lies in the fact that almost all the inpatient units experience a patient overload that increases the need for nurses. The nurse managers voiced the issue of the disparity between the demand for health services and the supply of nurses. Another critical factor in the resource debate is that there seems to be a problem with the skill mix where there are more of the lower categories of nurses and less professional nurses. A junior nurse manager supported this statement by indicating that she only has two professional nurses per day shift in a high-paced ward. The reality of staff shortage impedes the attendance of training sessions.

> *"I plot my staff's name on the in service training board on a monthly basis, right? So if we instance today the sister has to go to training but now a colleague didn't pitch for work. Umm, what I found was some say, told me. Yes, sister. You see, now I, I really wanted to go to this workshop but now I can't go because there's only once Sister and the ward is busy."* (Participant 8, female, junior manager)

Constraints in time: The participants indicated that they do make arrangements for staff to attend training sessions according to the in-service programme they have received from the clinical nurse training unit Excessive workloads and staff shortages left these managers no other choice but to withdraw staff from attending classes to attend to patients first. Some participants indicated that they did not even have time to coordinate a ward-based programme because of the heavy workloads. When faced with the decision to choose between staff attending the training sessions or remaining behind in the units to render patient care, the participants chose the latter option. It was evident that all managers regarded patient care above empowerment.

> *… we didn't even have time (to attend training) because every time there's one sister not here, then we have to do patient care. We just concentrate mostly on patient care in this ward here because also we have a fast cycle here.* (Participant 4, female, junior manager).

Shortage in material resources: The participants alluded to the important role that computers play in the empowerment process. Virtual training is presented via a computer application that cannot be accessed by more staff members mainly because of limited computers in the unit. The application for further formal training is done electronically. Besides the few computers in the clinical setting, the nurses did not have access to other computers to use. The issue of computer literacy was also raised by the participants singling out the older generation as those who required basic computer training to facilitate access to this resource.

> *"The in-service training and formal training is online. And some nurses really struggle to do it online because they're not computer literate."* (Participant 8, female, junior manager).

Budget constraints: Budgetary constraints were mentioned as a barrier in accessing many training opportunities such as external informal and formal training. The participants indicated that there is a budget allocated for human resource development, but this is managed by the human resource management unit and the finance department. The skills fund is also available to staff to fund training interventions. However, managers mentioned that access to these funds is stringent and subject to an adjudication process that is managed by the workplace skills committee. Transparency on the available funds and feedback on disapprovals of requests were vague, much to the frustration of some participants.

> *"If I can also say with when you say financial challenges, it's not necessarily always the finance, but the red tape that goes along with it. One of my biggest challenges so far is umm. I'm not sure if it's in other institutions the same, but in mine if you want to go for external training and you need funding you need to apply at least six weeks before the training. 90% of the time you won't know about the training six weeks in advance. So when you do apply for it, they say, it's not within the time frame. We cannot assist there."* (Participant 11, female, middle-level manager).

4.3.3.2 Sub-theme 2: Autocratic leadership

Elements of autocratic leadership surfaced throughout the nurse management tiers. Administrative delegation lists are seemingly compiled by junior managers without the input of their respective nurse subordinates. Junior managers are not allowed to approve any expenditure on their unit budgets. Access to the overtime budget is approved by the senior managers following a detailed motivation from the junior

manager. Some training initiatives were not approved by the Head of Nursing without any proper feedback to the units. One junior nurse manager stated that her requests for staff to perform overtime were not always approved or adjustments would be made to her initial request without prior consultation with her by her immediate supervisor.

> *"I have identified this training, identified this person to go to it and that's sometimes where it stops because most of the supervisors tell you oh, they don't see that is necessary for operational manager to attend this. Even with the motivations that they that you provide for it, they've already made-up their minds … They don't feel that it's appropriate for operational managers."* (Participant 11, female, middle-level manager).

4.3.3.3 Sub-theme 3: Staff attitudes towards empowerment

Despite the benefits that training and development may hold, the responses received from middle-level and junior-level nurse managers regarding the attitude of the staff towards empowerment as a whole echoed a sense of disengagement characterised by a total loss of interest in any form of empowerment the organisation has to offer. According to the participants, nurses cited family responsibilities and personal pressures as reasons for not engaging in empowerment initiatives. Other nurses became despondent following their failure to access formal training due to a change in admission requirements.

> *"… My experiences if I speak about my staff, I can say 50% of them. They are not really interested in in informal training. It's like if I send them for in service training they will make excuses and say no sister, I don't wanna go."* (Participant 7, female, junior nurse manager).

The findings in the study revealed that junior managers experienced issues of ill-discipline and mistrust from nurse subordinates in their units that impacted negatively on the empowerment process. One participant shared her experience with senior staff members who were former peers in the same unit before her promotion. The issue of professional jealousy and resistance to adapt to the change in the management of the unit played out with these staff members overtly challenging her authority.

> *"Daar is die twee persone wat, hulle is die wat altyd nie wil saamwerk nie, wat so difficult is. Sê maar ek gesels oor iets dan bly kyk hulle terug na die vorige OPM, sy het so gemaak dan sê ek dat ek is nie sy nie… is net met die twee persone wat ek heeltyd bietjie teenkanting het met alles wat ek bespreek of voorstelle wat ek maak of*

so…alles wat ek voorstel het 'n klompie vrae wat hulle vra voordat hulle besluit om dit te doen." (Participant 7, female, junior manager).

Translated response:

"There are these two persons who always don't want to operate, who are so difficult. When I talk about something, then they keep referring to the previous OPM and the way she did things, then I would reply by stating that I am not that person… it is only from these two persons that I always get some resistance with everything I discuss or suggestions I make … everything that I suggest is followed by many questions from them before they eventually decide to do it." (Participant 7, female, junior manager).

The disinterest that the nursing staff have towards empowerment often left managers feeling helpless and frustrated. The participants had to find renewed energy to continue encouraging and motivating their staff to seize available opportunities for professional development and growth. A junior manager pointed out that managers must first understand the context around the staff's feelings and then adjust their empowerment strategies accordingly.

"And then I have learned to realize that. Oh. This group are not really into learning or empowering themselves or that kind of things. And then these groups, they are always like kind of flying and willing to go extra. It's a challenge. But as time goes I realize that I really need to also understand where they're coming from… Now I have to see what strategy do I get use get to use to get them to see things now in a different manner to be able to come. And we agree on the same thing and then go with it. It takes time and it's like we have to be patient." (Participant 6, female, junior manager).

4.3.3.4 Sub-theme 4: Changes in nursing curriculum

The curriculum for formal nurse training was restructured nationally in South Africa. This restructuring directly influenced the admission requirements to all these nursing programmes. The participants did indicate that the NQF classification of all legacy nursing qualifications was poorly understood by most and also resulted in a situation where many nurses did not qualify for further training. Nurses were disqualified to access formal nurse training courses due to low NQF levels of their previous qualifications. Managers also mentioned the absence of a strategy like the previous Recognition of Prior Learning (RPL) that was designed to address the shortcomings that were identified.

> *"Due to the fact that the NQF level of people was taken into consideration, so people with a lot of interest to go and do these advanced training have a little bit of a setback and we are waiting on the recognition of prior learning to,to prioritize these people because at the moment we do not have a lot of people who did the basic training at a degree in the basic training. Most of the people that are currently here have got a diploma. Yeah, you know what the basic diploma in nursing?"* (Participant 3, male, senior manager).

The introduction of the new nursing curriculum limited the number of officials that could pursue postgraduate or improved qualifications due to non-alignment of their qualifications. The hospital has professional nurses with the basic bridging course (R683) qualification who, because of the low NQF score, cannot access postgraduate studies. Some nursing assistants and enrolled nurses could also not apply for formal training since they did not have the correct school subjects according to the admission requirements per nurse programme.

> *"… we've got very, umm, sharp nursing assistants and staff nurses, but the admission criteria at the higher education determines that they need to have this and that, and that other subject Matric with that subjects. So that is a little bit of a, of a setback."* (Participant 3, male, senior manager).

4.3.3.5 Sub-theme 5: Generational diversity

Some participants alluded to the different generations of nurses posing several difficulties to the empowerment process. The older generation of nurses is said to be selective in listening when given information. A middle-level nurse manager indicated that older nurses always feel that they know everything and they are very difficult to open up to new knowledge or ways of doing things. Compared to them, the younger generation of nurses is eager to learn new information. A middle-level manager mentioned that older-generation nurses experience real difficulties in adjusting to the new method of applications for further studies (electronic applications). The fact that they often lacked computer literacy is a setback. The younger nurse has computer skills or learns faster and can therefore navigate his or her way on the computer with ease.

> *"You have your different generations. Now with them comes also their life experiences and a big part of that is technology. So what you find is your older generations they are not yet comfortable enough to go over to make use of more technology. And where your younger generations myself, included I'm more comfortable using technology in*

> *everyday functions. So you kind of find that bridge it's getting broader and broader."* (Participant 11, female, middle-level manager).

The new nurse managers were challenged by older, more experienced nurses in accepting their authority and new ways of doing things. A middle-level manager stated that the older nurses found it difficult to adjust to the new changes that are introduced in the workplace. A junior nurse manager added to the generational discourse by stating that the nurse manager can manage these differences by being cognisant of the issues and adjusting empowerment strategies accordingly.

> *"And then the other thing that is a challenge is change, you know, sometimes. No, sister, but we're used to it. Been doing this for 20 years like this and now you are coming here and you want it to do it this way. At first it was a, a challenge because now … I think it was more people based if I have to say from both sides because now you don't want to let go. But as time goes I realize that I really need to also understand where they're coming from. I mean, you've been here for 20 years and this is how you've been doing things. Now I have to see what strategy do I get use get to use to get them to see things now in a different manner to be able to come."* (Participant 6, female, junior manager).

4.3.4 Theme 4: Politics in the workplace

Perceptions of PI: *The PI trained and worked in the study centre for almost 15 years. Based on previous experience, there is this perception that the selection of nurses for training, promotions and appointments is based on issues related to years of experience, race, gender, language and personal preferences. There was this belief that African black people won't fit into the organisation simply because the centre is serving predominantly Afrikaans-speaking communities, have a predominantly Coloured staff establishment and used Afrikaans as the language of communication within the hospital. It was also evident that career ladder ascension was not afforded to younger nurse professionals where the hospital stood loyal to its older staff by giving precedence to years of experience over ability and qualifications.*

4.3.4.1 Sub-theme 1: Prejudice in the workplace

Two junior managers of African descent shared their experiences where they were denied an opportunity to be exposed to new experiences. The underlined reason for this decision was that both lacked experience in their current jobs and would not qualify

to contend for the post for this very reason. The department was looking for a permanent person to act in the post of the assistant nurse manager who resigned, but all the experienced operational managers were not willing to accept the responsibility. The female manager indicated that there was inconsistency in the practices since this reason was not considered when they were all approached to rotate the responsibility of the office of the assistant nurse manager, but did apply this time.

