UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

TRANSFORMING THE WORKPLACE CULTURE TOWARDS PERSON CENTREDNESS IN A NURSING EDUCATION INSTITUTION IN SOUTH AFRICA

by

Queen Khanyisile Masimula

Student number: 18390863

Submitted in fulfilment of the requirements for the degree

PhD

in the

Department of Nursing Sciences

Faculty of Health Sciences

University of Pretoria

Supervisor: Prof. A van der Wath

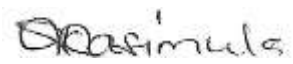
Co-supervisor: Prof IM Coetzee-Prinsloo

Date: December 2021

DECLARATION

I declare that the thesis titled: **"TRANSFORMING THE WORKPLACE CULTURE TOWARDS PERSON CENTREDNESS IN A NURSING EDUCATION INSTITUTION IN SOUTH AFRICA"** which I hereby submit for the degree Doctor of Philosophy in Nursing Science at the University of Pretoria is my own work and has not previously been submitted by me for a degree to any other university.

All the sources that have been used or quoted have been indicted and acknowledged by complete references in the text and bibliography.



Queen Khanyisile Masimula 30 November 2021

Signature of Student **Date**

Queen Khanyisile Masimula

ABSTRACT

Background: A person-centred workplace culture is essential for any organization including nursing education institutions. Transforming the workplace culture to person- centredness requires collaboration, inclusion and participation. Person centred values and beliefs translate into fundamental workplace culture changes for all individuals to benefit and flourish. Research evidence showed that a person-centred workplace culture is attained through purposefully planned and facilitated practice-oriented learning activities. Person-centredness is directly dependent upon the development of effective teamwork and leadership skills to achieve maximum personal and organisational goals.

Aim of the study: The aim of the study was to transform the workplace culture of a selected public nursing education institution in South Africa towards person-centredness.

The objectives were divided into three phases:
Phase 1: Assess the workplace culture of a selected PNEI in South Africa.
Phase 2: Implement a Transformative Practice Development program to transform the workplace culture to person-centredness
Phase 3: Evaluate the outcomes of the Transformative Practice Development programme.

Methodology: The study followed a sequential mixed method approach with quantitative and qualitative methods. Purposive and total population sampling methods were used to select participants who volunteered for the study. The study was conducted at a selected public nursing education institution, one of six PNEIs in the Gauteng Province in South Africa. The population of 92 potential participants included nurse educators and managers. In the quantitative phase 1, 63 respondents completed the questionnaires to assess the workplace culture for person centredness. in the qualitative phase 2, 46 participants volunteered and participated in consensus meetings, workshops and feedback sessions during implementation of the Transformative Practice Development program. In the quantitative phase 3, 69 respondents completed the questionnaires to evaluate the program outcomes. Triangulation of data collection methods

included consensus meetings, workshops and feedback sessions, field notes and questionnaires to ensure credibility of the study findings. Quantitative data analysis in phase 1 and 2 utilized descriptive and comparative statistical analysis. In Phase 2, thematic analysis and ranking of themes were done during consensus meetings.

Results: The themes that emerged from the consensus meetings for qualitative data collection were used to identify the topics to be utilised for facilitation of the workshops towards transforming the workplace culture to person-centredness, namely, healthy workplace relations, teamwork, communication and leadership. The qualitative findings from the feedback sessions revealed the changes participants experienced in terms of person-centredness, collaboration, inclusion and participation and the workplace culture. They experienced group cohesion, teamwork, reflective communication, sensitivity towards diversity, sharing of information and feedback, inspirational leadership, and leadership to facilitate change. The final quantitative results showed an enhancement towards a workplace culture of person-centredness.

Conclusion: This research contributes to the body of knowledge on transformative research practices, workplace culture, and person-centredness to benefit nurse educators. The research showed practical steps for transforming the workplace culture to person-centredness through capacitation, development of person-centred values, communication and work relationships; and facilitation of leadership skills. When applied in nursing education institutions, the program may contribute to achieve job satisfaction and decrease employee attrition to curb nurse educator shortages.

Keywords: Public nursing education institution, workplace culture, person-centredness, nurse educator, workplace transformation.

ACKNOWLEGEMENTS

I wish to convey my sincere gratitude and appreciation to several key people who have supported me in many valuable ways during the whole process of this research. This study would not have been completed without your support.

- To Prof Annatjie van der Wath and Prof Isabel Coetzee, my supervisors, who had provided me with endless cheerful support and graceful endurance of constant facilitation throughout the study; your contribution is much appreciated; thank you very much.
- To the University of Pretoria; thank you for granting me the permission and student grant to pursue the doctoral study in your institution
- To SG Lourens Nursing College and the Research Committee; thank you for granting me permission to conduct the study at the college.
- To SG Lourens program facilitators; thank you for your tireless support, flexibility and dedication during facilitation of outcomes at the workshops and consensus meetings
- To the nurse educators who acted as participants; thank you for your valuable inputs and sharing information with the readers of this study.
- To Ms Joyce Jordaan and Ms Ilja Deboer for knowledge and skills in quantitative data analysis; thank you for informative and skilful support.
- To Ms I Cooper, thank you for editing and linguistic revision and support
- To my family, my husband Thandokuhle Masimula and may three children, Makabongwe, Malibongwe and Sizwe Masimula for your love, cheerful support and graceful encouragement you provided while conducting this study
- To the Department of Health and Department of Education for granting permission to conduct research at the institution.
- To God Almighty, for all the mercy, strength, wisdom to conduct the study; without you Lord, nothing will be possible, I give you praise and honour.

DEDICATION

Success comes in cans; failure comes in cant's

- (Wilson Peterson)

Only one person receives the credit as having conducted the research, but in reality, the content of this research work has been given shape and meaning by the nurse educators who participated in this study at the public nursing education institution under study in South Africa. I dedicate this research to the University of Pretoria, the public nursing education institution where the study was conducted, and to my family, who tirelessly supported me towards transforming the workplace to person centredness.

Queen Khanyisile Masimula

TABLE OF CONTENTS

CHAPTER 7

MERGING AND MAPPING OF STUDY PHASES

LIST OF TABLES

LIST OF FIGURES

LIST OF ANNEXURES	
ANNEXURE A – RESEARCH APPROVALS	
ANNEXURE A1	APPROVAL FROM IN-HOUSE COMMITTEE
ANNEXURE A2	RESEARCH ETHICS COMMITTEE APPROVAL
ANNEXURE A3	PROVINCIAL PROTOCOL REVIEW COMMITTEE APPROVAL
ANNEXURE A4	APPROVAL FROM PUBLIC NURSING COLLEGE
ANNEXURE A5	PERMISSION TO USE THE PERSON-CENTRED PRACTICE INVENTORY
ANNEXURE B – GAINING ENTRY	
ANNEXURE B1	PROPOSAL PRESENTATION
ANNEXURE B2	INVITATION TO ACADEMIC STAFF TO ATTEND RESEARCH PRESENTATION
ANNEXURE C – COLLECTIION OF BASE-LINE DATA	
ANNEXURE C1	PARTICIPATION INFORMATION AND CONSENT DOCUMENT FOR ACADEMIC STAFF
ANNEXURE C2	GROUND RULES FOR CONSENSUS AND FEEDBACK MEETINGS
ANNEXURE C3	EXAMPLE OF CONSENSUS MEETING
ANNEXURE C4	EXAMPLE OF FEEDBACK SESSION NOTES
ANNEXURE C5	PCPI QUESTIONNAIRE
ANNEXURE D – TPD PROGRAM IMPLEMENTATION	
ANNEXURE D1	TPD PROGRAMME PLANNING
ANNEXURE D2	TPD PROGRAMME
ANNEXURE D3	PARTICIPANT INFORMATION AND CONSENT DOCUMENT FOR PROGRAMME FACILITATORS
ANNEXURE D4	PARTICIPANT INFORMATION AND CONSENT DOCUMENT FOR MANAGERS
ANNEXURE D5	TPD PROGRAMME PROCESSES
ANNEXURE E – DECLARATIONS	
ANNEXURE E1	DECLARATION FROM THE EDITOR
ANNEXURE E2	DECLARATION FROM THE STATISTITIAN
ANNEXURE F – AUTHORS' GUIDELINES	
ANNEXURE F1	ARTICLE 1: NURSE EDUCATION IN PRACTICE
ANNEXURE F2	ARTICLE 2: NURSE EDUCATION TODAY
ANNEXURE F3	ARTICLE 3: GENDER & BEHAVIOUR
ANNEXURE F4	ARTICLE 4: INTERNATIONAL JOURNAL OF AFRICA NURSING SCIENCES

LIST OF ABBREVIATIONS	
CHE	Council on Higher Education
CIP	Collaboration, Inclusion and Participation
DoH	Department of Health
ETQA	Education and Training Qualification Authority
FPL	Food Poverty Line
GCON	Gauteng College of Nursing
GHS	General Household Survey
HEI	Higher Education Institution
HEQSF	Higher Education Qualification Sub-framework
HPCSA	Health Professional Council of South Africa
LBPL	Lower-Bound Poverty Level
NHI	National Health Insurance
NQF	National Qualification Framework
NEIs	Nursing Education institutions
PCPI	Person Centred Practice Inventory
PHC	Primary Health Care
PNEI	Public Nursing Education Institutions
R.	Regulation
SANC	South African Nursing Council
SAQA	South African Qualification Authority
STATSSA	Statistics South Africa
TPD	Transformative Practice Development
UBPL	Upper-Bound Poverty Line
WHO	World Health Organization
WC	Workplace Culture

CHAPTER 1
ORIENTATION TO THE STUDY

1.1 INTRODUCTION

Public nursing education institutions (PNEIs) in South Africa are approved and accredited by the South African Nursing Council (SANC) to provide nursing education and training to student nurses. Governance of PNEIs is provided by the Department of Health (DoH) who mandates PNEIs to provide quality nursing education. PNEI practice is controlled and regulated by the Nursing Act (no 33 of 2005) (Republic of South Africa, 2005).

1.2 BACKGROUND TO THE STUDY

A workplace culture links individuals and collective behaviour and is embodied in individuals and shared by employees in an organisation (Carlstrom & Ekman 2012:176). Like all organisations, nursing education institutions are expected to display essential attributes indicative of a positive workplace culture. Globally, nursing education institutions face challenges of management and nursing staff collaboration; poor staff attitudes and work relationships; lack of teamwork; burnout; high staff turnover, and nurse educator shortages (Al Sayah, Szafran, Robertson, Bell & Williams 2014:2968; Topp & Chipukuma 2016:197,198; Reeves, Xyrichis & Zwarenstein 2018:1-3).

In Sydney, Australia, Beckett, Field, Molloy, Yu, Holmes and Pile (2013:595) found that ineffectual leadership, staff resistance, and an unresponsive organisational culture were common barriers to efforts to improve culture and practice. Beckett et al. (2013) created a practice development plan, which prioritised person-centred care, personal recovery, strengths-based principles, and evidence-based and values-based care, to enable professional development through participation, learning and empowerment. The outcomes highlighted the importance of leadership which paralleled the ideals promoted for clinical practice.

A workplace culture of person-centredness is evidenced by employees' needs being met in a person-centred way. Staff feel empowered and committed to meet individual and organisational goals and objectives. A study in Greece found that a person-centred workplace culture resulted in improved teamwork, increased morale, high productivity and efficiency, enhanced job satisfaction, collaboration,

effective work performance, reduced stress and retention of employees (Belias, Koustelios, Vairaktarakis & Sdrolias 2015:316).

Africa is faced with a myriad of challenges, such as HIV/AIDS, malaria and tuberculosis (TB), and a variety of political and historical complications that have affected the education systems for advanced nursing practice. In Kenya, Mutea and Cullen (2012:417) reported that the health education sector did not give nurses an opportunity to pursue graduate education after the basic diploma in nursing due to limited government support and the type of educational system existing in the country. Distance education was available for professionals, such as teachers, in public universities, but was unreachable for nurses who were working and needed to further their education. Nurses desired to have access to advanced practice education to equip them to cope with and address the complex health issues arising in the management and care of patients. Mutea and Cullen (2012:419) presented a collaborative model, consisting of hospitals and agencies, communities of interest, Kenyan universities, and international education partners, as a potential solution.

A shared purpose is an essential part of developing effective workplace cultures and a basic principle of practice development in establishing person-centred, safe and effective practices that enable everyone to flourish (Manley, O'Keefe, Jackson, Pearce & Smith 2014:2). Manley et al. (2014:4) stress that regardless of the size of any initiative, a shared purpose must be established at the start because collaboration, inclusion and participation enable a focus on achieving person-centred, safe and effective cultures at organisational and at micro-system levels. For successful teamwork, systems for learning, development, research, innovation and evaluation should be established that enable shared purposes and values in all activities (Manley et al. 2014:4).

In South Africa, managers in nursing education institutions (NEIs) are mandated to lead as programme facilitators and coordinators of transformative processes through participative decision making (Mkhize 2009:94). However, in his study of NEIs in four provinces, Mkhize (2009:99) found that limited training resources and unmanageable workloads impeded implementation of training mandates, caused staff complaints, limited compliance, poor staff relations and resistance in buying-in to academic policies for nursing education practice at the NEIs. Furthermore, lines of communication at the NEIs tended to be rigid, leaving limited space to participate in decision making processes and policies that involved students and nurse educators (Mkhize 2009:161,162). Accordingly, Mkhize (2009) developed a transformational leadership model for academic nurse leaders in NEIs, using theory development methodology.

In 2013, 18.8% of nurse educators in Tanzania, 26.5% in Malawi and 41.4% in South Africa were faced with unconducive workplace cultures due to limited resources and work overload, both in nursing education and clinical practice (Blaauw, Ditlopo, Maseko, Chirwa, Mwisongo, Bidwell, Thomas & Normand 2013:127). Currently, the challenge of having limited resources at the PNEI under study still exist, where the human and material resource is scarce for the teaching and learning arena and impedes proper implementation of teaching and learning mandates as evidenced in increased complaints for teaching and learning resources by nurse educators.

1.3 RATIONALE FOR THE STUDY

At the time of the study, Gauteng Province, South Africa, had six PNEIs. The six PNEIs share similar contexts and processes and are governed according to public service guidelines. The PNEI selected for the study is a nursing college that provides nursing education to student nurses to become professional nurses at level 7 of the National Qualifications Framework (NQF) (2008) in accordance with the National Qualifications Act (no 69 of 2008). The Nursing Ac (no 33 of 2005) controls and regulates the practice of PNEIs.

On average since 2000, the PNEI has recruited, admitted and trained 250-300 student nurses per year in the first year of the nursing programme and produced 200-250 professional nurses per year. The nursing education mandate to train high numbers of student nurses led to an increased nurse educator-student ratio imbalance of 1:150 minimum and 1:300 maximum per class sitting. These ratios resulted in heavy and unmanageable workloads for the nurse educators, which in turn contributed to nurse educator shortages, high turnover and job dissatisfaction, decreased academic staff productivity, compromised communication and collaboration, and problems with policy implementation. The latter further decreased staff morale that increased tension at the workplace leading to job dissatisfaction evidenced in increased staff absenteeism among nurse educators, high turnover evidenced in high rates of nurse educator resignations and frequent recruitment and appointment of new nurse educators to combat shortages (Manley, O'Keefe, Jackson, Pearce & Smith 2014:2; Mkhize 2009:93). At the time when the study was being concluded in 2021, the challenge of nurse educator shortages was still eminent as evidenced by high turnover rates of nurse educators that resigned, evinced by frequent recruitment and appointment processes of new nurse educators.

A workplace culture refers to shared values and practices, belief systems, and a set of assumptions that are shared across all groups in an organisation. The organizational culture is that complex whole which includes knowledge, beliefs, morals, law, customs and any other capabilities and habits acquired by employees as members of an organization (Ndlovu, Ngirande & Setati 2017:242). The

PNEI had challenges in developing a positive workplace culture and participative teamwork due to academic staff problems with student nurse training mandates and policy compliance, poor workplace relationships, low staff morale and increased tension at the workplace. As a nurse educator at the PNEI, the researcher observed these problems in most academic staff reports and meetings.

1.4 PROBLEM STATEMENT

The PNEI in the study had challenges in developing a positive workplace culture and participative teamwork due to academic staff problems with student nurse training mandates and policy compliance, poor workplace relationships, low staff morale and increased tension. Staff who are demotivated and tired are likely to develop burnout (Fong 2016:102,107; Kol, Ilaslan & Turkay 2017:e12557) and present with absenteeism and decreased job satisfaction which was the case at the PNEI under study.

If the workplace culture remained unchanged, without being addressed, it could reduce the optimal teaching and learning milieu and impact negatively on student nurse outcomes, nurse educator outcomes and organisational goals. According to McCormack (2010:63), the best solution to address workplace culture challenges is to adopt and implement a person-centred approach that manifests through human flourishing, enabled self-direction, supported and agreed upon values, beliefs and behaviours with achievement of participative decision-making platforms. The researcher's observations raised the question in her mind of how these problems could be addressed. Her daily experience and observations motivated the researcher to undertake this study. The study therefore wished to investigate the workplace culture problems and determine nurse educators' and other employees' perceptions of the workplace culture in the PNEI.

1.5 AIM AND OBJECTIVES OF THE STUDY

1.5.1 The study wished to answer the following research question:

How can the workplace culture of the selected PNEI be transformed to become more person-centred?

1.5.2 The aim of the study:

The aim of the study was to transform the workplace culture of a selected PNEI in South Africa to person-centredness. In order to achieve the aim, the objectives of the study were to

- Assess the workplace culture of the selected PNEI.

- Implement the Transformative Practice Development (TPD) programme to transform the workplace culture to person-centredness.
- Evaluate the outcomes of the TPD programme

1.6 SIGNIFICANCE OF THE STUDY

The study should contribute to nursing education knowledge and practice and provide guidance to PNEIs on transforming the workplace culture to person-centredness. Implementation of the study recommendations should contribute to achieving positive outcomes for student nurses, nurse educators, nurse managers and PNEIs.

1.6.1 Public nursing education institutions

Nursing education transformation to person-centredness may lead to a review of existing policies to improve nurse education practice and nurse educators' performance. The findings should be transferable to different educational contexts and could lead to transformation in the health system and nursing profession to foster person-centredness. The study should generate new knowledge and indicate which direction PNEIs should take in transforming workplace cultures to person-centredness.

1.6.2 Nurse educators and managers

The study may provide nursing education managers with person-centred knowledge and practices for transformation at NEIs. The study should facilitate nurse educators' ethical, effective, safe and competent person-centred practices of learning and development. The findings should also facilitate a participative team approach through collaboration, inclusion and participation (CIP) principles, inform policy formulation forums at all levels of implementation and leadership to broaden the scope of participation and inputs to relevant stakeholders and provide a source of reference to other scholars.

1.6.3 Student nurses

The study findings should improve student nurses' experience of transformed person-centred nursing education culture. Their experience of the person-centred approach to nursing practice in nursing education should improve person-centred patient care.

1.7 PARADIGM

Creswell (2014:18) describes a paradigm as a way of thinking about something or a belief system that guides the way we do things or establishes a set of practices ranging from thought patterns to action. A paradigm is a way of looking at natural phenomena, also called a world-view, that encompasses a set of philosophical assumptions that guide a researcher's approach to inquiry (Polit & Beck 2017:738). Polit and Beck (2017:738) add that paradigms are lenses helping to sharpen the researcher's focus on a phenomenon. The research paradigm thus provides the researcher with a frame of reference to ask and answer the research questions. Assumptions are "principles that are accepted as true based on logic or reason, without proof" (Polit & Beck 2017:739).

In this study, critical realism was the paradigm that informed the study (Archer, Bhaskar, Collier, Lawson & Norrie 2013). Critical realism complements the transformative paradigm about how the world and reality are perceived (Craig & Bigby 2015:311; Parlour & McCormack 2012:308). Critical realism is a philosophical approach to understanding science developed by Bhaskar (1975). Critical realism distinguishes between the 'real' world and the 'observable' world and brought real alternatives to both positivism and post-modernism activities. The four parts of Bhaskar's (1975:1) critical realism philosophy applied to transforming the workplace culture as follows:

1.7.1 Transcendental realism

Transcendental realism is concerned with objects of scientific discovery and investigation to develop knowledge in real entities. It therefore regards objects of knowledge as the structures and mechanisms that generate phenomena and knowledge as produced in the social activity of science (Archer et al. 2013:19). In this study, nurse educators served as generators of knowledge during their academic activities and with their contributions to the study.

1.7.2 Critical naturalist philosophy

Dolphijn (2016:115) emphasises that the social world is always pre-structured. The transformational model of social activity entails that social life possesses a recursive and non-teleological character, as agents reproduce and transform the very structures which they utilize, within the constraints of their substantive activities. In this study, the nurse educators acted as agents of transformation of their own workplace culture that they transformed to make it person-centred within the constraints of the workplace structures and activities.

1.7.3 Theory of explanatory critique

The theory of explanatory of critique opens up the possibility of being able to discover values, where beliefs prove to be incompatible with their own true explanation (Bhaskar 1975:1). In this study, values were clarified before the implementation of the programme to transform the workplace culture.

1.7.4 Dialectical critical concepts

Dialectical concepts are central to Bhaskar's information on transformation (Archer et al. 2013:15). Dialectical critical realism is essentially the positive identification and elimination of absences conceived as arguments, changes or augmentation from aspirations of freedom. The identification of absences in critical dialectic arguments depends upon the positive identification and elimination of mistakes, states of affairs and constraints that evolve from what is not known or absent that challenge the status quo (Bagley, Sawyerr, & Abubaker 2016:400). In this study, dialectical critical realism was manifested in the positive identification of values and beliefs that were absent before the transformation process and those values that acted as constraints to nurse educators, such as values to be addressed to prevent conflict.

1.7.5 Philosophical assumptions

Philosophical assumptions are principles that are accepted as true based on logic or reason without proof (Polit & Beck 2017:720). Critical realism is based on ontological, epistemological and methodological assumptions.

1.7.5.1 Ontological

Ontology is the study of being or reality. Ontology refers to the way individuals perceive life (Polit & Beck 2017:10). In addition, multiple realities exist and the content and form depend on how individuals interpret them. Ontological assumptions are concerned with the reality that is being investigated. Critical realists explain how we come to know what we know in the world by gaining a deeper understanding of the causes and causalities (Walsh & Evans 2014:4). According to realism's ontological assumptions, there are substances of research investigation that are observable through actual events and manifest in different behaviours to produce experiences to develop knowledge

through participants' views. Ontological depths refer to aspects of reality that are, in principle, unobservable with the potential to cause observable events (Walsh & Evans 2014:4).

In this study, the participants explained how they had experienced workplace values and beliefs in relation to a workplace culture of person-centredness. The environment of the PNEI was characterised by challenges to establish a bottom-up leadership approach and participative teamwork. The PNEI also struggled with insufficient resources, increased student numbers and insufficient policy participation that resulted in an unconducive workplace culture.

1.7.5.2 Epistemological

Epistemology is concerned with the nature of knowledge, its possibility, scope and general basis. Epistemology refers to the way individuals understand reality from what they know and what is observed through interaction with the environment (Grove, Burns & Gray 2013:58). In research, the interaction between researchers and participants generates knowledge and insight into the phenomenon under study (Polit & Beck 2017:13).

Knowledge in transformative research is subjective and bound by place and time and subject to the "true" experiences of participants. The transformative perspective believes that rich knowledge is optimized when the researcher interacts with those being researched and the findings are the creation of an interactive process (Polit & Beck 2017:10). According to Walsh and Evans (2014:3), critical realism holds that complex knowledge is filtered through an interpretive lens of epistemology and gaining knowledge is fundamental to research when the right questions are asked about reality.

The researcher asked questions related to reality at the PNEI, for example, "How can we transform the workplace culture of the PNEI under study?" In this study, knowledge was obtained through the questionnaires in the quantitative phase to obtain responses that informed the researcher on the current status of the workplace culture. Information to generate in-depth knowledge was obtained through the qualitative phase through consensus meetings with the participants to share their experiences and views in relation to their workplace culture beliefs and values. The researcher also took field notes during the study. The participants' experiences provided informed knowledge on the workplace culture.

1.7.5.3 Methodological

Methodology is a strategy or plan of action that links methods to outcomes and governs researchers' choice and use of methods and the process of the research (Creswell 2014:17). Methodological assumptions refer to how the researcher will gain knowledge from the participants (Polit & Beck 2017:10). The researcher selected a mixed methods research design with qualitative and quantitative phases to explore the participants' experiences and portray the phenomenon under study (Polit & Beck 2017:725).

Critical realism in transformative research believes that knowledge and understanding can be constructed by using more than one method to investigate a complex and wide range of views in order to enlarge classifications and concepts (Creswell 2014:37). Critical realism methodology spells out the relevant objects, structures, mechanism and conditions of the phenomenon being investigated. Critical realists move towards theory building beginning with participants' experiences to obtain explanations of reality (Walsh & Evans 2014:4).

1.8 PRACTICE DEVELOPMENT CONCEPTUAL FRAMEWORK

McCormack, Manley and Titchen (2014:8) define practice development as a continuous process of developing person-centred cultures. It is enabled by programme facilitators who authentically engage with individuals and teams to blend personal qualities and creative imagination with practice skills and practice wisdom. Learning brings about transformation of individual and team practices. The Practice Development Conceptual Framework categorized the main components of practice development and key components and interconnections applicable to workplace cultures. Figure 1.1 depicts the Practice Development Conceptual Framework (McCormack, Manley & Titchen 2014:8).

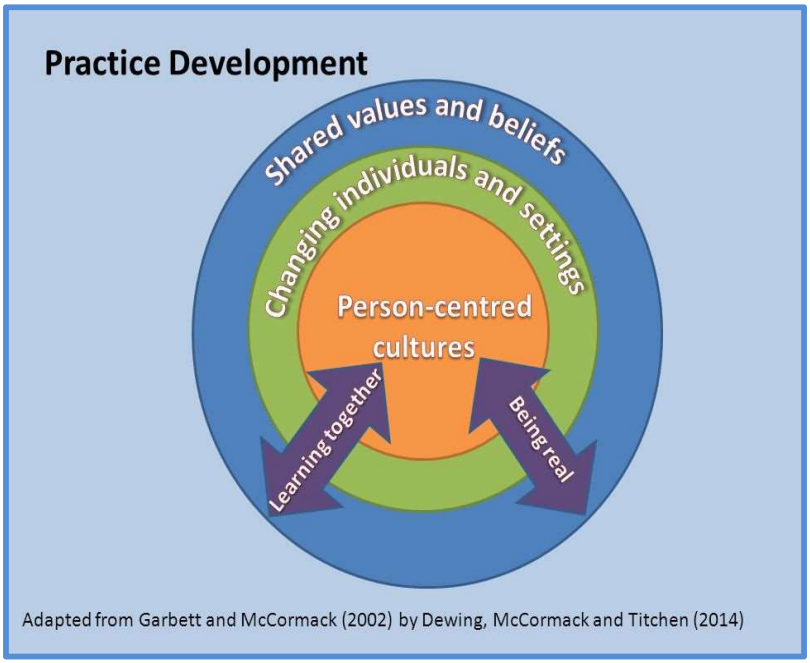


Figure 1.1 Overview of practice development conceptual framework
Source: McCormack, Manley & Titchen (2013:9)

In Figure 1.1, the "*shared values and beliefs"* of practice development shows that practice development activities are built upon a collective vision for ideal practices and values. Having a *"person-centred culture"* is seen as a state of movement towards the achievement of expected outcomes at the workplace. A shared vision by all stakeholders at the workplace begins with the process of identifying "*where we are now*" in terms of the reality of the workplace vision and the existence of a person-centred culture. The *"changing individuals and settings"* addressed the methods, processes and tools utilised to assist the participant teams to change towards a person-centred culture and provided answers to issues that needed to be changed. The *"learning together"* and *"being real"* processes addressed the matter of "*being real*" and "*being authentic*" as facilitators. The programme facilitators needed to know themselves to develop authentic relationships with the teams. "*Being rea*l" included utilisation of evaluation strategies that were in-line with the values of the practice development programme, utilising the principles of collaboration, inclusion and participation**.**

In this study the researcher used the *Practice Development Conceptual Framework* to guide the process of transforming the workplace culture towards person-centeredness for the PNEI. Consensus meetings were held with the participants to raise awareness on the workplace values and beliefs as practised at the PNEI. During the consensus meetings the practice development conceptual framework was discussed as a point of reference. Person-centred workplace values and beliefs were

explored for adoption to transform the workplace culture to person-centredness for everybody to flourish and improve organizational outcomes. The practice development conceptual framework is based on workplace values and beliefs such as sharing, changing individuals and settings, person-centred cultures, learning together and being real. The participants identified their workplace values to facilitate person-centredness as respect, sharing information, commitment, cultural sensitivity and diversity, healthy workplace relations, effective teamwork, effective communication and person-centred leadership. The participants were able to identify the unconducive, unfavourable workplace values and beliefs that hindered their workplace culture from being person-centred. The research participants worked with program facilitators to co-construct the TPD programme to facilitate the establishment of person-centred workplace values and beliefs during workshop sessions towards transforming the workplace culture to person-centredness.

1.9 RESEARCH CONTEXT

Polit and Beck (2014:392) define a research context and setting as the physical location and conditions under which data collection takes place for a study. The context in which the researcher conducted the study was a PNEI in the Gauteng Province of South Africa. At the time of the study, Gauteng Province, South Africa, had six PNEIs, which shared similar contexts and processes and are governed according to public service guidelines. These PNEIs provided nursing education to student nurses for the legacy qualifications for four years. The legacy qualifications refer to the Regulation 425 (R.425) programme in nursing that is currently being phased out. New nursing programmes are being phased in for both undergraduate and post-graduate nursing programmes. All the PNEIs are guided and regulated by the South African Nursing Council (SANC) through the Nursing Act (no 33 of 2005) and the Council on Higher Education (CHE) and governance provided by the Department of Health (DoH) and the Higher Education Act (no 101 of 1997 as amended).

The selected PNEI placed student nurses and post-basic student nurses in 10 hospitals and 64 clinics for clinical practice. The PNEI trained approximately 1,050 student nurses per year. The total population of the academic staff comprised 92 nurse educators and nurse managers. Population categories consisted of the principal and deputy principal, eight heads of departments and 82 nurse educators. The study was conducted to establish the status of the current workplace culture in relation to person-centredness towards the transformation agenda of the NEI in South Africa.

The researcher gave the principal of the PNEI a copy of the proposal for the study and explained the purpose of the study, and answered the principal's questions. On 7 December 2018, a meeting was

held with the PNEI management to discuss the proposed study and explain the advantages of the study for the participants and the PNEI.

The researcher had no problem gaining access to the PNEI as she was working there as a head of a department. It was not easy to gain the interest of the academic staff to buy-in and participate in the study, especially the nurse educators who seemed to have no time for research. The researcher wrote and submitted a formal letter to the principal requesting permission to conduct the study, which would take nine months. The researcher met with the chairperson of the Research Committee and the principal on 5 November 2018 to present the research proposal and obtained approval to conduct the study (see Annexure A:4). The researcher invited all the academic staff to attend a session to present the research proposal during the academic meeting (see Annexure B:2). The researcher presented the proposal to the academic staff, including nurse educators and managers, in order to recruit nurse educators and managers to participate in the study.

1.10 TRANSFORMATIVE RESEARCH

In this study, the researcher selected a transformative research approach.

1.10.1 Transformative Approach

The TPD programme was applied to transform the workplace culture of the PNEI. Creswell (2014:16, 228) describes transformative research as a research design that utilizes a theoretical lens of knowledge from social power. It is a design that contains both quantitative and qualitative methods.

In this study, the researcher selected a transformative approach with both the quantitative and qualitative phases to transform the workplace culture towards person-centredness. The outcomes of phase 1 led to phase 2 of the TPD programme implementation, followed by quantitative research in Phase 3 to evaluate the program. Phase 1 outcomes and phase 3 outcomes were then merged, mapped and compared. The themes that emerged from the consensus meetings were utilized to transform the workplace culture to person-centredness for the PNEI (see Figure 1.2). In TPD, producing knowledge means converting experiences into knowledge and understanding deeper experiences. Observation of actions for self and others in TPD assists in generating theory from practice and developing new ways of practising (Trede &Titchen 2012:2). The purpose of TPD in this study was to lead to human flourishing, in a creative, spiritual and ethical sense, for both the participants and the organisation and could enhance culturally conducive practices (McCormack, Manley & Titchen 2013:195).

Transformative practice development is an approach for transformation of nursing practice (Parlour & McCormack 2012:308). The participants implemented the planning of the TPD programme using the themes of self-awareness (being enlightened first), to be motivated to act by this self-awareness (empowered) and reflection through the principles of collaboration, inclusion and participation and lastly to implement the actions in everyday practice within a culture of on-going critique and learning (Manley, O'Keefe, Jackson, Pearce & Smith 2014:4). Figure 1.2 illustrates the flow sequence of the TPD.

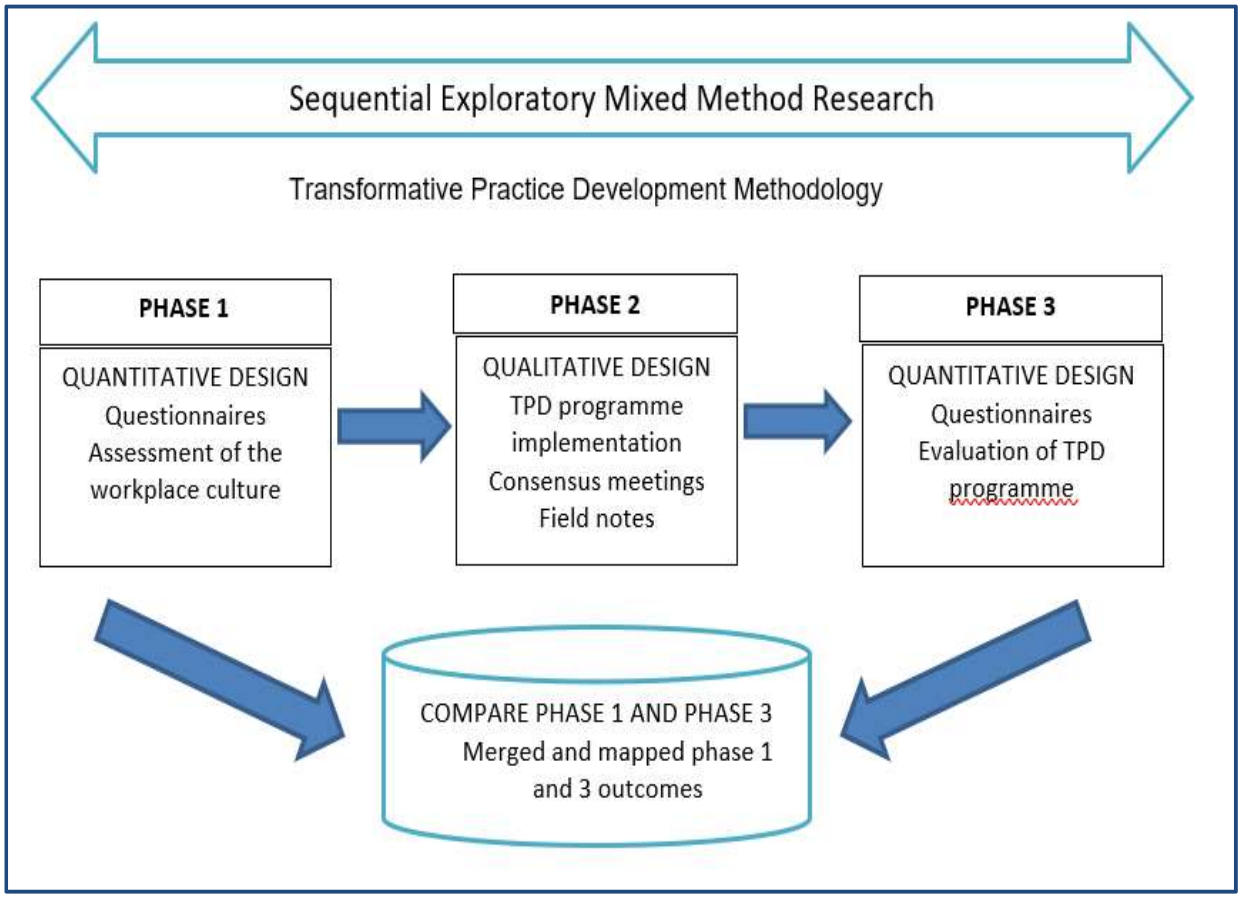


Figure 1.2 Process flow during the TPD programme

1.10.2 Transformative practice development process

Transformative practice development is a continuous process of transforming workplace cultures for person-centredness (McCormack, Manley & Titchen 2013:83). In this study, the TPD process was made possible by the programme facilitators who engaged with the participant nurse educators and

managers to blend their personal qualities and creative imagination with practice skills and wisdom of experience.

The learning that took place included the transformation of individual and team practices. The programme facilitators facilitated the processes to implement the TPD programme at the PNEI towards transforming the workplace culture. The processes focused on human flourishing where TPD approaches emphasised creating an effective and person-centred culture in the PNEI. The participant nurse educators and nurse managers became the primary focus rather than providers of tasks and services needed by the organisation (McCormack, Manley & Titchen 2014:84).

1.10.3 Transformative practice development programme facilitators

The TPD programme facilitators created opportunities for the participants to explain and explore individual experiences during implementation of the TPD programme. The facilitators used emancipatory action research processes that were collaborative, inclusive and participative and included participant reflection (Trede &Titchen 2012:14). During implementation of the TPD programme the facilitators needed to develop self-knowledge and awareness of the impact they had on others and set fundamental skills for use consistently in both TPD programme activities and daily work. The key skills for the programme facilitators were active listening, giving and receiving constructive feedback, asking enabling questions and providing a challenging and supportive environment (McCormack, Manley &Titchen 2013:110).

Fourteen programme facilitators participated and the researcher provided support to all the facilitators and participants during the TPD programme implementation (McCormack, Manley & Titchen 2013:111). The implementation of the TPD programme took nine months, from February to November 2019, and included three phases: assessment, implementation and evaluation of outcomes. The programme facilitators assisted the participants to de-construct and reconstruct their context through collaboration, inclusion, participation and reflexivity towards the transformative process (Trede &Titchen 2012:3; Parlour & McCormack 2012:311).

1.11 RESEARCH DESIGN AND METHODOLOGY

A research design refers to the overall plan for addressing a research question, including the specifications for enhancing the integrity of the study (Polit & Beck 2012:741). Grove, Burns and Gray (2013:214) describe a research design as a blueprint for conducting a study and controlling factors

that could interfere with the validity of the findings. This study wished to explore and describe the participants' experiences of the workplace culture of the PNEI in order to transform the workplace culture to person-centredness, using a mixed methods research design with qualitative and quantitative phases. The researcher conducted the study in three phases. Phase 1 assessed the workplace culture. Phase 2 implemented the TPD programme. Phase 3 evaluated the programme outcomes of the workplace culture after implementation of the TPD programme. The researcher merged, mapped and evaluated the programme outcomes for phase 1 and 3. Table 1.1 outlines the research design and methodology.

Table 1.1 Research design and methodology

<table>
<tr><td colspan="5">Phase 1: Assessment of the workplace culture</td></tr>
<tr><td colspan="5">Objective 1: To assess the workplace culture of the selected PNEI
• Step 1: Adaptation of the assessment tool
• Step 2: Pilot test
• Step 3: Distribution and collection of questionnaires</td></tr>
<tr><td colspan="5">Research design – Quantitative (descriptive explanatory)</td></tr>
<tr><td>Population</td><td>Sampling</td><td>Data collection</td><td>Data analysis</td><td>Rigor</td></tr>
<tr><td>All academic staff: principal, vice principal, heads of departments, nurse educators: 92 academic staff</td><td>Type:
Total population
Size: 92</td><td>Self-administered questionnaires</td><td>Descriptive analysis</td><td>Validity
Reliability</td></tr>
<tr><td colspan="5">Phase 1 Procedures: 1. Arranged appointment for presentation of the study. 2. Information session for the study. 3. Obtained informed consent, distributed participant information leaflets and participants returned to box 1. 4. Distributed the PCPI tool to all participants. 5. Allowed 30 minutes to fill the PCPI tool. 6. Participants returned PCPI tool separately in box 2 to maintain confidentiality. 7. Served refreshments to thank participants.</td></tr>
<tr><td colspan="5">Phase 2: TPD programme implementation</td></tr>
<tr><td colspan="5">Objective 2: To implement the TPD program
• Stage 1: Preparatory phase for TPD program implementation
• Stage 2: Co-construction of the TPD program
• Stage 3: Implementing the TPD program</td></tr>
<tr><td colspan="5">Research design – Qualitative (descriptive exploratory)</td></tr>
<tr><td>Population</td><td>Sampling</td><td>Data collection</td><td>Data analysis</td><td>Rigor</td></tr>
<tr><td>All academic staff: principal, vice principal, heads of departments, nurse educators: 92 academic staff members</td><td>Type:
Purposive
Size:46</td><td>Workshops
Consensus meetings
Feedback sessions
Field and reflective notes</td><td>Content analysis
Consensus through ranking and voting</td><td>Credibility
Transformability
Dependability
Confirmability
Authenticity</td></tr>
<tr><td colspan="5">Phase 2 Procedures: 1. Got volunteers to facilitate. 2. Conducted intervention topics in workshops with programme facilitators and provided role clarification, collaborative, inclusive and participative implementation (3 hours). 3. Obtained consent forms from programme facilitators. 4. Developed the TPD programme project plan and created groups for facilitation together with programme facilitators. 5. Used phase 1 outcomes to co-construct a full TPD programme consisting of workshops for implementation by programme facilitators in their relevant groups. Explored programme facilitators, nurse educators and managers' experiences during feedback sessions.</td></tr>
</table>

<table>
<tr><td colspan="5">Phase 3: Evaluation of workplace culture outcomes after TPD programme implementation (merging and mapping outcomes)</td></tr>
<tr><td colspan="5">Objective 3: Evaluate the current workplace culture of the selected PNEI after TPD programme implementation.
• Step 1: Obtained consent forms for post evaluation after TPD programme implementation
• Distributed and collected self-administered questionnaires after TPD programme implementation
• Step 2: Merged, mapped and compared phase 1 and phase 3 outcomes towards transforming the workplace culture.</td></tr>
<tr><td colspan="5">Research design – Quantitative (descriptive explanatory)</td></tr>
<tr><td>Population</td><td>Sampling</td><td>Data collection</td><td>Data analysis</td><td>Rigor</td></tr>
<tr><td>All academic staff: principal, vice principal, heads of departments, nurse educators: 92 academic staff members</td><td>Type:
Total population
Size:46</td><td>Self-administered questionnaires</td><td>Descriptive analysis</td><td>Validity
Reliability</td></tr>
<tr><td colspan="5">Phase 3 Procedures: Self-administered questionnaires. Merged, mapped and compared phase 1 and phase 3 outcomes towards transforming the workplace culture.</td></tr>
</table>

1.11.1 Phase 1: Assessment of the workplace culture

Phase 1 assessed the current workplace culture of the PNEI. The researcher arranged a meeting and addressed staff members, presented a *PowerPoint* presentation on the study and requested participation. The researcher distributed participant information leaflets and informed consent forms and provided a sealed box with an opening for participants to deposit the participant information leaflets and signed informed consent forms. The participants who volunteered to participate, posted the information leaflets and informed consent in the sealed box.

A quantitative method was followed in phase 1 and the results of this phase were used to inform phase 2 of TPD programme implementation (Creswell 2014:15).

1.11.1.1 Phase 1 Population

A research population refers to the entire set of elements, individuals or objects having some common characteristics in which a researcher is interested (Polit & Beck 2017:337). The population encompasses all elements that meet certain criteria for inclusion in a study (Grove, Burns & Gray 2013:544). Polit and Beck (2017:338) distinguish between the target and the accessible population. The target population refers to the entire group of individuals about which the researcher would like to generalize. The accessible population is the subset of the target population that are accessible as participants for the study.

In this study, the target and accessible population were all the academic staff members, namely, one principal and deputy principal, eight heads of departments, and 82 nurse educators, totalling 92 potential participants. Table 1.2 lists the population for phase 1.

Table 1.2 Population at the PNEI

Position at work	Number of Persons
Principal	1
Vice Principal	1
Head of department	8
Nurse educators	82
Total	**92**

1.11.1.2 Phase 1 Sampling and sample

Sampling refers to the practice of selecting a portion of the population in order to describe and analyse the characteristics of the phenomenon under study (Polit & Beck 2017:275). A sample refers to a subset of a population (individuals, elements or objects) or a group selected to act as representative of the population as a whole (Polit & Beck 2017:275). In this study, the total population of participants at the PNEI were invited to participate.

a) Inclusion and exclusion criteria

To be included in the study, the participants had to be academic staff employed for more than six months to ensure that they had sufficient experience of the PNEI workplace culture. The six months work experience at the PNEI would provide reasonable exposure and experience pertaining to the workplace culture practices to indicate whether the workplace culture was person-centred or not. In this phase, the inclusion criteria were all nurse educators and nurse managers that has been employed for more than six months at the PNEI and had signed the informed consent forms to volunteer to participate in the study. Exclusion criteria was all nurse educators and managers employed for less than six months at the PNEI and did not sign the consent form to participate in the study.

b) Sample

Sixty-three participants who met the inclusion criteria and volunteered to participate, returned the completed questionnaires and consent forms.

1.11.1.3 Phase 1 Data collection

Data collection is the process of collecting information (data) related to research questions in a systematic way to address a research problem (Polit & Beck 2017:725).

