Unit managers' role in improving nursing teamwork in a mental health care facility

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“COMING TOGETHER IS A BEGINNING,
KEEPING TOGETHER IS A PROGRESS,
BUT WORKING TOGETHER IS A SUCCES.”

PLAGIARISM DECLARATION

I hereby solemnly declare that this research document presents the work carried out by myself and to the best of my knowledge, does not contain any materials written by another person except where due reference is made, according to the North-West University Harvard style of 2012. I declare that all the sources used or quoted in this study are acknowledged in the bibliography, and that I complied with the ethical standards set by the North-West University, (Potchefstroom Campus).

Further I declare that the content of this research will not be handed in for any other qualification at any other tertiary institution.

Mariska Elizabeth Oosthuizen-van Tonder
01/09/2014

PREFACE

This study is unique in nursing science as the researcher used the graphic team sculpting technique as a data collection method together with a focus group. Graphic team sculpting is well known in psychology and social studies. The graphic team sculpting contributed to a rich description of the research findings.

The researcher hopes that this study will contribute to the improvement of teamwork within nursing teams, resulting in better quality care, reduce absenteeism, lower turn-over rates, fewer patient errors and safer practices for mental health care users. The research findings has an effect in both the mental health care user/patient and the nursing staff members (see chapter 2 for a detailed description).

Chapter 1 will give the reader an overview of the research as well as the methodology used. Chapter 2 is a literature review as the researcher explored theoretical and methodological literature regarding nursing teamwork within an international and national perspective. Chapter 3 is the discussion of the research findings according to the two phases of data collection combined with a literature integration. Finally chapter 4 is an evaluation, limitations and recommendations with specific reference to enhance nursing team work in a mental health care facility in Gauteng.

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ABSTRACT

The nursing team in a mental health care facility is a known dynamic at every hospital, rehabilitation centre and out-patient unit which enables these units to be functional. Currently nursing teams function in a challenged environment in mental health care facilities. The National Department of Health in South Africa states that one of the priority areas in the core standards of health care is to improve values and attitudes of health care professionals. One of the ways to accomplish this is that leaders at all levels should be positive role models to staff to encourage a culture of caring and positive attitudes that supports service delivery. However, mental health care in practice is in contradiction to this ideology of how mental health should function. In reality, regular involuntary treatment, minimal patient contact with therapists, negative attitudes, pressure of beds not being available as well as regular seclusions due to unmanageable situations are experienced in practice. The aim of this study is to explore and describe the role of the nursing unit manager to improve nursing teamwork in a mental health care facility in Gauteng in order to improve the quality of health care.

A qualitative, explorative, interpretive descriptive and contextual design was selected to address the research question at hand. Non-probability, purposive sampling was used. A focus group discussion was held (n=8) and graphic team sculptings were done with each participant (n=9). The state of the current nursing team was described and explored as well as the practical intervention aimed at improving nursing teamwork. Data of the focus group was analysed using content analysis. Graphic team sculptings were analysed by interpretation analysis.

The results of this research study indicated that nursing teamwork is influenced by various factors that can be categorized as organisational-, unit specific- and unit manager specific factors. There might be a negative organisational culture and negative attitudes of team members. There is uncertainty in the hierarchy structures, below the unit manager that causes power struggles, this has an effect on the responsibility and accountability in the absence of the unit manager. Individual team member's needs constant supervision and direction to complete their daily tasks. The unit managers feel like there is poor support from top management. The general ward assistants and administrative clerks is seen as part of the team, although they are not directly involved with patient care, they contribute to the teams functioning. Mental health care facilities are overcrowded and this increases the workload of the nursing team. Trust and cohesion within the teams is low with poor communication between team members due to clique formation. The unit manager plays a vital role through leadership, collaboration, fair

delegation and guidance. Individualism and diversity should be embraced. The unit managers acts as a role model and leader that bring the teams together and solve problems, facilitates effective communication and involves all the team members in decision making.

Keywords: Nursing teamwork, role, unit manager, mental health care facility, graphic family sculpting.

OPSOMMING

Die verpleegspan in ‘n geestesgesondheidsorg omgewing is ‘n bekende dinamiek aangesien elke hospitaal, rehabilitasiesentrum en buite-pasiëntfasiliteit oor ‘n verpleegspan beskik wat hierdie eenhede funksioneel maak. Tans funksioneer verpleegspanne in ‘n uitdagende omgewing in geestesgesondheidsfasiliteite. Die Nasionale Department van Gesondheid in Suid-Afrika voer aan dat een van die prioriteit areas in die kern standaarde, is om die verbetering van waardes en houdinge van gesondheidsorgwerkers te verseker, en dat een van die maniere om dit te bereik is om te sorg dat die leiers op alle vlakke positiewe rolmodelle is om ‘n omgee-kultuur en positiewe houdinge te kweek wat dienslewering sal verbeter. In werklikheid is geestesgesondheidsorg in die praktyk in teenstelling met die ideologie van hoe gesondheidsorg moet funksioneer. In realiteit is daar gereelde onwillekeurige behandeling, minimale pasiëntkontak met terapeute, negatiewe houdinge, druk as gevolg van ‘n tekort aan beskikbare beddens sowel as gereelde afsondering as gevolg van onhanteerbare situasies in die praktyk. Die doel van hierdie studie is om die rol van die verpleegeenheidbestuur te ondersoek en te beskryf in ‘n poging om verpleegspanwerk in ‘n geestesgesondheidsorgfasiliteit in Gauteng te verbeter sodat die kwaliteit van gesondheidsorg kan verbeter.

‘n Kwalitatiewe, ondersoekende, interpretatiewe beskrywend en kontekstuele ontwerp is gekies om die navorsingsvraag mee te ondersoek. Nie-waarskynlike, doelgerigte steekproefneming is gebruik. ‘n Fokusgroepbespreking is gehou (n=8) en grafiese spanbeelding is met die deelnemers gedoen (n=9). Die toestand van die huidige verpleegspan is beskryf en ondersoek sowel as die praktiese intervensie wat daarop gemik is om verpleegspanwerk te verbeter. Data vanaf die fokusgroep is ontleed met die gebruik van inhoudsanalise. Grafiese spanbeelding is ontleed deur interpretatiewe analise.

Die resultate van die navorsingstudie het bevind die verpleegspan deur verskeie faktore beïnvloed word wat as organisasie-, eenheids spesifieke- en eenheidsbestuurder spesifieke faktore gekatogeriseer kan word. Daar mag ‘n negatiewe organisasie kultuur met negatiewe houdinge van spanlede wees. Daar is onduidelikheid in die hierargie, onder die eenheidsbestuurder wat by dra tot magstryde tussen spanlede, dit het ‘n effek op die verantwoordelikheid en aanspreeklikheid in die afwesigheid van die eenheidsbestuurder. Individuele spanlede het konstante toesig en leiding nodig het om hulle daaglikse take te vervul. Die verpleegeenheidsbestuurders voel dat daar min ondersteuning van die top bestuur af is. Die algemene eenheids assistente en administratiewe klerk is as deel van die span gesien,

alhoewel hulle nie direk bydra tot die pasiënte sorg nie, speel hulle ‘n rol in die span funksionering. Geestesgesondheidsorgfasiliteite is oorvol wat die werksladings van die verpleegspan verhoog. Vetroue en kohesie tussen verpleegspan lede is laag as gevolg van slegte kommunikasie tussen die spanlede en groeperings. Die eenheidsbestuurder speel die allerhoogste rol deur leierskap, samewerking, regverdige delegering en leiding. Individualisme en diversiteit moet aangegryp word. Die eenheidsbestuurders tree as ‘n rol model en leier op waar hulle die span saambring, probleme oplos, kommunikasie bevorder en span lede betrek in besluitneming.

Sleutelwoorde: Verpleegspanwerk, rol, eenheidsbestuurder, geestesgesondheidsorgfasiliteit, grafiese gesinsbeelding.

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ABBREVIATIONS

A		
	AN	Auxiliary nurse
E		
	EN	Enrolled nurse
G		
	GFS	Graphic family sculpting
	GTS	Graphic team sculpting
I		
	ICU	Intensive care unit
M		
	MHCF	Mental health care facility
N		
	NUM	Nursing unit manager
O		
	OSD	Occupational specific dispensation
P		
	PHC	Primary Health Care
R		
	RN	Registered nurse
S		
	SA	South Africa
	SANC	South African Nursing Council
U		
	UM	Unit manager
W		
	WHO	World Health Organisation

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CHAPTER

CHAPTER 1:

OVERVIEW OF THE RESEARCH

1.1 INTRODUCTION

Chapter 1 provides an overview of the research. During the background the researcher formulates the argument that leads to the problem statement, research question, aim and objectives. The research question, aim and objectives direct the research design and method. After the measures to enhance rigour and ethical considerations are declared, the proposed chapter outline is declared.

1.2 TYPES OF TEAMS AND TEAMWORK CLARIFIED

In this research the concept “nursing teamwork” is used. Yet, there are different types of teams within health care in general such as the multi-disciplinary team; transdisciplinary – and interdisciplinary teams. To prevent confusion, the different types of teams are defined in Table 1.1 (below). As the background refers to different types of teams, Table 1.1 serves as a roadmap.

Table 1.1: Definitions of types of teams and teamwork used in the health care sector

Types of teams and teamwork	Description
Teamwork	It is a dynamic process involving two or more health professionals with complementary backgrounds and skills and who interact dynamically, interdependently and adaptively towards a common and valued goal/objective/mission and exercising concerted physical and mental effort in assessing, planning, or evaluating patient care (Kelly, 2008:247; World Health Organisation, 2009:22; Xyrichis & Ream, 2007:238).
Multi-disciplinary team	Members of different health care professions with individualized specialised skills working collaboratively together. Representatives of different disciplines who co-ordinate the contributions of each profession, which are not considered to overlap, in order to improve patient care (Miller-Keane Encyclopaedia and Dictionary of Medicine, 2003). All the members of the multidisciplinary team are from the health care sector.
Inter-disciplinary team/ Transdisciplinary team	A group of health care professionals from diverse fields who work in a coordinated fashion toward a common goal for the patient (Miller-Keane Encyclopaedia and Dictionary of Medicine, 2003). These members can come from different fields, for example history, health and ecology. It is thus a team composed of members of a number of different professions cooperating across disciplines to improve patient care through practice or research.
Nursing team	Accommodates several categories of nursing personnel in meeting the comprehensive nursing needs of a group of patients (Miller-Keane Encyclopaedia and Dictionary of Medicine, 2003).

This research focuses specifically on nursing teamwork as consisting of a group of nursing staff from different nursing categories working together interactively, within a unit to satisfy patient needs and working towards the same goal. When referring to a team in this study, a nursing team is meant if not specified as another type of team.

1.3 BACKGROUND

A South African perspective on mental health care

South Africa presents a unique mental health care content. Mental health care services refer to institutions, facilities, buildings or places where persons receive care, treatment, rehabilitative assistance, diagnostic or therapeutic interventions or other health-care services (South Africa, 2002). As South Africa functions from a Primary Health Care (PHC) philosophy (Lund & Flisher, 2002:157), mental health care can be described as unique to the South African context because primary mental health care nurses are the first contact with mentally ill patients as mental health care users. From the PHC perspective patients in urban areas are enabled to reach health care facilities referred to as PHC clinics (Lund & Flisher, 2002:157). Although South Africa experienced major political changes with the dawn of the new democracy in 1994, mental health care users still had limited rights (Lucas & Stevenson, 2006:195). It was only in 2002 with the implementation of the new Mental Health Care Act (Act No. 17 of 2002) that patients received equal rights and improved access to mental health care.

The South African public health sector has come a long way to enhance accessibility of health services. After improved accessibility of public health care facilities in general, the South African Department of Health (South Africa [SA], 2011:11) also strives towards quality health care for all. Yet accessible and quality mental health care is difficult when there is a lack of specialised mental health professionals to render the holistic services as proclaimed (SA, 2011:52). Furthermore there is a lack of specialised mental health professionals which may be due to a lack of trained and experienced mental health workers (Cleary & Freeman, 2006:986; Kalisch & Lee, 2012:2; Smith, 2010:576). Within the context of mental health service delivery within staff shortages, there is increased pressure on managers to improve mental health care in accordance with national norms and standards (SA, 2011:52). Yet managers don't have the necessary skills for human resource management and lack of training to acquire these skills. Mental health care in practice is in contradiction to the ideology of how mental health should function. The reality at mental health care facilities in South Africa are regular involuntary treatment, minimal patient contact with therapists, negative attitudes, pressure of beds not being available and regular seclusions due to unmanageable situations (Barker & Walker, 2000:539;

Cleary *et al.*, 2012:472). Unskilled managers and a shortage of nurses contribute to this poor service delivery in which the nursing team has to function (Cleary *et al*., 2012:473; Lund & Flisher, 2002:158; WHO, 2011:52).

The National Department of Health in South Africa (SA, 2011:6) states that one of the priority areas in the core standards of health care is improving values and attitudes of health care professionals. One of the ways to accomplish this, is that leaders at all levels should be positive role models to staff to encourage a culture of caring and positive attitudes that supports service delivery.

A nursing team versus a multi-disciplinary team

The multi-disciplinary team consists of sub-teams (doctors, social workers, occupational therapists, physiotherapists, psychologists and nurses) where each of these teams has a different concept of care (Kalisch *et al.,* 2009:303). It is expected that the multi-disciplinary team contributes to improving service delivery, yet Jones and Jones (2011:178) proved differently and stated that the role boundaries are unclear in a multi-disciplinary team, thus conflict arises between different teams and not within teams because conflict is task related. Conflict can be alleviated if the working team strives towards the same objective. But teams do not always have the same objectives and responsibilities, therefore conflict would always arise between groups. Wells *et al.* (2006:1841) support this statement by saying that members of different disciplines often bring conflict philosophies of care as well as a specific jargon into their interactions, which can result in conflict. In addition, role boundaries might be unclear in a multidisciplinary team (Jones, 2006:19; Xyrichis & Lowton, 2008:140). This confuses health care professionals about their specific responsibilities that overlap - job descriptions should be in place to define each health care professional's responsibilities to prevent conflict. An example of possible role confusion can be found in a study done in Worcester (Western Cape Province), South Africa, about effective teamwork between doctors and clinical nurse practitioners. The findings indicate that doctors perceived nurses as assistants who could be called on to run errands (Mash *et al.,* 2007:17). Shaw *et al*. (2007:372) also found that research of multidisciplinary teamwork in mental health care settings have uncovered tensions associated with differences in philosophies of care. Furthermore Berg and Hallberg (2000:323) argue that a multi-disciplinary team does not function well as a team, mainly because nurses lack professional confidence. A study done in a mental health care setting in the United States of America (USA) found that when mutual respect amongst staff was greater, the patients improved more over time and that nurses and social workers are more efficient than physicians at fostering mutual respect (Wells et al., 2006:1840). Various studies have been done about inter-disciplinary and multi-

disciplinary teams (Atwal & Caldwell, 2006:359; Hall, 2005:188; Lieberman *et al.*, 2001:1331), but there is no known study on improving teamwork specifically as a nursing team in mental health care in South Africa.

Multi-disciplinary and inter-disciplinary teams overlook the potential of tensions that may arise from differences in the interpretive frameworks which professionals bring to the task of collaboration, and downplay the impact of professional power differentials on the decision making process (Shaw *et al.,* 2007:357). If any team wants to work towards the same objective the members need the same mental model, which is defined as the shared organizational understanding of a specific topic or goal (Burtsher & Manser, 2012:1345). Mental models have a positive effect on teamwork in general because members can anticipate each other's needs and actions to coordinate teamwork more successfully (Burtsher & Manser, 2012:1345; Kalisch *et al.,* 2009:303). It is therefore argued that teamwork can be viewed as an important factor in health care service delivery in general.

A nursing team in general refers to a number of individual nursing staff members coming together to share their expertise with one another for the purpose of achieving a common goal (Begley, 2008:267; Jooste, 2010:139; Kalisch *et al.*, 2009:299; Kalisch *et al.*, 2013:215; Sullivan & Garland, 2010:79). A nursing team is necessary because no one nurse is able to meet the complex needs of a patient. This view is fortified by Cleary *et al.* (2012:473) stating that nurses perceived nursing teams as one of the most outstanding nursing achievements. The nursing team in a mental health care facility is a known dynamic present in every hospital, rehabilitation centre and out-patient facility, that makes these units functional.

The importance of a nursing teamwork in a challenged mental health care environment

Despite the valuable contribution of nursing teams, the functioning of these teams is impacted on by challenges associated with mental health care. The first challenge is the amount of violence towards staff in mental health care facilities. In the USA the assault rate was 8.3 per 10 000 workers (Privitera *et al.,* 2005:480). In South Africa, Lucas and Stevenson (2006:195) reported that 50% of patients experienced violence in South African mental health care facilities. Thus violence is both patient and staff orientated.

Secondly, the de-institutionalisation of mental health care resulted in the expansion of nurses' roles within primary mental health care. Despite the expansion of nursing roles, nurses still remain the cornerstones of mental health care services (Jones, 2006:19). De-institutionalisation also decreased the number of available mental health care nurses. This is especially

challenging when considering the prominent role mental health care nurses play in hospital and community settings of mental health facilities. This prominent role is captured in South African mental health care policies that emphasise a community-based rehabilitative model of mental health care within a comprehensive integrated health service (Lund & Flisher, 2002:157).

The third challenge is the shortage in nursing staff. Just within Gauteng, the most densely populated province (with a population of 11,328,203 people), there are only 60,929 nurses in general, bringing the ratio of population to nurses to 185:1 (South African Nursing Council [SANC], 2011:1). As mental health care is stigmatised, the shortage of nurses in a mental health care facility is even greater (Cleary *et al.,* 2012:473) than in general health care facilities. Across all professions, the global median rate for human resources working in the mental health sector is 10.7 workers per 100,000 of the population (WHO, 2011:52). The ratio of nurses is 5.8 nurses per 100,000 patients worldwide (WHO, 2011:52). In Africa the ratio of mental health care nurses is 0.61 nurses to 100,000 of the population (WHO, 2011:54). According to Lund and Flisher (2002:158) there are only 0.3% mental health care staff members per bed in public health care facilities in South Africa. In Gauteng there are 0.17% mental health care nurses per public hospital bed. Within the context of challenged mental health care facilities, nursing teamwork becomes even more important. Kalisch and Lee (2012:5) found that teamwork is more prominent in mental health care and pre-operative units compared to intensive care units (ICUs) and paediatric units. Within the large nurse to patient ratio in mental health care and against the literature portraying the necessity of teamwork in health care delivery in general, the question is asked whether nursing teams do have some advantage in practice.

Advantages of a nursing team

The advantages of a nursing team in a mental health care setting in South Africa are located both within the patient and the nursing personnel. The patient benefits from the comprehensive treatment that could be provided, focusing on all aspects of care as a holistic enterprise. A lack of teamwork leads to patient-focused errors (Jones & Jones, 2011:175; Kalisch & Lee, 2012:1) which is a major threat to patient safety.

When nurses work in effective teams they are more productive and less stressed, the quality of care they deliver is higher and fewer errors occur (Kalisch & Lee, 2012:1). Nurses reported feeling more energetic and motivated when they work within an excellent team (Cleary *et al.,* 2011:456). Teamwork contributes to high levels of job satisfaction, increases staff morale and would lower high turn-over rates of nurses (Jones & Jones, 2011:175; Kalisch *et al.,* 2010:938;

Kalisch & Lee, 2012:2; Toofany, 2007:24;). Burnout can be prevented through effective team functioning, which reduces the frustration of working in isolation (Berg & Hallberg, 2000:324).

Is the nursing team functioning efficiently?

According to research nursing teams are not functioning optimally. Kalisch and Lee (2012:2) state that 70% of patient incidents are due to a communication failure as the primary cause of these incidents. Communication difficulties can be due to different cultural groups in the workplace which may negatively influence the cohesiveness of teams (Toofany, 2007:24). As a team it can sometimes be hard to trust each other, especially with existing differences in team mental models (Kalisch *et al.,* 2009:303). Trust in a team is something every team should strive for. In a study done in Dublin, Ireland, it was proven that inter-professional learning is advantageous in developing more effective inter-professional teams (Begley, 2008:276). Nursing shortages, lack of support, resistance to change and insufficient commitment contribute to team ineffectiveness (Toofany, 2007:27), and this restricts inter-professional learning as a nursing team. There is no tertiary educational programme in South Africa which promotes nursing teamwork. It is the responsibility of senior managers to initiate programmes that develop leadership skills and team building (Toofany, 2007:25). Unclear levels of accountability and lack of leadership constitute a major factor that contributes to poor team functioning (Berg & Hallberg, 2000:326; Cleary & Freeman, 2006:992).

The crucial role of the nursing unit manager

Nursing unit managers' leadership and management styles play an important role in team cohesion. Toode *et al.* (2011:246) identified five factors that affect work drive in nurses namely; workplace characteristics, working conditions, personal characteristics, individual priorities and internal psychological states. In terms of nursing unit managers, it is their responsibility to create a positive work environment that facilitates teamwork (Registered Nurse' Association of Ontario, 2013). A satisfied nurse has a greater readiness to work collaboratively and deliver high quality care (Kalisch *et al.,* 2010:939). Staff members are an organization's most valuable asset; therefore, it is important to enable them through teamwork to become as productive as possible. It is the role of the nursing unit manager to improve the nursing teamwork.

1.4 PROBLEM STATEMENT AND RESEARCH QUESTION

From the information expounded in the background it can be stated that mental health care in South Africa has come a long way since the launch of the Mental Health Care Act, no 17 of

2002 (South Africa, 2002). Despite critical changes to mental health care there are still numerous challenges that have an impact on mental health care facilities. These challenges can be summarised as insufficient infrastructure and staff shortages (Cleary *et al*., 2012:473; Lund & Flisher, 2002:158; WHO, 2011:52), inadequate training of nurses (Jones, 2006:19), overburdened facilities, resistance to change (Toofany, 2007:27) and a lack of community support. Within these challenges mental health care nurses are the frontline health care professionals in direct contact with patients. International literature has indicated that strong teamwork amongst health care professionals in general has a positive impact on the mental health care rendered (Cleary & Freeman, 2006:986; RNAO, 2013).

The positive impact of a functional team in general results in quality holistic care, improve patient safety (Jones & Jones, 2011:175; Kalisch & Lee, 2012:1), leading to high levels of job satisfaction, increases in staff morale and may lower high turn-over rates of nurses (Jones & Jones, 2011:175; Kalisch *et al*., 2010:938; Kalisch & Lee, 2012:2; Toofany, 2007:24). In addition, the nursing unit manager is central to the initiation and maintenance of the nursing teamwork (SA, 2011:52) in health care in general. The gap identified is that there is limited national and international research on nursing teamwork specifically in mental health care facilities and equally little on the role of the unit manager to improve nursing teamwork. This led the researcher to ask; *what is the role of the nursing unit manager to improve nursing teamwork in a mental health care facility*?

1.5 RESEARCH QUESTION

Extrapolating from the literature above the researcher argues that nursing teamwork is essential for optimal unit functioning in a mental health care facility. Yet the nursing team doesn't function as it should according to international literature. The unit manager is the central point in the nursing team. The research question asked is what the role of the nursing unit manager is to improve nursing teamwork in a mental health care facility?

1.6 AIM AND OBJECTIVES

The research aim and objectives are declared as follows:

Table 1.2: Research question, aim and objectives of the research study

Research question and sub-questions	Research aim and objectives
Research question: What is the role of the nursing unit manager to enhance nursing teamwork in a mental health care facility?	**Aim:** To improve nursing teamwork in a mental health care facility in Gauteng.
Sub-questions: What is unit managers' understanding of nursing teamwork in a mental health care facility in Gauteng? What is the role of unit managers to enhance nursing team work in a mental health care facility in Gauteng?	**Objectives:** To explore and describe unit managers' view of nursing teamwork in a mental health care facility in Gauteng. To explore and describe the unit managers' role to improve nursing teamwork in a mental health care facility in Gauteng.

1.7 RESEARCH'S PARADIGMATIC PERSPECTIVES

A paradigm is the particular way in which a phenomenon is viewed (Burns & Grove, 2009:712). According to Botma *et al.* (2010:40) a paradigm is an accepted set of beliefs or values that guide research as it is the way the researcher views the world. In this section the researcher declares her paradigmatic perspective by way of a meta-theoretical-; theoretical– and methodological perspectives as applied to the study.

1.7.1 Meta-theoretical perspectives

View of man: The researcher views man from a Judeo Christian perspective, as God created individuals who are holistic and a unique human being. Every person also has his/her own viewpoint and can take decisions independently. In this study the researcher sees man as all the members of the nursing team, including the unit manager and all nursing categories. The patient/mental health care user is not part of the nursing team and won't be included in this specific study.

View of environment: As a Christian the researcher has a responsibility to look after the environment. In Gen 1:26-28, the following is stated God said, “Let us make mankind in Our image, after Our likeliness and let them have complete authority over the fish of the sea, the birds of the air, the beasts, and over all the earth, and over all that creeps upon the earth” (Holy Bible, 1987:1-2). The researcher views the work environment as a collaborative effort of all humans to improve and maintain the environment to strive for an optimally functional therapeutic workplace. This researcher sees the environment as the direct environment of the nursing care team in their unit and in the hospital that they are working in. The environment is the context within which the nursing team functions.

View of nursing: The researcher agrees with the definition of the International Council of Nurses (2010) that states that nursing can be seen as the total autonomous and collaborative care of individuals of all ages, families, groups and communities, whether they are sick or well, regardless of their settings. Nursing includes the promotion of health, prevention of illness and the care of the ill, disabled and dying people. Nursing is seen as the delivery of care to positively influence others to reach optimal health. In this study nursing is seen as the collaborative effort of the nursing team, working together to reach a common goal that contributes to patient outcomes.

Mental health/health: The researcher supports the wellness model of Anspuagh, Hamrick and Rosato (2003:3). To reach optimal health a person should reach optimal functioning in all seven aspects of wellness namely; intellectual, physical, social, environmental, occupational, spiritual and emotional, as shown in the figure below. Mental illness is seen as a deviation in emotional wellbeing or any mental disorder as classified in the DSM-IV-TR (American Psychiatric Association, 2000:13-26). In this study mental health is seen as the main focus of an effective nursing team where the nursing team strives to promote the wellness of all patients under the team’s care. The following figure 1.1, compiled by the researcher, illustrates the components of wellness as it is seen by the researcher;

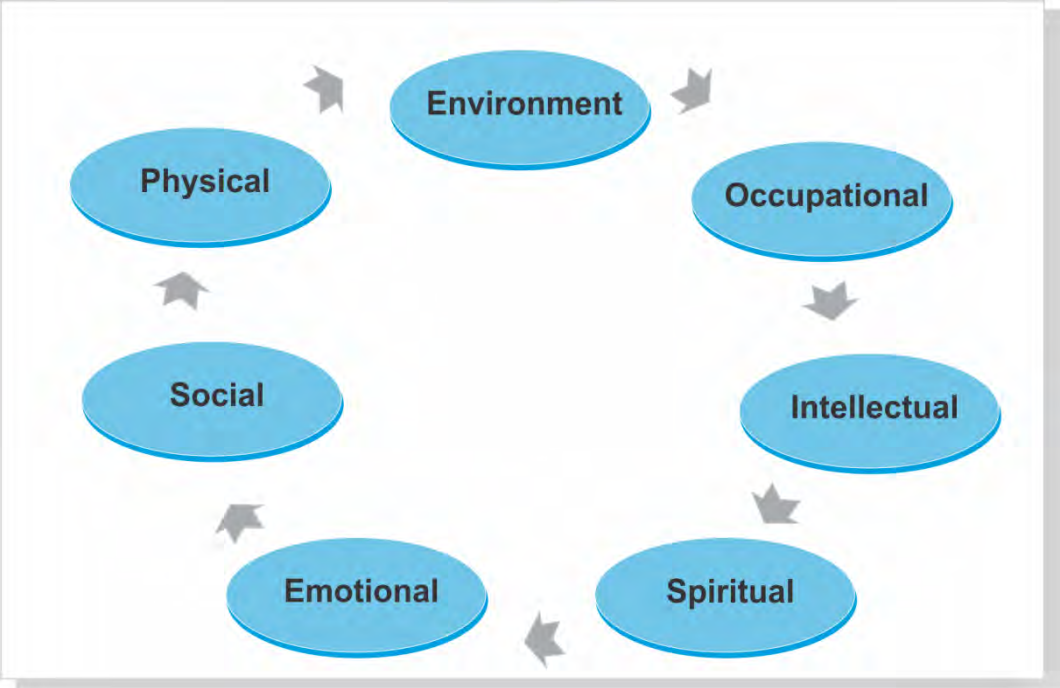


Figure 1.1: The seven components of wellness adapted from the wellness model of Anspuagh, Hamrick and Rosato (2003:3).

1.7.2 Theoretical perspectives

The theoretical perspectives are divided into a theoretical framework as conceptual definitions.

1.7.2.1 Theoretical framework

The researcher based her theoretical assumptions on the system theory of Katz and Kahn (1980). The system can be seen as the whole organisation, a division, department or a team. The following five points summarize the key components of the system theory (Katz & Kahn, 1980:489):

- The organisation is an open system, which interacts with the environment and is continually adjusting and improving.
- The organisation influences and is influenced by the environment in which it functions.
- If an organisation is to be effective it must pay attention to the external environment, and take steps to adjust itself to accommodate the changes in order to remain significant.

- All parts of the organisation are interconnected and inter-reliant; if one part of the system is affected, all parts are.
- It is not possible to know everything about the system, but if you look hard enough there are plenty of indications.

In this study the nursing team and the unit manager as leader of the nursing team function interconnected and inter-reliantly within smaller groups, within units and within a larger organisation where all parts affect the other.

1.7.2.2 Conceptual definitions

For the purpose of the study the following concepts can be defined as:

Family sculpting: Family sculpting is a non-verbal communication method used in family therapy, whereby a family member can physically place other members in a spatial relationship with one another, symbolising, among other things, his or her perception of the family members. The difference of power and degrees of intimacy within the family is also reflected through family sculpting (Goldenberg & Goldenberg, 2013:241).

Graphic family sculpting: Graphic family sculpting is a modified form of family sculpting that was developed by Venter in the 1980's. Graphic family sculpting is a powerful and effective diagnostic and therapeutic drawing technique. This technique requires a family member to draw his/her family on a sheet of paper by representing each person with a circle. The person must also then add other relevant information to the sketch. A variety of drawing techniques similar to graphic family sculpting are described in literature also referred to as "family art therapy, conjoint family drawing, symbolic drawing of the family space and "de gezinskaart" (Venter, 1993:12).

Graphic team sculpting: The researcher in conjunction with the founder of the graphic family sculpting technique (Venter) modified the original graphic family sculpting technique to a graphic team sculpting technique. This technique was modified to be appropriate to teams instead of families. The basic technique of data collection remained unchanged, but the word structure and question relevance were adjusted to be applicable to teams. The researcher will declare the application process of the graphic family sculpting to the graphic team sculpting in paragraph 1.8.2.2.

Mental health care facility: According to the Mental Health Care Act no 17 of 2002 (SA, 2002), a mental health care facility refers to facilities, buildings or places where persons receive care,

treatment, rehabilitation, diagnostic and therapeutic interventions or other mental health services. It includes facilities such as community health care clinics, rehabilitation centres, hospitals and mental health care facilities. The study focuses on a mental health facility in the public sector, which externally influences the nursing teamwork.

Nursing teamwork: Teamwork can be defined as a number of interdependent individual staff members, who comes together to share their expertise with one another for the purpose of achieving a common goal (Begley, 2008:267; Jooste, 2010:139; Kalisch *et al.,* 2009:299). For this study nursing teamwork specifically refers to a nursing team working in a mental health care facility.

Nursing unit manager: The unit manager is the person responsible for the process of planning, organising, staffing, leading and controlling the resources of the mental health care establishment to achieve organisational goals and maintain the highest standards (Jooste, 2010:78). These responsibilities are in correlation with the unit managers' job description of the specific hospital that is being studied. In this study the researcher sees the unit manager as the person who is responsible for the overall unit functioning and who is employed by the hospital to manage the unit according to his/her job description.

> ***T*he *researcher will refer to graphic team sculpting instead of graphic family sculpting as this is a modified technique for nursing teams. Where referred to graphic family sculpting the researcher refers to the original technique of graphic family sculpting before modifications.***

1.7.3 Methodological assumptions

The Botes Research Model (Botes, 1992:36-42) is used by the researcher as adapted from Mouton and Marais (1992:22). This model lends itself to a holistic perspective of the research process rather than a detailed description of the methods and techniques. The nursing activities are shown in three orders as follows;

- The first order is the practice of nursing in promoting the health of the patient. In this study the first order is the interaction of the team in a mental health care unit. The researcher identified a lack of teamwork in the work environment and subsequently strives to improve teamwork. By doing this, patient outcomes improve.

- The second order focuses on the research. The researcher, who functions at the second order, is continually in interaction with the practice situation. The researcher and the practice environment are interactive and influence each other. The researcher should be fully aware of the influence which he/she has on the practice environment and the influence that the environment has on the research. The practice environment can be seen as all the factors that have an influence on the nursing team.
- The third order is the belief system/paradigmatic perspective within which the research was done. The researcher declared all beliefs throughout the study and states them as limitations if they had an influence on the research.