> *"The area manager she was not here for too long, and then the post was advertised, was not yet advertised and then they were making rotation for acting. And then they came a point where no one wants to act. And then I said OK, I took myself the challenge I can act then I was told I was junior still operational manager They say three years minimum, three years as an operational manager. As much as I am still junior, but this is my third year*." (Participant 6, female, junior manager).

The issue of racial differences and perceived prejudice in the facilitation of the empowerment process emerged from a junior nurse manager's responses. A junior nurse manager stated that they are two African operational managers whom she felt were deliberately excluded by her peers in the department she is employed in. She would relate to issues of favouritism where the seniors would overlook her to coordinate the departments' nursing services and mentor new operational managers in the department. The junior manager made a plea to her immediate supervisor to be exposed to other training opportunities within the department but was never considered and found other colleagues to be awarded the opportunities she initially requested.

> "*… there were times that I felt that I was excluded where I should be included and there would be like certain people that are always there…the favouritism. I personally went to her and I say that I would love to have more experience if there is no one who is who is not there, can I please come and work with you or and then she said yes. But if one of the managers can't make it, she go and choose whoever she would want to choose to go and work with and then the excuse will always be like I also don't know the hospital. And then it came to me personally. We are only two black, black people in the operational Manager Department…Only two, and then the rest are coloured."* (Participant 6, female, junior manager).

> *"… there's like an allocation for new managers that comes in. They go to other clinics to for orientation, just to see what is happening in the clinics and this clinic is always not on the list."* (Participant 6, female, junior manager).

4.3.4.2 Sub-theme 2: Politics in hospital funding

A senior manager alleged that there is politics involved in the allocation of the hospital's budget in the province. He alluded to a further cut in the hospital's budget despite it being the largest hospital in the province and operating two hospitals under one roof with one budget allocation. When comparing the healthcare centres between the northern and southern parts of the province, it showed that the northern suburbs have more hospitals than the southern suburbs. However, the allocation of the equitable share to the northern suburbs was always less than their peers in the southern suburbs. The senior manager speculated on the fact that the CEO of their hospital has not been successful in negotiating a proper budget for the hospital thus far.

> *"There is no equity at all between the North and the South. The North has got Tygerberg hospital supported by, by Karl Bremer hospital. If you look at the health facilities in the South, that is supportive of, of Groote Schuur Hospital, there is a huge difference. If you look, if you look at the amount of health services in the North, looking at budgets for that health services and looking at the amount of health services in the South and look calculating all those budgets. You must remember they have got on the, on the South, they have got the Red Cross Children's Hospital and we have a Children's hospital within Tygerberg hospital larger than Red Cross hospital. And this Children's Hospital doesn't have the same or equal amount of budget as Red Cross hospital."* (Participant 3, male, senior manager).

A senior manager alluded to an uncomfortable experience he encountered whilst in the position of Acting Nursing Director. The hospital has an Employment Equity profile that must be adhered to during recruitment and selection processes. Before a recruitment interview takes place, the panel members must be clear about what the hospital's employment equity profile is, to guide the selection of the suitable candidate/s during the interview process. The senior manager related a return of an appointment submission by the HR unit for review of the employment equity in the post-class that was interviewed. This resulted in the selection and appointment of

candidates who best fit the Employment Equity target for that post-class, but who were not necessarily the best candidate. Although in agreement with the final decision by the recruitment panel, the nurse manager remained unhappy with this action.

> *"… So there are a lot of things in terms of Employment equity, those kind of things … Even when it comes to recruitment and selection, normally at this institution and it's becoming now really frustrating that it is not always the perfect candidate or the highest scorer during a interview that gets the position…nowadays your motivation for to get persons appointed gets sent back from our HR department because there's not a lot of, you know, of the equity profile within the appointment."* (Participant 3, female, senior manager).

4.3.4.3 Sub-theme 3: Cultural issues

The findings exposed a tribal issue that played out in one of the units where the nurse manager was confronted with a conflict between different race classes. The hospital has a diverse cultural disposition that is predominantly Coloured workers. The diversity in race and culture influenced the quality of staff relations and teamwork. A junior nurse manager realised that the Zulu and Coloured nurses formulated good alliances and could work together very effectively. On the other hand, the nurses that were from Zulu culture found it difficult to build meaningful alliances with other cultural groups in the workplace. According to the nurse manager, their work ethics were below standard, therefore, they required constant encouragement to complete daily tasks.

> *"It's like now, once they from that kind of a group then it gets worse because they spend a lot of time together and they are kind of...Even if you can try to break the little group. But they always find themselves there and then. They think the same, so there's nothing that you can do so and then I've learned to make peace … The Coloured and the Zulus they, they, they like excel. They were eager to learn. They are just there. And then I had the Xhosa they would like struggle even to complete the task. Like in allocated task that you are giving*." (Participant 6, female, junior manager).

4.5 SUMMARY

The nurse managers mentioned that the hospital under study has structured informal and formal empowerment structures that afford nurses the opportunities to be empowered but nurses are either reluctant or restricted to leave the practical settings to access them due to an array of health system barriers.

The hospital offered empowerment structures such as opportunities to develop, support from management to pursue studies, information on available opportunities that are timeously disseminated and the necessary resources such as contractual appointments to replace the staff who were selected for full-time nurse training as well as paid study leave for the duration of their training course. All the nurse managers experienced difficulties with the formal application process for further nurse studies. A lack of understanding of the admission requirements and the new curriculums was a huge concern for both the manager and the prospective student. The shortage of computers coupled with a lack of computer skills interfered with the timeous submission of applications by prospective students. Operational demands such as staff shortages, huge workloads and financial constraints were the primary reasons that underlined the restrictions on access to formal nurse training programmes.

The informal training system in the hospital is well structured and managed by the Clinical Nurse Facilitators but most nurse managers felt that the time slots for training sessions clash with their ward schedules, thus resulting in poor attendance of staff. Some managers suggested that there is no consultation with units in the planning of the monthly training programmes. Non-attendance of these sessions is a huge problem but sometimes inevitable as patient care takes precedence over empowerment. Despite this, there are still managers who manage this challenge by implementing innovative methods of information sharing and knowledge transfer.

Other barriers that were mentioned included despotic leadership, lack of leadership capacity and generational diversity that hampered the empowerment process. The despotic leadership style adopted by mainly the executive nurse managers impedes the transfer of power to nurse managers leaving them feeling powerless and frustrated. Some junior managers alluded to them not being mentored and supported by their supervisors to ensure that they reach autonomy within their positions. They seemed to rely heavily on peer training to gain confidence in their new posts. The issue of generational diversity harbours challenges for successful empowerment but can be successfully managed and converted into learning opportunities for all generations present in the workplace.

Lastly, sporadic episodes of exclusion and prejudice were highlighted by two junior managers within the same discipline and under the leadership of a specific senior

manager. These experiences were only restricted to a specific context and can, therefore, not be generalised.

The next chapter includes a discussion of the findings as related to the literature, the limitations of the study, recommendations based on the findings and the conclusion.

CHAPTER 5
DISCUSSION, CONCLUSION AND RECOMMENDATIONS

5.1 INTRODUCTION

The previous chapters contained the foundation of the study followed by the review of available literature on the topic under study. Chapter 3 contained a detailed narrative of the research methodology that was adopted during this study. This chapter provides a platform for the discussion of the findings as it relates to the study objectives, the limitations of the study, followed by recommendations on how to apply the new information in the workplace.

5.2 DISCUSSION

The purpose of the study was to explore the lived experiences of nurse managers on the health system barriers and enablers that influence their duties to empower and advance nursing staff. The study findings are discussed within the context of the study objectives, the research framework that underpins the study and the available literature on the phenomenon under study. Throughout the data analysis process, the empowerment structures of information sharing, support, resources, opportunities and the power notion emerged as it relates to the underlined research framework.

5.2.1 Objective 1: Discuss how the hospital's empowerment structures facilitate nursing staff empowerment and career advancement.

The findings of the study revealed that the study centre has empowerment structures that nursing staff can access (e.g., the training unit and an internal communication system). The findings also provided a clear understanding of how the four dimensions of structural empowerment such as opportunities, support, information and resources, as posited by Skytt *et al.* (2015:1003), play out in the organisation. Nursing staff have access to established structures that provide opportunities for professional growth. The support to access these structures is provided by all levels of nurse management and is further endorsed by the approval of paid study leave for formal training for all successful candidates. The dissemination of information is done through the application of various communication media which includes social media networks.

The participants alluded to the fact that professional development and growth increase the probability of career advancement. This statement is supported by a statement made by Sheikhi *et al.* (2016:2) who stated that career advancement is a formal empowerment structure that provides opportunities for professional growth and transferring power to nurses. The increased power translates into self-determination, confidence and autonomy to pursue professional goals to enhance their chances for promotion (Dan *et al.,* 2018:3).

The findings indicated that the administrative part of the performance appraisal system must be completed electronically. However, only nurse managers and professional nurses were trained to use the system at the time of conducting the study. Even though the participants had mixed feelings about the objectivity and the significance of the performance appraisal system, the system is meant to focus on the efficiency and effectiveness of employee performance (Agarwhal & Thakur, 2013:617). Huber (2017:401) stated that the PA system allows the nurse manager to take cognisance of how the nurse views his or her job and what significance he or she attaches to continuous professional development. The importance of having a PA interview is highlighted by Agarwal and Thakur (2013:617) who stated that the PA process allows nurse managers to provide feedback on individual employee performances whilst the employees get to voice their expectations and shortcomings in the job. The findings of this study showed the omission of the performance appraisal. Accordingly, the line manager and the subordinate are denied a voice in the process.

In the public hospital system, employee feedback on job performance is done through the Employee performance management development system (EPMDS (term used in the Western Cape province) which is done bi-annually and assists in determining the employees' developmental needs (Republic of South Africa, 2007). The training needs that are identified must find expression in an individual performance improvement plan and also the institutional workplace skills plan (WSP) (Aggarwal & Thakur, 200:617) Not having the interview to determine developmental needs raises a question of the true reflection of the developmental needs that are expressed in the WSP.

5.2.2 Objective 2: Describing the nurse managers' experiences in their role of providing nurses access to power structures in the workplace.

Nurse management positions have one critical key performance area of coordination of training and research. To be able to do this, the nurse manager must have the power to empower.