In order to explore and assess the current workplace culture of the PNEI in the study, data was collected using McCormack, Manley and Titchen's (2014:8) person-centred practice inventory (PCPI) assessment tool. The participants were allocated 30 minutes to complete the questionnaire.

a) Step 1: Adaptation of the assessment tool

Data was collected using the PCPI assessment tool (McCormack, Manley & Titchen, 2014), consisting of four sections:

- Section A: Demographic profile
- Section B: Person-centred workplace culture variables (PCPI)
- Section C: Collaboration, inclusion and participation (CPI) principles
- Section D: Workplace culture (WC) for person-centredness

The researcher adapted the assessment tool for the South African context to fit nursing education practice (see Annexure C:5 for permission to use and adapt the tool in the South African context). The tool was developed and used to assess a person-centred approach in clinical areas for nursing care in the United States of America (McCormack, Manley & Titchen 2014). During adaptation of the tool, the concepts related to clinical practice were changed to concepts that related to nursing education and training in order to provide information on nursing education and training and not on clinical practice. The concepts related to the values and beliefs of person-centredness in questions were not changed so that the participants were guided to share their experience of their workplace culture values and beliefs. The order of questions was not changed as the flow of the questions was relevant to nursing education and training. Four nursing education experts, with experience in nursing education practice, assisted the researcher to examine the concepts of each question in the tool to check whether the questions were phrased correctly to seek information related to person-centred workplace values and beliefs for the PNEI.

b) Step 2: Pilot test of questionnaire

Polit and Beck (2017:739) define a pilot test as a small-scale version or trial run done in preparation for a major study or to test feasibility. The pilot test assisted to assess the feasibility of the questionnaire and to determine if modifications of the questions were required. The researcher conducted a pilot test before the main study with five nurse educators who were not included in the

main study. The participants were invited verbally at a meeting in January 2019. The participants took 25 to 30 minutes to complete the questionnaire and reported that the questions were clear and acceptable. Based on their feedback, no changes were made to the questionnaire.

c) Step 3: Distribution and collection of the questionnaires

To assess the workplace culture for person-centredness, the questionnaires were distributed and collected from the PNEI as pre-arranged with management. During this phase, the processes included presentation to staff members in a personnel meeting, requesting voluntary participation. The recruitment meetings took place in February 2019. After the researcher placed an invitation to attend the research recruitment meeting on the bulletin board, 92 participants attended the research recruitment meeting. The researcher presented the research proposal and after that requested voluntary participation, informing participants they had the right to withdraw at any time without penalty should they wish to do so. The researcher assured the participants of confidentiality and anonymity. The researcher distributed 92 questionnaires and information leaflets and consent forms to the academic staff who indicated willingness to participate**.** The researcher made two boxes available, both labelled and closed for confidentiality with an opening, for respondents to drop the consent forms and questionnaires which was collected at the end of February 2019. Sixty-three completed questionnaires and consent forms were returned.

1.11.1.4 Phase 1 Data analysis

Data analysis is the systematic organisation and synthesis of research data (Polit & Beck 2012:725; Gray et al. 2017:695). Quantitative data analysis is the manipulation of numerical data through statistical procedures for the purpose of describing phenomena or assessing the magnitude and reliability of relationships among them (Polit & Beck 2017:741). Quantitative data analysis includes simple to complex computing procedures (Polit & Beck 2017:742). The statistical data was analysed using descriptive statistical analysis with the assistance of a statistician (see Annexure E:2). Reliability of the descriptive statistical analysis was done using Cronbach's Alpha method. Subscales for PCPI, CIP and workplace culture were created by calculating the means across the relevant items or questions. Descriptive statistics such as means, standard deviations and medians were computed for the pre- and post-subscales across the demographic variables. The median scores of the pre- and post-subscales were also compared across the demographic variables by performing the Mann-Whitney U test. Pearson chi square tests were computed to test whether there were associations between the demographic variables and the Pre- and Post-groups. Lastly, the Mann-Whitney U test was performed to compare the median scores of the three subscales across pre and post.

1.11.1.5 Phase 1 Data interpretation

Data interpretation is the process of making sense of study results and examining their implications (Polit & Beck 2017:745). Researchers attempt to explain the findings in light of prior evidence, theory, clinical experience and the adequacy of the methods used in the study. In this study, the researcher explained and described phase 1 results after discussion with the supervisors (see chapter 3).

1.11.1.6 Phase 1 Validity and reliability

The quality and rigour of research is determined by its validity and reliability.

a) Validity

Validity is the degree to which an instrument measures what it is supposed to measure (Polit & Beck 2017:747). The measurement of whether the TPD programme would transform the workplace culture to person-centredness or improve the workplace culture to person-centredness were key influences on the quality and expectations of the study. Phase 1 data were collected with questions that measured multiple dimensions of person-centredness, CIP principles and workplace culture practices in order to describe the workplace culture practices and person-centred behaviours. The questions assessed the PNEI's workplace culture for person-centredness. In this study, validity was assured by asking four nursing education experts to adapt the PCPI tool within the South African context of nursing education practice. The researcher, the supervisors and the nurse education experts checked, changed and adapted the items of the original questionnaire to address person-centredness within the nursing education context. The items were validated to ascertain if they would assess a person-centred workplace culture. Analytical methods were used to determine validity of the questionnaire outcomes such as Chi-square test, Alpha Cronbach and p-value were applied. The tool had 57 items with a four point scale (strongly disagree, disagree and strongly agree, agree) with 30 minutes time to complete it.

b) Reliability

Reliability is "the extent to which measures are consistent or repeatable over time" (Brink, van der Walt & van Rensburg 2018:157). Reliability refers to "the degree of consistency or dependability with which the instrument measures the attribute it is designed to measure. If the instrument is reliable, the results will be the same each time the test is repeated" (Polit & Beck 2017:747).

In this study, reliability was achieved by conducting a pilot test using the same questionnaire to exclude measurement errors from the assessment tool. The intervention in phase 2 resulted in meaningful impacts in phase 3. In this study, the pre-test (before TPD), and post-test (after TPD) were used simultaneously for phase 1 and phase 3 outcomes for comparison (see chapter 7).

The internal consistency of the statements on person-centredness, collaboration principles and culture were measured for reliability using the Cronbach's alpha. This indicated how closely related a set of statements are as a group and was a measure of scale reliability. As the average inter-item correlation increases, Cronbach's alpha increases as well (holding the number of items constant). For Section B Cronbach's Alpha was .854, for Section C .913, and for Section D .925, indicating good internal reliability. The questionnaire outcomes of Phase 1 were also compared with questionnaire outcomes of Phase 3 using the same assessment tool and similar respondents, 12 months apart.

In order to achieve statistical reliability, a statistician analysed and interpreted the statistical results. Statistical reliability refers to the probability that the results represented the larger group and not only the participants in a study (Polit & Beck, 2017:772). The statistician used descriptive statistical analysis to interpret the raw data and presented the results in tables, percentages, and graphs.

1.11.2 Phase 2: Transformative practice development programme implementation

The researcher implemented the TPD programme with the guidance of the Practice Development Conceptual Framework processes (McCormack, Manley & Titchen 2014:8). The researcher co-constructed the TPD programme implementation activities together with the programme facilitators towards transforming the workplace culture to person-centredness. Participation of the programme facilitators was voluntary, and the researcher explained their roles and responsibilities. The researcher and the programme facilitators drew up collaborative, inclusive and participatory project plan activities for the TPD programme implementation (see chapter 3 for planning conducted with programme facilitators and Annexure D:1). See chapter 6 for implementation of the TPD programme.

1.11.2.1 Phase 2 Population

The researcher invited the total population of 92 participants (82 nurse educators and 10 nurse managers) as potential participants for phase 2. The participants were invited to volunteer to participate in the implementation of the TPD programme and to volunteer as programme facilitators to facilitate the programme in phase 2.

1.11.2.2 Phase 2 Sampling and sample

In this study phase, non-probability or purposive sampling was used. Nurse educators were selected to be participants from the staff population at the PNEI. The nurse educators were the ideal potential participants selected to conduct the research for the academic department regarding the teaching and learning workplace culture. Purposive sample refers to selecting "subjects typical of the population in question or particularly knowledgeable about the issues under study'' (Brink et al. 2018:124).

a) Inclusion criteria and exclusion criteria

In this phase, the inclusion criteria were all nurse educators and nurse managers that has been employed for more than six months at the PNEI and had signed the informed consent forms to volunteer to participate in the study. Exclusion criteria was all nurse educators and managers employed for less than six months at the PNEI and did not sign the consent form to participate in the study.

b) Sample

According to Polit and Beck (2017:493), the key issues is to get a sample size big enough to generate enough in-depth data that can illuminate the patterns, categories and dimensions of the phenomenon applicable to the study. Out of the total population of 92 potential participants, 46 participants (nurse educators and nurse managers) volunteered to participate in the implementation of the TPD programme, which included 14 participants that volunteered to become programme facilitators. All 46 participants signed the informed consent forms to participate in the implementation of the TPD programme. The 14 programme facilitators signed informed consent to become program facilitators.

1.11.2.3 Phase 2 Programme implementation

The TPD programme was implemented in four stages: Preparation phase; co-construction of the TPD programme; implementation of the TPD programme, and feedback and evaluation of outcomes.

a) Stage 1: Preparation phase

The preparation phase consisted of baseline data collection and analysis during consensus meetings.

- **Baseline data collection**

Consensus meetings involve experts and professionals who share their views, decisions and judgements in reviewing aspects of practice, education and research priorities (Moule, Aveyard &

Goodman 2016:167). During the first two consensus meetings, baseline data were collected and analysed to generate themes to implement during the TPD programme (see chapter 6). Baseline data were collected to explore the participants' experiences of the workplace culture for person-centredness and to identify the themes for the TPD programme. The baseline data reflected the participants' perceptions of the workplace culture for person-centredness. Data were collected during two consensus meetings on 18 February and 3 May 2019, lasting six hours each. Two external nurse education experts with research expertise assisted to facilitate the consensus meetings in a lecture room free from disturbances, with an overhead projector and a whiteboard.

The consensus meetings consisted of five stages:

- In the first stage, the facilitators explained the purpose of the study and participants signed informed consent forms.
- In the second stage, the participants responded to questions.
- In the third stage, the participants shared ideas.
- The fourth stage allowed time for clarifying and discussing ideas.
- In the fifth stage, the participants voted and ranked ideas and themes.

The 46 participants were divided into small groups with six to seven participants in each group. Within their groups, participants worked together towards answering the main research question: "How can the workplace culture be transformed to person-centeredness?" The external facilitators posed five guiding questions to generate responses to the main research question, namely, "I believe the ultimate purpose of this practical development programme is…"; "I believe this purpose can be achieved by …"; "I believe the factors that will help us achieve this purpose are…"; "I believe the factors that will hinder us from achieving this purpose are..", and "Other values and beliefs that I consider important in relation to this practice development programme are…". Initially, the participants were instructed to write down their individual responses, and then combine their responses as a group. The answers generated by each group were displayed on a whiteboard and analysed by the whole group with the help of facilitators.

- **Baseline data analysis**

Data were analysed during the consensus meetings using Tesch's method (Creswell & Creswell 2018:182). All 46 participants contributed to the analysis of data towards generation of themes. Data analysis was facilitated by the two external nursing education experts. There were six small groups of six to seven participants per group that were tasked to rank the group themes as they unfolded in the consensus meeting. Each group ranked the themes in order of importance and showed their rankings

on a whiteboard. All the rankings of themes from all groups were also projected on a screen for transparency. The facilitators and participants discussed the proposed rankings until everybody agreed on the main themes for transforming the workplace culture to person-centeredness. The groups debated all disagreements in a friendly and acceptable manner until they agreed on the themes. All the groups received a hard copy of the final results and were requested to provide feedback and input to facilitate refinement and interpretation of the final themes (du Plooy-Cilliers, Davis & Bezuidenhout 2015:242).

Open coding was used during data analysis to generate relevant themes. In open coding, the themes are generated as the researcher works through the raw data. The data collected were treated as text analogues for explorative and descriptive data analysis. Content analysis was done using Tesch's method of open coding in thematic data analysis (Creswell & Creswell 2018:186), using the following steps:

- Read carefully through all written transcripts in order to get a general overall feeling for the written data and write down ideas that come to mind.
- Randomly choose one written transcript and read through it, answering the following questions, "what is it about? what is the underlying meaning?"
- Repeat the previous step for all written data (transcripts), then make a list of all topics, and cluster similar ones together. Draw three columns marked major topics, unique topics, and leftovers.
- Find the most descriptive topics and turn them into categories, grouping related topics together and drawing lines to indicate interrelationship.
- Make a final abbreviation for each category and alphabetize these codes
- Assemble the data for each category in one place and perform a preliminary analysis. (It is important to note unusual or useful quotes that can later be incorporated into the qualitative story).
- Re-code the existing data, if necessary.

The external nursing experts, participants and the researcher used the above protocol during consensus meetings.

Data analysis took place on 18 February 2019 and 3 May 2019 during the consensus meetings (see chapter 6 for the results obtained after reaching group consensus on themes during coding). The baseline data represented the participants' perceptions of person-centredness. Three main themes emerged: positive work relations (see chapter 6), and communication and leadership (see chapter 5).

The TPD programme implementation focused on the three main themes to transform the workplace culture to person-centredness.

b) Stage 2: Co-construction of the TPD programme

Practice development is complex and multifaceted; therefore, it needs programme facilitators with the necessary skills to transform the workplace culture and context using reflection to change what needs to change (McCormack, Manley & Titchen 2013:22). Programme facilitators have an important role of connectivity for the achievement of a person-centred culture in the workplace (McCormack, Manley & Titchen 2013:109).

- **Programme facilitator recruitment**

The researcher explained the study to the academic staff at a meeting at the start of the study. An invitation was posted at the beginning of the study on the main bulletin board to request voluntary participation of programme facilitators in the study (See Annexure B:2 for an invitation for a meeting to recruit programme facilitators on 12 February 2019). There were 15 programme facilitators who volunteered, but one resigned and 14 programme facilitators remained in the study.

- **Programme facilitator sampling**

The researcher needed a maximum of 15 programme facilitators for the implementation of the TPD programme. in this study, purposive sampling was used to select programme facilitators. The researcher needed at least two programme facilitators from each of the six academic departments and from the management department. The facilitators demonstrated their willingness and passion to facilitate groups towards transformation.

- **Programme facilitator inclusion criteria and exclusion criteria**

Inclusion criteria for programme facilitators were all nurse educators and nurse managers who had worked for more than six months at the PNEI. Exclusion criteria were all nurse educators and nurse managers who had worked less than six months at the PNEI in any academic department.

- **Programme facilitator sample**

The 14 programme facilitators represented nurse educators and nurse managers from each of the seven departments at the PNEI. There were six academic departments and one management department at the PNEI. Each of the six academic departments and the management department were assigned two programme facilitators according to their nursing experience and expertise to facilitate transformation and feedback sessions (two programme facilitators per department, times

seven departments, equals 14 programme facilitators). The programme facilitators signed two informed consent forms, firstly when they consented to participate in phase 2, and secondly to agree to be programme facilitators in phase 2 (Refer to Annexure D:3 for a consent form for programme facilitators). There were no programme facilitators that withdrew from the study, only one programme facilitator resigned from the PNEI and 14 remained until the end of the study.

- **Roles and responsibilities of programme facilitators**

The roles and responsibilities of programme facilitators were explained in order to gain cooperation from the academic staff members at the PNEI. The consent form also discussed the roles and responsibilities so that they were informed of what to do and expect as programme facilitators during the study before they could give consent (see Annexure D:3). Sørensen, Stenberg and Garnweidner-Holme (2018:5) discuss facilitators' roles and responsibilities as summarized below:

Apply collaboration, inclusion and participation principles

- Facilitate the TPD programme workshops according to the planned schedule
- Attend bi-weekly and monthly feedback session meetings
- Prepare a venue for workshops to ensure physical and emotional comfort – making sure that it is clean and well ventilated
- Facilitate knowledge sharing of experiences between participants
- Capture**,** field notes from participants and report back at feedback sessions.

Ensure collaboration with participants

- Enhance participant collaborative skills, reflective skills and monitoring of activities during feedback sessions for the TPD programme implementation**.**
- Allocate sufficient time for participants to share reflections and engage in mutual learning and understanding.

Ensure relational and contextual facilitation skills

- Refrain from self-bias when capturing events and moments from participants in a respectful way.
- Invest in professional relations that build trust, respect and continuity.
- Improve participants' knowledge of each other's skills and roles through contextual knowledge.
- Educate participants about the benefits of TPD programme implementation for person-centredness

- **Orientation of TPD programme facilitators**

During the orientation session, the researcher refreshed the programme facilitators on the aim and objectives of the study and answered any questions. All 14 facilitators received full orientation and training on how to facilitate the implementation of the TPD programme successfully through workshops sessions.

- **Values clarification workshops**

The programme facilitators attended two workshops on how to facilitate the workshops during implementation of the TPD programme. The programme facilitators were trained to become facilitators of the TPD programme implementation and not fixers of the identified problems towards transforming the workplace culture to person-centredness. The programme facilitators were also trained on roles and responsibilities that needed to be undertaken during the workshop sessions.

The programme facilitators were invited to attend workshops on 5 March 2019 and 17 June 2019 to facilitate self-awareness and assist participants to understand and be aware of their workplace values and beliefs towards person-centredness and on how they wanted the workplace culture to be transformed. The workshops were facilitated by one of the researcher's supervisors who is a nursing education expert. The participants reflected on experiences of a person-centred workplace culture to lead to transformation of the PNEI. The participants were given sticky notes to reflect in writing on their workplace culture values and beliefs during the workshops in order to assist them to collect and give feedback during feedback sessions. Reflection was based on the dimensions of the practice development conceptual framework of shared values and beliefs, which provide guidelines on being and becoming person-centred, learning together and being real about their workplace culture of person-centredness (see Figure 1.1).

b) Stage 3: Implementation of the TPD programme

The participants participated in the implementation of the TPD programme during workshops presented by the programme facilitators. The programme facilitators had to prepare for presentation of workshops for the TPD programme implementation using PowerPoint presentations. The programme facilitators had to forward their PowerPoint presentations to other programme facilitators for proofreading, reflection and feedback before facilitation of the workshops for quality assurance and authenticity of the presentation. The researcher and programme facilitators presented the topics to transform the workplace culture to person-centredness. The programme facilitators conducted one or two workshops per month according to the schedule between February 2019 and November 2019 (see chapter 6). Both the researcher and programme facilitators planned and facilitated feedback

sessions after each workshop. The researcher and programme facilitators used questions and actions from Beukes (2011:42) to develop and plan the TPD programme (see chapter 6 for a co-constructed TPD programme for transforming the workplace culture to person-centredness).

The implementation of the TPD programme by the programme facilitators was guided by the practice development conceptual framework processes through collaboration, inclusion and participation (McCormack, Dewing, Breslin, Coyne-Nevin et al. 2010:104). According to Filmalter, van Eeden, de Kock, McCormack, Coetzee, Rossouw and Heyns (2015:3), programme facilitators assist participants not to become fixers of identified problems, but find their own unique solutions to transform the workplace culture for person-centredness. During the workshops, the programme facilitators covered topics to transform the workplace culture to person-centredness. Person-centred collaborative activities were achieved by engaging the participants with critical questions. The participants reflected, worked in groups, learned together and engaged in active reflective practices during the workshops and feedback sessions. The programme facilitators and the researcher ensured that the participants' views were included through collective discussions about teaching experiences, personal and professional development and exposure to different workplace cultures. The participants were guided in the use of collaborative principles that required active involvement in sharing workplace values and beliefs, active participation and inclusion in all activities.

c) Stage 4: Feedback sessions and evaluation of programme outcomes

The feedback sessions consisted of data collection and analysis.

- **Data collection during programme implementation**

Twelve feedback sessions were conducted between February and November 2019 after each workshop to generate data on the outcomes of the TPD programme (Garbett, Hardy, Manley, Titchen & McCormack, 2007). The feedback sessions with the programme facilitators were conducted on scheduled dates, based on the availability of the programme facilitators between March 2019 and November 2019.

The researcher and programme facilitators recorded field notes and narratives during implementation of the TPD programme. Data were also captured from the feedback session meetings. In the different departments, the programme facilitators assisted to write field notes, facilitated feedback sessions, and encouraged active engagement of participants during the feedback sessions. The participants recorded reflective notes and shared ideas during feedback sessions about the workshops and how they experienced the TPD programme implementation. Data was collected using field notes,

narratives and recordings of the feedback sessions. Data saturation was achieved when the participants provided no new information.

- **Data analysis during programme implementation**

The same process of data analysis followed during the consensus meetings in stage 1, was implemented in the feedback sessions. The programme facilitators compiled a report after each feedback session and reported to the researcher. The findings of this phase were compared with the results of phase 1 to achieve final outcomes for the study and recommendations for implementation of the TPD programme.

1.11.2.4 Phase 2 Trustworthiness

Trustworthiness is "the degree of confidence that qualitative researchers have in their data, using the strategies of credibility, dependability, confirmability, transferability and authenticity" (Polit & Beck 2017:345).

a) Credibility

Moule and Goodman (2014:199, 455) state that a study retains credible findings if it reflects the experience and perceptions of the participants. The use of triangulation in data collection, prolonged engagement in the field and member checking are ways of ensuring credibility. In terms of participant triangulation, nurse managers and educators were used. Different methods were used, namely, consensus meetings, workshops and feedback sessions. The researcher and programme facilitators took field notes. The researcher had prolonged engagement with the participants during consensus meetings, workshops, and feedback sessions during implementation of the TPD programme which allowed for building of trust.

b) Confirmability

Confirmability refers to the objectivity, accuracy, relevance, or meaning of the data and the extent to which the data and interpretations reflect the phenomenon under study (Moule & Goodman 2014:455). The data was a true reflection of the information the participants provided, and the interpretation did not reflect the researcher's perceptions (Polit & Beck 2017:345). The researcher and the programme facilitators kept field notes which confirmed that collaborative, inclusive and participative principles were applied during TPD programme implementation (McCormack, Manley & Titchen 2013:52). The researcher and the programme facilitators continuously kept a written trail of the research activities in

a transparent manner that described the research steps from the start of the TPD programme implementation. Recordings of the research activities were kept throughout the study.

c) Transferability

Transferability refers to the applicability of the study findings to other research contexts. In order to establish if findings are transferable, comprehensive descriptive data is needed to allow readers to evaluate its applicability of the findings to other contexts (Polit & Beck 2017:560). An in-depth description of the research population, sample and context (chapter 2) as well as the views of the participants and programme facilitators were given.

d) Dependability

Dependability refers to the reliability of data over a period of time and circumstances, which gives an indication of whether the findings of the study will be the same if it were to be repeated with the same or similar participants and in the same or similar context (Polit & Beck 2017:559). Experienced researchers facilitated the consensus meetings and checked the extracted themes from the consensus meetings and feedback sessions for dependability.

e) Authenticity

Authenticity entails showing the extent to which researchers show a range of different realities. It reflects the emotional tone of participants' experiences as they are lived by them (Polit & Beck 2017:560). The researcher and facilitators kept field notes to give a full description of the sense of the moods, feelings, experiences, communicative language and the context of experiences of participants during TPD programme facilitation (Polit & Beck 2017:559).

1.11.3 Phase 3: Evaluation of workplace culture after TPD programme implementation

The objective of Phase 3 was to evaluate the outcomes of the TPD programme to transform the PNEI workplace culture to person-centredness. In this phase, phase 1 and phase 3 outcomes were merged and mapped to produce themes towards transforming the workplace culture to person-centredness for the PNEI. The outcomes from both phase 1 of the quantitative study and phase 3 of the quantitative study were merged, mapped and compared to acquire a deeper understanding of statistical descriptive themes during evaluation (Creswell & Creswell 2018:229). Figure 3 illustrates procedures for phase 1 and phase 3.

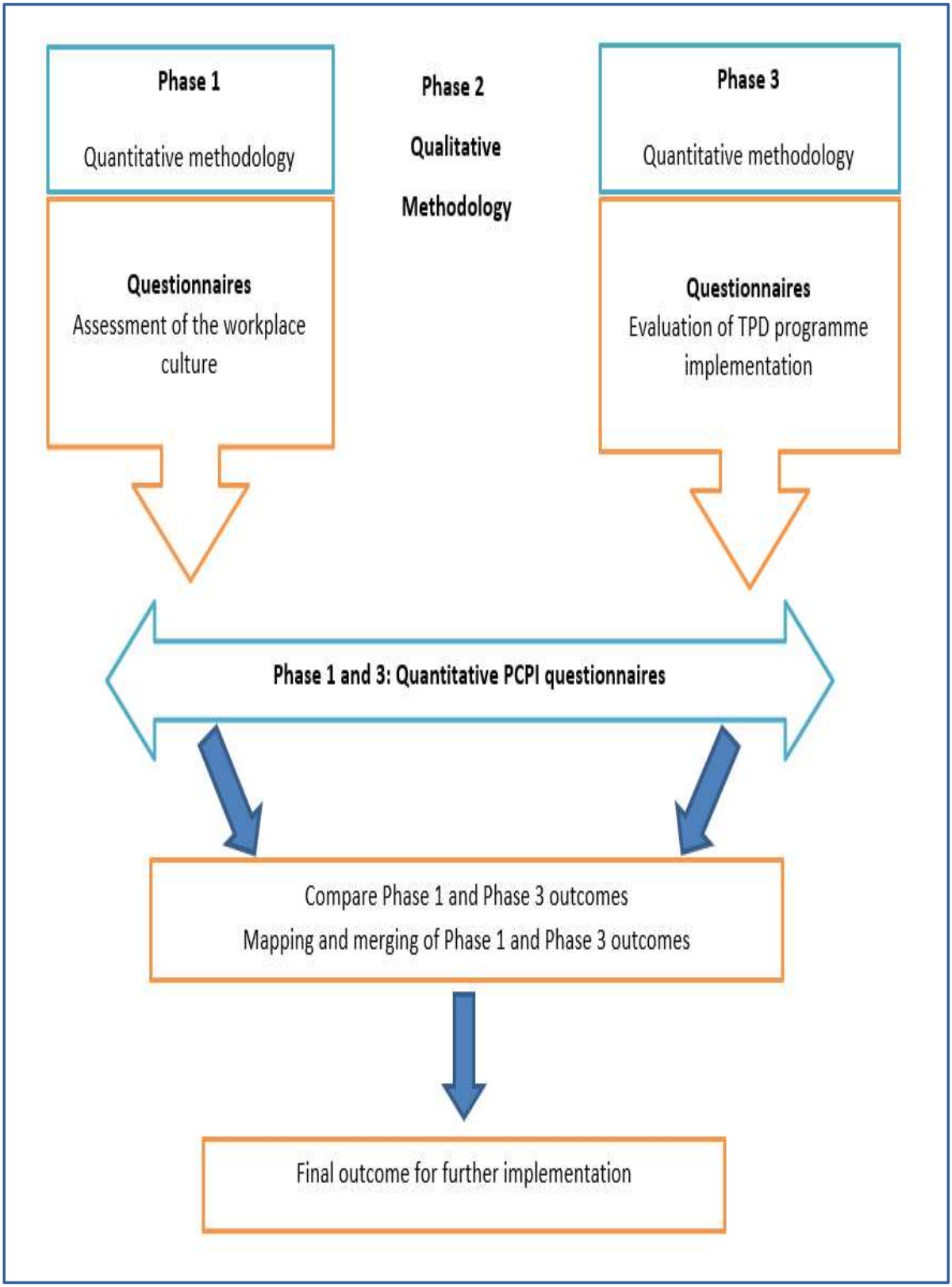


Figure 1.3 Procedures for phase 1 and 3

1.11.3.1 Phase 3 Methods

Two steps were followed in phase 3.

a) Step 1

In phase 3, all the procedures for phase 1 were repeated (see section 1.11.1.2), using the same population, sampling methods, inclusion criteria and questionnaire. For the sake of clarity in this research, consent forms had been distributed to all 92 potential participants during each of the three phases of the study to gain consent from participants to participate in each phase. It was important for the researcher to provide opportunities for all potential participants to participate in each phase of the study.

In phase 3, the researcher distributed 92 questionnaires. The researcher received 69 completed questionnaires and consent forms. There was an increase of six participants compared to phase 1. The cause of the increase of participants from 63 in phase 1 to 69 participants in phase 3 is not known, however, it can be interpreted as a positive move after the TPD programme was implemented.

The researcher distributed and collected the same self-administered questionnaires as for phase 1 after the TPD programme implementation. The data from the questionnaires were analysed in the same way as in phase 1. See chapter 7 for the results.

b) Step 2

The researcher merged, mapped and compared phase 1 and phase 3 outcomes to ascertain the changes that occurred during transforming the workplace culture to person-centredness. The outcomes of phase and 3 were compared using descriptive statistics, and the results presented in tables and graphs (see chapter 7 for the results).

1.12 RIGOUR

The TPD programme is categorised as transformative research where specific rigour applies. In transformative research, outcome, democratic, catalytic, and dialogic validity are applied (Herr & Anderson 2005:55-57). In this study, the outcomes of the quantitative phase 1 were compared with the outcomes of the quantitative phase 3 to determine if transformation took place after the implementation of the TPD programme in phase 2.

1.12.1 Outcome validity

Outcome validity considers proof of actions that were carried out to solve the stated problem (Herr & Anderson 2005:55-57). TPD programme outcomes were identified during phase 2 and phase 3 and wherever the researcher used the collaborative, inclusive and participative implementation principles to identify and solve workplace problems together with programme facilitators.

1.12.2 Democratic validity

Democratic validity refers to the extent to which participants' involvement was a collaborative effort during action research (Herr & Anderson 2005:55-57). In this study, the researcher worked collaboratively with the programme facilitators during phase 2.

1.12.3 Catalytic validity

Catalytic validity refers to the fitting role of change that takes place from both the researcher and the participants during action research (Herr & Anderson 2005:55-57). In this study, the researcher and the participants kept records of the changes that occurred in themselves and with and in the participants during the TPD programme implementation.

1.12.4 Dialogic validity

Dialogic validity looks at acceptance and approval of the research action reports through peer review processes (Herr & Anderson 2005:55-57). In this study, the researcher held peer review sessions with the programme facilitators to obtain different viewpoints on the study and results.

1.13 DEFINITIONS OF KEY TERMS

For the purposes of this study, the following key terms were used as defined below.

1.13.1 Public Nursing Education Institution

The South African Nursing Council (SANC) (2013:1) relates to a PNEI as a nursing education institution that provides nursing education to student nurses to become professional nurses and provides post-basic courses as approved by SANC. The Department of Health provides governance

to all PNEIs. All PNEIs are regulated by the provisions of the Nursing Act (no 33 of 2005). PNEIs provide quality nursing education in terms of the provisions of the Education Act (no 69 of 2008) and guidance of a university as assigned by the DoH. In this study, a PNEI referred to the PNEI at which the study was conducted.

1.13.2 Workplace culture

Barrientos-Trigo, Vega-Vazquez, De Diego-Cordero, Badanta-Romeo and Porcel-Galvez (2018:94) define a workplace culture as any context that consists of shared structures, routines, rules and norms that assist to provide guidance and control behaviour at work. In this study, the workplace culture referred to shared structures of nursing education activities for teaching and learning of student nurses within standard policies and procedures, rules and norms as applied to nurse educators and other relevant stakeholders. In this context, beliefs and values are clarified, learned and reinforced during collaboration with other nurse educators within a certain culture in the PNEI.

1.13.3 Nurse educator

A nurse educator refers to an academic staff member who is engaged in the dissemination of knowledge, involved in the critiquing and building of new knowledge as a researcher and innovator or by facilitating students to become researchers or scholars within an accredited education context (Crisp & Lincoln 2014:950). In this study, nurse educators referred to the participants who were qualified and employed at the PNEI under study to educate and train student nurses to become competent professional nurses in terms of R.425 of 19 February 1985 (as amended).

1.13.4 Person-centred approach

A person-centred approach refers to a set of personhood constructs that concerns treating people as individuals, respecting their rights as persons, building mutual trust and cultivating a therapeutic relationship (McCormack & McCance 2010:10) In this study, a person-centred approach referred to a workplace culture where nurse managers, nurse educators and student nurses treat each other with respect for their rights as persons to facilitate human flourishing. A person-centred approach also enables the development of positive workplace relationships to achieve nurse educator outcomes and organisational goals.

1.13.5 Nursing education management

Nursing education management refers to implementation of quality nursing education that leads to more effective nursing care and satisfied patients (Clement 2020:1). The PNEI under study is managed by nursing education managers who implement nursing education standards during training of student nurses towards attaining optimal nursing care to patients.

1.14 ETHICAL CONSIDERATIONS

Ethics deals with matters of right and wrong. When humans are used as study participants, care must be taken to ensure that their rights are protected (Polit & Beck 2017:139). Ethical considerations are concerned with the degree to which research procedures adhere to professional, legal and social obligations to study participants (Polit & Beck 2017:139). Accordingly, the researcher obtained permission to conduct the study and upheld the principles of beneficence, respect for human dignity, and justice.

The researcher obtained written ethical approval and permission to conduct the study from the University of Pretoria, Faculty of Health Science's Research Ethics Committee (see Annexure A:2) and from Gauteng Department of Health (see Annexure A:3) and the PNEI (see Annexure A:4).

1.14.1 Beneficence

Beneficence imposes a duty on researchers to maximize benefits and to minimize harm to participants and others (Polit & Beck 2017:141). The principle of beneficence assured the participants' right to freedom from harm and discomfort and to protection from exploitation (Polit & Beck 2017:141). The researcher ensured protection of personal information and showed respect to participants during all the study phases.

1.14.2 Respect for human dignity

Respect for human dignity includes the right to self-determination (Polit & Beck 2017:140). Self-determination means that participants can voluntarily decide whether to take part in a study, without risk of prejudicial treatment and freedom from coercion and have the right to full disclosure.

The researcher informed the participants of the purpose of the study, that participation in the study was voluntary and that they could withdraw from the study at any time if they wished to do so without penalty (Grove, Burns & Gray 2013:180). The participants were allowed to ask questions about study procedures. The participants signed informed consent forms to participate for each phase (see Annexures C:1, D:3, D:4). The participants' anonymity and confidentiality were affirmed by no names being given. During the study, one nurse educator withdrew because she resigned to work in another private institution.

1.14.3 Justice

The principle of justice includes the right to fair treatment and not to be discriminated and no intrusion into personal lives of participants (Polit & Beck 2017:141). In this study, no divulging of participants' information or names occurred; only numbers were attached to participants. The questionnaires and results were kept under lock and key in a safe cupboard and will be kept for 15 years and after that will be destroyed to protect the participants' identity.

During all consensus meetings and feedback session the researcher reminded the participants to keep the information confidential; to adopt non-judgemental attitudes and create a non-threatening environment free from harmful and egocentric cultural practices. The researcher and the participants established and agreed on rules to keep the study environment healthy and to protect all the participants.

The researcher and participants established the following ground rules prior to the workshops:

- Respect all inputs of participants.
- Cell phones on silent.
- Provide a safe place for psychological safety, non-judgmental environment and non-prejudice.
- Safe use of language.
- No ridiculing or making fun of other participants' inputs.
- No egocentric cultural practices.
- No disrespect for other participants of any nature.
- No disruption of meetings.

1.15 DISSEMINATION OF RESULTS

The results of the study are disseminated as a thesis. Articles were written for publication in accredited scientific journals and the findings presented at conferences and on research days. The results will be made available to the participants, the Gauteng Department of Health and the management of the PNEIs.

1.16 LAYOUT OF THE STUDY

Table 1.3 indicates the layout of the chapters. Chapter 1 outlines the study; chapter 2 describes the study context; chapters 3 to 6 were published and present the results and findings of the study as well as the programme implementation, while chapters 7 and 8 describe the outcomes, conclusions, limitations and recommendations of the study.

Table 1.3 Layout of the study

Chapter	Chapter title	Article
1	Overview of the study	
2	Research context	
3	Assessment of the workplace culture	Article 1: The workplace culture in a South African nursing education institution
4	Effective teamwork	Article 2: Promoting a person-centred workplace culture in a public nursing education institution in South Africa by fostering effective teamwork amongst nurse educators
5	Person-centred leadership	Article 3: Transforming workplace culture using person-centred leadership in a nursing education institution in South Africa
6	Implementation of the Transformative Practice Development programme	Article 4: Implementing a program to transform the workplace culture towards person-centredness in a public nursing education institution in South Africa
7	Merging and mapping of study phases	
8	Recommendations, limitations and conclusions of the study	

1.17 CONCLUSION

This chapter described the background, purpose, and research design and methodology of the study. The overall purpose of the study was to transform the workplace culture to person-centredness by implementing the TPD programme. Chapter 2 discusses the research context of the study.

CHAPTER 2
CONTEXT OF THE STUDY

2.1 INTRODUCTION

Chapter 1 outlined the problem, purpose, research design and methodology of the study. This chapter describes the context and setting in which the study was conducted. Polit and Beck (2017:392) define a research setting and context as the physical location and conditions under which data collection takes place in a study. In this study, the setting and context referred to a selected public nursing education institution (PNEI) in Gauteng Province, South Africa.

This chapter discusses the national, organisational, professional and policy context of the study.

2.2 NATIONAL CONTEXT

South Africa occupies the most southern tip of Africa with its long coastline stretching more than 3 000 km from the desert border with Namibia on the Atlantic coast southwards around the tip of Africa and then north to the border of subtropical Mozambique on the Indian Ocean. Most of South Africa's landscape is made up of high, flat areas called plateaus. These lands are covered with rolling grasslands, called Highveld, and tree-dotted plains called bushveld. To the east, south and west of the plateau lands is a mountainous region called the Great Escarpment (Mabogunje et al. 2021:1).

South Africa is listed as a third world or developing country with high unemployment and poverty rates despite having an abundance of goods and natural resources and being recognised as one of the largest industrialised countries in Africa in both wealth and Gross Domestic Product (Bakari & Ahmadi 2018:1). Developing countries are characterised by high rates of poverty; economic and/or political instability, and high mortality rates.

The public sector is a key component of the economy and plays a vital role in economic growth and development in a country (Fourie & Poggenpoel 2017; Inman & Rubinfeld 2013). The mandate of the public sector is to improve the general welfare of society by delivering public goods and services to individuals, and to private and other public sector organisations, playing a critical role in the country and global economy. Aspects impeding service delivery include incompetent public servants, a lack of accountability, poor human resource practices, inadequate procurement practices, and a lack of leadership. Key problem areas that have emerged include service delivery difficulties, poor management of finances, high levels of unemployment, nepotism and corruption (Cooperative Governance and Traditional Affairs, 2009; Fourie & Poggenpoel 2017).

2.2.1 Population statistics

In 2018, South Africa had an estimated population of 58.78 million people (Statistics South Africa [StatsSA] 2018). Of the population, 47.4 million were Black Africans, 5.2 million were Coloureds, 4.7 million were Whites, and 1.5 million were Indians/Asians (StatsSA 2018). Table 2.1 lists the estimated South African population by province and groups at mid-year 2018.

Table 2.1 South African population by provinces and groups, 2018

Province	Population per province	Population percentage	Total population per group
Gauteng	13.4 million	24.1 %	• Black Africans: 41 00 938 = 74.4% • Coloureds: 4 615 401 = 2.0% • Indians/Asians: 1 286 930 = 1.8% • Whites: 4 586 838 = 20.1% • Other unspecified: 280 454 = 0.005%
Free State	2 .8 million	5.1 %	
Limpopo	5.8 million	10.0 %	
Mpumalanga	4.3 million	7.8 %	
North West Province	3.7 million	6.7 %	
KwaZulu-Natal	11.1 million	19.9 %	
Eastern Cape	7.0 million	12.6 %	
Western Cape	6.3 million	11.3 %	
Northern Cape	1.2 million	2.1 %	

Source: StatsSA (2018)

Figure 2.1 illustrates the estimated South African population and groups at mid-year 2020.

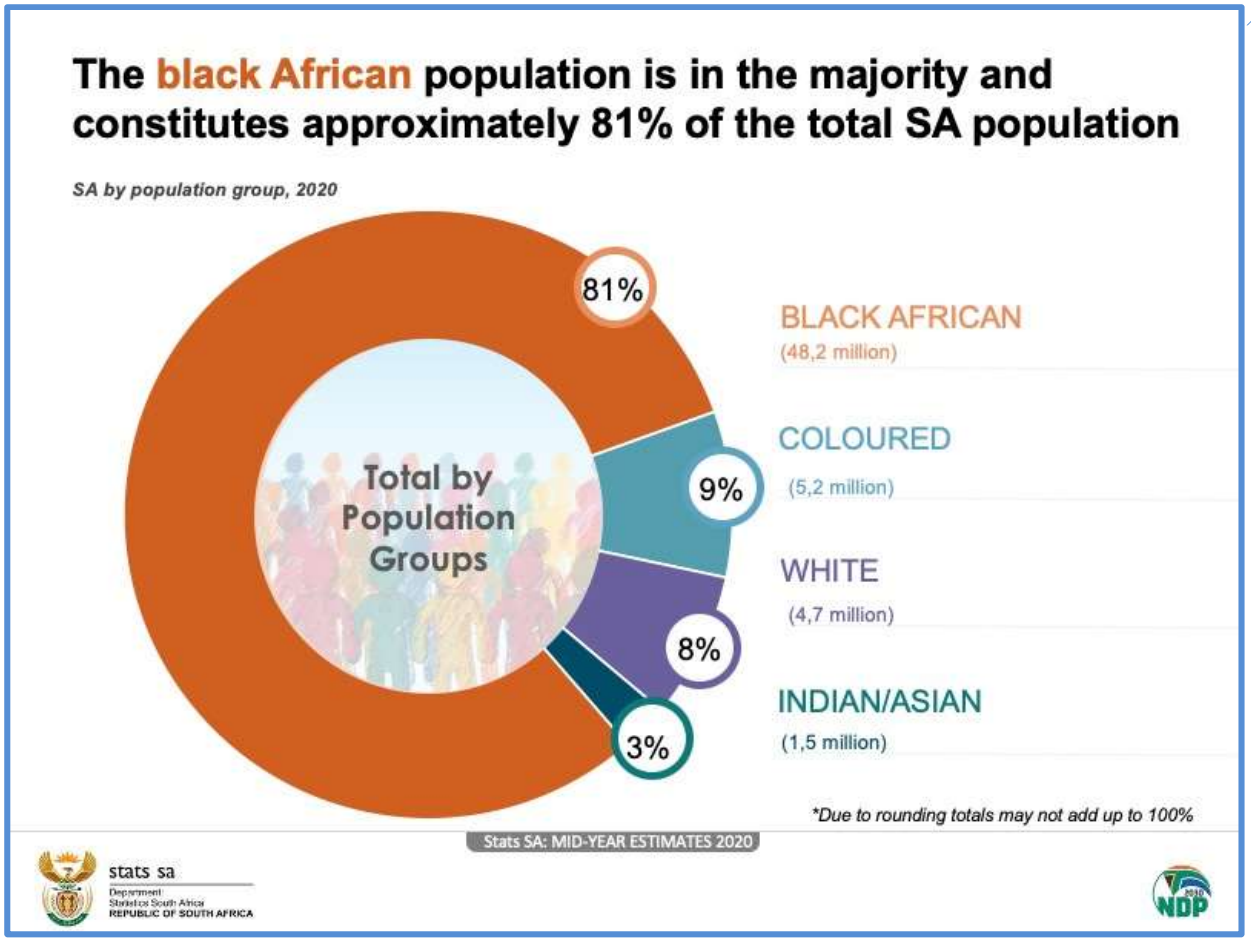


Figure 2.1 South African population groups, 2020

Source: StatsSA (2020)

2.2.2 Population of City X

The study was conducted in City X (not named for confidentiality reasons). The city where the study was conducted, in Gauteng Province, is the administrative capital of South Africa. It is among the six largest metropolitan municipalities in South Africa and the second largest as measured by Gross Domestic Product. The city region covers 6 368km^2 of Gauteng's 19 055km^2 (StatsSA 2016). In 2016, the city had an estimated population of 3 275 152 million, consisting of Black Africans (75.04%), Whites (20.08%), Coloureds (2.01%), and Indians/Asians (1.84%) (StatsSA 2016).

2.2.3 Poverty

StatsSA conducts annual General Household Surveys (GHS) which measure the living circumstances of South African households and collect data on education, health and social development, housing, access to services and facilities, food security, and agriculture.

The poverty threshold, poverty line or breadline, is the minimum level of income deemed adequate in a country. It is usually calculated by finding the total cost of all the essential resources that an average adult consumes in one year. The lower-bound poverty level (LBPL) adds expenditure on essential non-food items by households whose food expenditure is below but close to the food poverty line (FPL). The upper-bound poverty level (UBPL) refers to the food poverty level plus the average amount derived from non-food items of households whose food is equal to the food poverty line. In 2019, the UBPL in South Africa was R1,227.00 per person per month (estimated at April 2019 prices) (StatsSA 2019). The official poverty rate in South Africa in 2020 was 11.4%, the first increase in poverty in five years, and approximately 37.2 million people in South Africa were in poverty. This was exacerbated by the COVID-19 pandemic and national lockdown, and great loss of employment. The national inflation-adjusted poverty lines in April 2020 were: R585 FPL, R840 LBPL, and R1,268 UBPL (StatsSA 2019).

2.2.4 Health and health care

South Africa has a quadruple burden of disease resulting from communicable diseases (CDs) such as HIV/AIDS and Tuberculosis (TB); maternal and child mortality; non-communicable diseases such as hypertension and cardiovascular diseases, diabetes, cancer, mental illnesses and chronic lung diseases like asthma, and injury and trauma (StatsSA 2019). South Africa's biggest problem is that the health needs of its people exceed capacity. The vast majority of people actually do not know their health status which delays access to care. Moreover, the way the system is funded perpetuates inequality (StatsSA 2019).

Section 27(1) of the Constitution of South Africa (1996) states: "Everyone has the right to have access to – (a) health care services, including reproductive health care; (b) sufficient food and water, and (c) social security, including, if they are unable to support themselves and their dependants, appropriate social assistance."

The National Health Insurance (NHI) is a health financing system designed to pool funds to provide access to quality affordable personal health services for all South Africans based on their health needs, irrespective of their socio-economic status. In 2012, the government introduced NHI which would be implemented in phases over a 14-year period, starting in 2012. The objective of NHI is to provide access to quality health care for all South Africans as enshrined in the Constitution. The ultimate goal is to achieve Universal Health Coverage. The NHI Bill was presented to Parliament in 2019. It will still be some time before South Africa has full universal health coverage. The NHI Bill defines 'health care services' as "(a) health care services, including reproductive health care and emergency medical treatment, contemplated in section 27 of the Constitution; (b) basic nutrition and basic health care services contemplated in section 28(1)(c) of the Constitution; (c) medical treatment contemplated in section 35(2)(c) of the Constitution, and (d) where applicable, provincial, district and municipal health care services". Health coverage for asylum seekers and illegal foreigners starts and stops with emergency medical services. In particular, these classes of persons will not be covered and will not have the privilege of the NHI Fund's backing in accessing SRH, rare and dread diseases health care services (DoH 2019).

The majority of South Africans are dependent on public healthcare facilities for health care services (Mhlanga & Garidzirai 2020:4). In 2019, 71.5% of households used public healthcare facilities; 27.1% used private healthcare services, and 0.7% used traditional healers (StatsSA 2019).

In 2017, only 17 in 100 South Africans had medical insurance (medical aid), the essential key that opens the door to healthcare (StatsSA 2017). Table 2.2 indicates the population group access to private health care through medical aid in 2017.

