CLINICAL LEADERSHIP COMPETENCY: NEWLY QUALIFIED NURSES' UNDERSTANDING AND NEEDS

Gugulethu Waige Mathumo-Githendu

A research report submitted to the Faculty of Health Sciences, University of the Witwatersrand, Johannesburg, in partial fulfilment of the requirements for the Degree of Master of Nursing Science (Nursing Education)

Supervisor: **Lizelle Crous**

Johannesburg, 2018.

DECLARATION

I, **Gugulethu Waige Mathumo-Githendu** declare that this research report is my own, unaided work. It is being submitted for the Degree of degree of Master of Nursing Science (Nursing Education) at the University of the Witwatersrand, Johannesburg. It has not been submitted before for any degree or examination at any other University.

_____

(Signature of candidate)

11th day of June in 2018

I dedicate this research study firstly to God because without him I would not exist. Secondly, to my beloved husband Lovemore for his true love. To my children Michael (Mich) and Melchizedek (Melch) who are my biggest fans. My mother and grandmother, who have taught me to be strong. My father who inspired me, I also dedicate this study to all my brothers so that they may be inspired. To my treasured cousins who were there for me. To family and friends in the Seventh-day Adventist Student Movement (SDASM) as well as the church for their strong support.

ABSTRACT

Clinical leadership is essential for safe, effective and sustainable nursing services. The aim of this study was to establish the newly qualified nurses' understanding of clinical leadership and then explore their competency needs. This qualitative study used a convenience sample of 35 newly qualified nurses who were interviewed using a semi-structured interview guide. Template and content data analysis were used as well as the clinical leadership competency framework to identify a priori codes. Only one of the themes on the template was on average mentioned by 50% of the participants while the rest of them had scores below 50%. The competency needs that emerged included continuing personal development support in working with teams, applying knowledge and evidence as well as use of power and authority in setting direction. This study showed that newly qualified nurses have a limited understanding of clinical leadership and they have competency needs that can be addressed in nursing education curricula.

ACKNOWLEDGEMENTS

I would like to express my deepest appreciation to all those who provided me the possibility to complete this report. A special gratitude my supervisor Lizelle Crous, whose gave stimulating critique and suggestions that helped me to compile this report. Furthermore I would also like to acknowledge with much appreciation the crucial role of the staff and management of the hospital where data was collected. I would also like to thank Paidamoyo Guti for text and language editing.

TABLE OF CONTENTS

LIST OF FIGURES

LIST OF TABLES

CHAPTER 1: OVERVIEW OF THE STUDY

1.1 Introduction and Background

Delivering quality nursing care to populations is a solemn task. Nursing works collaboratively with other disciplines and within a healthcare system which in turn has its own strengths and weaknesses as it is affected by many subsystems. Clinical nursing is faced with limited human and financial resources. On the other hand, the upsurge of diverse diseases and patient acuity levels has challenged the internal and external strengths of nurses. To complicate the situation further, nursing has dynamic work environments and constantly changing roles. Therefore, it is not surprising that the nursing workforce is associated with high staff turnover and poor quality services (Picard, 2011; Geyer, 2013; Klopper & Uys, 2013). The problems encountered in clinical nursing can be so overwhelming to the extent that nursing services can appear counter-productive and ineffective as some authors have described such a situation as a perfect storm (Mannix, Wilkes & Daly, 2013). When the challenges that face nursing become more visible than the effort to deliver quality nursing, clinical leadership becomes critical.

Clinical leadership has many elements. It combines clinical competence, managerial and leadership skills so as to profit a tangible difference to the care delivery process. It also involves empowering, motivating and inspiring other nurses towards a clear vision so that an observable change is seen through achieved clinical goals and outcomes (Lau, Cross, Moss, Campbell, De Castro & Oxley, 2014; Mannix *et al.,* 2013). Furthermore, it looks toward services and has collegiate orientation and therefore cannot be ascribed to a specific nurse with a leadership position like those found in nursing or the healthcare sector.

Effective clinical leadership is associated with evidence-based, patient-centred care and improved patient safety and outcomes. It is also beneficial as it is linked with healthier work environments, increased job satisfaction and performance, lower staff turnover and positive outcomes for healthcare organisations and the nation at large (Curtis, De Vries & Sheerin, 2011; Daly, Jackson, Mannix, Davidson & Hutchinson, 2014).

The advantages of clinical leadership cannot be over emphasised because it has become one of the frequently highlighted requirements for safe, effective and high quality healthcare (Brown *et al.,* 2015). Traditionally incorporating clinical leadership only at post graduate for already qualified nurses seems to be no longer adequate. Therefore, it could be high time clinical leadership is made a critical competency and a key performance area for both practising and newly qualified nurses. A possession of specific knowledge, skills, attitudes and behaviours of clinical leadership would most probably help nurses to be more effective in care planning, care delivery and care management.

Brown *et al.,* (2015) did a doctoral research on clinical leadership in pre-registration nursing courses and focused on identification and verification of the antecedents of clinical leadership. They suggest that clinical leadership should be taught as a curriculum thread that starts from first year to the final year. This should be done in such a way that purposeful and opportunistic learning moments are fully utilised. When clinical leadership is incorporated in the curriculum the newly qualified nurses will hopefully understand their clinical leadership in practice.

The National Health Service Leadership Academy (2011) went as far as developing a clinical leadership competency framework which has 5 domains namely: demonstrating personal qualities, working with others, managing services, improving services and setting direction. Each domain has elements that further translate into more specific competencies. As an example, demonstrating personal qualities can be further described under the element of managing oneself. A competent nurse should be able to manage the impact of their emotions on their behaviour with consideration of the impact on others. Knowledge needed for achievement of this competency is that of the impact of personal physical and mental health on personal effectiveness while the skill needed will be that of maintaining own personal health and safety. Specific attitudes and behaviours include but are not limited to a professional attitude to self-care and balancing personal and work priorities (National Health Service Leadership Academy, 2011).

Most of the literature about clinical leadership is generated from western countries (Clark, 2012; Horsburgh & Ross, 2013; Kumaran & Carney, 2014; Stanley, 2014; Rice, 2016). These nations appear to have started to respond to the global outcry for

clinical leadership by incorporating it in undergraduate curricula thereby addressing the clinical leadership competency needs of newly qualified nurses (Picard, 2011; Doherty, 2013; Brown, Dewing & Crookes, 2015). The progress of South African still needs to be researched concerning this important issue. Newly qualified nurses in South Africa join the workforce yearly and some studies have shown that they struggle to accustom to the turbulent clinical working environment (Roziers & Ramugondo, 2014). Some undergo role transition shock as they find minimal orientation, supervision, preceptorship and mentorship. The situation is worsened by the fact that they have to also be competent clinical leaders who show the way to their followers or subordinates. Subsequently, they get frightened by the expected level of competency, responsibility and accountability (Thopola, Kgole & Mamogobo, 2013; Govender, Brysiewicz & Bhengu, 2015). Therefore, this study seeks to investigate their understanding of clinical leadership as well as their competency needs.

1.2 Problem Statement

The topic of interest in this study is clinical leadership competency which is vital for the deliverance of quality nursing services. The educational concern is the absence of visible clinical leadership competency in newly qualified nurses. The evidence for the issue appears in the South African studies done on newly qualified nurses as well as from practical experiences with these nurses (Thopola *et al.,* 2013; Roziers & Ramugondo, 2014; Govender *et al.,* 2015). In this body of evidence what is missing is whether newly qualified nurses understand and are adequately prepared for their clinical leadership role. Addressing what we need to know will help researchers to further investigate how clinical leadership is understood, practiced and acquired, educators in developing effective teaching strategies, policy makers to support and monitor clinical leadership in healthcare systems. Individuals such as those in the study can have an opportunity to reflect about their clinical leadership competency.

1.3 Definitions

1.3.1 Clinical leadership

Clinical leadership in this study refers to effective management and leadership of internal and external resources, self as well as others in order to create or maintain a therapeutic clinical milieu (Brown *et al.,* 2015).

1.3.2 Competency

An observable ability of a health professional to integrate multiple components such as knowledge, skills ,values and attitudes in order to perform the required role and functions effectively (Englander, Cameron, Ballard, Dogde, Bull & Aschenbrener, 2013).

1.3.3 Competency framework

An organised and structured set of interrelated competencies such as the clinical leadership competency framework (Englander *et al.,* 2013).

1.3.4 Newly qualified nurse

In this study a newly qualified nurse refers to a four year comprehensively trained nurse who qualified between the year 2014 and 2016.

1.4 Research Questions

The research questions for this research study are as follows:
(1) What do newly qualified nurses understand about clinical leadership?
(2) What are the newly qualified nurses' clinical leadership competency needs?

1.5 Research Objectives

The key objectives of this research study are as follows:
(1) To describe newly qualified nurses' understanding of clinical leadership.
(2) To explore their clinical leadership competency needs

1.6 Purpose of the Study

The purpose of the study is to describe the understanding of newly qualified nurses of clinical leadership and then explore their competency needs using a clinical leadership competency framework. Findings from the study may inform future nursing curricula development to purposefully include clinical leadership competency.

1.7 Significance of the Study

The research study will not only benefit nurse educators in South Africa but will also benefit stakeholders in different ways. The nurse participants will benefit as they reflect on their competency needs and identify learning gaps. This reflection may

possibly trigger the nurses to seek clinical leadership competency which will in turn influence patient care and outcomes.

1.8 Chapter Outline

Chapter 1 provided the introduction and relevant background information underpinning the research study highlighting the problem statement, research questions, purpose and significance.

Chapter 2 is an elucidation of the existing knowledge and reasoning which explain the convictions of the writer. It includes different types of information such as theories, facts and research findings from other scholars.

Chapter 3 details the methodology followed in this research study by discussing the research method, the research design and strategy, the research setting, the population and the sample, the instrument utilised and data collection process as well as the method of data analysis.

Chapter 4 will provide an overview of the research results before going on to highlight the important conclusions reached based on the study in form of a discussion.

Finally, the summary, limitations, recommendations and conclusion of the research study will be made in Chapter 5.

CHAPTER 2: LITERATURE OVERVIEW

2.1 Introduction

Clinical leadership has been conceived in long standing debates in the field of psychology as well as management. The health field has also joined in the debates as leadership has become more of a necessity rather than a luxury in healthcare. This literature review seeks to review information from textbooks and scholarly articles and will unveil the topic of interest, clinical leadership. Different leadership perspectives will be discussed first as they have a bearing on the understanding of clinical leadership in healthcare organisations. Secondly, clinical leadership in the healthcare field will be discussed in terms of clinical leadership at the front-line. Thereafter, the literature review will focus on newly qualified nurses, what research says about them in connection with clinical leadership internationally and in South Africa.

2.2 Leadership Perspectives

One cannot talk about clinical leadership without referring back to leadership theory. According to Antonakis and Day (2018) leadership theory dates as far back as the 20th century and it appears as if the Great Man or trait-based perspective was the first. This perspective puts emphasis on personal traits such as intelligence, physical attributes and it is associated with male dominance. Research data on this theory focused on studying mostly males and some of them who inherited leadership positions. This theory is noteworthy in nursing which is a female dominated profession. Being an effective or competent clinical leader may require much more determination in females compared to males not only because of difference in physical characteristics but also in gender roles. Female clinical leaders might need to be prepared to meet resistance and rejection by followers who still believe in the Great Man theory.