Power to empower - The literature states that power and status are connected to a position within the organisational hierarchy, denoting that a higher position inherently increases power, status and opportunity to influence authorities (Hughes *et al*., 2015:5). However, the study findings revealed that this power is lacking especially amongst the junior managers. The junior nurse managers shared experiences of being disempowered by an autocratic nursing hierarchy and that power is centralised (contained in senior and top managerial structures/positions). Connolly *et al.* (2018:883) did a mixed-method, non-experimental survey and found that the nurse managers' degree of powerlessness in the workplace can influence their perception of the degree of influence they have over their subordinates. Feelings of frustration were expressed by some nurse managers based on the fact that they are restricted from exercising their powers as decisions must be endorsed by senior managers before they can be implemented at the unit level. A descriptive cross-sectional study conducted by Gholami *et al.* (2019:1020) supported this finding by stating that the feelings of powerlessness among nurses are attributed to the uneven distribution of power in the workplace. Two middle-level managers stated that the Nursing Director's (the head of nursing) opinion on what is important in terms of nurse empowerment is regarded as final. This denotes the fact that giving power to top management officials only can weaken the autonomy and growth of lower-ranking managers (Gholami, 2019:2010). Hughes *et al*. (2015:6) explained this display of autocracy as a disregard for the intellectual capacity and cognitive abilities of lower-ranked nurse managers resulting in them feeling frustrated, oppressed and of little value to the organisation. Gholami *et al.* (2019:1020) warned that this centralisation of power in the top hierarchy of management harms the motivational levels of nurse managers', as was evident in this study's findings. Woodward (2020:137) in her concept analysis of individual nurse empowerment posited that the feelings of powerlessness and low morale that were reported by nurses can be addressed by prioritising the empowerment of managers to

grow confidence levels and lend them a voice to actively contribute to change in the organisation.

Training within the job - The study participants provided mixed responses on the subject of orientation and mentoring within their new positions with some having been oriented and mentored whilst others were not. Adeniran *et al.* (2013:438) supported this finding by stating that mentoring is a critical empowerment process that allows the exchange of information and knowledge between the mentor and the mentee to promote the confidence and competency levels of the mentees.

The research findings revealed observations made by the higher-ranking nurse managers on the shortcomings of the inexperienced and newly appointed junior nurse managers. This observation led to the arrangement of various training sessions that were specifically designed for nurse managers to address their shortcomings and allow them to gain confidence in their jobs. The findings of a descriptive quantitative study conducted by Regan and Rodriguez (2011:e105), showed that inexperienced nurse managers lack the structural power tools to accomplish their duties and can, therefore, not fully support the empowerment of their subordinates.

Changes in legislation required nursing education to be positioned in the higher education band and have therefore imposed a re-modelling of nurse education and training to comply with the legislative framework (Republic of South Africa, 2019:3). The study's findings shed light on the controversy and confusion that were brought by the introduction of the new nursing curriculum, changed admission requirements and realignment of legacy nursing qualifications in terms of the prescripts from the National Qualifications Act, 67 of 2008. In a policy analysis done by Blaauw *et al.* (2014:26401), they found that the two most important changes that were made include the requirement for a baccalaureate degree to qualify as a professional nurse and replacing the enrolled nurse training of two years (R683) with a three-year diploma course that will lead to registration as a Registered nurse (R171). The participants in this study were critical of the slow progress in the implementation of the new qualifications, the lack of proper governance from the South African Nursing Council (SANC) and the National Department of Health, restricted time for implementation and lastly, the fact that the proposals made were ill-suited for the South African context

(Blaauw *et al*., 2014:26402). The study reported similar feelings among the nurses which left them despondent and disinterested in furthering their nursing careers.

The nurse managers felt perturbed about the fact that the demanding workloads and staff shortages made it difficult for them to avail staff to attend training sessions. Choi and Kim (2018:1670), in their study on the effects of structural empowerment on professional governance and autonomy, found that time constraints due to heavy workloads are affecting the nurse's ability to participate in these training sessions.

Shared governance - Shared governance as an empowerment strategy involves delegating authority and power that is inherent to a position to another employee and giving him or her the autonomy and accountability to make decisions on work-related issues (Al-Qahtani *et al*., 2020:28). In the study findings, participants related how they empowered designated officials to fill in on their responsibilities in their absence. However, when the opportunity presented itself, the employee was expected to fulfil two roles, her or his own and that of the manager. The participants did mention of enactment of share governance that was under strict control of the more senior colleagues, not allowing the nurse to fully engage with the job. Effective implementation of shared governance requires the nurse manager to transfer power inherent to the job and relinquish authority to the person who is replacing her for some time to engage in autonomous decision-making (Huber, 2017:426). According to Weiss and Tappen (2015:80), the notion of sharing autonomy and authority creates an empowerment opportunity. Due to the responsible nature of shared governance, it is clear that the nurse manager must first ascertain the cognitive abilities and level of empowerment of the delegated employee before assigning the responsibility to him or her. In a quantitative research survey done by Wilson and Jones (2014:19), they posited that shared governance creates an opportunity for collaboration and support between nurse managers and nurse subordinates to achieve professional growth and an increase in productivity levels. The findings of a qualitative study conducted by Ott and Ross (2014:763) also supported the formation of a partnership between the nurse manager and the nurse subordinates in the journey of shared governance.

Supporting employee growth and development - The aspect of support is covered in many different formats in the study findings. The participants voiced their support for their staff's development and training by planning staffing schedules around the

training dates. A prerequisite in the selection process of prospective students for post-basic nurse training is the supply of a motivation written by the immediate nurse manager which serves as a recommendation for the applicant (Western Cape Government, 2022:3). The nurse managers showed their support to the staff by continuously motivating them to explore empowerment structures that will enable them to reach autonomy. Constant feedback and motivation endorse a manager's support (Skytt *et al*., 2014:1008) for her staff. In a South African study, the findings were just the opposite where nurse managers used their positional power to delay advancement of nurses (Van der Heever, 2018;254)

The performance review is a critical part of the Performance Appraisal system, which is conducted in a structured interview format between the manager and the employee to evaluate the quality of performance, identify shortcomings and devise plans to address these shortcomings before the next review cycle (Republic of South Africa, 2007:7). Although the results did not yield specific information on how the performance appraisal system process enfolds in the hospital, the participants mentioned the fact that it is now converted into an electronic format. The vagueness of the responses on the subject of Employee Performance Management and Development system created a perception that both the nurse managers and the nurse subordinates regard the performance appraisal system as an administrative exercise and would therefor engage in it for compliance purposes. This interpretation is supported by the outcome of a study done by Hendricks and Matsiliza (2015:128) where the findings exposed a lack of understanding, poor compliance and low commitment between nurse managers and nurse subordinates from staff during the performance cycle. The training of managers, supervisors and nurses on the Employee Performance Management and Development system is necessary to create better understanding and successful implementation (Republic of South Africa, 2007:8)

The study findings revealed that nurse managers supported the psychological well-being of their nurse subordinates by planning to arrange debriefing sessions for staff who are functioning under tremendous pressure. During the COVID-19 pandemic, the nursing staff in the Emergency department of the hospital, attended sessions that were arranged by the nurse managers and presented by Metropolitan. The attendees had positive reviews of these sessions in the sense that they gave them renewed vigour

to pursue job responsibilities. Li *et al.* (2018:1263) emphasised the fact that an individual must be motivated and confident (psychologically empowered) before he or she will be able to recognise and utilise empowerment structures for personal growth in the workplace. The Western Cape Department of Health (WCDH) also pledged its support to nurse development and training by allocating funds for formal nurse training at the NEIs and the appointment of nurses on contract to relieve the nurses that will be on full-time study leave for the duration of their course (Western Department of Health, 2016). Mlambo *et al*. (2021:7) stated that commitment and support from management can be viewed as a token of appreciation for the valuable contribution the nurses make to healthcare in the province.

The nurse manager must enable access to information and resources to enable successful empowerment - The study findings showed the diverse means that were employed by the participants to relay information to their staff. Nurse managers shared their experiences of implementing control measures to ensure that information was received and acted upon. Laschinger *et al*. (2012:879) state that being informed creates a sense of value and purpose for the employee which subsequently boosts commitment and productivity.

The Western Cape Department of Health allocated funds to support formal nurse training. This funding assists in maintaining staffing levels at the facility whilst other nurses are enrolled in full-time training (Western Cape Department of Health, 2009:13) According to the participants, the study centre has a budget allocation for human resource development (HRD) that is managed through the institutional skills committee but some nurse managers experienced problems with the bureaucracy around the process. The availability of resources is a critical component in the empowerment process. Employees need resources to be efficient in an organisation (Amor *et al*., 2021; Balay-odao, 2022:502).

The participants were vocal on the issue of time. They indicated that nurses have very little time to avail themselves of training or other empowerment initiatives Staff shortages reduced the number of nurses that are available to take care of patients thus creating inadequate nurse-patient ratios that do not allow much time for attending training sessions as reported by the participants. Heavy workloads, time constraints and staff shortages were also found to be the main reasons for staff not to attend the

continuous professional development (Brekelmans, Poelle & Van Wijk, 2012:319). Choi and Kim (2019:1670) also found that time constraints as a result of demanding workloads are hampering the attendance of training opportunities.

Nurses' attitudes towards empowerment - Nurses provided different reasons for their indifference towards continued development which included family responsibilities, being too old, and failure to meet admission requirements. Nurse managers have a constant struggle to get nurses motivated and determined to engage in continuous learning and development. Sparks (2012:452) investigated psychological empowerment in the different generations of nurses and found that a nurse's feelings towards her working environment determine his or her attitude towards empowerment. Li *et al*. (2018:1263) found that structural empowerment can only be successful once people feel motivated and self-determined. Nurse managers must strive to cultivate an empowering organisational climate and culture that will enable both structural and psychological empowerment as nurses will have access to empowering structures whilst also feeling motivated and confident (Trus *et al*.,2018:55).

Some managers shared their experiences of attempting to cultivate a learning culture and climate in their respective wards to motivate staff and allow them freedom of expression. These managers reported a positive outcome for staff. High-performance employees are created in an empowered organisation, which increases organisational efficiency and productivity (Dan *et al*., 2018:1).

Generational and cultural diversities -The study findings revealed several differences between the different generations that influenced the empowerment process on all levels. In a descriptive secondary analysis of data, Sparks (2012:452) stated that the different generations of nurses have varying insights on task orientation, autonomy, professional status, work environment and leadership support. Therefore, nurse managers have to adjust the empowerment structures to fit the learning needs or characteristics of all nurses. According to the literature, four generations are operating within the workplace today, which include the Baby Boomers (BB) - born from 1946 to 1964, the Generation X (Gen X) - born from 1965 to 1979 and lastly, Generation Y (Gen Y or millennials) - born from 1980 to 2000 and beyond (Farr-Wharton *et al*., 2011:3). The older nurses (Generation X) were mentioned as being reluctant to explore empowerment opportunities and accept changes. The findings of this study

viewed the older-generation nurses as being reluctant to incorporate technology in practice and being selective listeners, whilst the millennial nurses were found to respond to new knowledge. Millennials were viewed as being eager to explore new development opportunities and needed to be kept interested by exposing them to new knowledge and skills. It was also mentioned that older nurses are set on a hierarchy and act according to rules whereas younger nurses need structure and guidance from the manager to pursue daily tasks (Balay-odao *et al.,* 2021:502). Balay-odao *et al*. (2022:502) studied the influence of structural empowerment and work ethics on work engagement among millennial Saudi clinical nurses. The authors found that millennial nurses value structure in the workplace with visible managers to lead and direct them in the workplace.