Table 2.2 Population access to private health care through health insurance, 2017

Population access to private healthcare through health insurance				
White	Indian/Asian	Coloured	Black African	National Health Insurance coverage
72.9%	52%	17.1%	9.9%	16.4%

Source: StatsSA (2017)

The population statistics percentages in Table 2.2 refers to the citizens that have access to private healthcare through the national health insurance (medical aid) in the country from different population groups. The statistics indicate that 27% of Whites, 48% of Indian/Asians, 83% of

Coloureds, and 90% of Black Africans use public healthcare because they cannot afford medical aid. The 16.4% refers to the scope of the National Health Insurance coverage that is available in the country for all citizens.

Public healthcare is funded by the government from taxes and the healthcare segment has several challenges in health care delivery (StatsSA 2016; Young 2016:8; Maphumulo & Bhengu 2019). Figure 2.2 depicts pointers for health and development in South Africa's provinces, 2008.

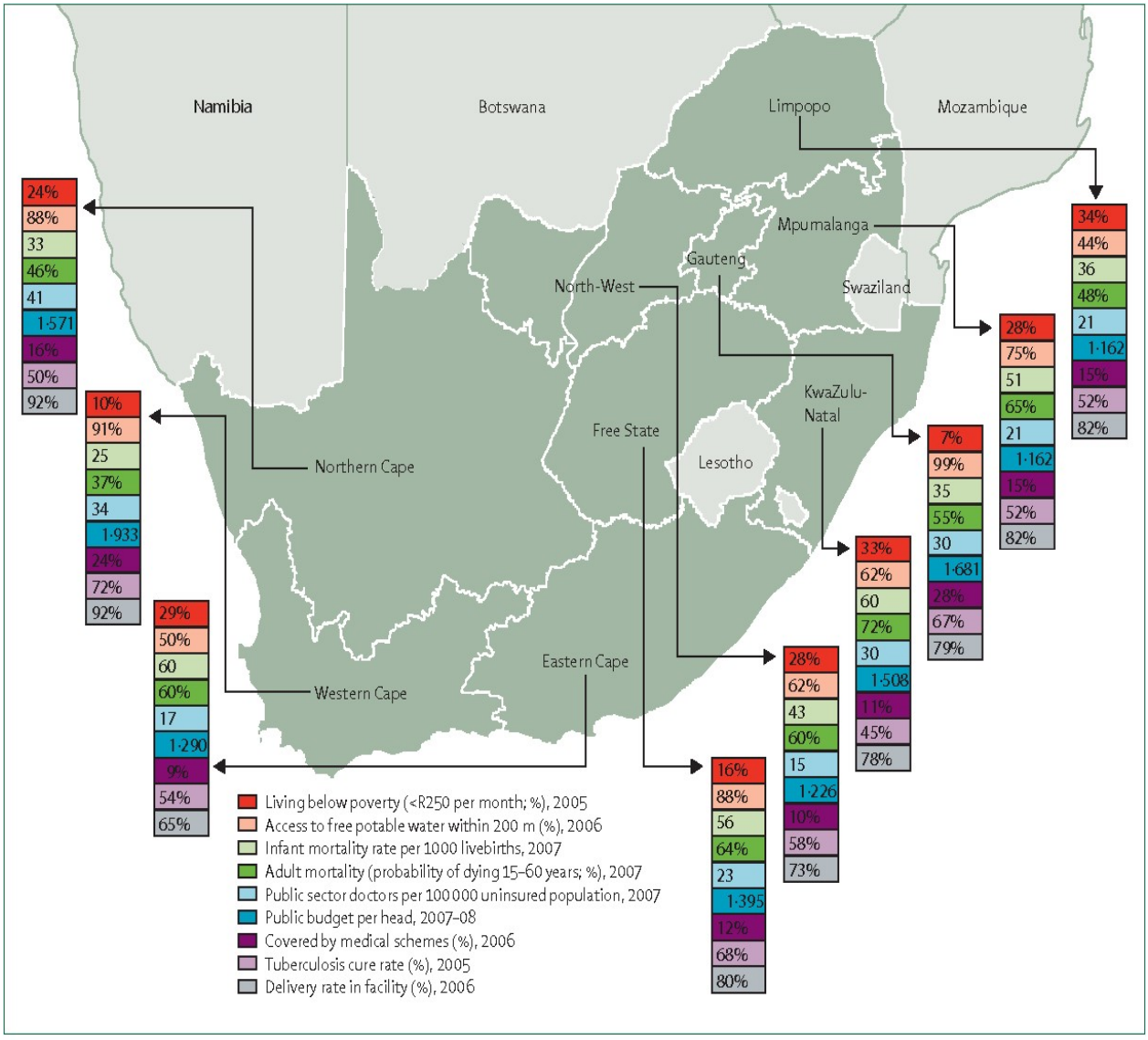


Figure 5: Indicators for health and development in South Africa's provinces, 2008
Data from reference 16. Reproduced with permission from reference 65 (Health Systems Trust, Durban).

Figure 2.2 Indicators for health and development in South Africa's provinces, 2008

Source: Health Systems Trust (2008)

South Africa has nine provinces. There are over 400 public and 200 private hospitals in South Africa. Larger public hospitals are managed at provincial level while smaller hospitals and primary health care clinics are managed at district level. Table 2.3 indicates the number of public and private hospitals and clinics in South Africa, by province, in 2016 (StatsSA 2016).

Table 2.3 Hospitals and clinics in South Africa, 2016

No	Province	Public hospitals	Private hospitals	Public clinics	Private clinics	Total
1	Western Cape	53	39	212	170	474
2	Northern Cape	16	2	131	10	159
3	North West	22	14	273	17	326
4	Mpumalanga	33	13	242	23	311
5	Limpopo	42	10	456	14	522
6	KwaZulu-Natal	77	12	592	95	776
7	Gauteng	39	83	333	286	741
8	Free State	34	13	212	22	281
9	Eastern Cape	91	17	731	44	883
Total		**407**	**203**	**3,863**	**610**	**5,083**

Each province is governed by local authorities or municipalities that are responsible for maintaining the growth and development of local infrastructure and essential healthcare services in alignment with the national health promotion policy and strategy, 2015-2019 (DoH 2015). Effective health care delivery faces many challenges.

Table 2.4 lists the 2016 death statistics in South Africa (StatsSA 2016) and Table 2.5 lists the top 10 causes of death from disease in South Africa in 2016 (StatsSA 2016).

Table 2.4 Deaths recorded in 2016

Item	No of deaths, 2016	Males	Females
Deaths in South Africa in 2016	456 612	• 240 001 • 52,7%	• 214 988 • 47.3%
Gender unspecified	1 623	-	-
Deaths due to non-communicable diseases	57.4%	-	-
Deaths due to communicable diseases	31.3%	-	-
Deaths due to injuries	11.2%	-	-
Male deaths at 60-64 years old	-	8.6%	-
Female deaths at 75-79 years old	-	-	8.3%
Assault deaths	14.8%	-	-
Transport and accidents	12.5%.	-	-

Table 2.5 Top 10 causes of death from disease in South Africa, 2016

No	Cause of death	Percentage (%)
1	Tuberculosis + DR –TB	11.6%
2	Influenza and pneumonia	7.2%
3	Intestinal infectious diseases	5.0%
4	Heart disease	4.7%
5	Cerebrovascular disease	4.5%
6	Disorders involving the immune system	3.6%
7	Diabetes mellitus	2.8%
8	Hypertensive Disease	4.4%
9	Chronic lower respiratory disease	2.4%
10	Other viral diseases	2.3%

2.2.5 National health expenditure

The South African Government is responsible for public funding for a wide range of social services (DoH 2016/17:8; StatsSA 2016). Figure 2.3 shows the health expenditure for 2016/2017.

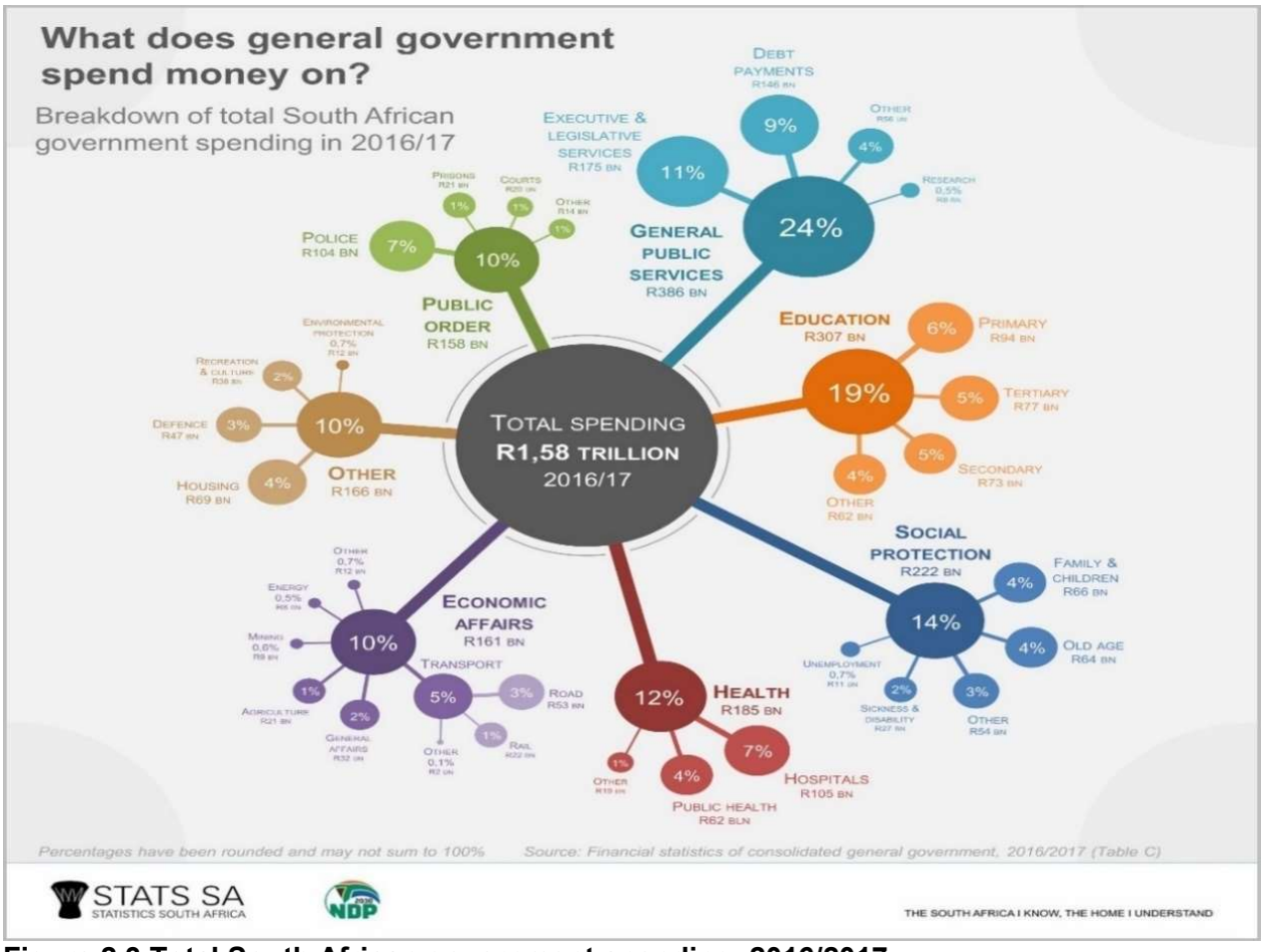


Figure 2.3 Total South African government spending, 2016/2017

Source: StatsSA (2016)

In South Africa, primary health care (PHC) services are free and utilized by South Africans who cannot afford private health care. Government hospital care services are paid a calculated minimum patient fee for those who cannot afford private hospital fees (StatsSA 2016/17). Private sector hospitals are paid by patients' private medical aid schemes. Private patients who do not have medical aid coverage pay cash at private hospitals.

The private healthcare structure is resourced by members' medical aid subscriptions. In 2019, approximately 16% of South Africans were covered by private health insurance and 84% used public health care.

2.2.6 National health system bodies

The National Health Act (no 61 of 2003) mandates the Department of Health (DoH) to provide a framework for a structured and unified health system for South Africa. The Act sets out the responsibilities of the national, provincial, and local levels of government in the provision of health services. The objectives of the Act are to protect and promote public health, control the risk to public health, and promote the control of infectious diseases. In 2015, the Department of Health (DoH) introduced the *national health promotion policy and strategy, 2015-2019* to enable, mediate and advocate health promotion by building healthy public policy; creating supportive encironments for health; strengthening community action for health; developing personal skills, and re-orienting health services. The aim was to enable people to increase control over and improve their health (DoH 2015).

The Health Professions Council of South Africa (HPCSA), founded in 1974, is a statutory regulator of healthcare professions in South Africa. Healthcare practitioners in South Africa are required to be registered with the HPCSA in order to practise their profession.

The South African Nursing Council (SANC) is an autonomous, financially independent, statutory body that is mandated to regulate the nursing profession by establishing and maintaining standards of nursing education, training and practice in South Africa. As a professional body, the SANC is entrusted to set and maintain quality standards of nursing education and practice in South Africa and operates under the Nursing Act (no 33 of 2005). Section 3 of the Nursing Act (no 3 of 2005) makes provision for the SANC to establish, improve and control conditions thus setting standards and quality of nursing education and training. The SANC is accredited by South

African Qualification Authority (SAQA) as an education and training quality authority body (ETQA) for the nursing qualifications (SAQA Act, no 58 of 1995, section 5). As an ETQA, the SANC provides directives and regulations for new nursing programmes/qualifications and endorses new curricula (SANC 2013b). The SANC sets and maintains nursing education standards and reviews nursing education and training to be in line with the country's needs.

In 2020, there were 401 543 registered nurses on the SANC Register (SANC 2020). During 2020, the SANC registered 8 103 professional nurses; 1 250 midwives, and 4 777 post-basic qualifications nurses. Of the post-basic qualifications registered, 1 248 were in nursing administration.

There is a growing shortage of nurses in South Africa. Mahlathi and Dlamini (2016:25) found that some nurse educators leave PNEIs over the Occupation Specific Dispensation (OSD) issue and join public hospitals and clinics for better remuneration and benefits. The nursing shortage is further exacerbated by the migration of nurses to other countries for better pay and workplace benefits (Rispel & Blaauw 2015:8). A further crisis is the ageing nursing population who will soon retire (SANC 2020).

Figure 2.4 illustrates the current ageing population of nursing professionals in South Africa (SANC 2020:3). As indicated in figure 2.4, 27% of registered nurses and midwives are over 50 years old and will soon retire, leaving between 21% and 26% of nurses aged 30-40 years to sustain the healthcare system.

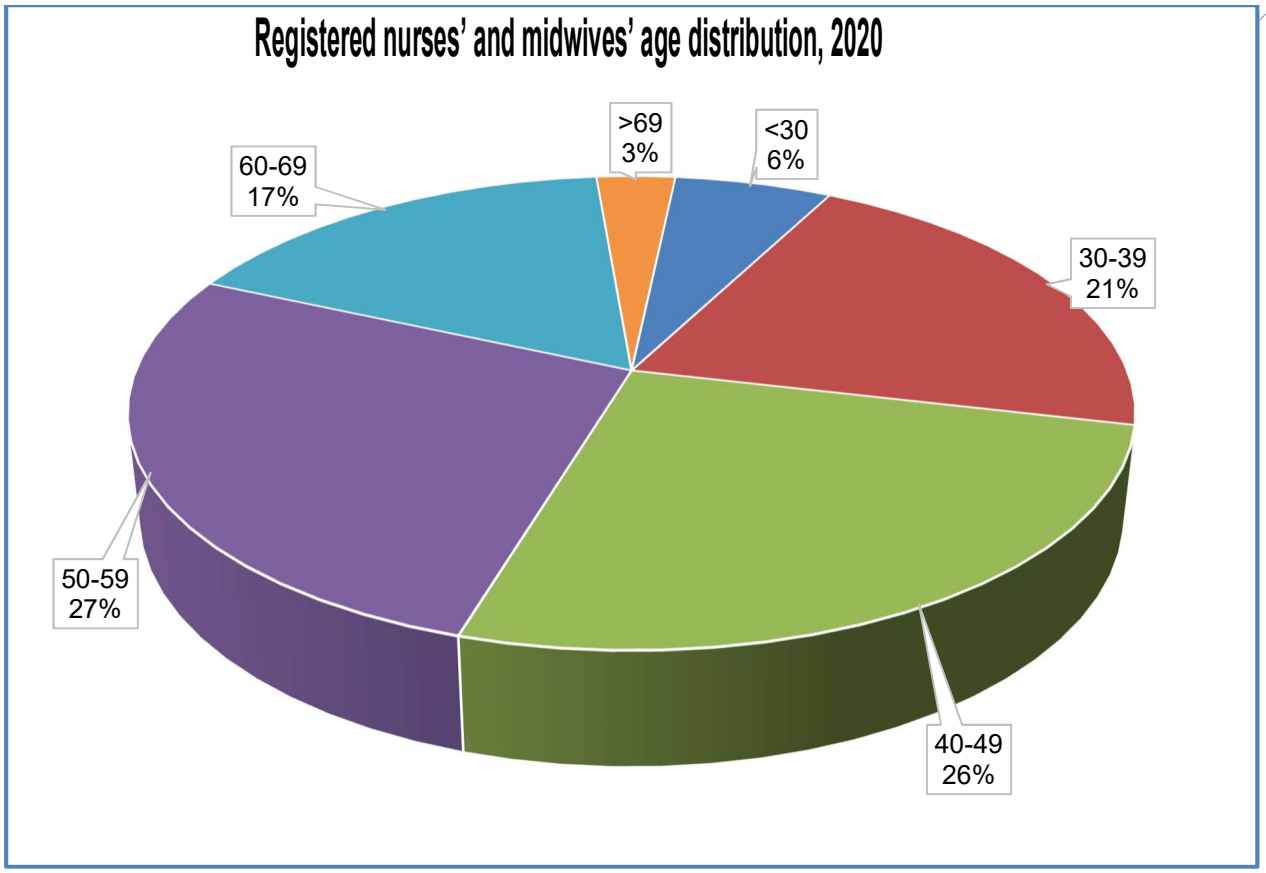


Figure 2.4 Registered nurses' and midwives' age distribution, 2020

Source: SANC (2020:1)

2.2.7 Nursing education and training

The main aim of nursing education throughout the world is to provide sufficient skilled health workers to provide efficient care to those in need. In response to the global shortage of health workers, the World Health Organization (WHO 2009) published global standards for the initial education of professional nurses and midwives and the transformation of health profession education to help policy makers develop policies and programmes to bolster the global health workforce. The dynamics that impact on health care delivery systems informs the necessary transformation to meet that aim. Currently the predominant trend in nursing education transformation is geared towards greater professionalisation as a strategy to provide universal health coverage (Armstrong & Rispel 2015:1; Blaauw, Ditlopo & Rispel 2014:3).

The transformation of nursing education in South Africa stems from the increased need for professionalism and a shift of training to the higher education setting, the present state of nursing

education, and demands of the education sector in the country (Blaauw, Ditlopo & Rispel 2014:2). PNEIs need to produce a great many nurses and midwives to meet the health service delivery needs and provide easy access to hospitals for theory-practice integration. The Constitution of the Republic of South Africa Act, 108 of 1996 provided for all tertiary education to be under the jurisdiction of the Minister of Education in a single coordinated higher education system. Accordingly, the Minister of Higher Education had the responsibility of accrediting all NEIs as higher education institutions (HEIs). The implementation of nursing qualifications aligned to the Higher Education Qualifications Sub-framework (HEQSF) required PNEIs to align their qualifications with the HEQSF, which included the development of their programmes through the Council on Higher Education (CHE) for accreditation, and for approval and registration by the SAQA (SANC 2016b). Consequently, PNEIs were expected to submit their reviewed curriculum to the SANC and CHE simultaneously (Zwane & Mtshali 2019:6). The aim was a unified nursing education system, progression in terms of access to postgraduate studies, enhanced career movement and full student status with more time for accompaniment. Moreover, the driving force for this transformation in South Africa is related to nursing workforce shortages due to increased numbers of ageing nurses and migration of nurses to developed countries.

In 2013, the Department of Health (DoH) published qualification regulations regarding the transformation of legacy programmes. The developments culminated in the process of phasing out of legacy qualifications and the phasing in of HEQSF-aligned nursing qualifications. PNEIs were requested to identify programmes relevant to address national priorities, and indicated the need for regulations relating to the approval of and the minimum requirements for the education and training of a learner leading to registration in the category staff nurse (R.171 of 8 March 2013) (SANC 2013a).

In terms of the national strategic plan for nurse education, training and practice, nursing education is expected to obtain national competence to enhance social accountability (DoH 2013:23; Armstrong & Rispel 2015:2). There are three categories of nurses: Professional Nurses with four years of training; enrolled nurses with two years of training, and nursing assistants or auxiliaries with one year of training. Training is provided by private and public NEIs and universities in all nine provinces. Private healthcare groups offer training for nurses for two years as enrolled and one year as auxiliary nurses. Professional nurses are registered according to the Nursing Act (no 33 of 2005). There are also post-registration programmes that are offered and registered by the SANC.

New curricula implemented at nursing education institutions will address the needs of the South African population (SANC 2013; Armstrong & Rispel 2015:2). At the time of this study, all PNEIs in South Africa were undergoing major curriculum changes to be declared institutions of higher education by the CHE. In 2020 the new curriculum dispensation was phased in. The legacy 4-year nursing qualifications programme was phased out in December 2019 and the phasing in of the new qualifications programme (R.174) commenced in January 2020. Table 2.6 lists the National Qualifications Framework (NQF) sub-frameworks and qualifications, according to the National Qualifications Framework Act, 67 of 2008.

Table 2.6 NQF sub-frameworks and qualifications

National Qualifications Framework (NQF)	
Level	**Sub-frameworks & qualifications**
10	Doctoral degree
9	Master's degree
8	Honours degree/Post-graduate degree
7	Bachelor's degree /Advanced diploma
6	Diploma/Advanced certificate
5	Higher certificate

(National Qualifications Framework Act, 67 of 2008)

In South Africa, universities are the only institutions that offer nursing education qualifications at post-graduate level. All PNEIs, private nursing education institutions and universities in South Africa are tasked and mandated with the responsibility of educating and training nurses at national level mandates of moving towards higher education institutions (DoH 2013:33, 42). Nurse educators obtain qualifications at universities in South Africa and abroad through a degree or a diploma (Mulaudzi, Daniels, Direko & Uys 2012:3).

2.2.8 Status on training of nurses

In South Africa, for a candidate to be admitted to the academic programmes that lead to registration as a professional nurse, the candidate must have passed Grade 12 at level 4 of the NQF as determined by the South African Qualification**s** Authority (SAQA) according to the NQF Act (no 67 of 2008 as amended). Previously, the NQF listed the R.425 legacy qualification at NQF level 6, which was offered over four years, after which candidates received a diploma qualification. The R.425 programme offered four qualifications in one, namely general nursing, community health nursing, psychiatric nursing, and midwifery. The R.425 competencies were

found no longer relevant to adequately address the emerging disease patterns in South Africa and were replaced with other programmes.

Chapter 2 and 3 of the Nursing Act (no 33 of 2005) focus on nursing education, particularly accreditation of new programmes, giving attention to quality control, nursing practice and ethics. The promulgations of the Nursing Act (no 3 of 2005) with reference to Chapter 2 and 3 led to a move towards accreditation of all nursing education institutions in South Africa to higher education institutions.

The R.425 legacy qualifications and Regulation 683 (R.683) bridging course qualification ceased intake in 2019 and the phasing out of programmes began. Phasing in of the new structured nursing programmes commenced gradually in 2020 and included the Diploma in Nursing (R.171 programme), Advanced Diploma in Midwifery (R.1497), Bachelor's degree in Nursing and Midwifery (R.174), and Specialist registered nurses for different postgraduate courses (see Table 2.7).

Table 2.7 Programmes phased in by nursing education institutions, 2020

Programmes being phased in (SANC Code)	SANC qualification	Number of years	Credits
R.171	Diploma in Nursing	3 years	360
R.1497	Advanced Diploma in Midwifery	1 year	120
R.174	Bachelor's degree in Nursing and Midwifery	4 years	480
Postgraduate diplomas R.635.	Specialist registered nurse	1 year	144
	Postgraduate Diploma in Child Nursing	1 year	144
	Community Health Nursing	1 year	144
	Postgraduate Diploma in Critical Care (Adult)	1 year	144
	Postgraduate Diploma in Emergency Nursing	1 year	144
	Forensic Nursing	1 year	144
	Infection Prevention and Control Nursing	1 year	144
	Postgraduate Diploma in Mental Health Nursing	1 year	144
	Postgraduate Diploma in Midwifery	1 year	144
	Postgraduate Diploma in Nephrology Nursing	1 year	144
	Postgraduate Diploma in Occupational Health Nursing	1 year	144
	Postgraduate Diploma in Oncology and Palliative nursing	1 year	144
	Ophthalmic Nursing	1 year	144
	Postgraduate Diploma in Orthopaedic Nursing	1 year	144
	Postgraduate Diploma in Peri-Operative Nursing	1 year	144
	Postgraduate Diploma in Primary Care Nursing	1 year	144
Non-clinical postgraduate diploma courses	Health Services Management	1 year	120
	Nursing Education	1 year	120

A new register of specialist nurses for the Postgraduate Diploma Qualification Framework was established by SANC and released in 2020 (SANC 2020) for all NEIs and PNEIs including universities (see Table 2.7). The R.425 legacy qualifications ceased intake in 2019 and R.171 was phased in at the beginning of 2020 (SANC 2020). The review of nursing qualifications was necessitated by the increasing burden and complexities of disease that required new competencies from nurses and by the changing post-school education articulated by the NQF and SANC (2016:1) nursing education and training standards.

2.3 WORKPLACE CONTEXT

Polit and Beck (2017:392) define a research setting and context as the physical location and conditions under which data collection takes place in a study. In this study, the setting and context referred to a selected PNEI in a metropolitan municipality, Gauteng Province. The organisational context includes internal and external factors at the workplace that influence the performance of the organisation positively or negatively. All contextual factors are equally important if organisations want to maximize the impact of time, effort and resources to develop, implement and improve programmes in health care settings (Harvey, Jas & Walshe 2015:48).

The PNEI has classrooms and lecture halls, a simulation laboratory, a library, and nurse educator offices. The PNEI placed student nurses and post-basic student nurses in 10 hospitals and 64 clinics for clinical practice for all programmes offered and trained approximately 1,050 student nurses per year. The academic staff comprised 92 nurse educators and nurse managers and 77 administrative staff, giving a total of 169 employees. The academic staff consisted of the principal and deputy principal, eight heads of departments and 82 nurse educators. The study was conducted to establish the status of the current workplace culture in relation to person-centredness towards the transformation agenda of the PNEI in South Africa. Data collection took place in the classrooms and lecture halls. The venues were booked in advance to ensure privacy and confidentiality while conducting consensus meetings for the study.

Table 2.8 lists the population of nurse educator categories at the PNEI. Table 2.9 indicates the numbers of staff and students at the PNEI.

Table 2.8 Nurse educator and nurse manager categories at the PNEI

Nurse educator category	Number
Principal (nurse manager)	1
Vice Principal (nurse manager)	1
Heads of departments (nurse managers)	8
Nurse educators	82
Total	**92**

Table 2.9 Academic staff and student profile per programme at the PNEI

Programme	Number of students	Black African	Coloured	Indian	White		Number of staff	Black African	Coloured	Indian	White
Legacy											
Programme A											
First year	260	256	2	0	2		18	10	4	0	4
Second year	256	252	2	0	2		22	12	6	0	4
Third year	252	249	2	0	1		20	15	3	0	2
Fourth year	250	247	2	0	1		20	15	3	0	2
Postgraduate Diplomas (PGDs) Programme B											
First year	40	38	1	0	1		6	3	2		10
Postgraduate Diplomas (PGDs) Programme C											
First year	37	33	2	1	1		6	4	1	1	0
Total	**1095**	**1075**	**11**	**1**	**8**		**92**	**59**	**19**	**2**	**12**

2.4 POLICY CONTEXT

Nursing education reform is an important strategy for enhancing health workforce performance and thereby improving the functioning of health systems (Blaauw, Ditlopo & Rispel 2014:1). Globally, a predominant trend in this reform has been towards greater professionalisation and university-based education. Nursing education reform in South Africa led to a new framework for nursing qualifications in 2013 (Blaauw, Ditlopo & Rispel 2014:7). This revision of nursing qualifications was also influenced by changes in the education sector, and took over ten years to complete. The nursing education and training of student nurses in the selected PNEI is controlled by national and institutional policy.

2.4.1 National

Public nursing education institutions in South Africa are approved and accredited by the SANC to provide nursing education and training to student nurses. Governance of PNEIs is provided by the Department of Health (DoH) who mandates PNEIs to provide quality nursing education. PNEI

practice is controlled and regulated by the Nursing Act (no 33 of 2005). As a professional body, the SANC is entrusted to set and maintain quality standards of nursing education and practice in South Africa and operates under Nursing Act (no 33 of 2005) (Bezuidenhout, Human & Lekhuleni 2013:2). Section 3 of the Nursing Act (no 3 of 2005) makes provision for the SANC to establish, improve and control conditions thus setting standards and quality of nursing education and training. The SANC is accredited by SAQA as an education and training quality assurance body (ETQA) for the nursing qualifications (SAQA Act no 58 of 1995, section 5). As an ETQA, the SANC provides directives and regulations for new nursing programmes/qualifications and endorses new curricula (SANC 2013b). The SANC sets and maintains nursing education standards and reviews nursing education and training to be in line with the country's needs. The SANC registers all nurses in South Africa for a licence to practise. The various categories of nurses pay different registration fees, which are adjusted annually, to practise as nurses.

In 2019 NEIs were declared institutions of higher education and learning. The phasing-in and phasing-out of nursing programmes took place for both under- and post-graduate nursing programmes for all NEIs in the country. All policies relating to the implementation of teaching and learning were reviewed for alignment with the Higher Education Act (no 101 of 1999, as amended). The NQF Act (no 67 of 2008) outlines the DoH quality assured national qualifications. The nursing curriculum agenda for phasing in of SANC Regulation 171 (R.171), Regulation 1497 (R.1497), and Regulation 174 (R.174) programmes was established and curriculum implementation for R.171 began in 2020, while the other programmes were still being developed. Table 2.10 lists the new programmes and proposed starting dates.

Table 2.10 New undergraduate nursing programmes

Qualification (SANC)	Programme	Years	Credits	NQF level	Proposed commencement date
Higher Certificate	R.169	1	120	5	To be announced
Diploma in Nursing	R.171	3	360	6	2020
Advanced Midwifery	R.1497	1	120	7	2022
Bachelor's degree	R.174	4	480	8	2023

2.4.2 Institutional

The selected PNEI has different policies that support the implementation of all nursing programmes offered, including on recruitment and selection; academic teaching and learning; internal guidelines and procedures; code of conduct during employment of nurse educators, and

human resource. Administrative and financial policies are developed and put in place by the national and provincial DoH to support the implementation of academic programmes in all NEIs. Nurse educators consistently and continuously collaborate, include and participate with diverse stakeholders to review, develop and align policies for new programmes. Workplace policies and specific standardized workplace procedures are developed by the PNEI Policy Development Coordination and Review Committee. Quality of the workplace policies is ensured by PNEI quality assurance officers.

The participants in this study were trained as nurse educators at universities and obtained a Diploma in Nursing Education qualification and registered with the SANC. In accordance with PNEI policy, only nurse educators registered with the SANC as nurse educators are employed. The higher education policy stipulates that nurse educators are allowed to teach a programme in which their qualification is higher than that which they are teaching.

However, the researcher observed a lack of participative teamwork which appeared to be the result of an ineffective workplace culture. A workplace culture refers to shared values and practices, belief systems, and a set of assumptions that are shared across all groups in an organisation. A shared purpose is an essential part of developing effective workplace cultures and a basic principle of practice development in establishing person-centred, safe and effective practices that enable everyone to flourish (Manley, O'Keefe, Jackson, Pearce & Smith 2014:2). For successful teamwork, systems for learning, development, research, innovation and evaluation should be established that enable shared purposes and values in all activities (Manley et al 2014:4). This underlined the importance and necessity of transforming the workplace culture to person centredness by using collaboration, inclusion and participation in academic policies in a teamwork approach to maximise achievement of organisational outcomes by implementing the TPD programme.

2.4.3 Professional

A professional context comprises leadership, organisational culture and features, teamwork, resources, and external environmental issues (Harvey, Jas & Walshe 2015:49). To build a professional context favourable to change and transformation, the influence of characteristics such as culture and leadership need to be considered (Cornelius & Nicol 2016:3).

The SANC governs professional nursing practice by establishing and maintaining accountable and responsible standards of nursing in South Africa (Dolamo 2018:4119). The Nursing Act (no 33 of 2005) provides directives and regulates the nursing profession in South Africa and describes the scope of practice for all nurses registered with the SANC. Three categories of nurses will be phased out by 2020, namely Registered Nurse, Enrolled Nurse and Enrolled Nurse Assistant. Categories of nurses that will be phased in from 2020 include the Diploma in Nursing (R.171), the Advanced Diploma in Midwifery (R.1497), Higher Certificate (R.169) and Professional Nurse degree (R.174). In terms of the Nursing Act (no 33 of 2005, section 30[1]), a registered nurse is regarded as an independent practitioner.

A nurse educator is a professional that facilitates collaborative and cooperative teaching and learning processes, including strategies to develop the full potential of student nurses, practitioners, researchers and leaders who are responsive to diverse population needs in a variety of health care settings. Nurse educators motivate students' learning and self-efficacy through consistent modelling processes to achieve satisfactory levels of competence. The nursing education qualification prepares nurses to become nurse educators employable at colleges and universities (Mulaudzi, Daniels, Direko & Uys 2012:3). Within the professional context, nurse educators must be registered with the SANC after obtaining a nursing education qualification as a postgraduate qualification after registration as professional nurse. The nursing education qualification requires successful completion of a one-year study programme at a higher education facility such as a university for a postgraduate diploma. The extended scope of practice and essential competencies required for nurses with additional specialities are measured and determined by the SANC with specific regulations for practice. In 2018, 1 773 nurse educators were registered, which represented a marginal increase from 2017 (SANC 2018:1).

The implications for nurse educators in the revised and new nursing qualifications framework is that nurse educators can only teach a programme when their qualification is higher than the level of the particular programme (SANC 2015). The professional challenge in the PNEI is that most of the nurse educators have enrolled at universities to either obtain a Bachelor's degree to teach R.171 and a master's degree to teach R.174 and a doctorate degree to teach Master's degree as guided by SANC and CHE. Therefore, the professional challenge for nurse educators at the PNEI is that the majority cannot teach Masters students and doctoral degree programmes as few of them have master's and doctoral degrees (see Table 2.6 for the NQF).

In South Africa, not all nurse educators are employed at PNEIs or at universities, as some work in clinical areas. This creates a gap at NEIs and nurse educator shortages (DoH 2013:42). In 2915, the nurse educator staffing ratio was 1:15 at minimum and 1:20 at maximum (SANC 2015). The new qualifications framework implies a revised workload distribution for nurse educators and calculation of teaching and learning times. The revised workload distribution will still be assessed to check whether it addresses the nurse educator challenges (SANC, 2015**:**2), especially when each programme is reviewed after each cohort of student output is achieved. Nurse educator capacity building at PNEIs includes attending conferences, in-house in-service training and formal coaching. However, the budget for nurse educator capacity building is limited (Mulaudzi, Daniels, Direko & Uys 2012:8). It is nine years down the line since the previous authors commented, but the researcher has observed that more needs to be done regarding improving nurse educator capacity building in a broader scope at the PNEIs. So far capacitation is focused on curriculum development of new programmes that are being phased-in.

In terms of section 42 of the Nursing Act (no 33 of 2005), it is unlawful for NEIs to provide training for nursing students unless both the institution and the programme for training are accredited by the SANC. Gauteng PNEIs are in the process of amalgamation and will be known as the Gauteng College of Nursing (GCON). The college will be redeployed from provincial departments of health to higher education to become part of a unified higher education system.

Private NEIs that produce nurses are also moving towards higher education (Zwane & Mtshali 2019:1). According to Zwane and Mtshali (2019:11), integration of PNEIs to higher education institutions became a consequence following political and legal changes in the country. This transformation of nursing education will improve the quality of nursing programmes, and align nursing programmes for global competency.

2.5 CONCLUSION

This chapter described the setting and context of the study, including the national, organisational, and policy context.

Chapter 3 discusses the workplace culture.

CHAPTER 3
ASSESSMENT OF THE WORKPLACE CULTURE

3.1 INTRODUCTION

In Chapter 2 an in-depth overview of the context of the study was provided. In this chapter the findings of phase 1 of the study will be provided in article format. The aim of phase 1 was to, assess the workplace culture of a selected PNEI in South Africa.

Workplace culture refers to the way things are done in the workplace, and describes how individuals in the organisation share values, beliefs, structures, routines, rules and norms that serve to guide and constrain behavior (Skolas, Roos, McCormack, Slater, Hahtela & Suominen 2016). Person-centredness in the workplace refers to a set of personhood constructs that concerns treating people as individuals, respecting their rights as persons, building mutual trust and cultivating a therapeutic relationship (McCormack et al 2010).

The manuscript with the title: The workplace culture in a South African nursing education institution, was submitted to Nurse Education in Practice on 10 December 2021, see the attached proof of submission at the end of this chapter. This chapter will be presented according to the headings of the authors guidelines as specified by the journal.

Nurse Education in Practice

The workplace culture in a South African nursing education institution.

Masimula, Queen K (M Cur)
Department of Nursing Science
University of Pretoria
Private Bag X20, Hartfield, 0028
+27 12 420 4670
queenmasimula@yahoo.com

van der Wath, Annatjie (PhD)
Department of Nursing Science
University of Pretoria
Private Bag X20, Hartfield, 0028
+27 12 420 4670
Annatjie.vanderwath@up.ac.za

Coetzee, Isabel M (D Litt et Phil)*
Department of Nursing Science
University of Pretoria
Private Bag X20, Hartfield, 0028
+27 12 420 4670
Isabel.coetzee@up.ac.za

*Corresponding Author: Coetzee, IM.

ABSTRACT

Introduction and background: Positive workplace culture in all organisations embraces person-centeredness, leadership development, collaboration, participation and inclusion of all stakeholders. Negative workplace culture in nursing education institutions is characterised by problematic work relations, ineffective teamwork, decreased morale, job dissatisfaction and high turnover of nurse educators.

Methodology: We assessed the workplace culture in a public nursing education institution in South Africa. Data were collected using an adapted person-centred practice inventory. We sampled the total population of nurse educators and nurse managers (86) in the institution.

Results: The person-centred practice inventory indicated challenges in the areas of person-centeredness, collaboration, inclusion and participation as well as workplace culture.

Conclusion: In this nursing education institution, certain challenges need to be addressed to ensure that the workplace culture is transformed towards person-centeredness.

Key words: person-centred workplace culture, public nursing education institution, person centeredness

1. Introduction

Workplace culture refers to the way things are done in the workplace, and describes how individuals in the organisation share values, beliefs, structures, routines, rules and norms that serve to guide and constrain behaviour (Skolas, Roos, McCormack, Slater, Hahtela & Suominen, 2016). Person-centeredness in the workplace refers to a set of personhood constructs that concerns treating people as individuals, respecting their rights as persons, building mutual trust and cultivating a therapeutic relationship (McCormack et al., 2010). Research in Transformative Practice Development investigates strategies to enable transformation and effectiveness, and allows individuals, teams, organisations and communities to deliver and co-construct new knowledge and practices about person-centred evidence based informed health care (Trede & Titchen, 2012). Creating a person-centred workplace culture in public nursing education institutions (PNEI) is a valuable yet challenging task (Department of Health, 2013; Flott & Linden, 2016). According to McCormack et al. (2010) the best way to create a person-centred workplace culture is to foster human endeavour, enable self-direction and collaboration, support agreed values, beliefs and behaviours that achieve participative decision making. We report on the first phase of a study which assessed the current workplace culture in relation to person-centeredness at a specific PNEI.

2. Methods

2.1 Design, participants and data collection

We followed a quantitative design, using the person-centred practice inventory (PCPI) to assess workplace culture (McCormack et al., 2010; McCormack et al., 2013). In this study, the population included all academic staff members, including the campus head, deputy campus head, eight heads of departments and nurse educators. We distributed informed consent forms and questionnaires to 86 potential respondents who met the inclusion criteria. The researcher received 63 informed consent forms and completed PCPIs.

2.2 Setting

The study was conducted in a PNEI in the Gauteng Province of South Africa. According to the South African Nursing Council (2019) there were 20 822 student nurses in 2019/202 in South Africa. The PNEI in this study registers approximately 1000 students every year. Annually, the PNEI graduates around 250 professional nurses who may register with the South African Nursing Council. We chose one specific PNEI with an aim of transferring research findings to the other PNEIs with similar contexts.

2.3 Research instrument

The PCPI tool originated from the practice development methodology perspective (McCormack et al., 2013). We adapted the assessment tool, for South African settings, in collaboration with four nursing experts, with the permission of the authors. The PCPI comprises four sections, Section A: demographic profile, Section B: measuring person-centred practice inventory (PCPI) variables, Section C: measuring collaboration, inclusion and participation (CIP) principles and Section D: measuring workplace culture (WC). Respondents answered the questionnaires in writing, indicating their agreement or disagreement with each of the statements. Each statement had four options; 1 = strongly disagree, 2 = disagree, 3 = agree and 4 = strongly agree.

2.4 Data analysis

Data were analysed using descriptive statistics and frequency distributions (Polit & Beck, 2017).

2.5 Ethical considerations

Before collecting data, the Department of Health and the University of Pretoria, Faculty of Health Sciences, Research Ethics Committee approved the study [760/2018]. All participants signed informed consent documents before participating in the study.

3 Results

The results are discussed in relation to the different sections of the PCPI; Section A: demographic profile, Section B: PCPI, Section C: CIP and Section D: WC.

3.1 Section A: Demographic profile of respondents

Table 1: Demographic profile of nurse educators who completed the PCPI in a public nursing education institution in South Africa

Variable	n=63	%	Mean	SD	Range	Min	Max
a) Age group			48.55	9.28	34	30	64
30-45 years	21	33.3					
46-55 years	26	41.2					
56-65 years	15	23.8					
Omitted	1	1.6					
b) Gender							
Female	57	90.5					
Male	5	7.9					
Omitted	1	1.6					
c) Highest level of education							
Bachelor's degree	35	55.6					
Master's degree & PhD	20	31.7					
Other	6	9.5					
Omitted	1	1.6					
d) **Years of experience**			9.18	8.426	43	1	44
≤5 years	22	34.9					
6-10 years	14	22.2					
≥10 years	19	30.1					
Omitted	3	4.7					
e) **Position at work**							
Nurse educator	54	85.7					
Management	6	9.5					
Omitted	1	1.6					

In this study, 62 respondents completed the study and were on average 48.55 years old, with the youngest respondent being 30 years and the oldest 64 years old. Most of the respondents were women 91.9% (n=57) and only five were men (8.1%). Most of the academic staff held post graduate qualifications.

One respondent had a PhD (1.6%), followed by 20 (32.3%) respondents with a Master's degree and 35 (56.6%) with a Bachelor's degree. Fifty-five respondents revealed their working experience. Twenty-two respondents (40%) had fewer than five years working experience. Fourteen (25%) respondents had 6-10 years working experience and 19 (35%) respondents had more than 10 years working experience. Most of the respondents, 54 (85.7%) are nurse educators. Other positions include six (9.5%) heads of departments, one vice principal, one principal and one academic registrar (other).

3.2 Section B: Person-centred practice inventory (PCPI)

Most respondents agreed with the statements in this section (Table 2), indicating high scores (84.1% to 98.4%) on person-centred practices. The only statement that participants indicated less agreement (76.2%) was the last statement: “I challenge colleagues when their teaching practices are inconsistent with our team's shared values and beliefs”. Challenging colleagues in a person-centred manner should not be difficult in a team where members share the same values and beliefs.

Table 2: Section B: Person-centred practice inventory completed by nurse education practitioners in a public nursing education institution.

	Disagree		Agree		
VARIABLE	N	%	N	%	Total
I have the necessary skills to negotiate educational choices	7	11.1%	56	88.9%	63
When I teach I pay attention to more than the immediate task	7	11.5%	54	88.5%	61
I actively seek opportunities to extend my professional competence	3	4.8%	59	95.2%	62
I ensure I hear and acknowledge others perspectives	1	1.6%	62	98.4%	63
In my communication with others I demonstrate the respect for others	1	1.6%	62	98.4%	63
I use different communication techniques to find mutually agreed solutions	3	4.8%	60	95.2%	63
I pay attention to how my non-verbal cues impact on my engagement with others	2	3.2%	61	96.8%	63
I strive to deliver high quality education to students	1	1.6%	62	98.4%	63
I seek opportunities to get to know my students in order to provide holistic care/support	4	6.3%	59	93.7%	63
I go out of my way to spend time with my students	8	12.9%	54	87.1%	62
I strive to deliver quality education that is evidence informed	2	3.2%	61	96.8%	63
I continuously look for opportunities to improve the education experience for students	2	3.2%	61	96.8%	63
I take time to explore why I react as I do in certain situations	4	6.3%	59	93.7%	63
I use reflection to check out if my actions are consistent with my ways of being real	4	6.3%	59	93.7%	63
I pay attention to how my life experiences influence my teaching practice	10	15.9%	53	84.1%	63
I actively seek feedback from others about my teaching practices	8	12.9%	54	87.1%	62
I challenge colleagues when their teaching practices are inconsistent with our team's shared values and beliefs	15	23.8%	48	76.2%	63

3.3 Section C: Collaboration inclusion and participation principles (CIP)

Most respondents agreed with the statements in this section (Table 3), indicating high scores (85.7% to 98.4%) on most of the CIP principles. The statement with the lowest (66.7%) agreement was: “My colleagues positively role model the development of effective relationships”. Only 77.8% of participants agreed with the statement that their HOD facilitates participation at all levels of organisation. Only 74.6% of respondents agreed that there was

support for developing new teaching practices. Whilst only 73% of the respondents agreed that they were supported to do things differently to support their teaching practices. It is evident that CIP in all levels of the organisation can be improved to ensure a person-centred workplace culture.