1.8 METHODOLOGY

Hereafter follows a discussion on the methodological approach used in the study; definitions of the key concepts present in the research problem and research question and collection methods. Clarification is given on the population and sampling, the data collection methods and the way in which the data analysis was done during the study.

1.8.1. Research design

The study is conducted from a qualitative, explorative, interpretive description and contextual design that aims to describe and explore nursing teamwork from a unit manager's viewpoint. A qualitative approach is used to understand human dynamics as the unit manager perceives it. The study design was helpful to explore the phenomenon and to get information on the current status of nursing teamwork and to make recommendations for future development in improving nursing teamwork in a mental health care facility. Exploratory studies are used to increase knowledge of a field of study and are not intended for generalisation to large populations (Burns & Grove, 2009:700). The design is thus contextual, because it is unique to a specific population and setting, namely a tertiary mental health care hospital in Gauteng province. Interpretive description (Thorne *et al.*, 2004:1) is an inductive qualitative analytic approaches designed to create ways of understanding clinical phenomena that yield applications implications. An interpretative design acknowledges the constructed and contextual nature of human experience that at the same time allows for shared realities (Thorne *et al.*, 2004:21). A qualitative approach is used to understand human dynamics as the unit manager perceives it. The study design was helpful to explore the phenomenon and to get information on the current status of improving

nursing teamwork in a mental health care facility and to make recommendations for future development in nursing teamwork.

Qualitative research refers to an interactive, subjective approach whereby phenomena are studied within their natural settings in an attempt to interpret the phenomena or to make sense thereof (Burns & Grove, 2009:717). The qualitative research approach, according to Denzin and Lincoln (2003:5) and Burns and Grove (2009:23) uses an interpretive, naturalistic approach to the world as the researcher examines the phenomena in their natural settings and enables the researcher to understand and give meaning to words that individuals shared. This research approach enables the researcher to use different strategies such as phenomenology, grounded theory, ethnography, historical research, philosophical inquiry and critical social theory (Burns & Grove, 2009:54). During the qualitative research approach the participant constructs the data as the researcher gathers and works with this data. In this study the researcher used graphic team sculpting to portray the current status of nursing teamwork, followed by a focus group in order to gain a deeper understanding in what is the role of unit managers to improve nursing teamwork within a mental health facility in Gauteng. .

Interpretive description (Thorne *et al.*, 2004:1) is an inductive, qualitative, analytic approach to create ways of understanding clinical phenomena that yield applications implications. An interpretative design acknowledges the constructed and contextual nature of human experience that at the same time allows for shared realities (Thorne *et al.*, 2004:21). Interpretive descriptions often involve multiple data collection strategies to avoid naïve over-emphasis that leads to research that does not offer comprehensive and contextualized interpretations of its central phenomena of interest. Descriptive designs are used to discover new facts about a phenomenon and to provide in-depth feedback and accurate picture of the characteristics of the population studied. This design gives the opportunity to interpret the theoretical significance of results and provides understanding and knowledge generated from the studied population (Brink et al., 2006:104; Burns & Grove, 2009:237-238).

Exploratory designs are used to increase knowledge of a field of study and are not intended for generalisation to large populations (Burns & Grove, 2009:700). The aim of exploratory research is to explore the full nature of a phenomenon with regard to the manner in which the phenomena exists and manifests as well as any other related factors. The research setting is within Gauteng, one of the nine provinces in South Africa (please refer to Figure 1.2 below).

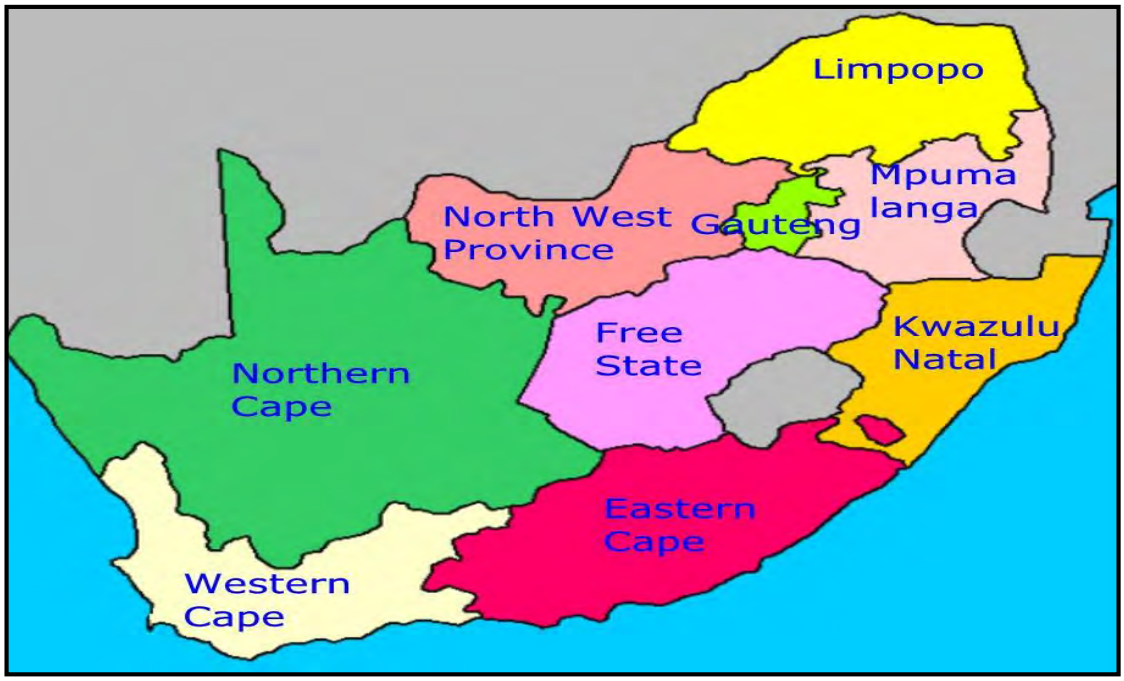


Figure 1.2: Map of South Africa (SA travel, 2013)

In figure 1.3. below a detailed picture of Gauteng is provided, with the six districts and major cities. In general Gauteng has a total of 33 hospitals spread across six districts (Johannesburg Metro, Tshwane, Ekurhuleni, West Rand, Sedibeng and Metsweding). In total, there are four central hospitals, two provincial tertiary hospitals, nine regional hospitals, 11 district hospitals and six specialised hospitals (Green, 2005).

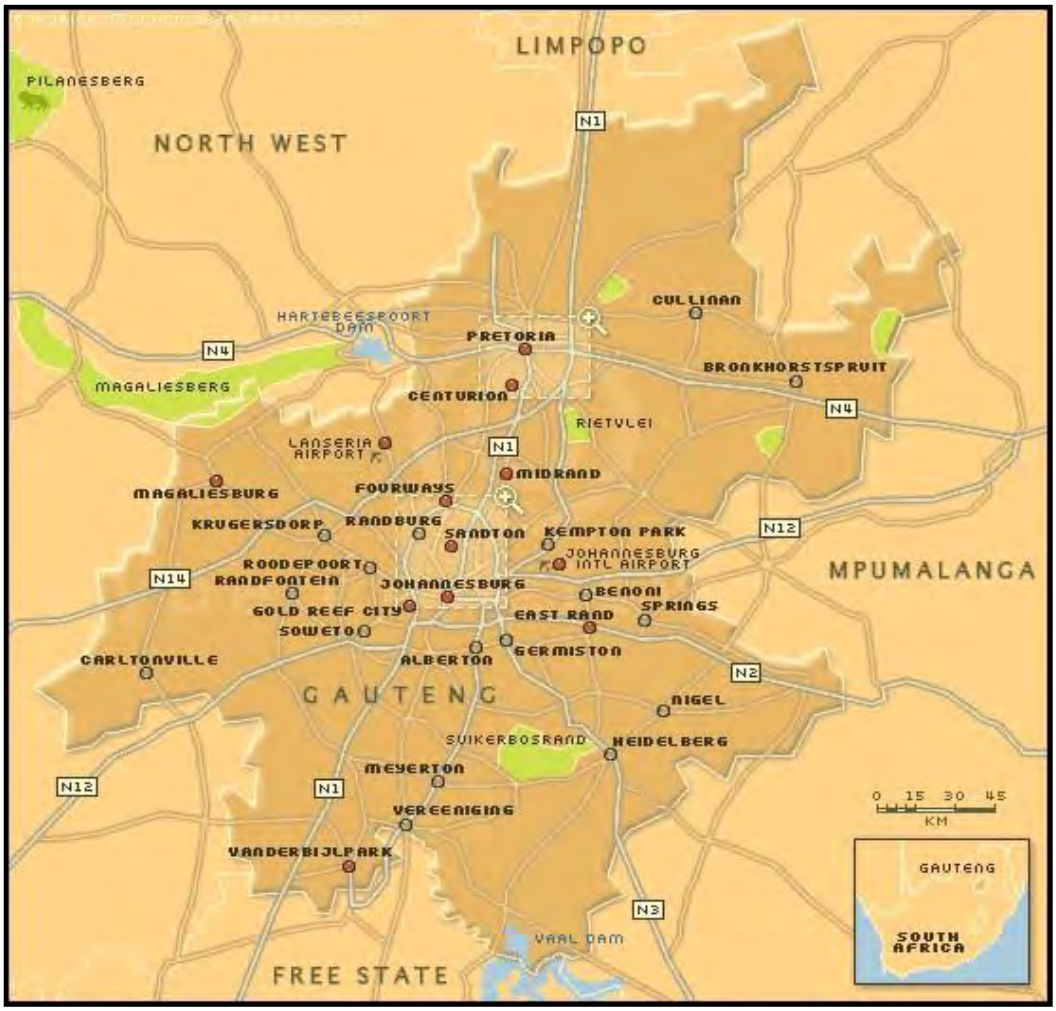


Figure 1.3: Map of Gauteng Province (Cyber Cape Town, 2013)

According to Green (2005) the census of 2011 confirmed that Gauteng Province has a population of 12.2 million people; a figure that has risen by 33.7% from a total of 7 million in the 1996 census. This makes it South Africa's most densely populated province accounting for 23.7% of the total population, despite occupying only about 1.4% of South Africa's land area, which makes it the smallest in size.

The mental health care hospital where the research was conducted is situated in the West Rand District of Gauteng. There are 17 functional wards and 613 usable mental health care user beds. There are 255 nurses including 13 unit managers working at the hospital (Green, 2005; Shuping, 2013). Green (2005) emphasised nine years ago that the hospital is over-populated and has too many patients for the total number of beds.

The context of data collection was a public mental health care specialised hospital that is situated in Gauteng; the hospital renders services to a 7.1 million mental health care users in their catch-up area (Shuping, 2013). The hospital has 820 approved beds, but due to limited resources only 613 are currently usable beds. The hospital renders the following mental health care services (Shuping, 2013);

- General and forensic psychiatry.
- Tertiary level in-patient care to Southern Gauteng.
- Forensic services to Southern Gauteng (mental observations: care treatment and rehabilitation of state patients).
- Forensic services for the North-West Province (mental observations).
- Male adolescent psychiatry (forensic).
- Dual Diagnosis Unit.
- Independent Living Unit (ILU).
- Anti-Retro Viral Centre/ Neuropsychiatric Unit.
- Human Immundeficiency Virus Counselling and Testing Centre.

Currently there are a total of 675 staff working in the hospital and 166 posts are vacant. The vacant posts are in part due to a high turnover rate and a slow employment rate. The total nursing staff consists of 255 nurses which can be categorized as follows (Shuping, 2013);

- 1 deputy manager (director in nursing).
- 7 assistant managers.
- 13 operational managers (unit managers).
- 137 professional nurses.
- 61 enrolled nurses.
- 36 enrolled nursing auxiliaries.

Depending on the ward structure and type there typically are 14 nursing staff personnel per ward (Shuping, 2013). The patient to staff ratio per shift is approximately five patients per nurse. This however, depends on the ward capacity, but it is clear that there are staff shortages within

the hospital. The hospital layout (wards, type and total beds) can be presented in table 1.3 below:

Table 1.3: Ward type and number of beds

Ward	Male/ Female	Type of ward	Total usable beds	Unit Manager
1A	F	Forensic observation and state patients	14	1 Unit manager (Ward 1A and 1B)
1B	M	Forensic adolescent observation and state patients	10	
2	F	Acute and long term	40	None (unit manager on full time study leave)
3	F	Acute admissions	20	Yes
4	F	Rehabilitation/Long-term and Geriatric care	40	Yes
5	**Not in use**			
6	M	Dual diagnosis	15	Vacant post.
7	M	Acute admissions	40	Yes
8	M	Acute admissions	40	Yes
9	M	Pre-discharge	40	Yes
10	**Not in use**			
11	M	Acute admissions	45	Yes
12A	**Not in use**			
12B	M	Geriatric and physically ill	20	Yes
13	M	Forensic state patient	65	Yes
14	M	Forensic state patient	65	Yes
15	**Forensic administration**			
16	**Closed**			

Ward	Male/ Female	Type of ward	Total usable beds	Unit Manager
17A	M	Forensic observations	30	Yes
17B	M	Forensic state patient (acute)	30	Yes
18	M	Forensic state patients	70	Yes
Independent living unit	M&F	Rehabilitation	13	None (Enrolled nurse managing the unit)

1.8.2. Research method

The research method is divided into data collection, data analysis and integrated discussion of the research results. In this study the researcher will combine two methods of data collection, namely graphic team sculpting (phase 1), then the focus group (phase 2) and the integrated discussion of the research results from both phases (phase 3). The reason for the combination of these two methods are to ensure rigour through data triangulation. The proposed research method with specific reference to the phases of data collection is outlined in figure 1.4 below.

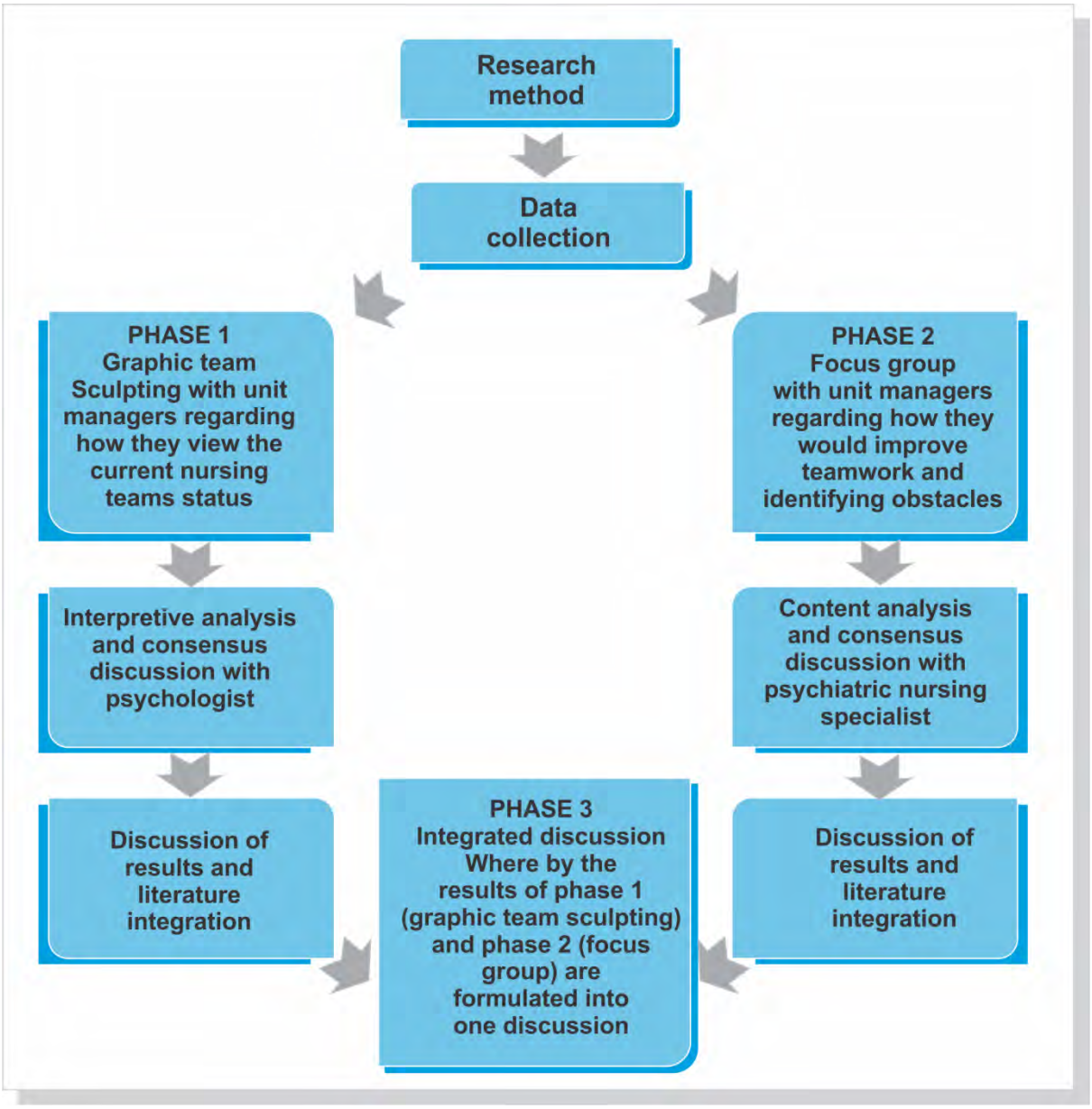


Figure 1.4: Overview of the research process regarding data collection, analysis and integrated discussion of results

1.8.2.1 Literature review

Botma *et al.* (2010:196) explains that a literature review of especially theoretical literature can be conducted as this fortifies the need why a qualitative study should be conducted and to explore the appropriateness of the research methods.

1.8.2.2 Data collection

The population, sample, sampling method with inclusion criteria, the method of data collection according to the phases of data collection and the sample sizes are described below. The data collection description was used for both the focus group and graphic tem sculpting.

Population: The population (Brink *et al.,* 2006:206) included in this study consists of thirteen unit managers in a public mental health care hospital in Gauteng.

Sample and sampling: The sample refers to a subset of the population that is selected to represent the population (Brink *et al.,* 2006:207). Non-probability, purposive sampling is used where participants are selected due to their information-rich characteristics. The sample is seen as the experts on the topic (Brink *et al.,* 2006:133). In this case the topic is nursing teamwork.

The researcher identified the participants during the recruitment process. The following **inclusion criteria** (Burns & Grove, 2009:703) were used in the sample:

Participants should

- be literate in English;
- be in active unit managers' posts and registered as professional nurses at the South African Nursing Council;
- have at least three years' experience as a mental health care provider (Registered nurse/ Operational manager in mental health) and;
- be working in a public mental health care hospital in Gauteng for a minimum of one year.

All unit managers who qualify according to the above-mentioned criteria were included in the sample (n=9). The **sample size** is not limited to a specific number because the researcher aimed to get rich and deep information about the phenomenon. The number of participants proved to be adequate when data saturation occurred (Burns & Grove, 2009:361). According to Thorne *et al.* (2004:6) interpretive description is the smaller scale qualitative investigation of a clinical phenomenon, for the purpose of capturing themes and patterns within subjective perceptions and generating an interpretive description capable of informing clinical understanding. Such studies often build upon relatively small samples. Interpretive descriptions often involve multiple data collection strategies to avoid naïve over-emphasis that leads to research that does not offer comprehensive and contextualized interpretations of its central

phenomena of interest. Thus data saturation does not have to occur to ensure high quality of data as long as data can be described interpretatively.

Graphic team sculpting as well as focus groups were used as **data collection methods** and will be outlined as phases 1 and 2. Graphic team sculpting is going to be the initial data collection method followed by a focus group, field notes were collected during both methods (by the researcher and co-facilitator). Graphic team sculpting was the primary method of data collection to ensure that the participants gave a true reflection of the current status of nursing teamwork in the different wards, data contamination was thus avoided.

PHASE 1: GRAPHIC TEAM SCULPTING

Graphic team sculpting, an adapted version of graphic family sculpting, was used as a data collection method. Graphic family sculpting is well known in psychology and social science but new to the nursing field. The graphic family sculpting technique was originally developed by Venter (1993:12). In this technique a family member or family members are asked to draw a picture of their family of origin or current family, presenting each family member with a circle. Other information, as requested by the researcher, is then also indicated on the drawing. In the present study Venter's instructions for the technique were adapted by the researcher, with the guidance of Venter, to focus on team members. The technique, graphic team sculpting, was thus developed.

The method was validated by Van Hoek (1991:188) who found that this is a valid multidimensional instrument. Three factors were identified, namely structure, process and intra-philological experiences. A discussion of the drawings with the unit managers will not be done by the researcher as it can distort data in the focus group.

Individual appointments were made telephonically with each qualifying participant to do the graphic team sculpting. Graphic team sculpting was done in a private room in each specific ward where the participant worked. Participants followed the steps as outlined in the paragraph below, to collect the data for the graphic team sculpting. This was done over a two month period as per appointments. During the sessions field notes were made. The participants each signed voluntary informed consent (Appendix B) and a demographic data sheet (Appendix C) was completed by each participant to provide the researcher with basic background information regarding each participant's age, experience and education.

Participants were provided with an A3 sheet of paper and an HB pencil and eraser (an A3 sheet is provided rather than an A4 sheet because nursing teams can consist of many members, thus more space to draw is required). Please refer to appendix H for examples.

- **Application steps of graphic team sculpting**

The following instructions were given to the participants;

  - On the one side of the paper you must draw the nursing team you work with, presenting each member of the team with a circle. You can draw the circles as small or as large as you wish. In each circle or next to it, write the name of the relevant team member.
  - Number each circle according to the order in which you have drawn them.
  - On the back of the paper, next to number 1, write down whether you have discovered anything new about the nursing team. If you did, what was it?
  - Next to each circle on your drawing, write whether the person presented is sitting, standing or lying down. You could describe the position more fully, etc. standing up straight or sitting and reading.
  - On the back of the paper, next to number 2, write down whether you have discovered anything new about the nursing team. If so, what?
  - Indicate the direction in which each person is looking. Do this by drawing an arrow from the team member in the direction in which he/she is looking. Choose one direction for each member. If you feel strongly that a person must look in more than one direction, secondary arrows can be presented by a dotted line. If you feel that one person is looking at everybody, you can draw one arrow and write everybody next to that arrow. A person can be looking away from the team members or look forward or even look inwards or 'not look'.
  - On the back of the paper, next to number 3, write down whether you have discovered anything new about the nursing team. If you did, what is it?
  - Allocate a label to each team member as you think the team has labelled that person, e.g. the quiet one, the cheeky one, the hard worker or the clever one. Next to each label write (L). If you can't decide on a label for a specific team

member you can put a question mark with a (L) next to that specific circle. If needed you can give more than one label to a person.

- On the back of the paper, next to number 4, write down whether you have discovered anything new about the nursing team. If you did, what was it?
- Allocate a particular emotion or feeling that you think is mostly experienced by each team member. Write the emotion or feeling next to each circle with an (E) after it. If you can't decide on an emotion you can put a question mark with a (E) next to it. If needed you can allocate more than one emotion to a person.
- On the back of the paper, next to number 5, write down whether you have discovered anything new about the nursing team. If so, what was it?
- Finally answer these questions on the back of the paper:
- Next to number 6, write down whether it was easy for you to draw your team. Yes or No, and why?
- Next to number 7, write down whether you have learned anything in the process. Yes or No?
- Next to number 8, write down whether you became emotional during the process. Yes or No? (Adapted from Venter, 1993:13).
- Next to number 9, write down whether you have referred to a specific shift. Yes or No? If you have referred to a specific shift indicate which one it is, etc. day or night.

This method is appropriate because a true reflection of the teams functioning most probably would be given, the data was richer (see rational of application process below) and it also eliminates the possibility of the unit managers modifying the answers.

- **The application rational of graphic team sculpting**

In the following paragraphs follows an adaptation of Venter's rationale for Graphic Family Sculpting in order for the reader to understand the use of this method of data collection.

- Graphic team sculpting is a visual spatial metaphor which enables one to redefine complexes and vague issues to simple workable form. This minimizes the possibility of misinterpretations (Venter, 1993:12).
- The unit managers are enabled to come into contact with his/her emotional experience of team issues. After each instruction the unit manager is asked to indicate if he/she learned anything new about the nursing team (Venter, 1993:12).
- The technique appeals to the right hemisphere functions of the brain, namely the functions responsible for a more holistic, creative and intuitive processes of the brain (Venter, 1993:12).
- In the application of graphic team sculpting the unit manager is intellectually involved in studying the material that has a high emotional content and comes to acquire new knowledge about the team. He/she can therefore be more objective about issues within the team and assumes an "I" position. This promotes individual self-differentiation within the nursing teams (Venter, 1993:12).
- As with family sculpting, graphic team sculpting has an adhesive effect on teams. The unit manager realises that the members establish a unit within the team and that each member is not only a crucial part of the team, but that their behaviour influences team functioning and nursing teamwork (Venter, 1993:12).
- The unit manager becomes aware of positive and negative characteristics within his/her nursing team, and how this characteristics influences professional and personal development (Venter, 1993:12).
- The information obtained during the application process can enable effective change within the team (Venter, 1993:12).

PHASE 2: FOCUS GROUP

A focus group discussion was done to explore the specific role of the unit manager in improving nursing teamwork. The focus group was done with nine nursing unit managers. Focus groups are groups that are designed to obtain a participant's perception in a specific area (Burns & Grove, 2009:701), it is a means of better understanding how people think or feel about a certain topic (Botma *et al.,* 2010:210). One focus group was held with 9 participants, which is best for sharing perceptions and experiences (Botma *et al.,* 2010:211). Before the focus group

construction and during recruitment, the participants were provided with basic information (Botma *et al.,* 2010:14) about the study in the form of an information leaflet. Written permission was obtained prior to the focus group. The session was digitally voice recorded and transcribed during the data collection and analysis phases (Botma *et al.,* 2010:214). The following questions were formulated to be asked during the focus group. A copy of the questions, as stated below, was provided to the participants. The participants were provided with the focus group questions to keep them focussed on the research topic.

- Please describe the status of nursing teamwork at present in your unit.
- What do you think is the role of the unit manager (operational manager) to improve teamwork?
- What factors hinders nursing teamwork?
- What would the role of the nursing unit manager be to improve teamwork (practical strategies)?

Appropriateness of the focus group questions was checked with experts, as feedback of the questions is essential for quality control (Botma *et al.,* 2010:211). The questions were discussed with an expert, to make sure that the questions are clear in a conversational manner and relevant.

During the comprehensive process of data collection **field notes** were kept by the researcher. It includes empirical and personal observations (Botma *et al.,* 2010:217). Personal notes are comments about the researcher's own feelings and perceptions while in the field (Botma *et al.,* 2010:218). Empirical notes refer to a reflection on strategies and methods used. The researcher documents thoughts about how to make sense of what is going on. It is the researcher's effort to attach meaning to the data collection, and serves as a starting point for analysis (Botma *et al.,* 2010:218). Therefore field notes are intended to give an account of what the researcher thinks, feels, sees and experiences about the course of interaction during the focus group. The researcher kept field notes during the whole research process, the field notes can be viewed as Appendix G.

During the focus group field notes were taken by the researcher and co-facilitator (Appendix E). The researcher conducted the session and the co-facilitator operated the voice recorder and took notes. Field notes give an account of what the researcher perceived, saw and experienced about the course of interaction during the focus group. It includes empirical- and personal observations (Botma *et al.,* 2010:217). Descriptive notes were taken about the physical setting,

position in the circle of each participant and events. Reflective field notes were also taken during a process that includes the researchers' personal thoughts, feelings, ideas, impressions and speculations (Botma *et al.,* 2010:218). Reflective notes about the methodology, theoretical and personal notes were made. Field notes about demographic surroundings were also made.

1.8.2.3 Data analysis

The type of data analysis differed between the types of data collection and will be outlined below:

PHASE 1: GRAPHIC TEAM SCULPTING

Interpretive analysis: The steps of interpretive analysis by Terre Blanche, Durrheim and Kelly as described by Botma *et al.,* (2010:226) was followed to analyse the collected data from the graphic team sculpting. The steps in the interpretive analysis is familiarisation, development of themes, coding, elaborating and interpreting.

The five steps of interpretive data analysis developed by Terre Blanche, Durrheim and Kelly (Botma *et al.,* 2010:226-227) were used during analysis namely;

1. Familiarisation and immersion: This initial steps starts during the gathering of information. During data collection the researcher started with data analysis, forming a preliminary understanding of the data. Field notes are essential as the researcher gets involved in the data.

2. Development of themes: In the second step the researcher started developing themes. Main and sub-themes were identified and stated in the participants original words to ensure that no meaning was lost.

3. Coding: Coding started while the researcher identified themes. During coding the themes where categorized according to the analysis steps of Venter (1993:3) as described below.

4. Elaboration: During elaboration various parts of the drawings and answers at the back of the team sculpting drawings were examined independently to identify any other themes. Similarities where identified in collaboration with the developer of graphic team sculpting.

5. Interpretation and checking: the drawings were analysed and interpreted in conjunction with the father of the technique, Prof Venter. The purpose is to bring a deeper and richer

understanding of the meaning to the description. The findings were structured according to the interpretative technique steps (steps 1-12) of Venter as described below.

Consensus discussion: A consensus discussion was held with the father of graphic team sculpting. The expert is a psychologist that developed graphic family sculpting and published this technique internationally and in South-Africa. The expert assisted the researcher in the adaption of the technique to be suitable for teams thus formulating graphic team sculpting.

The graphic team sculptings were interpretatively analysed by the method that Venter (1993:12-13) developed to interpret graphic family sculptings. The nine drawings were first done individually (See appendix H for examples) and the findings were then compared to identify main themes and important concepts. These comparative findings were then summarized to get a general picture of the teamwork in the hospital as a whole and themes were then identified. Interpretation was done by the researcher and the assistant supervisor individually and the interpretation was then discussed. The following steps were used during interpretation (Venter, 1993:12-13);

Analysis units according to the interpretation technique of Venter (1993:13) and modification together with the researcher:

1. **Gestalt** or wholeness of the sketch. Look at the horizontal/vertical placement of the circles in the sketch: this can give an indication of the hierarchy in the team.

2. **Placing** of each team member in the gestalt and the distance between them: this can provide information regarding the relationships that exist between the members.

3. The **direction** in which each team member is looking: this can provide important information regarding the relationships between the team members.

4. The horizontal/vertical **position** of each team member. This might suggest a team member's power or assertiveness. The participant could choose any position like standing, sitting, lying etc. for each team member.

5. The **label/name** allocated to each team member. This might be an important indication of the role which each team member plays within the team.

6. The **emotion** allocated to each team member - is the emotion predominantly positive or negative? This might indicate the members' dominant feeling about the team.

7. The **order** in which the circles where drawn and the relative size of each circle. This might indicate the importance of each team member.

8. The **line quality** of the circles and the extent of the erasures used. Is the line quality similar or is one circle erased and redrew a few times. What is the reason for this?

9. The **amount** of space taken up by the sketch. Why is it very small or very big?

10. The **location** of the sketch on the paper. Is it in the middle of the paper or in one corner, and what might it indicate?

11. Then lastly the researcher looked at the **answers** at the back of the sketch.

12. Other general statements.

**It should be noted that the conclusions of the sketches was made in congruence with the answers provided on the back of the graphic team sculptings.*

Literature integration: Literature integration was done to provide the themes with structure. The purpose is to bring a deeper understanding and richness of the meaning to the description (Botma *et al.,* 2010:227).

PHASE 2: FOCUS GROUPS

Content analysis: Content analysis was used for data analysis of the transcribed focus group. The researcher identified the main categories of the drawings, to identify the main themes (Burns & Grove, 2009:528). This was done through analysing the drawings. In the focus group the main themes were categorised. The principles of qualitative data analysis recommended by Tesch (Creswell, 1994:154-155) were used during analysis.

Consensus discussion: The researcher went back to a psychiatric nursing specialist that has experience in qualitative research and the specific data collection method and reached consensus on the data analysis themes that were identified. Themes must be agreed to by the whole group (supervisor, expert and colleagues). A discussion of the analysis was done as a

research team to ensure accuracy. The research team identified the themes and sub-themes, categorizing them into main ideas.

Content analysis was used that can be described as a technique that provides a systematic means of measuring the frequency, order or intensity of the occurrence of words, phrases or sentences (Burns & Grove, 2009:528; Hsieh & Shannon, 2005:1277). The data was then encoded and categorised into main and sub-categories, labelled into themes and then all the data is integrated (Botma *et al*., 2010:222).

The focus group voice recording was transcribed verbatim by the researcher and content analysis was performed on the transcriptions (Appendix I), in co-operation with the research supervisor and co-supervisor. The principles of qualitative data analysis recommended by Tesch (Creswell, 1994:154-155) were used during analysis;

- The researcher read through the transcriptions to get a sense of the whole. Basic ideas were written up**.**
- The researcher read through the document by searching for the underlying meaning. This was done by the researcher with the focus group session.
- The researcher made a list of all the topics that came to mind, the researcher grouped similar topics together.
- The data was categorised by taking these topics back to the data and finding the most appropriate descriptive words for the topics.
- The topics were grouped together to show interrelations.
- A final decision was made on each category.
- The data were assembled by the researcher (belonging to each category) and a preliminary analysis was conducted.
- Where necessary the existing data was re-coded.