5.2.3 Objective 3: Describe the barriers to nurse empowerment and advancement that may exist in the hospital.

The main barriers mentioned included a shortage of nurses, demanding workloads, staff attitudes toward empowerment, feelings of powerlessness, autocratic top management, prejudice and discrimination in the workplace.

Staff shortages - All the participants mentioned high patient numbers with low nurse staffing numbers resulting in a disparity between the demand for health services and the supply nursing staff to render the service. The findings of a mixed-method study by van der Heever and van der Merwe (2018:287) concurred that nursing staff shortages, high workloads and financial constraints are deterring nurses from participating in continuous development practices. Staff absenteeism compounded both the shortage in staff numbers and workload. Unsatisfactory work conditions such as high workloads and constant staff absenteeism cause shortages in nursing staff (Li *et al.,* 2018:1265; Battle, van der Heever & van der Merwe, 2022). Staff shortages hampered the ability to release staff for internal training sessions, select staff for formal training, effectively implement shared governance and cultivate a learning climate in the unit. Coventry *et al*. (2015:1) also cited staff shortages as a major contributor to the non-attendance of nurse training sessions. In response to the nursing shortage, efforts are needed to retain nurses by creating empowering work environments that allow employees to engage meaningfully with their job (Boamah & Laschinger, 2014:1).

Staff attitudes towards empowerment - The findings revealed a sense of disinterest amongst nurses regarding the attendance of in-service training sessions and applying for further studies. The underlined reasons for these feelings ranged from family responsibilities, personal stressors and failure to qualify for further formal training resulting from the change in the admission requirements to access formal nurse training. Li *et al.* (2018:1266) state that the employee's perception of his or her workplace determines the attitude he or she has towards the empowerment process. It is important to note that the success of empowerment can only yield an improvement in work engagement if the staff members are positive about their jobs and the working environment (Li *et al.*, 2018:1265). Therefore, by addressing the underlined reasons, the attitudes of staff towards empowerment may change. Boamah and Laschinger (2014:9) conducted a secondary review of data from a previous study and found that access to empowering working conditions will probably result in a change in staff attitudes and quality of work engagement.

Stringent control over workplace skills fund - Some managers alluded to the stringent control that is exercised over the workplace skills fund and the bureaucracy around access to the fund. Aboshaiqah *et al.* (2012:3) conducted a quantitative study in Saudi Arabia and found that lack of funding for continued education and the associated costs of replacement staff were barriers to continued professional development. By implication, this study motivated management to fund nurse education because nurses can become demotivated and discouraged to pursue further studies if they are required to fund their studies themselves (Aboshaiqah *et al.,* 2012:3).

Lack of power to influence others and mobilise resources - Almost all the participants voiced a lack of power despite being in a management position. Trus *et al*. (2017:343) confirmed the fact that nurse managers do experience feelings of powerlessness that make it difficult for them to function effectively within their appointed positions. The study findings revealed that the nursing department has a high hierarchy resulting in decision-making and power being centralised in the top-level positions. Gholami *et al.* (2019:1020) in their Iranian study found that the centralisation of power in the top nursing ranks had an adverse influence on the engagement of staff in the workplace.

Despite being ranked higher up in the hospital's hierarchy, some nurse managers were unable to direct their positional power towards the mobilisation of resources such as

funding. Hughes *et al*. (2015:2) posited that influence, authority and power are invested in a position - the higher the position, the greater the power, influence and ability to mobilise resources to meet workplace demands. Highly powered nurse managers are characterised by the strong ties they have with executive management which lends them the opportunities to be visible and actively participate in strategic planning sessions (Hughes *et al*., 2015:6). However, the study revealed that junior nurse managers could not exercise their duty of ensuring optimal staffing levels by sourcing overtime funding for replacement nurses in case of shortages without being recommended and approved by the senior nurse manager. Some managers also alluded to a lack of consultation in the decision-making process. Therefore, Ott and Ross (2014:761) stated that autocratic leadership styles must make way for a focus on empowerment, shared governance and participative decision-making in the workplace.

Cultural and political interferences in the workplace - The study findings revealed incidents of perceived discrimination against two young black managers within a specific unit where they were denied the opportunity to act in the post of an Assistant Nurse Manager despite the fact that all other managers of another race, declined the offer. One of these managers alluded to other incidents where an experienced colleague subtly averted the opportunity to coach her in the job. In an ethnographic study that was conducted by Iheduru-Anderson (2020:1) to explore the perceptions of black nurses in the United States on career advancement, the findings indicated black nurses still faced racial discrimination and are denied access to mentorship and support that are discouraging them to pursue advancement in nursing. In a South African study conducted by van der Heever and van der Merwe (2018:279) the findings concluded that the decision to provide nurses the opportunity to be exposed to managerial activities, were racially biased and fueled by the scepticism regarding the competencies of the black nurse. In an effort to correct the issue of racial discrimination in the workplace, top management should prioritize the introduction of a socialization process by means of diversity training to foster an appreciation of the uniqueness and valuable contribution each employee can bring to the organization (Mazibuko & Govender, 2017:2).

The perceived disparity in the allocation of the equitable share between the hospitals in the Northern Suburbs and those in the Southern Suburbs was raised. The participant raised speculations of discrimination based on language, with the English language that is used in the Southern suburbs, viewed as superior to Afrikaans-speaking facilities. However, available literature on public health financing negates that perception. The distribution of health care benefits or funding allocations are based on the service package offered at those facilities mainly which favors central and secondary hospitals that are predominantly situated in the urban areas of the provinces (Atabuga & Mc Intyre, 2012:i43). The perception is further validated by Stuckler (2011:171) who used multivariate regression to measure funding allocation in the South African public health care domain. The author found that health system capacity, measured by the number of doctors and hospitals, are determinants in health care allocations.

The study findings also revealed incidents of subtle covert political interference in recruitment and selection processes. The basis of suspicion was the fact that employment equity principles often led to the appointment of candidates that were not the highest scorers during employment interviews. The adherence of Human Resource Management units to legislative prescripts is correct since the EEA, no. 55 of 1998, Section 20, obligates all public entities to have an equity plan containing targets that must reflect equity in the appointments of persons from both genders and all races that will mirror the demographics of the country (Republic of South Africa, 1998). The EEA also draw attention to the prescripts on job experience and job requirements when undertaking recruitment and selection process in sections 15 and 16.

5.3 RECOMMENDATIONS

Nursing managers must enhance the nurses' sense of empowerment by providing opportunities for nurses to acquire professional knowledge and by creating supportive environments for nurses so that they can acquire the time, money, material, and supplies to achieve organisational goals. Linen and Rowley (2014:46) mentioned the fact that the nurse manager’s key performance indicator is to build an empowering nurse force that can make a positive contribution to staff morale, productivity and organisational outcomes.

5.3.1. Enacting empowerment

Nurse Managers must introduce shared governance as a precedent of empowerment (Khraisat *et al*., 2020:348). The emphasis must be placed on affording the nurse subordinate a meaningful experience when selected for this function at the managerial and ward level. Shared decision-making is central to shared governance, hence the importance of enacting it within the nurse management team and at ward level. The nurse manager, from senior to ward level, must create an enabling working environment where staff feel encouraged to express themselves, participate in decision-making, and offer creative and innovative ideas for change (Gholami *et al.,* 2019:1021). A transformational leader inspires employees to pursue professional growth and transcend the boundaries set by job descriptions (Amor *et al*., 2019:2). A workplace that supports the autonomous functioning of the employees and meaningful intra-and inter-professional collaborations promotes employee commitment and trust (Gholami *et al*., 2019:1021).

5.3.2. Enabling development of the manager in the role

Empowerment of the nurse managers must be prioritised to transfer power that will enable them to become visible in management structures and add their voice to decisions regarding the change (Woodward, 2020:137). A change in human resource management policies to include leadership standards such as mandatory induction, orientation and mentoring of new appointees is required. A review of the required experiential and academic requirements for appointment into managerial posts is needed to include a Nursing Management qualification as a mandatory qualification. This will ensure that the person with the correct skill set is appointed to the position. The revision of the performance appraisal cycle for probationary employees to include quarterly assessments will inform the introduction of empowerment structures that will enhance employee and organisational efficiencies (Huber, 2017:402). The introduction of compulsory CPD-accredited short courses on essential aspects of good leadership, assertiveness training, effective conflict management and performance appraisal is necessary to capacitate nurses. The teaching of soft skills such as communication, assertiveness, and resilience-building must be included in these training sessions to build a resilient and confident nurse manager corps (Aliem & Hashish, 2021:279).

5.3.3. Advocating for reinstatement of the Recognition of Prior Learning policy at Nursing Education Institutions

An understanding of the factors that influence nurses' participation in professional development and career advancement can support the development of relevant training programmes that will enable the engagement of nurses in professional development and career advancement. Such factors include the restrictions to access formal nurse training that was identified as a barrier to empowerment and subsequent advancement due to the realignment of legacy nursing qualifications to the NQF Act, 67 of 2008. Despite the reality of demanding work pressures and staff shortages, the prospect of improving qualifications with a promise of ascending the career ladder and gaining financial benefits was still a motivator for many nursing staff. The top nursing management must engage with NEIs to work on a strategy in the form of a policy to recognise prior experience to bridge the divide created by the legislation.

5.3.4. Building cognitions of psychological empowerment

Factors related to unrealistic workloads and resultant low staff morale are primary reasons why nurses resign from their positions as they feel neglected and have a perception of nurse managers being insensitive to their plight (Linnen & Rowley, 2014:46). The findings in this study revealed a similar situation of despondency and detachment of nurses caused by high patient load and staff shortages that result in low levels of enthusiasm. Nurse managers must invest in implementing strategies of psychological empowerment such as the introduction of reward systems that will improve job satisfaction by denoting a sense of value and meaning to the staff (Li *et al*., 2018:1274).

5.3.5. Prioritise empowerment of nurse managers

The hospital has four tiers of Nursing management and the findings suggested that power was centralised at the top level of nurse management. The culture of despotic leadership is evident throughout the nurse management hierarchy – from top to operational level. The underlined reason for this phenomenon may be attributed to a lack of confidence in the abilities of the lower level official or manager which can be

addressed through investing in empowerment of nurse managers through structured training sessions, coaching and mentoring programs. The successful empowerment of nurse managers will breed confidence, renewed commitment and a continuous pursuit of positive outcomes. This will allow top management the ease of mind to loosen the hold over total power and distribute appropriately and fairly along the different levels.

5.4 LIMITATIONS OF THE STUDY

The study findings cannot be generalised as it was conducted in one public tertiary setting in each context. If the study is to be repeated in a private setting, the findings may show a different outcome.

Virtual interviews were held that resulted in minor problems with connectivity for both the PI and the participant. The PI lost an opportunity to interview two managers on separate occasions due to problems with connectivity which prolonged the period of data collection. The other negative aspects of virtual interviews are that the PI could not properly assess the non-verbal language of the participants.

The study was conducted in merely one of the nine provinces of South Africa.