Table 3: Section B: Collaboration, inclusion and participation principles completed by nurse education practitioners in a public nursing education institution.

	Disagree		Agree		
VARIABLES	N	%	N	%	Total
I support colleagues to develop their teaching practice to reflect the team's shared values and beliefs	5	7.9%	58	92.1%	63
I recognise when there is a deficit in knowledge and skills in the team and its impact on teaching and learning	6	9.7%	56	90.3%	62
I value the input from all team members and their contribution to teaching and learning	1	1.6%	62	98.4%	63
I actively participate in team meetings to inform my decision-making	1	1.6%	62	98.4%	63
I participate in organisational decision-making forums that impact on teaching practice to inform	7	11.1%	56	88.9%	63
I am able to access opportunities to actively participate in influencing decision in my division	15	24.2%	47	75.8%	62
My opinion is sought in decision making forums	14	23.0%	47	77.0%	61
I work in a team that value my contribution to care	9	14.3%	54	85.7%	63
I work in a team that encourages everyone's contribution to person-centred care	12	19.4%	50	80.6%	62
My colleagues positively role model the development of effective relationships	21	33.3%	42	66.7%	63
The contributions of colleagues are recognised and acknowledged	15	23.8%	48	76.2%	63
I actively contribute to the development of shared goals	5	7.9%	58	92.1%	63
The leader (HOD) facilitates participation on all levels of the organisation	14	22.2%	49	77.8%	63
I am supported to do things differently to improve my teaching practice	17	27.0%	46	73.0%	63
I am encouraged and supported to lead new developments in teaching practice	16	25.4%	47	74.6%	63
I am able to balance the use of evidence with taking risks	19	30.6%	43	69.4%	62
I am committed to enhance learning by challenging teaching practices	8	12.7%	55	87.3%	63

3.4 Section D: Workplace culture (WC)

Respondents agreed with most of the statements (Table 4), particularly statements referring to students. Compared to the previous sections, more participants disagreed with certain statements. More participants disagreed (60.7%) with the statement: “I'm satisfied with performance management and development system (PMDS)”. Just over half of participants (51.6%) agreed with the statement: “In my team we take time to celebrate our achievements”. In addition, the statement “The organisation recognises and rewards success” was acknowledged by 61.3% of the respondents. In this PNEI, acknowledging and recognising team contributions seems to be a challenge. Similarly, only 56.5% of respondents agreed with the statement: “I am recognised for the contribution that I make to students having a good experience of teaching and learning”. Only 54.8% of respondents agreed with the statement:

"I work with the student within the context of their family and carers". The feedback depicts that the workplace does not support the professional well-being of all staff members.

Table 4: Section D: Workplace culture completed by nurse education practitioners in a public nursing education institution.

	Disagree		Agree		
VARIABLES	N	%	N	%	Total
I pay attention to the impact of the physical environment on students'/lecturers' dignity	1	1.6%	60	98.4%	61
I challenge others to consider how different elements of the physical environment impact on person-centeredness	15	24.2%	47	75.8%	62
I seek out creative ways of improving the physical environment	14	22.6%	48	77.4%	62
In my team we take time to celebrate our achievements	30	48.4%	32	51.6%	62
My organisation recognises and rewards success	24	38.7%	38	61.3%	62
I am recognised for the contribution that I make to students having a good experience of teaching and learning	27	43.5%	35	56.5%	62
I am supported to express concerns about an aspect of teaching and learning	21	34.4%	40	65.6%	61
I have the opportunity to discuss my practice and professional development on a regular basis	26	41.9%	36	58.1%	62
I integrate my knowledge of person centeredness into teaching and learning	6	9.7%	56	90.3%	62
I work with the student within the context of their family and carers	28	45.2%	34	54.8%	62
I seek feedback on how students make sense of their learning experience	6	9.7%	56	90.3%	62
I include students in teaching and learning decisions where appropriate	4	6.5%	58	93.5%	62
I work with the students to set goals for their future	19	30.6%	43	69.4%	62
I enable students to seek information about their teaching and learning	4	6.5%	58	93.5%	62
I try to understand the students' perspectives	1	1.6%	61	98.4%	62
I engage students in teaching and learning processes where appropriate	1	1.6%	61	98.4%	62
I actively listen to students to identify unmet needs	0	0.0%	61	100%	61
I gather additional information to help me support students	3	4.9%	58	95.1%	61
I seek to resolve issues when my goals for students differ from their perspectives	3	4.8%	59	95.2%	62
I ensure my full attention is focussed on the students when I am with them	1	1.6%	61	98.4%	62
I strive to gain a sense of the whole person (student)	3	4.8%	59	95.2%	62
I assess the needs of students, considering all aspects of their lives	9	15.3%	50	84.7%	59
I teach in a manner that takes account of the whole person (student)	7	11.5%	54	88.5%	61
I'm satisfied with performance management and development system (PMDS) at my work	37	60.7%	24	39.3%	61

4 Discussion

In this study, we identified gaps that the PNEI needs to address to ensure a person-centred workplace culture where employees may flourish. Dewing et al. (2014) reported that the PCPI assessment tool measures person-centeredness through engagement, establishment, formation and fostering healthy workplace relations. The first step towards establishing a

person-centred workplace culture in the PNEI, would be to establish shared values and beliefs (Wareing-Jones, 2016). Having shared values and beliefs enhances teamwork and creates healthy workplace relationships where all members feel valued, respected and able to flourish.

In this PNEI, there is room for improvement in the aspects of collaboration, inclusion and participatory practices. Nurse educators indicated that support and collaboration with team members and management were a challenge. Additionally, nurse educators felt that leaders in their organisation were not facilitating effective team work. According to Ovseiko et al. (2019), organisational leaders need to ensure collaborative, inclusive and participative practices where knowledge can be shared and inputs are valued. Participation and shared decision-making processes will promote healthy relations between team members. Burns and Mooney (2018) describe collaborative leadership as Transcollegial, which should enhance relationships between team members and ensure that all contributions are equally valued. Ovseiko et al. (2019) mentioned that there is a positive relationship between effective collaboration, inclusion and participation and the development of a person-centred workplace culture.

In this study, nurse educators' responses revealed challenges affecting workplace culture in the PNEI. Respondents indicated that individual successes and achievements were not always recognised and celebrated by team members or the organisation. In addition, 60.7% of respondents were dissatisfied with the performance management and development system implemented by the PNEI. This in turn may lead to dissatisfaction and demotivation if members do not feel valued and recognized for their achievements (Mitić et al., 2016; Ndlovu et al., 2017).

The PNEI in this study has to address certain challenges associated with workplace culture, which needs to be more person-centred for nurse educators to flourish. Ng et al. (2014) describe a healthy workplace culture as one that positively influences the functioning of an organisation and enhances unity between team members, which enables them to overcome challenges. A person-centred workplace culture improves staff wellbeing and job satisfaction as well as improves standards, quality and safety and higher satisfaction with care (Rathert et al., 2012; Teeling et al., 2020). In essence, person-centeredness focusses on the humanising of healthcare delivery (McCance et al., 2011). Person-centeredness also prioritises the individual person rather than anonymous collective tasks. Similar developments can be seen in the integration of person-centred frameworks into healthcare higher education (Cook et al., 2018). The PNEI in this study, should promote a person-centred work place culture where all members are valued, respected and acknowledged. This will enable the development of healthy work relationships where all members of the organisation can flourish.

5 Implications for practice

All organisations should be aware of the importance of having a person-centred workplace culture. The person-centred practice inventory may be used to assess an organisation's current workplace culture. Understanding current workplace culture, will allow an organisation to identify challenges and to develop strategies to create an environment where all members may flourish.

6 Conclusion

A person-centred workplace culture is important to facilitate personal and organisational growth. Challenges pertaining to workplace culture should be identified and addressed to ensure transformation towards a person-centred workplace culture to ensure that all members may flourish, which is important for the PNEI in this study. The PNEI needs to develop strategies based on the identified challenges. This in turn, may improve development, retention and job satisfaction of nurse educators.

Funding

No external funding was received.

Authors contributions

All three authors were part of the data collection process, conceptualisation of the manuscripts, writing as well as reviewing the final manuscript.

Conflict of interest

None to declare from any of the authors.

Acknowledgement

Dr. Cheryl Tosh for editing.

References

Burns, D. J., & Mooney, D. (2018). Transcollegial leadership: a new paradigm for leadership. *International Journal of Educational Management*, *32*(1), 57-70. https://doi.org/10.1108/IJEM-05-2016-0114

Cook, N. F., McCance, T., McCormack, B., Barr, O., & Slater, P. (2018). Perceived caring attributes and priorities of preregistration nursing students throughout a nursing curriculum underpinned by person-centredness. *Journal of Clinical Nursing*, *27*(13-14), 2847-2858. https://doi.org/https://doi.org/10.1111/jocn.14341

Department of Health. (2013). Government Gazette, 2013. The National strategic plan for nursing education, training and practice. Gauteng. (23-47).

Dewing, J., McCormack, B., & Titchen, A. (2014). *Practice development workbook for nursing, health and social care teams*. John Wiley & Sons.

Flott, E. A., & Linden, L. (2016). The clinical learning environment in nursing education: a concept analysis. *Journal of Advanced Nursing*, *72*(3), 501-513. https://doi.org/https://doi.org/10.1111/jan.12861

McCance, T., McCormack, B., & Dewing, J. (2011). An exploration of person-centredness in practice. *Online J Issues Nurs*, *16*(2), 1.

McCormack, B., Karlsson, B., Dewing, J., & Lerdal, A. (2010). Exploring person-centredness: a qualitative meta-synthesis of four studies. *Scandinavian Journal of Caring Sciences*, *24*(3), 620-634. https://doi.org/https://doi.org/10.1111/j.1471-6712.2010.00814.x

McCormack, B., Manley, K., & Titchen, A. (2013). *Practice development in nursing and healthcare*. John Wiley & Sons.

Mitić, S., Vukonjanski, J., Terek, E., Gligorović, B., & Zorić, K. (2016). Organizational culture and organizational commitment: Serbian case. *Journal of engineering management and competitiveness (JEMC)*, *6*(1), 21-27.

Ndlovu, W., Hlanganipai, N., & Setati, S. T. (2017). Existing organizational culture typologies and organizational commitment at a selected higher education institution in South Africa. *Investment Management & Financial Innovations*, *14*(2), 242-251. https://doi.org/http://dx.doi.org/10.21511/imfi.14(2-1).2017.09

Ng, J. L., Johnson, A., Nguyen, H., & Groth, M. (2014). Workplace culture improvements: A review of the literature. *A report for the Workforce Planning and Development Branch of the NSW Ministry of Health. Sydney, Australia: University of NSW and University of Sydney*.

Ovseiko, P. V., Pololi, L. H., Edmunds, L. D., Civian, J. T., Daly, M., & Buchan, A. M. (2019). Creating a more supportive and inclusive university culture: a mixed-methods interdisciplinary comparative analysis of medical and social sciences at the University of

Oxford. *Interdisciplinary Science Reviews*, *44*(2), 166-191. https://doi.org/10.1080/03080188.2019.1603880

Polit, D. F., & Beck, C. T. (2017). *Nursing research: Generating and assessing evidence for nursing practice*. Lippincott Williams & Wilkins.

Rathert, C., Wyrwich, M. D., & Boren, S. A. (2012). Patient-Centered Care and Outcomes: A Systematic Review of the Literature. *Medical Care Research and Review*, *70*(4), 351-379. https://doi.org/10.1177/1077558712465774

Teeling, S. P., Dewing, J., & Baldie, D. (2020). A Discussion of the Synergy and Divergence between Lean Six Sigma and Person-Centred Improvement Sciences. *International Journal of Research in Nursing*, *11*(1), 10-23. https://doi.org/10.3844/ijrnsp.2020.10.23

Trede, F., & Titchen, A. (2012). Transformational practice development research in the healthcare professions: a critical-creative dialogue. *International Practice Development Journal*, *2*(2).

Wareing-Jones, S. (2016). *Whispers and song: a phenomenological inquiry to discover nurses' lived experience of person-centred dementia care* Queen Margaret University, Edinburgh].

CHAPTER 4
EFFECTIVE TEAMWORK

4.1 INTRODUCTION

In Chapter 3 an in-depth overview of the current workplace culture of the specific PNEI were provided. In this chapter promoting a person-centred workplace culture by fostering effective teamwork will be presented in article format. Teamwork were identified as one of the challenges in the PNEI that hindered a person-centred workplace culture.

The World Health Organization (WHO) (WHO, 2015) supports effective teamwork to promote a person-centred workplace culture and retain human resources. Teamwork is one of the key components underpinning a person-centred workplace culture

Please note:

The page numbers of this chapter will be in accordance with the pages from the published article in the journal, Nurse Educator Today. The article was published on 22 January 2021 in Nurse Educator Today.

Nurse Education Today 99 (2021) 104783

Contents lists available at ScienceDirect

Nurse Education Today

journal homepage: www.elsevier.com/locate/nedt

Promoting a person-centred workplace culture in a public nursing education institution in South Africa by fostering effective teamwork amongst nurse educators

Queen Khanyisile Masimula, Annatjie van der Wath, Isabel Coetzee *

Department of Nursing Science, University of Pretoria, Pretoria, South Africa

ARTICLE INFO

Keywords:
Effective teamwork
Nurse educators
Nursing education institution
Workplace culture
Person-centeredness

ABSTRACT

Background: Promoting a person-centred workplace culture in organisations is one of the most challenging tasks for both employers and employees. Person-centred workplace cultures and effective teamwork have been linked to achieving optimal organisational outcomes.
Aim: We report nurse educators' perceptions of the elements required for effective teamwork to promote a person-centred workplace culture in a public nursing education institution in South Africa.
Methods: A consensus meeting with 32 participants, purposively selected from a population of nurse educators and nursing managers. Data were collected during the consensus meeting, which was facilitated by two external nursing education experts. Data were analysed thematically.
Results: Three main themes emerged during the consensus meeting in relation to effective teamwork. The first theme was positive work relations, with categories of: knowing self and others, respecting self and others and trusting self and others. The second theme that emerged was effective communication with categories of: sharing information, cultural sensitivity and diversity. The third theme was group cohesion with categories of: active participation, adherence to work plan, collective vision of goals and collective decision making.
Conclusion: Positive work relations open the door towards effective teamwork. Effective communication ensures the smooth dissemination of information and feedback to facilitate effective teamwork and in turn promote a person-centred workplace culture.

1. Introduction

The South African government has to manage a quadruple burden of disease with a shortage of nursing staff. South Africa has experienced difficulties in training enough nurses due to inadequate financial, material, infrastructure and human resources (Mkhize, 2009; NDoH, 2013). In 2011, the South African Health System held a Nurses' Summit to discuss the reform of Public Nursing Education Institutions (PNEIs) to enhance the output of competent professional nurses (National Department of Health (NDoH), 2013). In South Africa, the output of nursing professionals does not match the demand for health services in the South African community. To increase the output of professional nurses at PNEIs, the NDoH (2013) increased student nurse intakes. With the number of nurse educators staying the same, the increased student intake resulted in a ratio of one lecturer to 300 students (NDoH, 2013), creating an unmanageable workload for nurse educators. The situation was further exacerbated by reforming PNEIs to higher education institutions, which took place in November 2019. The first author, a nurse educator at a PNEI, observed that the high workload and on-going changes in PNEIs affected workplace culture, reducing nurse educators' job satisfaction resulting in high staff turnover and marked attrition. The unconducive workplace culture negatively affected organisational outcomes (NDoH, 2013) and an intervention was needed to retain nurse educators.

In other countries such as Norway, Canada, the United States, Australia and Denmark, person centred workplace culture forms the basis of health care system reforms, guiding the delivery of person-centred health care (McCance and McCormack, 2016). The World Health Organisation (WHO) (WHO, 2015) supports effective teamwork to promote a person-centred workplace culture and retain human resources (McCormack et al., 2015; Hanaysha, 2016; Thomson et al., 2015; Nadal et al., 2015; Logan and Malone, 2017). Teamwork can be

* Corresponding author.
E-mail address: Isabel.coetzee@up.ac.za (I. Coetzee).

https://doi.org/10.1016/j.nedt.2021.104783
Received 27 August 2020; Received in revised form 9 December 2020; Accepted 12 January 2021
Available online 22 January 2021
0260-6917/

accurately defined as a group of individuals who work cooperatively to achieve a specific task or goal (Sanyal and Hisam, 2018).

Given the experiences of the first author, we decided to explore nurse educators' perceptions of successful teamwork at a PNEI, as a way of promoting a person-centred workplace to achieve optimum organisational outcomes. Teamwork is one of the key components underpinning a personcentred workplace culture. For the purpose of this paper we adopted the following definition:

"Person -centredness is an approach to practice established through the formation and fostering of healthful relationships between all care providers, service users and others significant to them in their lives. It is underpinned by values of respect for persons (personhood), individual right to self-determination, mutual respect and understanding. It is enabled by cultures of empowerment that foster continuous approaches to practice development" (McCormack and McCance, 2017).

2. Methods

2.1. Study design

We employed a qualitative, consensus design, guided by a critical realism approach (Clark, 2008). The transformative paradigm believes that rich knowledge is optimised when researchers interact with those being researched and the findings are the creation of an interactive process (Polit and Beck, 2017).

In this paper, we report on the findings generated during a collaborative consensus meeting, where participants explored their perceptions of successful teamwork to promote a person-centred workplace culture. The consensus meetings took place at the PNEI in 2019.

2.2. Participants

This study was conducted at one of six PNEIs in the Gauteng province of South Africa. All PNEIs share the same context and are managed by the Department of Health. In South Africa, all PNEIs are controlled by the South African Nursing Council and governance is provided by the Nursing Act (Act No. 33 of 2005) and Council for Higher Education. The PNEI has 92 academic staff consisting of 82 nurse educators and 10 nursing managers.

Nurse educators and nurse managers were purposively sampled from a population of 92 academic staff members employed at the PNEI. We presented the study information during academic meetings, and invited potential participants to attend the consensus meeting. We included all nurse educators who had signed a consent form and had worked at the PNEI for more than six months. In total, 32 participants attended the consensus meeting that was presented as half day workshops. Based on the fact that the consensus meetings were facilitated during nurse educators official work hours, only the nurse educators who had no academic responsibilities for the morning could attend the workshops as not to disrupt any academic activities.

2.3. Data collection

Data were collected during a consensus meeting held in February 2019. We conducted the consensus meeting at a convenient time in a lecture room with a projector and whiteboard to display key findings during the discussion. Two consensus meetings were held and each lasted 6 h. The meeting was digitally recorded. Two external nursing education experts, who were experienced in consensus research, facilitated the workshops. The facilitators posed questions on workplace culture beliefs and values to initiate the meeting. The participants were divided into smaller groups of five to six participants and were asked to answer the following question: *How can teamwork be employed to promote a person centeredness workplace culture?* Each group collaboratively generated answers, which were summarised as themes and recorded on whiteboard pages.

2.4. Data analysis

The group, facilitated by the nursing education experts, analysed the data using the thematic data analysis method proposed by Creswell and Creswell (2018). Each group ranked the themes in order of importance and indicated their ranking on the whiteboard. Based on the rankings, the whole group reached consensus on the main themes pertaining to aspects of effective teamwork needed to promote a person-centred workplace culture. We assigned categories to each theme. Categories represented the actions required to achieve each theme. We gave participants a hard copy of the final results, and participants provided feedback to refine and interpret the final themes and categories as recommended by du Plooy-Cilliers and Bezuidenhout (2015).

3. Results

3.1. Participants demographics

The participants included 30 female and two male nurse educators, which was expected as nursing is a "female-dominated profession". The mean age of participants was 48.5 years, ranging from 30 to 64 years.

3.2. Themes and categories

Three main themes emerged in relation to nurse educators' perceptions of effective teamwork needed to promote the workplace culture to person-centredness. The three themes, and their associated categories were as follows: Positive work relations: *knowing self and others, respecting* self *and others,* and *trusting self and others.* Effective communication: *sharing information, cultural sensitivity and diversity;* Group cohesion: *adherence to work plans, collective vision of goals,* and *clear roles and responsibilities.*

3.2.1. Positive work relations

Participants indicated that positive work relations build effective teams and strengthen team efforts for maximum productivity. Resulting in teamwork and collaboration to reach set goals and organisational outcomes. Positive work relations amongst staff members it will promote a personcentred workplace culture.

They highlighted the type of behaviour desired for positive work relations, for example, a positive attitude.

> "I feel very good when our relationship is healthy in our work teams… we are able to assist each other with tasks…you don't struggle alone" [Participants No. 2, 8, 9, 22, 32]

3.2.1.1. Knowing self and others. From nurse educators' perspectives, being able to know and understand yourself in the team is the basis for knowing other person's needs. Transformation requires working relationships where nurse educators care for each other psychologically and emotionally. Caring attitudes ensure that teams are effective in every task. These caring attitudes and the fact that team members can complement each other's strengths and weaknesses will facilitate the promotion of a personcentred workplace culture where every staff member will be acknowledged and valued as a team member.

> "I think the truth that will help all of us to win as a team is the need to know yourself well in order to understand others in the team… people need to change". [Participants No. 11,14, 21, 27, 29]

Participants felt that knowing yourself allows you to know your strengths and your weaknesses. Team members need to balance each other's strengths and weaknesses for the team to succeed.

"*My belief is that we should help others develop to improve their weak points so that they can perform task better next time*" *[Participants No. 1, 5, 10, 20, 28]*

3.2.1.2. Respecting self and others. Nurse educators emphasised that respecting yourself and others reflects a responsible attitude. Responsibility towards yourself and others helps the team to accomplish their tasks effectively and successfully. Lack of respect influences the effectiveness of the team.

"I value to be treated with respect especially in our work teams… I can't be productive when I'm disrespected". [Participants No. 1,10, 13, 15, 20]

3.2.1.3. Trusting self and others. Nurse educators valued the importance of trust in themselves and amongst team members to ensure collaboration towards completion of tasks. Trust in each other is a vital component of a personcentred workplace culture. Nurse educators recognised that mistrust divides team members and affects team spirit, motivation and causes negative feelings while compromising team efforts.

"You can't trust other team members with certain task…they always bring disappointments" [Participants No. 3, 7, 9, 11, 29]

3.2.2. Effective communication

Nurse educators valued and acknowledged the importance of continuous feedback to establish effective communication and teamwork and they felt that continuous feedback was a challenge in their teams. A need was identified to facilitate effective feedback and communication to enhance teamwork and promote a workplace culture where everyone flourishes.

"I think we are challenged with communication in our work groups, we need effective communication…. and I mean not just communication…. to lessen frustrations in our daily tasks." [Participants No. 1, 9, 10, 11, 20, 32]

"I do not like to receive late feedback because it affects my performance in the team and I look like someone who is not vigilant to the work group" [Participants No. 8, 13, 20, 28, 30]

3.2.2.1. Sharing information. Most nurse educators preferred a direct dialogue when sharing information so that misinterpretations and misconceptions could be clarified immediately. Participants felt that other modes of communication such as emails, policies, circulars, minutes and procedures were not always properly communicated and did not help teams to perform tasks on time.

"I think having information is acknowledged but sharing it is powerful and all team members can benefit…I mean some people hardly share information". [Participants No. 9, 11,18, 23, 26]

3.2.2.2. Cultural sensitivity and diversity. Nurse educators voiced mixed views and feelings of concern and disagreement when they discussed cultural sensitivity and diversity. Some participants thought that one cannot be sensitive to another person's culture when such sensitivity is not mutual. Cultural diversity should be respected for everyone to flourish.

"Tolerance of each other's culture and respect for diversity in our teams are more essential for a healthy dialogue" [Participants No. 1, 9, 12, 14, 25]

"When dealing with culturally sensitive issues…my experience has always been that…as a person you have no choice, but to be as careful and patient as far as possible…cultural issues turn-out to great conflicts" [Participants No. 1, 5, 11, 20, 32]

3.2.3. Group cohesion

Participants mentioned that group cohesion was a challenge in their PNEI, and that it was difficult to facilitate effective teamwork. Nurse educators viewed group cohesion as being "glued" together when performing tasks in work teams.

"Sometimes we don't work together in our teams and compromised teamwork". [Participants No. 3, 10, 14,21, 30]

"My experience is that some group members do not want to work with other members, they pick and choose who they want to work with…then you find that the weak group members work together while the strong group members work together…that destroys team performance…" [Participants No. 1, 7, 9, 10,16, 22]

3.2.3.1. Adherence to work plans. From the nurse educators' perspective, all team members need to have will power to adhere to work plans. Nurse educators expressed that some team members did not adhere to the work plan, creating challenges in the workplace.

"I don't understand reasons of non-compliance from our team members, because most work policies are in place…I mean policies with lack of compliance is nothing….failure is obvious in poor adherence to work plans…I mean it's less stressful to comply than not to comply with work plans…" [Participants No. 4, 8, 11, 15, 29, 32]

3.2.3.2. Collective vision of goals. Nurse educators expressed that a collective vision of goals was needed. All members need to share similar interests towards building successful teams to achieve optimal workplace goals. Without collective goals, team members cannot execute an organisational vision.

"I think effective teamwork is dependent on a shared vision, shared goals and shared spirit, but I don't see it being practical here…."[-Participants No. 4, 13, 16, 29, 32]

3.2.3.3. Clear roles and responsibilities. Nurse educators reported problems with executing their roles and responsibilities. Poorly defined roles lead to conflict in the team.

"Some roles and responsibilities are not clear in our teams, they overlap with other roles and cause confusion and conflict..." [Participants No. 13, 14, 16, 24, 32]

"I believe that effective teamwork is reaping the fruits of having clearly articulated work roles and responsibilities… you become your own role model and it gives you a sense of so much satisfaction." [Participants No. 2, 3, 7, 11, 21, 23]

4. Discussion

Promoting a workplace culture that is person-centredness will enhance the collaboration, inclusion and participation amongst team members as suggested by McCormack et al. (2014). According to Parratt et al. (2016) effective teamwork consists of skills and learned behaviours that allow individuals to work towards team goals while upholding their own integrity.

Salman and Hassan (2016) argued that effective teamwork improves organisational motivation through performance of employees. The authors pointed out that effective teamwork is a central feature of any organisation and considered as a critical factor to create and sustain organisational improvements.

4.1. Positive work relations

Nurse educators felt that positive relations are complementary to effective teamwork to achieve organisational goals. According to An and Kang (2016), positive relations are important baseline organisational variables that need to be obtained to facilitate effective teamwork in nursing workplace cultures. Effective teamwork is supported by core values of participation, connectedness, humaneness, mutual trust, empathy and respect. Positive work relations create comfort, community spirit, intimacy and mutual respect (An and Kang, 2016). Without a positive attitude, nurses may become dissatisfied and find themselves working in a workplace dominated by increased interpersonal conflict, authority abuse, discrimination, social isolation, communication errors and political attitudes that compromise teamwork and outcomes (Pilch and Turska, 2015).

4.1.1. Knowing self and others

Nurse educators felt that knowing yourself and others entails being able to take control of yourself and others in a team. With this knowledge, team members can cooperate with others in groups to facilitate effective teamwork. In this study, some nurse educators had challenges with knowing themselves and found it difficult to know and relate well with others. As part of a team, nurse educators mentioned that not acknowledging the strengths but rather concentrating on weaknesses of other team members contributed to unhealthy work relations. Knowing yourself leads to attaining organisational outcomes based on self-observation, self-goal setting, focus on new ideas, competence development, cooperation, coordination and positive inner dialogue (Amundsen and Martinsen, 2015). Farmer et al. (2015) explained that if members do not know and lead themselves positively it could lead to ineffective teamwork with poor performance and unhealthy work relations.

4.1.2. Respecting self and others

Nurse educators believed that effective teamwork depended on respect for both self and others. According to Carmeli et al. (2015) respect for self and others relates to behaviours that express respect between team members. Facilitating respect for self and others through effective teamwork requires understanding and appreciating others, listening to and attending to other members' needs, and responsible communication that demonstrates caring (Carmeli et al., 2015). Mathieu et al. (2017) suggest that individuals need to work together to achieve shared goals, and the efficiency of the team depends on individuals' attitudes and behaviours. For nurse educators, respectful interactions in teams could prevent negative situations.

4.1.3. Trusting self and others

Nurse educators believed that effective teamwork required a certain level of trust in self and others. Participants indicated that some team members did not trust the standard of their own performance, dragging more efficient team members down to their level, creating poor work relations. Zak (2017) is if the opinion that effect teamwork depends on a trusting workplace. Furthermore Zak (2017) also suggests that employees in high-trust teams are more productive, more energetic at work, collaborate more with teammates, suffer less chronic stress and are more joyful with high performance. These employees stay longer with their organisations compared to employees with a low trust for both self and others. Stander et al. (2015) recommend that organisations should encourage managers to embrace a more authentic leadership style that will lead to higher levels of optimism, trust and effective teamwork to assist employees to manage demanding working environments.

4.2. Effective communication

Nurse educators in this study highlighted that effective communication is the cornerstone of effective teamwork. According to participants, poor communication leads to a lack of transparency, fragmentation of information, information overload, and poor listening. Anderson (2017) identified that teamwork is more likely if nurses demonstrate effective communication, such as listening to understand and with intent, repeating and validating the information received and seeking understanding. Anderson (2017) also highlighted that ineffective communication leads to team failure, human errors and negative outcomes. In nursing education institutions, inter-professional educational workshops are needed to improve communication skills to improve the workplace culture and foster effective teamwork (Orr, 2017).

4.2.1. Sharing information

One of the aspects of effective communication is the adequate, timeous sharing of information. Nurse educators in our study complained that some educators were reluctant to share important information, filing information away or sharing information in silos. Sharing information, timeously, facilitates effective teamwork by reducing mistakes, increasing effectiveness, improving integration and competencies (Lee et al., 2016; Nadal et al., 2015).

4.2.2. Cultural sensitivity and diversity

Nurse educators stated that effective teamwork relied on cultural sensitivity and appreciation for diversity. Despite efforts to improve cultural sensitivity, nurse educators still embraced and prioritised their own culture, compromising effective teamwork (this study). Tompos and Ablonczy-Mihályka (2018) highlighted that teams made up of different cultural backgrounds contribute new ideas, new knowledge and new approaches to solve team tasks while cultural diversity brings innovation to improve teamwork. Fostering cultural sensitivity and diversity at the workplace has many benefits, including fewer conflicts and disputes, more amicable workplace relations and stronger workplace core values and beliefs (Ferreira and Groenewalt, 2016). Our findings suggest that nurse educators first need to participate in intercultural training programmes to improve workplace culture (Tompos and Ablonczy-Mihályka, 2018) before teambuilding activities can start.

4.3. Group cohesion

Nurse educators mentioned a need for better group cohesion between team members. Poor group cohesion was evidenced in conflicts, poor relations, judgemental attitudes and lack of trust. Chen et al. (2016) found that group cohesion is important for social integration and emotional attachment amongst team members, while reducing conflict, inviting group harmony and enhancing positive emotional experiences of group members. According to Xie et al. (2019) group cohesion facilitates self-regulated and collaborative learning strategies amongst peers.

4.3.1. Adherence to work plan

Nurse educators struggled to adhere to work plans due to high workload and increasing student numbers. The overwhelming workload

also resulted in ineffective implementation of individual work plans and poor adherence to time lines, leading to disrupted work relations. Proper planning is required for employees to adhere to work plans (Ferreira and Groenewalt, 2016). Foster (2020) suggests that adherence to plans can be improved by monitoring adherence patterns, providing social support, developing action plans to address specific adherence barriers, providing support and regular re-assessment of action plans to attract adherence behaviours. For effective teamwork, all team members need to adhere to work plans and comply with time lines to reduce stress and tension in the team (Ferreira and Groenewalt, 2016).

4.3.2. *Collective vision of goals*

Nurse educators felt that teamwork was compromised by a lack of congruence between team goals and workplace goals. Collective goals and visions need to align with organisational outcomes so that managers and supervisors are able to manage subordinates. Everyone should plan around the organisational outcomes and there should be no surprises (Vanderstukken et al., 2018). Organisations may try to encourage compliance to organisational goals by using transformational leadership to help teams develop autonomy and realise the significance of a specific task while providing continuous feedback to enhance motivation towards effective teamwork (Barrick et al., 2015).

4.3.3. *Clear roles and responsibilities*

Nurse educators maintained that team members should have clear roles and responsibilities in relation to allocation of tasks. Nurse educators have a clear job description, but when tasks are allocated in teams some roles and responsibilities may overlap and cause confusion. According to Nkoma (2018), employees prefer having clear roles and responsibilities so that they know what activities they should do. Hanaysha (2016) recommends that roles and responsibilities should be delegated together with empowerment for the given task to reap the advantages of increased responsibility, high employee morale, a favourable workplace culture and effective teamwork.

5. Strengths and limitations of the study

In this study important aspect regarding teamwork were identified and addressed to promote a personcentred workplace culture in a specific PNEI. We raised awareness' of the importance of teamwork as a vital component of a personcentred workplace culture. Our findings are limited to one specific PNEI and only academic staff were included as participants.

6. Conclusion

Overall our findings provide encouraging indications that nurse educators could critical reflect and identify key aspects needed for effective teamwork to promote a personcentred workplace culture where all staff members can flourish. To enhance effective teamwork, nurse educators need to acquire self-awareness and mindfulness. They also emphasised the importance of respect and trust to promote a person-centred workplace culture. Participants viewed effective communication that entails sharing of information, feedback and cultural sensitivity as vital to teamwork. They valued group cohesion that could be achieved through active participation, adherence to work plans, collective vision of goals and decision making, and clear roles and responsibilities. Ultimately effective teamwork forms one of the key components underpinning a personcentred workplace culture.

Author statement

I hereby declare that the following revisions were made based on the feedback received by the reviewers. All three authors agreed on the following revisions;

- ✓ Title were changes as suggested to focus on team work and the impact on a personcentred workplace culture
- ✓ The introduction and conclusion were revised as suggested
- ✓ A Definition for teamwork and personcentred workplace culture were added
- ✓ The new references were added to the reference list
- ✓ We added the link between teamwork and the personcentred workplace culture throughout the manuscript
- ✓ Attention were given to editorial errors

Funding source

This study received no funding.

Ethical approval

Ethical approval for the study was obtained from the University of Pretoria Research Ethics Committee (Ethic Reference No: 760/2018).

Declaration of competing interest

The authors declare that there are no conflicting interests.

Acknowledgements

We wish to thank and acknowledge the nurse educators and nursing managers who supported the study with their time and experience.

References

Amundsen, S., Martinsen, Ø.L., 2015. Linking empowering leadership to job satisfaction, work effort, and creativity: the role of self-leadership and psychological empowerment. Journal of Leadership & Organizational Studies 22 (3), 304–323.
An, Y., Kang, J., 2016. Relationship between organizational culture and workplace bullying among Korean nurses. Asian Nursing Research 10 (3), 234–239.
Anderson, H.A., 2017. Effective Communication and Teamwork Improve Patient Safety. Walden University, USA, pp. 1–46. https://scholarworks.waldenu.edu/dissertations.
Barrick, M.R., Thurgood, G.R., Smith, T.A., Courtright, S.H., 2015. Collective organizational engagement: linking motivational antecedents, strategic implementation, and firm performance. Texas A&M University. Academy of Management Journal 58 (1), 111–135. https://doi.org/10.5465/amj.2013.0227 (2015).
Carmeli, A., Dutton, J.E., Hardin, A.E., 2015. Respect as an engine for new ideas: linking respectful engagement, relational information processing and creativity among employees and teams. Hum. Relat. 68 (6), 1021–1047.
Chen, C.C., Ünal, A.F., Leung, K., Xin, K.R., 2016. Erratum to: group harmony in the workplace: conception, measurement, and validation. Asia Pac. J. Manag. 33, 935–936.
Clark, A., 2008. Critical realism. In: Given, L.M. (Ed.), The SAGE Encyclopaedia of Qualitative Research Methods Volume 2. SAGE Publications Inc., California, pp. 167–169.
Creswell, J.W., Creswell, J.D., 2018. Research Design: Qualitative, Quantitative, and Mixed Methods Approaches. United Kingdom, p. 182.
du Plooy-Cilliers, F.D.C., Bezuidenhout, R., 2015. Research Matters. Juta and Company, Cape Town, p. 242.
Farmer, S.M., Van Dyne, L., Kamdar, D., 2015. The contextualized self: how team–member exchange leads to coworker identification and helping OCB. Journal of Applied Psychology 100 (2), 583.
Ferreira, E.J., Groenewalt, D., 2016. Administrative Management, 4th ed. Juta Publishers, Cape Town, p. 459.
Foster, B.J., 2020. Multicomponent interventions improve adherence—where do we go from here? Am. J. Transplant. 20 (1), 5–6.
Hanaysha, J., 2016. Testing the effects of employee empowerment, teamwork, and employee training on employee productivity in higher education sector. Int. J. Learn. Dev. 6 (1), 164–178.
Lee, J.C., Shiue, Y.C., Chen, C.Y., 2016. Examining the impacts of organizational culture and top management support of knowledge sharing on the success of software process improvement. Comput. Hum. Behav. 54, 462–474.
Logan, T.R., Malone, D.M., 2017. Nurses' Perceptions of Teamwork and Workplace Bullying. Wiley, Philadelphia, USA, pp. 411–418.
Mathieu, J.E., Hollenbeck, J.R., van Knippenberg, D., Ilgen, D.R., 2017. A century of work teams in the Journal of Applied Psychology. Journal of applied psychology 102 (3), 452.
McCance, T., McCormack, B., 2016. The person-centred practice framework. Person-centred practice in nursing and health care: theory and practice 36.
McCormack, B., McCance, T., 2017. Person -Centred Practice in Nursing and Health Care, Theory and Practice, 2nd ed. Blackwells, Oxford.

McCormack, B., Manley, K., Titchen, A., 2014. Practice Development in Nursing Healthcare, , 2nd.2013. Wiley-Blackwell, Oxford, p. 195.
McCormack, B., Borg, M., Cardiff, S., Dewing, J., Jacobs, G., Janes, N., Karlsson, B., McCance, T., Mekki, T.E., Porock, D., van Lieshout, F., Wilson, V., 2015. Person-centredness - the 'state' of the art. International Practice Development Journal 5 (Suppl.1), 1–15.
Mkhize, S.W., 2009. Transformational Leadingship Model for Nursing Education Leaders in Nursing Education Institutions (Pretoria : s.n), 2009, p. 93.
Nadal, C.T., Mañas, G.P., Bernadó, B.S., Mora, C.A., 2015. Assessing teamwork competence. Psicothema 27 (4), 354–361.
National Department of Health (NDoH), 2013. Gauteng : Government Gazette, 2013. The National Strategic Plan for Nursing Education, Training and Practice, pp. 23–47.
Nkoma, E., 2018. Perceptions of Zimbabwean trainee/educational psychologists regarding the training on their support roles and responsibilities in inclusive education. School Psychology International 555–572.
Orr, P., 2017. Integration of interprofessional education across a community college health technologies division: promoting a culture of effective communication and teamwork. Doctor of Nursing Practice (DNP) Projects 116. https://repository.usfca.edu/dnp/116.
Parratt, J.A., Fahy, K.M., Hutchinson, M., Lohmann, G., Hastie, C.R., Chaseling, M., O'Brien, K., 2016. Expert validation of a teamwork assessment rubric: a modified Delphi study. Nurse Educ. Today 36, 77–85.
Pilch, I., Turska, E., 2015. Relationships between Machiavellianism, organizational culture, and workplace bullying: emotional abuse from the target's and the perpetrator's perspective. J. Bus. Ethics 128 (1), 83–93.
Polit, D.F., Beck, C.T., 2017. Nursing Research: Generating And Assessing Evidence For Nursing Practice, 10. Wolters Kluwer, Philadelphis.
Salman, W., Hassan, Z., 2016. Impact of effective teamwork on employee performance. International Journal of Accounting & Business Management 4 (1), 76–85.
Sanyal, S., Hisam, M.W., 2018. The impact of teamwork on work performance of employees: a study of faculty members in Dhofar University. IOSR Journal of Business and Management 20 (3), 15–22.
Stander, F.W., De Beer, L.T., Stander, M.W., 2015. Authentic leadership as a source of optimism, trust in the organisation and work engagement in the public health care sector. SA Journal of Human Resource Management/SA Tydskrif vir Menslikehulpbronbestuur 13 (1). https://doi.org/10.4102/sajhrm.v13i1.675 (art. #675,12 pages).
Thomson, K., Outram, S., Gilligan, C., Levett-Jones, T., 2015. Interprofessional experiences of recent healthcare graduates: a social psychology perspective on the barriers to effective communication, teamwork, and patient-centred care. Journal of interprofessional care 29 (6), 634–640.
Tompos, A., Ablonczy-Mihályka, L., 2018. The sustainability of cultural diversity in the workplace: cultural values and intercultural mindset. European Journal of Sustainable Development 7 (1), 298.
Vanderstukken, A., Schreurs, B., Germeys, F., Vaden Broeck, A., Proost, K., 2018. Should supervisors communicate goals or visions?. The moderating role of subordinates psychological distance. Journal of applied social Psychology 671–683.
World Health Organization, 2015. WHO Global Strategy on people-centred and Integrated Health Services: interim report. Retrieved from: http://apps.who.int/iris/bitstream/10665/155002/1/WHO_HIS_SDS_2015.6_eng.pdf?ua=1&ua=1. (Accessed 4 February 2016).
Xie, K., Hensley, L.C., Law, V., Sun, Z., 2019. Self-regulation as a function of perceived leadership and cohesion in small group online collaborative learning. Br. J. Educ. Technol. 50 (1), 456–468.
Zak, P.J., 2017. The neuroscience of trust. Harv. Bus. Rev. 95 (1), 84–90.

CHAPTER 5
PERSON-CENTRED LEADERSHIP

5.1 INTRODUCTION

In Chapter 4 promoting a person-centred workplace culture by fostering effective teamwork was discussed. This chapter will be presented in article format. Person-centred leadership was identified as vital to promote a workplace culture were all staff members can flourish.

Person-centred leadership in the workplace governs better outcomes through affording dignity, respect, compassion, caring and coordinated support resulting in personal and professional growth for all team members. A person-centred workplace culture needs effective leadership to deliver high quality services and ensure human flourishing. The article is titled: Transforming workplace culture using person-centered leadership in a nursing education institution in South Africa.

Please note:
The page numbers of this chapter will be in accordance with the pages from the published article in the journal, Gender and Behavior. The article was published in December 2020.

Gender & Behaviour, 18(3), December 2020 16492 - 16500
 ISSN: 1596-9231

TRANSFORMING WORKPLACE CULTURE USING PERSON-CENTERED LEADERSHIP IN A NURSING EDUCATION INSTITUTION IN SOUTH AFRICA

Q. Masimula, I Coetzee & A van der Wath
Department of Nursing Science
University of Pretoria
South Africa

Abstract

Person-centered leadership in the workplace governs better outcomes through affording dignity, respect, compassion, caring and coordinated support resulting in personal and professional growth for all team members. A person-centered workplace culture needs effective leadership to deliver high quality services and ensure human progress. We intended to explore person-centered leadership as a way of transforming the workplace culture. A qualitative consensus design guided the study. Forty-six nurse educators and nurse managers were purposively sampled. During a consensus meeting, participants explored the influence of leadership practices on creating a person-centered workplace culture. Data were thematically analyzed. Four themes related to person-centered leadership emerged during the consensus meeting, namely: leadership skills, leading change, collaborative decision making and workplace motivation. We recommend that leaders adopt person-centered leadership values to create a positive workplace culture for employees.

Key concepts: person-centered leadership, transformation, workplace culture, person centeredness

Introduction and background

Person-centered workplace cultures require person-centered leadership that uses strategies such as empowering and engaging employees, strengthening governance and accountability, coordinating services around employee needs, integrating effective networks, creating and enabling the environment for change (McCance & McCormack, 2017; World Health Organization, 2015). Person-centered leadership improves the workplace culture for better outcomes by affording dignity, respect, compassion, caring and coordinated support to enable all individuals to grow (Harding, Wait & Scrutton, 2015). This article reports on stakeholders' views regarding ways to use person-centered leadership for transforming the workplace culture in South African nursing education institutions.

According to Alonso-Almeida, Perramon and Bagur-Femenias (2017) a gap exists in research on transformational leadership styles for organizational sustainability, effective management and optimal organizational performance. Some researchers encourage organizations to use evidence-based methods to facilitate transformation in the workplace using a person-centered leadership approach to achieve better outcomes and performance. Person-centered leaders motivate their employees to achieve organizational goals (Cardiff, McCormack & McCance, 2018; McCormack & Dewing 2019; Lynch, McCormack, McCance & Brown, 2018).

Recently, acceptable leadership styles have shifted from the traditional hierarchal leader or "follow me" approach, to a person-centered approach of being an "associate" leader, reflecting humanistic values to guide nursing practice. Person-centered leadership promotes self-awareness, but is also other-centered so that both the leader and the employee flourish and achieve better organizational outcomes (Cardiff, McCormack & McCance, 2018). Leaders who are authentically other-centered, mindful and caring, are able to gather information about self and others in order to evaluate the workplace performance. These leaders promote a person-centered workplace culture by viewing employees as more than just colleagues or nurses and valuing them as distinct individuals. They work to find a common ground, try to be open and optimistic and promote a safe and nurturing work space (Cardiff, McCormack & McCance, 2018; Morsiani, Bagnasco & Sasso, 2017).

In nursing, leaders have many intricate responsibilities necessitating multifaceted leadership skills. Leadership styles affect nurses' job satisfaction levels and attrition rates in health organizations (McCormack & McCance, 2017; Eide & Cardiff, 2017). The American Nurses Association (2013) found that nursing leadership styles have a direct impact on nurses' job satisfaction which in turn affects their intention to stay or leave, influencing turnover rates. A lack of person-centered leadership has been associated with increased job stress, job dissatisfaction, anticipated nursing staff turnover, and poor personal and organizational outcomes (Pishgooie, Atashzadeh-Shoorideh, Falcó-Pegueroles & Lotfi, 2019). Nurse managers need to switch to transformational leadership styles as a retention strategy for nurses and to improve job satisfaction (American Nurses Association,

2013). Similarly, Heyns and McCormack (2014) suggested that South African health care systems move from crisis intervention to person-centeredness to improve the shortage of nurses and nurse leaders in the workplace. Adopting person-centered leadership should also promote a nurturing workplace culture which will improve experiences of caring (Heyns & McCormack, 2014).