The trait perspective of leadership sparked further research into leadership as many psychologists were not satisfied with the research methods used to support the Great Man theory additionally there were other variables that were not yet studied such as environment in which leaders are groomed. Subsequently, in the 1930s, leadership scholars began to research on leadership behavior. Lewin and Lippit

(1938) described leadership style theory proposing that leaders either use the autocratic, democratic or the *laissez faire* style on their followers and thus putting emphasis on the behavior that leaders enacted and how they treated their followers. The leadership style theory is important in clinical leadership because competent clinical leaders are expected to switch between these styles depending on the situation and the type of followers at hand. Failure to do so may lead to ineffectiveness in the leadership process.

Fiedler (1967) came up with the Fiedler Contingency Model and stated that the leader-member relations, task structure and the position of power of the leader determine the effectiveness of the type of leadership exercised. So this knowledge added more diversity to the leadership theories and emphasis was on these factors in determining leader effectiveness. This theory may be significant in nursing as it occurs in the clinical environment where duties, tasks and responsibilities are the order of the day

The leader-member exchange theory on the other hand, emphasises the personal relationships between leaders and followers but more especially the transactions that are made between these two groups consciously or otherwise (Hunt, 2014; Hanse, Harlin, Jarebrunt, Ulin & Winkel, 2016). The leader-member exchange theory is significant in nursing because clinical leaders play different roles such as the role of the shift leader. During shift leading, the clinical leader has followers who must carry out the assigned tasks. The effectiveness of the shift leader will also depend on his or her personal relationships with the followers and the transactions they agree to exchange.

The information processing theory puts emphasis on information processing steps which include selective attention, encoding, storage and retention, information retrieval and judgement as far as leadership perception and behaviour is concerned (Lord, 1985). In other words, this perspective zooms into cognitive processes in the mind. This theory is important in nursing because it implies that a clinical leader needs to have the cognitive capacity to solve complex clinical problems as well as exercise clinical judgement. In other words, the clinical leader needs to have certain cognitive skills in order to be competent and effective.

Recently in the 21st century new neo-charismatic theories have emerged to fill in gaps that older leadership theories have not addressed like in a jigsaw puzzle. These include the transformational, visionary and charismatic styles of leadership and they emphasise on follower loyalty, motivation, admiration, trust, dedication and empowerment amongst other characteristics (Antonakis & Daly, 2017). These theories have implications in nursing because when applied they raise specific expectations of clinical leaders. The values these theories impose may sometimes clash personal values of some nurses.

Other scholars of leadership are now looking into other variables to answer leadership questions. These include biological influences such as hormones, culture, family of origin and the research continues (Antonakis & Daly, 2017; Moir, 2017). All these have impact in how clinical leadership takes place and is viewed in nursing. Other scholars have turned toward studying the followers and how their thoughts and behaviours impact the leadership process and effectiveness. Although the focus of the study is on the clinical leaders rather than followers, clinical leaders are sometimes followers or they may first need to be followers for them to be effective leaders. In addition, followers may affect the clinical leadership competency of the clinical leader. Further research on leadership is still on going and new discoveries will always have implications to nursing.

2.3 Clinical Leadership in Healthcare Organisations

In healthcare, leadership is also needed and sought for nevertheless finding the right theory to guide practice has come not come in a silver platter. There were intense debates between managers and clinicians upon issues of power in healthcare organisations that seems to date back to the 1980s both in the United States of America and United Kingdom (Doherty, 2013). Management reforms in the United Kingdom and United States America came up with performance related incentives to healthcare in an effort to increase their efficiency. This philosophy was then adopted by other countries. The problem with this was that governance, guidance and control were not synchronised with clinical practice. Thus, in an effort to harmonise clinical practice with the philosophy, many clinicians especially doctors were elected into leadership positions in the following years and this was called clinical leadership.

In this model of clinical leadership, the clinician is elected into a formal leadership role and is assigned tasks. The clinical leader in this case sits on the board or senior management team where he/she answers directly to the Chief Executive Officer in addition to devoting half of his or her time to leadership and management tasks. These tasks may include a clinical strategy, providing clinical advice to the board and setting clinical standards (Doherty, 2013).

Mountford and Webb (2009) cited in (Doherty, 2013) describe a more comprehensive view of clinical leadership by classifying clinical leaders into three groups namely: institutional leaders, service leaders and front-line leaders. These leaders have distinct identities, sources of power and competencies. Nowadays clinical leadership can be either top down or bottom up within a healthcare organisation. This research study will focus on front-line clinical leaders.

2.4 Clinical Leadership at the Front-line

Out of all the leadership theories, the one that seems to be underpinning most recent concept of clinical leadership in healthcare is the congruent and shared leadership theory. Congruent leadership was studied by Stanley (2014, 2017a) and he used grounded theory and phenomenology methodologies in the studies that were based in Australia and United Kingdom. He interviewed health professionals, and found out that clinical leaders are experts in their field and are followed because they match their actions with their values and beliefs about quality patient care. Stanley (2017b) in his book states that one cannot be an effective leader he or she cannot have direct contact with clinical work or be visible in practice. He also noted that clinical leaders can be any health professional regardless of title.

Leggard and Balding (2013) on the other hand, in their research conducted in Australia found out that clinical leadership is an organisational property. It has to be shared or distributed across the members that make up a healthcare organisation, this includes all healthcare professionals.

Lett (2002) appears to be one of the first authors to articulate a front-line definition of clinical leadership in nursing practice. This university nurse lecturer based in Australian Catholic University acknowledged that every nurse has the potential to be a clinical leader and also that nurses lead students, other nurses, and or members of the multi-disciplinary team as well as patients in their care. She also acknowledged

that that the term ‘clinical leadership’ was already being used by other health professionals such as doctors and pharmacists.

The current understanding of clinical leadership from literature and across the health professions is that it is situational, skills driven, value driven, collectively or co-produced, is an exchange of relationships and boundary spanning (Clark, 2012; Daly *et al.,*2014; Stanley, 2014). It can take place in any healthcare setting and it is not a respecter of any job position, job, title or badge. Clinical leaders show specific unique characteristics such as integrity, clinical competence, effective communication and emotional intelligence, among others. In a pilot study on perceptions of health professionals on clinical leadership, it was found that these were the top four skills of a clinical leader in addition to management skills (Stanley, Blanchard, Hohol, Hutton, MacDonald & Lee,2017).

2.4.1 Front-line clinical leadership and newly qualified nurses globally

The concept of clinical leadership in healthcare is not just gaining momentum because everyone wants better functioning organisations and systems, but also as a result of changing expectations of patients, increased regulation and scrutiny of health professionals as well as more emphasis on quality and safety (Rice, 2016). Newly qualified nurses on the other hand do not seem to be coping with these demands. Moreover, this seems to be a worldwide problem as evidenced by international literature.

In a comparative study of fourth year nurses and newly qualified general nurses in Ireland study by Suresh, Mathews and Coyne (2012) regarding stress, it was found that one of the challenges that newly qualified nurses had was excessive work load and difficult working relationships. In other words, the newly qualified nurses were struggling with the domains of demonstrating personal qualities and working with others in the clinical leadership competency framework. They mostly struggled with the elements of managing self as well as building and maintaining relationships.

Another study conducted by Feng and Tsai (2012) on the socialisation of new graduates into practice in four medical centres in Taiwan revealed results that were not surprising. The hardest work was perceived to be that of organisational socialisation process. This included fitting into the bureaucratic system, maintaining interpersonal relationships, unit rules and culture. Transition from being a student to

being a practising nurse was perceived as stressful. This also shows a problem on demonstrating personal qualities and working with others.

Horsburg and Ross (2013) did a study in the United Kingdom on care and compassion on newly-qualified staff nurses, they found that transition for the nurses was challenging and stressful and there was a perceived lack of support. This also shows that there was a problem with the competence of demonstrating personal qualities and working with others.

Kumaran and Carney (2014) studied role transition from study nurse to staff nurse in one of the academic hospitals in Ireland and found that the newly qualified nurses were excited to go into practice at first but became overwhelmed by responsibility and accountability that came with the job. This reflects problems with the domain of managing services specifically with the domain of managing self. This further adds to the evidence that clinical leadership is a challenge to newly-qualified nurses.

Gardiner and Sheen (2016) conducted a literature review focusing on articles in the period ranging from 2005 to 2016. The study which was on graduate nurse transition to practice revealed that graduates experienced stress and were overwhelmed by responsibility. This is also an indication of a problem in clinical leadership competency specifically on managing self.

2.4.2 Front-line clinical leadership and newly qualified nurses in South Africa

Roziers and Ramugondo (2014) did a study on newly qualified nurses who took on the role of community service practitioner after completing a 4-year diploma program. The study was conducted in the Western Cape Province and results showed that some of the newly qualified nurses had issues which include inability to solve conflict and manage workload. Again the domain of demonstrating personal qualities and working with others seemed to be affected.

Another study by Thopola *et al.,* (2013) on newly qualified nurses in Limpopo province was done with the aim of exploring and describing the experiences of newly qualified nurses. The results revealed that some of the problems that these nurses experienced were, *inter alia*, lack of team work, lack of confidence in competency, inability to solve conflict, inability to delegate as well as fear of victimisation by

others. In other words, they experienced problems with the first three domains of the clinical leadership competency framework.

A quantitative study by Govender *et al.* (2015) on perceptions of newly qualified nurse's performing compulsory community service in Kwazulu Natal province revealed that the two main difficulties experienced by these nurses were workload and role expectations. Furthermore more than half of the participants indicated difficulties with their workload, organising, and prioritising etcetera. This also can be linked to the domains of the clinical leadership competency framework.

While most of these studies that have been discussed used the qualitative principles of research and thus results cannot be generalised, the evidence raises concern over the competency of newly qualified nurses. Hansen-Salie and Martin (2014) conducted a study on the perceptions and factors influencing the competency in newly qualified professional nurses working in private hospitals in the Western Cape Province. They found that competency was determined by experience in nursing, learning opportunities, environment, motivation and confidence amongst other factors.

2.5 Implications for Nursing Education and this Research Study

Clinical leadership is essentially a requirement of health care system performance and achievement of health reform objectives. South Africa has a nurse-based health care system and a substantial number of nurses are educated and trained yearly to enter the health care system. Once in the system, these nurses are expected to make an impact on health outcomes by deliverance of quality nursing services.

Since competency improves role effectiveness, it is important to pause and put the newly qualified nurses under the microscope to see how well they are prepared for their clinical leadership role. This evaluation is important for nursing education and training whose social responsibility is to provide appropriate curricula that will ensure that newly qualified nurses are equipped for service (Armstrong & Rispel, 2015).

Consequently, this study seeks to identify the understanding of newly qualified nurses regarding clinical leadership and explore their clinical leadership competency so as to inform curricula in future.

2.6 Summary

The researcher has attempted to describe available literature on different perspectives on leadership in nursing. The leadership perspectives in turn affect affects how clinical leadership is viewed and practiced in different healthcare organisations and at the front-line. The literature review also incorporated studies on newly qualified nurses internationally and locally who are clinical leaders in their own right at the front-line in clinical units/wards where the actual care of patients is given. The chapter also covered the implications for nursing education and this research study. The research methodology and design will be discussed in the following chapter.

CHAPTER 3: RESEARCH METHODOLOGY

3.1 Introduction

This chapter presents the research methodology of this study. The research method, the research design and strategy, the research setting will be discussed as well as the study population and sample. Lastly, discussion of the data analysis method that was adopted in this study will be presented and the chapter will end with a summary.

3.2 Research Design

An explorative and descriptive qualitative design was used in this study. Surbhi (2016) clarifies the differences between exploratory and descriptive study. An exploratory study is primarily concerned with discovery of ideas and thoughts while a descriptive one is more into describing the characteristics of a particular group of people. To identify and describe the competency needs of newly qualified nurses and their understanding of clinical leadership, semi-structured interviews were used. The overall goal of this research was to find out what the ideas, thoughts and experiences of newly qualified nurses are with regard to clinical leadership and clinical leadership competency.