Although the study focused on barriers and enables empowerment, the empowerment of the managers themselves was not addressed

5.5 RECOMMENDATIONS FOR FUTURE RESEARCH

The following areas for future research are proposed:

Future research studies can focus on shared governance as a precursor for empowerment. Shared governance creates greater collaboration between nurses and managers, enhances confidence levels and self-determination, builds on existing knowledge and develop professional skills and enhances autonomy in practise (Khraisat, 2020:348).

The study shed light on how an important system such as the Employee Performance Management and Development system is undermined in the workplace hence the inability of public service to truly implement employee development in the workplace. The significance of this system is misconstrued with an opportunity to get monetary

incentives whilst ignoring the vital aspect of monitoring employee growth and development within their appointed positions to enhance the quality of the service and improve productivity. Future research studies aimed at determining understanding of the EPMDS throughout the ranks of nursing may highlight important issues for consideration during policy review and writing.

Repeating the same study in the private sector will give an idea of how nurse managers in the private sector experience systemic health challenges and their influence on nurse empowerment and advancement. It will be interesting to compare the findings to ascertain whether the effects of health systemic barriers on empowerment are endemic or not.

5.6 CONCLUSION

The available literature on the concept of empowerment provides an array of definitions, but in essence, it refers to a state or feeling of being in control. The literature identifies a distinction between structural empowerment – which focus on access to workplace power elements such as information, resources, support and opportunities and psychological empowerment which focuses on four cognitions of meaning, impact, competence and self-determination. In this study, the concept of social empowerment was brought into the fray as a process of liberation from historical oppression and discrimination in the workplace that impeded autonomy and efficiency. Chief to the empowerment discourse is the element of “power” that is vested within a job (formal power) and also found through meaningful relations with peers and seniors (informal power).

The findings of this study saw nurse managers acknowledging their responsibility in creating and sustaining opportunities for employee growth and development. There is also an acknowledgement that an empowered nurse has increased chances of ascending the career ladder because of higher levels of motivation and determination to gain control over his or her job. However, the study findings demonstrated how the discourse on empowerment is sometimes misconstrued as the ability to create only access to formal nurse training. It is evident from this study that there is real effort placed on creating formal training interventions to facilitate the development of knowledge and skill with little emphasis on shared governance and mentoring. Shared governance essentially refers to managers relinquishing total control and sharing

decision-making with subordinates, thereby cultivating a sense of value in the nurse subordinates. Mentoring refers to a process of positive role modelling and guidance being afforded to a new appointee to ease the transition into the new role.

The research findings highlighted the realities of the public healthcare system of staff shortages, demanding workloads, disengagement of staff, budgetary constraints, political and cultural issues and lack of power and how it influences the empowerment process. These systemic challenges are slowing down the process of empowerment, thus creating a need for capacitating the nurse management corps to effectively manage these barriers. The issue of centralisation of power in a tall hierarchical structure requires a change to a democratic leadership style that allows free expression, growth and self-determination. The increase in self-determination boosts the employee's motivation levels to explore empowerment structures, thus enhancing the chances for promotion and career advancement.

REFERENCES

Abel, S.E. & Hand, M.W. 2018. Exploring, defining, and illustrating a concept: Structural and psychological empowerment in the workplace. *Nursing Forum*, 53: 579-584.

Abd-EL Aliem, S.M.F. & Abou Hashish, E.A. 2021. The relationship between Transformational Leadership practices of First-line nurse managers and nurses' organisational resilience and job involvement: A structural equation model. *Worldviews on Evidence-based Nursing*, 18(5):273-282.

Aboshaiqah, A.E., Qasim,A., Abulwafah, N. & Al-Bashaireh, A.M. 2012. Barriers for CPD among nurses in Saudi Arabia. *Middle East Journal of Nursing*, 6(3):22-27.

Adeniran, R.K., Bhattacharya, A. & Adeniran, A. A. 2012. Professional Excellence and Career Advancement in Nursing- A Conceptual Framework for Clinical Leadership Development. *Nursing Administration Quarterly*, 36(1):41–51.

Adeniran, R.K., Smith-Glasgow, M.E. & Bhattacharya, A. 2013. Career advancement and professional development in nursing. *Nursing Outlook*, 61:437-446.

"Advancement" 2021, in *Merriam-Webster Dictionary*, Merriam-Webster, Springfield, Massachusetts, viewed 6 November 2021. <http://www/merriam-webster.com/dictionary/advancement.

Agarwal, A. & Thakur, G.S.M. 2013. Techniques of Performance Appraisal – A review. *International Journal of Engineering and Advanced Technology*. 2(3):617-621.

Akinyade, B.F. & Khan, T.H. 2018. Step-by-step approach for qualitative data analysis. *International journal of Built Environment and sustainability*. 5(3):163 – 174.

Alase, A. 2017. The Interpretative Phenomenological Analysis (IPA): A Guide to a Good Qualitative Research Approach. *International Journal of Education and Literacy Studies*, 5(2):9-19.

Albasal,N.A., Eshah, N., Minyawi, H.E., Albashtawy, M. & Alkhawaldeh, A. 2022. Structural and psychological empowerment and organizational commitment among staff nurses in Jordan. *Nursing Forum,* 57:624-631.

Alhalboosi, F.H.A.M. 2018. Human Resource Development. *Researchgate*. DOI:10.13140/RG.2.2.3432865 – *downloaded on 18.06.2022.*

Al-Jedaia, Y. & Mehrez, A. 2022. *The effect of Performance Appraisal on job performance in governmental sector: The mediating role of motivation*. Management Sciences Letters, 10:2077-2088.

Ali, Z., Mahmood, B. & Mehreen, A. 2019. Linking succession planning to employee performance: The mediating roles of career development and Performance appraisal. *Australian Journal of Career Development*, 28(2):112-121.

Al-Qahtani, A.M., Ibrahim, H.M., Elgzar, W.T., Abd Elwahab El Sayed, H., Abdelghaffar, T., Moussa, R.I. & Alenzy, A.R. 2021. Perceived and real barriers to workplace empowerment among women at Saudi universities: A cross-sectional study. *African Journal of Reproductive Health*. 25(1):26

Al-Niarat, T.F. & Abumoghli, F. 2019. Factors influencing Nursing students' empowerment: A literature Review. *Open Journal of Nursing*, 9:1240-1251.

Amor, A.M., Vásquez, J.P.A. & Fáiña, J.A. 2018. Transformational leadership and work engagement: Exploring the mediating role of structural empowerment. *European Management Journal*.

Austin, H & Backwell, K. 2000. Shaping the future of shared governance. *Nursing Times.* 96(47):38

Ataguba, J.E. & Mc Intyre, D. 2012. Paying for and receiving benefits from health services in South Africa: is the health system equitable? *Health Policy and Planning*, 27(1):i35-i45.

Bamford-Wade, A. 2012. Shared governance: A vehicle for engagement and change. *Nursing Education Today*, 32:191-194

Balay-adao, E.H., Cruz, J.P., Alquwez, N., Al Otaibi, A.K., Al Thobaity, A.A., Alotaibi, R.S., Valencia, J.A. & Danglipen, C.C. 2021. Structural empowerment and work ethics influence on work engagement of millennial nurses. *Journal of Nursing Management*. 30:501-510.

Bish, M., Kenny, A & Nay, R. 2012. Perceptions of structural empowerment: nurse leaders in rural health services. *Journal of Nursing Management*.22(1):29-37.

Blaauw, D., Ditlopo, P. & Rispel, L.C. 2014. Nursing Education reform in South Africa – lessons from policy analysis study. *Global Health Action*, 7(1):26401

Breakfast, N. B. & Maart, B. 2019. Enhancing diversity via affirmative action: A case study of the Nelson Mandela Metropolitan Municipality, *Africa's Public Service Delivery and Performance Review, 7(1):a275.*

Brekelmans, G., Poell, R.F. & Van Wijk, K. 2012. Factors influencing Continuous Professional Development, Journal of Training and development, 37(3):313-325.

Brink, H., Van der Walt, C. & Van Rencburg, G. 2006. *Fundamentals of Research Methodology for Health Care Professionals – 2nd edition*. Cape Town, Juta & Company.

Bvumbwe, T & Mtshali, N. 2018. Transition to practice guidelines: Enhancing the quality of nursing education. *African Journal of Health Professions Education*. 10(1):66-71.

Choi, S.E. & Kim, M. 2019. Effects of structural empowerment and professional governance on autonomy and job satisfaction of the Korean nurses. *Journal of Nursing Management*. 27:1664-1672.

Coventry, T. H., Martin-Prothero, S.E. & Smith, G. 2015. Organisational impact of nurse supply and workload on nurses continued professional development opportunities: an integrative review. Journal of Advanced Nursing. 71(12):2715-2727.

Connoly, M., Jacobs. S. & Scott, K. 2018. Clinical leadership, structural empowerment and psychological empowerment of registered nurses working in an emergency department. *Journal of Nursing Management*. 26:881-887.

Creswell, J.W. & Creswell, J.D. 2018. *Research Design – Qualitative, Quantitative, and Mixed-method Approaches* – 5th edition. California. Sage.

Dan, X., Xu, S., Liu, J., Hou, R., Lui, Y. & Bachelor, H.M. 2018. Relationships among structural empowerment, innovative behaviour, self-efficacy and career success in nursing field in mainland China. *International Journal of Nursing Practice.* 24(6): e12674

Davies, A. Wong, C.A. & Laschinger, H. 2011. Nurses participation in personal knowledge transfer: the role of the leader-member exchange. Journal of Nursing Management. 19:632-643.

De Chesnay, M. 2015, *Nursing Research using Phenomenology- Qualitative Designs and Methods in Nursing*. New York. Springer Publishing Company.

De Chesnay, M. 2015, *Nursing Research using Data Analysis - Qualitative Designs and Methods in Nursing*. New York. Springer Publishing Company.

Esterhuizen, W. & Martins, N. 2008. Organisational justice and employee responses to employment equity. *South African Journal of Labour Relations,* 32 (2): 66 – 85.

Fragkos, K.C., Makrykosta, P. & Frangos, C.C. 2019. Structural empowerment is a strong predictor of organizational commitment in nurses: A systematic review and meta-analysis. *Journal of Advanced Nursing*, 76: 939-962.

Gaede, B. & Versteeg, M. 2011.The state of the Right to Health in rural South Africa. *South African Health Review*,26: 99-106.

George, G. & Rhodes, B. 2012. Is there a pot of gold at the end of the rainbow? Has the Occupational Specific Dispensation, as a mechanism to attract and retain health workers in South Africa, levelled the playing field? *BMC Public Health*, 12:613.

Gholami, M., Saki, M., Pour, A.H.H. 2019. Nurse's perception of empowerment and its relationship with organisational commitment and trust in teaching hospitals in Iran. *Journal of Nursing Management*. 27:1020-1029.

Gilson, L. & Daire, J. 2011. Leadership and Governance within the South African Health System. *South African Health Review,* 2011 (1): 69-80

Gonzalez-Garcia, A., Pinto - Carral, A., Perez-Gonzalez, S. & Marques –Sanchez, P.2021.Nurse Manager's competencies – A scoping review. Journal of Nursing Management, 29 : 1410-1419.