Armstrong and Rispel (2015) and Blaaw, Ditlopo and Rispel (2014) suggest that flexible and efficient leadership styles should also be applied in nursing education institutions to improve nurse educator experiences. According to O'Donnell, Cook and Black (2017), we need to explore the academic experiences of students and nurse educators to promote person-centered practices at nursing education institutions. Nursing students need to learn about person-centered practices and workplace management from educators who are confident and knowledgeable managers themselves (O'Donnell, Cook & Black, 2017). Focusing on leadership in a nursing education institution in South Africa, we explored the best leadership approach for improving organizational outcomes and job satisfaction, to prevent attrition and provide a nurturing workplace for nurse educators.

Methods

Study design

We qualitatively explored leadership practices that could be used when transforming workplace culture towards person-centeredness. We used a consensus design within a critical realist paradigm to describe the experiences of participants. According to Clark (2008), the original author of critical realist paradigm, critical realism embraces a complex view of reality and is cognizant of the effect of work and structural factors predominant in human behavior. Stevens (2019) indicated that on an ontological level the researcher working within critical realism needs to prove that the events described and explored are real, actually occurred in principle, and represent the authentic experiences of the participants. The consensus meeting in this study allowed us to explore the experiences of nurse educators in their real work setting (Creswell & Creswell, 2018). The aim of the meeting was to agree on a possible leadership approach that could be adopted towards transforming the workplace culture to person-centeredness. We report on the results of two consensus meetings that took place in 2019 at a public nursing education institution (PNEI) in South Africa.

Participants

We purposively selected nurse educators from a potential population of 92 nurse educators and nurse managers, all at different levels of leadership in the PNEI under study. Nurse educators were personally recruited and invited during academic activities. Upon invitation, we formally presented information about the study to nurse educators. Nurse educators were included as suitable participants if they had been employed for six months or more at the PNEI and were willing to participate in the study. Nurse educators were excluded if they had worked fewer than six months at the PNEI.

Interested nurse educators signed informed consent forms before the consensus meeting. For clarity, participants refer to both nurse educators and nurse managers. A total of 46 participants attended two consensus meetings. The University of Pretoria Research Ethics Committee approved the study (Ethic Reference No. 760/2018).

Data collection

Data were collected during two consensus meetings in May 2019. Participants engaged during the consensus meetings to gain a deeper understanding of the leadership approach needed to transform the workplace culture towards person-centeredness. The consensus meetings were held in a classroom with an overhead projector, a computer, a whiteboard and markers to write key information during discussions. The consensus meetings were scheduled on college academic capacitation days and lasted six hours each.

The first author (QKM) is employed at the PNEI and was not involved in data collection to avoid bias. Two external nursing education experts, with experience in conducting consensus meetings acted as facilitators. The facilitators developed rapport through ice-breakers and sharing refreshments with participants to support socialization and engagement. The participants were randomly assigned to six small groups with six to seven participants in each group. The participants discussed the question posed by the facilitators: "What leadership practices should be employed to transform the workplace culture towards person-centeredness?" The facilitators moved between the groups and facilitated the discussions by acknowledging participants' contributions using reflective communication skills. Each of the groups generated answers, which they wrote on sticky notes.

Participants reported back to the consensus meeting and attached their answers to the white board. All the answers were recorded and stored for reference.

Data analysis

Data were analyzed during the consensus meeting using the Creswell and Creswell (2018) thematic data analysis method. All participants contributed to the data analysis.

The participants grouped the answers into themes, based on similarities. They ranked the themes in order of importance, and indicated their rankings on the whiteboard. All the rankings were also projected on a screen for transparency. The facilitators and participants discussed the proposed rankings until everybody agreed on the main themes or the best leadership approach for transforming the workplace culture to person-centeredness. The groups debated all disagreements amicably until they agreed on the themes. All groups received a hard copy of the final results and were requested to provide feedback and input to facilitate refinement and interpretation of the final themes as recommended by du Plooy-Cilliers, Davis, and Bezuidenhout (2014).

Results

Demographics of participants

The 46 participants were divided into six groups that included 42 women and two men. The ages of participants ranged between 30-64 years while the mean age of participants was 48.55 years.

Themes

The main theme, identified as person-centered leadership, was divided into the following four sub-themes: leadership skills, leading change, collaborative decision making, workplace motivation.

Person-centered leadership

Participants acknowledged and recognized that person-centered leadership is needed to develop person-centered values. They felt that person-centered leadership was neglected in their workplace. The participants described a person-centered workplace culture as respecting human dignity, personhood and nurturing. Participants felt that person-centered leadership would meet their need to be acknowledged and respected:

"I like my job, but the main challenge is that no one seems to realize that you are also a person with human needs at the workplace to support you to the job...like being given all together with the job... like be given respect as a person, the love, care, human dignity... and of course being paid well"
[Participants No.3, 11, 19, 20, 5 supported the quotation]

Participants felt that their workplace lacked person-centered leadership, because leadership was being impeded by conflicting priorities. According to participants, leadership is being pressurized by policy mandates, limited staffing and shortage of resources, coupled with challenges of an ever-changing context, as exemplified by the following participants:

"What is important at work is just to get the work done and not really the person doing the job... no one seems to care how you felt after running around working-out with insufficient resources"
[Participants No.22, 14, 1, 27, 6 supported the quotation]

Leadership skills

Participants agreed that person-centered leadership skills have the potential to create a safe and peaceful organizational culture that will motivate all employees to obtain quality outcomes. Participants indicated that the absence of person-centered leadership leads to challenges such as a lack of motivation, appreciation and empowerment. They expressed their experiences as follows:

"There is nothing motivating...you just have to do what you are told to do even if you are struggling with given mandates ... because you are not empowered enough, but when you talk about it it's like you are complaining ...so you work just to earn a living and for peace's sake"
[Participants No.13, 40, 2, 25, 28]

"Sometimes we overlap with our tasks because of staff shortages...but you get nothing ...no appreciation...it's as if you had done your normal job...but the other problem comes when others are acknowledged and others are not acknowledged for the same tasks"
[Participants No.19, 26, 32, 9, 20]
"I expect continuous coaching, orientation and empowered well for my task for quality purposes"
[Participants No.7, 46, 34, 3, 4]

Participants indicated that person-centered leadership would strengthen transformation of the workplace culture so that people could flourish at work. Participants felt that person-centered leadership skills including caring attitudes, mindfulness, respect, compassion, and continuous active engagement and mentoring were lacking.

"Respect for all is important, just like being mindful and compassionate during active engagement with our daily activities, but I become emotionally, spiritually and physically drained in the absence of these supportive leadership skills"
[Participants No.5, 39, 8, 17, 42]

"Some leaders are not caring on their communication...I mean they are not being mindful of their talking ... as other leaders are rough when talking...it's not respecting the other person" [Participants No.34, 10, 15, 28, 2]

"I was not mentored well...I had to do the task alone because my colleague was on leave ... then I struggle alone I mean leaders must plan activities smart"
[Participants No.4, 9, 27, 38, 12]

Leading change
Participants were open to embracing change and transforming the workplace culture to person-centeredness. Despite their willingness, they felt that changes were sometimes introduced too abruptly without proper communication, planning and allocation of sufficient resources:

"I get frustrated when a new activity is introduced at work without responsible resources allocated together with the task... you struggle with the changes... its demotivating really even if the change is good"
[Participants No.6, 19, 35, 18, 16]

Participants felt dissatisfied about changes being introduced without effective communication. They emphasized that leaders should communicate clearly and orientate all educators about intended changes:

It's good when change is introduced at work so that we are able to move with times, but I see orientation of some activities is not done thoroughly. I assume orientation to change should be done until everybody is competent and should be well modelled.
[Participants No.10, 22, 25, 45, 24]

Participants understood that skilled leadership is required to facilitate a person-centered workplace culture. Participants viewed the process of leading change as requiring collaborative planning and consistent coaching skills, however, participants were concerned that proper change management was lacking.
"I like the changes that are taking place at work...but they lack a lot of continuous responsible coaching from some leaders at different levels, sometimes everyone seems to be leading, I become confused with everybody giving directions..."
[Participants No.34, 4, 15, 28, 2]
"I believe we should be capacitated well on all these changes that are taking place but what I see most is hands-on the job activities...some changes lack ownership and there's no expect for changes...and that gives me a concern"
[Participants No.3, 1, 15, 29, 10]

Collaborative decision making
Participants identified collaborative decision making as an important leadership skill to connect all stakeholders with shared values and beliefs to transform workplace culture to the benefit of all employees. Participants

identified an absence of collaborative decision-making platforms and they were not sure how these could be established.

"We are not involved in decision making platforms ...instead you are told how things have been decided at other levels...but you are the user and not involved" [participant-2, 7, 29, 33, 42]

"I would like to participate in collaborative transformation platforms, to be included in decision making is connectedness...I would appreciate if my inputs on decisions could be tabled no matter how small it may be" [Participants No.4, 19, 5, 42, 40]

According to the participants, successful leadership requires teamwork and participative leadership interaction at all levels. The participants found that collaborative decision making was lacking at different levels and suggested that all contributions must be welcomed and debated:

"I don't believe there is collaborative decision making over one vocal leader who dominates the meeting with ideas over other leaders' ideas...all ideas must be welcomed and debated" [Participants No.30, 1, 7, 37]

"Political leadership is a good way of collaborative decision making, but it must be well managed to transform our workplace practices so that everybody could benefit, that's my take" [Participants No.5, 17, 13, 38, 21]

"I think the biggest thing with me is actually to find myself being part of the decision making process...it actually makes me feel better to be informed and to be part of the decision making processes...I believe forming part of collective decision making will make me commit more on task with an informed understanding" [Participants No.23, 19, 45, 6, 42]

Workplace motivation

In the context of workplace motivation, participants felt that workplace motivation was not only attributed to incentives such as remuneration, but also to the leadership approach. They identified appreciation, acknowledgement and sharing of information as motivating aspects that were lacking but are needed to improve person-centered leadership practices:

"...for me, motivation at work is not all about money, but a sense of appreciation for the work done is more than enough" [Participants No.44, 1, 21, 38, 17]

"I like praises and acknowledgement especially when I have done my best and have gone an extra mile, but sometimes I don't get acknowledged or a simple thank you... I get demotivated...motivation helps me to do better on my next task and even help me to reflect more on how best must I improve... that's my opinion...". [Participants No.14, 10, 25, 29, 46]

Sharing of information concerning task that I do is motivating... but I get disappointed when information on work issues is not well distributed and it's like where have you been...and yet the information was not formally shared".

Discussion

Person-centered leadership

We qualitatively explored the perceptions of nurse educators and nurse managers in a nursing education institution regarding the leadership qualities needed to facilitate a person-centered workplace culture. Participants viewed person-centered leadership as being treated with dignity and respect. To meet the need expressed by participants to feel cared for, leaders are advised to acquire person-centered attributes that create relational processes (McCormack & McCance, 2017). These attributes include connectedness, coaching and mentorship, awareness of self and others, guidance and advice. To balance the needs of the workplace and those of employees, person-centered leaders should communicate towards sameness of vision and oneness of goals, contextualising transformational activities (McCormack & McCance, 2017).

Although not directly mentioned by participants, transformational leadership, including person-centered leadership, also increase job satisfaction, reduce nurse turnover, and retain nurses within the healthcare system (Madathil, Heck & Schuldberg, 2014). This is important considering that nursing education institutions are struggling to retain nurse educators. Nasiripour, Tabibi and Mokhtari (2014) found a relationship between nursing leaders' leadership skills and nurses' anticipated turnover or decisions to stay or leave an organization. Ebrahimzade, Mooghali, Lankarani and Sadati (2015) also reported that nursing managers' leadership styles contributed positively to curb nurses' anticipated turnovers.

Leadership skills

Participants indicated that leadership skills such as appreciation, mindfulness, compassion and respect are essential to create a supportive work culture where employees feel empowered and motivated. Lynch, McCormack, McCance, and Brown (2018) explained that leaders should engage in critical reflective practices to develop person-centered leadership skills. Reflective self-talk that consists of a healthy inner dialogue has a positive effect on the leader's behavior, feelings and self-esteem and helps to control stress levels (Lynch, McCormack, McCance, & Brown, 2018). Apart from being self-aware, person-centered leaders should also be mindful of others, have emotional intelligence, be good listeners, be inspirational, unify others through collaboration, inclusion, participation and appreciation, and trust others.

In this study participants mentioned mentoring and coaching as leadership skills. According to Cardiff, McCormack and McCance (2018) person-centered leadership creates a work atmosphere conducive to collaboration, mentoring and coaching. Through positive inter- and intrapersonal skills, workplace satisfaction improves because of caring, while staff become critical yet transparent and fair to one another. While participants in this study expressed a need to feel empowered, Cardiff, McCormack and McCance (2018) indicated that person-centered leadership increase the willingness of staff to take more responsibility, and to become more involved in decision making. The absence of person-centered skills leads to mistrust, culminating in conflicts between employees and organizational issues, leading to job dissatisfaction and increasing attrition rates.

Leading change

Participants felt dissatisfied with the leadership provided during periods of change. They hinted that coaching and capacitation may encourage educators to take ownership for workforce changes. According to Bushe and Marshak (2016), leading change requires leaders to empower and mobilize stakeholders to develop self-initiated actions, be involved in mentorship, monitoring, evaluation, consultation and employ the most user-friendly change processes and policies. Change may afford nurse educators in the study context opportunities to develop their full capacity and to respond with creativity and innovation (Masood & Afsar, 2017). Leading change requires person-centered leaders who move away from managing employees and assume a more parental, protective, directive, empowering, coaching and mentoring role to stimulate trust and independency (Cardiff, McCormack & McCance, 2018). Change may fail if there is lack of empowerment. Participating stakeholders may suffer unresolved conflicts and lack of managerial accountability, while other stakeholders may withdraw from the change process (Stouten, Rousseau & De Cremer, 2018).

Participants also expressed a need for communication and orientation about intended changes. Communication during change means "attending to, listening to, and including marginalized or excluded voices" in order to consider change-related factors, influences, and stakeholders (Bushe & Marshak, 2016:45). With regards to proper planning, Horrell, Lloyd, Sugavanam, Close and Byng (2018) suggest that leading change will succeed if there is coherent planning, implementation, monitoring and support. To conclude, Cardiff, McCormack and McCance (2018) explain that leading change is a complex, dynamic, relational and contextual practice where a person-centered leader enables employees to achieve self-actualization, empowerment and wellbeing.

Collaborative decision making

In this study, nurse educators and leaders indicated that they would like to be involved in collaborative decision-making platforms so that they can make informed decisions.

A review of literature on how this collaboration can be achieved, revealed the following: On an intrapersonal level, leaders who display self-awareness, attentiveness and accountability are more open to collaboration. On an interpersonal level, leaders need to foster a workplace culture where employees feel safe to give and receive open and honest feedback (Subrahmanyam, 2018). An inclusive person-centered approach should be followed that empowers everyone to contribute, while actively discouraging behaviors that limit inclusion. To avoid leader-

centric approaches leaders need to do things "with people rather than to them" and address conscious and unconscious biases that may lead to prejudice and inequalities in teams (Amin, Till & McKimm, 2018:403). McCormack and McCance (2017) explained that person-centered leaders have the ability to find a common ground with employees and create a platform of a shared vision that may help to enhance feelings of inclusion.

Gonnerman, O'Rourke, Crowley and Hall (2015) highlighted that complex problems necessitate collaborative decision making to generate answers that integrate both academic and non-academic sources. A study done by the European Union Institution (Müller & van Esch, 2020), suggests that collaborative decision making enables stakeholders to help each other to achieve own goals, become equally involved in joint structures and pursue shared resources for the success of the organization.

Workplace motivation

In this study, nurse educators and leaders identified appreciation and acknowledgement as factors that enhance workplace motivation. Participants felt de-motivated when leaders did not appreciate them or involve them in sharing of workplace information that impacts their performance. Literature findings similarly revealed that employees may become demotivated if they feel they are not able, have no value, and are not engaged or involved. Leaders can improve motivation of employees, according to Turnnidge and Coté (2017), by engaging them in transformational coaching workshops that foster behaviors of respect for all, teamwork, unity, compassion and empathy. Prentice (2019) highlighted the importance of intrinsic and extrinsic motivational factors and the direct impact of these on job satisfaction and turnover rates for nurses in the healthcare system. Person-centered leaders should rely on intrinsic motivational factors such as supervisor support and caring and appreciation of employees. Extrinsic motivational factors such as remuneration and benefits are expensive workplace liabilities that can be used to motivate and retain employees (Prentice, 2019).

The motivational strategies discussed by Fryer and Bovee (2018) also highlighted the value of support, but stressed the need to empower and capacitate employees through engaging them in learning and workplace activities. Employees require constructive feedback from leaders and peers, rewards when goals are met, effective remuneration and career development (Prentice, 2019; Khan, Quinn Griffin & Fitzpatrick, 2018). Lastly, Khan, Quinn Griffin and Fitzpatrick (2018) stated that transformational leaders are known for their inspirational motivation, directly influencing positive relations between employees. Motivation empowers employees, resulting in work satisfaction and reducing turnover and burnout.

Strengths and limitations of the study

The strength of this study is that the nurse educators' views and experiences are original and come from an emic perspective. The vast years of experience of nurse educators ensured rich and authentic findings and provided innovative solutions to the research problem. The originality of the findings may convince others in similar settings to implement person-centered leadership practices. The researcher was not involved in data collection or data analysis. The analysis was facilitated by two external nursing education experts to avoid bias and power struggles.

This study is limited by a lack of transferability. We only explored the perceptions of nurse educators and leaders from one of the six PNEIs in South Africa. The transferability of the findings to other institutions need to be confirmed in less similar contexts. The study did not include all the employees, it excluded the administrative staff who work with the nurse educators which may affect the transformation of the workplace culture to complete person-centeredness.

Conclusion

The person-centered leader is important in transforming the workplace culture for all nurse educators to flourish. The study highlighted that a person-centered leader needs to lead during periods of change, and motivate others using both intrinsic and extrinsic factors. These leaders must be able to participate in collaborative decision-making platforms to negotiate availability of responsible resources to transform the workplace culture to person-centeredness. It is important that further research be conducted to include the administrative staff to involve them in person-centered practices. The study findings may be implemented and tested in similar contexts, using action or implementation research.

Funding source
This study received no funding.

Ethical approval
Ethical approval for the study was obtained from the University of Pretoria Research Ethics Committee (Ethic Reference No: 760/2018).

Declaration of competing interest
The authors declare that there is no conflicting interest.

Acknowledgements
We wish to thank and acknowledge the nurse educators and nursing managers who supported the study with their time and experience.

References

Alonso-Almeida, M. D. M., Perramon, J., & Bagur-Femenias, L. (2017). Leadership styles and corporate social responsibility management: Analysis from a gender perspective. *Business Ethics: A European Review, 26*, 147-161.

American Nurses Association (2013). *The Nursing Shortage: Solutions for the Short and Long Term.* Available from: http://www.nursingworld.org/MainMenuCategories/ThePracticeof Professional Nursing/workforce/Recruitment, accessed 25 March 2014

Amin, M., Till, A., & McKimm, J. 2018. Inclusive and person-centred leadership: Creating a culture that involves everyone. *British Journal of Hospital Medicine, 79*(7), 402-407.

Armstrong, S.J., & Rispel, L. C. (2015). *Transforming Nursing in South Africa. Social Accountability.* Johannesburg: Global Health Action.

Blaaw, D., Ditlopo, P., & Rispel, L. C. (2014). *Nursing Education Reform in South Africa: Lessons learnt From a Policy Analysis Study.* South Africa: Global Health Action.

Bushe, G. R., & Marshak, R. J. (2016). The dialogic mindset: Leading emergent change in a complex world. *Organization Development Journal, 34*(1), 37-65

Cardiff, S., McCormack, B., & McCance, T. (2018). Person-centered leadership: A relational approach to leadership derived through action research. *Journal of Clinical Nursing, 27*(15-16), 3056-3069.

Clark, A. (2008). Critical realism. In: Given, L.M. (Ed), *The SAGE Encyclopaedia of Qualitative Research Methods*, Volume 2. California: SAGE Publications Inc. pp.167-169

Creswell, J. W., & Creswell, J.D. (2018). *Research Design: Qualitative, Quantitative, and Mixed Methods Approaches*, 5th edition. Washington DC: SAGE Publishers.

Du Plooy-Cilliers, F., Davis, C., & Bezuidenhout, R. M. 2014. *Research Matters*. Cape Town: Juta & Company Ltd. Ebrahimzade, N., Mooghali, A., Lankarani, K. B., & Sadati, A. K. (2015). Relationship between nursing managers' leadership styles and nurses'

job burnout: A study at Shahid Dr. Faghihi Hospital, Shiraz, Iran. *Shiraz EMedical Journal, 16*(8), 1–5. https://doi.org/10.17795/semj27070.

Eide, T., & Cardiff, S. (2017). Leadership research: A person-centered agenda. In: van Dulmen, S., Eide, H., Skovdahl, K., & Eide, T. (Eds), *Person-Centered Healthcare Research*, Chichester, UK: Wiley-Blackwell. pp. 99-115.

Fryer, L. K., & Bovee, H. N. (2018). Staying motivated to e-learn: Person-and variable-centered perspectives on the longitudinal risks and support. *Computers & Education, 120*, 227-240.

Gonnerman, C., O'Rourke, M., Crowley, S.J., & Hall, T.E. (2015). Discovering philosophical assumptions that guide action research: The reflexive toolbox approach. In: Huang, H. B., & Reason, P. (Eds), *The SAGE Handbook of Action Research*, 3rd edition. Thousand Oaks, CA: SAGE Publications, pp. 1-11.

Harding, E., Wait, S., & Scrutton, J. (2015). The state of play in person-centered care. *The Health Policy Partnership Ltd. The Health Foundation Journal*, 1-37. Available from: http://www.healthpolicypartnership.com/person-centred-care/, accessed 13 September 2020.

Heyns, T., & McCormack, B. (2014). Moving from crisis intervention towards person-centeredness. *Nursing in Critical Care, 119*(4), 162-163.

Horrell, J., Lloyd, H., Sugavanam, T., Close, J., & Byng, R. (2018). Creating and facilitating change for person centered coordinated care (P3c): The Development of the Organisational Change Tool (P3C-OCT). *Health Expect. 21*, 448– 456. https://doi.org/10.1111/hex.12631.

Khan, B. P., Quinn Griffin, M. T., & Fitzpatrick, J. J. (2018). Staff nurses' perceptions of their nurse managers' transformational leadership behaviors and their own structural empowerment. *JONA: The Journal of Nursing Administration, 48*(12), 609–614. https://doi.org10.1097/NNA.0000000000000690.

Lynch, B., McCormack, B., McCance, T., & Brown, D. (2018). The development of the Person-Centered Situational Leadership Framework: Revealing the being of person-centeredness in nursing homes. *Journal of Clinical Nursing, 27*(1–2), 427–440. https://doi.org/10.1111/jocn.13949

Madathil, R., Heck, N. C., & Schuldberg, D. (2014). Burnout in psychiatric nursing: examining the interplay of autonomy, leadership style, and depressive symptoms. *Archives of Psychiatric Nursing, 28*(3), 160–166. https://doi.org/10.1016/j.apnu.2014.01.002.

Masood, M., & Afsar, B. (2017). Transformational leadership and innovative work behavior among nursing staff. *Nursing Inquiry,* 24, e12188.

McCance, T., & McCormack, B. (2017). The person-centered practice framework. In: McCormack, B., & McCance, T. (Eds), *Person-Centered Practice in Nursing and Health Care: Theory and Practice*, 2nd edition. Chichester, UK: Wiley-Blackwell, pp. 36-64.

McCormack, B., & Dewing, J. (2019). International Community of Practice for Person-centred Practice: Position statement on person-centredness in health and social care. *International Practice Development Journal, 9*(1), 1-7.https://doi.org/10.19043/ipdj.91.003

McCormack, B., & McCance, T. (2017). Underpinning principles of person-centred practice. In: McCormack, B., & McCance, T. (Eds), *Person-Centered Practice in Nursing and Health Care: Theory and Practice*, 2nd edition. Chichester, UK: Wiley-Blackwell, pp. 1-35.

Morsiani, G., Bagnasco, A., & Sasso, L. (2017). How staff nurses perceive the impact of nurse managers' leadership style in terms of job satisfaction: a mixed method study. *Journal of Nursing Management, 25*, 119-128.

Müller, H., & F. A. W. J. Van Esch (2020) Collaborative leadership in EMU governance: A matter of cognitive proximity, *West European Politics, 43*, 5, 1117-1140. https://doi.org/10.1080/01402382.2019.1678950

Nasiripour, A. A., Tabibi, S., & Mokhtari, R. (2014). The relationship between head-nurse's managerial skills and nurses' turnover intention in private hospitals. *Health Care: Current Reviews, 2*(1), 1- 5. https://doi.org/10.4172/hccr.1000117.

O'Donnell, D., Cook, N., & Black, P. (2017). Person-centered nursing education. In: McCormack, B., & McCance, T. (Eds), *Person-Centered Practice in Nursing and Health Care: Theory and Practice*, 2nd edition. Chichester, UK: Wiley-Blackwell, pp. 99-117.

Pishgooie, A. H., Atashzadeh-Shoorideh, F., Falcó-Pegueroles, A., & Lotfi, Z. (2019). Correlation between nursing managers' leadership styles and nurses' job stress and anticipated turnover. *Journal of Nursing Management, 27*(3), 527-534. https://doi:10.1111/jonm.12707

Prentice, J. J. (2019). *"Tell Someone Who Cares"– Participatory Action Research of Motivation and Workplace Engagement Among Caregivers in Aged Residential Care, New Zealand.* Doctoral thesis. University of Otago, Dunedin.

Stevens, A. (2019). *The 'Ontological Politics of Drug Policy': A Critical Realist Approach.* In: 13th Annual Conference of the International Society for the Study of Drug Policy, University of Kent. Paris. pp. 1-24. https://kar.kent.ac.uk/73

Stouten, J., Rousseau, D. M., & De Cremer, D. (2018). Successful organizational change: Integrating the management practice and scholarly literatures. *Academy of Management Annals, 12*(2), 752-788.

Subrahmanyam, S. 2018. Corporate leadership: A study of the decision making skills in growing in the corporate world. *International Journal of Research,* 5(1), 2348-6848.

Turnnidge, J., & Côté, J. (2017). Transformational coaching workshop: Applying a person-centered approach to coach development programs. *International Sport Coaching Journal, 4*(3), 314-325.

World Health Organization (2015). *WHO Global Strategy on People-centered and Integrated Health Services: Interim Report.* Available from: http://apps.who.int/iris/bitstream/10665/155002/1/WHO_HIS_SDS_2015.6_eng.pdf?ua=1&ua=1, accessed 4 February 2016.

CHAPTER 6

IMPLEMENTATION OF THE TRANSFORMATIVE PRACTICE DEVELOPMENT PROGRAMME

6.1 INTRODUCTION

In Chapter 5 a discussion in article format was presented on transforming workplace culture using person-centred leadership in a nursing education institution in South Africa. In this chapter the implementation of the transformative practice development programme will be presented in article format. The manuscript was submitted to the Journal of African Nursing Science and is currently under review. The manuscript is titled: Implementing a programme to transform the workplace culture towards person-centredness in a public nursing education institution in South Africa. This chapter will be presented according to the headings of the authors guidelines as specified by the journal.

Implementing a program to transform the workplace culture towards person-centredness in a public nursing education institution in South Africa

Queen K. Masimula[a], Anna E. van der Wath[a*], Isabel Coetzee[a]

[a]*Department of Nursing Science, University of Pretoria, Private Bag X20, Hartfield, Pretoria, South Africa*

*Corresponding author at: Department of Nursing Science, University of Pretoria, Private Bag X20, Hartfield, Pretoria, South Africa
E-mail address: annatjie.vanderwath@up.ac.za (A.E. van der Wath)

ORCID
Queen Masimula
Anna van der Wath https://orcid.org/0000-0001-5117-9272
Isabel Coetzee https://orcid.org/0000-0001-9671-2990

ABSTRACT

Ineffective workplace relationships and an inconducive workplace culture contribute to poor job satisfaction and high nurse educator turn-over rates. The aim of the study was to implement a program to transform the workplace culture towards person-centredness in a public nursing education institution in South Africa. The study followed a Transformative Practice Development design using a participatory action research approach. The Transformative Practice Development method guided a program implemented from February 2019 to November 2019 to promote a person-centred workplace culture. From a population of nurse educators and nurse managers, we purposively sampled 46 participants. Baseline data were collected during consensus meetings in February and May facilitated by two independent nursing education experts. Twelve feedback sessions were conducted to obtain feedback during program implementation. Data were thematically analyzed. During implementation, the program addressed positive work relations, communication and leadership. The participants indicated that the program facilitated person-centered work relations through group cohesion, change processes, and real and authentic attitudes. Person-centred communication was achieved through reflective communication and cultural sensitivity. Leaders enhanced their leadership style by evaluating and transforming their leadership traits and processes.

*Keywords: C*ommunication, Healthy work relations, Leadership, Person-centredness, Transformation, Workplace culture

Implementing a program to transform the workplace culture towards person-centredness in a public nursing education institution in South Africa

1. Introduction

A shortage of nurse educators impedes the intake of nursing students amidst a growing need for professional registered nurses (American Association of Colleges of Nursing [AACN], 2019). Globally, the lack of qualified educators limits the availability of nurses equipped to provide safe, quality care (Gazza, 2015). Although strategies to address the problem have been developed (see for example Nardi & Gyurko, 2013), the shortage of nurse educators will persist for some time due to the complex issues surrounding the problem. Researchers should consider the experiences of nurse educators and develop creative strategies to recruit and retain educators (Laurencelle, Scanlan, & Brett, 2016).

A positive workplace culture that embraces peer and managerial support may help to retain staff, while an unsupportive climate may contribute to staff feeling powerless and exhausted (Catling, Reid, & Hunter, 2017). We describe a Transformative Practice Development (TPD) program that was implemented to create a person-centred workplace culture in a public nursing education institution (PNEI). The PNEI under study is one of six PNEIs in Gauteng Province, South Africa

The global shortage of nurse educators is compounded by budget constraints, aging nurse educators, increasing job competition from clinical sites (AACN, 2019), task overload, inadequate capacity in nursing schools, increasing requirements to take part in non-academic activities (Fawaz, Hamdan-Mansour, & Tassi, 2018), global migration of nurses, decreased satisfaction with educator roles, poor salaries and a seemingly persistent devaluation of nurse educators by academic institutions (Nardi & Gyurko, 2013).

In South Africa, nursing education is provided by universities and public and private nursing education institutions (South Africa Department of Health, 2013). Public nursing education institutions graduate 73-80% of professional nurses every year (Geyer, 2020). In South Africa, nursing qualifications were revised to include a baccalaureate degree to qualify as a professional nurse. These changes were implemented after apartheid to strengthen nursing education and ensure a strong healthcare system (Blaauw, Ditlopo, & Rispel, 2014).

To accommodate these changes, PNEIs, previously governed by the Department of Health (Blaauw, Ditlopo, & Rispel, 2014), were redeployed to higher education (Zwane & Mtshali, 2019).

Changes in the nursing curriculum were characterized by slow progress, governance problems and ineffective planning (Blaauw et al, 2014), challenges that still exist in South African PNEIs. A study at a PNEI by Mokoboto-Zwane (2015) found nurse educators to be discouraged, demotivated, frustrated, miserable, unappreciated and unsupported. These feelings mostly stemmed from their interactions with nursing students. In this study, we identified several challenges in a specific PNEI. Nurse educators experienced increased workload, poor job satisfaction, high nurse educator turn-over rates and ineffective workplace relationships. These challenges represent an unconducive workplace culture (Beckett et al, 2013).

Various authors stress the need for research on preparing, recruiting, and retaining nurse educators. We need to understand nurse educators' needs for succeeding in their careers (Hoeksel, Eddy, Dekker, & Doutrich, 2019). Studies should also explore the tipping point, when negative factors outweigh motivating factors, forcing nurse educators to search for alternative employment (Westphal, Marnocha, & Chapin, 2016). Currently, there is limited research exploring the meaning of being a nurse educator and what attracts nurses to academia in the 21st century (Laurencelle et al, 2016).

Nurse educators may benefit from access to professional development resources, mentoring support and communities of practice to develop collaborative networks for ongoing support (Berland et al, 2020). In addition, Hoeksel et al (2019) suggest that nurse educators also require a range of non-vocational skills including sensitivity regarding culture and language, team building, mentoring models, change management strategies, strategies for teaching with technology, communication models/strategies and maintaining healthy work environments.

Creating a person-centred workplace culture in PNEIs may help to retain nurse educators. Blaauw et al (2014) support transforming working environments in nursing education institutions to retain nurse educators and improve job satisfaction

In this study, we implemented a TPD program to improve job satisfaction and reduce nurse educator attrition rates in a PNEI. The TPD program focused on creating a more person-centered workplace culture. TPD embraces the philosophy of whole person learning that recognizes the need to develop a person's mental, emotional, physical and spiritual dimensions (Childs, 2019; Muff, 2013). The workplace culture is changed by generating new insight and drawing knowledge from participants' experiences (Filmalter et al, 2015). Participants co-construct new knowledge and practices about person centred, evidence-based practice. A conducive, person-centred workplace culture improves teamwork, raises

morale, increases productivity and efficiency, enhances job satisfaction, collaboration and work performance, reduces stress and ensures employee retention (Manley, Sanders, Cardiff, & Webster, 2011). A person-centered approach is about respecting and valuing colleagues as unique beings and engaging employees in a way that promotes their dignity, sense of worth and independence (Dewing & McCormack, 2017).

In this study, the TPD program was based on a critical inquiry process to improve educational practice through action research (Trede & Hill, 2012). The TPD was conducted in four stages. The findings of Stage 1 (baseline data) were described in two previous publications (Removed for blinded review). This article reports on the TPD program implementation (Stages 3, 4 and 5). The program focused on the personal and professional development of nurse educators, enabling them to revise their workplace beliefs and values and engage in a caring manner (Childs, 2019; Muff, 2013). The program aimed to develop person-centred values such as empathy, honesty, transparency and collaboration among nurse educators as advised by Trede and Titchen (2012), Slater, McCance, and McCormack (2017) and Wedding (2020).

2. Aim of the study

The aim of the study was to report on implementing a TPD program aimed at transforming the workplace culture in a PNEI towards person-centredness.

3. Research design

Practice development is a systematic approach that helps practitioners and health care teams to evaluate their practice and identify how they can improve their workplace culture (Slater et al, 2017). TPD programs are implemented using an action research approach that reduces injustice and improves culturally acceptable practices (Trede & Hill, 2012). TPD liberates and reveals the voices of marginalized people and aims to transform the workplace culture to person-centeredness through collaboration, inclusion, participation and reflective practices (Manley & Jackson, 2019).

In TPD, teams gather around research platforms to debate real-life work experiences towards a person-centered approach (Muff, 2013). An inclusive research environment fosters collective creativity combining the experiences of different stakeholders to debate, reflect and challenge workplace issues (Muff, 2013). Workplace transformation is complex and some issues are hard to solve, demanding creative and divergent approaches, therefore, active participation of participants becomes important (Muff, 2013). Reflective practices allow participants to interpret and learn from past experiences and ponder the future (Muff, 2013).

4. Methods

4.1 Setting and sample

The study was conducted in one of six PNEIs in Gauteng Province. The PNEI is under the supervision and direction of the South African Ministry of Higher Education and provides nursing education and training for up to 1200 undergraduate and postgraduate nursing students.

The target population included academic staff comprising 82 nurse educators and 10 nurse managers, giving a total population of 92 potential participants.

We used a non-probability purposive sampling method (Creswell & Creswell, 2018) to recruit nurse educators and nurse managers during an information session about the TPD program. Prospective participants included all nurse educators and nurse managers who were employed for longer than six months at the PNEI and who signed informed consent to participate in the study. All nurse educators and nurse managers who did not meet the inclusion criteria were excluded from the study.

According to Polit and Beck (2017), data saturation is reached when enough in-depth data is generated to illuminate patterns, categories and dimensions of the phenomenon under study. We applied the principles of data saturation in this study. The sample size was decided by the research team to fit the constructs for implementing the TPD program.

Forty-six nurse educators and nurse managers met the inclusion criteria and participated in the study. Of these participants, 14 volunteered to be program facilitators. For the sake of clarity, both nurse educators and nurse managers are referred to as participants. Refer to Table 1 for demographic data of participants.

Insert Table 1 See Annexure D

4.2 Data collection

Baseline data for the TPD were collected during four consensus meetings. Feedback sessions were conducted to collect data during TPD program implementation.

Baseline data collection

Baseline data were collected to explore the experiences of nurse educators regarding the workplace culture to identify the themes for the TPD program. Data were collected during two consensus meetings in February 2019 (Removed for blinded review). Two more consensus meetings were conducted in May 2019 to explore person-centred leadership (Removed for

blinded review). Consensus meetings involve experts and professionals who share their views, decisions and judgements in reviewing aspects of practice, education and research priorities (Moule, Aveyard, & Goodman, 2016).

Two external facilitators with research expertise facilitated the consensus meetings. A facilitator explained the purpose of the study and participants signed informed consent forms. Initially, participants were requested to write down individual responses to the following questions: *"I believe the ultimate purpose of this practice development program is…"; "I believe this purpose can be achieved by …"; "I believe the factors that will help us achieve this purpose are…"; "I believe the factors that will hinder us from achieving this purpose are.."; "Values and beliefs that I consider important in relation to this program are…".* Next, the participants were divided into small groups with six to seven participants in each group. The participants worked together and combined their responses as a group to answer the main research question, namely *"How can the workplace culture be transformed to person-centredness?"* The answers generated by each group were displayed on the whiteboard and analyzed by the whole group guided by the facilitators (Removed for blinded review).

Data collection during program implementation

Nurse educators and managers participated in the TPD program during workshops presented by the program facilitators. The workshops covered topics aimed at transforming the workplace culture to person-centredness. Twelve feedback sessions were conducted between March and November 2019 after each workshop to generate data on the outcomes of the TPD program that included a reflective review process (Garbett, Hardy, Manley, Titchen, & McCormack, 2007). The feedback sessions were audio-recorded and participants were asked to keep personal reflective notes.

4.3 Ethical considerations

The principle investigator (initials removed for blinded review) did not struggle to gain access to the PNEI, where she is employed as a nurse educator. The researcher obtained permission from the Research Committee of the PNEI, and ethical approval from the Research Ethics Committee of the Faculty of Health Sciences of the University of Pretoria (Ethics Reference No: 760/2018). All potential participants were invited to the TPD information session. After the TPD information session, the attendees were invited to participate in the study, voluntarily, by signing the informed consent document. Potential participants who volunteered to participate in the study were informed of their roles and responsibilities.

4.4 Data analysis

Baseline data analysis

The data were thematically analyzed (Creswell & Creswell, 2018). The external facilitators guided the participants to group their answers into themes. Each theme reflected an aspect that needed to be addressed to transform the workplace culture towards person-centredness. The themes were considered, reviewed, discussed, and ranked in order of importance (Moule et al, 2016). The ranking was displayed on the whiteboard for reflection, debate and discussion until all participants agreed on the importance of each theme towards transforming the workplace culture (Removed for blinded review).

Data analysis during program implementation

Data were analyzed using creative hermeneutic data analysis by Boomer and McCormack (2010). The researcher and program facilitators collaborated to identify and confirm themes generated from the data. Two nursing education experts checked the data for originality and authenticity. The data were analyzed as follows:

- The researcher, nurse educator experts and facilitators read through different forms of feedback and reflective notes to create a general image, thoughts and feelings to capture the essence of the data.
- Facilitators paired and one “told the story” while the second facilitator wrote verbatim. Each facilitator commented on the themes that emerged from the story.
- Facilitators formed small groups to discuss and share the identified themes. Facilitators agreed on all themes and categories. Each group of facilitators matched their categories with the raw data.
- The researcher and facilitators matched their themes to form a final set of themes. Experts checked the final set of themes and categories for authenticity and representativeness.

4.5 Rigor

Moule et al (2016) maintains that findings are credible if they reflect the experiences and perceptions of the participants. In this study, we ensured credibility by using triangulation in data collection, prolonging engagement in the field and member checking.

In this study, two independent facilitators managed the consensus meetings to mitigate possible research bias. The researcher and program facilitators (research team) took reflective field notes during the TPD workshops and feedback sessions. These field notes

were used to confirm that collaborative, inclusive and participative implementation principles were maintained during TPD implementation (Manley, 2016)

Throughout the study, member checking involved giving feedback on the workshops during feedback sessions with participants. The research team reviewed the planned workshop presentations for authenticity and recommended amendments. After each workshop, feedback from each workshop was consistently implemented and the research team continuously engaged over a period of 10 months.

5. Program implementation

The TPD program followed four stages: Stage 1: baseline data; Stage 2: co-construction of the TPD program; Stage 3: implementation of the TPD program; Stage 4: feedback and evaluation of outcomes.

5.1 Stage 1: Baseline data

The baseline data, collected during the consensus meetings, reflected what the nurse educators perceived constituted a person-centered workplace culture. The analysis of the baseline data, generated three main themes to implement during the TPD program, namely: *positive work relations, communication* and *leadership* (Removed for blinded review). The TPD program focused on these three themes to transform the workplace culture to person-centredness.

5.2 Stage 2: Co-construction of the TPD program

The research team identified and agreed on interventions to promote positive work relations, communication and leadership. The strategies were converted into an action plan. The action plan included the topics, contents, dates, times and presenters for workshops, as well as dates and times for feedback sessions. See Table 2 for the TPD program.

Insert Table 2. See Annexure D

The facilitators decided to present the topics in workshops, a short presentation on the topic followed by group discussions. One or two workshops per month (March to November 2019) were planned, depending on the academic calendar. Feedback sessions were planned after each workshop. The development and planning of the TPD program were guided by questions and actions adapted from Beukes (2011), as summarized in Table 3.

Insert Table 3. See Annexure D

5.3 Stage 3: Implementing the TPD program

Transformative practice development is complex and multifaceted (Manley, 2016), therefore the program facilitators participated in a training workshop on how to facilitate the TPD program. They were trained as facilitators and not fixers of the identified problems in the PNEI. The facilitators helped the participants to find their own unique solutions to transform workplace culture (Filmalter et al, 2015).

The research team implemented the program for nine months from March to November 2019. They were guided by the practice development conceptual framework processes (collaboration, inclusion and participation) (McCormack et al, 2010) during the workshops and feedback sessions. Collaboration was achieved by engaging participants with critical questions that facilitated person-centred practices. Participants were allowed to reflect, work in groups and learn together to transform workplace culture. The research team ensured that participants' views were included through collective discussions about teaching experiences, personal and professional development and different cultures. The participatory principle required participants to be actively involved, share values and beliefs, and engage in reflective practices during workshops and feedback sessions.

5.4 Stage 4: Feedback sessions and evaluation of program outcomes

The program outcomes are set out in the results' section.

6. Results

All but two participants were female nurse educators. The participants ranged in age from 33 to 64 years and represented a vast range of experience in nursing education. All participants had at least a Bachelor's degree in nursing, seven had a Master's degree and one had a PhD degree in nursing. See Table 1 for demographic data of participants.

The themes and sub-themes that emerged from the feedback sessions and reflective notes are summarized in Table 4. The themes are presented with quotes that illustrate what participants gained from the TPD program and are formulated in terms of actions they intend to implement to build a person-centred workplace culture.

Insert Table 4 See Annexure D

6.1 Positive work relations

Participants identified group cohesion as important for positive work relations. Participants planned to ensure group cohesion by working and learning together in different teams and to avoid always working in their favorite workgroups. Participants also verbalized that participating in academic meetings, research days and team building activities (special celebrations and wellness days) would strengthen group cohesion.

> *"We believe that teamwork begins by building a trust relationship, where coming together becomes the beginning of change and keeping together as a team is progress and success"* [Participants 13, 21, 33, 46].

> *"…well group cohesion is what we need to work together towards a common vision and none of us is as smart as all of us to transform our workplace culture to gain more together"* [Participants 31, 11, 40, 6].

Participants also mentioned that positive work relationships were associated with embracing change and transformation. Firstly, team members need to recognize and acknowledge problems or a need to change. Person-centred employees need to approach change with a helping attitude to enhance collaboration. Participants felt that being open and helpful was motivating for the whole team. Nurse educators also realized that they had to be aware of different responses to change, including anxiety, happiness, fear, threat, guilt, depression, hostility, gradual acceptance and, sometimes, disillusionment.

> *"To be honest, we felt very anxious and depressed about the whole transformational changes that were introduced at work… and was like okay… want to see how they will solve these old and big problems…will everyone buy into this transformation?"* [Participants 3, 32, 36, 46].

> *"At first, we feared that some colleagues did not believe in the transformational issues in our teams, but gradually accepted the transformational changes as they were introduced and became happy that we were going to benefit too"* [Participants 7, 13, 22, 25].

Lastly, participants associated positive work relations with being real with an authentic attitude. Such an attitude is developed through three aspects: self-awareness (know yourself to be able to develop authentic relationships in teams), a reflective attitude (reflect on own and others' behavior) and the principles of collaboration, inclusion and participation.

"Self-awareness is a skill, knowing yourself as individual will help you to change in order to fit in the team" [Participants 1, 18, 30, 45].

"It will help all of us to be reflective thinkers, because you can only change what you are aware of than what you are not aware of. Knowing self and others is intelligence and wisdom that support collaboration relationships with others" [Participants 9, 24, 39,15].

6.2 Communication

During the TPD program participants learned about reflective communication as a person-centered skill, and embraced the following guidelines. Reflective communication requires that participants need to ask themselves: "How did I talk?" and ask for example, "Did I communicate the objectives clearly?" To obtain insight in communication, participants realized that they need to ask themselves: "What are the key facts and trends from the events of today?" Lastly, to facilitate foresight, participants need to ask themselves: "What will I do best in the future?".

"We believe in a mindful reflective and careful communication because it's most important to understand that people may hear your words, mostly they feel your attitude at your workspace" [Participants 14, 19, 12, 26].

"We have seen and observed leaders communicating without insight… Other leaders are not person centred, they believe in one-way communication and forget to listen to their employees" [Participants 8, 1, 20, 31].

The TPD program also taught participants that person-centred communication is improved by respecting and being sensitive towards diversity and cultural differences. Participants planned to respect and appreciate different cultural practices and religions. They also wanted to learn from different cultures and values. Participants agreed that all conversations should be conducted in English to accommodate and include everyone. Participants also realized that as a mostly female group, they needed to accommodate and be sensitive towards male nurse educators. Lastly, they wanted to ensure a workplace culture that provides for all racial groups, employees and students with disabilities.