Literature integration: The researcher went back to the literature to identify any new information that contributes to the body of knowledge. According to Botma *et al.* (2010:196) literature integration is often used in exploratory studies, the researcher seeks to build an understanding on what is heard from the participants in the focus group.

PHASE 3: INTEGRATED DISCUSSION OF RESULTS

Although the researcher provides a literature integration of the research results obtained through the graphic team sculpting and the focus groups, an integrated discussion of the two sets of data was conducted.

1.9 MEASURES TO ENSURE RIGOUR

Qualitative reliability was ensured through (Botma *et al.,* 2010:231): documenting the data accurately, a consistent approach during data collection and analysis, checking the transcriptions for correctness, regular communication with the coders and inter-coder agreement. Qualitative validity was ensured through the following techniques: Triangulation of data, triangulation of analysis by co-coders and facilitators, providing a rich and thick description of the setting and self-reflection (Botma *et al*., 2010:231-232).

Rigour is the striving for excellence in research through the use of discipline, scrupulous adherence to detail and strict accuracy (Burns & Grove 2009:720). Rigour in qualitative research is ensured through trustworthiness that consists of five standards as established by Lincoln and Guba, as discussed below (Botma *et al.*, 2010:233-234):

Truth value and credibility: Estimates as to whether the research is credible. This is achieved through member checking, triangulation, prolonged engagement, peer examination and group discussions. Triangulation was done through using different data collection methods. The researcher is familiar with the setting where the research was conducted and was thus engaged in the environment. Peer examination was done through member checking during data analysis (content and interpretive analysis with the various experts). The research reports were written as clearly as possible.

Applicability and transferability: Can the research findings be applied elsewhere? Are the findings transferable to another mental health care hospital? This is the ability to extrapolate the findings to a larger population in the same context. The research findings cannot be generalised, due to the context, but the researcher gave an accurate thick and dense description of the sampling and state of mental health care teams throughout South Africa, in Gauteng. Through using the same selection process in the same content the data may be transferred to another setting.

Consistency and dependability: How consistent are the research findings? Is the data the same if the research is repeated elsewhere in a mental health care hospital in South Africa?

This refers to the quality of the data, data quality was ensured by data collection triangulation. This was ensured by providing a rich description of the steps in data collection and reporting the findings precisely as well as data triangulation. Graphic team sculpting and focus group were both used to give a deeper viewpoint of how nursing teams function and how it can be improved from both the individual viewpoint as well as a groups' viewpoint.

Neutrality and confirmability: Is there a sense of operational neutrality without any prejudiced ideas from the researcher. The findings should be relevant to the information gathered from the participants and not be due to biases. Confirmation is used as a strategy to ensure neutrality. Congruency of data was determined between two independent people during data analysis. The graphic team sculpting was discussed throughout the total process with a psychologist that is an international author on the technique. Consensus discussion was held with a psychiatric nurse specialist that is a senior expert on qualitative research.

Authenticity**:** This refers to the extent to which the researcher fairly and faithfully shows a range of different realities. The researcher stayed objective during the study and gave a true reflection of the reality. The researcher used quotes during the presentation of the data in the research report to make sure the data reflects the lived experience, feeling and tone of the participants as they experience teamwork. This was done through self-reflection and self-scrutiny to ensure that interpretations are valid and grounded in the data.

1.10 ETHICAL CONSIDERATIONS

This study forms part of a research program titled "Leadership and governance as mechanisms towards excellence in South African health systems". Ethical clearance was obtained from the North-West University, Potchefstroom Campus (NWU-00050-12-S1) and ethical principles were adhered to in this study namely;

International ethical frameworks were adhered to namely the Helsinki declaration, Belmont report, and the Nuremburg code (Manual for postgraduate studies, North-West University, 2008:3840). The Constitution of the Republic of South Africa (Act 108 of 1996) protects human dignity and rights. The researcher made sure that the study adheres to all international and national ethical standards by adhering to their ethical framework for guidance. Ethical clearance was obtained from the North-West University, Potchefstroom Campus (Appendix D). In addition to the adherence to international ethical frameworks, the researcher obtained also consent from the Acting Chief Executive Officer in the mental health care facility where the research was conducted (Appendix E) and the Director of the West-rand District, Region A, Department of Health (Appendix F).

Furthermore the researcher declares that this study was conducted with a continuous adherence to the principles of ethics in research (Manual for postgraduate studies, North-West University, 2008:34). These principles will be discussed in combination of the activities and interventions conducted to adhere to these principles.

- **Respect for persons**

Anonymity was ensured by using codes for both the hospital and the participants when analysing and reporting data. There were no hidden cameras, one-way mirrors or hidden microphones. The **participants** were **informed** that they had the **right to withdraw** from the study at any given time without discrimination against them (Brink *et al.,* 2006:37). Permission was obtained from the relevant hospital before recruiting any participants.

- **Beneficence**

Participants were **protected from discomfort and harm**, through close observation of any symptoms of muscle pain, boredom and stress and then referring them to a counsellor or general practitioner (Brink *et al.,* 2006:39). During data analysis comfort of all participants was ensured by selecting a comfortable and accessible venue. There was however no discomfort or harm experienced during the study by the participants.

- **Justice**

Informed consent (Appendix B) was obtained from each participant, by ensuring the participants gave voluntary consent. All the information about the research study was provided to them in an understandable language (Brink *et al.,* 2006:35). An information leaflet was given to each participant in the recruiting phase. The participants were recruited by giving each qualifying participant a personal invitation. The selection process was **fair** (Brink *et al.,* 2006:33) as every participant had an equal chance to take part in the research study. During recruitment the researcher gave an overview about the research topic and answered any questions (Brink *et al.,* 2006:337), to ensure that the participants have a good understanding of the research study. A date and venue were set for data collection. No unauthorised people would have access to the information and all investigators would sign a **confidentiality** agreement. Information would also be stored in a safe locked place. It was not compulsory for the participants to give the researcher information. The person who accepts the information has the responsibility to keep it **private**. As a scholar the researcher is responsible to ensure that ethical principles are applied throughout the study, to be honest and have integrity at all times, as it was stated in the declaration on page two.

Ethical approval was obtained (from the acting CEO and the research team) by the public hospital where the research was conducted (Appendix E), the Department of Health in Gauteng, West-Rand (Appendix F) and the ethics committee of the North-West University, Potchefstroom Campus (Appendix D). The unit managers who complied with the inclusion criteria were identified by the researcher and gave informed consent (Appendix B).

Specific ethical considerations were made during the course of this research and these considerations are described in the following paragraphs.

1.10.1 Ethical guidelines of the North-West University

The Research Ethics Committee of the North-West University is responsible for the formulation of ethics guidelines for the University, for evaluating and approving research protocols and for monitoring the progress of such research (Manual for postgraduate studies, North-West University, 2008:34). This specific study was allocated to a project which resort under a broad research programme and therefore carries out the research project under the ethics approval obtained for the research programme, namely "Leadership and governance as mechanisms towards excellence in South African health systems". Please refer to Appendix D for a copy of the ethical consent certificate.

1.10.2 National and international ethical governance

National guidelines have been formulated in order to ensure that there is compliance with equivalent standards on the national level. In general the guidelines contain the minimum standard that must be complied within South Africa. In South Africa the Medical Research Council (MRC) is the body that formulates ethics guidelines for research (Manual for postgraduate studies, North-West University, 2008:37).

The researcher also adhered to the Constitution of the Republic of South Africa (Act 108 of 1996) concerning human rights.

From an international perspective, the researcher chose to adhere to the code of ethical principles and guidelines (Manual for postgraduate studies, North-West University, 2008:38-40).

- Council for International Organizations of Medical Sciences (CIOMS) - The Guidelines relate mainly to ethical justification and scientific validity of research,
- Belmont Report,

- World Medical Association Declaration of Helsinki's ethical principles for medical research that involves human subjects and,
- The Nuremberg Code.

1.10.3 Prevention of plagiarism

The researcher acknowledged the North-West University's policy to prevent plagiarism (Manual for postgraduate studies, North-West University, 2008:31-34) and declared to adhere to this policy.

1.10.4 Ethical principles ensured

Ethical practice in scientific research, in particular medical research involving human individuals, is governed by four main principles. The following ethical principles received attention in this research and strategies for their assurance are stipulated in the consecutive paragraphs. These principles form the basis of all national and international ethics guidelines and policies.

1.10.4.1 Autonomy

The principle of respect for others rests upon the autonomy of others (Manual for postgraduate studies, North-West University, 2008:34) and therefore emphasises each person's right to be treated with human dignity. The researcher respected each participants of autonomy by first confirming members' availability to participate voluntary. In the event that a member either refused or terminated participation, it was accepted without discrimination.

1.10.4.2 Benefit

The principle of benevolence refers participants' right to maintain well-being through the research process (Manual for postgraduate studies, North-West University, 2008:34). Besides maintaining their well-being, any form of emotional discomfort be avoided or minimalized. Therefore the researcher submitted a research proposal and written request for consent to the North-West University's (Potchefstroom Campus), Ethical Committee as well as other stakeholders. Participants were informed of expectations during data collection and the time frame.

1.10.4.3 Non-harmfulness

Research participants were informed about the possible harm of the research (boredom, high stress levels, muscle pains and fatigue). If the participants had any symptoms they were

referred to a debriefing session and counselling or to a general practitioner where applicable. If any discomfort was experienced the research process was stopped immediately.

1.10.4.4 Justice

The principle of justice (Manual for postgraduate studies, North-West University, 2008:34) refers to the participants' right to a fair selection. After non-probability purposive sampling of the participants was conducted, members were requested to complete an informed letter of consent, agreeing to participate in this research voluntary. Members were informed of the reason(s) why they were included in the sample, with specific reference to their field of experience and position as unit managers. The data sheets, graphic team sculptings and focus group were anonymous and all measures possible were taken to ensure privacy during the data collection process, data analysis and the publication of the research results.

1.11 RESEARCH REPORT OUTLINE

The outline of the chapters in this mini-dissertation is as follows:

Chapter 1: Overview of the research. In this chapter the reader is introduced to the research problem, the proposed research methodology, aspects to enhance trustworthiness and ethical considerations.

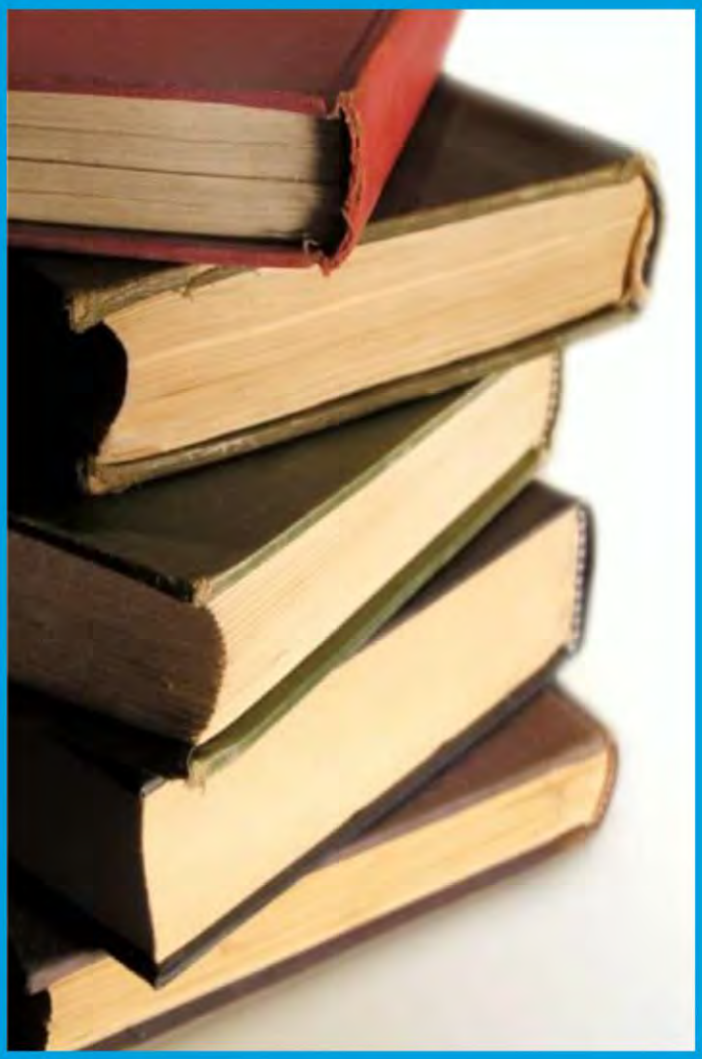
Chapter 2: Literature review. Chapter 2 is a literature review as the researcher explored theoretical and methodological literature regarding nursing teamwork within an international and national perspective.

Chapter 3: Discussion of the research findings according to the two phases of data collection combined with a literature integration.

Chapter 4: Evaluation, limitations and recommendations with specific reference to improve nursing team work in a mental health care facility in Gauteng.

1.12 SUMMARY

Concluding this chapter, a description has been given about the significance of a nursing team and the current situation internationally as well as in South African mental health care facilities. The research methods were discussed. Rigour and ethical considerations was described. Expectations of the research and how the study was conducted were systematically discussed.



2

CHAPTER

CHAPTER 2:

LITERATURE REVIEW

2.1 INTRODUCTION

In chapter one the researcher discussed the overview of the research study pertaining to, the background and problem statement, research question, -aim and objectives, paradigmatic perspective and the research methodology proposed. In this chapter, an extensive literature review follows.

A literature review is an analysis and synthesis of research-related and non-research related literature sources aimed at generating a picture of what is known and not known about a particular situation or research problem (Burns & Grove, 2009:720). As indicated in chapter 1 the concept of nursing teamwork within mental health care and even more so the role of the unit manager to enhance nursing teamwork within the South African mental health care context deemed little exploration. This served as a dominant impetus for the researcher to first conduct a literature review in order to confirm if the selected research methodology is appropriate. Most research about teamwork conducted entailed fields other than nursing, like the aviation and automotive industries. Research in healthcare has focussed on identifying characteristics of effective teams and developing questionnaires for measuring team effectiveness (Buljac-Samardzic *et al*., 2011:308).

2.2 LITERATURE SEARCH STRATEGY

The search strategy followed for this literature review was firstly to read as much as possible to get a broad understanding of the literature available. The search strategy entailed different phases whereby the researcher increased the search criteria.

The first phase in the search strategy revealed 949 articles, of which not all was relevant. A total of 152 of these articles were skimmed and only 33 were finally selected as highly relevant to the study and were used as the sample size. The sample size also included hard copies, mostly textbooks about management and leadership.

Literature was excluded from the search based on the following criteria:

- Articles in languages other than English and Afrikaans;
- Secondary sources (Brink *et al.,* 2006:70);
- Articles not applicable to the current research topic;
- Outdated articles (i.e. articles published prior to the year 2000).

On the home page of the North-West University Library, quick links were utilised to access the complete list of databases. First, the A-Z journal list was consulted to determine the electronic availability of journals identified. “Ebsco-Host”, “Scopus”, “ProQuest”, “Sabinet”, “Google Scholar” and “Science Direct” were used as search engines for articles. To exclude secondary sources, the researcher examined the reference lists of articles that were used as primary sources. The literature review research was conducted between 2012 and 2013.

The following keywords were used: nursing teamwork, teamwork, unit manager, psychiatric*, mental health, job satisfaction, burnout, quality care, leadership.

2.3 NURSING TEAMWORK DEFINED

Nursing rendered through a nursing team approach serves as the point of departure in this literature review. Nursing teamwork was defined in Chapter 1 as a number of interdependent individual staff members, who come together to share their expertise with one another for the purpose of achieving a common goal (Begley, 2008:267; Jooste, 2010:139; Kalisch *et al.,* 2009:299; Kalisch *et al.*, 2013:215; Sullivan & Garland, 2010:79; Toseland *et al.,* 1986:46).

The following can be added to the definition: It is a dynamic process involving two or more health professionals (nurses) with complementary backgrounds and skills, sharing common health goals, in this case quality care, and exercising concerted physical and mental effort in assessing, planning, or evaluating patient care (Kelly, 2008:247). This is accomplished through interdependent collaboration, open communication and shared decision-making. This in turn generates value-added patient, organizational and staff outcomes (Kelly, 2008:247; Xyrichis & Ream, 2007:238). The WHO (2009:22) also has the same view of teamwork (or team behaviour): it is a dynamic process involving two or more people engaged in the activities necessary to complete a task.

A nursing team approach is a decentralized system in which the care of a patients is shared amongst the members of a group working in coordinated effort. The unit manager delegates authority to a team leader who usually is a registered nurse. This nurse leads the team, usually

of 4 to 6 members, in the care of between 15 and 25 patients (Mosby medical dictionary, 2009). The team leader assigns tasks, schedules care, and instructs team members in details of care. A team meeting is held at the beginning and end of each shift to allow team members to exchange information and the team leader to make changes in the nursing care plan for any patient (Mosby medical dictionary, 2009). This is in contrast with primary nursing that is, nursing of one patient by one nurse for a certain length of a time. The nurse performs all necessary tasks for the day. Primary nursing is seen in ICU's and midwifery in South Africa, and is discussed in this chapter as a model of care delivery (Barr & Dowding, 2012:75).

The concepts of teamwork and collaboration are very similar but not the same - when two health care providers work collaboratively they work together but take decisions independently. Collaboration is found in formal groups. A group can be defined as a collection of individuals each with their own thoughts, ideas, abilities and objectives (Barr & Dowding, 2012:75; Yoder-Wise, 2011:346). They differ from a team, as a team has a much higher cohesion and strives towards a common goal.

The antecedents of teamwork are:

- Two or more health care professionals with complementary backgrounds or skills must be involved.
- There is open communication and information sharing amongst the team's members.
- There has to be an understanding of each members' professional's role.
- A team must have common goals.

The attributes of teamwork are team effort, interdependent collaboration and shared decision making (Xyrichis & Ream, 2007:237).

2.4 MODELS OF NURSING CARE DELIVERY

As nurses' shortages are likely to continue in South Africa, fewer registered nurses are used on a shift (SA, 2011:52). Thus no one method fits every ward or type of hospital setting, and more importantly may vary from shift to shift. The nursing unit manager has to consider patient needs and staff abilities when deciding on a model of care delivery. The different models of nursing care namely; functional model, team nursing, case model, primary nursing, modular nursing,

total patient care and patient-focussed care are described below. As previously mentioned, this study focuses on nursing teams thus multidisciplinary and interdisciplinary teams were excluded.

2.4.1 Functional model

This model was first used in the Second World War, where a large number of patients had to be cared for by a limited number of nurses. Nurses were trained to perform basic skills. Auxiliary nurses were first seen as temporary nurses but became a permanent structure in hospitals due to a population explosion after World War II (Marquis & Huston, 2012:307). In the functional care model different nursing tasks are separated and every nurse in the unit is assigned for one or more nursing tasks for a number of patients. The responsibilities flow from the unit manager downwards to the staff members and, the person in charge is primarily responsible for all nursing activities performed (Booyens, 2000:209; Kelly, 2008:331). The functional model is followed in most mental health care institutions.

Advantages: This model is very efficient, as it helps with a heavy workload and tasks are completed quickly (Marquis & Huston, 2012:307). This model is preferred during nursing staff shortages and in an emergency situation. A specific staff member can usually become very competent in the one task. This is the preferred method when a large number of patients only need routine care (Booyens, 2000:310).

Disadvantages: Staff can experience their work as repetitive and boring. Holistic care is not provided and documentation is of a low standard, little time is devoted to the patient's psychosocial and spiritual needs (Duffield *et al.*, 2010:2243). A patient issue may be ignored due to a lack of communication between staff members. Neglect is high due to divided responsibilities (Booyens, 2000:311) and the patient may feel care is disjointed (Kelly, 2008:331). At first glance it seems economical due to lower ranks of nurses needed, but supervision has to increase which can result in more supervisors needed per unit.

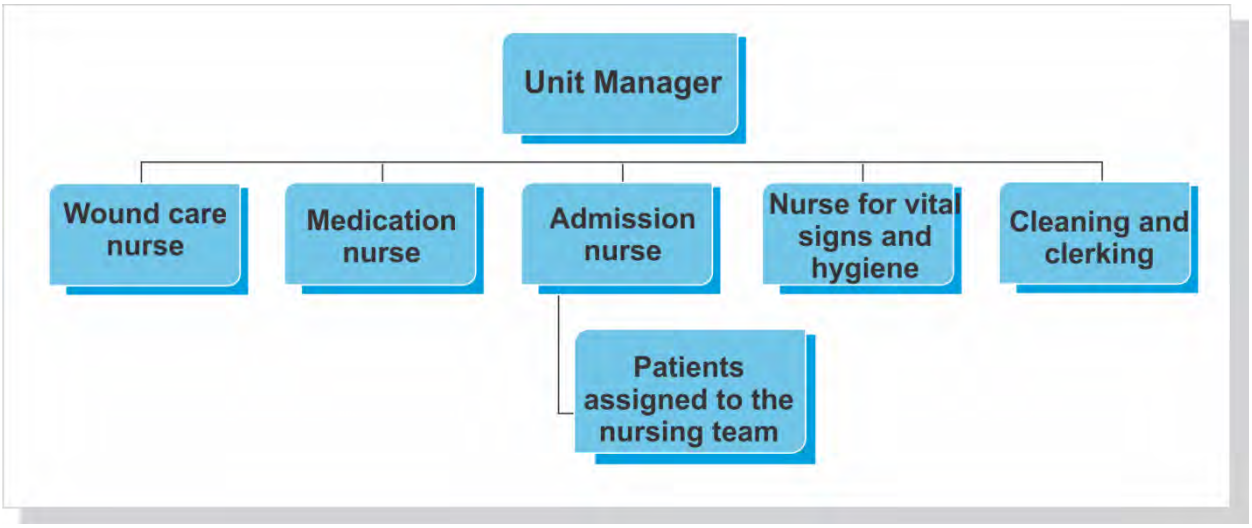


Figure 2.1: Graphic depiction of the functional nursing model

2.4.2 Team nursing

The second nursing care model is team nursing. The patients in the unit are divided into different groups and each of these groups is nursed by a specific team of nurses. The team varies according to the number of categories of nurses available and the patients group sizes according to the severity of their disease. The team should not consist of more than five team members (Marquis & Huston, 2012:308). The team of nurses is led by a registered nurse, referred to as the team leader, and is accountable for the total nursing care of the group of patients. The leader of the team delegates duties to the members of the nursing team and reports to the unit manager. The focus is more on the individual needs of the patients instead of just performing duties (Booyens, 2000:313; Kelly, 2008:331).

Advantages: The registered nurse develops leadership skills yet individual skill and knowledge are emphasised because each member contributes to the planning of nursing care. Communication raises staff morale and job satisfaction. Patients are more satisfied with the holistic care provided (Booyens, 2000:313). There is high supervision that leads to fewer patient errors (Duffield *et al.*, 2010:2243).

Disadvantages: Registered nurses often do not possess the relevant interpersonal, clinical or leadership skills to act as a leader. If teams are constructed poorly they are ineffective. If the composition of the team changes regularly the team spirit may be lost (Booyens, 2000:314). Teams need time for planning and communication (Marquis & Huston, 2012:308) to be effective.

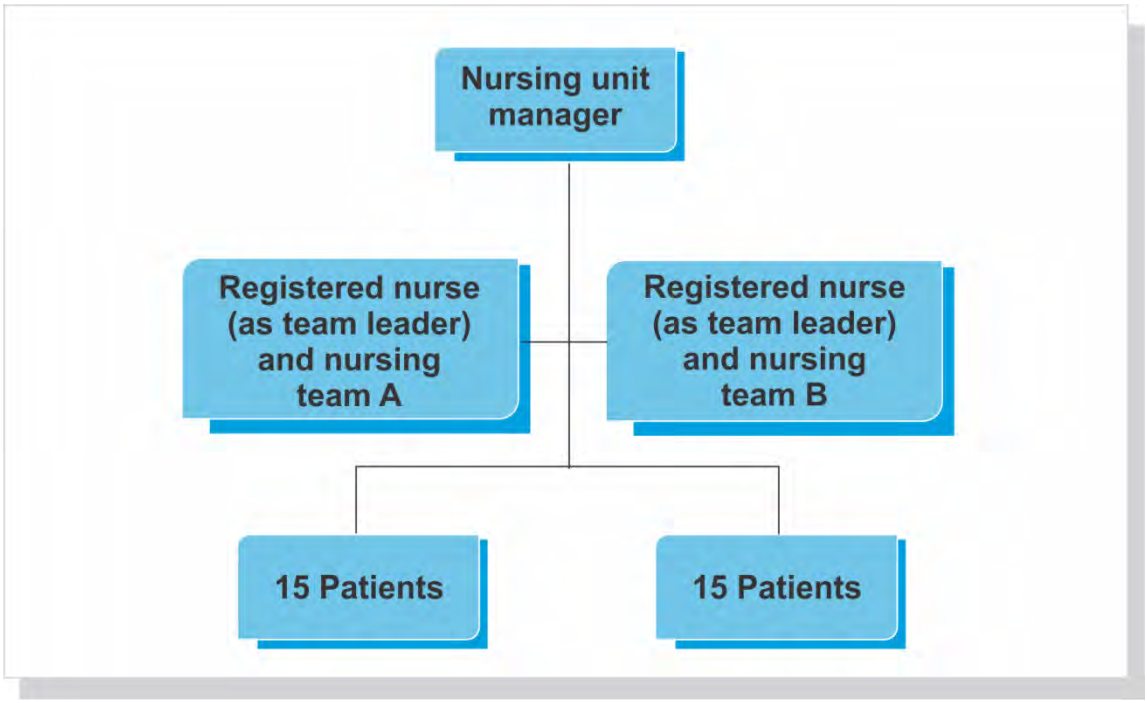


Figure 2.2 A graphic depiction of the team nursing model

2.4.3 Case model

In the case model, a registered nurse is totally accountable for the care of one or more patients for the period of their shift. This method is used in ICU's (Booyens, 2000:311). This was the first and dominant nursing care model in the 19th century that developed from home-based nursing (Kelly, 2008:30; Marquis & Huston, 2012:305). During the great depression in the 1930's people could no longer afford home-based care and started to access hospitals. This model is not fit for mental health care nursing because the patients are ambulant, which could make care provision difficult.

Advantages: The organisation of work is made easy for the nursing unit manager and accountability is easy to trace. Nurse-patient relationships are stronger and a higher level of work satisfaction is experienced by nurses because holistic care is provided and the nurse is with the specific patient until the path of recovery (Booyens, 2000:311). Assigning patients is simple and direct and does not require much planning (Marquis & Huston, 2012:305).

Disadvantages: There are a large number of registered nurses required for this type of nursing and is not cost effective. Confusion may result when each nurse orders supportive services separately for each patient (Booyens, 2004:312).

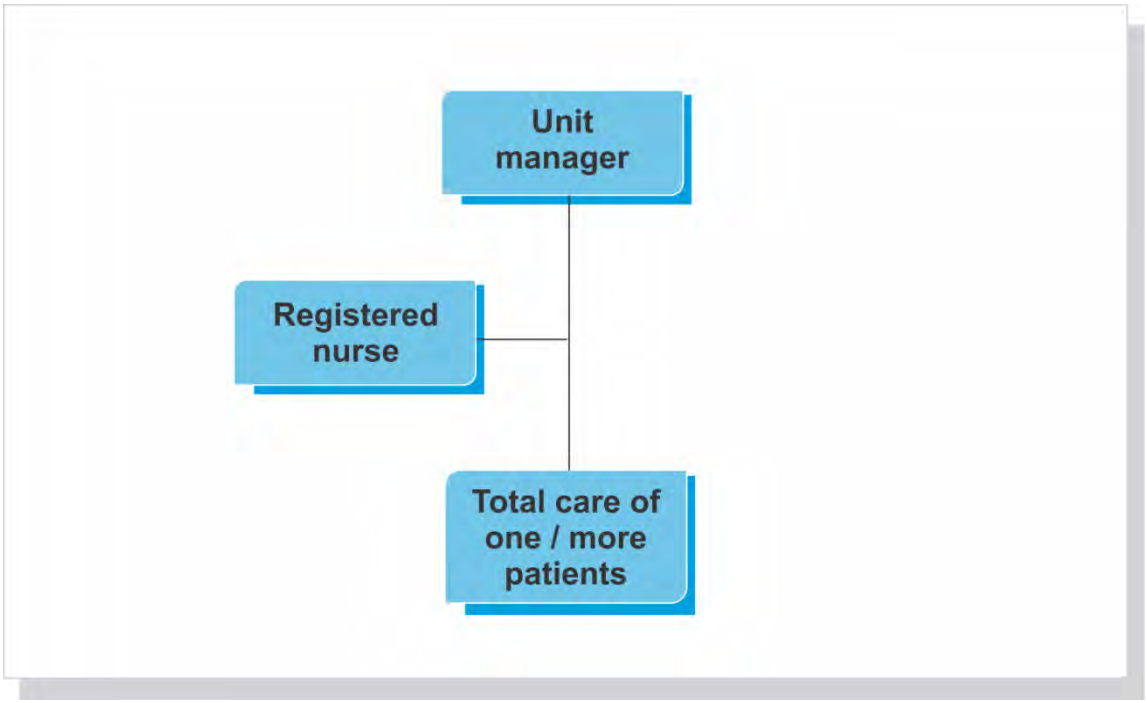


Figure 2.3: Graphic depiction of the case model

2.4.4 Primary nursing

Also known as relationship-based care, this model of care was developed in 1968 to bring the registered nurse (RN) back to the patient's bedside (Duffield *et al.*, 2010:2243; Marquis & Huston, 2012:310) and to promote continuous care. Comprehensive, coordinated and individualized nursing care is delivered to a patient by a RN who has the autonomy and authority to plan, deliver care and evaluate the outcome. The RN is responsible for providing 24-hour care, and is assisted by a secondary nurse whom the nurse delegates her duties to if he/she goes off duty. If the RN is off duty she is still responsible for the patients and can be contacted at any time if needed (Booyens, 2000:315; Kelly, 2008:332). Despite international evidence that primary nursing is effective, this model is rarely used in South African hospitals.

Advantages: Holistic quality of nursing care is good. Nurses feel that they are functioning more effectively under this type of nursing care. Job satisfaction is also higher because one nurse is involved in the entire care of a patient. It meets the emotional and physical needs of the patients as it has a holistic approach rather than a shift-to-shift focus. The nurse builds a trusting relationship with the family and patient (Kelly, 2008:32; Marquis & Huston, 2012:311). This model is more cost-effective because the patient's hospital stay is shorter and medico-legal risks are limited to the minimum (Marquis & Huston, 2012:311).

Disadvantages: Not all registered nurses feel that they are competent to handle total care of a patient. The role of the assistant nurses (AN) is ill-defined in this type of nursing care and they may thus not be utilised to the full capacity (Booyens, 2000:316). With no geographical boundaries the nurse may be required to travel long distances to deliver care (Kelly, 2008:332). Recruitment of RN can be difficult.

Figure 2.4: A graphic depiction of the primary nursing model

2.4.5 Modular nursing

The modular nursing model is a modification of the team- and primary nursing model. It is sometimes used when there are not enough registered nurses available. Patients are divided into groups according to the layout of the ward. These groups of 10-12 patients are then nursed by mini-teams, consisting of three members and a team leader, who is an RN. The group is then responsible for the total care of these patients from admission until discharge. Each team of nurses must arrange for another team of nurses to care for the patients during their off duty hours. The nursing unit manager is responsible for supervising the nursing care of all the patients in his/her unit (Booyens, 2000:316-317; Kelly, 2008:331). Work is usually standardised.

Advantages: Productivity is high. Communication and cooperation between different staff members are also better because the team is smaller (Booyens, 2000:317; Marquis & Huston, 2012:310).

Disadvantages: When a patient moves from one bed or room to another, he or she falls into a different group of care and needs to get accustomed to a new set of nurses. There is a division between the final accountability of care between the unit manager and the team leader (Booyens, 2000:317; Kelly, 2008:332). Patients can receive fragmented depersonalized care.

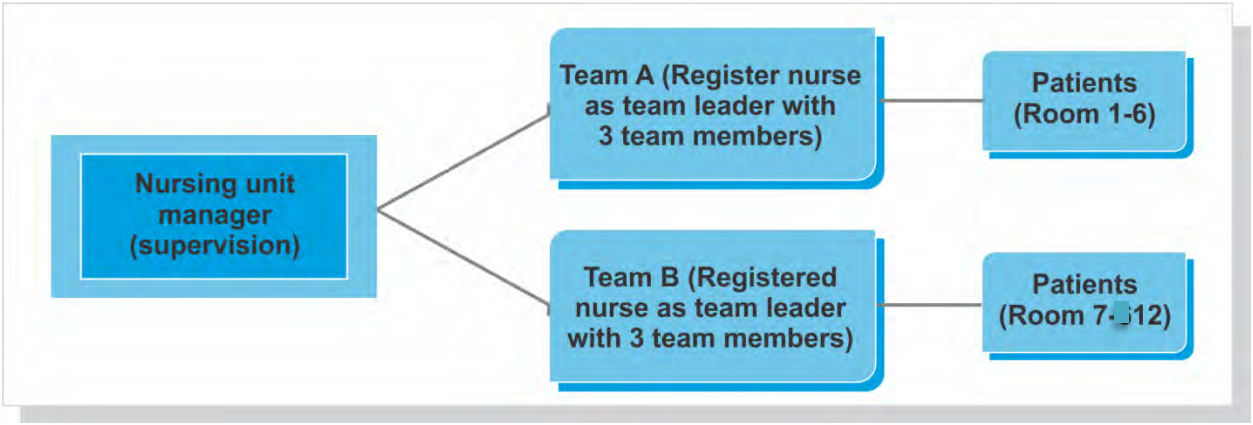


Figure 2.5: Graphic depiction of modular nursing model

2.4.6 Total patient care

The total patient care model refers to when the unit manager nurse is responsible for the total care of assigned patients for the shift worked. The RN is responsible for these patients and may have help from other nursing categories but they are not assigned to specific patients (Kelly, 2008:331).