Govender, S., Gerwel Proches, C.N. & Kader, A. 2018. Examining leadership as a strategy to enhance health care service delivery in regional hospitals in South Africa. *Journal of Multidisciplinary Health care*, 11:157-166.

Gray, J.R., Grove, S.K.& Sutherland, S. 2017.*The Practise of Nursing Research – Appraisals, Synthesis and Generation of evidence*. 8th edition. China: Elsevier, Incorporated.

Graebe, J. & Cosme, S. 2022. The Future of Workforce Development in Professional Nursing Practice. *Journal of Continuing Education in Nursing*. 53(6):246-250.

Grove, S. K., Gray, J.R. 2019. *Understanding Nursing Research- Building an Evidence-Based Practice*. 7th edition. China: Elsevier, Incorporated.

Halvorsen, K., Dihle, A., Hansen, C., Nordhaug, M., Jerpseth, H., Tveiten, S., Joranger, P. & Knutsen, I.R. 2020. Empowerment in healthcare: A thematic synthesis and critical discussion of concept analyses of empowerment. *Patient Education and Counselling*. 103:1263-1271.

Hendricks, C.C. & Matsiliza, N.S. 2019. Management of employee performance in the South African Public Service: the case of the National Department of Rural Development and Land Reform in the Western Cape. *Problems and Perspectives in Management*, 13(3-1):125-131

Huber, D. 2010. Leadership and Nursing Care Management – 4th edition. Iowa: Elsevier.

Huber, D. 2017. *Leadership and Nursing Care Management* – 6th edition. Iowa: Elsevier.

Hughes, K., Carryer, J.B. & White, J. 2015. Structural positioning of nurse leaders and empowerment. *Journal of Clinical Nursing.* 24(15-16):2125-2132.

Iheduru – Anderson, K. 2020. Barriers to advancement in the nursing profession: Perceptions of Black nurses in the United States. *Nursing Forum*, 2020:1-14

Kirya, M. T. 2020. Promoting anti-corruption, transparency and accountability in the recruitment and promotion of health workers to safeguard health outcomes. *Global Health Action*, 13:1-9.

Khoele, A & Daya, P. 2014. Investigating the turnover of middle and senior managers in the pharmaceutical industry in South Africa. *South African Journal of Human Resource Management,* 12(1), Art. #562.

Khotari, C.R. 2004. *Research Methodology – Methods & Techniques* – 2nd edition. New Delhi: New Age International Publishers.

Khraisat,O., Al-awamreh, K., Hamdan, M., Al-Bashtawy, M., Al khawaldeh, A., Qaddumi, J.A.S. & Haliq, S. 2020. Shared governance: a children's hospital journey to clinical nursing excellence. *Journal of Research Nursing*, 25(4):347-358.

Kumar, R. 2011. Research Mathodology – a step-by-step guide for beginners - 3rd edition. Los Angeles: SAGE publications.

Lammintakanen, J., Kivinen, T. & Kinnunen, J. 2008. Human Resource development in nursing: views of nurse managers and nursing staff. *Journal of Nursing Management,* 16:556-654.

Laschinger, S. H. K., Gilbert, S., Smith, L.M. & Leslie, K. 2010. Towards a comprehensive theory of nurse/patient empowerment: applying Kanter's empowerment theory to patient care. *Journal of Nursing Management*, 18: 4-13.

Lethbridge, K., Andrusyszyn, M.,Iwasiw, C., Laschinger, H.K.S. & Fernando, R. 2011. Structural and Psychological Empowerment and Reflective Thinking: Is There a Link? *Journal of Nursing Education*, 50(11):636-645.

Laschinger, H.K., Wong, C.A., Grau, A.L., Read, E.A. & Pineau Stam, L.M. 2011. The influence of leadership practices and empowerment on Canadian nurse manager outcomes. *Journal of Nursing Management*, 20:877–888

Li, H., Shi, Y., Li, Y., Xing, Z., Wang, S., Ying, J., Zhang. M & Sun, J. 2018. Relationship between nurse psychological empowerment and job satisfaction: A systematic review and meta-analysis. *Journal of Advanced Nursing*, 74:1264–1277.

Linnen, D. & Rowley, A. 2014. Encouraging clinical nurse empowerment. *Nursing Management*, 45(2):44-47.

Lopez, K. A. & Willis, D. G. 2004. Descriptive versus Interpretive Phenomenology: Their Contributions to Nursing Knowledge. *Qualitative Health Research*, 14 (5): 727-735.

Machi, L.A. & Mc Evoy, B.T. 2016. *The literature review: Six steps to success*. 3rd edition. California:Corwin-Sage

Maluka, H. R. & Mayeza, C. A. (2019, July 03−05). Student nurses' perceptions of the nursing profession at a higher institution of learning [Paper presentation]. *International Conference on Public Administration and Development Alternatives*, Johannesburg, Gauteng, South Africa. http://hdl.handle.net/10386/2681

Mandlenkosi, M. Silén, C. & Mc Grath, C. 2021. Lifelong learning and nurses' continuing professional development, a meta-synthesis of the literature. *BMC Nursing,* 20:62

Mazibuko, J.V. & Govender, K.K. 2017. Exploring workplace diversity and organizational effectiveness. A South African exploratory case study. *South African Journal of Human Resource Management*, 15(0): a865.

McGehee, G. 2012. Interview Techniques. In Dwyer, L, Gill, A.A. & Seetaram, N. *Handbook of Research Methods in Tourism: Quantitative and Qualitative approaches* (p. 365-376). Cheltenham, United Kingdom: Edward Elgar Publishing Limited.

Meng, L., Liu, Y.,Liu, H.,Hu, Y.,Yang, J.& Liu, J. 2013. Relationships among structural empowerment, psychological empowerment, intent to stay and burnout in nursing field in mainland China – based on a cross-sectional questionnaire research. *International Journal of Nursing Practice*, 21: 303-312.

Mlambo, M., Silén, C. & McGrath, C. 2021. Lifelong learning and nurses' continuing professional development, a metasynthesis of the literature. *BMC Nursing*. 20:62

Morse, J.M. 2015. *Critical analysis of strategies for determining rigor in qualitative inquiry*, Mexico: Cuarto Congreso Global.

Motsosi, K.S. & Rispel, L.C. 2012. Nurses perceptions of the implementation of Occupational Specific Dispensation at two district hospitals in the Gauteng Province of South Africa. *Africa Journal of Nursing and Midwifery*, 14(2):130-144.

Motaung, L. L., Bussin, M. H. R. & Joseph, R. M. 2017. Maternity and paternity leave and career progression of black African women in dual-career couples. *South African Journal of Human Resource Management,* 15(0), a902.

Naicker,V. & Hoque,M. 2017. Leadership effectiveness within the function of nursing management. *Journal of Contemporary Management*,14: 291-329.

Ofei, A.M.A., Paarima, Y., Barnes, T. & Poku, C.A. 2022. Toxic leadership behaviour of nurse managers on perceived job satisfaction and productivity of nursing workforce in Sub-Saharan Ghana: A multi-centre cross-sectional study. *Journal of Nursing Management.* :1-10

Oliver, B., Gallo, K., Griffin, M. Q., White, M. & Fitzpatrick, J. 2014. Structural Empowerment of Clinical Nurse Managers. *Journal of Nursing Administration*, 44 (4): 226-231.

Oosthuizen, R. M. & Naidoo, V. 2010. Attitudes towards and experience of Employment Equity. *South African Journal of Industrial Psychology,* 36 (1), Art 836.

Oosthuizen, R. M., Tonelli, L. & Mayer, C-H. 2019. Subjective experiences of employment equity in South African organisations. *South African Journal of Human Resource Management*,17(0), a1074.

Orgambidez-Ramos, A. & Borrego-Alés. 2014. Empowering Employees: Structural Empowerment as Antecedent of Job Satisfaction in University Settings. *Psychological Thought*, 7(1):28-36.

Ott, J. & Ross, C. 2013. The journey toward shared governance: the lived experiences of nurse managers and staff nurses. *Journal of Nursing Management,* 22(6):761-768.

Pessoa, A.S.G., Harper, E., Santos, I.S. & Da Silva Gracino, M.C. 2019. Using Reflexive Interviewing to Foster Deep Understanding of Research Participant's Perspectives. *International Journal of Qualitative Methods*, 18: 1-19.

Pietkiewisz, I. & Smith, J.A. 2014. A practical guide to using Interpretative Phenomenological Analysis in qualitative research psychology. *Psychological Journal,* 20 (1) : 7-14.

Polit, D. F. & Beck, C. T. 2014. *Essentials of Nursing Research – Appraising Evidence for Nursing Practise*. 8th edition. China: Wolters Kluwer Health Lippincott Williams & Wilkins.

Public Service Commission. 2013. *Fact Sheet on the Blockages in the Filling of posts in the Public Service*. Pretoria: Government Printing Works.

Public Service Commission of South Africa. 2016. *Fact sheet on irregular appointments in the public service.* Pretoria: Government Printing Works.

Public Service Commission of South Africa. 2018. *Evaluation of effectiveness of recruitment and selection system of the Public Service*. Pretoria: Government Printing Works.

Rao, A. 2012. The Contemporary Construction of Nurse Empowerment. *Journal of Nursing Scholarship,* 44:396-402.

Regan, S., Laschinger, H.K.S & Wong, C. 2015. The influence of empowerment, authentic leadership, and professional practice environments on nurses' perceived inter-professional collaboration. *Journal of Nursing Management*, 24: E54–E61.

Regan, L.C., Rodriquez, L. 2011. Nurse Empowerment from Middle-Management perspective: Nurse Managers and Assistant Nurse Managers' workplace empowerment views. *The Performance Journal,* 15(1):2101-2107.

Reid, S. 2018. 20 Years of community service in South Africa: what have we learnt? *South African Health review*. 41-50

Reiners, G. M. 2012. Understanding the Differences between Husserl's (Descriptive) and Heidegger's (Interpretive) Phenomenological Research. *Journal of Nursing Care,*1 (5):1-4.

Republic of South Africa. 1996. *Constitution of the Republic of South Africa, Act 108 of 1996,* Cape Town: Typeface Media.

Republic of South Africa. 2009. *Department of Education, Human Resource Development Strategy*. Pretoria: Government printers

Republic of South Africa. 2019. *Department of Health, National Policy on Nurse Education and Training*. Pretoria: Government printers

Republic of South Africa. 2019. *Department of Health, National Strategic Direction for Nursing and Midwifery Education and Practice - 2020/21 – 2025/26*. Pretoria: Government printers

Republic of South Africa. (2007). *Department of Public Service and Administration, Employee Performance Management and Development System (EPMDS).* Pretoria: Government printers.

Republic of South Africa. (2007). *Department of Public Service and Administration, Occupation Specific Dispensation.* Pretoria: Government printers.

Republic of South Africa. (2019). *Department of Labour*: *19th Commission for Employment Equity – Annual report 2018-2019*. Pretoria: Government printers.