3.3 Research Method

According to Brink, van der Walt and van Rensburg (2012:11) the distinguishable features of a qualitative research are that more emphasis is on the participants' personal interpretations of events and circumstances, rather than the researcher's interpretation. Moreover, in qualitative research, the researcher captures the context of the research in its entirety and does not attempt to control it, embraces subjectivity as a cornerstone to understanding human experience, collects data without structured instruments and constantly interacts with the participants in their own environment during the data collection process.

Noteworthy are the key features of qualitative research as presented by Babbie and Mouton (2001:270) together with Leedy and Ormrod (2010:135). The features which this research resembles are as follows:

- Study is conducted in the real-life circumstances. This study was done in a hospital specifically in the actual clinical units/wards where the nurses work.

This is important because the nursing unit is the heart of a healthcare organisation such as the hospital. It is at the front-line where care planning, delivering and management are done and also where clinical leadership should ideally take place.

- Emphasis is on process as opposed to the product or outcome. The researcher sought the opinion of the participants and ensured a safe psychological environment. The interview rooms offered privacy and confidentiality. The participants were comfortable to share their thoughts and feelings even sensitive information. In addition, the researcher did not wear a uniform which could have misled other participants to think the researcher works in the hospital. This in turn could have influenced the way they respond to questions during interviews. Furthermore, the researcher thanked every participant after every interview and reassured them of anonymity. This enabled the researcher to establish rapport with the participants. This was important in case the participants wanted to contact the researcher for further information or clarity.
- The research aimed at an in-depth description and understanding of people's beliefs, actions and events in their complexity. The researcher asked the newly qualified nurses their understanding of clinical leadership and asked them to describe it in the context of the respective units they work in. This enabled the researcher to have a clear picture of how they view and experience clinical leadership in the units where they practice nursing in case there were variations between the different units. This is important because clinical leadership curricula components can then be developed based on the different variations noted. Probing questions were used to get more information and clarify gathered information.
- The reason for the study was to get a deeper understanding of the findings instead of a mere generalisation. The researcher asked the participants to give examples using their unique circumstances.
- The usually inductive nature of the research naturally generates more questions and hypotheses. The researcher had more questions after each interview. One participant explained that in Intensive Care Unit he worked in; there were no opportunities for him to practice clinical leadership due to the

fact that hierarchical nature of power and authority was rigid. This allowed the researcher to reflect on certain organisational factors which may impact the attainment of clinical leadership competency such as organisational hierarchy and culture.

- The researcher is viewed as the main instrument and is subjectively immersed in the process of the research. The researcher was indeed immersed in the research because she was studying a topic she is deeply interested in. As the main instrument the researcher conducted the study on her own accord and did not make use of field workers. This allowed interpreting the 'human factor' of the participants and providing clarity whenever there was likelihood for misconceptions to arise.

3.4 Research Setting

The research setting refers to the specific place where the data was collected (Brink *et al.,* 2012). In this study the data was collected in the wards which is a natural setting where the newly qualified nurses work and where clinical leadership is enacted at the front-line. The front-line is where the actual patient care is done and health outcomes are determined. The research site was one of the hospitals in Gauteng. It is a tertiary hospital that employs a large number of healthcare professionals including nurses. It is subsystem of the broader South African healthcare system.

3.5 The sampling process

The concepts of population, sample, sampling method and sample size will be discussed as they apply to this study.

3.5.1 Population

A population can be defined by geographical, economic or socio-economic characteristics, such as age, sex, income, marital status, household size or time frames (Collins & Hussey, 2014).Brink *et al.,* (2012) simply define a population as the collection of the persons that meet the criteria of the study at hand.

The target population is defined by Collis and Hussey (2014)as a group of people that research is aimed towards, that is, the total number of people or objects for which generalisations from the sample must be made. A population which can be

reached with ease is known as the accessible population or study population (Brink *et al.,* 2012; Collis & Hussey 2014).It is almost impossible to access the target population as this comes with an enormous financial burden and time consumption.

In this study, the target population was all the newly qualified nurses in South Africa. The researcher wanted to know what newly qualified nurses understand about clinical leadership in order to have an idea of what they have been taught about the subject matter in nursing education and training which might give a glimpse into the current curricula. The researcher also wanted to know their competency needs so as to gather information that could inform future curricula.

The population that the researcher could access were newly qualified nurses at one of the hospitals in Gauteng. The hospital not only employs a large number of newly qualified nurses but is also affiliated with the Witwatersrand University where the researcher studies. In terms of population size, the hospital receives about 70 (i.e. N =70) newly qualified nurses per annum according the nursing service manager of the hospital. After getting permission from the area managers, the researcher visited all the blocks of the hospital which contains various units and asked the unit managers for permission to advertise and recruit newly qualified nurse participants. An invitation letter was issued and an appointment set if the newly qualified nurse accepted to be part of the study.

3.5.2 Sample

According to Brink *et al,* (2012), a sample can be simply defined as “a part or fraction of a whole, or a subset of a larger set” of the population defined by the researcher that will take part in the study. In this study, all the newly qualified nurses that consented to participate in the research and were interviewed made up the sample of the study. The inclusion criterion to participate in the study was the fact that the nurse participant completed basic four year training between 2014 and 2016.All other practicing nurses that did not meet this criterion were excluded. The reason being is that newly qualified nurses in their early years of practice have recently left nursing education institutions and are in a good position to recall the subject matter taught during their training compared to nurses that have practised for longer.

3.5.3 Sampling Method and Sample Size

A convenience sampling technique was used and it a form of non-probability sampling (Brink *et al*., (2012.Interviews were conducted on various days of the week in order to accommodate the work schedules of the nurses. Data saturation was only reached after 35 interviews and no new information came afore.

3.6 Data Collection

Several data collection techniques for qualitative research in health sciences exist in literature, chief among them observation, self-reporting and physiological. Brink *et al*., (2012) provide an overview of these three data collection techniques.

Self-reporting techniques are the most appropriate for this study since these techniques seek to find out what people believe, think or know, where questions are directed to the participants to collect, factual information about the respondents, figure out their thoughts, perceptions, attitudes, beliefs, feelings, experiences and knowledge (Brink *et al*., 2012). Of the two main self-reporting techniques, interviews and questionnaires, interviews were found to be more appropriate for the research questions after a comparison of the advantages and disadvantages of the two techniques were considered. The main advantages of interviews for this research are that participants could be more alert during the interview, non-verbal communication could be observed and questions could be clarified if a misunderstanding arose, resulting in in-depth responses.

The researcher personally went to the hospital to send out invitation letters, book appointments and conduct the interviews. Data collection was done using semi-structured interviews guided by an interview guide. Specific data regarding the clinical leadership competency needs was extracted with the help of probing questions. A definition of clinical leadership was given to those participants who were uncertain as to what it entails thereafter follow up questions were asked including those in the interview guide. Since it was a semi-structured interview the researcher allowed room for the interviewees to speak freely of other issues which they thought were important in light of the research topic. See **Annexure G**.

Interviews were conducted during the day at a convenient time for both researcher and participant in order to reduce the impact of fatigue that could influence their

responses. The interviews were audio recorded and then transcribed by the researcher to a Microsoft Word document for analysis. In order to reduce anxiety, the researcher assured the participants of their anonymity. This was ensured by giving each participant a unique code and only referring to the participant by that code. To prevent the participants from social desirability bias, the researcher emphasised the purpose of the study and the fact that their participation would not in any way affect their remuneration or career progression in the hospital. Raw data collected in the study was stored in a password protected data storage device that could be only accessed by the researcher and supervisor.

3.7 Data Analysis Process

Semi-structured interviews were done and audio recordings were obtained which were then transcribed before analysis. The interview transcripts were cross checked for accuracy against the audio recordings by the researcher and research supervisor before analysis. The study made use of the template data analysis as well as latent content analysis to analyse the information gathered from the participants (Hsieh & Shannon, 2005; Waring & Wainwright, 2008; King, 2017). **Figure 3.1** illustrates the data analysis process which had 5 steps.

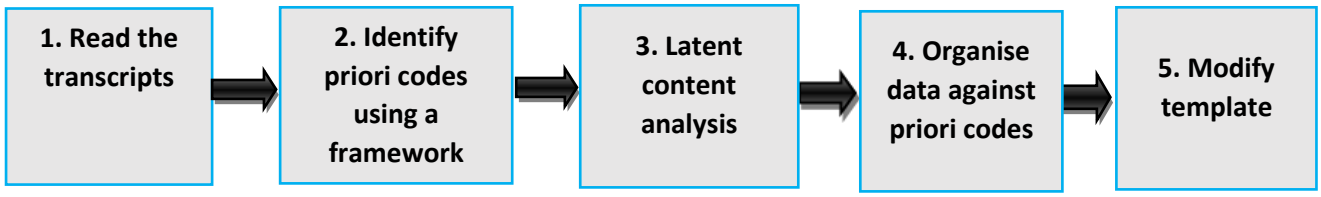

Figure 3.1 Data analysis process

3.7.1 Step 1

The first step of the data analysis process was to read the transcripts several times in order to for the researcher to familiarise with the data.

3.7.2 Step 2

The clinical leadership competency framework from the National Health Service Leadership Academy (2011) was used to determine priori codes. See **Annexure H**.

The Clinical Leadership Competency Framework is derived from the Medical Leadership Competency Framework which was jointly developed by the National Health Service Institute for Innovation and Improvement and the Academy of Medical Royal Colleges which is now being embedded throughout undergraduate and postgraduate medical education in the United Kingdom.

The framework can be used by students, medical and allied health care professionals. It has five domains namely demonstrating personal qualities, working with others, managing services, improving services and setting direction. The domains are further divided into four specific elements each. These elements can be further translated to specific competencies. It is important that clinical leaders are competent on all five domains together with the specific competencies that will be described in detail when discussing the final template.

3.7.3 Step 3

The second step was to code significant words and phrases and thereby employing the qualitative content analysis method. The coding was done electronically on Microsoft Word (Hsieh & Shannon, 2005; Waring & Wainwright, 2008; King, 2017). Qualitative content analysis focuses on the characteristics of language as communication with attention to the content or contextual meaning of the text content.

3.7.4 Step 4

The fourth step was to organise the coded data against the priori codes and thus employing the template data analysis method (Waring & Wainwright, 2008; King, 2017).

3.7.5 Step 5

The last step of the data analysis method was to modify the initial template. Revision of the template by inserting new elements and competencies was important in order to have a template that represents what is of importance to participants in this South African study. This was in consideration of the fact that the clinical leadership competency framework might not have an exhaustive list of all the specific competencies involved in clinical leadership. Waring and Wainwright (2008) support

this idea of template revision as it addresses what is important to the interviewees rather than the researcher and is in line with the principles of qualitative research which have been discussed in Chapter 3.

The revised template was cross checked for relevance by the research supervisor. Nothing was deleted from the initial template because the elements and competencies that were not mentioned by the participants were added onto their competency needs. This will be more evident in the discussion of results that follows after the discussion on the final template. See **Annexure I**.

3.8 Final Template

The final template had all the five domains of the clinical leadership competency namely demonstrating personal qualities, working with others, managing services, improving services and setting direction. They will be discussed in detail below as they are presented in the National Health Service Leadership Academy (2011).