Advantages: High consistency of care, which enables the patient, nurse and family to develop a trusting relationship. The degree of autonomy and control is higher in total patient care (Duffield *et al.*, 2010:2243).

Disadvantages: Requires a high level of registered nurses that can be cost consuming for the hospital. This model only works well in specialized units.

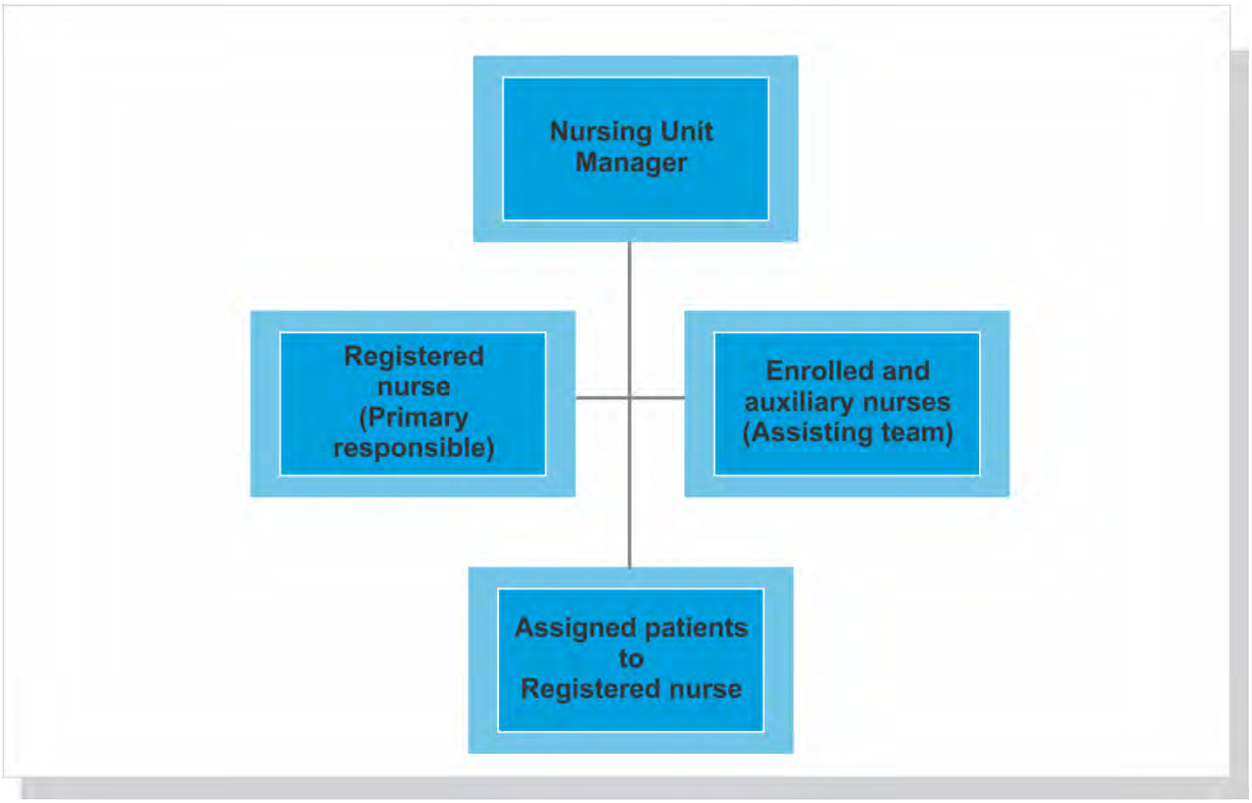


Figure 2.6: Graphic depiction of the total patient care model

2.4.7 Patient-focused care

The seventh model under discussion is the patient-focused care model designed to focus on patient needs rather than staff needs. In this model required care and services are brought to the patient and all patient services are decentralised to an area. Staffing is based on patients' needs and is not consistent. Patient-focused care places an effort into having the right person do the right thing (Kelly, 2008:332).

Advantages: Interdisciplinary involvement is high and holistic care is provided to the patient.

Disadvantages: Number of staff is dynamic that can lead to confusing and inconsistent staffing.

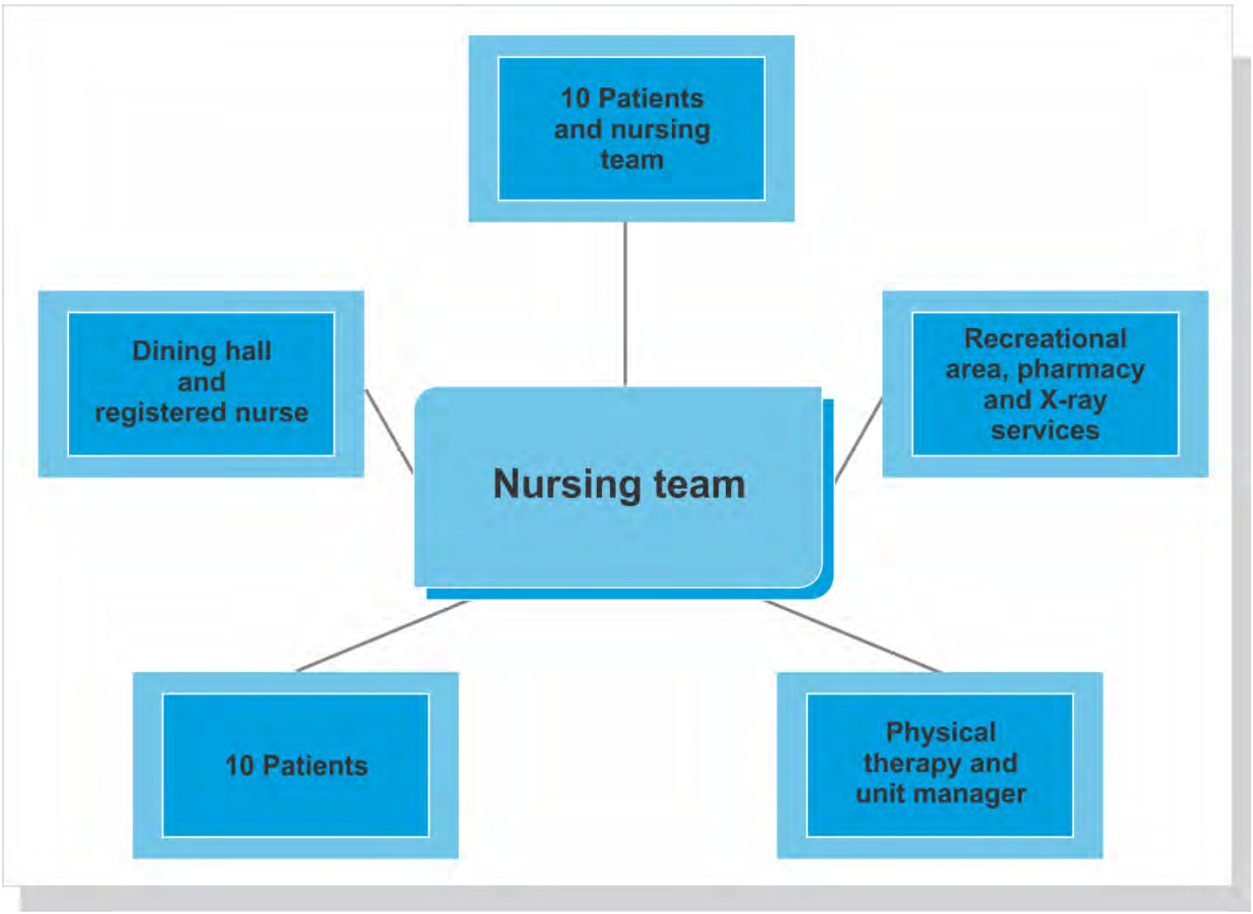


Figure 2.7: Graphic depiction of the patient-focused care model

2.5 THEORIES OF TEAMWORK

The theory of the team development process by Tuckman and Jensen (1977), is widely used and adopted to this literature review. This theory identified five stages of team development namely forming, storming, norming, performing and adjourning which are explained in table 2.1 below.

Table 2.1: Stages of a team process according to Tuckman and Jensen (1977)

Forming	Forming refers to role development, team orientation, identification of role expectations and exploring. The first phase entails the beginning of team interactions and boundary setting.
Storming	During the second stage follows storming, which refer to interpersonal interaction and reaction, dealing with conflict and tension.
Norming	Effective co-operation and collaboration, resolutions of conflict, expression of personal opinions, formation of goals and group cohesion serve as the third stage of a team development process.
Performing	The fourth stage refer to group maturity and stable relationships, team roles become more functional and flexible, structural issues are resolved, supportive task performance, group collaboration and resource sharing.
Adjourning	The final phase entails termination and consolidation, team goals and activities are met leading to closure, evaluation and outcome review, reforming if there is a need for improvement.

When a number of people are placed together they don't necessarily form a team, but can be seen as a group. The group then goes through the five steps, identified by Tuckman and Jensen (1977:149), to become a team. Not all teams reaches the adjourning stage and can get stuck at a specific level of functioning. The team would then be ineffective. The unit manager can facilitate the group formation by doing the following (Barr & Dowding, 2012:82-86):

Forming stage – Help the team members to get to know each other. Make sure the purpose and tasks of the group are clearly defined and understood by all members. Give the team time to get comfortable with each other.

Storming stage – Do not ignore conflict, acknowledge this as a natural developing process. Review ground rules and re-visit the purpose of the group.

Norming stage – The cohesion stage where each task takes on new significance. Facilitate and redefine each task and provide time for feedback.

Performing stage – Facilitate direction, decision-making and team management problems.

Adjourning stage – Identify team roles. Develop the positive features of each team member not focusing on the negative aspects.

2.6 ADVANTAGES OF NURSING TEAMWORK

Various advantages of nursing teamwork in general have been identified in the literature and will be discussed in the following paragraphs.

- **Nursing teamwork enhances patient safety**

Teamwork promotes safe and efficient care delivery. There are fewer patient and medical errors if teamwork is high (Buljac-Samardzic *et al.*, 2011:307; Kalisch *et al.*, 2013:214). Team communication is the central factor to safe care delivery (Kelly, 2008:248; WHO, 2009:17). Patient errors occurred due to incomplete shift handovers, poor quality of information recorded in patient files, status affecting junior staff of communicating effectively to senior personnel and difficulties of transmitting information in large organisations. The WHO (2009:6) stated that there is limited awareness of the role that human factors play on patient safety. Human factors include environmental, organisational and job factors and individual characteristics which influence behaviour at work in a way which can affect health and safety. The study, human factors in patient safety, found that a transactional leadership style of middle management lead to fewer patient safety risks (WHO, 2009:13), as well as authentic leadership can lead to better safety outcomes for patients. Good teamwork can help reduce patient incidents and safety risks and can improve the team morale and team functioning. It is thus crucial for managers to understand how teamwork can be developed to ensure patient safety.

- **Leadership can be developed through nursing teamwork**

Effective leadership is a key characteristic of an effective team. Equalizing of power amongst members through governance improves individual leadership skills. It is an effective tool to promote clinical responsibility, ownership and accountability amongst all team members (Kelly, 2008:248). A team leader, in this case, a nursing unit manager, needs to delegate duties according to individual strengths to promote individual qualities and growth. If employees view their jobs as challenging and not particular rewarding this can be due to poor leadership. In hospitals with low levels of decision making, employees reported a greater dissatisfaction with

their work and higher levels of stress (Aronson *et al.,* 2005:289). Leadership must not be underestimated in the team process and supervisors needs to be aware of the effects on each team member.

- **Nursing teamwork is a cost-efficient alternative**

Nursing shortages are a common phenomenon and as this continues to rise the current health care systems are not capable of meeting society's needs (Cleary *et al*., 2012:473; Lund & Flisher, 2002:158; WHO, 2011:52). Teamwork improves productivity, decreases absenteeism and stabilizes the workforce. This has financial benefits for the hospital (Kalisch *et al.*, 2013:214; Kelly, 2008:248). By improving teamwork a hospital can benefit from it economically. Mental health care hospitals, like many other hospitals, have been identified as a difficult place to work, and have high turnover rates (Aronson *et al.*, 2005:285). A study done by Aronson *et al.* (2005:286) reported that hospitals in mental health care, in Pennsylvania, experience a high turnover, falling profits and an increase in competition, increase in patient and insurer litigation and shorter lengths of stay. To remain economical viable, South African mental health care hospitals must explore all methods of financial improvement. Improving employee's satisfaction is one of the most important methods of improving a hospital's financial standing.

- **Enhanced job satisfaction**

Teamwork improves professional relationships and job satisfaction (Kalisch *et al.*, 2013:214). An effective team promotes free exchange of ideas, team cohesion, trust, mutual respect and personal satisfaction. Stress levels are also lower due to sharing of responsibilities and accountability (Sullivan & Garland, 2010:80), work attitudes are more positive due to cooperation of the team. Studies have shown that increased workload, inadequate time off, restricted autonomy, burnout, and emotional exhaustion can lead to high levels of stress and decrease job satisfaction (WHO, 2009:36). Effective teamwork can help to relieve stress and thus improve job satisfaction. Teamwork influences job satisfaction in various professions. In a study done in a radiology department (Hutton & Eddy, 2012:5) a research participant reported that she found her job satisfying when everyone worked together. Even in transportation services it has been stated by Morrow *et al.* (2011:1214) that teamwork has an effect on job satisfaction and is a fundamental aspect of morale. Low levels of job satisfaction is associated with factors like high turnover rates, poor teamwork, inefficiency, low pay, lack of educational and personal growth, inflexibility of working hours and poor inter-relationships among employees (Aronson *et al.*, 2005:286; Chang *et al.,* 2009:1945). Hospital managers and nursing leaders have to work together to improve working relationships and job satisfaction among health care providers to improve the quality of patient care (Chang *et al.,* 2009:1945).

- **Quality of care is improved through nursing teamwork**

Higher levels of teamwork in nursing result in a higher quality of care (Kalisch *et al.*, 2013:214) as well as higher productivity. Health care teams that have clear objectives, high levels of participation, and innovation provide high quality of care to patients (Sullivan & Garland, 2010:80). It has been proven by Kalisch *et al.* (2013:215) that patients reported that they were happier with the care delivered when teamwork was higher in a unit. Burnout is common among mental health care professionals, and there is evidence that burnout can affect the entire staff of a ward, leading to a "front line collapse" and declines in quality of care (Aronson *et al.*, 2005:285). Positive interproffesional relationships improve quality of patient care and staff job satisfaction (Chang *et al.*, 2009:1946). Understanding how team members perceive their relationships with each other can improve quality of care. The improvement of communication and integration of care, leads to new and improved ways of delivering patient care. Clinical supervision by the nursing unit manager, or team leader, is an important tool in improving quality of care. The challenge is not whether care is delivered in teams, but rather how well care is delivered within teams.

2.7 NURSING UNIT MANAGER

Nursing unit managers today face new challenges to successfully manage teams. It is required that the nursing unit manager should understand each team member's values, characteristics, attitudes towards the organisation and authority (Begley, 2008:267; Jooste, 2010:139; Kalisch *et al*., 2009:299). External work factors also play a role. As a nursing unit manager it can be hard to manage all these factors to improve team functioning. This section clarifies the nursing unit manager's role in teamwork as well as strategies of enhancing a nursing teamwork according to literature.

A team leader should organize, facilitate and manage the entire team. The unit manager as the team leader should examine his/her own qualities and strengths and use this to develop an effective team. Various learning styles, cultural diversity, and personal differences play a part in team dynamics (Kelly, 2008:253).

The role of the unit manager is to maximise the potential benefits and minimise the weaknesses of the team. The unit manager is not only responsible for co-ordination of care but should lead, manage and coach the team (SA, 2011:6). Teamwork barriers include changes in environment and roles, medical hierarchy and individual perceptions of care.

Teamwork does not just happen - it requires an understanding of the characteristics of effective teams and knowledge about how teams function and ways of maintaining effective functioning (Barr & Dowding, 2012:74). There are a few strategies and methods that can be used to improve a team's cohesion and functioning.

2.8 IMPROVING NURSING TEAMWORK

Effective teamwork is not the immediate result of grouping people together. Certain strategies are necessary to ensure effective teamwork. These strategies that can be used by the nursing unit manager and are discussed below.

- **Shared approach**

Develop a shared approach to the visioning, planning and assuming of responsibility (Lawford, 2003:26). Take time to make sure that all team members understand the vision, mission, philosophy and core values of the organisation. This ensures that all team members move in the same direction that is associated with the team goals and not in individual directions for individual achievements. Encourage team members during nursing team meetings to share responsibility and leadership by delegating duties equally. When staff members have limited time, they focus solely on themselves and their personal work load instead of the responsibilities of the entire team (Kalisch & Lee, 2012:7). Therefore regular review of the organizational vision, mission and objectives keeps staff more team orientated.

- **Team mental models**

Team mental models or otherwise known as team cognition can be explained as teams developing compatibility in member's cognitive understanding of key elements of their performance environment, and by doing so are able to operate efficiently without the need of overt communication (De Church & Mesmer-Magnus, 2010:33). It is the shared organizational understanding of a specific topic that has a positive effect on teamwork because members can anticipate each other's needs and actions, thus to co-ordinate more effectively (Burtsher & Manser, 2012:1345; Kalisch *et al.,* 2009:303). Shared team mental models advance the understanding of shared cognition in teams and enhance team performance (Lim & Klein, 2006:415). Managers need to be aware of different views that exist among team members and their perceptions of what makes a team effective (Buljac-Samardzic *et al*., 2011:315). Understanding how team members think can improve teamwork.

- **Equality within teams**

The nursing unit manager needs to value all team members equally (Lawford, 2003:26). The nursing unit manager needs to make sure that all team members' voices are heard and that the team understands that everyone is important for functioning of the team. Assign tasks to team members that help them to utilise their strengths.

- **Respect between team members**

In a study done in a USA mental health care setting, the research found that when mutual respect among staff was greater, the patients improved more over time. Nurses and social workers are also more efficient than physicians at fostering mutual respect (Wells *et al.,* 2006:1840). Respect levels depend on the team's stage of development. Tuckman's model of team development stages as discussed previously identified the following stages; forming, storming, norming and performing. Respect would be higher if the team is in the performing stage. Status differences and hierarchy structures inhibits teamwork and affects communication (Kelly, 2008:252).

- **Communication**

Kalisch and Lee (2012:2) state that 70% of incidents are due to a communication failure as the primary cause. Wells *et al.* (2006:1844) also found that smaller teams function better. Teamwork among a small team is better because as the team grows the communication structure becomes more complex. Effective leaders can facilitate communication in teams by maintaining an atmosphere in which group members can feel free to discuss concerns, make suggestions and share ideas. Communication is crucial to ensure continuity of care.

- **Team size**

According to Kalisch *et al.* (2013:215) aspects of team size are an important factor that should be considered in team building. An average number of teams across industries are usually between 5-12 team members. Yet in nursing teams, acute mental health care teams can be as big as 20 team members (Shuping, 2013). If the teams are too small, members felt as though the professional relationship blurred with the personal one, and conflict arose. Larger teams, on the other hand, face coordination and communication failures, and are prone to motivation losses and have greater difficulty developing and maintaining role structures. It was also found that the greater the number of auxiliary nurses in a team the poorer the teamwork was (Kalisch *et al.*, 2013:222). For teams to maintain effective communication and trust, big units should be divided into smaller parts and the nursing teams should be divided into two smaller groups. This

results in better nurse-to-nurse interaction and better teamwork through effective communication.

- **Socialization**

Socialization and catching up were important aspects of shift reports and played a large part in team building (Yonge, 2008:45). Rapport built through socialization in the workplace leads to better teamwork (Jones & Jones, 2011:178). A contradiction to this statement was found in the study of Kalisch *et al.* (2009:304) who state that excessive socialization during shift reports adversely affected teamwork. Socialization should be controlled by the manager to a certain extent, to ensure that socialization doesn't affect work productivity. Swaleh (2007:25) suggested days away from work (nursing team socializing outings) to maximize socialization and team building. During away day's team building activities was done. This can also improve their commitment towards the organization. Romero and Cruthirds (2006:58) proved that the use of the correct style of humour strengthens staff morale, enhance communication and mitigate disagreements.

- **Staff morale**

When staff morale is high the team tends to work more enthusiastically, confidently, productively, and in a disciplined manner (Booyens, 2000:206). To create a high morale the nursing unit manager should find out what the values are, which the staff regard as "caring for the worker". These values should be matched in everyday management. Negative workplace relationships can disrupt team performance, creating an environment that can lead to burnout, increased staff turnover and poor patient outcomes (Becker & Visovsky, 2012:210).

- **Trust in a team**

Mutual trust plays a big role as it affects open communication. Ensure that all team members feel supported, emotionally, psychologically and physically. According to Jones and Jones (2011:175) regular team meetings, shared record keeping and goal setting can significantly improve interproffesional teamwork. During team meetings staff gets the opportunity to build rapport. Rapport can also be built through social activities from time to time (Lawford, 2003:27). Time should be set aside for morning meetings where the unit manager can assist in improving communication and relationship building between staff members in meetings. A study done by Kalisch and Lee (2012:5) proved that staff working on night shifts had more trust, team orientation, and back-up scores than staff working on the day shift and those who missed work had lower trust. Jones and Jones (2011:177) proved that collegial trust is essential for a productive and a safe working environment. Trust is built over time and would thus be better in

a team that has been functional for a longer time. Trust is built through experience and good communication.

- **Supportive environment**

Developing a supportive and conductive environment for teamwork requires constant effort and time. Physical design of the environment/ward can have an impact on teamwork by influencing productivity, confidentiality, work attitudes and professional image. Factors that should be considered are noise control, privacy, seating space and convenience (Kelly, 2008:252).

- **Social factors**

Social factors should be considered like clear identification of ownership of the team goal, decision-making, conflict resolution, communication, and participation, acceptance of strengths and limitations of each team member. Then the political environment also plays a role, which is the support and encouragement from top management (Kelly, 2008:252) that plays a major part in establishing a stimulating environment that facilitates teamwork.

2.9 SUMMARY

From the literature review it can be concluded that the nursing unit manager should clearly communicate expectations of the organization to the team, acknowledge differences, foster collegial relationships among staff members and be a role model of effective communication to build a cohesive team that reflects the shared values of all team members. A major task is to bring the team together in a fair way and to provide equitable opportunities for personal growth. This requires of the nursing unit manager not only to act as a manager but as a nursing team leader.

3

CHAPTER

CHAPTER 3:

DISCUSSION OF RESEARCH FINDINGS

3.1 INTRODUCTION

Chapter 3 is an in-depth discussion of the realisation of both phases of data collection and associated data analysis, followed by literature integration. The research results are declared for the graphic team sculpting followed by the focus group whereafter an integrated discussion is formulated.

3.2 REALISATION OF DATA COLLECTION AND ANALYSIS

The researcher initially planned to do both the focus group session and the graphic team sculpting on one day. For the first attempt only two unit managers reported for both phases of the data collection. As the population group was thus too small for meaningful analysis, they then only participated in the graphic team sculpting. The initial venue was in the management building at the identified hospital, which is far away from the wards implying that it might have been challenging for participants to attend the data collection. Furthermore it was found that the poor attendance of the first data collection attempt was due to staff shortages, high workloads, no support from nursing management and some of the unit managers were on leave.

A second session was organized two weeks after the first attempt. The unit managers were all invited again to participate in the focus group session. The participants were contacted telephonically or seen in person and they were informed about the new venue, date and time. Transport was arranged for them as some of the wards are far from the venue. A central point was used for the venue location namely a private room in one of the wards. The unit managers perceived this as less threatening compared to the management building where the first session was held. The participants were reminded on the day of the focus group about the appointment. The second session was more successful with eight participants (n=8) and a focus group of approximately an hour was done, during the unit managers lunch time.

The total population consisted of thirteen unit managers (N=13) in the specific hospital that qualified according to the above-mentioned criteria. Non-probability, purposive sampling was used. Out of this thirteen unit managers, nine (n=9) participated in the graphic team sculpting

and eight (n=8) in the focus group. No unit manager was excluded from participating (they all qualified according to the criteria), the unit managers participated where they could considering ward coverage and time constrains. The sample size was thus sufficient as sufficient numbers were available that presents the total population. According to Thorne *et al.* (2004:6) interpretive description is the smaller scale qualitative investigation of a clinical phenomenon for the purposes of capturing themes and patterns within subjective perceptions and generating an interpretive description capable of informing clinical understanding. Such studies often build upon relatively small samples. Data saturation does not have to occur to ensure high quality of data as long as data can be described interpretatively. Non-probability, purposive sampling was used where participants were selected due to their information rich characteristics. The sample is seen as the knowledgeable experts on the topic (Botma *et al.,* 2010:201; Brink *et al.,* 2006:133), which was in the study nursing teamwork within a mental health care facility.

3.3 DEMOGRAPHIC DATA

The demographic data presented were formulated from individual information sheets (Appendix C) that participants completed at the consent of data collection. The demographic data is presented in graphic manner below. The population size was 13 unit managers (N=13) of which nine participants (n=9) participated in both the graphic team sculpting and focus group and in the focus group only eight participants (n=8) participated.

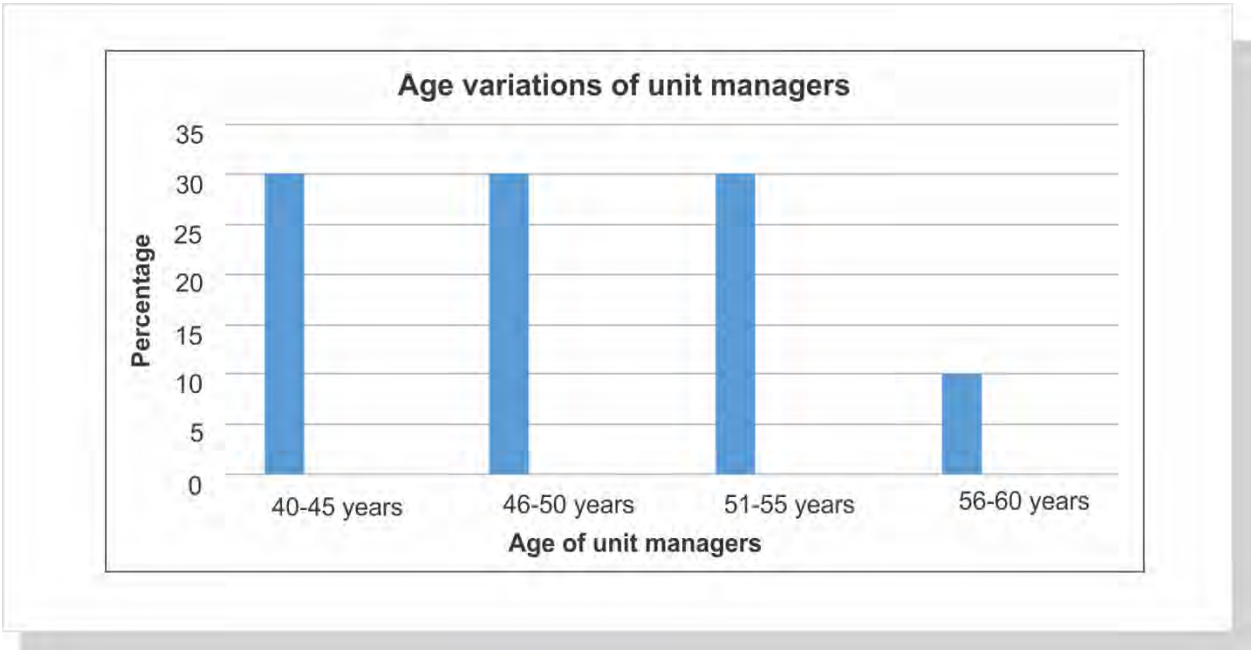


Figure 3.1: Age variations of the unit manager

All of the unit managers in this specific hospital are older than 40 years with 10% being in their late 50's. This corresponds with the statistics of registered nurses kept by SANC where the largest percentages of 31% are between 50-59 years of age, 30% are between the ages of 40-49 years and 19% between 30-39 years of age (SANC, 2012).

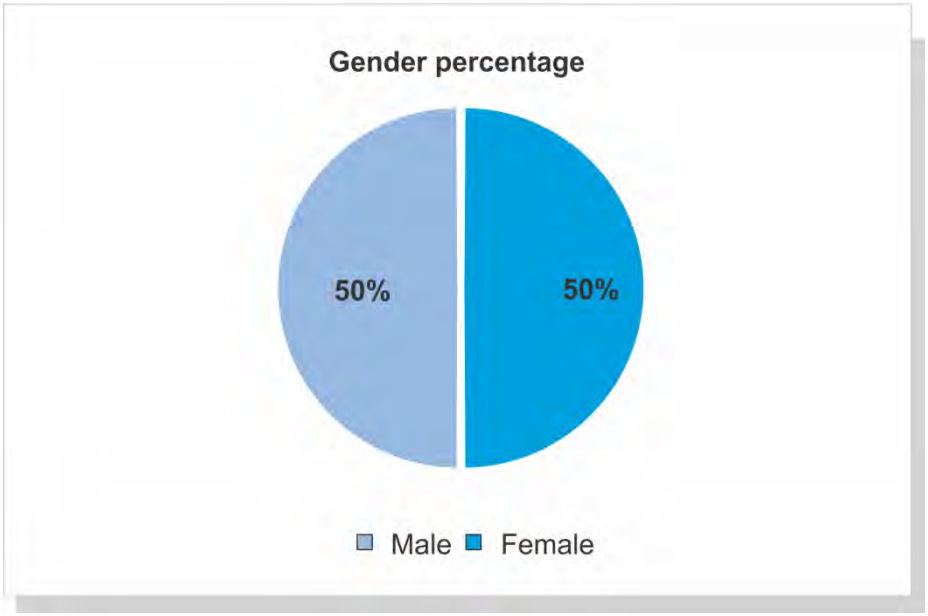


Figure 3.2: Gender of unit manager

The unit managers that participated in the study (n=9) were 50% male and 50% female. The gender of participants was mostly dependent on the type of ward they were working in, namely a male or female ward. Males are placed in male wards for better control of patients (Shuping, 2013). The hospital is fortunate to have so many male staff as there are only 1 874 male registered nurses working in Gauteng (in all disciplines of nursing) in 2012 compared to 30 232 female registered nurses (SANC, 2012).

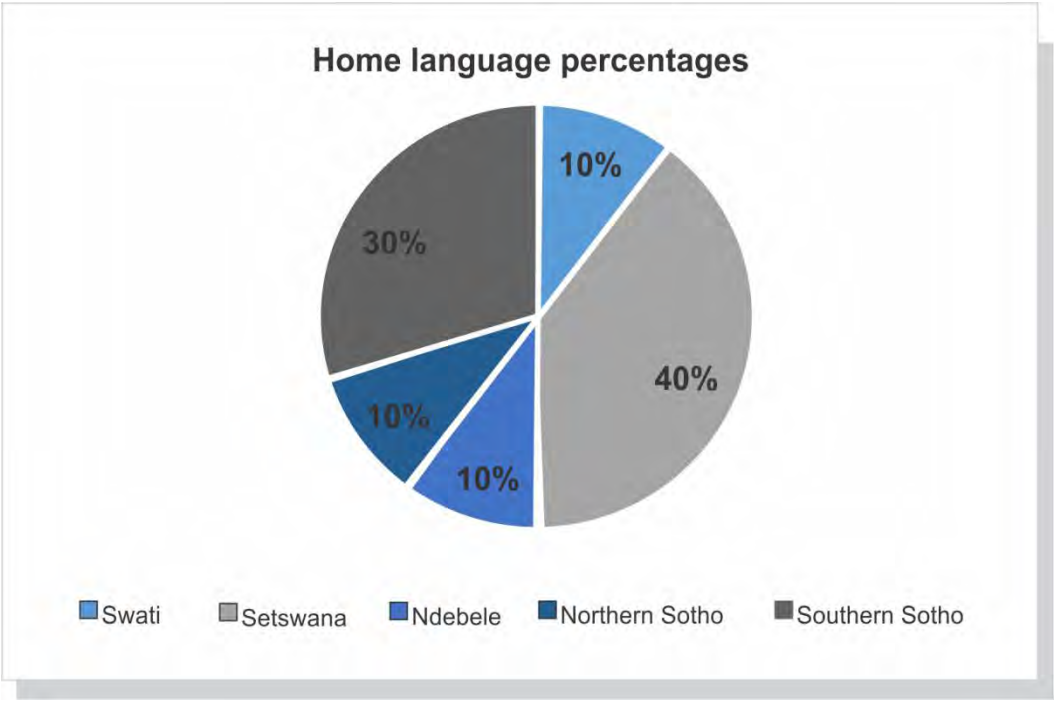


Figure 3.3: Language variations of unit managers

The home language of the unit managers varied according to their area in which they were raised. The official communication language in the hospital is, however English, despite the diversity of the staff members.