Republic of South Africa. (2012). *Department of Public Service Administration Incentive policy framework for employees on salary levels1 to 12 and those covered by Occupation Specific Dispensations (OSD's)*. Pretoria: Government Printing Works.

Republic of South Africa. (2012). *Department of Public Service Administration Recruitment and Selection policy*. Pretoria: Government Printing Works.

Republic of South Africa. (1998). *Employment Equity Act, Act no 55 of 1998.* Pretoria: Government Printing Works.

Republic of South Africa. (2018). *Public Service Commission Report: Evaluation of the Effectiveness of the Recruitment and Selection system of the Public Service,* Pretoria: Government Printing Works.

Republic of South Africa. (2018). *Public Service Commission Report: Evaluation of the Effectiveness of the Recruitment and Selection system of the Public Service,* Pretoria: Government Printing Works.

Republic of South Africa. (1997). *Skills Development Act, Act no 97 of 1998.* Pretoria: Government Printing Works.

Republic of South Africa. (2011). *Statistics South Africa*. Pretoria: Government Printing Works.

Republic of South Africa. (2007). *The Minister of Public Service and Administration Occupation Specific Dispensation for Professional Nurses*. Pretoria: Government Printing Works.

Republic of South Africa. (1995). *White Paper for Transformation of Public Service,* Pretoria: Government Printing Works.

Ritruechai,S, Khumwong, W., Rossiter, R. & Hazelton, M. 2018. Thematic analysis guided by Max van Manen: Hermeneutic (interpretative) phenomenological approach. *Journal of Health Science Research,* 12 (2) – December 2018 : 40-48.

Rispel, L.C. 2016. Analyzing the progress and fault lines of health sector transformation in South Africa*. South African Health Review*, 1:17-23.

Rao, A. 2012. The Contemporary Construction of Nurse Empowerment. *Journal of Nursing Scholarship,* 44: 396-402.

Rodham, K., Fox, F. & Doran, N. 2015. Exploring, analytical trustworthiness and the process of reaching consensus in Interpretative Phenomenological Analysis: Lost in Transcription. *International Journal of Social Research Methodology*, 18- 2015(1):1-29.

Roji, G. & Jooste, K. 2020. Perceptions of nurses on access to structural empowerment in a hospital in the Western Cape. *Curationis*, 43(1) – a2018

Ryan, F. Coughlan, M. & Cronin, P. 2009. Interviewing in qualitative research: The one-to-one interview. *International Journal of Therapy and Rehabilitation*, 16 (6): 309-314.

Shava, E. & Chamisa, S. F. 2018. Cadre Deployment Policy and its Effects on Performance Management in South African Local Government – A critical Review. *Journal of Public Administration*, 49 (3): 891-990.

Sheikhi, M.R., Khoshknab, F., Mohammadi, F. & Oskouie, F. 2016. The role of working environment in nurses' career advancement from nursing mangers' perspectives: A qualitative study. *Journal of Hospital Administration*. 5(4):1-7.

Skytt, B.,Hagerman, H., Strömberg, A. & Engström, M. 2015. First-line managers' descriptions and reflections regarding their staff's access to empowering structures. *Journal of Nursing Management*, 23:1003-1010.

Smith, J.A. & Osborn, M. 2008. *Interpretative phenomenological analysis*. IN: J.Smith edition, *Qualitative psychology: A practical guide to research methods*. London : Sage.

Sparks, A.M. 2012. Psychological empowerment and job satisfaction between Baby boomer and Generation X nurses. *Journal of Nursing Management*, 20:451-460.

Stuckler, D. 2011. Health care capacity and allocations among South Africa's provinces: Infrastructure – Inequity traps after the end of Apartheid. *American Journal of Public Health*, 101(1): 165-172.

Ta'an, W. F., Alhurani, J., Alhalal, E, Al-Dwaikat, T. N. & Al-Faari, I. 2020. Nursing Empowerment – How Job Performance is affected by a structurally empowered work environment. *The Journal of Nursing Administration*. 50(12): 635-641.

Tau, B. Du Plessis, E., Koen, D. & Ellis, S. 2018. The relationship between resilience and empowerment leader behaviour of nurse managers in the mining healthcare sector. *Curationis*, 41(1):a1775.

Taylor, S.J., Bogdan, R. & DeVault, M.L. 2016. *Introduction to Qualitative Research Methodology – A guidebook and Resource.* 4th edition. New Jersey: John Wiley & Sons.

Terreblanche, M., Durrheim, K. Painter, D. 2006. *Research in Practise – Applied Methods for the Social Sciences.* 2nd edition. Cape Town: UCT Press.

Trus, M., Galdikiene, N., Balcuinas, S., Green, P., Helminen, M. & Suominen, T. 2018. Connection between organisational culture and climate and empowerment: The perspective of nurse managers. *Nursing Health Science*, 21(1):54-62.

Trus, M., Razbadauskas, A., Doran, D. & Suominen, T. 2012. Work-related empowerment of nurse managers: A systematic review. Nursing and Health Sciences, 14(3):412-420.

Tyagu, Tshishonga, N. 2014. Cadre Deployment and its implications on service delivery in South Africa: A human development capability approach. *Journal of Public Administration,* 49(3): 891 – 905.

Tygerberg Hospital .2016. *Annual Report* [Online]. Available https://www.westerncape.gov.za/your_gov/153/documents/annual_reports. [2020, June 10]

United Nations Women / Women Count. 2020. *Guidelines for conducting qualitative research during COVID 19*. Nairobi: Esaro Publications.

Van der Heever, M.M..2018. *A Framework to facilitate the appointment of women nurses of colour to leadership positions in hospitals*. Dissertation for Doctorate of Philosophy.

Van Rensburg, H. C. J. 2014. South Africa's protracted struggle for equal distribution and equitable access – still not there. *Human Resources for Health,* 12 (26).

Wagner, J.I.J., Cummings, G., Smith, D.L., Olson, J., Anderson, I. & Warren, S. 2010. The relationship between structural empowerment and psychological empowerment for nurses: a systematic review. *Journal of Nursing Management*, 18:448–462

Wang, S. & Lui, Y. 2015. Impact of professional nursing practice environment and psychological empowerment on nurses' work engagement: test of structural equation modelling. *Journal of Nursing Management*, 23(3):287-296.

Weiss, S.A. & Tappen, R.M. 2015. *Essentials of Nursing Leadership and Management.* 6th edition. Philadelphia, F.A. Davis Company

Western Cape Government Health. 2016. *Provincial Nursing Strategy: 2016 -2030*. Cape Town, Government Printers.

Western Cape Provincial Government. (2020). *Western Cape Department of Health (WCDOH) Strategic Plan 2020*. Cape Town, Government Printers.

Western Cape Provincial Government. (2022). *Western Cape Department of Health (WCDOH) Standard Operating Procedure – Application, Nomination and Selection for study leave*. Cape Town, Government Printers.

Wilson, J. & Jones, R.A. 2014. Exploring how nurses and managers perceive shared governance. *Nursing2014*, July:19-22

Wolfe, R., Tonelli, L. & Mayer, C. 2019. Subjective experiences of employment equity in South African organisations. *South African Journal of Human Resource Management*,17(0). a1074.

Wong, C.A. & Laschinger, H.K.S. 2013. Authentic leadership, performance, and job satisfaction: the mediating role of empowerment. *Journal of Advanced Nursing,* 69(4), 947–959.

Woodward, K.F. 2019. Individual nurse empowerment: A concept analysis. *Nursing Forum,* 55:136-143.

Yu, X., Huang, Y. & Liu, Y. 2022. Nurses' perception of continuing professional development: a qualitative study. *BMC Nursing*, 21:162

Zhou, H. & Chen, J. 2021. How does psychological empowerment prevent emotional exhaustion? Psychological safety and organisational embeddedness as mediators. Frontiers in Psychology, 12:546687

Zulu, P. S. & Parumasur, S. B. 2009. Employee perceptions of the management of cultural diversity and workplace transformation. *South African Journal of Industrial Psychology,* 35 (1): 1-9.

APPENDICES

APPENDIX A: ETHICAL APPROVAL

[redacted]

Approval Notice

New Application

06/01/2022

Project ID :22117

HREC Reference No: S21/04/071

Project Title: Health system barriers and enablers to the empowerment and subsequent career advancement of nurses: experiences of nurse managers at a tertiary hospital in the Western Cape.

Dear Mrs R Esau

The **response** received on 25/11/2021 was reviewed and **approved** by members of **Health Research Ethics Committee** via **expedited** review procedures on 06/01/2022.

Please note the following information about your approved research protocol:

Protocol Approval Date: 06 January 2022

Protocol Expiry Date: 05 January 2023

Please remember to use your Project ID 22117 and Ethics Reference Number S21/04/071 on any documents or correspondence with the HREC concerning your research protocol.

Please note that the HREC has the prerogative and authority to ask further questions, seek additional information, require further modifications, or monitor the conduct of your research and the consent process.

After Ethical Review

Translation of the informed consent document(s) to the language(s) applicable to your study participants should now be submitted to the HREC.

Please note you can submit your progress report through the online ethics application process, available at: Links Application Form Direct Link and the application should be submitted to the HREC before the year has expired. Please see *Forms and Instructions* on our HREC website (www.sun.ac.za/healthresearchethics) for guidance on how to submit a progress report.

The HREC will then consider the continuation of the project for a further year (if necessary). Annually a number of projects may be selected randomly for an external audit.

Please note that for studies involving the use of questionnaires, the final copy should be uploaded on Infonetica.

Provincial and City of Cape Town Approval

Please note that for research at a primary or secondary healthcare facility, permission must still be obtained from the relevant authorities [redacted] Department of Health and/or City Health) to conduct the research as stated in the protocol. Please consult the Western Cape Government website for access to the online Health Research Approval Process, see: https://www.westerncape.gov.za/general-publication/health-research-approval-process. Research that will be conducted at any tertiary academic institution requires approval from the relevant hospital manager. Ethics approval is required BEFORE approval can be obtained from these health authorities.

We wish you the best as you conduct your research.

For standard HREC forms and instructions, please visit: Forms and Instructions on our HREC website https://applyethics.sun.ac.za/Project/View/Index/22117

If you have any questions or need further assistance, please contact the HREC office at [redacted]

Yours sincerely,

[redacted]

Coordinator

HREC1

APPENDIX B: INSTITUTIONAL APPROVAL

[redacted]

[redacted]
Reference:
Research Projects
Enquiries:
[redacted]
Manager: [redacted]

Ethics Reference: S21/04/071; Project ID 22117

NHRD Reference: [redacted]_202201_035

Title: Health system barriers and enablers to the empowerment and subsequent career advancement of nurses: experiences of nurse managers at a tertiary hospital in the Western Cape.

Dear Ms Racheal Esau

PERMISSION TO CONDUCT YOUR RESEARCH AT TYGERBERG HOSPITAL

1. In accordance with the [redacted] Health Research Policy and Protocol of **April 2018**, permission is hereby granted for you to conduct the above-mentioned research here at [redacted] for a year based on your HREC approval.