"We hope this transformation will make us realize the importance of cultural diversity and sensitivity to help us communicate better than being egocentric…it creates a lot of

misunderstanding…forgetting that strength lies in differences and not in similarities" [Participants 14, 11, 30,16].

"People are becoming more and more interconnected because of the technology…but we believe it's also more important to realise that tolerance, inter-cultural dialogue and respect for cultural diversity and sensitivity are more essential than ever for transformation to take place at work" [Participants 15, 2, 46, 7].

6.3 Leadership

Participants felt that they had developed a better understanding of transformational leadership traits, for example, leadership as an inherent trait versus related to a position. Participants who were leaders intended to practice inspirational leadership. They also understood leadership as the ability to teach, inspire and learn from others, while a leader needs to practice self-leadership and share his or her vision on leadership.

"More lessons needed to revive others on how you can be coached to lead yourself first before leading others" [Participants 6, 11, 34, 19].

Participants provided feedback on leadership issues that emerged during workshop discussions, including ways to practice more effective decision-making skills. Policies posed problems for some nurse educators and participants realized that leaders should highlight the importance and benefits of adhering to policies; concomitantly, policies should be revised when needed to reduce workplace frustration. Participants mentioned that remuneration was a barrier to workplace transformation, consequently participants in managerial positions realized the need to advocate for fair remuneration and consider the role of remuneration in motivating employees.

"We believe in the leader who spends energy to inspire poor employees to do better and motivate those who are doing better with recognition, revised polices, improved workplace conditions and better remuneration for job satisfaction" [Participants 8, 21,10,46].

Participants acknowledged that capacitation of nurse educators was part of transformational leadership. Leaders need to identify the needs of nurse educators and address these needs through capacitation and provide the necessary resources. As person-centered leaders, participants decided to embrace the quotation: "You don't build a business – you build people – and then people build the business" (Ziglar & Ziglar, 2012).

"We are not capacitated on most of the new workplace activities and new policies…would like to learn new things from old things" [Participants 14, 22, 33, 43].

7. Discussion

In this PNEI, nurse educators and managers participated in a TPD program aimed at creating a person-centred workplace culture. The program successfully helped participants to experience how positive workplace relations coupled with effective communication and transformational leadership could transform the workplace culture to person-centredness. Participants reported improved workplace relations between different departments and suggested improving policies and communication structures. The TPD program empowered nurse educators to identify common organizational goals guided by shared values and beliefs, and mutual respect.

The findings of this study are consistent with literature that support the idea that individual relationships at work directly impact on group cohesion which greatly influences employees' self-regulation strategies and behavior with others (Xie, Hensley, Law, & Sun, 2019). In this study, participants acknowledged that group cohesion was important for establishing positive workplace relations, and work groups that enhance authentic workplace attitudes and behaviors. Studies have shown that novice nurse educators, especially, often lack skills to professionally interact with staff and students, and require continuous peer support and mentoring (Fritz, 2018). Teamwork and collaboration should be fostered with colleagues, other educational and clinical institutions, and on a broader scale with the international community (World Health Organization, 2016).

Aside from promoting effective teamwork, recognizing cultural diversity and cultural sensitivity also contributes to effective communication (Tompos & Ablonczy-Mihalyka, 2018). Interestingly, employees from different cultural backgrounds performed better when working together, suggesting that culturally diverse teams may have a competitive advantage (Tompos & Ablonczy-Mihalyka, 2018). In this study, participants mentioned that cultural diversity and sensitivity are facilitated by reflective and person-centred communication, and focusing on achieving mutual goals. The World Health Organization (WHO) states that nurse educators should demonstrate effective communication skills that promote collaborative teamwork and enhance partnerships between educational and clinical health professions (WHO, 2016). In our study, participants focused on intercultural communication with peers, while the WHO emphasized interdisciplinary communication between nursing educators, students and other stakeholders. We believe that these forms of communication require similar essential skills,

which need to be taught to nursing students to prepare them for the complex health care system of the 21st century (Fawaz et al, 2018).

A person-centred leader shares his or her vision and creates opportunities to acknowledge and capacitate employees. Our findings coincide with transformational, ethical and self-leadership models. Khan, Griffin, and Fitzpatrick (2018) indicate that transformational leadership improves job satisfaction, provides inspirational motivation, intellectual stimulation, reward systems, and participative management. In this study, participants felt that transformational leadership traits are inherent in the practices of an inspirational leader. A leader who values ethics is honest, fair and cares for employees (Beckett et al, 2013), while ethical leadership is associated with engaging with team members and trusting relationships (Engelbrecht, 2017).

Self-leadership is described by Jooste et al (2015) as closely linked to concepts of shared leadership, reflective leadership, and collaborative leadership. This self-leadership framework was developed in a nursing context and proposes that "…a person must first be able to lead himself/herself before the next level of effective group leadership can be attained" (Jooste et al, 2015).

Leadership is a core competency in nursing education. Nurse educators are leaders in their profession "…to create, maintain and develop desired nursing programs and shape the future of education institutions" (WHO, 2016). In this study, nurse educators felt that they had to support each other during change as part of maintaining positive work relationships. The WHO (2016) urges nurse educators to actively act as a change agents, and manage change, transition and innovation in response to globalization (Berland et al, 2020).

Our findings add to the growing knowledge base on workplace culture in nursing practice (Hahtela, Paavilainen, McCormack, Helmine, & Suominen, 2015; Davis, White, & Stephenson, 2016; Wilson et al, 2020), and explored the implementation of a practice development model (TPD) in a nursing educational context. Programs to enhance a conducive workplace culture in nursing education settings seem to deserve a place in guidelines and strategies to retain nurse educators.

8. Limitations

Not all nurse educators could attend the workshops at the same time as some of them were assessing students at different intervals. In future, we recommend including administrative staff in any interventions, since they work with nurse educators to transform the workplace culture to person-centredness.

The TPD program presented in this study focused on nurse educator and management teams in the PNEI, therefore educational and teaching practices were not addressed. Person-

centred relationships with students were mentioned, but not fully explored in the workshops. Relationships with students form an integral part of the workplace culture in nursing education, and have also been mentioned as a source of stress for nurse educators in South Africa. We recognize that person-centred relationships are not limited to relationships between work colleagues but also extend to relationships between educators and students. Educators may benefit from applying TPD principles to their work with students. This study was only done in one PNEI and generalizability to other contexts should be further explored. Different PNEIs are likely to have different challenges, and it is likely that interventions to change workplace cultures will require unique inputs.

9. Recommendations

Transforming the workplace culture to person-centredness requires a sustained effort from both nurse educators and nurse managers in the institution. Future research should assess the long-term effects of the program to determine if a person-centred work place culture is associated with job satisfaction and nurse educator attrition rates.

The TPD program should be further developed to include a module on person-centred educator-student relationships. The authors recommend implementing TPD programs in other nursing education institutions to adapt the contents for different contexts.

10. Conclusion

This study came at the right time when organizational structures, programs and policies were revised to facilitate integration of the PNEI into higher education. The nurse educators and managers participated in designing new policies and improving standard operation procedures, so that most of the skills and ideas learned during the TPD program were implemented in work groups and new polices to improve working conditions.

Teamwork and leadership are required to transform the management's decision-making processes from a top-down approach to a bottom-up approach. Adopting this approach will lead to the successful employment of the principles of collaboration, inclusion and participation. In the PNEI, managers need to continuously encourage all employees to acquire and practice consistent healthy workplace relations by taking care of each other to enable human flourishing within the PNEI. TPD may help to retain nurse educators by facilitating a person-centred workplace culture.

References

American Association of Colleges of Nursing. (2019). Fact sheet: Nursing faculty shortage. Retrieved from https://www.aacnnursing.org/Portals/42/News/Factsheets/Faculty-Shortage-Factsheet.pdf [Accessed April 2021].

Beckett, P., Field, J., Molloy, L., Yu, N., Holmes, D., & Pile, E. (2013). Practice what you preach: Developing person-centred culture in inpatient mental health settings through strengths-based, transformational leadership. *Issues in Mental Health Nursing*, *34,* 595–601. https://doi.org/10.3109/01612840.2013.790524

Berland, A., Capone, K., Etcher, L., Ewing, H., Keating, S., & Chickering, M. (2020). Open education resources to support the WHO nurse educator core competencies. *International Nursing Review*, *67*(2), 282-287. https://doi.org/10.1111/inr.12583

Beukes, S. (2011). The accreditation of vocational assessment areas: Proposed standard statement and measurement criteria. *South African Journal of Occupational Therapy, 41*(3), 42-49. Retrieved from file:///C:/Users/u04120396/Downloads/The_accreditation_of_vocational_assessment_areas_P.pdf [Accessed April 2021].

Blaauw, D., Ditlopo, P., & Rispel, L. C. (2014). Nursing education reform in South Africa-lessons learnt from a policy analysis study. *Global Health Action 7*(1), 1-12. https://doi.org/10.3402/gha.v7.26401

Boomer, C. A., & McCormack, B. (2010). Creating the conditions for growth: A collaborative practice development programme for clinical nurse leaders. *Journal of Nursing Management*, *18*(6), 633-644. https://doi.org/10.1111/j.1365-2834.2010.01143.x

Catling, C. J., Reid, F., & Hunter, B. (2017). Australian midwives' experiences of their workplace culture. *Women and Birth*, *30*(2), 137-145. https://doi.org/10.1016/j.wombi.2016.10.001

Childs, D. (2019). Critical reflection on practice development. *International Practice Development Journal, 9(*1), 1-5. https://doi.org/10.19043/ipdj.91.012

Creswell, J. W., & Creswell, J. D. (2018). *Research design: Qualitative, quantitative, and mixed methods approaches* (5th ed.). Washington DC: SAGE Publishers.

Davis, K., White, S., & Stephenson, M. (2016). The influence of workplace culture on nurses' learning experiences: A systematic review of qualitative evidence. *JBI Evidence Synthesis*, *14*(6), 274-346. https://doi.org/10.11124/JBISRIR-2016-002219

South Africa Department of Health. (2013). *The National strategic plan for nursing education, training and practice 2012/13–2016/17*. Pretoria: Department of Health.

Dewing, J. & McCormack, B. (2017). Creating flourishing workplaces. In B. McCormack & T. McCance (Eds.), *Person-centred practice in nursing and health care: Theory and practice* (pp. 150-161). London: Wiley-Blackwell

Engelbrecht, A. S. (2017). Integrity, ethical leadership, trust and work engagement. *Leadership & Organization Development Journal, 38*(3), 368-379. https://doi.org/10.1108/LODJ-11-2015-0237

Fawaz, M. A., Hamdan-Mansour, A. M., & Tassi, A. (2018). Challenges facing nursing education in the advanced healthcare environment. *International Journal of Africa Nursing Sciences*, *9*, 105-110. https://doi.org/10.1016/j.ijans.2018.10.005

Filmalter, C. J., van Eeden, I., de Kock, J., McCormack, B., Coetzee, I., Rossouw, S., & Heyns, T. (2015). Critical reflection on practice development. From fixers to facilitators: The start to our South African journey**.** University of Pretoria, South Africa. *International Practice Development Journal, 5*(1), 1-8. http://www.fons.org/library/journal.aspx

Fritz, E. (2018). Transition from clinical to educator roles in nursing: An integrative review. *Journal for Nurses in Professional Development*, *34*(2), 67-77. https://doi.org/10.1097/NND.0000000000000436

Garbett, R., Hardy, S., Manley, K., Titchen, A., & McCormack, B., (2007). Developing a qualitative approach to 360-degree feedback to aid understanding and development of clinical expertise. *Journal of Nursing Management*, *15*(3), 342-347. https://doi.org/10.1111/j.1365-2834.2007.00692.x

Gazza, E. A. (2019l). Alleviating the nurse faculty shortage: Designating and preparing the academic nurse educator as an advanced practice registered nurse. *Nursing Forum, 54*(2), 144-148. https://doi.org/10.1111/nuf.12307

Geyer, N. (2020). Nursing education in 2020. *Professional Nursing Today*, *24*(2), 26-28.

Hahtela, N., Paavilainen, E., McCormack, B., Helminen, M., Slater, P., & Suominen, T. (2015). Nurses' perceptions of workplace culture in primary health care in Finland. *International Nursing Review*, *62*(4), 470-478. https://doi.org/10.1111/inr.12207

Hoeksel, R., Eddy, L. L., Dekker, L., & Doutrich, D. (2019). Becoming a transformative nurse educator: Finding safety and authenticity. *International Journal of Nursing Education Scholarship*, *1*(open-issue). https://doi.org/10.1515/ijnes-2018-0073

Jooste, K., Arunachallam, S., Julie, H., Essa, I., Willemse, J., Rashe, H. V., ... & Hoffman, J. C. (2015). The meaning of self-leadership for nursing academics in the context of a leadership programme at a higher education institution in South Africa. *Africa Journal of Nursing and Midwifery, 17*(1), 122-133. http://hdl.handle.net/10520/EJC186366

Khan, B. P., Griffin, M. T. Q., & Fitzpatrick, J. J. (2018). Staff nurses' perceptions of their nurse

managers' transformational leadership behaviors and their own structure empowerment. *JONA.* *48*(12), 609-614. https://doi.org/10.1097/NNA.0000000000000690

Laurencelle, F. L., Scanlan, J. M., & Brett, A. L. (2016). The meaning of being a nurse educator and nurse educators' attraction to academia: A phenomenological study. *Nurse Education Today*, *39*, 135-140. http://dx.doi.org/10.1016/j.nedt.2016.01.029

Manley, K. An overview of practice development. In B. McCormack & T. McCance (Eds.), *Person-centred practice in nursing and health care*: *Theory and practice* (pp 133-149). London: Wiley-Blackwell.

Manley, K., Sanders, K., Cardiff, S., & Webster, J. (2011). Effective workplace culture: The attributes, enabling factors and consequences of a new concept. *International Practice Development Journal*, *1*(2), 1-29. http://www.fons.org/library/journal.aspx

Manley, K., & Jackson, C. (2019). Microsystems culture change: A refined theory for developing person-centred, safe and effective workplaces based on strategies that embed a safety culture. *International Practice Development Journal*, *9*(2), 1-21. https://doi.org/10.19043/ipdj.92.004

Removed for blinded review

McCormack, B., Dewing, J., Breslin, L., Coyne-Nevin, A., Kennedy, K., Manning, M., ... & Slater, P. (2010). Developing person-centred practice: Nursing outcomes arising from changes to the care environment in residential settings for older people. *International Journal of Older People Nursing*, *5*(2), 93-107.

Mokobotho-Zwane, S. M. (2015). Today's students are tomorrow's colleagues: Exploring the nurse educator-student relationship in an emerging democracy in South Africa. *Africa Journal of Nursing and Midwifery*, *17*(1), 118-132. https://doi.org/10.25159/2520-5293/148

Moule, P., Aveyard, H. & Goodman, M. (2016). *Nursing Research: An introduction* (3rd ed.). London: Sage Publications.

Muff, K. (2013). Developing globally responsible leaders in business schools: A vision and transformational practice for the journey ahead. *Journal of Management Development, 32*(5), 487-507. https://doi.org/10.1108/02621711311328273

Nardi, D. A., & Gyurko, C. C. (2013). The global nursing faculty shortage: Status and solutions for change. *Journal of Nursing Scholarship*, *45*(3), 317-326. https://doi.org/ 10.1111/jnu.12030

Polit, D. F. & Beck, C. T. (2017). *Nursing research: Generating and assessing evidence for nursing practice* (10th ed.). Philadelphia: Wolters Kluwer Health.

Slater, P., McCance, T., & McCormack, B. (2017). The development and testing of the Person-centred Practice Inventory–Staff (PCPI-S). *International Journal for Quality in Health Care*, *29*(4), 541-547. https://doi.org/10.1093/intqhc/mzx066

Tompos, A., & Ablonczy-Mihalyka, L. (2018). The sustainability of cultural diversity in the workforce: Cultural values and intercultural mindset. *European Journal of Sustainable Development, 7*(1), 298-306. https://doi.org/10.14207/ejsd.2018.v7n1p298

Trede, F. & Hill, B. (2012). Intercultural communication. In J. Higgs, R. Ajjawi, L. McAllister, et al. (Eds.). *Communicating in the health and social sciences* (3rd ed.) (pp. 195-205).

Trede, F., & Titchen, A. (2012). Transformational practice development research in the healthcare professions: A critical-creative dialogue. *International Practice Development Journal*, *2*(2), 1-20. Retrieved from http://www.fons.org/library/journal.aspx [Accessed April 2021].

Wedding, J. S. (2020). *Designing leadership: Using design thinking to create, practices, and implement a formal leadership development program* (Dissertation, University of the Pacific, Sacramento, CA). Retrieved from https://scholarlycommons.pacific.edu/uop_etds/3663 [Accessed April 2021].

Westphal, J., Marnocha, S., & Chapin, T. (2016). A pilot study to explore nurse educator workforce issues. *Nursing Education Perspectives*, *37*(3), 171-173. https://doi.org/10.5480/14-1332

World Health Organization. (2016). Nurse educator core competencies. Geneva: World Health Organization. Retrieved from http://who.int/hrh/nursing_midwifery/nurse_educator050416.pdf. [Accessed April 2021].

Wilson, V., Dewing, J., Cardiff, S., Mekki, T. E., Øye, C., & McCance, T. (2020). A person-centred observational tool: devising the Workplace Culture Critical Analysis Tool®. *International Practice Development Journal, 10*(1), 1-15. https://doi.org/10.19043/ipdj.101.003

Xie, K., Hensley, V. L., & Sun, Z. (2019). Self-regulation as a function of perceived leadership and cohesion in small group online collaborative learning. *British Journal of Educational Technology, 50*(1), 456-468. https://doi.org/10.1111/bjet.12594

Ziglar, Z., & Ziglar, T. (2012). *Born to Win: Find your success code*. Dallas: Success Media.

Zwane, Z. P., & Mtshali, N. G. (2019). Positioning public nursing colleges in South African higher education: Stakeholders' perspectives. *Curationis*, *42*(1), 1-11. https://doi.org/10.4102/curationis.v42i1.1885.

Table 6.1

Demographic details of the Transformative Practice Development program participants

DEMOGRAPHIC INFORMATION		**n**	**n**	**n**	**n**	**n**	**n**
Gender	Male	2					
	Female	44					
Race	African		42				
	Coloured		3				
	Indian		1				
Age group	30-40			12			
	41-50			24			
	51-60			8			
	61-65			2			
Work position	Manager				8		
	Educator				38		
Highest qualification	B degree					38	
	M degree					7	
	PhD					1	
Years' experience	1-10						42
	11-20						4
TOTAL		**46**	**46**	**46**	**46**	**46**	**46**

Table 6.2

Transformative Practice Development program

Topic	Date and time[a]	Overview of content covered	Presenter	Feedback from participants (examples of direct quotations in italics)
Positive work relations				
Effective teamwork to transform the workplace culture towards person-centredness	Consensus meetings 18022019 25022019	• Positive attitude: know, respect and trust self and others, and mindfulness • Effective communication: sharing information, cultural sensitivity and diversity • Group cohesion: active participation, adherence to work plans, collective vision of goals, collective decision making and roles and responsibilities	Facilitator N	*Management to involve all stakeholders when forming strategic initiatives to achieve effective teamwork.* *Need more engagement of person-centred activities to promote transformation through effective teamwork.* *It's all about teamwork - sometimes you are the star, but sometimes you help the star* *Develop the mindset to volunteer to help others towards building effective teams*
Workplace values and beliefs to achieve a person-centred workplace culture	Workshop: 22032019 Feedback session: 29032019	• What are values and beliefs? • Development of values and beliefs • Person-centred values: respect, love, care, acknowledgment	Facilitator M	*The values and beliefs were unpacked well and clear for understanding.* *Appreciated the awareness on the need to develop workplace values and beliefs to support transformation.* *Appreciated the person-centred activities applied during the workshop related to values and beliefs.*
Factors affecting a conducive workplace culture (Overcoming challenges for all to flourish)	Workshop: 26042019 Feedback session: 30042019	• Factors affecting the workplace culture of person-centredness: poor leadership styles, toxic working relationships, negative attitudes, lack of policy implementation, lack of respect, lack of information sharing and knowledge • Ways to address challenging factors	Facilitator L	*No one could have addressed our workplace challenges better, continue to teach us.* *I appreciated this workshop that addressed poor workplace relationships and how to address them in a loving manner.* *Incapacitation was addressed very well and the objectives of employee capacitation was outstanding*
Facilitating healthy work relations for a person-centred workplace culture	Workshop: 06062019 Feedback session: 20062019	Healthy workplace relations to transform towards person centredness: be strong but not rude, kind but not weak, bold but not a bully, thoughtful but not lazy, humble but not timid, proud but not arrogant, humour but without folly	Facilitator K	*We have started to capacitate our colleagues in our departments on healthy workplace relations so that we are all in this transformation, everyone must know and join in for our happiness.* *The factors needed to establish healthy workplace relations were addressed well and thought provoking.* *Appreciated how facilitators engaged participants into self-introspection activities in a non-provoking manner.*
Transformation of the workplace	Workshop: 17072019	Effective teamwork: know and respect self and others, acknowledgement, share knowledge and information, open communication, positive	Facilitator D	*Many questions were asked on effective teamwork and guidance on how to deal with some workplace issues was well clarified.*

culture through effective teamwork	Feedback session: 26072019	attitudes and support, collective decision making		*Facilitator creativity and confidence was eye catching and realistic.* *We appreciated the facilitators walking the talk of effective teamwork.*
Communication				
Investing in cultural diversity for a person-centred workplace culture	Workshop: 12082019 Feedback session: 23082019	Person-centred attention to cultural, racial and religious diversity through sensitive use of language, dress codes and religion	Facilitator F	*Celebrate each other's strong points /success and support each other's culture.* *Embrace cultural days.*
Transformational values and beliefs	Workshop: 09092019 Feedback session: 27092019	• Participation in organisational decision-making forums • Respect for student's/lecturer's dignity • Creative ways to develop the self, others and the organisation • Personal and professional development	Facilitator C	*How can each person improve workplace practice for person centeredness? Was answered well in activities.* *Participants were actively involved in activities that demonstrated their understanding and interest of the topic.*
Building a person-centered workplace culture through communication, feedback and information sharing	Workshop: 17092019 Feedback session: 30092019	Effective communication at the workplace through: openness, continuous feedback, information sharing, attention to medium of communication	Facilitator I	*The workshop was relevant and need to be repeated and monitored that the proposed activities are implemented effectively.* *There is a need to develop a policy on communication to facilitate the objectives of this workshop in the future for continuity.*
"Not a workplace, but a wow place"	Workshop: 04102019 Feedback session: 18102019	• Transformation is complex and risky and brings changes to the organisation, work procedures and values • Employees to find peace, satisfaction and flourish at work despite challenges	Facilitator J	*Found the topic to be informative and want a follow-up as we didn't exhaust all what we had to address.* *Repeat the topic as colleagues that were not present need to hear it.*
Factors that will help to achieve a person-centred workplace culture	Workshop: 25102019 Feedback session: 31102019	• Feedback reports • Flexibility for self and others • Motivation, dedication and commitment • Positive attitude • Embracing differences • Collective decision making • Collaboration, inclusion and participation	Facilitator E	*Actively engaged in group work sessions and asked a lot of questions that were well addressed.* *The factors to achieve a person-centred workplace was informative and outstanding as practical examples for understanding were used.*

Transform the workplace culture through skills diversity and relevance	Workshop: 01112019 Feedback session: 15112019	Embrace skills diversity and relevance: • Continuous development and capacitation • Mentorship and evaluation • Healthy working relationships: respect/trust	Facilitator A	*Were very pleased and appreciated the boldness of the facilitators when addressing workplace issues that were real but could not be touched*.
Leadership				
Developing person-centred leadership to transform the workplace culture to person centredness	Consensus meetings 03052019	Person-centered leadership: • Leadership skills • Leading change • Collaborative decision making, • Workplace motivation.	Facilitator M	*Enjoyed the workshop that mimicked a real work situation.* *As a leader, you don't build a business, you build people – and then people build a business.* *A dream written down with a date becomes a goal to inspire followers.* *A goal broken down into steps becomes a plan backed up by collaborative decision making.* *A plan backed down by action makes your dreams becomes true.*
Leading yourself before leading others to achieve a person-centred workplace practice	Workshop: 13052019 Feedback session: 31052019	Based on the book: "Who said elephants can't dance": "…that which you thought can't change can still change" (Gerstner 2002:1) Everyone has the potential to change towards person centredness for all to flourish.	Facilitator B	*The participants were motivated to see the elephants dancing on the power point giving the lesson that there is nothing you cannot do.* *More lessons needed to revive others on how you can be coached to lead yourself first before leading others.*
Transformational leadership traits and person-centred leadership	Workshop: 21082019 Feedback session: 30082019	• Transformational leadership and learning • Transformational leadership traits: inspire, teach, learn from, listen to, mentor and coach others • Be bold and humble	Facilitator H	*Appreciated the topic and wanted a repeat before the college could close as everyone needs to learn.* *Learned in the work sessions and self-presentation during active work groups that we participated in.* *During transformation everyone learns new things.*

[a]3 hours per workshop and 2 hours per feedback session

Table 6.3

Co-construction of the Transformative Practice Development program for creating a person-centred workplace culture

Questions	**Actions**	**Responsible person** ***Timelines***
What must be done? *Who does what?* *When should the TPD program be presented?*	Develop and present sub-topics from the three main topics that emerged from the consensus meetings (positive work relations, communication and leadership). Facilitate group discussions Send invitations to the workshops Book venues. Ensure participants sign informed consent and attendance registers Facilitate feedback sessions	Program facilitators *Three workshops per month, three hours per workshop.* Researcher *Every session* *After each workshop*
What are the key concepts that guide the TPD program implementation?	Transformation, workplace culture, person-centredness, practice development, collaboration, inclusion, participation and reflection	Research team
What values will guide the program facilitators?	Adherence, compliance, integrity, faithful replication, completeness and compliance to protocols	Research team
What satisfaction indicators will guide the TPD program?	Attendance, feedback/ comments, representativeness of target population, engagement, attendance and retention.	Research team
How should quality be ensured during implementation of the TPD program?	Monitor the TPD program delivery, ensure that program protocols are observed, and capture participant comments and feedback during the workshops and feedback sessions.	Research team Researcher
Which resources are needed for the TPD program?	Stationary, laptops, overhead projector, microphone, refreshments.	Researcher

Adapted from Beukes (2011)

Table 6.4

Themes and subthemes describing Transformative Practice Development outcomes from feedback sessions

Theme	Subthemes
Positive work relations	Group cohesion • Ensure group cohesion in teams • Avoid always working in favourite workgroups • Participate in academic meetings and research days. • Participate in team building activities
	Change process (transformation) • Admit when then there is a problem (need to change) • Change attitude • Address change in a collaborative manner • Motivate self and others to act and to change • Be aware of responses to change
	Real and authentic attitude • Self-awareness • Reflective attitude • Apply the principles of collaboration, inclusion and participation
Communication	Reflective communication • Hindsight • Insight • Foresight
	Diversity and cultural sensitivity • Respect and appreciate diversity • Celebrate cultural diversity. • Appreciate and learn from different cultures and values. • Use English to accommodate everyone • Sensitivity towards different genders, racial groups and disabilities
Leadership	Transformational leadership traits • Leadership as an inherent trait versus a position • Inspirational leadership • Ability to teach, inspire and learn from others • Ability to share vision on leadership

	Transformational leadership processes • Decision making • Policies • Remuneration • Capacitation

CHAPTER 7
MERGING AND MAPPING OF STUDY PHASES

7.1 INTRODUCTION

Chapter 6 discussed the implementation of the TPD programme and the results of the assessment of the workplace culture for person centredness. This chapter discusses the results of phase 3 and compares the results of phase 1 and phase 3.

7.2 OBJECTIVE OF PHASE 3

The objective of phase 3 was to

Evaluate the outcomes of the TPD programme to transform the workplace culture to person-centredness.

7.3 METHODOLOGY

Phase 3 was quantitative, and data was collected by means of structured questionnaires in order to evaluate the outcomes after implementation of the TPD programme. As in phase 1, the questionnaire was for person-centred practice inventory (PCPI) assessment tool as adapted with permission for the study McCormack, Manley and Titchen's (2014:8). The researcher merged, mapped and evaluated the programme outcomes for phase 1 and 3.

7.3.1 Population

The population was the same as for phase 1. After the TPD programme implementation (phase 2), the researcher distributed questionnaires to the potential respondents and arranged to collect the completed questionnaires that were returned.

Recapping on the research activities for phase 1, the researcher distributed questionnaires to 92 potential respondents to volunteer to participate in phase 1 by signing informed consent forms. Of the 92, 63 respondents completed and returned the questionnaires. In phase 3, the

researcher distributed questionnaires to the same 92 potential respondents that were used in phase 1. In phase 3, 69 respondents completed and returned their questionnaires and informed consent.

7.3.2 Sampling

The type of sampling that was used was total sampling of respondents from the accessible population, this was the portion of the available population to which the researcher had reasonable access from the target population of academic staff. The inclusion criteria for phase 3 were all nurse educators that were employed at the PNEI for more than six months that had also signed the informed consent to participate in this phase. The exclusion criteria for phase 3 were all nurse educators who had been employed for less than six months at the PNEI, and who did not sign informed consent.

7.3.3 Data collection

Data were collected using the same tool (questionnaires) as in phase 1, namely the person-centred practice inventory (PCPI) assessment tool as adapted with permission for the study (McCormack, Manley & Titchen 2014:8). The researcher distributed the self-administered questionnaires on 12 February 2019 after the TPD programme implementation. The respondents were requested to deposit the completed questionnaires in a special box provided for the purpose. In phase 3, 69 completed questionnaires were returned and collected by the researcher on 22 February 2019.

7.3.4 Data analysis

A statistician analysed the data for phase 3, using the IBM SPSS 19.0 statistical software program. The pre-test and post-test results were analysed using comparative descriptive analysis. Variables were expressed as means and standard deviations, articulated medians and range for minimum and maximum, and the results presented in diagrams, graphs and tables (see chapter 3 for discussion of validity and reliability of the instrument).

7.4 RESULTS

The results are discussed in terms of “pre-test”, namely before the TPD programme implementation (phase 1), and “post-test”, namely after the implementation (phase 3). The results reported in 7.4.1 are in relation to the pre-test and post-test assessments for Section

A: Demographic profile, Section B: Person-centred practice inventory (PCPI), Section C: Collaboration, inclusion and participation (CIP) principles, and Section D: Workplace culture (WC).

7.4.1 Pre-test and post-test assessments

The pre-test and post-test assessments are discussed for Section A: Demographic profile, Section B: Person-centred practice inventory (PCPI), Section C: Collaboration, inclusion and participation (CIP) principles, and Section D: Workplace culture (WC).

7.4.1.1 Section A: Respondents' demographic profile

The respondents' demographic profile included age, gender, years of experience as an educator, highest level of education, and position at work (see Table 7.1).

Table 7.1 Pre-test and Post-test respondents' demographic profile

Age group	**N**		**%**		**Mean**		**SD**		**Range**		**Min**		**Max**	
	Pre	**Post**	**Pre**	**Post**	**Pre**	**Post**	**Pre**	**Post**	**Pre**	**Post**	**Pre**	**Post**	**Pre**	**Post**
	n=63	n=69	%	%	48.55	47.91	9.278	9.285	34	34	30	28	64	62
25-45 years	21	25	34	37										
46-55 years	26	24	42	36										
56-65 years	15	18	24	27										
Omitted	1	2	1.6	2.9										
Gender	**Pre**	**Post**	**Pre**	**Post**										
Female	57	62	90.5	89.9										
Male	5	6	7.9	8.7										
Omitted	1	1	1.6	1.4										
Highest level of ed*	**Pre**	**Post**	**Pre**	**Post**										
Bachelor's degree	35	44	55.6	63.8										
Master's/PhD degree	20	23	31.7	33.3										
Other	6	2	9.5	2.9										
Omitted	1	0		0										
Years of experience	**N**		**%**		**Mean**		**SD**		**Range**		**Min**		**Max**	
	Pre	**Post**	**Pre**	**Post**	**Pre**	**Post**	**Pre**	**Post**	**Pre**	**Post**	**Pre**	**Post**	**Pre**	**Post**
	n=63	n=69	%	%	9.18	8.8554	8.426	6.6708	43	30.42	1	.58	44	31
≤5 years	22	26	40	37.6										
6-10 years	14	21	25	30.4										
≥10 years	19	21	35	30.4										
Omitted	3	1	4.8	1.4										
Position at work	**Pre**	**Post**	**Pre**	**Post**										
Nurse educator	54	62	85.7	89.9										
Head of Department	6	5	9.5	7.2										
Vice Principal		1		1.4										
Omitted	1	1	1.6	1.4										
Other		0		0										

*Ed = education

The results reflected the number of respondents, mean, median, variance for the pre- and post-test comparative analysis. There was an increase in the number of respondents from 63

to 69. Figure 7.1 indicates that the mean, median and variance showed a good fit across all groups.

The respondents' average age was 47 years, ranging from 28 to 62. Of the respondents, 90% were females, and nurse educators; 64% had a Bachelor's degree, and 34% had a Master's/Phd degree. The respondents had an average of nine years' experience as nurse educators.

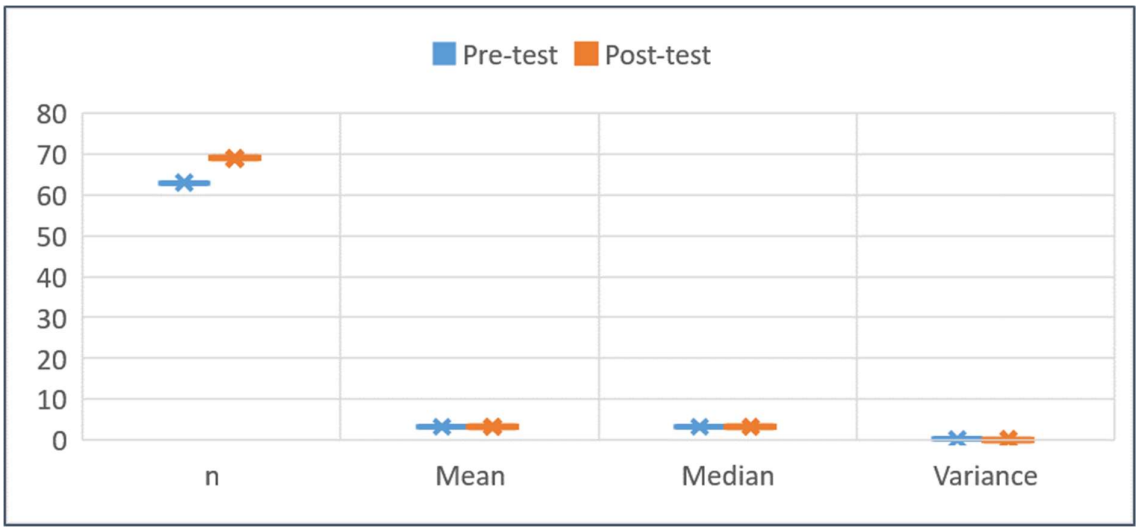


Figure 7.1 Comparative descriptive statistics for pre- and post-test

The pre- and post-test respondents' demographic results are compared next.

a) Pre- and post-test respondents' age

There was a slight variance in the spread of the respondents' age. In the pre-test, 34% (n=21) of the respondents were 30-35; 42% (n=26) were 46-55, and 24% (n=15) were 56-65 years old. In the post-test, 37% (n=25) were 25-45; 36% (n=24) were 46-55, and 27% (n=18) were 56-65 years old. This accounted for a slight variance of 6.3%, which had no significant effect on the results and indicated good consistency in terms of age. One respondent in the pre-test and two in the post-test did not record their ages (see Table 7.1 and Figure 7.2).

Organisations involve individuals with diverse backgrounds, skills and experience; they work together as a supportive entity to attain definite goals and objectives (Elewa & El Banan 2019:10). Elewa and El Banan (2019:12) emphasise that it is important to generate and sustain a positive organisational culture and organisational trust that is free of lack of respect. Arnold (2017:164) highlights the need to train and develop the workforce to think, relate and learn continuously.

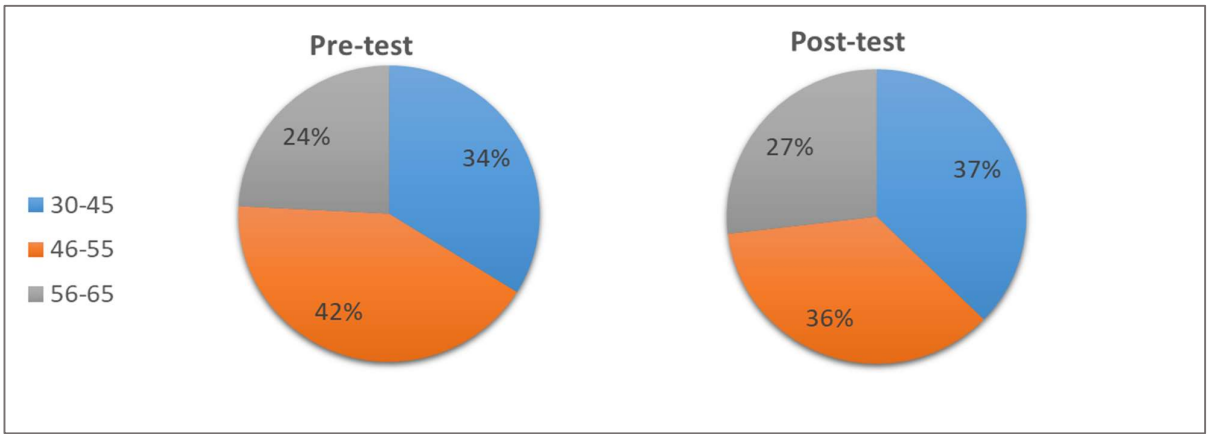


Figure 7.2 Pre- and post-test respondents' age

b) Pre- and post-test respondents' gender

In both the pre- and post-test, the respondents were mainly female, refer to figure 7.3. The results showed 1 more male during phase 3. In the pre-test, 90.5% (n=57) of the respondents were females and in the post-test, 89.9% (n=62) were females, indicating a variance of 0.6% (n=5), reflecting a slight change between pre- and post-test results. In the pre-test, 7.9% (n=5) of the respondents were males and in the post-test, 8.7% (n=6) were males, indicating a variance of 0.8% (n=1) One respondent in the pre-test and one in the post-test did not record their genders (see Table 7.1 and Figure 7.3).

Nursing is a female-dominated profession and there is still gender inequality of the workforce at the PNEI. The ability of the nursing profession to recruit and retain male nurses in nursing schools and in the workforce is due to several reasons, including stereotypes of nursing; lack of male interest in the profession, and perceived lack of the empathy needed to be nurses (MacWilliams, Schmidt & Bleich 2013; Nursing and Midwifery Council 2013:38).

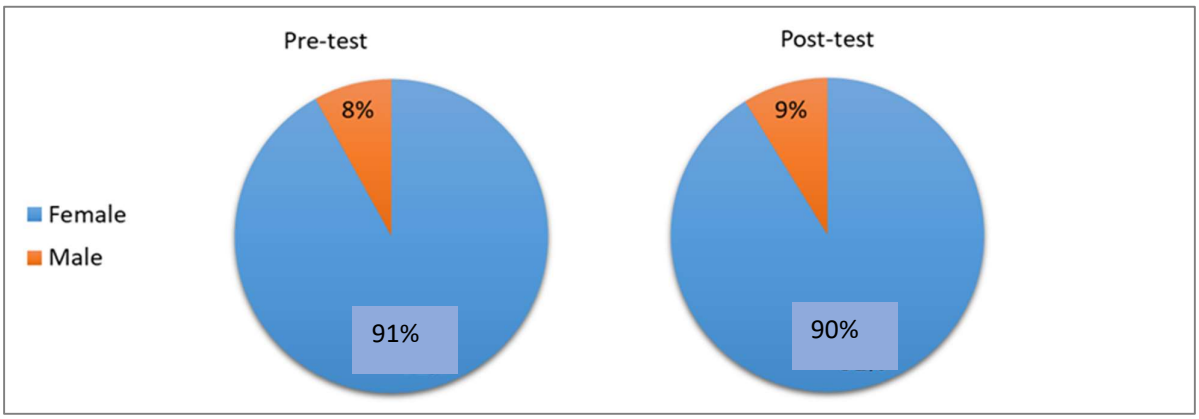


Figure 7.3 Pre- and post-test respondents' gender

c) Pre- and post-test respondents' highest level of education

In the pre-test, 56% (n=35) of the respondents had a Bachelor's degree and in the post-test 64% (n=44) had a Bachelor's degree, indicating a difference of 8% (n=6). In the pre-test, 32% (n=20) of the respondents had a Master's/PhD degree, compared to 33% (n=23) in the post-test, indicating a difference of 1% (n=3). In the post=test 1% (n=1) had a PhD. In the pre-test 10% (n=6) and in the post-test, 3% (n=2) had other diploma qualifications, indicating a difference of 7% (n=5). One respondent omitted the highest qualification in the questionnaire (see Table 7.1 and Figure 7.4). Figure 7.4 provides a more detailed breakdown of the highest level of education.

The implications for nurse educators in the revised and new nursing qualifications framework is that nurse educators can only teach a programme when their qualification is higher than the level of the particular programme (SANC 2015). The professional challenge in the PNEI is that most of the nurse educators have enrolled at universities to either obtain a Bachelor's degree to teach R.171 and a Master's degree to teach R.174 and a doctorate degree to teach Master's degree as guided by the SANC and CHE. Therefore, the professional challenge for nurse educators at the PNEI is that the majority cannot teach postgraduate students as few of them have master's and doctoral degrees. Table 7.2 lists the National Qualifications Framework (NQF) sub-frameworks and qualifications according to the National Qualifications Framework Act, 67 of 2008.

Table 7.2 NQF sub-frameworks and qualifications

NQF level	Sub-frameworks and qualifications
10	Doctoral degree
9	Master's degree
8	Honours degree/ Post-graduate diploma
7	Bachelor's degree /advanced diploma
6	Diploma/advanced certificate
5	Higher certificate

Source: National Qualifications Framework Act, 67 of 2008

In a study in Kenya to assess the effects of workplace cultural factors on employee performance, Kelemba (2019:148) found a correlation between the highest level of qualification and skills performance which demonstrated commitment to lifelong learning. The researcher is of the opinion that employees with higher levels of education could help develop a workplace culture of person-centredness.

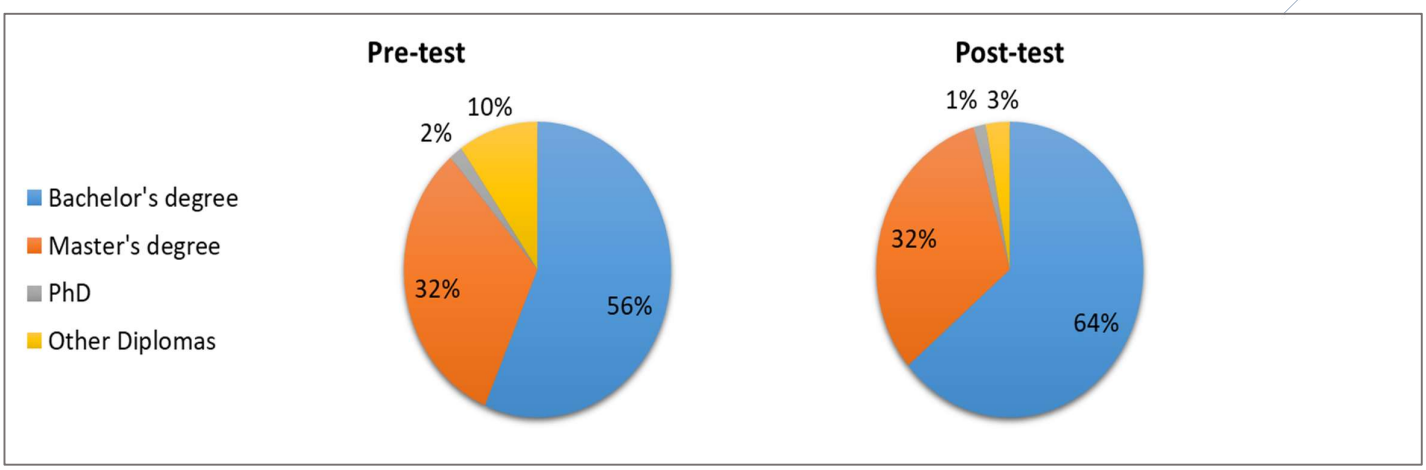


Figure 7.4 Pre- and post-test respondents' level of education

d) Pre- and post-test respondents' years of experience

In the pre-test, 40% (n=22) of the respondents had 1-5 years' experience and in the post-test, 38% (n=26) had 1-5 years' experience, indicating a difference of 2% (n=1). In the pre-test, 25% (n=14) had 6-10 years' experience and in the post-test, 31% (n=21) had 6-10 years' experience, indicating a difference of 6% (n=5). In the pre-test, 20% (n=13) had 11-15 years' experience and in the post-test, 21% (n=15) had 11-15 years' experience, indicating a difference of 1% (n=2). In the pre-test, 15% (n=9) had over 15 years' experience and in the post-test, 10% (n=7) had over 15 years' experience, indicating a difference of 5% (n=2). Three respondent in the pre-test and one respondent in the post-test omitted their years of experience (see Table 7.1 and Figure 7.5). Figure 7.5 provides a more detailed breakdown of the years of experience.

Organisations involve individuals with diverse backgrounds, skills and experience; they work together as a supportive entity to attain definite goals and objectives (Elewa & El Banan 2019:10). It is important to generate and sustain a positive organisational culture and organisational trust that is free of lack of respect. There is a significant relationship between a positive, ethical, supportive organizational culture and employees' years of experience and organisational commitment (Elewa & El Banan 2019:16; Mitonga-Monga, Flotman & Cilliers 2016:327). Arnold (2017:164) highlights the need to train and develop the workforce to think, relate and learn continuously.