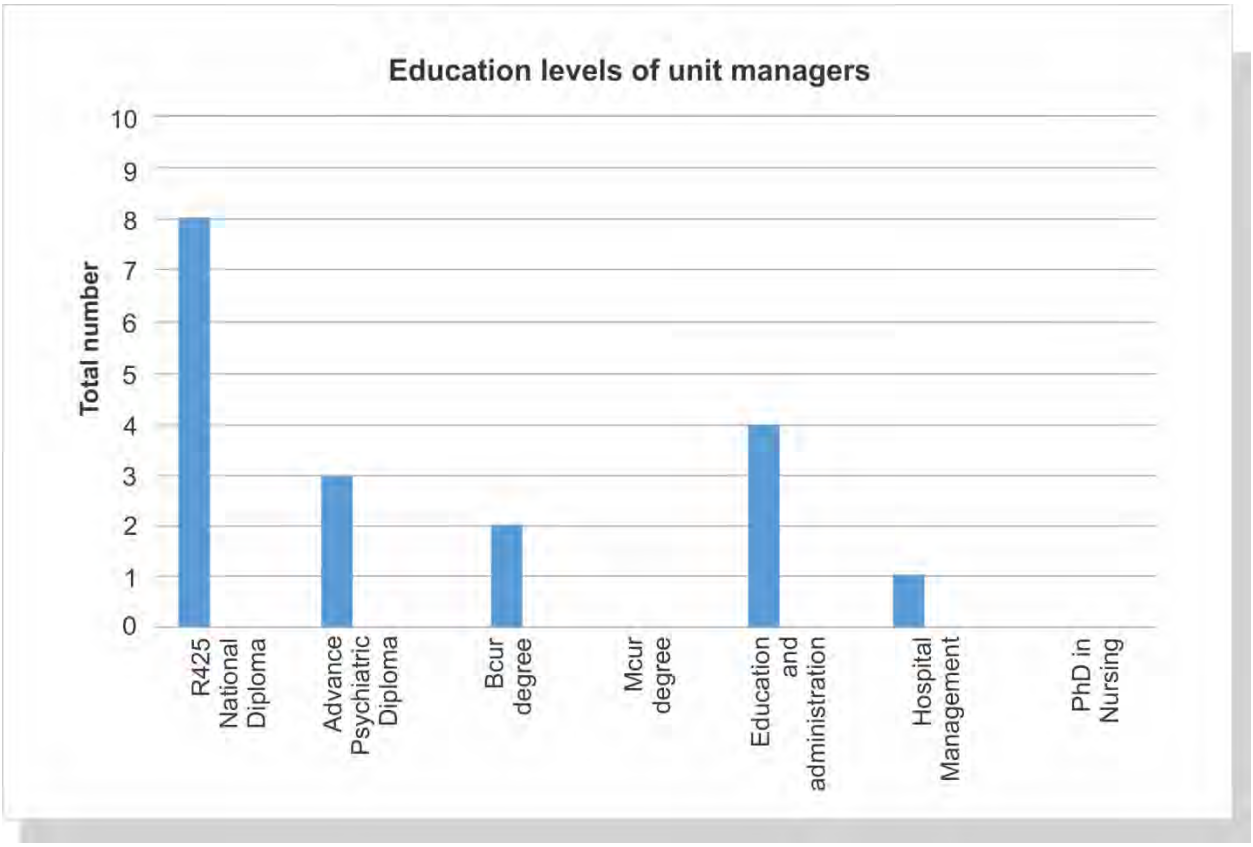


Figure 3.4 Education levels of unit managers

Analysing this graph it is clear that eight of the unit managers working at this specific hospital have done a R425 national diploma in nursing, only two have done a B.Cur-degree and one have done both. No one has obtained a M.Cur- or PhD-degree in nursing science. Three have done an advance psychiatric (also known as mental health) diploma, and four has done a diploma in nursing education and -administration. One unit manager has a diploma in hospital management. Some of the unit managers have more than one qualification. It is evident that the participants have their minimum qualifications but that there might be insufficient managerial training when acknowledging that these participants are employed as unit managers.

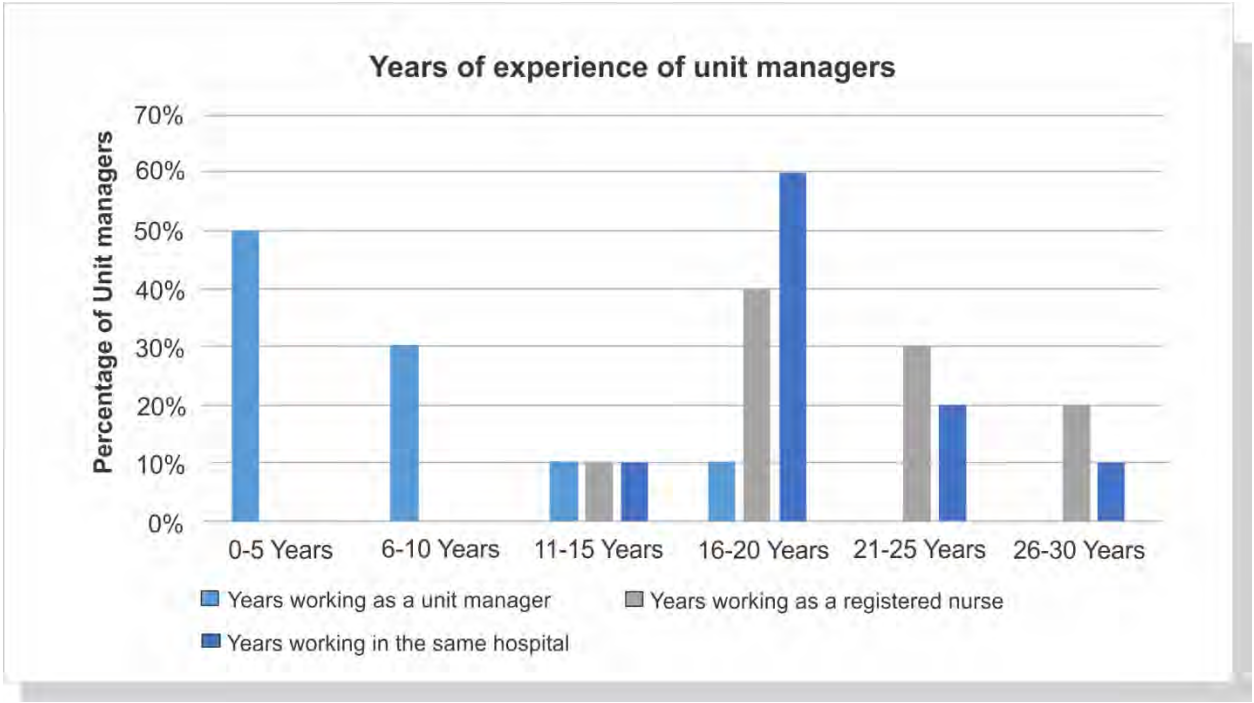


Figure 3.5: Years of experience

Figure 3.5 (compiled from the participants basic information sheets) indicates that 50% of the unit managers were relatively new to management and have been unit managers for less than 5 years. 30% have five to ten years' experience as a unit manager. 40% of the unit managers have been in the nursing profession for 16 to 20 years and 30% of them between 21 to 25 years. Sixty percent (60%) have been working in the sample hospital for 16 to 20 years. Sixty percent (60%) of the participants started working as a professional nurse in the sample hospital and have been working there to this date.

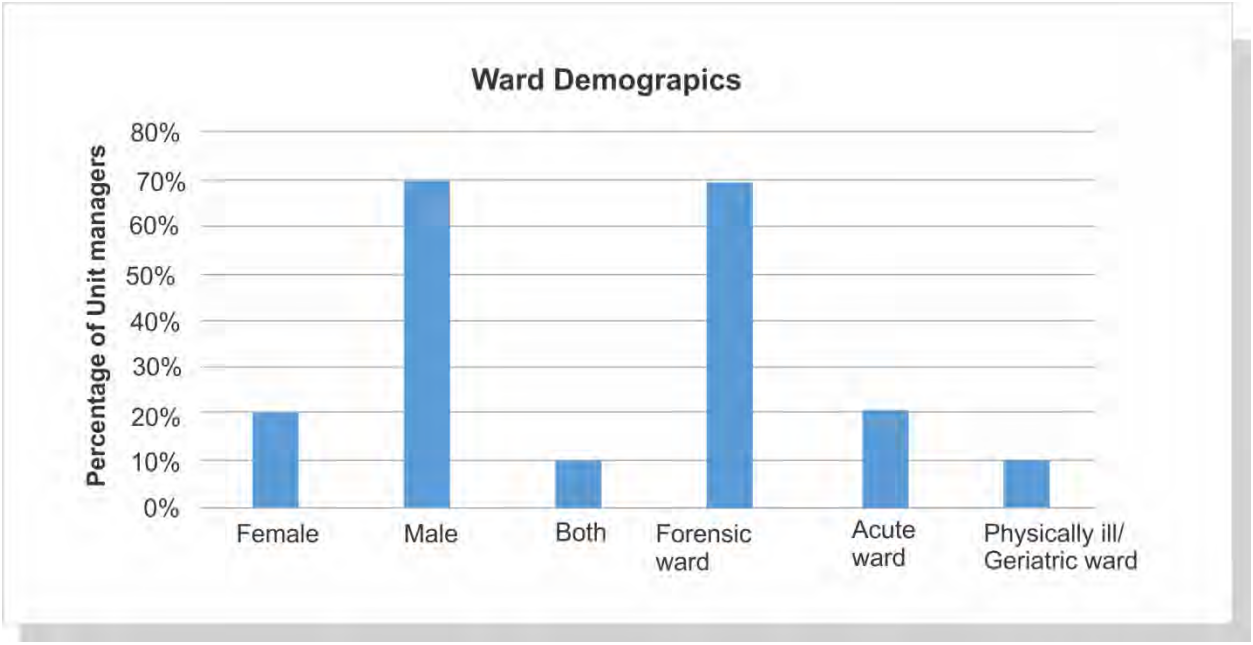


Figure 3.6: Ward demographics

Seventy percent (70%) of the participants work in a male ward and 20% in a female ward with 10% in a male and female ward. Seventy percent (70%) work in a forensic ward with 20% in an acute setting and 10% in a geriatric/physically ill ward. This is not a surprise as 12/17 of the wards in the sample hospital are male wards with 7/12 of them being forensic wards. In forensic wards the patients tend to stay longer in the hospital compared to the acute wards (Shuping, 2013).

3.4 RESULTS AND LITERATURE INTEGRATION

In the following paragraphs the reader will first be accompanied with detailed feedback regarding the graphic team sculpting results integrated with literature. Thereafter a similar sequence will be conducted on the focus group.

3.4.1 Graphic team sculpting (Phase 1)

The following table (refer to table 3.1 below) presents the main and sub-themes identified during analysis of the graphic team sculpting. The sub-themes are categorized into team member factors, team factors and organizational factors. The themes where categorized during data analysis, the researcher realized there is predominantly facilitating and hindering factors. These

factors affect different parts of the organisation namely the nursing team, the team member as an individual and the hospital as an organisation.

Table 3.1: Main and sub-themes of graphic team sculpting

MAIN THEME	Facilitating factors that enhance nursing teamwork in a mental health facility in Gauteng
Sub-themes	
Results regarding the team member factors	• Each member is seen as unique. • Good diversity within teams. • Some are contributing to the team.
Results regarding team factors	• General ward assistants are seen as part of the team. • Unit manager provides guidance to teams.
Results regarding organisational factors	• Hierarchy structures • Female wards tend to be more positive (emotions and labels)
MAIN THEME	**Hindering factors that impact negatively on nursing teamwork in a mental health facility in Gauteng**
Sub-themes	
Results regarding the team member factors	• Job satisfaction is low and team members are unsatisfied/ unhappy. • Team members are lacking motivation. • Team members are seen as immature. • Team leader feels hopeless. • Team leader is not familiar with all team members.

MAIN THEME	Hindering factors that impact negatively on nursing teamwork in a mental health facility in Gauteng
Sub-themes	
Results regarding team factors	• Group/clique formation • Low trust within teams • Poor communication within teams • The teams long for structure. • Cohesion is low.
Results regarding organisational factors	• Assistant managers are not involved with teams at ward level. • Mediocrity/Negative organisational culture.
•	

The interpretation technique developed by Venter (1993:12-13) for graphic family sculptings was modified with the developer's assistance to fit into a team context. The graphic team sculptings were thus analysed through the following steps (please refer to paragraph 1.8.2.3.for a full description of the application steps):

1. Gestalt,
2. Placement,
3. Direction,
4. Position,
5. Label,
6. Emotion,
7. Order,
8. Line quality,
9. Space,
10. Location,
11. Answers at the back of each sculptings/drawings and
12. General statements.

3.4.1.1 Gestalt

In **gestalt** analysis it was clear that in 66.6% of the teams the unit manager might have played the key figure in the team, because they were placed on the top of the sculpting in their own hierarchy line (Appendix H – Example 1). 33.3% of the drawings had no hierarchy; their circles were arranged in a circle (Appendix H – Example 3). This is in correlation with the sub-theme in the focus group (refer to paragraph 3.4.2.), that *hierarchy structures* are present within the team. In a study done to improve public health one of the main findings was that participants valued importance of evidence at the top of the quality hierarchy while others emphasized the importance of personal experience (Atkins *et al.*, 2013:1). This is thus not an uncommon phenomenon.

3.4.1.2 Placement

When **placing** the team members 66.6% of the unit managers were placed at the top/central role (Appendix H - Example 1). 22.2% at the centre of the team (Appendix H - Example 3) and 11.1% within the team. In 33.3% of the sculpting there were no ranks (no clear indication of hierarchy) used (Appendix H - Example 3), it could possibly be said that the cohesion in these teams is better compared to the 66.6% that used ranks (Appendix H – Example 3).

The themes identified in correlation with the sub-themes of the focus group is that, there is *low cohesion in teams*, a study done found that if there is lower cohesion in teams the risk of burnout increases (Eriksson *et al.*, 2013:660). *Hierarchy structures present* by the use of ranks in the sketches. The *unit manager is seen as the central role*, Tanger-Brown (2011:195) found that as a manager, one is often stuck in the middle of the operational needs of one's unit and the ideals of the organization's leadership team.

3.4.1.3 Direction

The **direction** in which each of the team members is looking; 33.3% of the team members in the sketches is looking at the unit manager this could possibly be for guidance, 33.3% is looking at other team members (Appendix H – Example 1, team member C6) and can either indicate group separation within the team and poor cohesion or partial cohesion between some members. 11.1% of the team members are looking at the patients and is more service delivery orientated. The team members are working together as a team, as 22.2% of the team members are looking at everybody (Appendix H, - Example 1, and team member C 15). The sub-themes identified is; *group/ clique formation,* as this is necessary for social identity it can be a negative factor in a team as groups either polarize into opposing cliques or unthinkingly conform to the

leader's will (Zweig, 2009:2). The second sub-theme is that the *unit manager provides guidance to team members as a central figure,* as the team members are looking at the unit manager.

3.4.1.4 Position

It could be said that the **positions** allocated to each team member might present their assertiveness and contribution towards the team, thus the majority of the team members are actively contributing to the teamwork because they are standing (Appendix H – team member C6, Example 1). The team members that is lying down (Appendix H – team member H6, Example 3) or sleeping is not contributing to the team. The team members that are sitting (Appendix H – Example 3, team member H3) are partially contributing to the teamwork.

Table 3.2: Positions in graphic team sculpting

Position	%
Standing	53.8
Sitting	27.9
Lying down	12.4
Sleeping	3.4
None	2.5
Total	**100**

The theme identified is *some members are contributing to the teamwork*. This can indicate mediocrity and a negative organisational culture as only some (not everyone) is contributing to the team. Mediocrity is maintained by a key social process: the marginalization of the adept, which is a response to the group problem of what to do with the highly able (Hermanowicz, 2013:363).

3.4.1.5 Labels

There are three categories of labels, namely positive, negative and neutral labels. Positive labels is 48.7%, negative labels 22.3%, neutral labels 18% and 11% of the team members had no label allocated to them (total of 100%). When analysing the **labels** in the sketches, 48.7%, of the team members had positive labels. The positive labels include the following:

Table 3.3: Positive labels in graphic team sculpting

Labels	%
Hard worker	29.5
Friendly	3.1
Mothering/Caring	0.5
Clever	1.0
Humble	2.0
Extrovert/Loud/Talkative	2.5
Loyal	1.0
Communicator	0.5
Orientate	0.5
Learner/Still developing	1.0
Diligent	0.5
Trusted	0.5
Assertive	1.0
Funny	0.5
Polite	3.1
New ideas	1.5
Total	**48.7**

When looking at these positive labels this might indicate the team members general personality and/or attitude towards their work is positive (Jones & Jones, 2011:175; Kalisch & Lee, 2012:1). In addition 22.3% of the team members had negative labels which included the following descriptions:

Table 3.4: Negative labels in graphic team sculpting

Label	%
Lazy	6.7
Cheeky	2.5
Dodgy	3.1
Loafing	0.5
Bully	1.0
Absent	1.5
Non-compliant	1.5
Manipulator	0.5
Disorientated	0.5
Non-player/not interested	2.0
Not loyal	0.5
Stubborn	1.0
Abusive	0.5
Mistakes	0.5
Total	**22.3**

An identified theme is *mediocrity/negative organisational culture.* A study done in public social services found that insufficient resources to do their jobs, inconsistent or inadequate training experiences, negative perceptions of the organizational culture and management (e.g. minimal recognition and inadequate support for professional growth or innovation). It was found that perceptions of organizational culture significantly predicted duration of employment (Thaden *et al.,* 2010:407). Staff retention is thus higher if the organizational culture is negative. Neutral labels were allocated to 18% of team members, and this was described according to the following labels:

Table 3.5: Neutral labels in graphic team sculpting

Label	%
Average/Moderate worker	9.3
Shy/Quiet	6.2
Emotional	0.5
Questions	0.5
New	1.0
Needs guidance	0.5
Total	**18**

11% of the team members had no label allocated to them, this indicates that *unit manager does not know all team members* and this might have negative effect on teamwork (Kelly, 2008:252) as there is no support and communication between this team members.

3.4.1.6 Emotions

The emotions is categorized into positive emotions (39.3%), negative emotions (25.7%), neutral emotions (14.4%) and no emotions allocated to team members (20.6%) this makes a total of 100%. With allocating a specific **emotion** to each team member, 39.3% of the team members were described by the unit manager as being positive. The unit manager used the following positive emotions:

Table 3.6: Positive emotions in graphic team sculpting

Emotion	%
Happy/Laugh	35.2
Caring	3.1
Strong	0.5
Matured	0.5
Total	**39.3**

These positive emotions might be indicative of their general attitude towards life but also their attitude in the workplace / this coincides with the labels given (SA, 2011:6). In the team sculpting 25.7% of the participants had negative emotions:

Table 3.7: Negative emotions in graphic team sculpting

Emotions	%
Frustrated/irritable	7.7
Angry	3.1
Stressed	3.6
Sad	6.2
Cold/not interested	3.1
Anxious	1.0
Manipulator	0.5
Annoying	0.5
Total	**25.7**

These negative emotions might indicate a negative attitude towards the workplace and has been categorised that *mediocrity/a negative organisational culture* is present. *Team members are unhappy/unsatisfied* which might go hand-in-hand with low job satisfaction and can lead to burnout as already stated (Barker & Walker, 2000:539; Cleary *et al.*, 2012:472). From the graphic team sculpting 14.4% of participants presented with neutral emotions as listed in Table 3.8 below:

Table 3.8: Neutral emotions in graphic team sculpting

Emotions	%
Shy/quiet	3.1
Mixed	6.2
Normal	2.0
Emotional/ Sensitive	3.1
Total	**14.4**

It was interesting to note that 20.6% of the team members presented with no emotions allocated to them.

3.4.1.7 Order

The **order** in which the circles were drawn is dominated by the unit managers first (77.7%) with the rest of the circles followed according to ranks. The unit managers thus might see themselves as the head figure and value structure. Eleven point one percent (11.1%) of the participants drew the unit manager last and 11.1% of the participants drew the unit manager first but with no particular rank order (Appendix H – Example 3). In one sculpting the assistant manager had a very large circle compared to the rest of the team (Appendix H – Example 1) and in one sculpting the unit manager's circle was very large compared to the team. The themes identified from the order of the circles are that the *unit manager views him/herself as the central figure in the team* and there is a clear *presence of hierarchy.*

3.4.1.8 Line quality

There was no significance in **line quality** and the use of the eraser.

3.4.1.9 Amount of space

There was no significance in the **amount of the paper** taken up by the sculpting.

3.4.1.10 Location

There was no significance in the **location of the sketch** on the paper.

3.4.1.11 Answers

The **answers** on the back of the sculpting had the following main themes: the cohesion of the group is low (22.2%); there is clique or group formation within the team (22.2%); 55.5% of the unit managers has emphasized that each team member is unique/individual; there is a need for structure and motivation of the teams (11.1%); poor teamwork and communication is reported in 22.2% of the teams and 11.1% said that their team is very diverse; 11.1% said that they feel that their staff is immature; 22.2% of the unit managers experienced irritability; 22.2% of the unit managers feel hopeless as they don't have control over who is allocated to their ward; 11.1% reported that there is no trust within the team and that there is no job satisfaction from team members. *Low trust* is directly connected to low job satisfaction (Sullivan & Garland, 2010:80), trust also has an effect on communication and results in *poor communication and low cohesion in teams* as teamwork would be poor. *Unsatisfied team members* due to low job satisfaction.

Unit manager feels hopeless. The unit manager can feel hopeless because staff is negative and the teamwork is low. *Diversity* should be embraced. This leads to a positive work environment as the six areas that influences a healthy/positive work environment include leadership, collaborative practice, workload and staffing, professionalism, embracing diversity and workplace health, safety, and well-being (RNAO, 2013). *Longs for structure* (The importance of hierarchy). *Motivation levels is low* this is due to a negative organisational culture and low levels of job satisfaction. *Staff immature at times. Formation of cliques/groups*. *Team members are unique,* each unit manager should facilitate growth by focussing on the individuals strengths.

3.4.1.12 General

In **general** the following has been found while comparing the graphic team sculpting; the positions (horizontal/vertical) is not congruent with ranks but per individual characteristics, team members is seen as unique individuals by the unit manager. Each team member can be seen as unique, their label, emotion and position depend on individual circumstances and personality. Unit manager seen as the leader of the team (in 66.6% of the sculpting most of the team members are looking at the unit manager). Unit manager plays a central role in the team. Each ward differs according to type of ward, total of patients and staff. There was formation of cliques/groups within the team in 44.4% of the sculpting's. Female wards were viewed to be more positive according to their emotions and labels. There is no clear difference between the acute and forensic wards. Female wards are more positive. In a study done about staff attitude (Munro & Baker, 2007:196) in acute mental health the results demonstrate that a wide range of attitudes are held by mental health nurses towards acute, mental health care. Overall, the results indicate generally positive attitudes. Significant differences were found between qualified and unqualified staff, and males and females for some questions but recommendations are made for future attitudinal research of mental health staff as there is no clear evidence why there is a difference between gender attitudes (Munro & Baker, 2007:196). Twenty two point two percent (22.2%) of the graphic team sculpting included the assistant manager that could be seen as a lack of support from top management as this percentage is low and that they don't form part of the team in 88.8% of the sculpting's. Senior management is not involved in teams as already discussed (Thaden et al., 2010:407), negative perceptions of the organizational culture and management (e.g. minimal recognition and inadequate support for professional growth or innovation) can lead to high turnover rates of staff. Forty four point four percent (44.4%) included general ward workers as part of the nursing team. General ward assistants form part of the team as they contribute to the cleanliness and everyday functioning of the ward and the unit managers saw them as a key figure in the team. Twenty two point two percent

(22.2%) included the ward administration clerk as part of the nursing team. There was no team separation between different shifts (day and night shift).

3.4.1.13 Conclusion statements of the graphic team sculpting

From the analysed graphic team sculpting and accompanied discussion and literature integration, the following conclusion statements are formulated:

- There are various factors that either facilitate or hinder nursing teamwork within a mental health facility in Gauteng.
- Clear hierarchical structures are present within nursing teams and unit managers perceive these hierarchical structures as important and included it in the sketches. Yet despite clear hierarchical structures, there is a need for more operational structures within the units.
- In addition to the clear hierarchical structures, unit managers provide the nursing team with guidance and play a central role in these teams.
- Only some of the team members work hard and contribute to nursing teamwork whilst general ward assistants played a key role in the functioning of nursing teams.
- Although teams are viewed as diverse, every team member is viewed as unique yet not all the unit managers were familiar with all their nursing team members.
- Despite feedback of functioning nursing teams, there are indications that the cohesion in these nursing teams is low.
- There are indications that groups (cliques) might be forming within the nursing teams which was visible in the direction that the team members are looking in.
- The majority of labels and emotions are not positive but rather neutral or negative and this might be an indication of a negative organisational culture which the researcher also referred to as mediocrity. Furthermore some of the team members were described as being unhappy and/or dissatisfied with low trust within the nursing teams.
- Hindering factors such as poor communication within teams; team members' low motivational levels; and perceived immature staff. In addition unit managers conveyed a possible feeling of helplessness.
- Senior management (referred to as assistant managers at the mental health facility in Gauteng) does not play a key role in teams and it could thus be said that they might not be actively involved in nursing team functioning.

3.4.2 Focus group (Phase 2)

The results from the focus group included the organisational factors, unit-specific factors and unit manager-specific factors as main themes with both facilitating and hindering factors. During data analysis the research identified that the main themes is predominantly positive and negative and thus categorized the themes according to facilitating and hindering factors. These factors affect different parts of the organization, the hospital itself as a organisation, the unit/ward and the unit manager as a team leader.

Table 3.9: Main and sub-themes of focus group

MAIN THEME	HINDERING FACTORS THAT ENHANCE NURSING TEAMWORK IN A MENTAL HEALTH FACILITY IN GAUTENG
SUB-THEMES	
Unit-specific factors	• Try to work as a team.
Unit manager-specific factors	• Unit managers' ability toward effective delegation. • Unit manager views him/herself as manager and leader. • Unit manager is a role model. • Fairness within the team. • Strive towards cohesiveness. • The unit manager acts as a problem - and conflict solver. • Value each team member as unique. • Communication and decision-making.
Organisational factors	• A negative organisational culture. • The influence of occupation-specific dispensation. • Absence of clear hierarchy below unit manager level. • Poor support from top management. • Team leader feels hopeless. • Team leader is not familiar with all team members.

MAIN THEME	HINDERING FACTORS THAT ENHANCE NURSING TEAMWORK IN A MENTAL HEALTH FACILITY IN GAUTENG
SUB-THEMES	
Unit-specific factors	• Ward structure and type (forensic, males, aggressive behaviour). • Increased workload and low staff patient ratio. • Absenteeism of nurses in the wards. • Supervision/delegation needed. • Staff mix needed (male/female and ranks). • Staff set in their ways with routine work. • Staff needs problem solving skills and direction. • Negative attitudes, jealousy and culture of mediocrity, burnout and lack of motivation from team. • Unclear hierarchy causes uncertainty and power struggles. • Staff doesn't take responsibility/ accountability. • Team groupings cause division between team members. • Unit manager's authority diminishes in his/her absence. • Power struggle to be operational manager. • Team needs unit manager to function.

3.4.2.1 Facilitating factors that enhance nursing teamwork in a mental health facility in Gauteng

The facilitating factors identified in the focus group are discussed as

- unit-specific - and
- unit manager-specific factors.

- **Unit-specific factors**

Only one sub-theme that was unit-specific was identified, namely that the nursing team does try to work together.

Unit managers are *trying to increase team effectiveness and collaboration*, which contributes to teamwork. Unit Manager (UM) 0 motivates the team: "But I am trying to motivate them so that it

will remain like that." UM 4 see the formation of a team as an ongoing process: "I am still trying to build the team so that we can have this cohesiveness, working together." UM 2 is putting pressure on the team to perform: "We need to achieve as a team." Motivation appeared to be influenced to some degree by a number of factors, including rewards, leadership behaviours, goal setting, and the career goals of team members (Englyst *et al.,* 2008:15). Thus team performance and motivation can be seen as key factors in contributing to effective teamwork.

- **Unit manager-specific factors**

The facilitating factors regarding the unit manager are discussed below with literature integration and supportive quotes from the focus group. The identified sub-themes are;

The first sub-theme is the unit manager's ability towards effective *delegation.* Delegation can be seen as the act of giving a team member responsibility to complete a specific task or duty (Jooste, 2010:81). In this study effective delegation referred to the ability of unit managers to indicate which team member is responsible for which task. UM 5 states that delegation is giving someone else the responsibility: "Delegation so he is depending on those people to do his job on his behalf." UM 6 says that delegation needs to be fair: "So, then also we need to be, especially with the delegation we need to be impartial not to take sides, in conflict and all those things." UM 0 uses delegation as an empowering tool: "But for good practice you give them, you delegate." Kelly (2008:248) found that a team leader needs to delegate duties according to individual strengths to promote individual qualities and growth.

The second sub-theme was that unit managers view themselves as *managers* and *leaders*. Leadership is a process by which a person influences others to accomplish an objective and directs the organization in a way that makes it more cohesive and coherent (Jooste, 2010:189). This sub-theme indicates that unit managers perceived themselves as possessing both managerial and leadership abilities and that both are present although the ration between the two abilities wasn't indicated. UM 4 views him-/herself as a leader: "I am the team leader or operational leader." UM 7 emphasises the importance of a team leader: "You cannot walk without a head, the leader is the head." Lack of leadership is a major factor that contributes to poor team functioning (Berg & Hallberg, 2000:326; Cleary & Freeman, 2006:992). Leadership is the key element in the process of creating team functioning.

Thirdly the unit manager is described as being a *role model*. In the focus group the unit managers voiced that unit managers are necessary to portray teamwork to team members. A role model is an individual who can be looked up to and who inspires others. UM 6: "I think maybe we need to emphasise that the operational manager needs to take lead." UM 0: "Be a

role model." Both these unit managers understand the importance of setting an example. UM 3 identifies consistency as a positive role example "And you as a leader, If you are not consistent and being considerate or flexible. The people will not make a good team." The National Department of Health in South Africa (SA, 2011:6) states that one of the priority areas in the core standards is improving values and attitudes of health care professionals, and that one of the ways to accomplish this is that leaders at all levels should be positive role models to staff to encourage a culture of caring and positive attitudes that supports service delivery.

Unit managers' voiced the presence and need for *fairness* within the nursing teams as the fourth sub-theme. Unit managers listed fairness as an important aspect in nursing teamwork. Fairness can be seen as the quality of making decisions that are fair judgements (Kalisch & Lee 2012:2). UM 6 and UM 7 state that fairness in delegation is very important: "So, then also we need to be, especially with the delegation we need to be impartial not to take sides, in conflict and all those things." and by saying "Try to share the job equally, to be accommodative." Fairness is important in avoiding conflict and formation of groups within the team (Kelly, 2008:248).

In the fifth place, voice managers voiced that they *strived towards group cohesion* within nursing teams UM 6 stated that: "When the OM is around, he kind of becomes the unifying force." In this statement it is clear that the unit manager plays an important role in improving cohesion and that the unit managers acknowledged that group cohesion is not spontaneously present. Kalisch *et al*. (2013:214) state that an effective team promotes free exchange of ideas, team cohesion, trust, mutual respect and personal satisfaction.

In addition to enhancing group cohesion, unit managers are aware that challenges are present within groups and that problem- and conflict solving is necessary. Unit managers therefor also act as *problem* – and *conflict solvers* as voiced by UM 7: "If the leader is there you can unite them, there are those who have conflicts you can bring them and bring them together. You should help them solve the problem; you are the leader you should be there". UM 6: "It will not help, conflict is always there and then you must intervene." Hospital managers and nursing leaders have to work together to improve working relationships and job satisfaction among health care providers to improve the quality of patient care (Chang *et al.,* 2009:1945). Jones and Jones (2011:178) stated that conflict can be alleviated if the working team in general works towards the same objective. The unit manager should thus solve conflicts by focusing the team on a common goal.

Although unit managers voiced their active involvement in solving problems and conflict resolution, unit managers also deliberately focused on the uniqueness of each team member. In this study the uniqueness of each team member and team was emphasised, as unit managers viewed every team member as *unique*. UM 5 states that each team member should contribute "Involve everybody in decision making." UM 4 knows that appreciation is a powerful tool used within team dynamics: "And you have to value each and every person, they should be aware of their value, to realise that they have value in the team you know." UM 2 supports UM 4 "Also I think what we need to observe is that we are a team but we are made of individuals. Every person has strengths and weaknesses."