2. Researchers, in accessing the Provincial Health facilities, are expressing consent to provide the department with an electronic copy of the final feedback within six months of completion of research. This can be submitted to the Provincial research Co-Ordinator [redacted]

[redacted]

MANAGER: MEDICAL SERVICES

Date: 09/05/2022

[redacted] [redacted]

APPENDIX C: PARTICIPANT INFORMATION LEAFLET AND CONSENT FORM

PARTICIPANT INFORMATION LEAFLET AND CONSENT FORM

TITLE OF RESEARCH PROJECT:	
HEALTH SYSTEM BARRIERS AND ENABLERS TO THE EMPOWERMENT AND SUBSEQUENT CAREER ADVANCEMENT OF NURSES: EXPERIENCES OF NURSE MANAGERS AT A TERTIARY HOSPITAL IN THE WESTERN CAPE.	
DETAILS OF PRINCIPAL INVESTIGATOR (PI):	
Title, first name, surname: Mrs Racheal Esau	**Ethics reference number:** S21/04/071
Full postal address: [redacted]	**PI Contact number:** [redacted]

We would like to invite you to take part in a research project. This leaflet contains information about the research project. Please take some time to read the leaflet. Please discuss any queries about the research project with the researchers. You may question them on any aspects of the project that you do not fully understand. It is **very important** that you are completely satisfied that you clearly understand what this research entails and how you could be involved. Also, your participation is **entirely voluntary,** and you are free to decline participation. In other words, you may choose to take part, or you may choose not to take part. Nothing bad will come of it if you say no, it will not affect you negatively in any way whatsoever. Refusal to participate will involve no penalty. You are also free to withdraw from the study at any point, even if you do agree to take part initially.

The Health Research Ethics Committee at Stellenbosch University has approved this study**.** The study will be conducted according to the ethical guidelines and principles of the international Declaration of Helsinki, the South African Guidelines for Good Clinical Practice (2006), the Medical Research Council (MRC) Ethical Guidelines for Research (2002), and the Department of Health Ethics in Health Research: Principles, Processes and Studies (2015).

What is this research study all about?

- *This study seeks to explore the experiences of nurse managers, in a central public hospital in the Western Cape, with facilitators and barriers to nurse empowerment and subsequent advancement. The reason for this study is to explore whether nurse managers are aware of the pivotal role they play in ensuring that nurses have access to power structures in the workplace to empower themselves and ultimate grow and improve their chances of advancement in their occupational fields. Empowered staff also contribute positively to the attainment of organisational goals through increased productivity and autonomy in decision-making on the job.*
- *The study will be conducted* [redacted]

[redacted]. *A total number of not less than 10 or more than 15 participants will be recruited from the facility. The exact number will depend on whether the researcher is satisfied with the responses of the lowest number of respondents. The sample will consist of 3-5 nurse professionals from each rank of nursing management excluding the position of Director of Nursing or Nursing Manager for a period longer than 12 months. These are the nurse management categories that the study is focusing on. Virtual or face-to-face semi-structured interviews will be held with all participants following the receipt of a signed written consent by the participants. The choice of interview will be dependent on the National Covid 19 alert level at the time of data collection and also the choice of the participant. Strict Covid 19 precautionary measures will apply during face-to-face interviews. During these interviews, a range of open-ended questions will be posed to the participant who will be requested to answer and engage in a free and open conversation. The entire interview process will be recorded on an audiotape to facilitate transcription and later analysis. No medication will be used at any point of the research project.*

- *You will select a pseudonym that will serve as your identity during these interviews to ensure confidentiality. The audio recordings and transcriptions will be stored on Google cloud, Microsoft OneDrive and an external hard drive that are access controlled. Data will be shared with the study supervisor,* [redacted] *who together with the PI are the only persons that will have access to the stored data. Other sensitive data will be encrypted using codes only known to the PI and the study supervisor.*

Why do we invite you to participate?

- *You fit the inclusion criteria for the study by being an appointed nurse manager at the study centre.*

What will your responsibilities be?

- *You will only be requested to participate in answering all questions posed to you freely, honestly and without fear of intimidation. You are also allowed to ask questions to the investigator.*

Will you benefit from taking part in this research?

- *There will be no direct benefits to the researcher. The findings of the study will hopefully highlight the barriers and enablers within the health system that influence nurse managers' efforts to empower and advance their nursing staff. Furthermore, the findings will reveal the realities nurse managers are facing in the workplace when dealing with nurse empowerment and advancement. The findings may lead to the review and remodelling of current empowerment and advancement structures in nursing.*

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

- *There are minimal risks to the study. Should you experience any degree of discomfort or become injured, you will be assisted by means of a direct referral to the institutional Employee Assistance Program or the Accident and Emergency unit at the study centre.*

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

- *Your refusal to participate will be respected without any consequences to your person or position.*

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

- *Both virtual and face-to-face participants will receive a token of appreciation to the value of R50. Virtual participants will receive an additional reimbursement to the value of R100 to cover expenses for data used during the telephonic interviews. Both will be paid through electronic funds transfer.*

Is there anything else that you should know or do?

- *You can phone **Mrs Racheal Esau** at [redacted] if you have any further queries or encounter any problems.*
- *You can phone the **Health Research Ethics Committee** at [redacted] if there still is something that the principal investigator has not explained to you, or if you have a complaint.*
- *You will receive a copy of this information and consent form for you to keep safe.*

Declaration by participant

By signing below, I ……..…… agree to take part in a research study entitled (**The experiences of nurse managers on health system barriers and facilitators to the empowerment and subsequent career advancement of nurses.)**

I declare that:

- I have read this information and consent form, or it was read to me, and it is written in a language in which I am fluent and with which I am comfortable.
- I consent that the interview be recorded.
- I have had a chance to ask questions and I am satisfied that all my questions have been answered.
- I understand that taking part in this study is **voluntary,** and I have not been pressurised to take part.
- I may choose to leave the study at any time and nothing bad will come of it – I will not be penalised or prejudiced in any way.
- I may be asked to leave the study before it has finished, if the researcher feels it is in my best interests, or if I do not follow the study plan that we have agreed on.

Signed at (*place*) ……..…….. on (*date*) ……...…….. 202….

…… ……

Signature of participant **Signature of witness**

Declaration by investigator

I *(name)* ……..…… declare that:

- I explained the information in this document in a simple and clear manner to ……..
- I encouraged him/her to ask questions and took enough time to answer them.
- I am satisfied that he/she completely understands all aspects of the research, as discussed above.
- I did/did not use an interpreter. (*If an interpreter is used then the interpreter must sign the declaration below.)*

Signed at (*place*) .....……..…….. on (*date*) ……..…….. 202..

....

Signature of investigator **Signature of witness**

Permission to have all anonymous data shared with journals:

Please carefully read the statement below (or have them read to you) and think about your choice. No matter what you decide, it will not affect whether you can be in the research study, or your routine health care

When this study is finished, we would like to publish results of the study in journals. Most journals require us to share your anonymous data with them before they publish the results. Therefore, we would like to obtain your permission to have your anonymous data shared with journals.

Tick the Option you choose for anonymous data sharing with journals:

I agree to have my anonymous data shared with journals during publication of results of this study

☐ Signature_____

OR

I do not agree to have my anonymous data shared with journals during publication of results of this study

☐ Signature_____

APPENDIX D: INTERVIEW GUIDE

ANNEXURE 1 : Interview guide

Title:

HEALTH SYSTEM BARRIERS AND ENABLERS TO THE EMPOWERMENT AND SUBSEQUENT CAREER ADVANCEMENT OF NURSES: EXPERIENCES OF NURSE MANAGERS AT A TERTIARY HOSPITAL IN THE WESTERN CAPE.

SECTION 1: Demographic data

Appointed position:.....

Appointment date (*month & year***):**.....

SECTION 2: Interview questions

Introduction

During my tenure as Operational Manager and Acting Nursing Manager, I participated in nurse empowerment and advancement through creating power structures in the workplace. Nurse managers have the critical responsibility of implementing legislative frameworks like the Employment Equity Act and Skills Development Act to facilitate nurse empowerment and advancement but are often met with systemic barriers impeding the realization of this responsibility. Through this study I wish to explore how other nurse managers experience the influence of systemic barriers and enablers on nurse empowerment and subsequent advancement.

The questions in this interview guide are aimed at exploring your experiences as nurse managers on the health system barriers and enablers that influence that your duties to (i) empower and (ii) advance nursing staff in the hospital.

1. **As a nurse manager / operational manager / assistant manager/ deputy manager, tell me how you would go about empowering the nurses you are supervising?**

Probes: *providing access to information; avail necessary resources to facilitate empowerment; support staff empowerment and advancement; create opportunities for growth/ role of HRD unit in nurse empowerment?*

2. **Tell me about possible factors or structures in the hospital that enable nurse empowerment in your hospital?**

Probes: *budget as a facilitator to strengthen your goals for the nursing staff; legislation e.g. employment equity, skills development; organisational structures such as study leave, in-service training program, personnel management development system that support the role; human resources that support this role; managerial power to attain the mentioned goals; support from senior management; your efforts to manage/use the facilitators in the advancement and empowerment of nurses?*

3. **Tell me about challenges that you may have experienced with empowering and advancing nurses in the hospital?**

Probes: *budgetary constraints to your role; legislation e.g., employment equity, skills development; organisational structures that impedes the role; human resources that impedes this role; constraints pertaining to managerial power; how do you manage such; constraints related to senior management, legislation, lack of networking?*

Thank you for your participation.

Racheal Esau

Student M.Cur

APPENDIX E: DECLARATION LANGUAGE EDITOR

VSE

Van Schalkwyk Editorial Services

Email: [redacted]

LinkedIn profile: https://www.linkedin.com/in/ar%C3%A9-van-schalkwyk-0214202a/

02/12/2022

DECLARATION OF PROFESSIONAL EDIT

I declare that I have edited Racheal Esau's master's thesis. My involvement was restricted to language usage and spelling, completeness and consistency, reference style, and formatting of headings, captions and tables of contents. I did no structural rewriting of the content and did not influence the academic content in any way.

Mr Aré van Schalkwyk

BA (Languages)

Accredited service provider of the University of Pretoria, Stellenbosch University,

the University of Johannesburg, and other institutions

APPENDIX F: DECLARATION TECHNICAL EDITOR

RUKSHANA ADAMS
Editing Services

4 Nerina Avenue,
Brantwood,
Kuilsriver.
7580
+27 71 768 4141
ruadams@uwc.ac.za

CERTIFICATE OF TECHNICAL FORMATTING AND EDITING

This is to certify that the thesis titled

" The experiences of nurse managers on health system barriers and facilitators to the empowerment and subsequent career advancement of nurses"

Written by

Racheal Esau

Was Reviewed for Technical Formatting and Editing by **RUKSHANA ADAMS**

DATE: 4 December 2022
SIGNATURE: R. Adams