3.8.1 Demonstrating personal qualities

Demonstrating personal qualities means that the clinical leader is able to show visible leadership characteristics that can be seen by observers. Elements of demonstrating personal qualities include but are not limited to developing self-awareness, managing oneself, acting with integrity. 'Acting various leadership roles' was an inserted element. These elements will be described in more-depth shortly.

Developing self-awareness

Clinical leaders show leadership by developing self-awareness. Developing self-awareness is about being aware of personal values, principles and assumptions as well as being able to learn from experience. Specific competencies under this element include but are not limited to articulating personal values, identifying own strengths and limitations, obtaining and analysing feedback from multiple sources.

Managing yourself

Clinical leaders are expected to organise and manage themselves while taking into account the needs and priorities of others. Specific competencies include managing own behaviour and emotions, being reliable in meeting responsibilities and commitments amongst others.

Continuing personal development

Continuing personal development includes learning through participating in continuous professional development activities, from experience and from feedback. Specific competencies under this element include seeking opportunities to contribute, participating in continuous professional development as well as behavioural change in light of education, feedback and reflection.

Acting with integrity

Acting with integrity entails behaving in an open, honest and ethical way. Competent clinical leaders uphold personal, professional, organisational values and ethics. They also communicate effectively in order to counter the social, cultural, religious, and ethnic and gender differences. Moreover, competent clinical leaders take appropriate action when ethics and values are compromised.

Acting various roles

Acting different roles was added as an element on the template as it was frequently mentioned by participants. See **Annexure I.** This entails switching smoothly between different leadership roles as situation demands. Competent clinical leaders are confident to take different leadership roles such as being manager, teacher, role model, scientist, mentor etcetera.

3.8.2 Working with others

Working with others means that the clinical leader is able to work with people for the benefit of the patient. In order to do this the clinical leader needs to establish rapport, build and maintain relationships. The clinical leader also needs to be able to work within the different clinical teams, offer support and encourage contribution. Another important element of working with others is developing networks. The elements of working with others will be discussed in more detail soon.

Developing networks

Developing networks is about working in collaboration with different stakeholders such as patients, care givers, service uses or their representatives as well as other health care professionals within and across the healthcare system. Specific competencies under developing networks include but are not limited to establishing beneficial networks, creating opportunities to get together to achieve goals,

promoting sharing and distribution of information and resources as well as actively seeking the views of others.

Building and maintain relationship

Clinical leaders show leadership by building and maintain relationships. Specific competencies include listening, empathising, communicating effectively and establishing rapport. Conflict resolution was highlighted as a specific competency as it was viewed very important by participants. See **Annexure I**. Conflict resolution is very important considering diversity of people working in the clinical environment.

Encouraging contribution

Encouraging contribution is an element of working with others and it enables the clinical environment to have a psychological safe atmosphere where opportunities to contribute are valued. Specific competencies under the element of encouraging contribution include but are not limited to providing encouragement, respecting and acknowledging the roles others play as well as their expertise at the same time keeping the focus of contribution on delivering and improving services.

Working within teams

Clinical leaders automatically find themselves in different clinical teams which are established in order to deliver and improve services. Specific competencies under this element include but are not limited to having a clear sense of role and responsibilities, knowing purpose and goals of team, adopting a team approach. A very important competency noted by participants under working with others is offering support to other team members and so support was highlighted as a specific competency under working with others on the template. See **Annexure I**.

3.8.3 Managing services

The third domain is of managing services. Managing services means to exercise the executive, administrative and supervisory duties. It involves management cycle of planning, managing resources, people and performance. These elements will be discussed in detail shortly.

Planning

Competent clinical leaders are able to identify the appropriate type and level of resources required for safe and effective patient care services. Planning involves taking stock of tasks that need to be done

Managing resources

Managing resources involves the accurate identification of the appropriate type and level of resources necessary to deliver safe and effective services and also ensuring that services are delivered within allocated resources. Moreover, this element also entails the minimisation of waste and taking remedial action when there is inefficient and ineffective utilisation of resources.

Managing people

Managing people involves providing direction in the form of supervising and delegation. Due to the fact that the participants in the study frequently mentioned delegation and supervision these were highlighted as specific competencies on the template. See **Annexure I**. It also involves reviewing performance, motivating and promoting quality and diversity.

Managing performance

Managing performance is about analysing feedback from multiple sources and taking action to improve performance. Competent clinical leaders should be able to collect data and appraise it in relation to performance. They also know the job descriptions and key performance areas of those they are assessing performance on. Other competencies include counselling on performance and supporting others to reach their performance objectives.

3.8.4 Improving services

This involves ensuring patient safety and satisfaction, critically evaluating, encouraging improvement and innovation as well as facilitating transformation. Ensuring patient satisfaction was added on to the elements of improving services because it is distinct from patient safety as it addresses the interests and wants of the patient. The elements will now be discussed in detail.

Ensuring patient safety

Competent clinical leaders are able to identify and quantify the risk to patients using information from multiple sources, use evidence, both positive and negative, to identify options, use risk management principles in assessing and minimising risk. Other competencies include monitoring the effects and outcomes of change.

Ensuring patient satisfaction

This element was added because of its importance and relevance to clinical leadership from the participants' perspective. See **Annexure I.** It is about collecting data in form of compliments and complaints from the patients who are customers in the healthcare system. Competent clinical leaders are able to analyse such data and find ways to include it in the quality improvement plans.

Critically Evaluating

Specific competencies on critical evaluation include but are not limited to obtaining and acting on patient, carer and service user feedback and experiences. It also involves assessing and analysing processes using quality improvement methodologies, identifying healthcare improvements and creating solutions through collaborative working as well as appraising care options and plans.

Encouraging improvement and innovation

Competent clinical leaders question the status quo, act a positive role model for innovation, and encourage dialogue and debates that may lead to improvement in healthcare services. Other competencies include being able to develop solutions to transform services and care.

Facilitating transformation

This element is about contributing to change processes that can lead to improving health care delivery. Competent clinical leaders model the change expected, articulate need for change and can calculate the effects of change on the healthcare system. They also motivate and focus others to change amongst other competencies.

3.8.5 Setting direction

The domain of setting direction is about contributing to the strategic goals and aspirations of the healthcare organisations within the broader healthcare system. It

also involves acting in a manner consistent with organisational values within the professional and legal regulatory frameworks. Elements of setting direction include identifying contexts for change, applying knowledge and evidence, making decisions and evaluating impact. In addition influencing and use of authority and power were added as they were viewed important elements of setting direction by participants. See **Annexure I**. The elements will now be discussed in more detail.

Identifying contexts for change

Competent clinical leaders demonstrate awareness of political, social, technical, economic, organisational and professional environment. They also understand and interpret relevant legislation and accountability frameworks; they scan for ideas, best practices, emerging trends that will impact healthcare. Another competency under this element is that of developing and communicating aspirations.

Applying knowledge and evidence

Competent clinical leaders show leadership by using knowledge and evidence. Specific competencies under this element include gathering data in form of research to produce evidence which in turn challenge systems and processes

Making decisions

Clinical leaders make decisions using their values and evidence to make informed decisions. Other competencies include participating in organisational decision-making, acting in a manner consistent with values and priorities, contributing unique perspectives to team, department, organisation and system decisions.

Evaluating impact

Evaluating impact is an element of setting direction and it involves measuring and evaluating outcomes as well as taking corrective action where necessary. It also involves being accountable for decisions taken. Other competencies include testing and evaluating new service options, standardising and promoting new approaches and overcoming barriers to implementation.

Influencing

Influencing is an added element to the template as it emerged a very important element to setting direction. See **Annexure I**. Specific competencies under this element include being able to influence others to use knowledge and evidence in

order to achieve best practices as well as formally and informally disseminating best practices.

Use of power and authority

This element is an also an added one as it emerged critical to setting direction. See **Annexure I**. Competent clinical leaders are aware of the inherent power and authority they possess by virtue of being a health professional and by the knowledge they possesses from education and experience. They are able to use this power and authority appropriately to set direction with and towards others so that best practices are implemented. Other competencies include not abusing power and authority.

In summary the clinical leadership template has five domains namely demonstrating personal qualities, working with others, managing services, improving services and setting direction. These domains have elements and the elements further translate to specific competencies that are otherwise known as knowledge, skills, attitude and behaviours. These clinical leaders need to have to be effective in delivering healthcare services. These elements are not in isolation but rather complement each other. Next, the discussion of results will be presented.

3.9 Trustworthiness

Trustworthiness will be discussed in terms of transferability, dependability, confirmability and credibility(Brink *et al.,* 2012).

3.9.1 Transferability

Transferability is difficult as the research was based on the views and experiences of the participants during the study. The data was collected using self-reporting techniques which are subjective in nature. However, all boundaries and limitations were observed and documented for other researchers who might be interested in replicating the study in another context. Limitations will be discussed in detail in Chapter 5.

3.9.2 Dependability

The researcher reflected and documented how the data was collected. With an understanding of how the research was conducted it becomes possible to replicate

the research in different contexts in order to improve on the outcomes in future research studies.

3.9.3 Confirmability

The researcher was explicit on reasons for documenting the various methods. In order for the study to have an audit trail, a self-reflective journal was used to reflect on the research process as well as field notes to note down significant events. These were used for confirmability.

3.9.4 Credibility

Firstly, frequent debriefing with research supervisor provided the researcher an opportunity to identify own preferences and biases that might reduce credibility of the study. In addition, member checking also known as participant/respondent validation was used. Member checking for completeness and correctness of the information obtained was done during the interview, where the researcher clarified with the participant to ensure correctness and exclude any discrepancies that might have occurred (Birt, Scott, Cavers, Campbell & Walter, 2016).

Two independent data analysers, the researcher and the research supervisor, were involved in data analysis so that this process is as objective as possible.

3.10 Ethical Considerations

The researcher considered the ethical principles as discussed by Emanuel, Wendler, Killen and Grady (2004) and addressed them accordingly before the commencement of this research study.

3.10.1 Collaborative Partnership

This study enabled collaborative partnership between the researcher and the Department of Health. It seeks to describe newly qualified nurses' understanding of clinical leadership and to explore their clinical leadership competency needs. Information generated can be used to improve clinical leadership of newly qualified nurses in future. This can contribute to the health outcomes of the country.

3.10.2 Social Value

The researcher also sought the opinion of potential participants, colleagues and lectures on whether they thought the topic was important and relevant prior to conducting the research study. These confirmed that indeed clinical leadership was a researchable. Information was given to the study participants regarding the value of their contribution in the invitation letters as well as verbally. See **Annexure A**. Contact details were made available for those who wanted more information or to make specific contribution.

This research study has generated information which can be used to inform nursing education curricula which in turn may improve the clinical leadership competency of newly qualified nurses. Competent nurses may in turn positively impact health outcomes.

3.10.3 Scientific Validity

The research method/design ensured that the study was scientifically valid by consulting literature to clarify, confirm or exclude information. The study was feasible within social, political and cultural context and will contribute toward improvements in nursing education in South Africa.

3.10.4 Fair Selection of the Study Population

Due to the researcher's commitment to ensuring that all newly qualified nurses had a fair chance of being invited to participate in the study, even though a convenience sampling method was being employed, hospital communication platforms were utilised to create awareness about the research. In addition, the researcher visited all the blocks of the hospital which contains various clinical units/wards in order to recruit participants. However, it should be noted that the small sample will not allow for generalising the research results to the general population of newly qualified nurses.

3.10.5 Favourable Risk-benefit Ratio

The researcher reflected upon the potential risks that may be posed by the study and found none compared to the benefits. The benefits of this study are directly linked to its significance to newly qualified nurses who have the potential to influence patient

care positively. The researcher is not employed at the hospital where the study was done and therefore has no influence on their career paths.