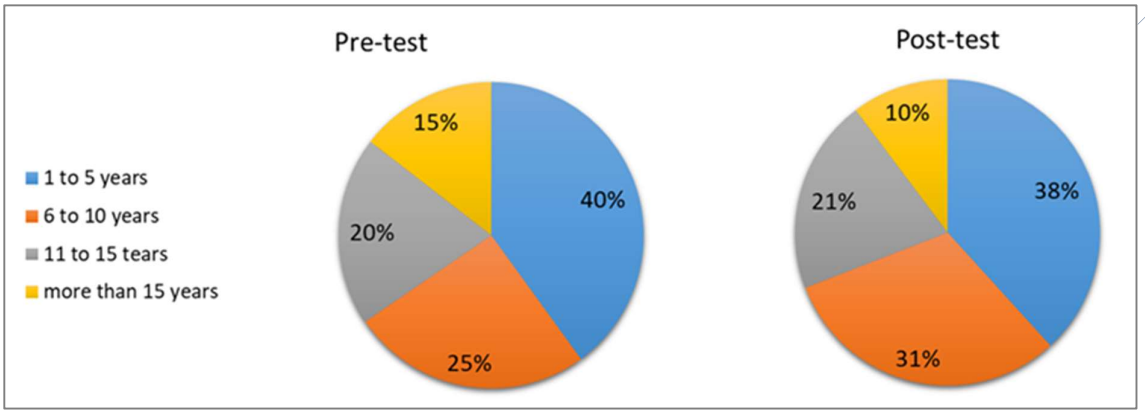


Figure 7.5 Pre- and post-test respondents' years of experience

e) Pre- and post-test respondents' position at work

In the pre-test, there were 86% (n=54) and in the post-test, there were 90% (n=62) nurse educators, indicating a difference of 4% (n=8). In the pre-test, there were 9% (n=6) and in the post-test, there were 7% (n=5) heads of departments or managers, indicating a difference of 2% (n=1). In the pre-test, there were 1% (n=1) and in the post-test, 2% (n=1) vice principals. The principal, being only one, was the same for pre- and post-test. In the pre-test, 2% (n=1) of the respondents indicated "other" for position at work, while in the post-test, all respondents disclosed their positions. (see Table 7.1 and Figure 7.6). Figure 7.6 provides a more detailed breakdown of the years of experience.

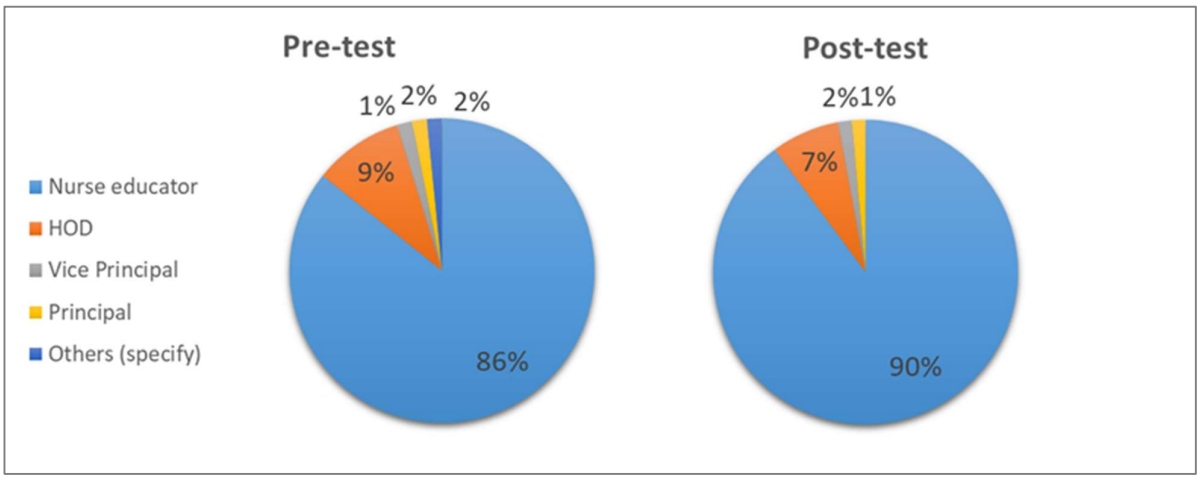


Figure 7.6 Pre- and post-test respondents' position at work

7.4.1.2 Section B: Person Centred Practice Inventory (PCPI)

This section presents the pre- and post-test results of Section B (PCPI) comparative analysis. This section consisted of 17 statements. See Table 7.3.

Figure 7.7 compares each pre- and post-test statement by means of a spider graph and depicts the differences between the pre- and post-test responses. The results revealed that the respondents experienced a degree of impact after the TPD programme. The respondents' agreement with the statements increased as follows:

- *I pay attention to how my life experiences influence my teaching practice* increased from 73% to 87%, giving a difference of 14%, showing an increase in respondents paying attention to how their own life experiences influence own teaching practice.
- *I actively seek feedback from others about my teaching practices* increased from 87% to 97%, giving a difference of 10%, showing an increase in educators actively seeking feedback from others about teaching practices.
- *I have the necessary skills to negotiate educational choices* increased from 88.9% to 98.6%, giving a difference of 9.7%. This revealed an increase in having the necessary skills to negotiate educational choices.
- *When I teach I pay attention to more than the immediate task* increased from 88.5% to 97.10%, giving a difference of 8.6%, results revealing an increase in paying attention to more than the immediate task when teaching. (see Table 7.3).

However,

- *I challenge colleagues when their teaching practices are inconsistent with our team's shared values and beliefs* - showed a slight decrease from 76.2% to 73.9%, giving a difference of 2.3%.

The average percentage of improvement for this scale was 14%.

A person-centred workplace culture includes transforming the workplace to systems that enable shared decision-making processes, healthy workplace relations, organizational systems that are supportive, power sharing in nature with shared potential innovative strategies (McConnell, McCance & Melby 2016:38). McCormack and McCance (2010:8) state that a person-centred workplace culture includes a suitable skills mix, facilitates systems of

sharing decision making at diverse platforms, healthy work relations and caring for all to flourish.

Table 7.3 Pre-test and post-test results for Person Centred Practice Inventory per statement

	Code	Disagree				Agree				Total			
		Count Pre	Count Post	% Pre	% Post	Count Pre	Count Post	% Pre	% Post	Count Pre	Count Post	Missing Pre	Missing Post
I have the necessary skills to negotiate educational choices	B1	7	1	11.10%	1.40%	56	68	88.90%	98.60%	63	69	0	0
When I teach I pay attention to more than the immediate task	B2	7	2	11.50%	2.90%	54	67	88.50%	97.10%	61	69	2	0
I actively seek opportunities to extend my professional competence	B3	3	2	4.80%	2.90%	59	67	95.20%	97.10%	62	69	1	0
I ensure I hear and acknowledge others perspectives	B4	1	1	1.60%	1.40%	62	68	98.40%	98.60%	63	69	0	0
B5 In my communication with others I demonstrate the respect for others	B5	1	0	1.60%	0.00%	62	68	98.40%	100.00%	63	68	0	1
I use different communication techniques to find mutually agreed solutions	B6	3	1	4.80%	1.40%	60	68	95.20%	98.60%	63	69	0	0
I pay attention to how my non-verbal cues impact on my engagement with others	B7	2	1	3.20%	1.40%	61	68	96.80%	98.60%	63	69	0	0
I strive to deliver high quality education to students	B8	1	2	1.60%	2.90%	62	66	98.40%	97.10%	63	68	0	1
I seek opportunities to get to know my students in order to provide holistic care/support	B9	4	4	6.30%	5.80%	59	65	93.70%	94.20%	63	69	0	0
I go out of my way to spend time with my students	B10	8	7	12.90%	10.10%	54	62	87.10%	89.90%	62	69	1	0
I strive to deliver quality education that is evidence informed	B11	2	1	3.20%	1.40%	61	68	96.80%	98.60%	63	69	0	0
I continuously look for opportunities to improve the education experience for students	B12	2	0	3.20%	0.00%	61	69	96.80%	100.00%	63	69	0	0
I take time to explore why I react as I do in certain situations	B13	4	5	6.30%	7.20%	59	64	93.70%	92.80%	63	69	0	0
I use reflection to check out if my actions are consistent with my ways of being real	B14	4	2	6.30%	2.90%	59	67	93.70%	97.10%	63	69	0	0
I pay attention to how my life experiences influence my teaching practice	B15	10	3	15.90%	4.40%	53	65	84.10%	95.60%	63	68	0	1
I actively seek feedback from others about my teaching practices	B16	8	2	12.90%	2.90%	54	67	87.10%	97.10%	62	69	1	0
I challenge colleagues when their teaching practices is inconsistent with our team's shared values and beliefs	B17	15	18	23.80%	26.10%	48	51	76.20%	73.90%	63	69	0	0

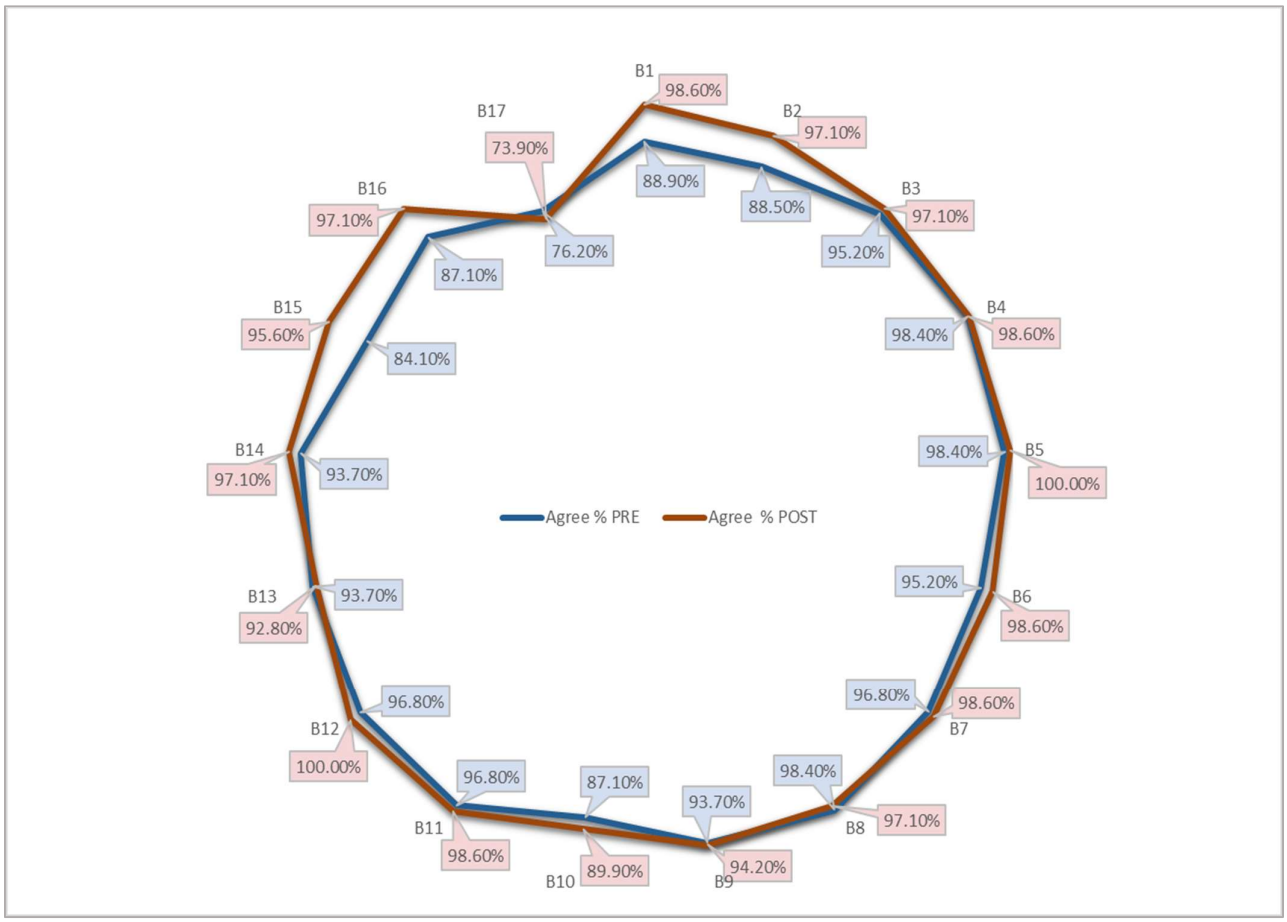


Figure 7.7 Differences between the pre- and post-test responses for PCPI

7.4.1.3 Section C: Collaboration, Inclusion and Participation (CIP) principles

Section C of the questionnaire consisted of 17 statements. Overall, the results revealed that the respondents did experience an impact after the programme implementation. See Table 7.4 and Figure 7.8. An improvement was seen in the respondents' agreement with the following statements:

- *My colleagues positively role model the development of effective relationships* increased from 66.7% to 85.5%, giving a difference of 18.8%
- *I am able to access opportunities to actively participate in influencing decisions in my division* increased from 75.8% to 89.9%, giving a difference of 14.1%.
- *I am encouraged and supported to lead new developments in teaching practice increased* from 74.6 to 86.6%, giving a difference of 12% (See Figure 7.8 and Table 7.3).

Regarding collaboration, inclusion and participation, there was a 12% improvement after the TPD. This indicated a need for continuation of interventions towards transforming the workplace culture to person-centredness.

The perception of team cohesiveness within the workplace environment was found to be significant. Healthy and supportive work environments are imperative to nurses' health, well-being and satisfaction. Improvements in the workplace can help prevent negative consequences, improve health outcomes for patients and nurses, and reduce nurse turnover (Wu, Singh-Carlson, Odell, Reynolds & Su 2016:166).

Table 7.4 Pre-test and post-test results for Collaboration, Inclusion and Participation principles

	Code	Disagree				Agree				Total PRE		Total POST	
		Count PRE	Count POST	% PRE	% POST	Count PRE	Count POST	% PRE	% POST	Count	Row N %	Count	Row N %
I support colleagues to develop their teaching practice to reflect the team's shared values and beliefs	C1	5	3	7.90%	4.30%	58	66	92.10%	95.70%	63	100.00%	69	100.00%
I recognise when there is a deficit in knowledge and skills in the team and its impact on teaching and learning	C2	6	5	9.70%	7.20%	56	64	90.30%	92.80%	62	100.00%	69	100.00%
I value the input from all team members and their contribution to teaching and learning	C3	1	0	1.60%	0.00%	62	69	98.40%	100.00%	63	100.00%	69	100.00%
I actively participate in team meetings to inform my decision-making	C4	1	0	1.60%	0.00%	62	69	98.40%	100.00%	63	100.00%	69	100.00%
I participate in organisational decision-making forums that impact on teaching practice to inform	C5	7	9	11.10%	13.00%	56	60	88.90%	87.00%	63	100.00%	69	100.00%
I am able to access opportunities to actively participate in influencing decision in my division	C6	15	7	24.20%	10.10%	47	62	75.80%	89.90%	62	100.00%	69	100.00%
My opinion is sought in decision making forums	C7	14	10	23.00%	14.50%	47	59	77.00%	85.50%	61	100.00%	69	100.00%
I work in a team that value my contribution to care	C8	9	5	14.30%	7.20%	54	64	85.70%	92.80%	63	100.00%	69	100.00%
I work in a team that encourages everyone's contribution to person centred care	C9	12	9	19.40%	13.20%	50	59	80.60%	86.80%	62	100.00%	68	100.00%
My colleagues positively role model the development of effective relationships	C10	21	10	33.30%	14.50%	42	59	66.70%	85.50%	63	100.00%	69	100.00%
The contributions of colleagues are recognised and acknowledged	C11	15	12	23.80%	17.40%	48	57	76.20%	82.60%	63	100.00%	69	100.00%
I actively contribute to the development of shared goals	C12	5	2	7.90%	2.90%	58	67	92.10%	97.10%	63	100.00%	69	100.00%
The leader (HOD) facilitates participation on all levels of the organisation	C13	14	8	22.20%	11.60%	49	61	77.80%	88.40%	63	100.00%	69	100.00%
I am supported to do things differently to improve my teaching practice	C14	17	12	27.00%	17.40%	46	57	73.00%	82.60%	63	100.00%	69	100.00%
I am encouraged and supported to lead new developments in teaching practice	C15	16	9	25.40%	13.40%	47	58	74.60%	86.60%	63	100.00%	67	100.00%
I am able to balance the use of evidence with taking risks	C16	19	13	30.60%	18.80%	43	56	69.40%	81.20%	62	100.00%	69	100.00%
I am committed to enhance learning by challenging teaching practices	C17	8	5	12.70%	7.20%	55	64	87.30%	92.80%	63	100.00%	69	100.00%

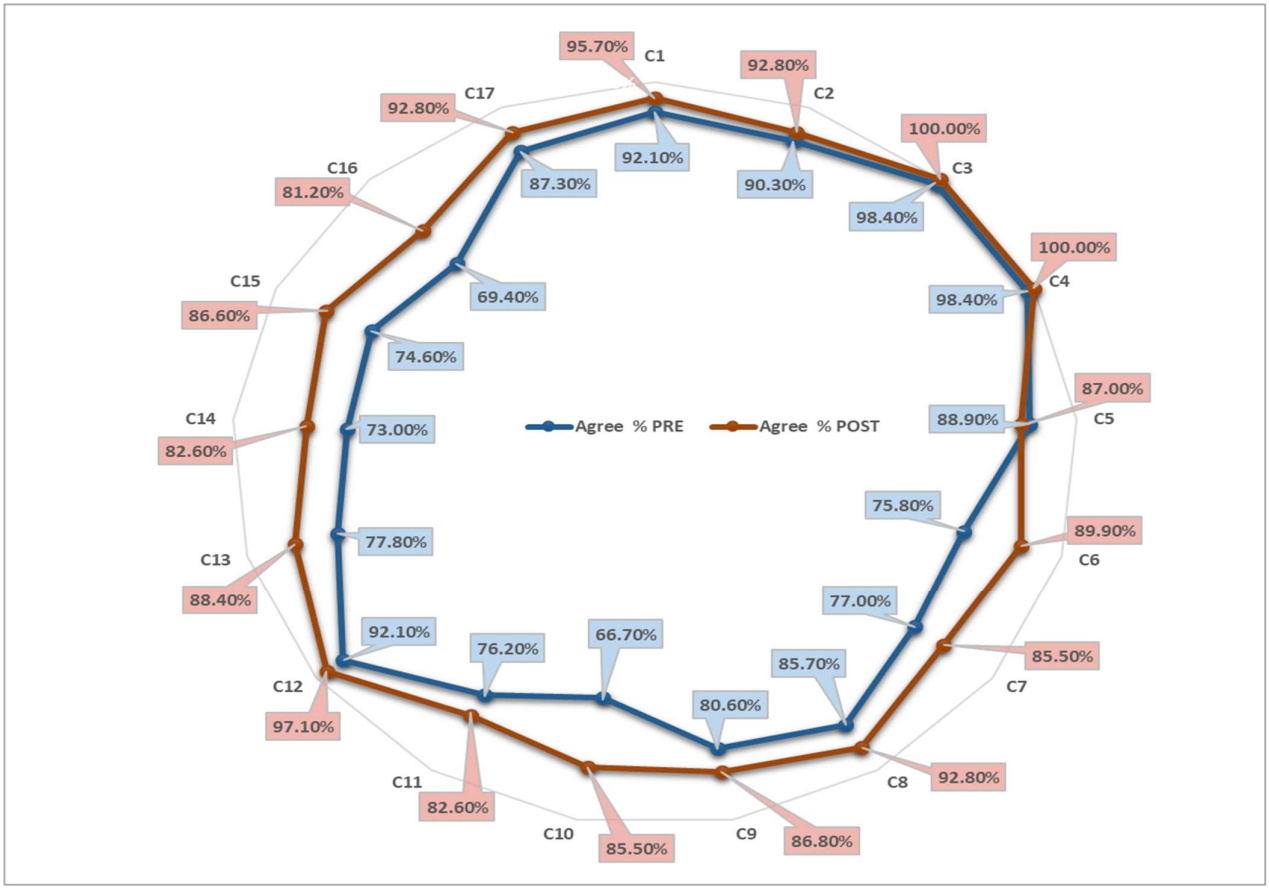


Figure 7.8 Differences between the pre- and post-test responses for Collaboration, Inclusion and Participation principles

7.4.1.4 Section D: Workplace culture

Section D consisted of 24 statements relating to work workplace culture. Table 7.5 shows the results of the pre- and post-test comparative analysis for the workplace culture. Figure 7.9 illustrates the results for each statement of the comparative analysis of the pre- and post-test on the workplace culture.

Generally, the results revealed that the TPD programme had an impact on the respondents. The following statements showed an improvement:

- *I am satisfied with the Performance Management and Development System (PMDS) at my work*, rated from 24 to 38 with a variance of 14 (36.8%).
- *In my team we take time to celebrate our achievements*, rated from 32 to 48 with a variance of 16 3(3.3%).

- *I work with the students within the context of their family and carers*, rated from 34 to 50 with a variance of 16 (32.0%).
- *I have the opportunity to discuss my practice and professional development on a regular basis* rated from 36 to 50 with a variance of 14 (28.0%).
- *I am supported to express concerns about an aspect of teaching and learning*, rated from 40 to 52 with a variance of 12 (23.0%).
- *I challenge others to consider how different elements of the physical environment impact on person centredness*, rated from 47 to 61 with a variance of 14 (22.95%).
- *I work with the students to set goals for the future*, rated from 43 to 55 with a variance of 16 (21.82%).

These statements revealed a variance score of between 21.82% minimum and 36.84% maximum. The remaining 17 statements showed a variance between 7.58% (minimum) and 19.15% (maximum). The results revealed that there was an impact after implementation of the TPD programme .

Table 7.5 Pre-test and post-test results for workplace culture per statement

Culture	PRE	POST	Variance	%
I'm satisfied with performance management and development system (PMDS) at my work	24	38	14	36.84%
In my team we take time to celebrate our achievements	32	48	16	33.33%
I work with the students within the context of their family and carers	34	50	16	32.00%
I have the opportunity to discuss my practice and professional development on a regular basis	36	50	14	28.00%
I am supported to express concerns about an aspect of teaching and learning	40	52	12	23.08%
I challenge others to consider how different elements of the physical environment impact on person-centredness	47	61	14	22.95%
I work with the students to set goals for their future	43	55	12	21.82%
My organisation recognises and rewards success	38	47	9	19.15%
I am recognised for the contribution that I make to students having a good experience of teaching and learning	35	43	8	18.60%
I assess the needs of students, taking into account all aspects of their lives	50	61	11	18.03%
I teach in a manner that takes account of the whole person (student)	54	65	11	16.92%
I seek feedback on how students make sense of their learning experience	56	67	11	16.42%
I gather additional information to help me support students	58	69	11	15.94%
I seek out creative ways of improving the physical environment	48	57	9	15.79%
I integrate my knowledge of person centredness into teaching and learning	56	66	10	15.15%
I include students in teaching and learning decisions, where appropriate	58	66	8	12.12%
I enable students to seek information about their teaching and learning	58	66	8	12.12%
I seek to resolve issues when my goals for students differ from their perspectives	59	67	8	11.94%
I strive to gain a sense of the whole person (student)	59	67	8	11.94%
I ensure my full attention is focused on the students when I am with them	61	69	8	11.59%
I pay attention to the impact of the physical environment on students'/lecturers' dignity	60	67	7	10.45%
I actively listen to students to identify unmet needs	61	68	7	10.29%
I engage students in teaching and learning processes, where appropriate	61	67	6	8.96%
I try to understand the students' perspectives	61	66	5	7.58%

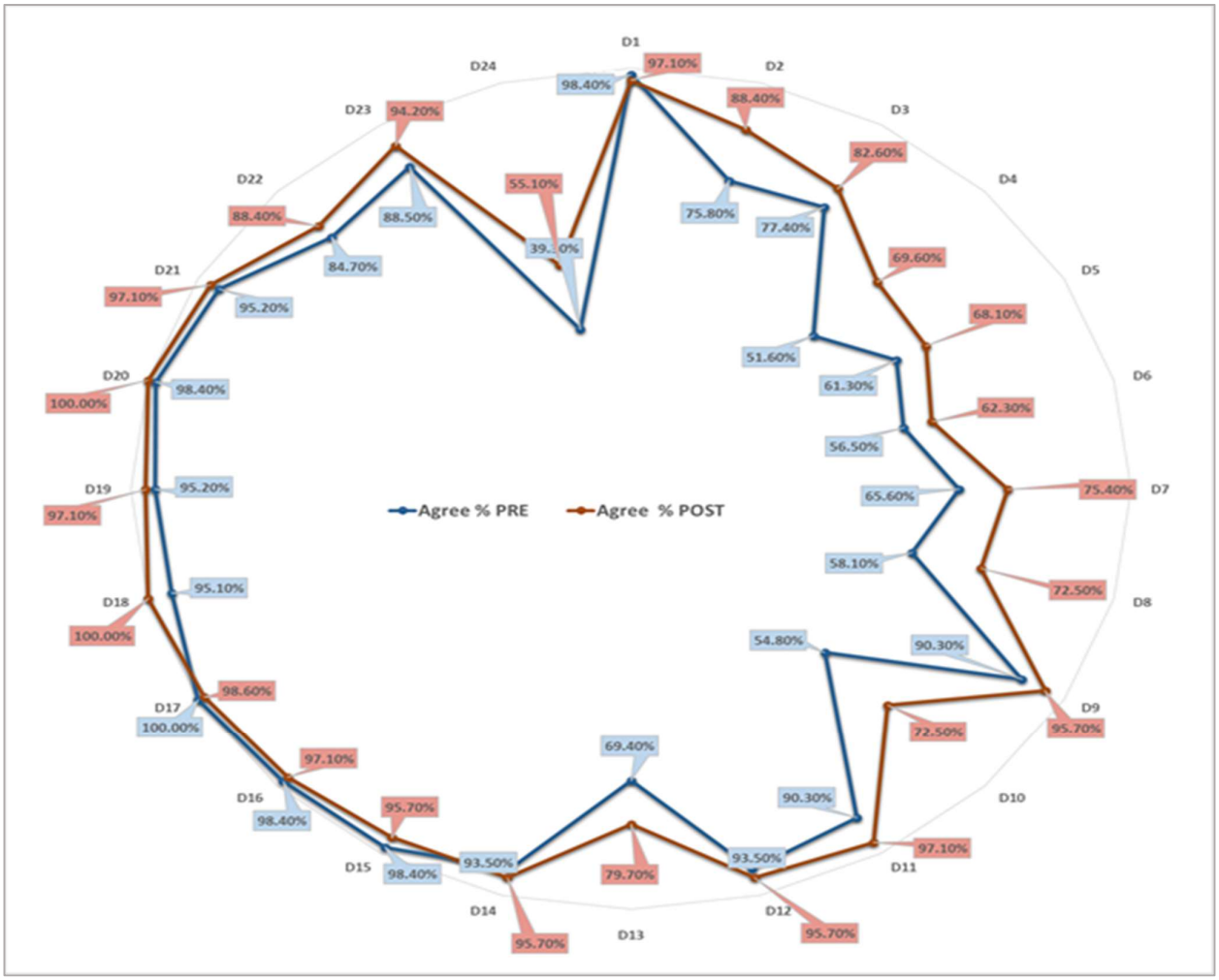


Figure 7.9 Differences between the pre- and post-test responses for workplace culture

7.4.1.5 Summary of results of the pre- and post-tests

The overall comparison of the phase 1 and phase 3 results are discussed next.

a) Person-centred practice inventory

The average percentage of improvement for this scale was 14%. The respondents experienced the following positive effects of the intervention after phase 1:

- The greatest impact was on their ability to pay attention to more than the immediate task when teaching.
- They now sought feedback from others about their teaching practices more freely.

- They were more confident in their negotiation skills when it came to educational choices;
- They paid more attention to how life experiences influenced their teaching.

They experienced little impact on

- Challenging colleagues when their teaching practices were inconsistent with the team's shared values and beliefs;
- Striving to deliver high quality education to students;
- Taking time to explore why they reacted as they did in certain situations.

b) Collaboration, inclusion and participation, inclusion and participation

The average percentage of improvement was 12%. The respondents experienced the following positive effects of the intervention after phase 1:

- The greatest impact was on their perception of their colleagues' positive role in developing effective relationships.
- They were more readily able to access opportunities to actively participate in influencing decisions in their division.
- They were more able to balance the use of evidence with taking risks.

They experienced little impact on

- Participating in organizational decision-making forums that affected teaching practice to inform decision-making.
- Actively participating in team meetings to inform their decision-making.

c) Workplace culture

The average percentage of improvement was 18%. The respondents experienced the following positive effects of the intervention after phase 1:

- They were satisfied with performance management and development system (PMDS) at work.
- They now took more time to celebrate achievements;
- There was an improvement in working with students in the context of their family and carers.
- They believed they had more opportunity to discuss their practice and professional development on a regular basis.

They experienced little impact on

- Trying to understand students' perspectives.
- Engaging students in teaching and learning processes, where appropriate

7.4.2 Comparison of scores across demographic factors

A Pearson's chi-square test was performed to compare scores across the demographic factors. The Pearson's chi square test indicated that the only significant associations were across demographic factors. There was a significant association between age group and years of work experience, as well as between age group and highest qualification level. Years' of work experience and highest qualification level were not significantly associated.

In a study in the USA and Canada, Wu, Singh-Carlson, Odell, Reynolds and Su (2016:E166) found that the perception of team cohesiveness within the workplace environment was significant. Healthy and supportive work environments are imperative to nurses' health, well-being and satisfaction and improvements in the workplace can help prevent negative consequences, improve health outcomes for patients and nurses, and reduce nurse turnover (Wu, Singh-Carlson, Odell, Reynolds & Su 2016:E168).

7.5 CONCLUSION

The chapter discussed the results of phase 3 and compared the results of phases 1 and 3. The findings revealed the effect that the respondents experienced after implementation of the TPD programme towards transforming the workplace culture to person-centredness.

Chapter 8 presents the conclusion and limitations of the study and makes recommendations for policy, education, and further research.

CHAPTER 8
RECOMMENDATIONS, LIMITATIONS AND CONCLUSIONS

8.1 INTRODUCTION

Chapter 7 discussed the outcomes after comparing the results of phase 1 and phase 3 to establish the effects of the implementation of the Transformative Practice Development (TPD) programme to transform the workplace culture of the selected PNEI to person-centredness. This chapter discusses the findings, contributions, and limitations of the study and makes recommendations nursing education policy, nursing education institutions, nursing education management, and further research.

The PNEI in the study had challenges in developing a positive workplace culture and participative teamwork due to academic staff problems with student nurse training mandates and policy compliance, poor workplace relationships, low staff morale and increased tension. The study therefore investigated the workplace culture problems and determined nurse educators' and managers' perceptions of the workplace culture in the PNEI.

8.2 AIM AND OBJECTIVES OF THE STUDY

The aim of the study was to transform the workplace culture of a selected PNEI in South Africa to person-centredness. In order to achieve the aim, the objectives of the study were to

- Assess the current workplace culture of the selected PNEI.
- Implement the Transformative Practice Development (TPD) programme to transform the workplace culture to person-centredness.
- Evaluate the outcomes of the TPD programme.

The study therefore wished to answer the following research question:

- How can the workplace culture of the selected PNEI be transformed to become more person-centred?

8.3 SUMMARY OF THE PHASES

Conclusions of the study are based on a summary of the findings of the three phases and related objectives, and the merging and mapping of the final findings. This section summarises the three phases of the study.

8.3.1 Phase 1: Assessment of the workplace culture

Objective 1: To assess the workplace culture of the selected PNEI

Step 1: Adaptation of the assessment tool
Step 2: Orientation of TPD programme facilitators
Step 3: Distribution and collection of questionnaires

Quantitative methodology was used to assess the workplace culture in three steps as follows:

Step 1: Adaptation of the assessment tool

The researcher adapted the Person-centred Practice Inventory (PCPI) questionnaire (McCormack, Manley & Titchen 2014:8) in collaboration with nursing experts. The questionnaire contained 57 questions, covering person-centredness, collaboration, inclusion and participation (CIP) principles and workplace culture (see Annexure C:5).

Step 2: Pilot test

A pilot test was conducted with five respondents who did not participate in the main study. The participants answered the questions within 30 minutes and indicated that the questions were clear and well understood with no changes or suggestions.

Step 3: Distribution and collection of questionnaires

The researcher distributed questionnaires to the respondents and collected the completed questionnaires.

8.3.2 Phase 2: Transformative practice development programme implementation

Objective 2: To implement the Transformative Practice Development programme

Stage 1: Preparation for TPD programme implementation
Stage 2: Co-construction of the TPD programme
Stage 3: Implementation of the TPD programme
Stage 4: Feedback sessions and evaluation of outcomes

To achieve objective 2, the researcher and facilitators used phase 1 outcomes to co-construct a TPD programme. The aim of the programme was to facilitate the implementation of activities towards transforming the workplace culture to become more person-centred. The research team facilitated the implementation of the TPD programme in four stages, namely, preparatory phase; co-construction of the TPD programme; implementation of the TPD programme, and feedback and evaluation of outcomes.

Stage 1: Preparatory phase for TPD program implementation

During the preparatory phase, data was collected during consensus meetings and feedback sessions to reflect the respondents' views.

Stage 2: Co-construction of the TPD programme

The researcher and the programme facilitators co-constructed the TPD programme based on the Phase 1 findings. The researcher and the programme facilitators identified and agreed on interventions to promote positive workplace relations, communication and leadership. The strategies were converted into an action plan that included the topics, content, dates, times and presenters for the workshop.

Stage 3: Implementing the TPD programme

The researcher and facilitators implemented the programme for nine months from March to November 2019, using CIP principles to engage the participants with critical questions that facilitated person-centred practices. This stage included consensus meetings and feedback sessions at different phases of implementation.

Stage 4: Feedback sessions and evaluation of programme outcomes

The themes and sub-themes that emerged from the feedback sessions and reflective notes were summarised.

8.3.3 Phase 3: Evaluation of workplace culture

Objective 3: To evaluate the current workplace culture of the selected PNEI after the TPD programme implementation.

Step 1: Distribute and collect self-administered questionnaires after TPD programme implementation
Step 2: Merge, map and compare phase 1 and phase 3 outcomes towards transforming the workplace culture.

Step 1: Distribute and collect self-administered questionnaires after Transformative Practice Development programme implementation

In phase 3, the researcher used the same questionnaires as in phase 1 to collect data to evaluate the TPD programme.

Step 2: Merge, map and compare phase 1 and phase 3 outcomes towards transforming the workplace culture

In this step, the researcher mapped and merged the outcomes of phase 1 and phase 3 to evaluate how implementation of the TPD programme transformed the workplace culture towards person-centredness. This step presented the final outcomes for the study as outlined in Tables 8.1, 8.2 and 8.3.

Table 8.1 Positive work relations

POSITIVE WORK RELATIONS				
ASSESSMENT →		IMPLEMENTATION →	EVALUATION	
Phase 1: Quantitative	Phase 2: Qualitative	Phase 2: TPD program	Phase 2: Qualitative	Phase 3: Quantitative
My colleagues positively role model the development of effective relationships (33.3% disagree)	Positive work relations	Facilitating healthy work relations for a person-centred workplace culture	Positive work relations	My colleagues positively role model the development of effective relationships (14.5% disagree)
I challenge colleagues when their teaching practices is inconsistent with our team's shared values and beliefs (23.8% disagree).	Knowing self and others Respecting self and others Trusting self and others.	Workplace values and beliefs to achieve a person-centred workplace culture	Real and authentic attitude • Self-awareness • Reflective attitude	-I challenge colleagues when their teaching practices is inconsistent with our team's shared values and beliefs (26.1% disagree).
In my team we take time to celebrate our achievements (48.4% disagree).	Group cohesion Collective vision of goals Clear roles and responsibilities. Adherence to work plans	Transformation of the workplace culture through effective teamwork and person centred leadership	• Apply principles of collaboration, inclusion and participation Group cohesion • Ensure group cohesion in teams • Participate in academic meetings and research days. • Participate in team building activities.	+In my team we take time to celebrate our achievements (30.4% disagree).
I am supported to do things differently to improve my teaching practice (27.0% disagree). I am encouraged and supported to lead new developments in teaching practice (25.4% disagree) I am able to balance the use of evidence with taking risks (30.6% disagree). I seek out creative ways of improving the physical environment (22.6% disagree).	Factors affecting a conducive workplace culture See leadership table	See communication table	Change process (transformation) • Admit when there is a problem (need to change) • Change attitude • Address change in a collaborative manner • Motivate self and others to act and to change • Be aware of responses to change	+I am supported to do things differently to improve my teaching practice (17.4% disagree). +I am encouraged and supported to lead new developments in teaching practice (13.4% disagree) +I am able to balance the use of evidence with taking risks (18.8% disagree).+I seek out creative ways of improving the physical environment (17.4% disagree).

Table 8.2 Communication

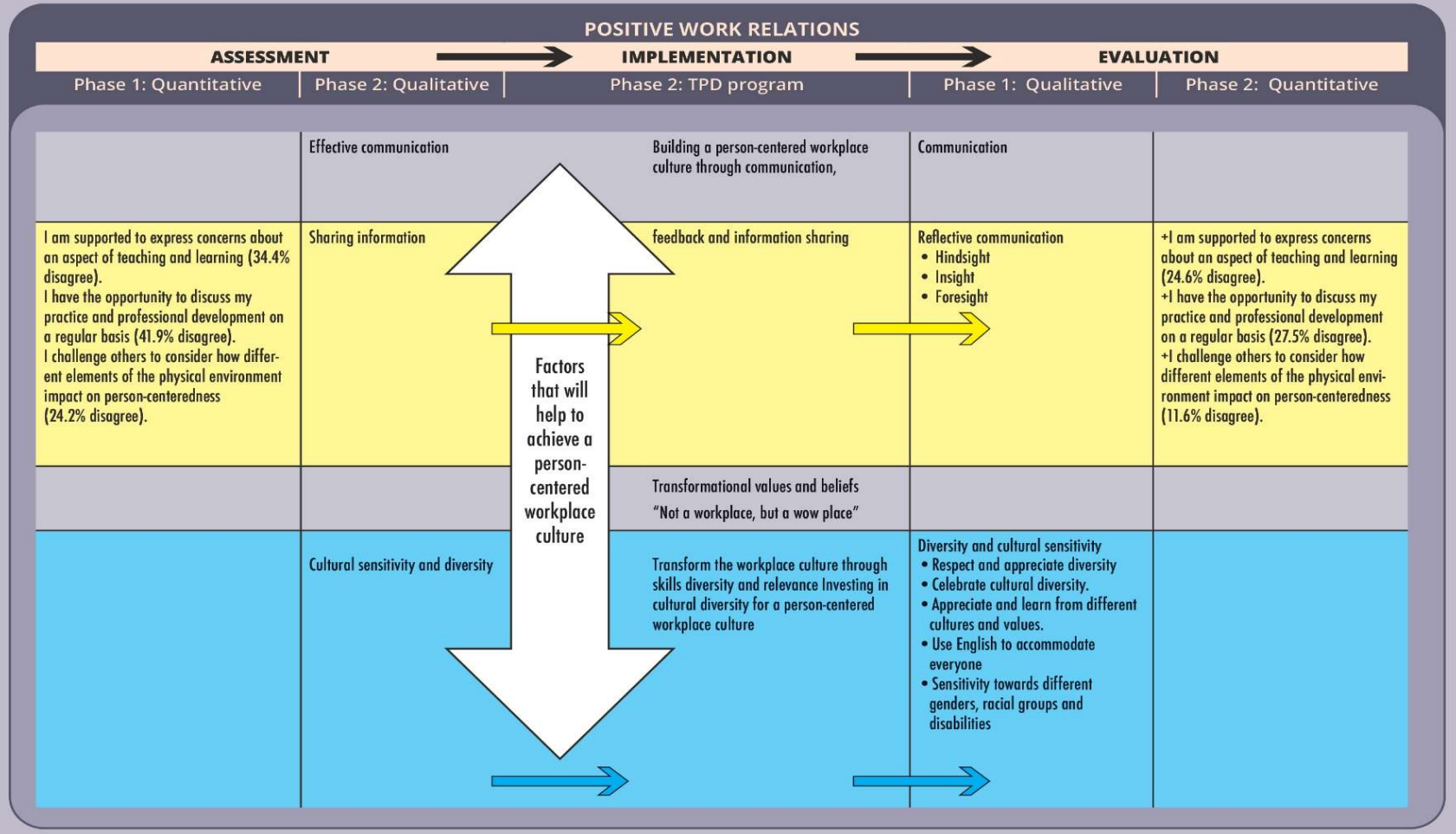


Table 8.3 Leadership

POSITIVE WORK RELATIONS				
ASSESSMENT →		IMPLEMENTATION →		EVALUATION
Phase 1: Quantitative	Phase 2: Qualitative	Phase 2: TPD program	Phase 1: Qualitative	Phase 3: Quantitative
	Person-centered leadership Leadership skills	Developing person-centred leadership to transform the workplace culture to person centredness	Leadership	
The leader (HOD) facilitates participation on all levels of the organisation (22.2% disagree). I am able to access opportunities to actively participate in influencing decision in my division (24.2% disagree)	Collaborative decision making		Transformational leadership processes (decision making, policies, remuneration, capacitation).	+The leader (HOD) facilitates participation on all levels of the organisation (11.6% disagree). I am able to access opportunities to actively participate in influencing decision in my division (10.1% disagree)
		Transformational leadership traits and person-centred leadership	Transformational leadership traits • Leadership as an inherent trait versus a position • Ability to share vision on leadership	
The contributions of colleagues are recognised and acknowledged (23.8% disagree). My organisation recognises and rewards success (38.7% disagree). I am recognised for the contribution that I make to students having a good experience of teaching and learning (43.5%). I'm satisfied with performance management and development system (PMDS) at my work (60.7% disagree).	Workplace motivation.	Leading yourself before leading others to achieve a person-centred workplace practice	• Inspirational leadership • Ability to teach, inspire and learn from others	+The contribution of colleagues are recognised and acknowledged (17.4% disagree). +My organisation recognises and rewards success (31.9% disagree). +I am recognised for the contribution that I make to students having a good experience of teaching and learning (37.7% disagree). +I'm satisfied with performance management and development system (PMDS) at my work (44.9% disagree).

8.4 MERGING AND MAPPING OF OUTCOMES

The outcomes are summarised according to the three main themes that emerged from the results as the most important topics to be addressed in the TPD programme, namely positive work relations, communication, and leadership.

8.4.1 Positive work relations

Table 8.1 lists the positive work relationships. In phase 1, 33.3% of the respondents disagreed that their *colleagues positively role model the development of effective relationships*. Participants in the consensus group identified *positive work relations* as a main theme to be addressed to transform the workplace culture. Accordingly, *facilitating healthy work relations for a person-centred workplace culture* was one of the topics in the TPD programme. After the TPD programme implementation, *positive work relations* was indicated as an outcome, and 14.5% of the respondents disagreed that their *colleagues positively role model the development of effective relationships.*

Another aspect that indicated that work relationships were a problem was that in phase 1, 23.8% of the respondents disagreed that *colleagues will challenge them when their teaching practice is inconsistent with the team's shared values and beliefs*. During the consensus group, aspects such as *knowing, respecting and trusting self and others* emerged as subthemes under work relations that might have affected the openness of the team to challenge each other. These were addressed in the TPD programme as *workplace values and beliefs to achieve a person-centred workplace culture.* The participants identified *real and authentic attitude, self-awareness and reflective attitude* as outcomes. In phase 3, 26.1% of the respondents disagreed that *colleagues will challenge them when their teaching practice is inconsistent with the team's shared values and beliefs.* This made the researcher realise that one cannot directly relate a single result to the successful or non-successful implementation of the TPD programme as several variables are involved. However, this might be an aspect requiring attention in future programmes and research.

The participants reached consensus that *teamwork (group cohesion)* was a subtheme that needed attention under work relations. They felt that roles and responsibilities and adherence to work plans were not well attended to. Regarding teamwork, in phase 1, 48.4% of the respondents disagreed that their *achievements were celebrated in the team*. Teamwork was addressed in the

TPD implementation as *transformation of the workplace culture through effective teamwork and person-centred leadership.* A qualitative finding indicated application of principles of *collaboration, inclusion and participation, group cohesion and participation in different teams, meetings and team building activities* as outcomes. In phase 3, 30.4% of the respondents disagreed that their *achievements were celebrated in the team*.

The last aspect addressed under work relationships was *change processes (transformation)*. Although this did not seem directly related to work relationships, in phase 1**, 27.0%** of the respondents disagreed that they were *supported to do things differently to improve their teaching practice* and in phase 3, 17.4% disagreed. In phase 1, 30.6% of the respondents disagreed that they *were able to balance the use of evidence with taking risks*, and in phase 3, 18.8% disagreed. In the consensus groups, the participants identified change as a problem in the PNEI and categorised it as a leadership problem, namely *leading change*. During the TPD programme, change processes were addressed under two topics: *transformational values and beliefs*, and *not a workplace, but a wow place* under the main theme of communication as it became clear from the feedback sessions that the problems with change in the PNEI related to communication skills. The participants categorised the change process as an outcome under work relationships, as the TPD contents related to change improved their work relationships. After the TPD implementation, the respondents experienced *change as a collaborative process, enhanced by a need to change, change attitudes and awareness and motivation from self and others to respond to change*. In phase 1, 25.4% of the respondents disagreed that they were *encouraged and supported to lead new developments in teaching practice*, and in phase 3, 13.4% disagreed.

The topic *factors affecting a conducive workplace culture* in the TPD programme addressed all aspects of work relationships in general (indicated within the arrow across the table).

8.4.2 Communication

Table 8.2 depicts aspects related to communication. Communication emerged as a main theme in the initial consensus meeting where participants wanted *effective communication and sharing of information* addressed in the TPD programme.

In phase 1, 34.4% of the respondents disagreed that they were *supported to express concerns about an aspect of teaching and learning* and in phase 3, 24.6% disagreed. In phase 1, 41.9%

disagreed that they had *the opportunity to discuss my practice and professional development on a regular basis*, and in phase 3, 27.5% disagreed. In phase 1, 24.2% disagreed that they *challenge others to consider how different elements of the physical environment impact on person-centredness*, and in phase 3, 11.6% disagreed.

In the TPD programme, the topic: *building a person-centred workplace culture through communication, feedback and information sharing* provided training on communication.

Although not measured in the questionnaire, the respondents expressed a need during the consensus meeting to address cultural sensitivity and diversity in the TPD programme under the topics: *transform the workplace culture through skills diversity and relevance*, and *investing in cultural diversity for a person-centred workplace culture.* The respondents described the outcomes as *respect for and appreciation of diversity, celebration of cultural diversity, learning from different cultures and values, and sensitivity towards different languages, genders, racial groups and disabilities.* The participants grouped this subtheme under communication as they received training during the TPD programme to use non-verbal and verbal communication skills to talk about and express appreciation for diversity, understand different cultures and address language issues.