The final sub-theme regarding unit manager-specific factors that facilitate nursing teamwork was that *communication* and *decision-making* are two important functions of the unit manager**.** UM 7 realises that problems should be solved as a team: "Having meetings with them you should try and attend to each and everyone's problem." UM 5 uses assertiveness during problem-solving: "And also assertiveness, if you have a problem bring it to the table you discuss and you solve it there and then." UM 4 realises the importance of communication: "I heard somebody say communication, I would say poor communication. If there is poor communication I think it is going to impact also, the good teamwork, you know." UM 3 supports the above statement: "I think to facilitate communication because I think communication is the key, some of the problems you can throw back at the very same subordinates." Kalisch and Lee (2012:2) state that 70% of incidences can be said to be due to a communication failure as the primary cause. Communication improves patient safety as collaboration between the team increases. It can thus be seen as a vital factor in quality care.

3.4.2.2 Hindering factors

From the focus group factors were categorised together as hindering the nursing teamwork in a mental health facility in Gauteng. These hindering factors were grouped as factors relating to the organisation, namely the level 3 mental hospital where the data was collected; hindering factors specific to the units where unit managers are employed and thirdly hindering related specific to unit managers.

- **Organisational factors**

Unit managers voiced that the *organisation's culture is negative* as it hinders nursing team work because the culture is perceived as laissez faire and mediocre. *Organisational culture* can be seen as emanating from a group of people who have a history and stability which form a culture. This is formed by experiences once a group has learned to hold common assumptions,

resulting in automatic patterns of perceiving, thinking, feeling, and behaving to provide meaning, stability, and comfort it can be said that that group of people have an organisational culture (Schein, 2004:17).

The following statements represent organisational culture. UM 5: said “I hear you saying that maybe people are spoiled, they are not spoiled, I don’t know. It is their culture.” UM 5 also sees that the employers need external motivation “So we are not blaming each other, that is what I observed the culture of (the hospital) they need to be pushed” UM 3 supported this by saying that they need motivation by saying that the people are refusing to work “But they are refusing.” UM 7 also experienced this in his/her particular ward “Like someone, you can delegate them and if he is not happy about that, then they will display a negative attitude. The next thing he is not going to come to work because he was not happy with you.” UM 2 feel that they are tolerating the organisational culture and this impact negatively on teamwork: “Well I, I’m not sure but in the culture we tolerate some wrong things until they are skin-deep. We do that as a facility and in the wards, so now if we try to do something right it becomes a problem. People will make reference to it but they will get away with murder even if they refuse to contribute. There are those things that look, I am saying on paper thing look so much better than in practice we are quite a negative organisation culture. And we don’t often talk about it; we protect a certain incident and talk soft about it. That is hindering.” A negative organisational culture is not uncommon in health care.

Organisational culture transformation is necessary to improve quality health care. The negative organisational factors should be identified and there must be some hope that interventions and management strategies can have a predictable impact on cultural attributes, as a precursor to bringing about performance improvement for transformation (Davies *et al.,* 2000:117).

It was evident from the focus group that *occupation specific dispensation (OSD)* was viewed as a hindering factor in nursing team work as it is viewed as an unfair financial incentive that impacts negatively on staff morale and nursing teamwork. OSD can be seen as a financial incentive strategy, to attract, motivate, and retain health professionals in the public sector (Ditlopo *et al.*, 2013:138).

UM 5 sees OSD as an incentive that can cause inequality: “I wanted to say that, Occupational Specific Dispensations created a lot of problems. It is not clearly, you know, defined as he saying, who is the hierarchy. Everybody is a PN there is no differentiation.” UM 4 goes even further by stating: “Because of you know this beast this animal that was created by OSD.” OSD created a lot of unhappiness in the public sector and even led to a loss of morale and staff

grievances. The implementation of financial incentives requires careful planning and management in order to avoid loss of morale and staff grievances (Ditlopo *et al.,* 2013:138). It is not only nurses who see OSD as being unfair, Gray (2009:52) stated that OSD seems far removed from that initial promise, and many pharmacists in the public sector feel betrayed.

There seems to be a clear organisational hierarchy from unit managers and above but there is an *absence of a clear hierarchy below unit manager level.* As there is no ranking of registered nurses it is not clear who is in charge when the unit manager is off duty and during weekends. UM 6 is uncertain of the hierarchy structures and says "But mostly the hierarchy after the OM is kind of not well defined." UM 4 supports UM 6 by referring to OSD: "Well after the OM's all PN's are equal in terms of the compensation." UM 2 verbalises that it even creates power struggles between registered nurses: "Take an example of a PN who takes the lead in a shift. With the PN's some of them are quite experienced as they have been here for a long time. Now it is a situation of who is telling who, it does surface." In reality teams vary and their structures change but there is a need for an effective structure as this influences team effectiveness. According to Mickan and Rodger (2000:206) appropriate team structures and processes can maximise individuals' contributions and limit the potential for inter-professional conflict within a team. Power struggles is a form of interpersonal conflict. Hierarchy also influences communication in teams; three role factors that reflect overarching issues of hierarchy, status, and professional identity that challenge nurses' communication in the healthcare team (Apker *et al.*, 2005:93). A team needs a leader to function effectively; the presence of a team leader results in a significant improvement in team performance (Van der Heidjen *et al.,* 2009:39).

Unit managers indicated that there is *poor support from top hospital's management* as teams felt as if the support from senior management was insufficient. UM 2 felt as if there had been no change: "Even at higher levels there is nothing that has been done about it." UM 5 emphasises the need for more support: "Also the support system from top management is not well." UM 2 feels as if issues of staff shortages are not resolved: "some of the issues are key to human resources management, we don't have a human resource manager, understand. We are talking about a professional that is able to identify these problems and to increase the numbers but we don't have." UM 0 expresses her concerns about not having a CEO: "Like in this case of our CEO, that is poor organisation." A study done by Jassawalla and Sashittal (2001:38) found that collaboration behaviour does not exist in teams that have poor trust, creativity and collaboration between the teams and senior management. Support and collaboration are thus necessary between team leaders and senior management to produce effective collaborative teamwork.

Positive work environments and appropriate support to nursing staff can lower nurse retention, positively influence staff shortages and increase teamwork (Cleary & Freeman, 2006:986).

- **Unit-specific factors**

The *ward structure and type* is a sub-theme as every ward can be seen as unique. The ward structure, type and resources have an impact on the teamwork, in this study the ward structure refers to the type of patients in the ward, according to the different sections of the Mental Health Care Act (SA, 2002), as well as the physical outlay of the ward. UM 4 felt that the ward was insufficient in providing for their team needs: "There is a need as per infrastructure and resources." UM 7 highlighted the notion that the type of patients in the ward influences the team: "Like in my unit I am working with the forensic patients, they are all from prison; they still have that criminal element in them whatever they are doing and their behaviour. Even if they are a mentally ill patient, the element is still there." UM 4 also states that each ward is unique: "The dynamics will differ in each ward, so the dynamics will lead me to the problem"

Quality care is related to ward structure as Adams and Bond (2000:542) state. This includes the quality of ward facilities and of services provided to the ward by other departments, which affect nurses' ability to do their work. One of the major challenges in mental healthcare is insufficient infrastructure (Cleary *et al.,* 2012:473; Lund & Flisher, 2002:158; WHO, 2011:52).

Increased workload and overcrowding of patients can be seen as the amount of work that is being expected to be done and the number of patients that needs care (Jooste, 2010:97). Workload increases according to the staff-patient ratio and level of care that a patient requires. UM 7 stresses that they feel overworked: "There is too much work because there is an overcrowding of patients. You see having few people with many patients. So at the end there are those things that cause the teamwork to fail". UM 4 feels that the staff patient ratio is too low: "Staffing levels I would say no they are very low, and it needs to be upped, to be increased, and to be proportionate to the number of patients." The ward's workloads have a major influence on their job satisfaction (Adams & Bond, 2000:542). One of the six areas to influence a healthy/positive work environment includes workload and staffing (RNAO, 2013). Studies have shown that increased workload, inadequate time off, restricted autonomy, burnout, and emotional exhaustion can lead to high levels of stress and decrease job satisfaction (WHO, 2009:36).

Absenteeism is a sub-theme as it a problem in the specific hospital (Shuping, 2013). Absenteeism is the voluntary non-attendance at work, without valid reason and usually does not include missing work for recognized holidays, family vacations, jury duty, bereavement, sick

leave, and family emergencies (Camden & Ludwig, 2013:166). In this study absenteeism is seen as not reporting on duty due to personal reasons, sick leave or being absent without a reason. UM 7 stated that “In our unit the teamwork is good but there are those challenges that is affecting us like absenteeism” UM 1 also perceives absenteeism as a hindering factor in teamwork “But note as my colleague is saying, sometimes we have challenges due to absenteeism, yesterday we had a problem because two staff were absent and also last month we had some on leave, most people were taking their leave so we had a lot of shortages.” UM 4 agrees with UM 1: “Yes ummm absenteeism is a problem ja, it is a problem, some of the people is not ummm it is not even a question I would say it is a habit now of not coming at all and that actually impacts on the team shift.” Teamwork improves productivity, decreases absenteeism and stabilizes the workforce but one of the numerous challenges that has an impact on mental health care facilities is the matter of staff shortages (Cleary *et al*., 2012:473; Lund & Flisher, 2002:158; WHO, 2011:52).

Supervision and delegation is a sub-theme that affects a specific unit. Supervision can be seen as the monitoring of care (Jooste, 2010:169) to ensure that delegated duties was performed according to national and departmental standards. In this study we mainly focus on the supervision of nursing team members by the nursing unit manager. Supervision and delegation are needed as unit managers emphasised that the team needs constant supervision to perform their daily duties. UM 0 said: “During my presence the people perform but in my absence they decide to sit.” UM 5 confirmed this by saying: “If the operational manager is not there they don’t want to do their job always they need a policeman to be there.” A study showed that team supervision is a challenge to supervisors because strict supervision improves mutual understanding, but also increases tension (Hyrkas & Appelqvist-Schmidlechner, 2003:188).

Staff mix is a sub-theme of unit specific factors, as each unit needs different individual team members on a shift according to their qualifications, experience, gender and personal strengths. Staff mix means achieving a specific mix of different types of personnel, with an increasing interest in evidence about the value and contributions of different staff-mixes to patient, personnel, and organisational outcomes (Dubois & Singh, 2009:2). The following statements supported that the male/female ratio causes difficulties in team functioning; UM 5: “The females are more, males are less. So sometimes I encounter problems”, UM 4: “No maybe we need to contain a male ward we will we need more males”, UM 7: “You can imagine if you have 20 males, male patients, and then you have two male staff members and let’s say 10 females. It is like you don’t have staff.” UM 5: “I also come from ward 5 a forensic unit with the same charges. So the gender it is a problem in the sense that, you know that males they have this tendency of

taking females for granted." UM 0 has problems mixing different ranks within her team: "So it is still a challenge to mix them". There is no clear evidence from literature that gender differences have an influence on teamwork, it could thus be said that this phenomenon is unique to the specific mental health care hospital setting. The evidence suggests that no matter which workers are employed or what their roles are, it is only by tackling organisational issues that a fully efficient and effective workforce can be generated (Dubois & Singh, 2009:37). Another study done by Hall (2003:224) suggests that there need not be a great concern about whether staff mix models affect nursing outcomes as it appears that other variables within the work environment might have had greater influence the outcomes examined than the independent variable of staff mix.

Staff members are set in their ways with routine work as some staff members choose to do the same routine and procedures on a daily basis as this is their way of doing things. They are not comfortable with changing their routine or way of doing things. UM 3 gives a great example of this by saying: "The people that are long in this hospital, they got this thing they are so influential. They have got this pulling down syndrome and they are influential. I don't know if it is a burnout thing, really. They will always say in our times this is what we used to do and you are not going to tell me." Routine work can provide structure and guidance to team members but if the members are not open to change and new techniques (as the situation is in this hospital), it can be a hindrance to teamwork (Booyens, 2000:310).

Unit managers voiced that *staff was needing problem-solving and direction* within the nursing teams. Problem-solving can be seen as self-directed cognitive-behavioural process by which an individual attempts to identify effective solutions for specific problem encountered in everyday living. Directing is when the unit manager gives orders, communicates, motivates and supervise nursing team members (Jooste, 2010:83). UM 4 states that team members should be involved in problem-solving and take part in the process: "Make the people, your followers aware that, make them own the problem. Make them aware of such." Involvement in decision-making and problem-solving would influence teamwork positively as independent collaboration and shared decision making are among the attributes of teamwork (Xyrichis & Ream, 2007:237).

A *negative attitude towards teamwork, mediocrity and demotivation* is a major hindering factor in teamwork. Team members is seen as negative as they are resistant to change their negative attitudes and views of their work environment. The National Department of Health in South Africa (SA, 2011:6) states that one of the priority areas in the core standards is improving values and attitudes of health care professionals; this is thus a common hindrance to quality health care in South Africa. Burnout is a prolonged response to chronic emotional and

interpersonal stressors on the job, and is defined by the three dimensions of exhaustion, cynicism, and inefficacy (Maslach *et al.,* 2001:397). UM 7 said that there was a specific culture in the hospital: “Yes it is very important the culture, very important.” UM 0 perceives this culture as a negative attitude: “An attitude”. UM 5 confirmed these negative attitudes: “So we are not blaming each other that is what I observed the culture of (sample hospital) they need to be pushed.” Also stating “They just come and go they no longer show interest”, and “But to be strategic because they can manipulate you by requesting whatever.” UM 1 stated that not all staff are negative by saying: “They differ like for example if I phone another ward to ask for a relieve for my ward the attitude that side where I am requesting, if they have a bad attitude they will refuse to come and help me, so that is a hindrance also because we will remain short staff even if they are many, but they are not willing to help. It is the attitude.” UM 1 has witnessed professional jealousy among team members: “They would say that you are now better.” UM 5 supports this by saying: “And another thing is I think people are feeling inferior they have this complex because now things have changed they did not have the same opportunities in school. But now the opportunities are open for all, they have this fear that the children are now taking over they are telling us what to do. That also hinders teamwork and it leads to this pulling down syndrome. And a lack of information, and the information is available.” “People are lazy to read. If you don’t read to them they won’t take a file and read, they are so tired. Getting that information is a problem they need to be pushed to put food in their mouth. They are not confident enough to do that on their own.” UM 6 experienced conflict and a lack of compassion: “Patients are fighting en the staff said no just leave them, others want to intervene because there will be a number of injuries. So there will be conflict if the one staff says no let them fight.” UM 4 thinks that the team members may be suffering from burnout: “But I also think there is burnout, even when something happens that is wrong it is like something that is normal.” UM 7 also says: “So there is nothing to motivate change.” A positive attitude and teamwork have a high correlation, a study done in the oil industry reported that positive attitudes to interpersonal aspects of the task were indicated, with high levels of teamwork being reported (Crichton, 2005:679). As already known in health care a positive attitude also plays a major role in quality health care. Maslach *et al.,* (2001:419) stated that neither changing the setting nor changing the individuals is enough to combat burnout; effective change occurs when both develop in an integrated fashion.

Unclear hierarchy causes uncertainty and power struggles. This can be seen as an organisational factor that has an effect on the unit as well. The team members is not certain of who should take responsibility in the absence of the unit manager. This uncertainty has a negative impact on teamwork as stated above. UM 7 stated: “Some still are still having

questions so and so is on top of me, but so and so is not performing but according to the hierarchy he is my senior, that is the challenges what we are facing guys." Leadership is an effective tool to promote clinical responsibility, ownership and accountability amongst all team members (Kelly, 2008:248) and would thus minimizes power struggles and uncertainty.

*Team groupings cause division between team members***.** There is some division within teams in the unit where there are certain groups and cliques forming that cause friction. A group can be defined as a collection of individuals each with their own thoughts, ideas, abilities and objectives (Barr & Dowding, 2012:75; Yoder-Wise, 2011:346). They differ from a team, where a team has a much higher cohesion and strives towards a common goal. This definition proves that a group is not goal-orientated like a team this would thus inhibit team functioning. UM 6 states that there is division within the unit: "Then this develops friction; there will be those who is supporting so and so and those who are supporting so." UM 6 also sees group formation as a problem within the team: "Interpersonal relations, is another factor, when in the work place you kind of deal with more of social problems of individuals against each other, not because they have clashed due to a delegation or tasks which was not done, but it is something else which is not related to the work situation. It is in the form of gossips, I think I have found that to be a problem."

Staff don't take responsibility/ accountability, between the power struggles and hierarchy uncertainties no one stands up to take the role as a leader of the team in the absence of the unit manager. This is supported by the following quotes UM 6: "No one wants to take responsibility. And no one steps up to take that responsibility, it becomes a problem." UM 5 states that the root of the problem is hierarchy uncertainties "Responsibility, because now they are all PNs." UM 4 contributes by saying: "The ones that is actually has to be seen taking the lead in the absence of the Operational Manager is actually shying away and not taking responsibility as is expected." Responsibility and hierarchy go hand in hand as there are unclear hierarchy structures - the responsibility should have improved according to the following: equalizing of power amongst members through governance improves individual leadership skills. It is an effective tool to promote clinical responsibility, ownership and accountability amongst all team members (Kelly, 2008:248).

- **Unit-manager specific factors**

The first unit manager-specific hindering factor was that these participants voiced that their *authority diminished* when they were absent from their wads. Authority can be seen as the right to decide on specific matters concerning a group. UM 0 raised a concern about authority that diminishes in the absence of the unit manager and that team members do as they please: "So during my presence they do that if I am not there then they don't on weekends and just like after

four." UM 6 feels that authority is not respected: "The power to delegate is no longer there, it diminished." The amount of authority given to an individual depends on his/her position and background; authority should be dependent on certain factors (Jooste, 2010:131).

The second hindering factor listed under unit manager-specific factors is that unit managers experienced a *power struggle* between professional nurses and unit managers in general to be promoted to operational managers. Power struggles are confirmed again as a hindering role in unit-management factors due to hierarchy uncertainties as stated above (Kelly, 2008:252). UM 6 said that: "I don't know but it seems like there is some kind of a power struggle between the members on who is going to take the role and who is going to fill the gap for the OM."

Lastly it was found that the *unit manager brings focus to team members,* as the unit manager plays a role in leading the team, and keeping them goal-orientated. Without the unit manager the team is not as functional. UM 6 stated: "When the OM is around he kind of becomes the unifying force. So when there is no recognised leader to focus them towards a goal." UM 5 even goes as far as stating that she brings her team to life: "Bring them back to life." Kalisch and Lee (2012:7) state that is the responsibility of the unit manager to keep the team orientated to strive towards organisational goals.

There were various hindering factors identified in the focus group. The unit manager plays the key role in managing these factors; staff mix is a problem in the specific mental health care hospital, but as stated by Hall (2003:224) stated that staff mix is not the main variable in nursing outcomes as other factors in the environment affect nursing outcomes. The other factors which the unit manager should focus on is managing team members workload, to be an advocate for improvements in the infrastructure (Adams & Bond, 2000:542), support from top management and employing more nursing personnel (RNAO, 2013). The unit managers should feel free to discuss these specific management issues with top managers, so that they collaboratively resolve the organisations hindering factors. As a unit manager they should resolve and identify patterns of absenteeism. As there is no clear hierarchy beyond the unit manager which causes power struggles, it is the role of the unit manager to identify the hierarchy structures in their specific ward and to facilitate accountability and situational leadership within the hierarchy. Clear hierarchy structures have a positive impact on clear communication (Apker et al., 2005:93) and improve team performance (Van der Heidjen et al., 2009:39). As there is grievances about OSD (Ditlopo et al., 2013:138) and negative attitudes together with a lack of motivation the unit manger needs to be an impetus in motivating staff members, implementing changes and cultivating positive attitudes towards the work environment. The unit manager needs to involve each team member in problem solving and decision-making, this influences

teamwork positively, as independent collaboration and shared decision making are among the attributes of teamwork (Xyrichis & Ream, 2007:237). Barr and Dowding (2012:75) state that a group is a collection of individuals each with their own thoughts, ideas, abilities and objectives, the unit managers role is to align these different ideas, thoughts and objectives to one goal that is in correlation with the hospitals vision, mission and philosophy so that individual group members forms a team (Kalisch & Lee, 2012:7). The unit manager plays a role in leading the team, and keeping them goal-orientated.

The unit managers are already facilitating teamwork through some of them are motivating the team members to strive for improvement in nursing teamwork. Motivation appeared to be influenced to some degree by a number of factors, including rewards, leadership behaviours, goal setting, and the career goals of team members (Englyst et al., 2008:15). As unit managers they are fair in delegating daily responsibilities, they resolve problems in the unit, they are role models and they unite the team and facilitate communication (Kalisch & Lee 2012:2). The unit managers view themselves as leaders which is the key element in team functioning (Berg & Hallberg, 2000:326; Cleary & Freeman, 2006:992).

3.4.2.3 Conclusion statements of the focus group

The following conclusion statements were formulated from the main- and subthemes as obtained from the analysed focus group:

- Participants voiced both facilitating and hindering factors that might impact either positively or negatively on nursing teamwork from a unit manager's perspective within a mental health facility in Gauteng.
- The organisation's culture impact on the nursing teamwork's functioning especially when staff forms cliques and when staff need constant supervision from managers to guide them and don't solve problems on their own as team members struggle to perform tasks independently; yet team members are not necessarily open to change and rather prefer routine work,
- Occupation specific dispensation is perceived as causing inequalities amongst all levels of nurses and is therefore experienced as negative by unit managers.
- There seems to be an absence of hierarchy from below the unit manager which presents with the following consequences: power struggles between members, lack of taking responsibility and accepting accountability, jealousy and diminished authority of

the unit managers. The absent hierarchy is also applicable to senior management whereby unit managers experienced insufficient support from top management.

- According to the unit managers there is a greater need for males in the teams as they believe that this improves team functioning but no literature could be found that supports this statement.
- Unit managers strive to delegate team members to optimize learning, building strengths and fairness, and unit managers are making an effort to improve nursing teamwork.
- Unit managers see him/herself as a leader and a role model within nursing teamwork and acts as a problem solver.
- Unit managers view improved cohesion as an active attempt within a nursing team whereby team members are appreciated in their diversity and through effective communication and trust and that involvement in decision-making and clear communication are important in team functioning.

3.5 INTEGRATED DISCUSSION (PHASE 3)

An integrated discussion between the analysed data from the graphic team sculpting and the focus group have been formulated from the research results;

Every team is complex with different factors influencing the teams' functioning. The focus group and graphic team sculpting proved that both organisational, unit specific and unit manager specific factors has an effect on the teams overall functioning as a team.

The unit manager plays a vital role through leadership and guidance. Every ward, individual and team are unique according to their structure, individual characteristics and type of ward, and this diversity should be embraced (Adams & Bond 2000:542).

The unit managers plays a central role in enhancing teamwork through collaboration, fair delegation and providing guidance. The unit managers acts as a role model and leader that bring the teams together and solve problems, facilitates effective communication and involves all the team members in decision making where appropriate. The unit managers' recognise that each team member is unique with his/her own strengths and weaknesses, the unit manager should focus on each team members strength and use his/her best qualities to improve nursing teamwork (Kelly,2008:248; SA, 2011:6).

There might be a negative organisational culture in the hospital, this is evident by the negative labels, attitudes and emotions in the sculpting as well as the quotes from the focus group. The negative attitudes contributes to absenteeism. During the focus group it was also proven that the team members are resistant to change. The team members as low motivation and do not take responsibility and accountability for managing the ward in the absence of the unit manager. The individual team members is not empowered to solve their own problems, as they require a lot of direction and supervision (Barker & Walker, 2000:539; Cleary *et al.*, 2012:472).

There is inequality within teams due to OSD, formation of cliques and power struggles which causes team division and low cohesion. Uncertainty in the hierarchy structures below the unit manager contributes to the power struggles within the nursing team. The uncertainty of hierarchy also has an influence on responsibility and accountability (Apker *et al.*, 2005:93; Ditlopo et al., 2013:138).

Only some of the team members are contributing towards the team. It was interesting to note that the general ward assistants and administrative clerks are also seen as part of the team even though they are not nurses, and not directly involved with patient care, they have an important function in the team.

The unit managers feel like there is poor support from top management. The wards are overcrowded with patients and this increases the workload of the nursing team, there is a need for better staff mix as more males are needed for effective functioning according to the unit managers (Dubois & Singh, 2009:37).

Within the team there is individuals forming cliques, this inhibits the trust and communication between the team members. The unit manager needs to improve cohesion by keeping the team goal directed and working on trust between the individuals (Kalisch & Lee 2012:2; Toofany, 2007:24).

3.6 SUMMARY

The realisation of the data as well as data analysis was described. The discussion of the study findings was done according to the main themes and the sub-themes that emerged from the analysis of data obtained through focus-group discussions and graphic team sculpting with the participating unit managers. In chapter 4 a limitations of the study and recommendations was discussed.

4

CHAPTER

CHAPTER 4:

EVALUATION, LIMITATIONS AND RECOMMENDATIONS

4.1 INTRODUCTION

In this final chapter of the study the researcher reflects on the findings of the study motivated during the exploration and description of the role of the nursing unit manager to improve nursing teamwork in a mental health care facility in Gauteng. In this chapter, the researcher reflects on the findings by means of an evaluation of the attainment of the objectives as set out in chapter 1. The limitations encountered during the study are discussed, followed by recommendations for nursing practice, research, education and policy development.

4.2 EVALUATION OF THE STUDY

The objectives of the study were

- To explore and describe nursing unit managers' view of nursing team work in a mental health care facility in Gauteng on nursing teamwork.
- To explore and describe the unit managers' role in improving nursing teamwork in a mental health care facility in Gauteng.

Objective one was obtained. Every unit manager who participated explained the nursing teamwork in detail in his/her specific ward. This provided the researcher with a clear picture of the current status of nursing teamwork in the specific setting. The graphic team sculpting supported the description and exploration of the nursing teamwork. In addition a literature was conducted regarding nursing teamwork within the perspectives of mental health care in South Africa.

The **second objective** was to explore and describe the unit managers' role in improving nursing teamwork. It is argued that this objective has been obtained as both the graphic team sculpting and focus group enabled the researcher to describe unit managers' role on how to improve nursing teamwork within a mental health care facility in Gauteng. In addition unit

managers also described factors that hindered nursing teamwork which was presented to the reader as well.

4.3 LIMITATIONS OF THE STUDY

The following limitations to this study are listed:

- The study was conducted in one public mental health care facility in Gauteng, thus limiting the findings to the specific setting and the public sector. But the information can be extrapolated to another setting with minor adjustments. Yet it has been declared that this research is contextual in nature and therefore a dense description has been formulated to enhance trustworthiness.
- One of the limitations was that the gender of the team members presented in the graphic team sculpting sketches was not provided which might have provided the researcher with valuable information regarding the influence of gender on teamwork in a mental health care facility.
- The graphic team sculpting technique represented the perception of each unit manager in his/her specific setting and may have been influenced by preconceived conceptions of unit managers toward the team members.
- In order to meet the objectives of the study, individual interviews of the drawings was not done after the graphic team sculpting. This detracted from the richness of data that could have flowed from graphic team sculptings if the participants had been questioned about their sculptings individually.

4.4 RIGOUR

As stated in Chapter 1 the researcher adhered to the standards of trustworthiness. The five standards as established by Lincoln and Guba, as discussed below (Botma *et al.*, 2010:233-234);

Truth value and credibility: This was achieved through member checking, triangulation, prolonged engagement, peer examination and group discussions. Triangulation was done through using different data collection methods, namely graphic team sculpting and a focus group. The researcher is familiar with the setting where the research was conducted and was

thus engaged in the environment. Peer examination was done through member checking with the research supervisors during data analysis. Reports were written as clearly as possible.

Applicability and transferability: The research findings cannot be generalised but an accurate, thick and dense description of the sampling and state of mental health care teams throughout South Africa was given.

Consistency and dependability: This was ensured by providing a rich description of the steps in data collection and reporting the findings precisely as well as data triangulation.

Neutrality and confirmability: The information was neutral, without any prejudiced ideas and biases. Confirmation was done and member checking was used as a strategy to ensure neutrality.

Congruency of data was determined between two independent people during data analysis.

Authenticity**:** The researcher was objective during the study and gave a true reflection of the reality. This was done through self-reflection and self-scrutiny to ensure that interpretations are valid and grounded in the data.

4.5 RECOMMENDATIONS

Recommendations are formulated for practice, nursing research, education in nursing as well as policy in nursing.

4.5.1 Recommendations to improve nursing practice

- To make the findings generally available to all nursing staff so that collaboration can be enhanced in teamwork and quality care. This will be done by doing a presentation on the research results during the annual mental health seminar. As well as providing the research committee with a copy of the research.
- To use a team nursing/modular nursing method instead of a functional method to increase staff morale and job satisfaction.
- Implement the findings of this study in life skills workshops.
- To identify appropriate role-models and leaders to mentor inexperienced nursing unit managers.

- To establish an effective and sustainable workforce to lighten the workload of team members.
- To establish standards in public sector and despite the limited resources to create a positive practice environment.
- To enhance communication and involvement between the nursing unit managers and the top management.
- Hospital management and unit managers should be made aware of the influence of positive practice environments on teamwork.
- To send teams on team-building programmes to improve teamwork during service delivery.
- To decrease the effects of burnout and negative attitudes. A sensory stimulation therapy room in the hospital might be helpful for team members.

4.5.2 Recommendations for research

There is still a need for further research on nursing teamwork, which has been identified in this study and therefore the following themes for further research are recommended:

- Research should be conducted to describe the influence of teamwork on mediocrity.
- Research should be conducted to explore the influence of gender on teamwork in a mental health care facility.
- A framework of a team-building programme should be developed for mental health care facilities in Gauteng.
- The negative attitudes of staff in general and mental health care facilities in the public sector should be compared and assessed.

4.5.3 Recommedations for nursing education

The following recommendations are formulated regarding nursing education:

- The curriculum of students should include management of nursing teamwork within a diverse context.
- To include management of a nursing team and leadership skills within M.Cur psychiatry/advance psychiatry and B.Cur management degrees and relevant diplomas.
- To do training for unit managers on how to facilitate teamwork and to offer presentations on teamwork to increase awareness on ward management levels.
- Hospital management and unit managers should familiarize themselves with strategies to improve nursing teamwork and to implement this in their specific wards.

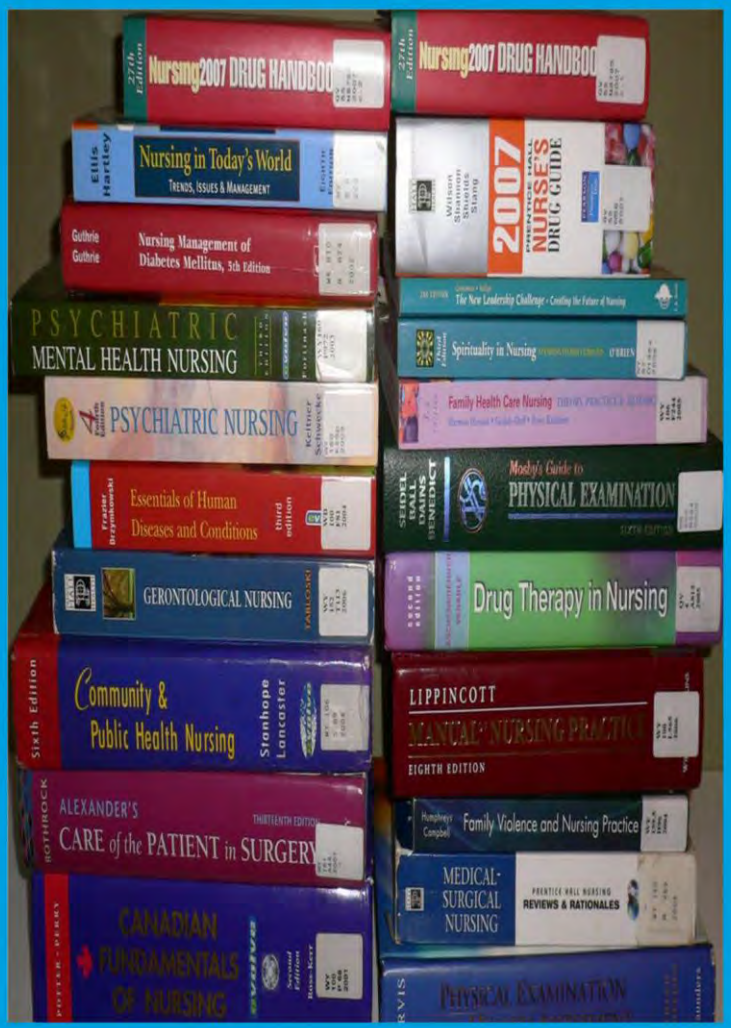
4.5.4 Policy

The following recommendations are made to assist in the national, provincial and organisational programs and policies to improve nursing teamwork within mental health care facilities:

- Develop an instrument/questionnaire to evaluate nursing teamwork in mental health care facilities.
- Develop policies on the improvement of nursing teamwork.
- Policy-makers and managers should customise their interventions for different types of teams according to individual settings.
- The researcher suggests that research emanating from this study should be done at a national level to develop a national strategy of improving nursing teamwork in mental health care facilities.