3.10.6 Independent Review

The research proposal was submitted to the Human Research Ethics Committee at the University of Witwatersrand for consideration. An ethics clearance with reference number **M170510** was granted. See **Annexure B**. This confirms that the research complied with general ethical considerations. In addition, another copy of the research proposal was uploaded on the Department of Health Research website for another independent review and a letter of approval was issued. See **Annexure C**.

3.10.7 Informed Consent

The study participants all had informed consent for the interviews as well as recording and transcription. The consent forms were read, understood and signed prior to the interviews. Questions were addressed and the researcher gave the participants contact details for the participants if they had further questions. The forms were prepared in simple English language which is the medium of instruction and examining in nursing schools, colleges and universities in South Africa. See **Annexure D & E**.

3.10.8 Respect for Recruited Participants and Study Communities

The researcher showed respect for those in higher authority hence permission was sought first before the study was conducted. Before accessing this research site, permission was sought from the hospital management to advertise the study, enrol participants and conduct interviews. See **Annexure F**. In addition, on the consent form and verbally, participants were assured of their right to withdraw from study without penalty. No participant was coerced to participate in the study. The researcher ensured that raw data was stored in password locked devices so that it will not be abused.

A research report was compiled which can be published in a peer reviewed journal as an attempt to disseminate the research study to the wider scientific community. Results will also be given in report format to the hospital management. The report has signed declaration of originality. The researcher acknowledged information used

from other researchers using the Harvard Referencing Style, in the text as well as in the reference list.

3.11 Summary

This chapter's main objective was to present the methodology followed in this study and to provide the rationale thereof. It was shown that the research questions, purpose and objectives could only be justly dealt with using the qualitative research method using a descriptive and explorative research design. The next chapter will discuss the results of the data collection and the interpretation thereof.

CHAPTER 4: RESEARCH FINDINGS

4.1 Introduction

This section presents the research findings. In a qualitative study, findings are usually presented in terms of the themes that emerged from the data by way of substantiation and illustration (Brink *et al*., 2012). In this study, the researcher made use of the template analysis method and the clinical leadership competency framework was the initial template. A key feature of the template analysis method is the development of a coding template which summaries the themes emerged from the data set (Brooks & King, 2014).

4.2 Findings

The five domains of the clinical leadership competency framework which were discussed in the preceding chapter make up the themes for the discussion of results. The participants of the research study are also called respondents.

4.2.1 Theme 1: Demonstrating personal qualities

The following **Table 4.1** seek to display the frequency of codes that fell under Theme 1 which is about demonstrating personal qualities on the clinical leadership competency framework.

Table 4.1: Demonstrating personal qualities

Code	Words/Phrases	Frequency
1.1 Developing Self Awareness	No strengths and weaknesses	6
1.2 Managing yourself	Psychologically and emotionally deal with things	2
1.3 Continuing personal development	Workshop, study further, in-service training.	34
1.4 Acting with integrity	Treat colleagues fairly, to be fair	11
1.5 Acting various roles	Shift leader, coach, mentor, teaching.	26

As reflected in **Table 4.1** above, the frequently mentioned codes under the theme of demonstrating personal qualities were continuing professional development acting

various roles and acting with integrity with 97%[1], 74% and 31% of the respondents, respectively, mentioning these elements. Very few of the respondents touched on the elements of developing self-awareness and managing yourself which scored 17% and 5%, respectively. Examples of quotes that contained elements of demonstrating personal qualities are below:

"…I think also if I can…*eeh*…get chance for improving the skills that I have like having more in-serving training or being sent out to study further about this leadership workshop…"
(Participant, 022)

"…when you have, you get allocated students in the unit…and you have to show them the way things are done in this place…"
(Participant, 007)

"….like teaching about equipment or diseases or whatever you can, you can guide the person through, whatever you can monitor, you can be *uhhm* , what's that called? A role, not a role model, when you couch…"
(Participant, 051)

"…Be trauma trained, in that way, I can have more information to impart or the. On my subordinates…"
(Participant, 010)

4.2.2 Theme 2: Working with others

The second general theme is of working with others. **Table 4.2**below displays the frequency of codes under the general theme of working with others.

Table 4.2: Working with others

Code	Words/Phrases	Frequency
2.1 Developing networks		0
2.2 Building and maintaining relationships	Managing conflict, solve workplace conflict, fights	13
2.3 Encouraging contribution	Include everyone, hear from everyone	26
2.4 Working within teams	team, teamwork, work together	27

[1] This is calculated as follows: $\frac{Number\ of\ participants\ who\ mentioned\ the\ code}{Total\ number\ of\ participants}$. This is how all the other percentages that follow were calculated, unless specified otherwise.

The most mentioned codes under the general theme of working with others were working within teams, encouraging contribution and building and maintain relationships with scores of 77%, 74% and 38%, respectively. In terms of team work, some participants mentioned supporting one another as part of clinical leadership. However support was discussed from different angles. While other participants spoke of support by colleagues in the respective ward others spoke of clinical facilitators in the teaching department and other health care professionals. The following quotes support this observation:

"….So obviously we will need to be team players and have to be able to work with teamwork…"
(Participant, 033)

"…we should have clinical mentorships in the wards..."
(Participant, 016)

"…they clinical tutors or clinical sisters] must come, *ehh*, emergency trolley, maybe if they can come to the ward and teach us because, you don't know most of the things in the emergency trolley."
(Participant, 048)

Some participants felt that inclusion by other team members in departmental meetings and research is part of clinical leadership. For example:

"…To be more involved in the classes and the discussions because it is only doctors. I have never heard of nurses who are invited…"
(Participant, 011)

With regard to building and maintain relationships participants made emphasis on emphasis on conflict resolution. Some examples are quotes below:

"….I have been a clinical leader…..*uuum*….because I have been…. able to solve…*ama…ama…ama*…to solve work place conflicts. *Cos* we have had fights before like here *nhe*….and I have managed to…. I have managed to solve that *nje*…..like we didn't…it was not….we managed to sit down and solve our differences because everything becomes physical..."

(Participant, 028)

"…management conflict for example: if you come up with a conflict in the workplace, how you deal with that..."
(Participant, 007)
It is interesting to note that none of the participants described clinical leadership as entailing networking.

4.2.3 Theme 3: Managing services

The third theme is of managing services. The following **Table 4.3** shows the frequency of codes under the general theme of managing services.

Table 4.3: Managing services

Code	Words/Phrases	Frequency
3.1 Planning		0
3.2 Managing resources	Stock control, checking stock	9
3.3 Managing people	Delegate, supervise	32
3.4 Managing performance	Performance appraisal	8

The most common codes under managing services were managing people with 91%, managing resources with 26% and managing performance with 26%. Specific emphasis on supervision and delegation was noted and is evidenced by the following quotes below:

"…then you delegate a task to each and every one according to their competencies"
(Participant, 057)

"…As much as I am giving medication I should also check if everything is done. If vital signs is not done, I need to call someone who is delegated vital signs to come do the vital signs and such things..."
(Participant, 027)

No one mentioned planning under this theme of managing services.

4.2.4 Theme 4: Improving services

The fourth theme is that of improving services. The following **Table 4.4** reflects the frequency of codes under the general theme of improving services. The most common codes on this theme were critically evaluating, encouraging improvement

and innovation and ensuring patient safety with scores of 69%, 34% and 26%, respectively.

Table 4.4: Improving services

Code	Words/Phrases	Frequency
3.1 Ensuring patient safety	Prevent medico-legal hazards, patient identification	9
3.2 Ensuring patient satisfaction	Patient satisfaction, complaints, handle complaints	6
3.3 Critically evaluating	Evaluate care given, auditing files	24
3.4 Encouraging improvement and innovation	Improve, innovation, new ideas	12
3.5 Facilitating transformation	Bring change, new ways.	3

Below are quotes on improving services and incorporating different elements.

"…. so we have to try by all means that we have to make our patient satisfied with our services."
(Participant, 033)

"…the proper identification of patients here in nursing, prevention of medical-legal hazards, from performing procedure to wrong patient, also importantly the environment, cleanliness.."
(Participant, 011)

"…we evaluate, we see that it's properly done *cos* this space here, *(demonstrating)* it's not just an empty space supposed to be left empty. Stuff like that, especially with vitals *cos* I feel like junior staff or our junior categories, sometimes, they either lack that information or they forget…"
(Participant, 030)

"…*cos* these people will come to me and ask some of the things that…that they don't know. So I am supposed to be…sought of have a clue and ways of how to solve some problems and try to understand their frustrations or their….*aah*….I don't know how can I put it? Anything that they come across that they cannot be able to solve so that they can be able to give total patient care.
(Participant, 033)

"…transformation was mostly on...on.... on the line of gender not necessarily on race. So that's one thing I have struggled with…"
(Participant, 031)

4.2.5 Theme 5: Setting direction

The fifth theme is that of setting direction. The following **Table 4.5** displays the frequency of codes under the general theme of setting direction.

Table 4.5: Setting direction

Code	Words/Phrases	Frequency
5.1 Identifying the contexts for change	Monitoring change	2
5.2 Applying knowledge and evidence	Evidence based, research	27
5.3 Making decisions	Decide, decide	13
5.4 Evaluating impact	Properly done, done the right way	2
5.5 Influencing	Encourage change	3
5.6 Use of power and authority	Subordinates, guide, call into order	22

The most frequent codes under the theme of setting direction were of application of knowledge and evidence with 77%, use of power and authority with 63% and making decisions with 37%. Examples of quotes under application of knowledge and evidence include:

"..I think it's the research. The research that is left behind because normally we don't, I don't know about the others but with me…"
(Participant, 039)

"…I think I still need few more…. not years, but, I don't know, more experience and more situations, *cos* I feel as for clinical leadership some of the things, you would say *ok* let's now study….*aah*…what I *wanna* say? But for example if you *gonna* be like leader in *Rescus* for example you wouldn't say…you wouldn't set up situation for that such things…..those things just pop up from nowhere.."
(Participant, 007)

Under the use of power and authority participants indicated that clinical leadership involves use of power and authority and the following quotes attest to this:

"…to those that are under you or under your jurisdiction."
(Participant, 031)

"…sometimes you have challenges like as a newly qualified professional nurse…sometimes you get those people who*….uuum….*who won't comply with your leadership, maybe they will say because I am senior that you so I am not *gonna* take your orders. Like they won't listen to what you are saying…"
(Participant, 022)

"…how do you discipline someone who is older than you? Someone who is more experienced than you. Or someone who knows, whom you think knows more than you?"
(Participant, 025)

Issues of use of power and authority can be linked to other competencies such as encouraging improvement and innovation, delegation and supervision amongst other competencies. Moreover, some participants voiced need to have influence to set direction as evidenced by these examples:

"…just like influence as well and its perhaps uhhm…I am young and I have only started working here just this year and I don't know…"
(Participant, 050)

"…..we don't have the voice. When you voice it out, it's like you are disrespecting, you don't want to do the way things have been done…. I feel some people they are just suppressing our ideas"
(Participant, 057)

Issues of decision making emerged from 37% of participants. Decision making is also an element of setting direction. The following quotes are on decision making:
"…. Like *mina* personally I hate being a shift leader. It's so annoying, sometimes someone will say, no, why did you delegate me for this? I don't *wanna* do that. Because maybe, plus, you are a *Comm Serve*. Yes, you have to consult certain things you don't know but the fact that, so you don't have the final word as a leader."
(Participant, 006)

"..Decision making, you always include other people, you take their views into consideration and you have to be careful that they don't bully you into making that decision…"
(Participant, 057)

The other sub themes of setting direction were also mentioned but by only a few participants.

4.3 Discussion of Findings

The discussion of findings will be discussed according to the two research objectives which are to describe newly qualified nurses' understanding of clinical leadership as well as to explore their clinical leadership competency needs.

4.3.1 Understanding of clinical leadership

The results above show that clinical leadership was discussed from the front-line perspective. All the themes which are covered by the breath of the clinical leadership competency framework emerged. Specific emphasis was on working with others and demonstrating personal qualities as evidenced by the frequencies of codes under these themes. The frequency of codes was generally used to gauge the understanding. As discussed in the literature review, some recent studies on clinical leadership suggest that clinical leadership is most effective at the front-line where the clinical leader is involved directly with patient care (Clark, 2012; Daly *et al.*, 2014; Stanley, 2014). However, one participant stood out by describing clinical leadership from an organisational point of view as evidenced by this statement:

"So I am in the paediatric department so I understand it to extrapolate as far as leadership as a whole in the paediatric department."
(Participant, 024)

One might wonder if the other types of clinical leaders such as service and institutional also agree to this understanding of clinical leadership or there could be difference in understanding. Further studies on this could bring more information that could guide practice. It is progress on the part of the nursing education institutions in South Africa that there is some inclusion of front-line clinical leadership in the curricula. However, a concern is that newly qualified nurses have a very limited

understanding of the concept. Another concern could be that the different institutions might be doing it in different ways or in an unstructured manner. This is shown by the below average scores on all the themes except Theme 2 as reflected in **Table 4.6**. Moreover, some participants needed more probing to discuss the questions while others provided contradicting and incoherent answers. This could affect how clinical leadership is enacted in practice by the graduate nurses or their competency. The following are some of the answers to first question of the interview before probing:

(*Nervous*) "Okay so, *hum*…I think it is clinical we are looking at the workplace right, where we are *uh*…so if we are talking about leadership in a clinical area…it is *uh*… the way you…what is this… you take charge in a certain for instances in a clinical environment, regardless maybe you find…maybe in a *Rescues* with students around with… I think that's what it entails."
(Participant, 007)

"*Aah*...Clinical leadership. I understand clinical leadership is *aah,* how how…I am a leader. How I am able to manage *aah* the internal and external factors of the unit and also myself. *Yah.*..that is how I understand it."
(Participant, 013)

In terms of leadership theories, some participants did mention different leadership styles such as autocratic, democratic and laissez faire which are found in literature (Lewin & Lippit, 1938; Fiedler, 1967). An example is a quote below.

"Automatically someone is going to think: I am going to be a laissez faire leader, just relaxes. We have different situations and you have different leadership styles. You need to know today I am going to be democratic or you must dictate because you cannot please everyone. As I said you have different situations and different leadership styles. You must look at the situation at hand and decide how you are going to handle it."
(Participant, 006)

These are older leadership theories and could indicate that these new qualified nurses were taught older leadership theories rather than new ones. It will be beneficial for new qualified nurses to be taught the current theories such transformational, visionary and charismatic styles of leadership which according to

Antonakis and Daly (2017) emphasise on follower loyalty, motivation, admiration, trust, dedication and empowerment amongst other characteristics.

On the other hand, the results of this study are similar to studies that have been conducted internationally and even in South Africa. Roziers and Ramugondo (2014) as well as Thopola *et al*., (2013) in their studies showed that the newly qualified nurses have a problem in the domain of demonstrating personal qualities and working with others. Govender *et al.,* (2015) also added to the evidence that clinical leadership in newly qualified nurses is a problem as discussed in chapter 2. With the changing healthcare contexts in South Africa, these gaps could become increasingly bigger and therefore they need urgent attention.

4.3.2 Clinical leadership competency needs

With regard to the domains of clinical leadership, the newly qualified nurses seemed to have discussed all of them although setting direction was discussed less frequently. None of the participants mentioned developing networks in working with others and planning in managing services. One could wonder whether the newly qualified nurses in this study by coincidence forgot these two or were not taught about them. A significant statement that was mentioned by one of the participants in the study further provoking the researcher's thoughts is as follows:

"…I doubt it was more of a...a structured teaching that...this is what you supposed to do once you are out there. But it was more of the rigorousness of the course itself that....*aah*...the assessments the way they were conducted like actually....it forces you to grow within that mindset.. So, it wasn't a structured thing per se but it was more of how the course went on. You, you develop them over time."
(Participant, 031)

This participant seems to be implying that some nursing education institutions use the hidden curriculum to teach clinical leadership. Another concern then becomes of the efficacy of teaching method. A structured tool such as the clinical leadership competency framework could help nursing education institutions to demystify the concept and give clarity to the specific elements and competencies it entails.

In terms of clinical leadership competency needs, the results of this study suggest that newly qualified nurses have needs that need to be addressed by nursing education institutions. Competency is an observable ability of a nurse to integrate multiple components such as knowledge, skills, values and attitudes in order to perform the required role and functions effectively (Englander *et al.*, 2013). The researcher took note of statements that showed that the participant was not competent in a particular component of the clinical leadership competency framework. For example:

"…. Like *mina* personally I hate being a shift leader. It's so annoying…"
(Participant, 006)

This above statement shows that the participant has developed a negative attitude towards the role of being a shift leader probably due to a bad past experience. Never the less, it is an indication of failure to smoothly switch into the role but the participant seems not to be aware that it is a competency need. These needs were not only evident in the domain of demonstrating personal qualities but also in other domains. These competency needs included continuing personal development under demonstrating personal qualities which was flagged by twenty six participants. This domain was followed by support in working with teams, applying knowledge and evidence as well as use of power and authority in setting direction.

The fact that networking and planning were not mentioned by any of the participants may be another indication that newly qualified nurses have competency needs that need to be addressed. It could be because the newly qualified nurses either lack knowledge and skills or they are unable to apply what they were taught. Further research into the factors that influence competency attainment and maintenance could shed more light and help bridge the competency gap.

The qualitative research methodology chosen for this study proved to be appropriate as the objectives were met by the outcomes. The next chapter will have the summary, main findings, limitations, recommendations and conclusion.

CHAPTER 5: LIMITATIONS, RECOMMENDATIONS AND CONCLUSIONS

5.1 Introduction

In this chapter a summary will be presented of the study highlighting the main findings deduced from the results. Limitations of the research will be discussed and finally include recommendations for nursing education, practice and research.

5.2 Summary

The purpose of this study was to describe the newly qualified nurses understanding of clinical leadership as well as explore their clinical leadership competency needs using a clinical leadership competency framework. A qualitative research methodology was used. Semi structured interviews were used to collect data and the interviews were recorded and transcribed. A total of thirty five participants were interviewed until data saturation was reached. The data from the newly qualified nurses was organised and analysed using template and content analysis. The clinical leadership competency framework has five domains namely demonstrating personal qualities, working with others, managing services, improving services and setting direction that was used to determine a priori codes.

This study showed that newly qualified nurses have very limited understanding of front-line clinical leadership and they have clinical leadership competency needs that can be addressed by nursing education and training.

5.3 Main findings

All the five themes presented by the clinical leadership competency framework, which focuses on front-line clinical leadership emerged from the 35 participants' discussion on clinical leadership. Some were more frequent than others. Only one of the themes was on average mentioned by 50% of the participants while the rest of them had scores below 50%. The most popular themes were those of working with others and demonstrating personal qualities.Developing networks in working with others as well as planning in managing services was not mentioned by any of the participants in their discussion of clinical leadership. Competency needs included continuing personal development under demonstrating personal qualities which was flagged by twenty six

participants. This domain was followed by support in working with teams, applying knowledge and evidence as well as use of power and authority in setting direction.

5.4 Limitations

The challenge was that it was difficult to get a suitable time and venue for the interviews as nurses are very busy most of the times and they greatly value their tea and lunch time as it is the only time they have to refresh and eat. Although the interviews were scheduled, it was sometimes difficult to get the full attention of the participant because sometimes legitimate emergencies arose that needed urgent attention or a colleague would interrupt the interview to discuss an important issue. This might have influenced the study by disturbing their thoughts and making them have divided attention or competing interests. In future one might consider finding a different location from the workplace to conduct the interviews.

Furthermore, English not being most participants' first language might have had an impact on their ability to fully express their views. It was assumed that all newly qualified nurses were able to communicate fluently in English language because they are taught in nursing education institutions in the language. However, some of them found it very difficult to express themselves in the interviews in Englishand their views might not have been fully captured. In future, one might need to consider an interpreter. Nevertheless, this was not a major limitation for the researcher as she is fluent in the African languages and could interpret the odd words participants used.

Although the researcher tried to explain the purpose of the research, social desirability bias might have still remained due to the gathering of data through interviews. The use of self-reported data alone may have compromised the quality of the data collected as it relies solely on what the participants say and there was no way to confirm the truthfulness or accuracy of the responses. In future studies, one may consider an additional method of data collection such as direct observation. Additionally, providing some participants with the definition of clinical leadership might have influenced amplified the social desirability bias.

5.5 Recommendations for Nursing Education and Training

Based on the results of this study the researcher would like to recommend that the understanding of newly qualified nurses regarding clinical leadership be

strengthened by incorporating new evidence about the topic in nursing education curricula. Specific elements of the clinical leadership framework such as networking and planning can be addressed as well so as to strengthen the clinical leadership competency needs of newly qualified nurses. Specific focus could be made on problem areas such as demonstrating personal qualities and working with others. This could help newly qualified nurses overcome competency deficiencies. In service training can also be an effective means in bridging the competency gap. It is a joint responsibility between nursing education institutions and health care organisations.

5.6 Recommendations for Nursing Research

Nursing research could further look into factors that impact clinical leadership competency as these are not yetabundantly discovered. These can be studied under different clinical settings as much of the research in the literature has been done in hospital settings. In addition, observational studies could be utilised to investigate clinical leadership competency.

5.7 Recommendations for Nursing Practice

The different clinical leaders including front-line, service and institutional leaders need to have a common understanding of clinical leadership so as to facilitate acquisition of competency and enacting of role. Newly qualified nurses need to be encouraged to identify their competency needs using feedback from multiple sources. Opportunities should also be availed at work for further personal development. Supervisors, clinical facilitators and competent members of the multi-professional team can be utilised to assist newly qualified nurses to apply knowledge and evidence to practice so that they can be competent clinical leaders.

With regard to use of power and authority, the role of shift leading should be recognized as a clinical leadership role and newly qualified nurses must be given the space to exercise their professional power and authority in leading others. Clearly demarcating the chain of command and the span of control is one way of doing it however it should be noted that clinical leadershipis situational, skills driven, value driven, collectively or co-produced, is an exchange of relationships and boundary spanning (Clark, 2012; Daly *et al.,*2014; Stanley, 2014). It will be very beneficial for the job description of the professional nurse to clearly state the activities expected

from the clinical leader as well as key performance areas. This will help with further competency attainment and maintenance.

5.8 Conclusion

Clinical nursing is facing many challenges that require nurses to be well equipped with clinical leadership competency. The aim of this study was to establish the newly qualified nurses' understanding of clinical leadership and then explore their competency needs.35 newly qualified nurses were interviewed and the clinical leadership competency framework was used for data analysis. Only one of the themes on the template was on average mentioned by 50% of the participants while the rest of them had scores below 50%. The competency needs that emerged included continuing personal development support in working with teams, applying knowledge and evidence as well as use of power and authority in setting direction. This study showed that newly qualified nurses have a very limited understanding of front-line clinical leadership and they have competency needs that can addressed by nursing education and training.