4.6 SUMMARY

In this Chapter the researcher reflected on the objectives by means of an evaluation of the study. Limitations and recommendations were also evaluated. In drawing this study to a close it is vital to recognise the importance of nursing teamwork in improving service delivery to the patient and ensuring that staff is more satisfied with their work environments. Hospital management needs to assess how nursing unit management and organizations may promote positive attitudes of team members. Ensuring optimal work environments for nurses contributes to their wellbeing and nursing job-satisfaction to improve the safety and quality of patient care in South Africa.



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ANNEXURES

APPENDIX A

PARTICIPANT INVITATION

Dear …….

Ward: ……..

It is my privilege to invite you to participate in my research study.

Date: …….

Time: ……

Venue: …….

INFORMATION LEAFLET

TITLE OF THE STUDY

A unit manager's role in improving a nursing team approach in a mental health care facility

INTRODUCTION

I am here by inviting you to participate in a research study on improving nursing teamwork in a mental health care facility. I am currently a Maters-degree candidate at the North-West University, (Potchefstroom campus) and would like to provide you with the necessary information so that you can decide whether you would like to participate in the research study.

ETHICAL APPROVAL

Ethical approval was obtained from the Research Ethics Committee of the Faculty of Health Science at the North West University, Potchefstroom Campus (NWU-00050-12-S1).

PURPOSE OF THE STUDY

The purpose of this study was to improve a nursing team approach, thus using the unit manager to identify the effective functioning of a nursing team by explaining and describing the nursing team. You as a nursing unit manager are an important source of information to improve the health care systems.

EXPLANATION OF PROCEDURES

Data collection will be done through a group contact session with all the unit managers that fulfil the requirements for the study. In this contact session graphic team sculpting is going to be used to get the information, this requires you to make a simple drawing to illustrate your nursing team. A group discussion (known as a focus group) follows thereafter. This will be at a convenient time that will suit participants and it is anticipated that the focus group will last for 30 minutes to one hour.

POTENTIAL BENEFITS

Although you would not directly benefit from this study, it would contribute to the body of knowledge to improve nursing teamwork in the future. This would improve service delivery, improve patient safety, and prevent work retention and burnout.

RISKS INVOLVED

There are no major risks involved in this study. The contact session are going to take some of your time, but this wouldl be scheduled at a convenient time for you. If there is any discomfort during the study please don't hesitate to contact the researcher to resolve this problem.

RIGHTS OF THE PARTICIPANT

Your participation is entirely voluntary; you can withdraw at any time without any negative effects.

Your identity would be protected at all times and the information is confidential.

CONFIDENTIALITY

Your name would not be mentioned on any reports, a code would be used so that data cannot be linked to your name. The name of the hospital would also stay anonymous. All data would be stored in a safe place where no one except the research team would have access to it.

FURTHER INFORMATION

If you have any questions about the study please feel free to contact the researcher (Mariska Oosthuizen-van Tonder) on 073 238 1179 or oosthuizen.m.e@gmail.com.

APPENDIX B

CONSENT FORM

NORTH-WEST UNIVERSITY
YUNIBESITI YA BOKONE-BOPHIRIMA
NOORDWES-UNIVERSITEIT
POTCHEFSTROOM CAMPUS

Private Bag X6001,

Potchefstroom

South Africa 2520

Tel: (018) 299-1111/2222

Web: http://www.nwu.ac.za

Dear Participant

INFORMATION LEAFLET AND CONSENT FORM

TITLE

A unit manager's role in improving a nursing team approach in a mental health care facility

INTRODUCTION

I am here to invite you to participate in a research study on improving nursing teamwork in a mental health care facility. I am currently a Maters-degree candidate at the North-West University, (Potchefstroom Campus) and would like to provide you with the necessary information so that you can decide whether you would like to participate in the research study.

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EXPLANATION OF PROCEDURES

Data would be collected through a group contact session with all the unit managers that fulfil the requirements for the study. In this contact session graphic team sculpting is going to be used to get the information, this requires you to make a simple drawing to illustrate your nursing team. A group discussion (known as a focus group) follows thereafter. This will be at a convenient time that will suit participants and it is anticipated that the focus group will last for 30 minutes to one hour.

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FURTHER INFORMATION

If you have any questions about the study please feel free to contact the researcher (Mariska Oosthuizen-van Tonder) on 073 238 1179 or oosthuizen.m.e@gmail.com.

CONSENT TO PARTICIPATE IN THIS STUDY

I have discussed the above points with the participant. It is in my opinion that the participant understands the risks, benefits and obligations involved in participating in this study.

| --- | --- | --- |
| Researcher full name | Signature | Date |

I understand that my participation in this study is voluntary and I am free to withdraw at any time, without any penalty or repercussions. I understand the risks, benefits and obligations involved in this study.

| --- | --- | --- |
| Participant full name | Signature | Date |

| --- | --- | --- |
| Witness full name | Signature | Date |

APPENDIX C

DATA INFORMATION SHEET

INDIVIDUAL INFORMATION SHEET

Age		
Gender	Male	Female
Home Language		
Ward (number)		
Type of ward (admissions, acute male, forensic female etc.)		
Highest level of education (Please specify)	Diploma:	University degree:
	Advanced Diploma:	Masters' degree (MCur):
	Doctoral (PhD):	Other: (please specify)
Total number of years working as a unit manager (Operational manager)		
Total number of years working in this specific hospital		
Total number of years working as a registered nurse		

APPENDIX D

NWU ETHICAL APPROVAL

NORTH-WEST UNIVERSITY
YUNIBESITI YA BOKONE-BOPHIRIMA
NOORDWES-UNIVERSITEIT
POTCHEFSTROOMKAMPUS

Privaat sak X6001, Potchefstroom
Suid-Afrika, 2520
Tel: 018 299-1111/2222
Web: http://www.nwu.ac.za
Fax Tel: 018 299 4237
E-pos:10055355@nwu.ac.za

Aan wie dit mag aangaan

13 Augustus 2012

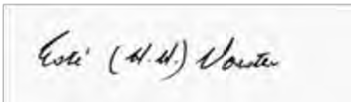
Geagte Prof./Dr./Mnr./Me,

Etiek aansoek: NWU-00050-12-S1

"Leadership and governance as mechanisms towards ecxellence in South African health systems"

Die komitee is tevrede dat die kommentaar van die paneel voldoende aangespreek is en etiese goedkeuring word aanbeveel.

Vriendelike groete



Prof. H.H. Vorster

Voorsitter

APPENDIX E

HOSPITAL ETHICAL APPROVAL

health and
social development
Department: Health and Social Development
GAUTENG PROVINCE

[redacted]
CLINICAL DEPARTMENT
Enquiries: *Prof. Subramaney*
Telephone : *(011)951-8341*
Facsimile : *(011) 951-8391*
e-Mail: Hannie.Smith@gauteng.gov.za

[redacted]
Acting Chief Executive Officer
[redacted]

[redacted]

STUDY : HOW CAN A NURSING UNIT MANAGER IMPROVE TEAMWORK IN A MENTAL HEALTH CARE FACILITY?
RESEARCHER: ME MARISKA ELIZABETH OOSTHUIZEN-VAN TONDER

The above study was discussed at the Research Committee meeting. We recommend that permission be granted that [redacted] Hospital be used as a site for the above research.

However, since this is a research project involving voluntary participation, we cannot guarantee participation of individuals/staff members.

Upon completion of the study, a copy thereof should be submitted to [redacted] Hospital

Thank you.

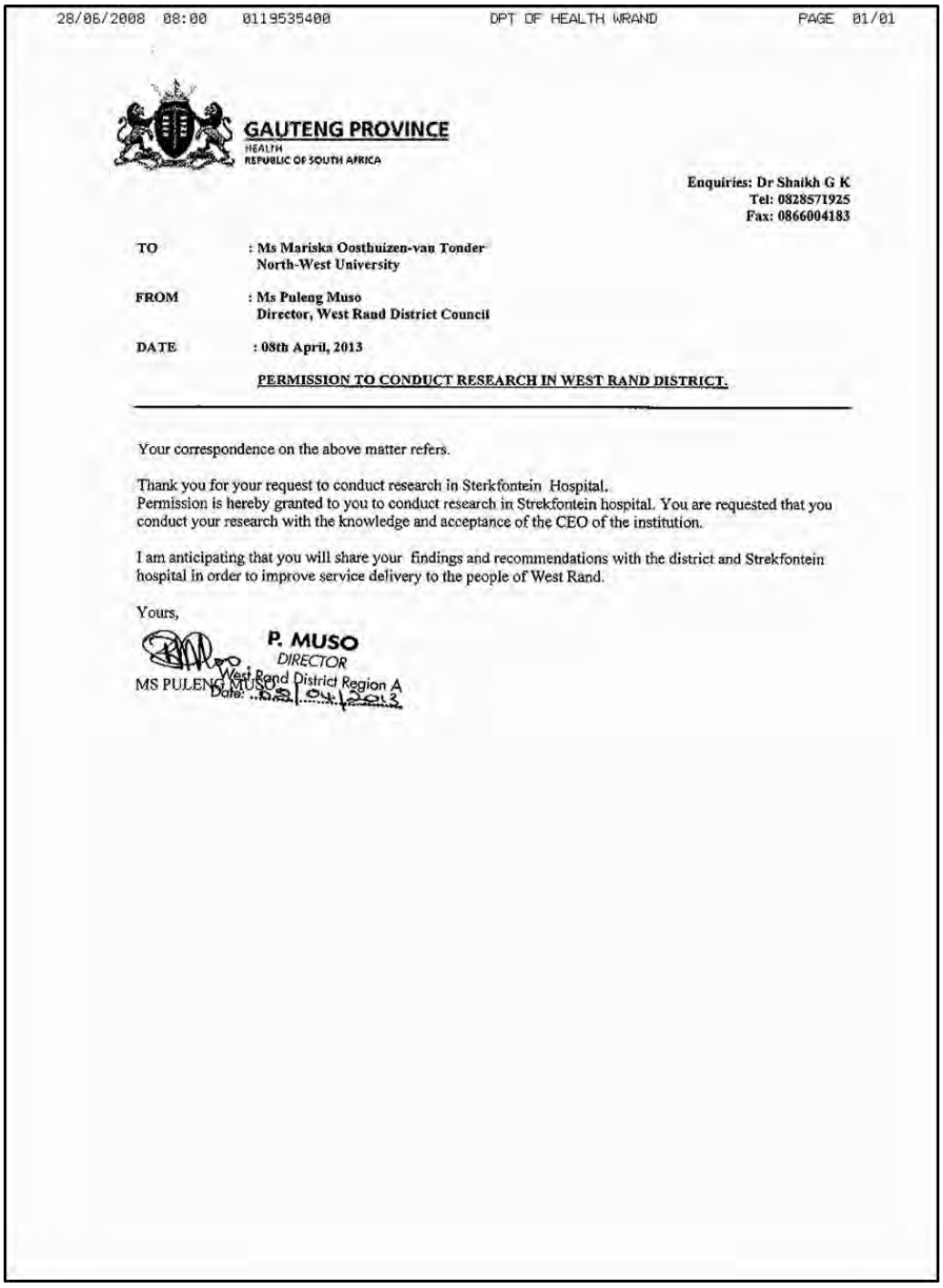
.....
[redacted]
CHAIRPERSON: RESEARCH COMMITTEE
17/05/2013

Approved.

Mahlola.
.....
[redacted]
ACTING CHIEF EXECUTIVE OFFICER

APPENDIX F

ETHICAL APPROVAL GAUTENG DEPARTMENT OF HEALTH



28/06/2008 08:00 0119535400 DPT OF HEALTH WRAND PAGE 01/01

GAUTENG PROVINCE
HEALTH
REPUBLIC OF SOUTH AFRICA

Enquiries: Dr Shaikh G K
Tel: 0828571925
Fax: 0866004183

TO : **Ms Mariska Oosthuizen-van Tonder**
North-West University

FROM : **Ms Puleng Muso**
Director, West Rand District Council

DATE : **08th April, 2013**

PERMISSION TO CONDUCT RESEARCH IN WEST RAND DISTRICT.

Your correspondence on the above matter refers.

Thank you for your request to conduct research in Sterkfontein Hospital.
Permission is hereby granted to you to conduct research in Strekfontein hospital. You are requested that you conduct your research with the knowledge and acceptance of the CEO of the institution.

I am anticipating that you will share your findings and recommendations with the district and Strekfontein hospital in order to improve service delivery to the people of West Rand.

Yours,

P. MUSO
DIRECTOR
West Rand District Region A
MS PULENG MUSO
Date: 08/04/2013

APPENDIX G

FIELD NOTES

Focus group field notes: (2nd attempt)

24/07/2013 at 13:30 till 14:50 (Duration: one hour and 20 minutes)

Held in quiet private room, in a ward. Chairs arranged in a circle, windows open, door closed for privacy, a distance away from patients and other team members. Eight participants were present.

Methodological notes	Theoretical notes	Personal notes
• Researcher used minimal verbal response to get participants to participate. • The last question was unclear and had to be repeated (participants could not think of strategies on how to improve teamwork). Participants struggled to think about practical ways on how they can improve teamwork	• Females are more quiet when males are around – as if they are taking lead • Gender plays a big role in the setting especially in teams (there was a debate about the influence of male versus female and teamwork) • Non-verbal language expressed during the group (nodding head, smiling, frowning, shaking head sideways, using hands gestures) • Generally good participation • Group used humour	• Had a few late comers (especially men who arrived 20 min late) – this was disruptive for the group • People walking past the window and talking loudly were disturbing • Researcher feels that the focus group is successful due to good participation in the group. Everybody got the chance to give their opinion • One participant looked bored and played on his phone towards the end of the group (UM 7)

Had refreshments (cake and cold drinks) after the session. The participants were then in a hurry to get back to work. Had a brief informal discussion about the poor support from top management after the session.

GRAPHIC TEAM SCULPTING FIELD NOTES (SKETCH G)

Done individually in specific ward during lunch time 14:00-15:00. (21/07/2013). Done in participant's office.

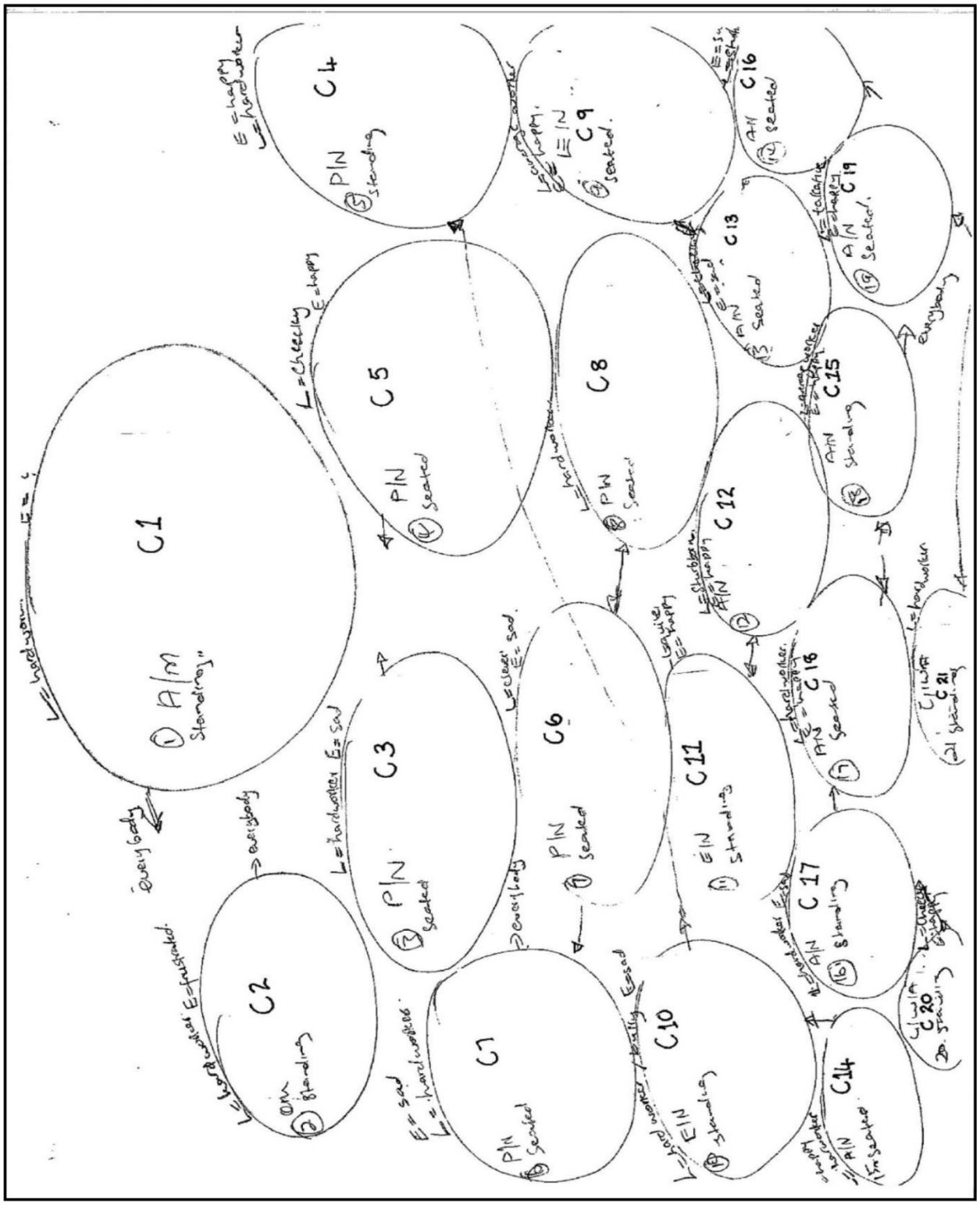
Methodological Notes	Theoretical Notes	Personal Notes
• When asking the first question on the back of the paper (no 1) participant thought it is relevant to team member no 1 and not the whole team. Had to re-explain • Was difficult for participant to draw arrows.	• Shows good initiative, participant wanted to start with the sculpting after the initial introductory meeting and then realised he/she had no clear instructions. • Used the organogram as a basis thus does not know the team well • Very descriptive in allocating the labels • Forgot to indicate (E) presenting an emotion and (L) for presenting a label	• Quiet in office • Interrupted by office phone twice during the allocation of emotions, participant also indicated that "They don't show their emotions" this disruption could have influenced the participant's answers.

Participant seems tired and reports that it has been a long week, but participant is still friendly and willing to co-operate. Reported at the end that it was easy and that he/she now has a new perspective of her team, the sculpting got him/her thinking of details that he/she usually does not think about, like how each team member is feeling.

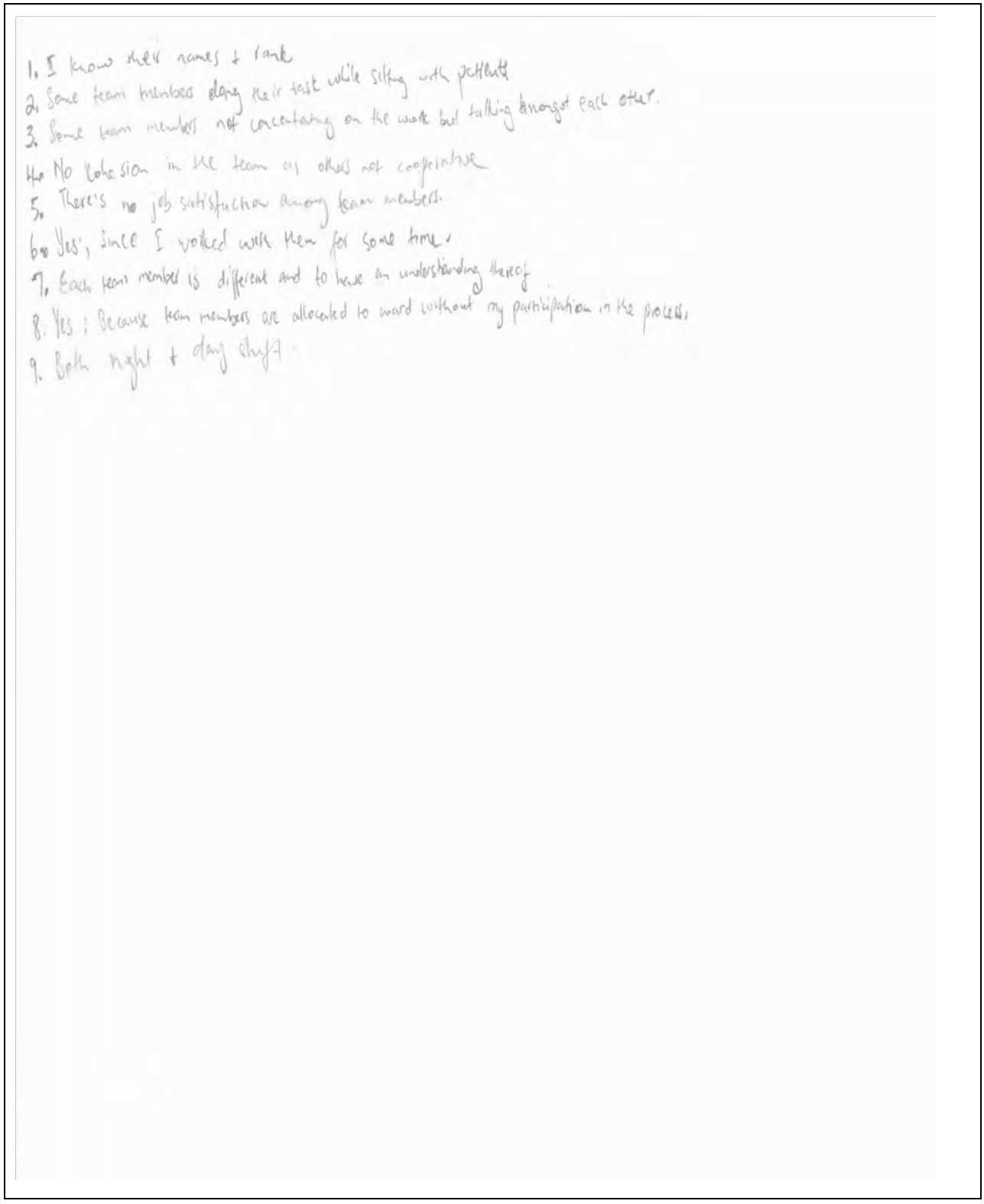
APPENDIX H

EXAMPLES OF GRAPIC TEAM SCULPTING

EXAMPLE 1



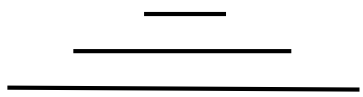
ANSWERS AT THE BACK OF THE DRAWING (OF EXAMPLE 1)



STEP BY STEP ANALYSIS OF THE GRAPHIC TEAM SCULPTING OF EXAMPLE 1:

This is a male forensic ward

1. Gestalt: There is clear hierarchy present in a horizontal position; the AM is placed first at the top of the page, followed with the OM and then PN's etc. This is horizontal hierarchy.

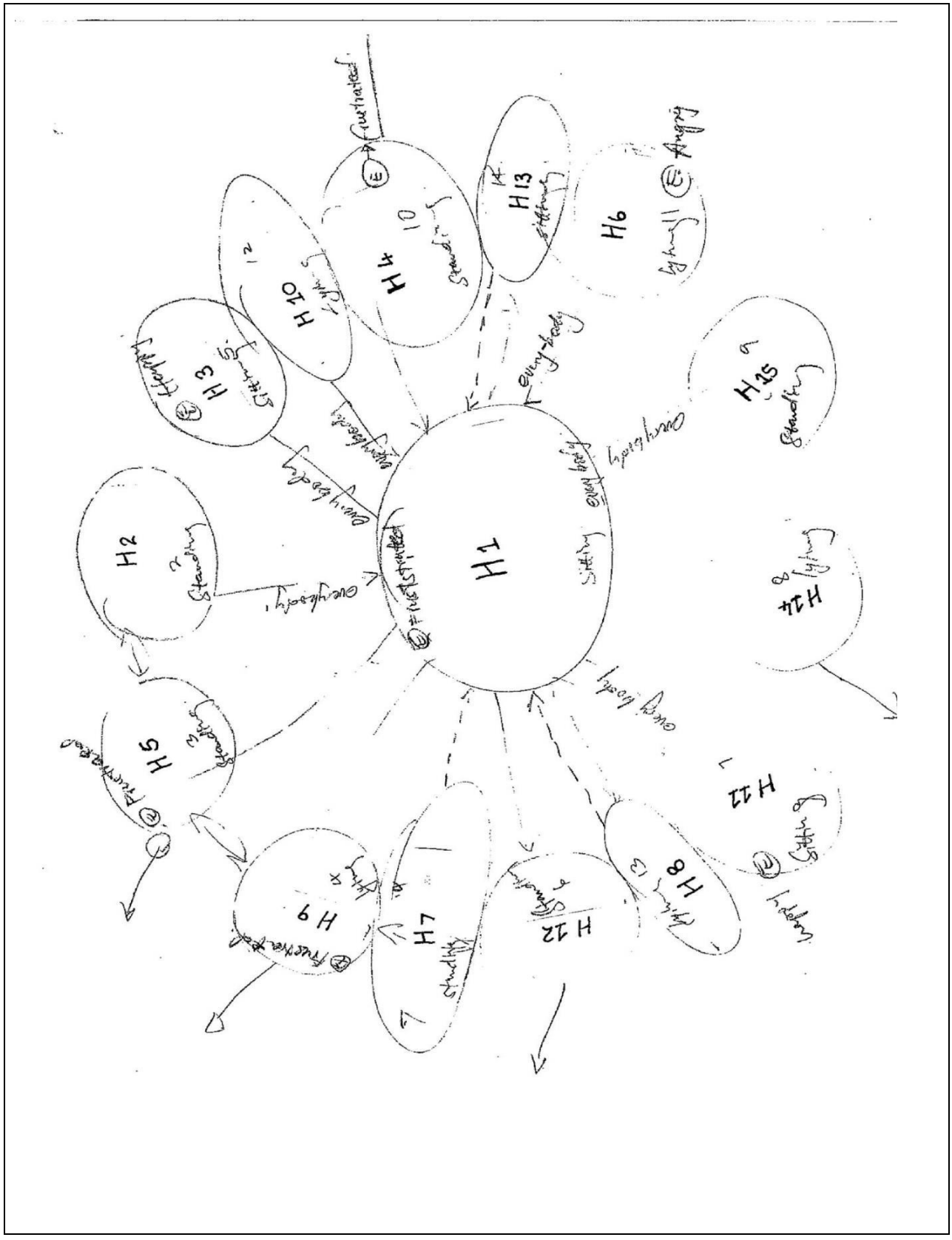


2. Placement: The AM (Assistant manager/Matron) is included. A clear hierarchy is present because the AM is placed at the top of the page, followed by the unit manager (OM). The team members are ranked. At the bottom of the page two general ward assistants is included.
3. Direction: The unit manager is looking at everybody. Team member's is looking at each other (mostly in pairs) this could indicate clique formation or a buddy system.
4. Positions: No one is lying down. 9/21 of the team members are standing. 1/21 has no position. 11/21 is sitting. In question 2 the unit manager indicates that the team is doing their tasks while sitting, it could thus be said that every person in this team are contributing towards the team.
5. Labels: 10/21 labels indicate that they are hard workers. 3/21 is seen as cheeky. Some is seen as stubborn (2/21). Most of the team has positive labels but this is not congruent with their emotion as some of the members are hard workers but according to their emotion they are sad/frustrated (Team member C2 and C3). This can be due to a high workload.
6. Emotions: 10/21 is happy and has a positive emotion. The rest of the team members are sad/frustrated. One should also note that the unit manager is frustrated her-/himself.
7. Order: The AM has a very big circle compared to the rest of the team. The general ward assistants (GWA) have very small circles. This can be that the unit manager felt that the AM plays a more important role in the team according to his/her position compared to the GWA that plays a smaller part in the team functioning.
8. Line quality: No significance

9. Amount of space: No significance

10. Location: No significance

11. Answers at the back: According to the unit manager some members are gossiping within the team (this confirms the clique formation of the direction in number 3). The unit manager also states that there is no cohesion and job satisfaction. The unit manager is frustrated as she has no say in who comes to her ward.


H1
H2
H3
H4
H5
H6
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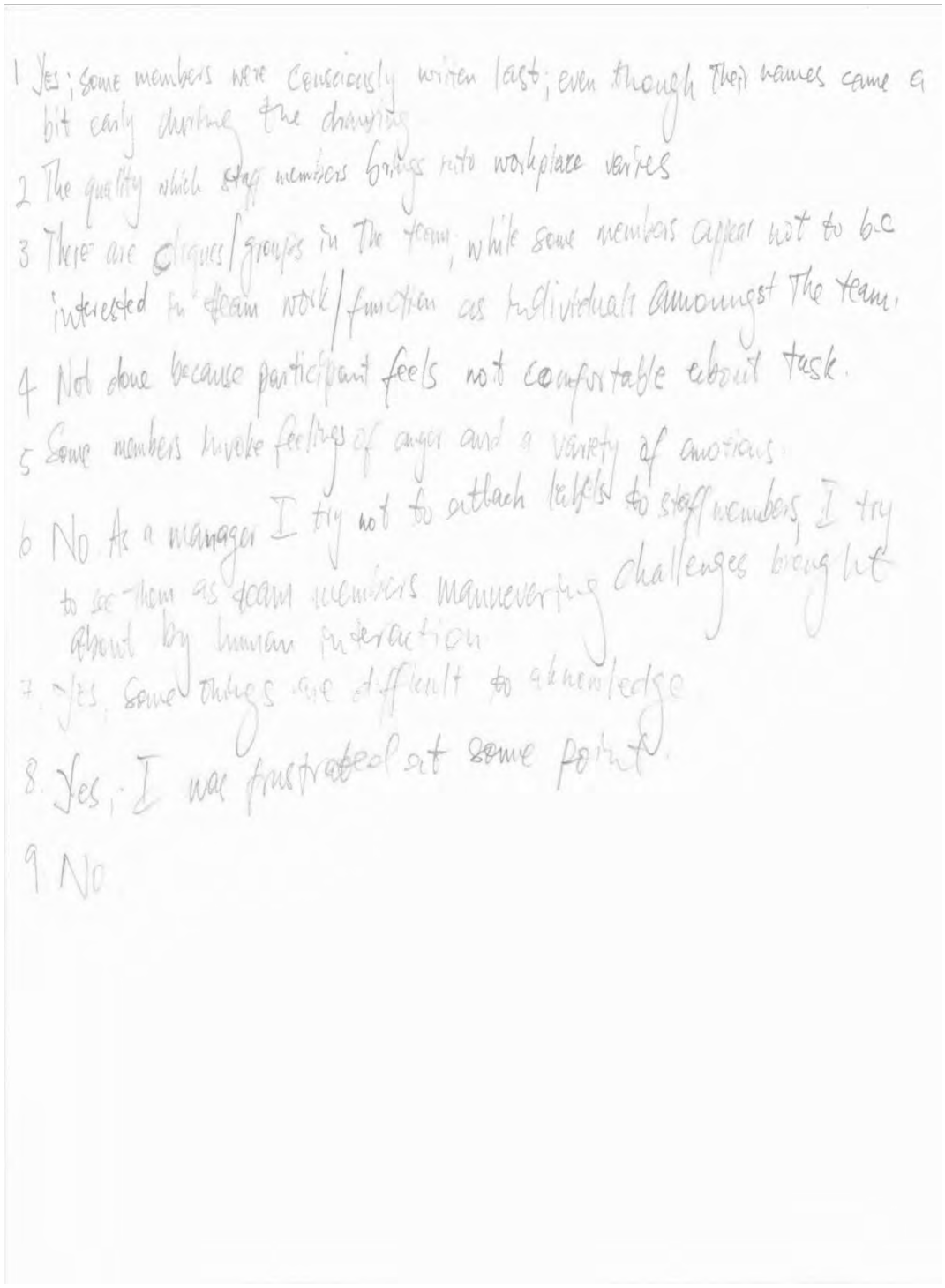
H10
H11
H12
H13
H14
H15

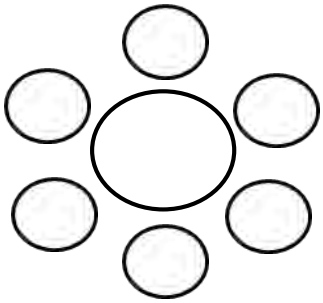
ANSWERS AT THE BACK OF THE DRAWING (OF EXAMPLE 2)



STEP BY STEP ANALYSIS OF THE GRAPHIC TEAM SCULPTING OF EXAMPLE 2:

Male observation ward

1. Gestalt: Arranged in a circle. No hierarchy indicated. The unit manager is the central point of the team.



2. Placement: the unit manager is at the centre, he/she thus plays a key role in team functioning. There is no ranks indicated to the team members, every team member is seen as equal, this has a positive effect on team cohesion.
3. Direction: The unit manager is looking at everyone. 4/15 team members is looking away and thus not interested in the team. 6/15 are looking at everybody. There is no clique formation in the sketch, but according to the unit manager (answer 3) he/she thinks that there are cliques within the team.
4. Positions: 6/15 is standing, 4/15 is sitting and 5/15 is lying. It could be said that the team members who is lying is not contributing to the team. Only 40% of the team (standing members) is putting an effort into teamwork/functioning.
5. Label: No labels were indicated as the unit manager felt that he/she does not want to judge the team members. The unit manager stated at the answers that he/she is not comfortable with this.
6. Emotions: Only indicated emotions to 7/15 team members. 4/7 is frustrated, 2/7 happy and 1/7 is angry. The majority of the emotions are negative.
7. Order: The unit manager has a very big circle and drew him-/herself first, the rest of the team is drawn randomly and not according to hierarchy.

8. Line quality: No significance

9. Amount of space: No significance

10. Location of the sketch: No significance

11. Answers at the back of the sculpting: The unit manager feels that the quality of care provided by the team varies according to the individual team member. The unit manager is not comfortable with the labelling of the team members. He/she is frustrated.

APPENDIX I

FOCUS GROUP TRANSCRIPTION

Transcription of focus group:

The following questions were asked in the focus group. A copy of the questions was provided to each participant.

1. Please describe the status of nursing teamwork at the present in your unit.

2. What do you think is the role of the unit manager (operational manager) to improve teamwork?

3. What factors hinders good nursing teamwork

4. What would the role of the nursing unit manager be to improve teamwork?

Code names were used in the transcription process to protect the privacy and confidentiality of participants.

**UM- Unit manager (number as a code name)*

R - Researcher

Participant	Interaction	Theme identified
R	I think we can start, I will give you time to read the consent form first.	
UM 7	No it is fine	
R	So you will listen in both places?	
UM 7	No I can	
R	You are as good as a women	
UM 7	(Laughs)	

Participant	Interaction	Theme identified
R	I think everybody knows me, my name is (R) and this is my research assistant M. He is just here to take notes and stuff like that.	
UM 5	The scriber	
R	Yes something like that, I just want to tell you guys, I think you still know what this is about but just to remind you again. The aim of my research is to, find out how a unit manager can improve teamwork, in the hospital in the teams that they work with so it is the nursing teams and not the MDT teams. And then, here is a voice recorder, I am voice recording the session to transcribe and to do data analysis. But all the information is confidential, your name is not going to be there, and if we mention names I just beep it out. And then why I have you guys, the research is for all the OM's in the hospital, but the reason why I chose OM's is that you have the knowledge and the expertise about the subject and I would like your viewpoint, your perceptions and your ideas. There is no right or wrong answers so you can say anything. Today we are going to have a focus group which means we are going to talk within a group. We are going to answer these four questions that is on your papers. So, I think, let's do the first one and if we are finished we will move on to the second one.	
UM 0	Mmmm	
UM 5	Mmmm	
R	So the first question is; please describe the status of the nursing teamwork at present in your unit	
	(silence)	
UM 5	The status	

Participant	Interaction	Theme identified
R	Mmmm you can say how teamwork is looking at the moment in your unit? Just describe to me is it good? Is it bad?	
UM 5	It is fair, in ward 5 where I work. Why because of I am running a shortage of males. The ratio of males is less than the females. The females are more, males are less. So sometimes I encounter problems. Especially in the mornings with the morning routine for bathing. You will find that I have got only one male, and then we have got females. So teamwork is fair.	Male ratio is low Teamwork is fair (males)
UM 7	Ja in our unit the teamwork is good but there are those challenges that is affecting us like absenteeism. Those are the things that causes is to make it feel like it is not okay and then it like an overload of work. There is too much work because there is an overcrowding of patients. You see having few people with many patients. So at the end there is those things that causes the teamwork to fail.	Absenteeism Overcrowding of patients Work overload
UM 1	I think my unit I can say it is good, due to the fact that I am having less patients. At present I only have 5, at work there is 6 at least, we don't have that much workload. We are able to supervise them in the morning thoroughly because we are there at least I can say that it is fair. But note as my colleague is saying, sometimes we have challenges due to absenteeism, yesterday we had a problem because two staff were absent and also last month we had some on leave, most people were taking their leave so we had a lot of shortages. But it is good, mmm, generally it is good.	Ward structure and type plays a part If patients is less the workload is lighter Absenteeism

Participant	Interaction	Theme identified
UM 0	With me, I can say it is better. Because people can accept that I mix staff of each ward. But during my presence the people perform but in my absence they decide to sit and say I am from ward 1A, it is because of absenteeism. So it is still a challenge to mix them. They can't relieve by themselves. They get complains, no sister will remain in ward 1B even if the child was one, because originally she was from there. But during my presence I think they try to mix as I delegate them, go this side, and go this side.	Supervision needed Challenge to mix staff Absenteeism
R	But they don't do it out of their own	
UM 0	On weekends they don't I will get complains from others that sometimes it is an enrolled nurse and a nurse originally from ward 1A working in ward 1 A with 12 patients, and that side is two patients and a professional nurse and an auxiliary, whereby the professional should come this side. At least the enrol that side. But I am trying to motivate them so that so that it will remain like that. That they are mixed according to their allocation.	Staff is set in their ways (routine work) Mixed scope of practice
R	Mmmm	
UM 0	So during my presence they do that if I am not there then they don't on weekends and just like after four.	Supervision
UM 5	After four	Confirming that they need supervision
UM 0	Mmmm	
R	Sorry, welcome we are discussing question number 1 that is on your paper. Everybody is describing how their, how is the teamwork looking in their units. What do you think of the teamwork in your unit?	

Participant	Interaction	Theme identified
UM 4	Ja, In ward 4. It is an acute male ward, ja, we can accommodate 40 patients, but we can also push for five if there is a need as per infrastructure and resources, yeah. Well in terms of the team although I was not there but I will tell you that we try to work as a team. Ummm why I am saying that because of I am not really a permanent, you know, team leader or operational leader, ja, as I am actually supposed to work at night but we have actually swapped the responsibilities. Me and *my colleague. Ahhh I don't know where he was in terms of building the team, you know, but what I can tell you is that I am still trying to build the team so that we can have this cohesiveness, working together so that everybody else can actually play an active part in the team in fact. Yes ummm absenteeism is a problem ja, it is a problem, some of the people is not ummm it is not even a question I would say it is a habit now of not coming at all and that actually impacts on the team shift. And affect the morale also of patients, I would say ja. Staffing levels I would say no they are very low, and it needs to be upped, to be increased, and to be proportionate to the number of patients. Because sometimes you will find that the ummm especially we need males because it is a male ward. No maybe we need to contain a male ward well we need more males. Uhhh ja.	Ward structure Infrastructure and resources Sees himself as a leader not just a manager Teamwork in progress Cohesiveness Absenteeism Staff patient ratio low Male ration low (Need male RN)
R	You guys are saying something very interesting that I am hearing, you are referring to gender. Why is gender, the male/female, why is it influencing the teamwork?	
	silence	
R	Is it just in male wards?	

Participant	Interaction	Theme identified
UM 7	It does because the hospital or the wards that we are talking about they are male dominated patients. And males are known to be violent, to be aggressive, you see, and then most of the time it is difficult to attend to such people. Like in my unit I am working with the forensic patients, they are all from prison; they still have that criminal element in them whatever they are doing and their behaviour. Even if they are a mentally ill patient, the element is still there. So it is difficult for a female to attend alone	Forensic factors play a role on gender Difficult patient behaviours
UM 1	Aggressive	Behavioural problems confirmed
R	Mmmm	
UM 7	You can imagine if you have 20 males, male patient and then you have two male staff members and let's say 10 females. It is like you don't have staff.	Low male ratio
UM 4	Maybe to elaborate on that. Some patients in acute, you will find from resources they come with a history of being maybe sexually inappropriate. And how do you deal with such a patient. And even let's say the person will be presented to the doctor and maybe an intervention in the form of a medication will be ordered. But how long is the medication going to take? We have to now manage the patient until then. As a female you also need to feel safe in our working environment. It needs to be safe, conducive for you to carry out your duties.	Forensic/history of patient factors play a role
UM 1	Your duties	

Participant	Interaction	Theme identified
R	So am I correct if I say the females if it is not safe and there is not enough men they are not that pro-active in working? They are more relaxed?	
UM 1	No	
UM 0	Not really, but they don't feel free to perform their duties, in a male ward if there are few males.	Females uncertain
UM 1	You cannot go to the bathroom,	
UM 7	You can imagine how you are going to perform if you are scared. Like in our case we also take into consideration their charges. Some of the charges is related to females.	Females not performing Charges related to females
UM 0	Females rape	
UM 7	Assault	Forensic factors confirmed Patient Behaviour difficulties
UM 1	Assault	
UM 7	Ja so knowing that also is going to make you scared. Knowing what kind of patient are you facing. Knowing that it is rape or maybe it is murder. Being a female….it is not that males are not scared but really…	Females uncertain
UM 5	No, I beg to differ; I also come from ward 5 a forensic unit with the same charges. So the gender it is a problem in the sense that, you know that males they have this tendency of taking females for granted. That is what I am seeing. And also with the routine, bathing, with the morning routine we need males to be there. Because if the females are there the male patients don't feel okay.	Male ratio is low Gender is a problem (routine)

Participant	Interaction	Theme identified
	And the capacity in forensic is increased. It is not that females are useless	
UM 5 (continues)	in the sense that they cannot, because I am running ward 5 and the same charges that they have in their wards I've got such patients, so the challenge is that. Somewhere somehow we need males in large numbers, to help us just for control sake. Females can only control up to a certain extend and there is some encounters that I had that the females ask please come and assist me with reprimands or in controlling this patient because they are taking us for granted.	Males can control ward better
UM 1	But you are seconding our complain	
UM 7	Exactly ja that is what I wanted to say you are actually saying the same thing	
UM 1	We are having limited males	Low male ratio
UM 0	And even the culture	Culture
UM 7	Yes it is very important the culture, very important	
R	Welcome we were just discussing question point one; everybody is describing how teamwork is looking in their unit. And then there was a discussion a little bit how gender plays a role, being absent and that it actually depends on the type of ward the capacity and also what kind of patient you have.	
UM 6	Okay	
UM 5	Another thing that I can add, (researcher) . The people that they are spoiled in a way. If the OM is not there they don't want to do their job always they need a policeman to be there. Because when we are there people behave as if they can work as a team but when we are not there, they just rest.	Supervision

Participant	Interaction	Theme identified
UM 5 (continues)	You will get a lot of complains about incidents and problems. But when you are there they do try. So I don't know if it is being spoiled. If the OM should always be there to be like the police.	
UM 7	I don't think it is that, it is like being the leader is wearing a head. You cannot walk without a head, the leader is the head. If the leader is there you can unite them, there are those who has conflicts you can bring them and bring them together. And then you can also assist in solving the problems if they are there. You should help them solve the problem; you are the leader you should be there. A leader's role is very important. So it's not like they want you to be there, you are the leader, you know if you are sitting there and there is no leader anybody can talk at any time.	Need guidance Solving conflict Leader solves the problems
UM 5	Mmmm, they should be there but not all the time. Like the president he is not everywhere he has got MEC he has got what, what….Delegation so he is depending on those people to do his job on his behalf.	Disagrees with guidance Delegation plays a part
UM 7	I hear you	
UM 5	So even if you are not there they must continue	supervision
UM 0	They must continue	
UM 7	I hear you saying that maybe people are spoiled, they are not spoiled.	
UM 5	I don't know. It is their culture	Culture
UM 0	An attitude, we are discussing isn't it?	Negative attitude of staff
UM 7	Ja we are discussing	

Participant	Interaction	Theme identified
UM 5	So we are not blaming each other, that is what I observed the culture of (the hospital) they need to be pushed	Needs supervision to perform, Lack of motivation
R	So you feel that as OM's you need to let's say motivate your team otherwise there is no teamwork?	
UM 5	We get unnecessary complains like writing the report, 4'o clock we are not there the report is written by the others, when you are attending a meeting listen to what Mrs M is saying about the way the reports is written. So always it comes back to you as OM's. As if before you go off at 4 you must write the report because of the mistakes that people do.	Supervision
R	Okay do you think that we can move to the next question? Is there still somebody that wants to contribute?	
UM 5	Yes him	
R	O sorry, can you tell us how your teamwork looks in your ward	
UM 6	Ja like my colleagues has said, it varies, when the OM is around he kind of becomes the unifying force. But when the OM is away, I don't know but it seems like there is some kind of a power struggle between the members on who is going to take the role and who is going to fill the gap for the OM. And it is not usually resolved or decided upon in an orderly manner. Then this develops friction, there will be those who is supporting so and so and those who is supporting so. So when there is no recognised leader to focus them towards a goal.	Power struggle to be in charge Teams divide and take sides Leader keeps them focussed

Participant	Interaction	Theme identified
UM 0	Mmmm	
UM 6	But mostly the hierarchy after the OM is kind of not well defined.	Hierarchy uncertain
UM 5	I wanted to say that, Occupational Specific Dispensations created a lot of problems. It is not clearly, you know, defined as he saying, who is the hierarchy. Everybody is a PN there is no differentiation. The definition is for the OM upwards, but beyond that there is a problem. And that also affects the teamwork because no one….	Hierarchy uncertain
UM 6	Wants to take responsibility	Accountability Responsibility
UM 5	Responsibility. Because now they are all PN's	Accountability
UM 6	And no one steps up to take that responsibility, it becomes a problem.	
UM 0	Mmmm	
UM 4	Mmmm	
UM 1	They would say that you are now better	Jealousy
UM 7	They are all PN's that is the problem	
UM 1	Why am I acting like an OM?	Jealousy
UM 6	The power to delegate is no longer there it diminished	Hopeless Power to delegate
UM 5	It affects allot	

Participant	Interaction	Theme identified
UM 7	This PN issue of everybody that is in the same rank, all PN's but probably they are not earning the same, it is a problem. Because if we are in the same rank, we are all OM's, then we know that we are earning the same. Some still are still having questions so and so is on top of me, but so and so is not performing but according to the hierarchy he is my senior, that is the challenges what we are facing guys.	Unequal Salaries Hierarchy uncertain
UM 4	I think to add on what you are saying, I think this OSD that I think this has created, what? If you know the animal farms story. Well after the OM's all PN's are equal in terms of the compensation. The ones that is actually has to be seen taking the lead in the absence of the Operational Manager is actually shying away and not taking responsibility as is expected. Because of you know this beast this animal that was created by OSD.	No accountability Sees OSD as a monster
R	So it is not clear who is in charge when the OM is away so there is some power struggles?	
UM 4	Mmmm	
R	Then our next question is, what do you think is the role of the OM or unit manager to improve teamwork? So how can you guys improve teamwork?	

Participant	Interaction	Theme identified
UM 6	I think first it needs to exist between members. So in terms of inter- in terms of interpersonal relations I think it is just the amount of, of time the level of engagement. When does it become, tradition and when does it become just day to day communication with the subordinates. Because I believe that if in the unit I were to delegate some kind of job for someone more than the others it will create problems. So, then also we need to be, especially with the delegation we need to be impartial not to take sides, in conflict and all those things.	Active process/effort Interpersonal relations Level of engagement Fairness
R	So you think if you work on that in the ward it will help with the team?	
UM 6	It will not help, conflict is always there and then you must intervene. You should be impartial. You should work according to the facts, I can make an example. You find that you have got a member who maybe has got that has a kind of problem that limits him or her in doing some kind of job in the ward or whatever. You as an OM you realise and accept that due to this condition this person can be excused from such tasks. Now the next person after a couple of weeks someone will start questioning why it is always me doing this task. And at the same time you cannot if someone comes to you and reports a certain problem you cannot therefore call a meeting and say that there is a problem and so and so will no longer be doing this. So it becomes kind of difficult you know on what to do, but I think you should be seen as impartial.	Problem-solver Consider each individual situation Fairness

Participant	Interaction	Theme identified
UM 7	I also think that certain people actually they also, ummm, having meetings with them you should try and attend to each and everyone's problem. Cause in the meetings that is where you can be seen as impartial and involve people, all of them, try to involve everyone. And when it comes to delegation don't delegate one thing to a person more, this one can't always write the matron's report and this one is always running around. Try to share the job equally. You must involve.	Meetings Staff involvement in decision making Fairness Job equally
UM 3	I think to facilitate communication because I think communication is the key. Some of the problems you can throw back at the very same subordinates. Because I think it also works, especially the top structure those we have problems with. The PN's, as soon as you have them then the rest will follow. Because the problem is up there if there is a problem.	Communication Staff involvement
UM 5	And also assertiveness, if you have a problem bring it to the table you discuss and you solve it there and then	Staff involvement
UM 3	It discourages gossips, that is why I said communication	
UM 5	And also being flexible	Flexibility
R	In what way flexible?	
UM 5	In all the way, whatever, drafting of offs, involve everybody in decision making, not to cut, involve people. Put it on the table so that everybody can give his opinion. Even changing the offs, be able to do it, not stereotyping.	Involvement
UM 1	But to be strategic because they can manipulate you by requesting whatever	Not to lose control
UM 5	You need to be concerning off duties, that is needed, if there is manipulation	

Participant	Interaction	Theme identified
UM 7	Yes to be accommodative	Flexible
UM 5	Mmmm	
UM 3	Can I give an example of off duties? With off duties nobody wants to do off duties, I don't know it. With you, because they say this one will do his off. Where the operational manager can just do	Avoiding accountability
UM 3	But they are refusing	Negative attitude
	(laughs)	
UM 1	That is where flexibility comes in and reducing absenteeism, moderate them	Control the situation
R	You say that teamwork will be better if you involve them in decision making, for everything, even if it is a problem in the ward, in on and off duties.	
UM 3	Mmmm	
UM 7	Ja Involve them	Involvement
UM 6	I think it depends	
UM 2	I think that it is a decision that you must make. Consultation in your decisions. So if you are in a situation where you can read it correctly, then involve the team, where you have to take a decision and they have to abide you know I would say 80% you can be very democratic involving the staff but 20% you need to take decisions for yourself. You understand. There are people who will influence decisions that goes against the system that disrupts everyone, you understand.	Decision making process, to still be independent
UM 6	Mmmm	

Participant	Interaction	Theme identified
UM 4	I agree with them, I also think that it is not only as a unit manager you, for you to be seen as a leader obviously you have got to have a team. And you have to value each and every person, they should be aware of their value, to realise that they have value in the team you know? Then there is a change, if you are not there, you are off Duty, and somebody will take leadership. But obviously ja, hierarchy will play a role, ja	Team has to follow Value each person Empower Hierarchy/power
UM 2	Also I think what we need to observe is that we are a team but we are made of individuals. Every person has strengths and weaknesses. You need to acknowledge that, and do something about it. I know that we are all equal and that people are alike and so forth but in terms of developmental, academic and skills wise we are not the same so I think we need to look at, and do something about that. We have some supportive documents like PMDS but whether we are using that to its full potential is a topic for another day but I think that to acknowledge the strengths and weaknesses we need to try to optimize the output.	Uniqueness Individual strength and weaknesses Build the team
R	So it is to use someone's strengths	
UM 2	Ummm, Ja	
R	So you said how a unit manager can improve teamwork is to look at, the individual problem and see them as individuals, treat them equally, to involve them, to have regular meetings, to solve problems, to have good communication, not to be too rigid but to be flexible and to value their strengths.	
UM 5	Mmmm	
UM 4	Mmmm	

Participant	Interaction	Theme identified
R	Is there something that we are missing that someone wants to add?	
	Silence	
UM 6	I think maybe we need to emphasise that the OM needs to take lead, we need things to…it won't just fall in place.	Need to take charge Lead Role model
UM 0	Be a role model	Role-model
R	So they need a role model to motivate them?	Motivation
	silence	
UM 5	Yes that is the key	
R	Then what factors do you think hinders your teamwork, what is the main obstacles? You guys already mentioned being absent, the hierarchy that there is power struggles, what else?	
UM 6	Interpersonal relations, is another factor, when in the work place you kind of deal with more of social problems of individuals against each other, not because they have clashed due to a delegation or tasks which was not done, but it is something else which is not related to the work situation. It is in the form of gossips, I think I have found that to be a problem.	Interpersonal conflict
R	So it is personalities that is clashing	
UM 6	Ja	
	(Silence)	
UM 1	Mmmm also with us, the attitude	
R	How is the attitude of the staff?	

Participant	Interaction	Theme identified
UM 1	They differ like for example if I phone another ward to ask for a relieve for my ward the attitude that side where I am requesting, if they have a bad attitude they will refuse to come and help me, so that is a hindrance also because we will remain short staff even if they are many, but they are not willing to help. It is the attitude.	Negative attitude Absenteeism
UM 7	Also the attitude contributes to absenteeism. Like someone, you can delegate them and if he is not happy about that, then they will display a negative attitude. The next thing he is not going to come to work because he was not happy with you	Negative attitude Absenteeism
UM 4	I heard somebody say communication, I would say poor communication. If there is poor communication I think it is going to impact also, the good teamwork, you know.	Communication
R	They are not working together because they are not communicating with each other?	
UM 4	Mmmm	
UM 3	And you as a leader, If you are not consistent and being considerate or flexible. The people will not make a good team	Role-model Flexibility Fairness
R	So if the leader is not a good example the team won't function?	
UM 3	Will not be functioning	

Participant	Interaction	Theme identified
UM 2	Well I, I'm not sure but ja the culture we tolerate some wrong things until they are skin-deep. We do that as a facility and in the wards, so now if we try to do something right it becomes a problem. People will make reference to it but they will get away with murder even if they refuse to contribute. There are those things that look, I am saying on paper thing look so much much better than in practice we are quite a negative organisation culture. And we don't often talk about it; we protect a certain incident and talk soft about it. That is hindering.	Negative attitude Lack of discipline
UM 6	I also wanted to say goals; you find that most of the time, management have certain targets and goals that they want to reach. They plan everything according to that, in ward level it is the same But sometimes you will find that the OM's	Work related goals
	goals that links with management goals clashes with or are not well defined to the subordinates.	
UM 6 (continues)	To an extend some people they don't know why they come to work, what is our purpose in here.	
UM 3	And the interpretation of the goals.	Lacks insight
R	So the nurses they don't have a purpose to come to work, is that what you are saying? They just	No purpose/goal orientation
	come here to be here they don't strive for something?	
UM 2	It is just routine	No purpose/goal orientation
UM 5	They just come and go they no longer show interest	No purpose/goal orientation
UM 6	Just just go with no plan at all	

Participant	Interaction	Theme identified
UM 0	Mmmm	
UM 5	They leave the patients	
UM 6	Patients are fighting en the staff said no just leave them, others wants to intervene because there will be a number of injuries. So there will be conflict if the one staff says no let them fight.	Negative attitude/negligence
UM 4	But I also think there is burnout, even when something happens that is wrong it is like something that is normal.	Burnout
UM 6	But I don't think it is burnout, maybe we can debate. In our work situation we have got incidents. And then you come up with strategies, we say we are going to control matches; we are not going to let matches in the ward. And then the patient will come and give staff one rand and say please bring me matches, the next thing the ward is burning. In your knowledge what is available in the ward according to your knowledge is a lighter which in this case is not accessible to the patients. Then you ask yourself	Burnout Negative attitude/negligence
UM 6 (continues)	how did the patient set fire, someone bought it the matches for whatever reason.	
UM 3	The people that are long in this hospital, they got this thing they are so influential. They have got this pulling down syndrome and they are influential. I don't know if it is a burnout thing, really. They will always say in our times this is what we used to do and you are not going to tell me. We so it like this.	Negative attitude Burnout
UM 1	I have been here 20 years	

Participant	Interaction	Theme identified
UM 2	Definitely. They will say I have been here. Burnout is a factor; we don't have any strategies or means to see how we are going to mitigate this problem, so it is a factor. And you will have to look at the individual incidents to see if it was a factor in this one and not in this one, but it is there.	Burnout Uniqueness
UM 7	Even staying in the ward for a long time. He stays in this ward and he knows in this ward it is how they are working. So there is nothing to motivate change. They know in the morning when we come we are going to play games and sit in the sun. But if you go to another ward you know things are not the same you have to do something especially if you work in a rehab ward then go to acute ward they differ. Those people they seem to differ, so if someone is not going to be changed that is why they come to the ward not knowing why they are there. Because there is nothing that makes them effective.	No purpose/goal orientation Lack of motivation
UM 0	Given the same task	No purpose/goal orientation
UM 5	And another thing is I think people are feeling inferior they have this complex because now things have changed they did not have the same opportunities in school. But now the opportunities is open for all, they have this fear that the children are now taking over they are telling us what to do. That also hinders teamwork and it leads to this pulling down syndrome. And a lack of information, and the information is available. People are lazy to read. If you don't read to them they won't take a file and read, they are so tired. Getting that information is a problem they need to be pushed to put food in their	Jealousy Inequality Unwillingness to learn/fear of change
UM 5 (continues)	mouth. They are not confident enough to do that on their own.	

Participant	Interaction	Theme identified
UM 2	Take an example of a PN who takes the lead in a shift. With the PN's some of them are quite experienced as they have been here for a long time. Now it is a situation of who is telling who, it does surface.	Hierarchy/power struggle
R	So…yes	
UM 6	I want to add training; Unfortunately in nursing the way that training is done inherently is going to bring problems. If we were from the same standards at training level some of the problems would not arise. I make an example of people going to private colleges and the kind of exposure that they get. I don't think the people working in this environment has got psych exposure until they come to this place. I believe it is only the PN's that has got psych theory and also during training exposure in a psych setting. So most of our enrolled nurses and axillaries they really don't have those core basics which are the fundamentals how a psych patient is treated.	Education/training
UM 4	I think also inconsistencies as well in terms of the application of the process and positions the procedures is actually supposed to inform us on the how, but it is not as such, so now they start blaming each other. Skof A will be blaming skof B. And there will be friction.	Lack structure Communication Accountability
R	So what is your role, in all the obstacles that we have mentioned how can you improve this and make these things positive things? What we mentioned…	
UM 5	Resign	Avoiding Leave profession Staff ratio low
UM 3	Run away	Avoiding
	(laughter)	

Participant	Interaction	Theme identified
R	We said that the obstacles is a negative attitude, being absent, not good communication, that they don't have a purpose, that there is some form of burnout and that the training is not the same. So how can you as a unit manager improve teamwork in your ward?	
	silence	
R	The million dollar question	
UM 4	There must be a team firstly, ja me as a team leader, as a manager, I should know, Identify the obstacles like we have identified them and come up with an intervention. Is it not the dynamics will differ in each ward, so the dynamics will lead me to the problem?	Systematic unique approach
R	So you are saying that you want to look at what the problem is and solve that problem	
UM 4	Yes but not alone collectively, make the people, your followers aware that, make them own the problem. Make them aware of such. It is concerned with the working togetherness in the ward. Ja and then ummm at the end of the day the whole team should be involved, the solution that you are going to come with should not be for you it should be for the team. You know…	Involvement Goal orientation
R	To involve them to work towards the same thing?	
UM 4	Yes	
UM 5	Is it not similar to question 2?	
UM 0	Is it similar? No	
R	The one was what is your role this question is how can you improve	
UM 0	It is not the same	

Participant	Interaction	Theme identified
UM 5	The improvement is not your role?	
R	It is almost the same	
UM 5	Like we said you must work on communication we must talk in the meetings, I think we must…we answered	Communication
R	In question number four I want practical steps.	
UM 6	In-service is a way to improve it	Education
UM 4	In-service, yes and identify the shortfalls	
UM 3	Empowerment	Motivation/Empowerment
UM 5	Bring them back to life	
R	And the in-service links with the training again.	
UM 0	Mmmm	
R	You say bring them back to life, how will you do that?	
UM 5	I think you bring them back to life in motivating them cause really eish these people, team building…	Motivation
UM 0	Let the PN run the ward and see, start afresh and build the team start and motivate.	Delegation
UM 5	Maybe we can come up with something because team building it is chaotic	
UM 3	Like we said each and everyone's contribution, if you take each case on its own, you can't treat them collectively. Especially if you recognise and motivate them they feel so proud.	Motivation
R	Okay to recognise them?	
UM 3	Give them responsibilities	Delegation

Participant	Interaction	Theme identified
R	Does it empower someone if you give them responsibilities?	
UM 3	It does if they're interested	Negative attitude
UM 6	The issue of people of people doing exactly what we spoke about like the matches, somewhere somehow we have to discipline them	Discipline/lack of structure
UM 3	And avoid disruptivism, that is one other thing that influences the team	Discipline/lack of structure Disruptive attitude
R	How can you discipline someone?	
UM 6	Ummm when we lie we say it should be progressive but no…..	
	(laughter)	
UM 7	You cannot discipline someone in that manner	
R	Like giving warnings?	
UM 2	The thing is from a personal point of view we know what to do, but having a disciplined environment that is where the problem starts. We might all be working together as a team, well-disciplined and there might not be a need for discipline measures against anyone in the ward. You understand? We need to achieve as a team.	Team and process focussed
R	Then I think you guys answered my questions you gave me a lot of information, thank you for that, is there still someone that wants to contribute, something that you feel we missed?	

Participant	Interaction	Theme identified
UM 5	Ja when I said bring back to life, maybe we also need to introduce the purpose of why we are here. If we repeatedly we do that, “Why are you here, why do you still think you need to be here?” You know just to introspect themselves of the purpose of why they are here. Maybe that will take us somewhere	Goal orientation Motivation
UM 4	Mmmm	
R	To give them something to work for, or towards actually.	
UM 5	Yes	
UM 3	I think we said two things that does not seem to have a solution, burnout and attitude is one of them. Umm over the years in the department attitude is one of the six priorities, if you look at nursing, what programs are they putting in place	Negative attitude Burnout
	to deal with staff attitude? There is nothing, you understand, so that is where the problem comes in. There is no possible solution for that. Even at higher levels there is nothing that has been done about it. In terms of burnout and the staff, we don’t have the financial resources, nothing is done about it that support actually in terms to deal with it. I know at some point you went to Amazing Grace you were one of the lucky people that could go there. For those sessions, when you come back to the ward the burden of the ward is heavier than the amount of relieve that you have. So I think we must actually identify this right and come with purposeful steps. We are a mental care facility; burnout is more of a psychological origin. So we have lots of psychologist, and mental health care professionals that should be able to be resourceful in cases like this.	Strategies to improve burnout/Need for support

Participant	Interaction	Theme identified
R	Do you think that if you refer someone to a psychologist it would help with their burnout?	
UM 2	For me, I see this in a team context. Let's take ward 17 B as the heaviest ward in the hospital. Every time it is incident after incident. How many times are the staff taken for time-out in a relaxed environment be able to sort of regain that motivation again, it does not happen. But yet, month after month this is happening the incidents is getting heavier on their shoulders but there is no one that is relieving them from that heaviness.	Need for support Increase or decrease workload
R	So debriefing will help them?	
UM 2	Temporarily	
	(laughs)	
UM 5	Debriefing is not the solution; there is a lot of dissatisfaction about issues, which could not be resolved. Starting from the OSD, service-training in the hospital is not enough. It is monotonous; there is not something that we are gaining from it. There is a lot of things that is not treated like in other hospitals; in general they send you for training, in psychiatric you need to pop out the money out of your own pocket to develop yourself. With psych it is different you need to do it yourself; ja there is a lot of issues.	Education OSD Hierarchy Lack of opportunities
UM 2	Look in terms of not therapeutically, debriefing is more like ja, but copy from corporate, they invest in their people they take them for those sessions as a team. And that helps?	Needs more support
R	Do you think that if you change the work environment in any way it would influence teamwork?	

Participant	Interaction	Theme identified
UM 2	For the positive ja	
R	What needs to change?	
	(laugh)	
UM 2	We will have to move from public to private. There is a world's difference.	
UM 6	Resources	Need resources (staff and infrastructure)
UM 2	Ja resources and staff	
UM 6	Sometimes you come to work and you sit, you take over and wait for the staff to come as time passes, when your phone rings you panic and think who is not coming.	Patient staff ratio is low
UM 5	Yes	
UM 6	You, see things like those. Then you look at your schedule for the day, what should be done and after another fifteen minutes another staff comes then you realize this is it, we are two.	Overworked/ Burnout Workload
UM 0	Half past seven	
UM 6	Then you phone and tell them your situation, three on duty and three movements…	
	(laughter)	
UM 5	Also the support system from top management is not well	Lack support Attitude

Participant	Interaction	Theme identified
UM 2	Currently we are taking about, some of the issues is key to human resources management, we don't have a human resource manager, understand. We are talking about a professional that is able to identify this problem and to increase the numbers but we don't have. You will need a CEO, each and every department has…	Low staffing levels Poor management
UM 6	Got a head	
UM 2	Someone who is qualified and competent in that area. When I say this it sounds like I am not knowing what I talk about because there is people in positions. But umm that does not necessary lead to good outputs.	Poor management
UM 0	Like in this case of our CEO, that is poor organisation. They took our CEO but did not replace him. They knew that the time of the CEO is nearer, but they did not provide a new one. Now Mrs M is acting, doing a dual job. She is overloaded.	Poor management Lacks support Overworked/Burnout
UM 4	Those are the politics of work	Poor management
UM 2	Okay	
R	Thank you so we said mostly that you need more support from the top structures, you need to do inservice training motivate your staff more to improve teamwork.	
UM 2	So what we are sitting with in the ward is not necessary our doing it is departmental issues.	Not taking accountability for teamwork
R	Thank you so much for your input and your time, I really appreciate it. Then we are done for today.	
UM 2	Totsiens	

APPENDIX J

DECLARATION

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Declaration

This is to declare that I, Annette L Combrink, accredited translator/language editor of the South African Translators' Institute, have edited the study by

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with the title

A unit manager's role in improving nursing teamwork, in a mental health care facility

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