This study has implications on nursing education and training. Curricula can be designed in such a way that it addresses all the elements of the clinical competency leadership competency. This will ensure that newly qualified nurses are well prepared for their clinical leadership role. In addition, nursing research may need to further investigate clinical leadership competency. On the other hand, nursing practice may also need to provide opportunities for newly qualified nurses' opportunities to develop their clinical leadership competency.

REFERENCES

Antonakis, J & Daly, D.V (Eds). 2018. *The nature of leadership*. 3rd edition. SAGE Publication Inc.: United States.

Armstrong, S. J &Rispel, L. C. 2015. Social accountability and nursing education. *Global Health Action,* 8.

Babbie, E, & Mouton, J. 2001. *The Practice of Social Research*. Oxford University Press: South Africa.

Birt, L., Scott, S., Campbell, C., & Walter, F. 2016. *Qualitative Health Research*, 26(13):1802-1811.

Blaauw, D., Ditlopo, P &Rispel, P. 2014. Nursing education reform in South Africa-lessons from policy analysis study. *Global Health Action*, 7: 14-25.

Brink, H., Van der Walt, C. & Van Rensburg, G. 2012. *Fundamentals of Research Methodology for Healthcare Professionals.* 3rd Edition. Juta & Company: South Africa.

Brooks,J& King, N. 2014. Doing template analysis: evaluating an end-of life care service. [Online]. Available: http://eprints.hud.ac.uk./19707/ [Accessed 26 November 2017].

Brown, A., Dewing, J. & Crookes, P. 2015. Clinical leadership as an integral curriculum thread in pre-registration nursing programmes. *Nurse Education Today*, 38: 9-14.

Chávez, E.C & Yonder, L.H. 2015. Staff nurse clinical leadership: a concept analysis. *Nursing Forum,* 50(2).

Clark. J. 2012. Medical leadership and engagement: no longer an optional extra. *Journal of Health Organization and Management*, 26 (4): 437-443.

Collis, J. & Hussey, R. 2014. *Business Research: A practical guide for undergraduate and postgraduate students.* 4th edition. Palgrave Macmillan: United Kingdom.

Curtis, E.A., De Vries, J & Sheerin, F.K. 2011. Developing leadership in nursing: exploring core factors. *British Journal of Nursing,* 20 (5):306-309.

Daly, J., Jackson, D., Mannix, J., Davidson, P.M. & Hutchinson, M. 2014. The importance of clinical leadership in the hospital setting. *Journal of Healthcare Leadership,* 6: 75-83.

Department of Health. 2015. The white paper on National Health Insurance for South Africa. Department of health: South Africa.

Doherty, J. 2013. *Clinical leadership in hospitals: a review of international and South African literature.* Centre for Rural Health, University of the Witwatersrand*:* Johannesburg.

Emanuel, E.J, Wendler, D., Killen J & Grady, C. 2004.What makes clinical research in developing countries ethical? The benchmarks of ethical research. *Journal of Infectious Diseases*,189(5):930-937.

Englander, R., Cameron, T., Ballard, A. J., Dogde, J., Bull, J & Aschenbrener, C. A. 2013. Toward a common taxonomy of competency domains for the health professions and competencies for physicians. *Academic Medicine,* 88(8): 1088-1094.

Feng, R. F & Tsai, Y. F. 2012. Socialising of new graduates to practising nurse. The *International Voice of Nursing Research, Theory & Practice,*21 (13-14):2064-2071.

Fiedler, F. E .1967. *A theory of leadership effectiveness*. Macgraw Hill: United States.

Fiedler, F. E .1971. *Leadership.* Learning Press: United States.

Gardiner, I. & Sheen, J. 2016. Graduate nurse experiences of support: A review. *Nurses Education Today*, 40: 7-12.

Geyer, G. (Ed). 2013. *A new approach to professional practice*. Juta & Co: South Africa.

Govender, S., Brysiewicz P. & Bhengu, B., 2015, 'Perceptions of newly-qualified nurses performing compulsory community service in KwaZulu-Natal', *Curationis* 38(1), 1474-1482.

Hadi, M., Hamid, A. Y. S., Kamso, S., Sutoto, S., Pratiknya, A. W., Nursalam, N., Efendi, F. 2017. The improvement of competency in a clinical study in Indonesia: what factors played an important role. *Jurnal Ners,* 12: (2):151-157.

Hanse, J. J., Harlin, U., Jarebrunt, C.,Ulin ,K & Winkel, J. 2016. The impact of servant leadership dimensions on leader-member exchange among healthcare professionals.*Journal of Nursing Management,* 24 (4):228-234.

Hansen-Salie, N. & Martin, P. D. 2014. The perception and factors influencing the competency in newly qualified professional nurses working in private hospitals in the Western Cape, South Africa. *African Journal for Physical, Health Education, Recreation and Dance*, (Supplement 1:2): 538-553.

Horsburg, D & Ross, J. 2013. Care and compassion: the experience of newly qualified staff nurses. *The International Voice of Nursing Research, Theory and Practice*, 22(7): 1124-1132.

Hughes, S.J. & Quinn, F. M. 2013. *Quinn's Principles and Practice of Nurse Education*. Nelson Thornes Ltd : United States.

Hunt, T. J. 2014. Leader-member-exchange relationships in health management. [Online]. Available: https://www.ncbi.nlm.nih.gov/pmc/artcles/PMC3995491/ [Accessed 23 November 2017].

Hsieh, H & Shannon, S. E. 2005. Three approaches to qualitative content analysis. Qualitative Health Research. [Online] Available: http://qhr.sagepub.com/content/15/9/1277.[Accessed 28 March 2017].

King, N. 2017. What is template analysis? University of Huddersfield. [Online]. Available: www.hud.ac.uk[Accessed 28 March 2017].

Klopper, H.C & Uys, L.R. 2013. *The state of Nursing in Africa: a country-by-country review*. Sigma Theta Tau: Indianapolis.

Kumaran, S & Carney, M. 2014. Role transition from student nurse to staff nurse: facilitating the period. *Nurse education in Practice,*14(6): 605-611.

Lambert, V.A. 2012. Qualitative Descriptive Research: an acceptable design. *Pacific Research RinInternational Journal of Nursing Research*, 16(4): 255-256.

Lau, R., Cross, W., Moss, C., Campbell, A., De Castro, M. & Oxley, V. 2014. Leadership and management skills of general practice nurses: experience or education. *International Journal of Nursing Practice*, 20: 655-661.

Leedy, P. & Ormrod, J. 2010. Practical Research: Planning and Design. 9th edition. Pearson Education: United Kingdom.

Leggard, S. G & Balding. 2013. Achieving organisational competence for clinical leadership: the role of high performance work systems. *Journal of Health Organisation and Management*, 27(3):312-329.

Lett, M. 2002. The concept of clinical leadership. *Contemporary nurse,* 12(1):12-16.

Lewin, K & Lippit, R. 1938. An experimental approach to the study of autocraticy and democracy: a preliminary note. *Sociometry,* 1(3/4): 292-300.

Lord, R. G. 1985. An information processing approach to social perceptions, leadership and behavioural measurement in organisations. *Research in organisational Behaviour*, 7: 8-128.

Mannix, J., Wilkes, L & Daly, J. 2013. Attributes of clinical leadership in contemporary nursing: an integrative review. *Contemporary Nurse*, 45(1):10-21.

Moir, J. 2017.Contextual leadership: context as a mediator of leader-effectiveness. *Psychological Behavioural Science International Journal,* 3(4): 1-2.

Mountford and Webb cited inDoherty, J. 2013. Clinical leadership in hospitals: a review of international and South African literature. Centre for Rural Health, University of the Witwatersrand: South Africa

National Health Service Leadership Academy, 2011. *Guidance for Integrating the Clinical Leadership Competency Framework into Education and Training*. NHS. Institute of NHS Institute for Innovation and Improvement: United Kingdom

National Health Service Leadership Academy, 2011.*The Clinical Leadership Competency Framework*. NHS Institute ofNHS Institute for Innovation and Improvement: United Kingdom

Picard, C. 2011. *The power of ten; 2011-2013: Nursing leaders address the profession's ten most pressing issues.* Sigma Theta Tau International: United States.

Rice, M. 2016. Talking Leadership: Mathew Rice on clinicians leading change. [Online]. Available: https://www.kingsfund.org.uk/publications/mathew-rice-clinicians-leading-change [Accessed 20 November 2017].

Roziers, R. L & Ramugondo. E. L. 2014. Newly qualified South African nurses 'livedexperience of the transition from student to community service nurse: A phenomenological study.*The Journal of Continuing Education in Nursing*, 4(2):91-100.

Stanley, D. 2014. Clinical leadership characteristics confirmed. Journal of Nursing Research, 19 (2): 119-128.

Stanley, D., Blanchard, D. Hohol, A., Hutton, M., MacDonald, A & Lee, A. 2017. Health professionals perceptions of clinical leadership: a pilot study. [Online] Available: https://researchoutput.csu.edu.au [Accessed 12 December 2017].

Stanley. D. 2017a. Congruent leadership defined. Nursing and Healthcare, 3(3):20-50

Stanley. D. 2017b. *Clinical leadership in nursing and healthcare: values in action*. 2nd edition. John Wiley & Sons: United States.

Streubert, H. J. & Carpenter, D. R. 2011. *Qualitative Research in Nursing: Advancing the Humanistic Imperative*. 5th edition. Lippincott: United States.

Surbhi, S. 2016. Difference Between Exploratory and Descriptive Research. Key Differences. [Online]. Available: http://keydifferences.com/difference-between-exploratory-and-descriptive-research.html [Accessed 19 September 2016].

Suresh, P., Mathews, A & Coyne, I. 2012. Stress and stressors in the clinical environment: a comparative study of fourth year student nurses and newly qualified general nurses in Ireland. *Journal of Nursing, Research, Theory and Practice,* 22(5-6):770-779.

Thopola, M.K., Kgole, J.C. & Mamogobo, P.M. (2013). Experiences of newly qualified nurses of University at Limpopo, Turfloop Campus executing community services in Limpopo Province, South Africa. *African Journal for Physical, Health Education, Recreation and Dance*, March (Supplement 1), 169-181.

Waring, T. & Wainwright, D. 2008. Issues and Challenges in the Use of Template Analysis: Two Comparative Case Studies from the Field. *The Electronic Journal of Business Research Methods,* 6(1): 85-94.

ANNEXURE A: INVITATION LETTER

Invitation to participate in the research study titled:

"CLINICAL LEADERSHIP COMPETENCY: NEWLY QUALIFIED NURSES' UNDERSTANDING AND NEEDS"

Dear newly qualified nurse,

I am studying towards a Master's degree at the University of the Witwatersrand. I am conducting interviews as part of a research study to increase our understanding ofclinical leadership competency. Research is just the process to learn the answer to a question. The aim of this study is to establish what you, as a newly qualified nurse understands about clinical leadership competency and then also explore your competency needs. As a newly qualified nurse you are in an ideal position to give us valuable first-hand information in an interview. The interview will take about 30 minutes.

Your responses to the questions will be kept confidential. There is no compensation for participating in this study. The findings or results of this research will not have any bearing on your work environment as the results cannot be linked to a specific response or name. Your voluntary participation will be a valuable addition to this research and findings could lead to greater public understanding of clinical leadership competency in the nursing field. Please note that information collected in the study will be stored in a password protected data storage device that only the researcher and supervisor will have access to. After completion of the study, all the information collected will be eventually destroyed.
If you have any questions or have need of further information or would like to report adverse events related to this study, please do not hesitate to ask me. In the case that you need to report any complaints or problems please use the following contact details:

Wits Human Research Ethics Committee
Peter.cleaton-jones @wits.ac.za
Chairperson

Ms ZaneleNdlovu/Mr RhulaniMkhansi/ Mr Lebo Moeng
011 717 2700/2656/1234/1252
HREC-Medical.ResearchOffice@wits.ac.za
Administrators

Thank you for your participation.
Yours
Ms G.W Mathumo-Githendu
078 025 8845
Researcher

ANNEXURE B: ETHICS CLEARANCE

R14/49 Ms Gugulethu Mathumo-Githendu

HUMAN RESEARCH ETHICS COMMITTEE (MEDICAL)

CLEARANCE CERTIFICATE NO. M170510

NAME: (Principal Investigator)	Ms Gugulethu Mathumo-Githendu
DEPARTMENT:	Nursing Education [redacted]
PROJECT TITLE:	Clinical Leadership Competency: Newly Qualified Nurses' Understanding and Needs
DATE CONSIDERED:	26/05/2017
DECISION:	Approved unconditionally
CONDITIONS:	
SUPERVISOR:	Lizelle Crous
APPROVED BY:	Professor P. Cleaton-Jones Chairperson, HREC (Medical)
DATE OF APPROVAL:	07/08/2017

This clearance certificate is valid for 5 years from date of approval. Extension may be applied for.

DECLARATION OF INVESTIGATORS

To be completed in duplicate and **ONE COPY** returned to the Research Office Secretary in Room 10004,10th floor, Senate House/3rd floor, Phillip Tobias Building, Parktown, University of the Witwatersrand. I/We fully understand the conditions under which I am/we are authorised to carry out the above-mentioned research and I/we undertake to ensure compliance with these conditions. Should any departure be contemplated, from the research protocol as approved, I/we undertake to resubmit to the Committee. **I agree to submit a yearly progress report**. The date for annual re-certification will be one year after the date of convened meeting where the study was initially reviewed. In this case, the study was initially review May and will therefore be due in the month of March each year. Unreported changes to the application may invalidate the clearance given by the HREC (Medical).

Principal Investigator Signature Date

PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES

ANNEXURE C: LETTER OF APPROVAL FROM THE HOSPITAL

GAUTENG PROVINCE
HEALTH
REPUBLIC OF SOUTH AFRICA

[redacted]

Enquiries:
Ms. G. Ngwenya
Office of the Nursing Director
Tell: (011): 488-4558
Fax: (011): 488-3786
27 September 2017

Mrs. Gugulethu Mathumo Githendu
University of the Witwatersrand
Department of Nursing Education
Faculty of the Health Sciences
NHRD REF: GP_201708_036

Dear. Mrs. Gugulethu Mathumo Githendu

RE: "Clinical leadership competency: newly qualified nurses' understanding and needs"

Permission is granted for you to conduct the above recruitment activities as described in your request provided:

1. Charlotte Maxeke Johannesburg Academic hospital will not in anyway incur or inherit costs as a result of the said study.
2. Your study shall not disrupt services at the study sites.
3. Strict confidentiality shall be observed at all times.
4. Informed consent shall be solicited from patients participating in your study.
5.

Please liaise with the Head of Department and Unit Manager or Sister in Charge to agree on the dates and time that would suit all parties.

Kindly forward this office with the results of your study on completion of the research.

Supported / ~~not supported~~
Ms. M.M Pule
Nursing Director
Date: 2017/09/27

Approved / not approved
Ms. G. Bogoshi
Chief Executive Officer
04.10.2017

ANNEXURE D: INTERVIEW CONSENT FORM

CONSENT TO BE INTERVIEWED

You are being asked to take part in a research study entitled **"CLINICAL LEADERSHIP COMPETENCY: NEWLY QUALIFIED NURSES' UNDERSTANDING AND NEEDS".** You being are asked to participate because you are a newly qualified nurse. Please read this form carefully and ask any questions you may have before agreeing to take part in the study.

What the study is about: The purpose of the study is to establish the competency needs of and understanding of newly qualified nurses for their clinical leadership role in view of the fact that findings may be incorporated into nursing curricula in future.

What will you be asked to do: If you agree to be in this study, you will asked questions in an interview. This will take about 30 minutes to complete.

Risks and benefits: There are no known risks to participating in this study. Nevertheless, there are non-financial benefits to you. Clinical leadership competency is on demand in contemporary nursing and this study offers you an opportunity to reflect on what you could possibly need to acquire it. This will be important for your learning.

Compensation: There is no compensation for participating in this study.

Your answers will be confidential. The records of this study will be kept private. In any sort of report made public it will not include any information that will make it possible to identify you. Research records will be kept in a locked file; only the researcher and research supervisor will have access to the records.

Taking part is voluntary: Taking part in this study is completely voluntary. If you decide to take part, you are free to withdraw at any time without any penalty.

If you have questions: The researcher conducting this study is Gugulethu Mathumo-Githendu and the research supervisor is Lizelle Crous. Please ask any questions you have now. If you have questions later, you may contact the researchers at **1446871@students.wits.ac.za** and**lizelle.crous@wits.ac.za**

Statement of consent: I have read the above information, and have received answers to any questions I asked. I consent to take part in the study.

Your Signature _____
Date _____
Your Name (printed)
_____
Signature of person obtaining consent _____
Date _____
You will be given a copy of this form to keep for your records.

ANNEXURE E: RECORDING AND TRANSCRIPTION FORM

CONSENT TO AUDIO RECORDING & TRANSCRIPTION

Title of Study:

"**CLINICAL LEADERSHIP COMPETENCY: NEWLY QUALIFIED NURSES' UNDERSTANDING AND NEEDS**"

The purpose of the study is to establish the competency needs of and understanding of newly qualified nurses for their clinical leadership role in view of the fact that findings may be incorporated into nursing curricula in future.

This study involves the audio recording of your interview with the researcher. Neither your name nor any other identifying information will be associated with the audio recording or the transcript. Only the research and supervisor will be able to listen to the recordings.

The tapes will be transcribed by the researcher and erased once the transcriptions are checked for accuracy. Transcripts of your interview may be reproduced in whole or in part for use in presentations or written products that result from this study. Neither your name nor any other identifying information (such as your voice) will be used in presentations or in written products resulting from the study.

By signing this form, you are allowing the researcher to audio record you as part of this research. You also understand that this consent for recording is effective as soon as it is signed. The audio recordings will be eventually destroyed after they have fulfilled their purpose.

Your Signature _____
Date _____
Your Name (printed)
_____
Signature of person obtaining consent _____
Date _____
You will be given a copy of this form to keep for your records.

ANNEXURE F: LETTER REQUESTING PERMISSION TO CONDUCT STUDY

Charlotte Maxeke Academic Hospital
16 Jubilee Road, Parktown
Johannesburg, Gauteng
2193

10 Hendale Centre
Corner Main & New Street
Unified Florida
1709

05 April 2017

Dear Nursing Service Manager

RE: REQUEST FOR PERMISSION TO CONDUCT ONE ON ONE INTERVIEWS WITH NEWLY QUALIFIED NURES

I am a registered student at the University of the Witwatersrand studying a MSc Nursing Degree. The title of my research study is "CLINICAL LEADERSHIP COMPETENCY: NEWLY QUALIFIED NURSES' UNDERSTANDING AND NEEDS." The purpose of the study is to describe the understanding of newly qualified nurses of clinical leadership and then explore their competency needs. Research objectives are as follows: To identify newly qualified nurses' understanding of clinical leadership and secondly explore their clinical leadership competency needs. Findings from the study may inform future nursing curricula to include clinical leadership competency. I therefore request to advertise the study, enrol participants and conduct interviews with newly qualified nurses working at your hospital.

I am hoping to interview about 20 nurses. After contacting the nurses and getting their permission to participate, we will set up a mutually convenient time, outside normal working hours for them to be interviewed.

The university Ethics Committee requires some proof that I have requested permission for the study and so I kindly request it so I can furnish it together with my ethics clearance application. I would be grateful for your assistance.

Yours faithfully

Ms G.W Mathumo-Githendu (Student Number: **1446871**)

……

ANNEXURE G: INTERVIEW GUIDE

1. What is your understanding of clinical leadership?

   Clinical leadership refers to effective management and leadership of internal and external resources, self as well as others in order to create or maintain a therapeutic clinical milieu (Brown *et al*., 2015).

2. What aspects of Clinical Leadership were you taught during your training?
3. Tell me more about opportunities you had to practice clinical leadership?
4. What would help you to improve your clinical leadership competency in future?

Probing questions were be used to elaborate or clarify on responses

ANNEXURE H: INITIAL TEMPLATE

1. DEMONSTRATING PERSONAL QUALITIES
a)Developing Self Awareness
b)Managing yourself
c)Continuing personal development
d)Acting with integrity
2. WORKING WITH OTHERS
a) Developing networks
b) Building and maintaining relationships
c) Encouraging contribution
d) Working within teams
3. MANAGING SERVICES
a) Planning
b) Managing resources
c) Managing people
d) Managing performance
4. IMPROVING SERVICES
a) Ensuring patient safety
b) Critically evaluating
c) Encouraging improvement and innovation
d) Facilitating transformation
5. SETTING DIRECTION
a) Identifying the contexts for change
b) Applying knowledge and evidence
c) Making decisions
d) Evaluating impact

Source: National Health Service Leadership Academy (2011)

ANNEXURE I: FINAL TEMPLATE

1 DEMONSTRATING PERSONAL QUALITIES
1.1 Developing Self Awareness
1.2 Managing yourself
1.3 Continuing personal development
1.4 Acting with integrity
1.5 Acting various roles
2 WORKING WITH OTHERS
2.1 Developing networks
2.2 Building and maintaining relationships
2.2.1 conflict resolution
2.3 Encouraging contribution
2.4 Working within teams
2.4.1 support
3 MANAGING SERVICES
3.1 Planning
3.2 Managing resources
3.3 Managing people
3.3.1 Delegation
3.3.2 supervision
3.4 Managing performance
4 IMPROVING SERVICES
4.1 Ensuring patient safety
4.2 Ensuring patient satisfaction
4.3 Critically evaluating
4.4 Encouraging improvement and innovation
4.4 Facilitating transformation
5 SETTING DIRECTION
5.1 Identifying the contexts for change
5.2 Applying knowledge and evidence
5.3 Making decisions
5.4 Evaluating impact
5.5 Influencing
5.6 Use of power and authority

Source: Adapted from National Health Service Leadership Academy (2011)

ANNEXURE J: EDITOR'S CERTIFICATE

Editing by Paidamoyo Michelle Guti

(BA in English and Communication, Post Graduate Certificate in Education, Teaching English to Speakers of Other Languages (TESOL), Teaching English as a Foreign Language (TEFL), Education First Instructor)

Editing date: 2 April 2018

CERTIFICATE OF ENGLISH EDITING

To whom it may concern

This is to certify that the paper with the title CLINICAL LEADERSHIP COMPETENCY: NEWLY QUALIFIED NURSES' UNDERSTANDING AND NEEDS, submitted by Gugulethu Waige Mathumo-Githendu, was edited for language. Neither the research content nor the author's intentions were altered in any way during the editing process.

Paidamoyo M. Guti guarantees an educational quality of English language in this paper, provided the editor's changes were accepted.

DocuSigned by:

2822CF4562684FB...

Paidamoyo Michelle Guti
BA English and Communication, PGCE
TESOL, EF Instructor

Dubai British School Jumeirah Park, Dubai, United Arab Emirates
gutipaidamoyo@gmail.com / pguti@dubaibritishschooljp.ae
Mobile: +971 55 879 1610