The topic *factors that will help to achieve a person-centred workplace culture* in the TPD programme addressed all aspects of communication in general, and is indicated within the arrow across the table.

8.4.3 Leadership

Table 8.3 depicts specific leadership aspects. The participants indicated that they wished to explore person-centred leadership skills and focus on *collaborative decision making*. This was addressed in the TPD programme topic: *developing person-centred leadership to transform the workplace culture to person-centredness.*

The results indicated that in phase 1, 22.2% of the participants disagreed that *the leader (HOD) facilitates participation on all levels of the organization*, and in phase 3, 11.6% disagreed. In phase 1, 24.2% of the participants disagreed that they were *able to access opportunities to actively participate in influencing decisions in my division (decision-making)*, and in phase 3, 10.1% disagreed.

During the TPD implementation, the participants expressed a need to learn more about *transformational leadership traits* and how transformational leadership compared to person-centred leadership. After the session, they described *leadership as an inherent trait versus a position*, and reported that they felt more open to *share their visions on leadership* and *leadership motivation*. The TPD facilitators addressed motivation under the topic: *leading yourself before leading others to achieve a person-centred workplace practice*. This led to a description of *inspirational leadership* as an *ability to teach, inspire and learn from others*.

Regarding leadership and motivation, in phase 1, 23.8% of the participants disagreed that *the contributions of colleagues are recognised and acknowledged*, and in phase 3, 17.4% disagreed. In phase 1, 38.7% disagreed that the organisation recognises and rewards success, and in phase 3, 31.9% disagreed. In phase 1, 43.5% of the participants disagreed that *I am recognised for the contribution that I make to students having a good experience of teaching and learning*, and in phase 3, 37.7% disagreed. In phase 1, 60.7% disagreed that they were *satisfied with [the] performance management and development system (PMDS) at my work*, and in phase 3, 44.9% disagreed. The performance management system is a departmental system that all PNEIs must follow. Future research could explore nurse educators' dissatisfaction with the system.

The three main themes overlapped. For example, communication is a component of positive work relations, and leadership is based on positive work relations. Although the TPD programme covered specific topics, in this study they were presented in an integrative manner to emphasise the interrelationships between the three main themes. Although the results of the questionnaire cannot be directly related to the successful or non-successful implementation of the TPD programme, the findings do indicate a positive effect on the workplace culture.

8.5 CONTRIBUTIONS OF THE STUDY

The study made theoretical, methodological and nursing education contributions to the body of knowledge.

8.5.1 Theoretical

The study contributed to the body of knowledge by demonstrating the use of a person-centred approach in TPD program implementation in a PNEI. The collaborative stakeholder participation

included active involvement of nurse educators to influence change and transformation of the workplace culture in the PNEI.

The study added to the theoretical knowledge on the use of a TPD conceptual framework for practice development activities based on a collective vision for ideal practices and workplace values for all employees to flourish. The TPD conceptual framework guided the process of transforming the workplace culture to person-centredness, using the participants' learning experiences to generate information to support change. Programme facilitators were trained to accompany and guide the participants in the change process by facilitating the programme and not becoming fixers of the problems. The TPD programme used the collaboration, inclusion, participation principles to in the development of person-centredness. The use of the person-centred approach in action research towards transforming the workplace culture to person-centredness was unique to nursing education.

The study provided guidance on how to train the programme facilitators to become facilitators of the TPD programme and not fixers of the problems during implementation. The study also assessed the workplace culture, effective teamwork, person-centred leadership, and implementation of the TPD programme.

8.5.2 Methodological

The methodological contribution of the study was the use and application of the adapted Person-centred Practice Inventory (PCPI) tool. Other researchers can use the tool to assess the workplace culture in a nursing education context. The combination of data-collection strategies of consensus meetings and feedback sessions yielded rich data that informed the TPD programme on a continuous basis. The TPD programme and methodology was initially used in clinical settings to improve patient-centred care, and in this study the TPD methodology was adapted for use within the nursing education context. The collaboration, inclusion and participation (CIP) principles enabled the participants evaluate the workplace culture based on their experience and assessment, which facilitated stakeholder inclusion in a person-centred approach.

8.5.3 Nursing education

The study led to the transformation of the workplace culture in the selected PNEI to become more person-centred to improve nurse educator job satisfaction, reduce nurse educator turnover and improve organizational outcomes. The TPD programme facilitated effective communication, teamwork, and person-centred leadership to improve workplace relations, awareness of cultural sensitivity and diversity. The study employed a bottom-up approach using the principles of collaboration, inclusion, participation and a reflexive approach for joint decision-making in a person-centred approach.

Nursing education managers and nursing education institutions with similar contexts can transform their workplace culture using the TPD processes.

8.6 LIMITATIONS

The researcher identified the following limitations in the study:

The study was conducted in one selected PNEI in one province, therefore, the findings cannot be generalised to other PNEIs and provinces. The participants were academic staff members only and did not include administrative staff. Future research could include administrative staff and their perspectives on a person-centred workplace culture. The facilitation of the TPD programme should be ongoing to ensure stability of the transformation process to person-centredness. In this study, the researcher was prevented from continuing facilitation and implementation by work responsibilities. The questionnaire guided the researcher in identifying the three main themes, namely, work relations, communication and leadership. The researcher is of the opinion, however, that the questionnaire might not have assessed the actual problems that the respondents experienced with regard to the workplace culture. Another limitation of the study was that it was conducted only in the public sector and the private sector was not included.

8.7 RECOMMENDATIONS

Based on the findings, the researcher makes the following recommendations for nursing education policy, nursing education institutions, nursing education management, and further research.

8.7.1 Nursing education policy

The SANC, DoH and CHE should develop

- nursing education policy that promotes participation, collaboration, cultural respect, inclusivity, and teamwork.
- work policies and guidelines with relevant stakeholders in a collaborative, inclusive, and participative (CIP) manner to stimulate active and cohesive stakeholder participation and create a positive organisational culture.
- policy and standard operational procedures to improve workplace relations, communication, leadership, and job satisfaction.
- a common policy and standard operational procedures according to identified nursing education and training needs to transform workplace cultures and improve workplace relations, communication, leadership and job satisfaction.

8.7.2 Nursing education and training institutions

Public and private nursing education and training institutions should

- Train nurse educators and managers in transformational practice development to achieve a person-centred workplace cultures to ensure positive workplace relations, achieve maximum positive compliance with nursing education policies and student training mandates, achieve person-centred and positive communication, achieve high staff morale, and person-centred leadership traits and practices.
- Include person-centred nursing values and beliefs in nursing education curricula to promote person-centred nursing practice.
- Develop a capacitation project for nurse educators on transformation of the workplace culture to person-centredness to improve job satisfaction, reduce nurse educator turnover, and achieve improved nurse educator and organisational outcomes.

8.7.3 Nursing education management

Management should

- Promote and facilitate person-centred leadership traits such as transformational leadership practices, based on leading the self before leading others, and leading change in the nursing education context in South Africa, observing cultural sensitivity.
- Support nurse educators to facilitate processes within the nursing education context to foster person-centred values and beliefs.
- Develop nursing education policies, procedures and student nurse training mandates in a collaborative, inclusive and participative manner to promote teamwork and group cohesion among nurse educators.
- Identify programme facilitators to facilitate change towards transforming the workplace culture to person-centredness.
- Provide person-centred leadership during transformational changes to ensure a collaborative, inclusive and participative process whereby all nurse educators identify the need for change, engage in problem solving and motivate each other.
- Acknowledge nurse educators' contributions to ensure they feel appreciated and motivated.
- Facilitate person-centred leadership practices among nurse educators to promote and foster positive workplace relations, effective teamwork, cultural sensitivity and diversity, effective communication, and participative and reflective leadership.
- Ensure a good work ethic workplace, practice person-centred communication, appraise and acknowledge nurse educators where its due and practice person-centred discipline to achieve optimum organisational outcomes.

8.7.4 Further research

Further research should be conducted on the following topics:

- The development and implementation of the curriculum at meso-, macro- and micro-levels in a context of person-centredness
- Assessing the transformation of the workplace culture to person-centredness in nursing education institutions
- The capacitation and involvement of academic and administrative staff in a person-centred workplace culture
- Nurse educators' perceptions of the performance management system.
- The research to be conducted at other public sector educational institutions.

8.8 CONCLUSION

The study wished to examine and transform the workplace culture of a selected PNEI to person-centredness. The study assessed the workplace culture for person-centredness, effective teamwork, person-centred leadership, and implementation of the TPD programme. The study was conducted in three phases. Phase 3 evaluated the programme outcomes of the workplace culture after implementation of the TPD programme. The researcher merged, mapped and evaluated the programme outcomes for Phase 1 and 3. The researcher concluded that the TPD programme initiated the transformation process with regard to workplace relationships, communication and leadership.

A person-centred workplace culture enhances human flourishing because it promotes the growth, development, and holistic well-being of individuals and populations. It serves as a moral basis for what it means to be a human being. This study promoted the transformation of the current workplace culture towards a person-centred workplace culture where nurse educators and students could flourish.

"...Human flourishing occurs when we bound and frame naturally coexisting energies, when we embrace the known and yet to be known, when we embody contrasts and when we achieve stillness and harmony. When we flourish, we give and receive loving kindness..."

~ McCormack and Titchen, 2015~

LIST OF REFERENCES

Alonso-Almeida, MDM, Perramon, J & Bagur-Femenias, L. 2017. Leadership styles and corporate social responsibility management: analysis from a gender perspective. *Business Ethics: A European Review*, 26(2):147-161.

Al Sayah, F, Szafran, O, Robertson, S, Bell, NR & Williams, B. 2013. Nursing perspectives on factors influencing interdisciplinary teamwork in the Canadian Primary Care setting. *Journal of Clinical Nursing*, 23(19-20):2968-2979.

American Association of Colleges of Nursing (AACN). 2019. *Fact sheet: Nursing faculty shortage*. Washington, D.C. AACN. Retrieved from https://www.aacnnursing.org/Portals/42/News/Factsheets/Faculty-Shortage-Factsheet.pdf.

American Nurses Association (ANA). 2013. *The nursing shortage: solutions for the short and long term*. Silver Spring, MD: ANA. Available from: http://www.nursingworld.org/MainMenuCategories/ThePracticeof Professional Nursing/workforce/Recruitment, accessed 25 March 2014.

Amundsen, S & Martinsen, ØL. 2015. Linking empowering leadership to job satisfaction, work effort, and creativity: the role of self-leadership and psychological empowerment. *Journal of Leadership & Organizational Studies*, 22(3):304-323.

An, Y & Kang, J. 2016. Relationship between organizational culture and workplace bullying among Korean nurses. *Asian Nursing Research*, 10(3):234-239.

Archer, MS, Bhaskar, R, Collier, A, Lawson, T & Norrie, A (Eds). 2013. *Critical realism: essential readings*. 1st Edition. Abingdon-on-Thames, Oxfordshire: Routledge.

Armstrong, SJ & Rispel, LC. 2015. Transforming nursing in South Africa: social accountability. *Global Health Action*, 8(27879): 8.

Arnold, A. 2017. Building a learning workplace culture and prevention of error - to near miss or not. *Journal of Medical Radiation Sciences*, 64(3):163-164.

Bagley, C, Sawyerr, A & Abubaker, M. 2016. Dialectic Critical Realism: Grounded Values and Reflexivity in Social Science Research. *Advances in Applied Sociology*, 6:400-419. http://dx.doi.org/10.4236/aasoci.2016.612030.

Barrientos-Trigo, S, Vega-Vázquez, L, De Diego-Cordero, R, Badanta-Romero, B, Porcel-Gálvez, AM. 2018. Interventions to improve working conditions of nursing staff in acute care hospitals: Scoping review. *Journal of Nursing Management,* 26(2):94-107. doi: 10.1111/jonm.12538. E-pub 2018 Jan 11. PMID: 29327478.

Beckett, P, Field, J, Molloy, L, Yu, N, Holmes, D & Pile, E. 2013. Practice what you preach: developing person-centred culture in inpatient mental health settings through strengths-based, transformational leadership. *Issues in Mental Health Nursing*, 34(8):595-601.

Behilak, S & Abdelraof, ASE. 2019. The relationship between burnout and job satisfaction among psychiatric nurses. *Journal of Nursing Education and Practice*, 10(3):8-16.

Belias, D, Koustelios, A, Vairaktarakis, G & Sdrolias, L. 2015. Organisational culture and job satisfaction of Greek banking institutions. *Procedia-Social and Behavioral Sciences*, 175:314-323.

Berland, A, Capone, K, Etcher, L, Ewing, H, Keating, S & Chickering, M. 2020. Open education resources to support the WHO nurse educator core competencies. *International Nursing Review*, 67(2):282-287.

Beukes, S. 2011. The accreditation of vocational assessment areas: Proposed standard statement and measurement criteria. *South African Journal of Occupational Therapy*, 41(3):42-49.

Bezuidenhout, S, Human, S & Lekhuleni, M. 2013. The new nursing qualifications framework. *Trends in Nursing*, 1(1):1-12. Available at: http://fundisa.journals.ac.za http://dx.doi.org/10.14804/1-1.

Bhorat, H, Naidoo, K, Oosthuizen, M & Pillay, K. 2016. *Demographic, employment, and wage trends in South Africa. Understanding the African Lions-Growth Traps and Opportunities in Six Dominant African Economies. Development Policy Research Unit*. Cape Town. Africa Growth Initiative at Brookings: UNU-WEDER.

Bitew, A, Workie, A, Seyum, T & Demeke, T. 2016. Utilization of obstetric analgesia in labour pain management and associated factors among obstetric care givers in Amhara Regional State Referral Hospitals, Northwest Ethiopia: a hospital-based cross-sectional study. *Journal of Biomedical Sciences*, 5(2):3. doi:10.4172/2254-609X.100029.

Blaauw, D, Ditlopo, P, Maseko, F, Chirwa, M, Mwisongo, A, Bidwell, P, Thomas, S & Normand, C. 2013. Comparing the job satisfaction and intention to leave of different categories of health workers in Tanzania, Malawi and South Africa. *Global Action*, 6(1):127-128.

Blaauw, D, Ditlopo, P & Rispel, LC. 2014. Nursing education reform in South Africa: lessons learnt from a policy analysis study. *Global Health Action,* 7(1):1-12. https://doi.org/10.3402/gha.v7.26401

Boamah, SA, Read, EA & Laschinger, HKS. 2017. Factors influencing new graduate nurse burnout development, job satisfaction and patient care quality: a time-lagged study. *Journal of Advanced Nursing*, 73(5):1182-1195.

Boomer, CA & McCormack, B. 2010. Creating the conditions for growth: a collaborative practice development programme for clinical nurse leaders. *Journal of Nurse Management*, 18(6):633-644.

Brink, H, van der Walt, C & van Rensburg, G. 2018. *Fundamentals of research methodology for healthcare professionals*. 3rd edition. Cape Town: Juta.

Britnell, M. 2015. *In search of the perfect health system*. London: Macmillan.

Brugha, R & Walsh, A. 2017. *Brain drain to brain gain: Ireland's two-way flow of doctors. Ireland country case study, Year 2*. Ireland. Royal College of Surgeons in Ireland. Report. https://doi.org/10.25419/rcsi.10776443.v2

Buckley, C, McCormack, B, Oxon, DP & Ryan, A. 2017. Working in a storied way: narrative-based approaches to person-centred care and practice in older adult residential care settings. *Journal of Clinical Nursing*, 27(5-6):e858-e872.

Burns, D & Mooney, D. 2018. Transcollegial leadership: a new paradigm for leadership. *International Journal of Educational Management.* 32(1):57-70. https://doi.org/10.1108/IJEM-05-2016-0114.

Bushe, GR & Marshak, RJ. 2016. The dialogic mindset: leading emergent change in a complex world. *Organization Development Journal*, 34(1):37-65.

Cabrerizo, FJ, Chiclana, F, Al-Hmouz, R, Morfeq, A, Balamash, AS & Herrera-Viedma, E. 2015. Fuzzy decision making and consensus: challenges. *Journal of Intelligent & Fuzzy Systems*, 29(3):1109-1118.

Cardiff, S, McCormack, B & McCance, T. 2018. Person-centered leadership: a relational approach to leadership derived through action research. *Journal of Clinical Nursing*, 27(15-16):3056-3069.

Cardon, PW & Marshall, B. 2015. The hype and reality of social media use for work collaboration and team communication. *International Journal of Business Communication*, 52(3):273-293.

Carlstrom, E & Ekman, I. 2012. Organisational culture and change: implementing person-centred care. *Journal of Health Organisation and Management*, 26(2):175-191.

Carmeli, A, Dutton, JE & Hardin, AE. 2015. Respect as an engine for new ideas: linking respectful engagement, relational information processing and creativity among employees and teams. *Human Relations*, 68(6):1021-1047.

Catling, CJ, Reid, F & Hunter, B. 2017. Australian midwives' experiences of their workplace culture. *Women and Birth*, 30(2):137-145.

Chen, CC, Ünal, AF, Leung, K & Xin, KR. 2016. Group harmony in the workplace: conception, measurement, and validation. *Asia Pacific Journal of Management*, 33:903-934.

Childs, D. 2019. Critical reflection on practice development. *International Practice Development Journal*, 9(1):1-5. https://doi.org/10.19043/ipdj.91.012

Chipunza, C & Malo, B. 2017. Organizational culture and job satisfaction among academic professionals at a South African university of technology. *Problems and Perspectives in Management*, 15(2):148-161.

Choi, JP, Jeon, DS & Kim, BC. 2019. Privacy and personal data collection with information externalities. *Journal of Public Economics*, 173:113-124.

Clark, A. 2008. Critical realism. In: *The SAGE Encyclopaedia of Qualitative Research Methods* edited by LM Given. Thousand Oaks. CA: Sage.

Clark, C. 2013. *Creating and sustaining civility in nursing education*. Indianapolis. IN: Sigma Theta Tau International.

Clement, I. 2020. *Management of nursing services and education*. India. Elsevier India.

Collier, A. 1994. *Critical realism: an introduction to Roy Bhaskar's philosophy*. London: Verso.

Cook, N, McCance, T, McCormack, B, Barr, O & Slater, P. 2018. Perceived caring attributes and priorities of preregistration nursing students throughout a nursing curriculum underpinned by person-centredness. *Journal of Clinical Nursing*, 27(13-14): 2847-2858. https://doi.org/10.1111/jocn.14341.

Cornelius, S & Nicol, S. 2016. Understanding the Needs of Masters Dissertation Supervisors: Supporting Students in Professional Contexts. *Journal of Perspectives in Applied Academic Practice,* 4(1):2-12. https://doi.org/10.14297/jpaap.v4i1.161

Craig, D & Bigby, C. 2015. Critical realism in social work research:examining participation of people with intellectual disability. *Australian Social Work*, 68(3):311-314.

Creswell, JW. 2014. *Research design. Qualitative, quantitative and mixed thethods approaches.* 4th edition. Canada. SAGE Publications.

Creswell, JW & Creswell, JD. 2018. *Research design: qualitative, quantitative and mixed methods approaches*. 5th edition. Thousand Oaks, CA: Sage.

Crisp, NMA & Lincoln, C. 2014. Global supply of health professionals. *New England Journal of Medicine*, 370(10):950-957.

Davis, K, White, S & Stephenson, M. 2016. The influence of workplace culture on nurses' learning experiences: a systematic review of qualitative evidence. *JBI Evidence Synthesis*, 14(6):274-346.

Department of Health (DoH). 2011. *HRH strategy for the health sector 2012/13-2016/17*. Pretoria: Government Printers.

Department of Health (DoH). 2013. *Strategic plan for the prevention and control of non-communicable diseases, 2013-2017*. Pretoria: Government Printers.

Department of Health (DoH). 2013. *The national strategic plan for nurse education, training and practice, 2012/13–2016/17*. Pretoria: Government Printers.

Department of Health (DoH). 2015. *The national health promotion policy and strategy, 2015-2019*. Pretoria: Government Printers.

Department of Labour. 2020. Department of Labour force rate by age group, 2020/statistics-South Africa, 2020. https://www.worldometers.info.

Dewing, J, McCormack, B & Titchen, A. 2014. *Practice development workbook for nursing, health and social care teams*. Oxford. Wiley Black-well.

Dewing, J, McCormack, B & Titchen, A (Eds). 2015. *Practice development workbook for nursing, health and social care teams*. Hoboken. NJ: Wiley

Dewing, J & McCormack, B. 2017. *Creating flourishing workplaces. In Person-centred practice in nursing and health care: theory and practice*, edited by B McCormack and T McCance. London. Wiley-Blackwell.

Ditlopo, P, Blaauw, D, Rispel, L, Thomas, S & Bidwell, P. 2013. Policy implementation and financial incentives for nurses in South Africa: a case study on the Occupation Specific Dispensation. *Global Health Action*, 6:138-146.

Dolamo, BL. 2018. Maintaining nursing practice standards while changing with times: SANC perspective. *Biomed Journal of Scientific and Technical Research*, 4(5):4117- 4122.

Dolphijn, R. 2016. Critical naturalism: a quantum mechanical ethics. *Rhizomes: Cultural Studies in Emerging Knowledge*, 2016(30):115.

Dong, Y, Chen, X & Herrera, F. 2015. Minimizing adjusted simple terms in the consensus reaching process with hesitant linguistic assessments in-group decision making. *Information Sciences: an International Journa*l, 297(c):95-117.

Drabek, M & Merecz, D. 2013. Job stress, occupational position and gender as factors differentiating workplace-bullying experience. *Medycyna pracy*, 64(3):283-296.

Du Plooy-Cilliers, F, Davis, C & Bezuidenhout, R (Eds). 2015. *Research matters*. Claremont. Juta.

Ebrahimzade, N, Mooghali, A, Lankarani, KB & Sadati, AK. 2015. Relationship between nursing managers' leadership styles and nurses' job burnout: a study at Shahid Dr. Faghihi Hospital, Shiraz. *Shiraz E-Medical Journal*, 16(8):1-5. https://doi.org/10.17795/semj27070.

Eide, T & Cardiff, S. 2017. *Leadership research: a person-centered agenda. In Person-centered healthcare research,* edited by B McCormack, S van Dulmen, H Eide, K Skovdahl and T Eide. London: Wiley.

Elewa, AH & El Banan, SHA. 2019. Organizational workplace culture, organizational trust and workplace bullying among staff nurses at public and private hospitals. *International Journal of Nursing Didactics*, 9(4):10-20.

Engelbrecht, AS, Heine, G & Mahembe, B. 2017. Integrity, ethical leadership, trust and work engagement. *Leadership Organization Development Journal*, 38(3):368-379. https://doi.org/10.1108/LODJ-11-2015-0237

Eskola, S, Roos, M, McCormack, B, Slater, P, Hahtela, N & Suominen, T. 2016. Workplace culture among operating room nurses', J*ournal of Nursing Management,* 24 (6): 725-734. https://doi.org/10.1111/jonm.12376.

Farmer, SM, Van Dyne, L & Kamdar, D. 2015. The contextualized self: how team-member exchange leads to coworker identification and helping OCB. *Journal of Applied Psychology*, 100(2):583-595.

Fatemeh, A, Marzieh, P, Borhani, F & Malihe, N. 2019. Correlation between workplace culture, learning and medication errors. *Revista Latino Americana de Hipertensión*, 14(1):102-109.

Fawaz, MA, Hamdan-Mansour, AM & Tassi, A. 2018. Challenges facing nursing education in the advanced healthcare environment. *International Journal of Africa Nursing Sciences*, 9:105-110.

Feldman, V, Grigorescu, E, Reyzin, L, Vempala, SS & Xiao, Y. 2017. Statistical algorithms and a lower bound for detecting planted cliques. *Journal of the ACM (JACM)*, 64(2):1-37.

Ferreira, EJ & Groenewalt, D (Eds). 2016. Administrative *management*. 4th edition. Cape Town: Juta.

Filmalter, CJ, van Eeden, I, de Kock, J, McCormack, B, Coetzee, I, Rossouw, S & Heyns, T. 2015. From fixers to facilitators: the start to our South African journey. *International Practice Development Journal*, 5(1):1-8. http://www.fons.org/library/journal.aspx.

Flott, EA & Linden, L. 2016. The clinical learning environment in nursing education: a concept analysis. *Journal of Advanced Nursing*, 72(3):501-513.

Fong, CM. 1990. Role overload, social support, and burnout among nursing educators. *The Journal of Nursing Education*, 29(3):102-108. doi: 10.3928/01484834-19900301-07. PMID: 2156971.

Fourie, D & Poggenpoel, W. 2017. Public sector inefficiencies: Are we addressing the root causes? *South African Journal of Accounting Research*, 31(3):169-180.

Fritz, E. 2018. Transition from clinical to educator roles in nursing: an integrative review. *Journal for Nurses in Professional Development*, 34(2):67-77.

Fryer, LK & Bovee, HN. 2018. Staying motivated to e-learn: person- and variable-centered perspectives on the longitudinal risks and support. *Computers & Education*, 120:227-240.

Garbett, R, Hardy, S, Manley, K, Titchen, A & McCormack, B. 2007. Developing a qualitative approach to 360-degree feedback to aid understanding and development of clinical expertise. *Journal of Nursing Management*, 15(3):342-347.

Garner, SL, Raj, L, Prater, LS & Putturaj, M. 2014. Student nurses' perceived challenges of nurses in India. *International Nursing Review*, 61(3):389-397.

Gazza, EA. 2019. Alleviating the nurse faculty shortage: designating and preparing the academic nurse educator as an advanced practice registered nurse. *Nursing Forum*, 54(2):144-148.

Geyer, N. 2020. Nursing education in 2020. *Professional Nursing Today*, 24(2):26-28.

Ghilan, K, Al-Taiar, A, Al Yousfi, N, Al Zubidai, R, Awadh, I & Al-Obeyed, Z. 2013. Low back pain among female nurses in Yemen. *International Journal of Occupational Medicine and Environmental Health*, 25(1):605-614.

Gonnerman, C, O'Rourke, M, Crowley, SJ & Hall, TE. 2015. Discovering philosophical assumptions that guide action research: the reflexive toolbox approach. In: *The Sage Handbook of Action Research* edited by H, Bradbury Huang and P, Reason. 3rd Edition. London: Sage.

Grove, SK, Burns, N & Gray, JR. 2013. *The practice of nursing research: appraisal, synthesis, and generation of evidence*. 7th edition. Philadelphia. PA: Elsevier.

Grove, SK, Gray, JR & Burns, N. 2015. *Understanding nursing research: building an evidence-based practice*. 6th edition. Philadelphia, PA: Elsevier.

Hahtela, N, Paavilainen, E, McCormack, B, Helminen, M, Slater, P & Suominen, T. 2015. Nurses' perceptions of workplace culture in primary health care in Finland. *International Nursing Review*, 62(4):470-478.

Halpin, Y, Terry, LM & Curzio, J. 2017. A longitudinal, mixed methods investigation of newly qualified nurses' workplace stressors and stress experiences during transition. *Journal of Advanced Nursing*, 73(11):2577-2586.

Hanaysha, J. 2016. Testing the effects of employee empowerment, teamwork, and employee training on employee productivity in higher education sector. *International Journal of Learning and Development*, 6(1):164-178.

Hansson, E, Ekman, I, Swedberg, K, Wolf, A, Dudas, K, Ehlers, L & Olsson, LE. 2016. Person-centred care for patients with chronic heart failure: a cost-utility analysis. *European Journal of Cardiovascular Nursing*, 15(4):276-284.

Hardiman, M & Dewing, J. 2019. Using two models of workplace facilitation to create conditions for development of a person-centred culture: a participatory action research study. *Journal of Clinical Nursing,* 28(15-16):2769-2781. https://www.doi.org/10.1111/jocn.14897.

Harding, E, Wait, S & Scrutton, J. 2015. *The state of play in person-centered care: a pragmatic view of how person-centred care is defined, applied and measured, featuring selected key contributors and case studies across the field*. London: Health Policy Partnership. *The Health Foundation Journal.* 1: 1-37. http://www.healthpolicypartnership.com/person-centred-care

Harvey, G, Jas, P, Walshe, K. 2015. Analysing organisational context: case studies on the contribution of absorptive capacity theory to understanding inter-organisational variation in performance improvement. *BMJ Quality & Safety*, 24(1):48-55.

Heckel, R, Shah, NB, Ramchandran, K & Wainwright, MJ. 2019. Active ranking from pairwise comparisons and when parametric assumptions do not help. *The Annals of Statistics*, 47(6):3099-3126.

Hennessey, C & Fry, M. 2016. Improving patient and staff outcomes using practice development. *International Journal of Health Care Quality Assurance*. 29(8):853-863. https://www. doi.org/10.1108/IJHCQA-02-2016-0020.

Herr, K & Anderson, GL. 2005. *The action research dissertation: a guide for students and faculty*. Thousand Oaks, CA: Sage.

Heyns, T & McCormack, B. 2014. Moving from crisis intervention towards person-centeredness. *Nursing in Critical Care*, 19(4):162-163.

Ho, SM & Hancock. 2018. *Context in a bottle: Language-action cues in spontaneous computer-mediated deception.* Philadelphia. PA: Elsevier.

Hoeksel, R, Eddy, LL, Dekker, L & Doutrich, D. 2019. Becoming a transformative nurse educator: finding safety and authenticity. *International Journal of Nursing Education Scholarship,* 16(1): 2018-0073. doi: 10.1515/ijnes-2018-0073. PMID: 31377740.

Hollis, LP. 2018. Bullied out of position: Black women's complex intersectionality, workplace bullying, and resulting career disruption. *Journal of Black Sexuality and Relationships*, 4(3):73-89.

Horrell, J, Lloyd, H, Sugavanam, T, Close, J & Byng, R. 2018. Creating and facilitating change for person centered coordinated care (P3C): the development of the Organisational Change Tool (P3C-OCT). *Health Expectations*, 21(2):448-456.

Human Research Development Council of South Africa (HRDC). 2017. *National human research development strategy 2018-2020*. Pretoria: HRDC.

Inman, RP & Rubinfeld, DL. 2013. Understanding the democratic transition in South Africa. *American Law and Economic Review*, 15(1):1-38. http://dx.doi.org/10.1093/aler/ahs023

Jacobson, SK, Seavey, JR & Mueller, RC. 2016. Integrated science and art education for creative climate change communication. *Ecology and Science*. 21(3):30.

Jobe, I, Lindberg, B, Nordmark, S & Engström, Å. 2018. The care-planning conference: Exploring aspects of person-centred interactions. *Nursing Open*, 5(2):120-130.

Jobe, I, Engström, A & Lindberg, B. 2021. Exploration of how to make the collaborative planning process work: a grounded theory study. *Cogent Medicine*, 8(1):1-19. DOI: 10.1080/2331205X.2021.1896426.

Jones, SM, Bodie, GD & Hughes, SD. 2019. The impact of mindfulness on empathy, active listening, and perceived provisions of emotional support. *Communication Research*, 46(6):838-865.

Jooste, K, Arunachallam, L, Julie, H, Essa, I, Willemse, J, Rashe, HV, Bimray, P, Ahanohuo, L & Hoffman, JC. 2015. The meaning of self-leadership for nursing academics in the context of a leadership programme at a higher education institution in South Africa. *Africa Journal of Nursing and Midwifery*, 17(1):122-133.

Juliff, D, Russell, K & Bulsara, C. 2016. Male or nurse what comes first? Challenges men face on their journey to nurse registration. *The Australian Journal of Advanced Nursing,* 34(2):45-52.

Kahn, T. 2010. Plea for details of health insurance plan. *Business Day*, 30 September 2010. Available at: http://www.businessday.co.za/articles/Content.aspx?id=122325 (accessed 24 October 2017).

Karadimitriou, SM, Marshall, E & Knox, C. 2018. *Mann-Whitney U test*. Sheffield. University of Sheffield.

Kelemba, J, K. 2017. *Assessment of employee performance in the public service in Kenya*. Doctoral thesis. Nakuru: Kabarak University.

Kelemba, JK. 2019. Effect of socio-cultural factors on employee performance in the public service in Kenya. *Journal of African Interdisciplinary Studies*, 3(5):4-14.

Khan, BP, Quinn Griffin, MT & Fitzpatrick, JJ. 2018. Staff nurses' perceptions of their nurse managers' transformational leadership behaviours and their own structural empowerment. *The Journal of Nursing Administration*, 48(12):609-614.

Kol, E. Ilaslan, E & Turkay, M. 2016. The effectiveness of strategies similar to the Magnet model to create positive work environment on nurse satisfaction. *International Journal of Nursing Practice*, 23(4):1322-7114.

Labonté, R, Sanders, D, Mathole, T, Crush, J, Chikanda, A, Dambisya, Y, et al. 2015. Health worker migration from South Africa: causes, consequences and policy responses. *Human Resources for Health*, 13:92. doi:10.1186/s12960-015-0093-4.

Laurencelle, FL, Scanlan, JM & Brett, AL. 2016. The meaning of being a nurse educator and nurse educators' attraction to academia: a phenomenological study. *Nurse Education Today*, 39:135-140.

Lee, JC, Shiue, YC & Chen, CY. 2016. Examining the impacts of organizational culture and top management support of knowledge sharing on the success of software process improvement. *Computers in Human Behavior*, 54:462-474.

Lee, Y & Lee, HK. 2018. The convergence factors of nursing organizational culture on the nurses' professional quality of life. *Journal of the Korean Convergence Society*, 9(11):491-500. Doi10.15207/JKCS.2018.9.11.491.

Lieshout, FV & Cardiff, S. 2015. Reflections on being and becoming a person-centered facilitator. *International Practice Development Journal*, 5(Suppl):1-10. http://www.fons.org/library/journal.aspx.

Liu, R, Yujuan, X, Zhang, S & Wang, Z. 2020. Study and suggestion on industrial energy efficiency of national 13th five-year plan for the development of strategies. *Basic and Clinical Pharmacology and Toxicology, 165:01023.*

Logan, TR & Malone, DM. 2017. *Nurses' perceptions of teamwork and workplace bullying.* Philadelphia, PA: Wiley.

Luke, D & Bates, S. 2014. Using critical realism to explain indeterminacy in role behaviour systematically. *Journal for the Theory of Social Behaviour*, 45(3):331-351.

Lynch, B, McCormack, B, McCance, T & Brown, D. 2017. The development of the Person-Centered Situational Leadership Framework: revealing the being of person-centeredness in nursing homes. *Journal of Clinical Nursing*, 27(1-2):427-440. https://doi.org/10.1111/jocn.13949

MacWilliams, B, Schmidt, B & Bleich, M. 2013. Men in nursing. *American Journal of Nursing (AJN)*, 113(1):38-44

Madathil, R, Heck, NC & Schuldberg, D. 2014. Burnout in psychiatric nursing: examining the interplay of autonomy, leadership style, and depressive symptoms. *Archives of Psychiatric Nursing*, 28(3):160-166. https://doi.org/10.1016/j.apnu.2014.01.002.

Mahlathi, P, Dlamini, J. 2016. *From brain drain to brain gain: understanding and managing the movement of medical doctors in the South African health system.* Pretoria: African Institute for Health and Leadership Development.

Makombo, T. 2016. Public health sector in need of an antidote. *Fast Facts*, 6 (298):1-39.

Manley, K. 2016. *An* overview *of practice development. In Person-centred practice in nursing and health care*: *theory* and p*ractice*, edited by B McCormack and T McCance. London. Wiley-Blackwell.

Manley, K, McCormack, B & Wilson, V. 2008. *Introduction.* In *International practice development in nursing and healthcare,* edited by K, Manley, B, McCormack and V, Wilson. Oxford: Blackwell.

Manley, K, O'Keefe, H, Jackson, C, Pearce, J & Smith, S. 2014. A shared purpose framework to deliver person-centred, safe and effective care: organisational transformation using practice development methodology. *International Practice Development Journal*, 4(1):1-31.

Manley, K, Sanders, K, Cardiff, S & Webster, J. 2011. Effective workplace culture: the attributes, enabling factors and consequences of a new concept. *International Practice Development Journal*, 1(2):1-29.

Manley, K & Jackson, C. 2019. Microsystems culture change: a refined theory for developing person-centred, safe and effective workplaces based on strategies that embed a safety culture. *International Practice Development Journal*, 9(2):1-21.

Maphumulo, WT & Bhengu, BR. 2019. Challenges of quality improvement in the healthcare of South Africa post-apartheid: a critical review. *Curationis,* 42:1-9. doi: 10.4102/curationis. v42i1.1901.

Mariam, AA & Mazin, H. 2019. Working experience and perceived physical activity and exercise barriers. *Sport Mont,* 17(2):47-52.

Masood, M & Afsar, B. 2017. Transformational leadership and innovative work behavior among nursing staff. *Nursing Inquiry*, 24(4):e12188.

McCance, T, & McCormack, B. 2017. *The person-centred practice framework.* In *Person-centered practice in nursing and health care: theory and practice* edited by B McCormack and T McCance. 2nd Edition. London: Wiley.

McCance, T, McCormack, B & Dewing, J. 2011. An exploration of person-centredness in practice. Online Journal of Issues in Nursing, 16 (2) [1]: 1-9.

McConnell, D, McCance, T, & Melby, V. 2016. Exploring person-centredness in emergency departments: a literature review. *International Emergency Nursing*, 26:38-46.

McCormack, B. 2008. *Practice development nursing care framework. In Practice development in nursing,* edited by B McCormack, K Manley and R Garbett. Philadelphia. PA: Elsevier.

McCormack, B. 2010. *Practice Development Nursing Care Framework.* Queen Margaret University. Elsevier.

McCormack, B, Dewing, J, Breslin, L, Coyne-Nevin, A, Kennedy, K, Manning, M, Peelo-Kilroe, L, Tobin, C, Slater, P. 2010. Developing person-centred practice: nursing outcomes arising from changes to the care environment in residential settings for older people. *International Journal of Older People Nurse.* 5(2):93-107. doi: 10.1111/j.1748-3743.2010.00216.x. PMID: 20925711.

McCormack, B, Henderson, E, Wilson, V & Wright, J. 2009. Making practice visible: the Workplace Culture Critical Analysis Tool (WCCAT). *Practice Development in Health Care*, 8(1):28-43. https://www.doi.org/10.1002/PDH.273.

McCormack, B & McCance, T. 2010. *Person-centred nursing: theory and practice*. Oxford: Wiley Blackwell.

McCormack, B & McCance, T (Eds). 2017. *Person-centred practice in nursing and health care: theory and practice*. 2nd Edition. London: Wiley.

McCormack, B, Manley, K & Titchen, A. 2014. *Practice Development in Nursing Healthcare.* 2 nd. Oxford. Wiley-Blackwell.

McCormack, B & McCance, T. 2010. *Person-centred nursing: theory, models and methods.* Edinburgh. Wiley.

McCormack, B & Dewing, J. 2019. International Committee of Practice for Person-centred Practice: position statement on person-centredness in health and social care. *International Practice Development Journal*, 9(1):1-7. https://doi.org/10.19043/ipdj.91.003.

McCormack, B & Garbett, R. 2003. The characteristics, qualities and skills of practice developers. *Journal of Clinical Nursing*, 12(3):317-325.

McCormack, B, Manley, K & Titchen, A. 2013. *Practice development in nursing healthcare*. 2nd Edition. Oxford. Wiley-Blackwell.

McCormack, B, Borg, M, Cardiff, S, Dewing, J, Jacobs, G, Janes, N, Karlsson, B, McCance, T, Mekki, TE, Porock, D, van Lieshout, F & Wilson, V. 2015. Person-centredness: the 'state' of the art. *International Practice Development Journal*, 5(Suppl.1):1-15.

Mhlanga, D & Garidzirai, R. 2020. The influence of racial differences in the demand for healthcare in South Africa: a case of public healthcare. *International Journal of Environmental Research and Public Health*, 17(14):5043. https://doi.org/10.3390/ijerph17145043.

Midlöv, P, Nilsson, PM, Bengtsson, U, Hoffmann, M, Wennersten, A, Andersson, U, Malmqvist, U, Carlsson, KS, Ranerup, A & Kjellgren, K. 2020. Person-centredness in hypertension management using information technology (PERHIT): a protocol for a randomised controlled trial in primary health care. *Blood Pressure*, 29(3):149-156. DOI: 10.1080/08037051.2019.1697177.

Mishra, P, Pandey, CM, Singh, U, Gupta, A, Sahu, C & Keshri, A. 2019. Descriptive statistics and normality tests for statistical data. *Annals of Cardiac Anaesthesia*, 22(1):67-72. https://doi.org/10.4103/aca.ACA_157_18.

Mitic, S, Vukonjanski, J, Terek, E, Gligorovic, B & Zoric, K. 2016. Organizational culture and organizational commitment: Serbian case. *Journal of Engineering Management and Competitiveness*, 6(1):21-27. Retrieved from http://www.tfzr.rs/ jemc/files/Vol6No1/V6N12016-03.

Mitonga-Monga, J, Flotman, AP & Cilliers, F. 2016. Workplace ethics culture and work engagement: the mediating effect of ethical leadership in a developing world context. *Journal of Psychology in Africa*, 26(4):326-333.

Mitra, RS. 2019. Importance of standardization in overcoming cross-cultural communication difficulties. *Indian Journal of Commerce & Management Studies*, 11(3):01-07.

Mkhize, SW. 2009. leadership model for nursing education leaders in nursing education institutions. *Journal of Nursing Education and Practice*, 11(2):93.

Mokobotho-Zwane, SM. 2015. Today's students are tomorrow's colleagues: exploring the nurse educator-student relationship in an emerging democracy in South Africa. *Africa Journal of Nursing and Midwifery*, 17(1):118-132.

Moore, GA & Dienemann, JA. 2014. Job satisfaction and career development of men in nursing. *Journal of Nursing Education and Practice*, 4(3):86-93.

Morsiani, G, Bagnasco, A & Sasso, L. 2017. How staff nurses perceive the impact of nurse managers' leadership style in terms of job satisfaction: a mixed method study. *Journal of Nursing Management*, 25:119-128.

Moule, P & Goodman, M. 2014. *Nursing research: an introduction*. London. Sage.

Moule, P, Aveyard, H & Goodman, M. 2016. *Nursing research: an introduction*. 3rd Edition. London. Sage.

Muff, K. 2013. Developing globally responsible leaders in business schools: a vision and transformational practice for the journey ahead. *Journal of Management Development*, 32(5):487-507. https://doi.org/10.1108/02621711311328273

Mulaudzi, FM, Daniels, FM, Direko, KK & Uys, L. 2012. The current status of the education and training of nurse educators in South Africa. *Trends in Nursing*, 1(1):79-90.

Müller, H & Van Esch, FA. 2020. Collaborative leadership in EMU governance: a matter of cognitive proximity. *West European Politics*, *43*(5):1117-1140. https://doi.org/10.1080/01402382.2019.1678950.

Nadal, CT, Mañas, GP, Bernadó, BS & Mora, CA. 2015. Assessing teamwork competence. *Psicothema*, 27(4):354-361.

Naidoo, S. 2012. The South African National Health Insurance: a revolution in health care delivery. *Journal of Public Health*. 34(1):149-150.

Nardi, DA & Gyurko, CC. 2013. The global nursing faculty shortage: status and solutions for change. *Journal of Nursing Scholarship*, 45(3):317-326.

Nasiripour, AA, Tabibi, S & Mokhtari, R. 2014. The relationship between head-nurse's managerial skills and nurses' turnover intention in private hospitals. *Health Care: Current Reviews*, 2(1):1- 5. https://doi.org/10.4172/hccr.1000117.

Nemati, M, Ebrahimi, B & Nemati, F. 2020. Assessment of Iranian nurses' knowledge and anxiety toward COVID-19 during the current outbreak in Iran. *Archives of Clinical Infectious Diseases*, 15(COVID-19):e102848.

Ndlovu, W, Ngirande, H & Setati, ST. 2017. Existing organizational culture typologies and organizational commitment at a selected higher education institution in South Africa. *Investment Management and Financial Innovations*, 14(2-1):242-251. doi:10.21511/imfi.

Ng, JL, Johnson, A, Nguyen, H, Groth, M. 2014. *Workplace Culture Improvements: A Review of the Literature - A report for the Workforce Planning and Development Branch of the NSW Ministry of Health.* Sydney. UNSW and the University of Sydney.

Nkoma, E. 2018. Perceptions of Zimbabwean trainee/educational psychologists regarding the training on their support roles and responsibilities in inclusive education. *Psychology in the Schools*, 55(5):555-572.

Nowacki, A. 2017. Chi-square and Fisher's exact tests. *Cleveland Clinic Journal of Medicine*, 84:E20-E25.

O'Donnell, D, Cook, N & Black, P. 2017. *Person-centered nursing education. In Person-centered practice in nursing and health care: theory and practice,* edited by B McCormack and T McCance. London: Wiley Blackwell.

Ovseiko, PV, Pololi, LH, Edmunds, LD, Civian, JT, Daly, M & Buchan, AM. 2019. Creating a more supportive and inclusive university culture: a mixed-methods interdisciplinary comparative analysis of medical and social sciences at the University of Oxford. *Interdisciplinary Science Reviews*, 44(2):166-191. DOI: 10.1080/03080188.2019.1603880. https://doi.org/10.1080/03080188.2019.1603880

Özşahin, M, Zehir, C, Acar, AZ & Sudak, MK. 2013. The effects of leadership and market orientation on organizational commitment. *Social and Behavioural Sciences*, 99(6):363-372. https://doi.org/10.1016/j. sbspro.2013.10.504.

Padavic, I, Ely, RJ & Reid, EM. 2020. Explaining the persistence of gender inequality: the work-family narrative as a social defence against the 24/7 work workplace culture. *Administrative Science Quarterly*, 65(1):61-111.

Palese, A, Falomo, M, Brugnollia, A, Mecugni, D, Marognolli, O, Montalti, S,Tameni, A, Gonella, S & Dimonte, V. 2017. Nursing student plans for the after graduation: a multicentre study. *International Nursing Review*, 64(1):99-108.

Parlour, R & McCormack, B. 2012. Blending critical realist and emancipatory practice development methodologies: making critical realism work in nursing research. *Nursing Inquiry*, 19(4):308-321.

Parratt, JA, Fahy, KM, Hutchinson, M, Lohmann, G, Hastie, CR, Chaseling, M & O'Brien, K. 2016. Expert validation of a teamwork assessment rubric: a modified Delphi study. *Nurse Education Today*, 36:77-85.

Pishgooie, AH, Atashzadeh-Shoorideh, F, Falcó-Pegueroles, A & Lotfi, Z. 2019. Correlation between nursing managers' leadership styles and nurses' job stress and anticipated turnover. *Journal of Nursing Management*, 27(3):527-534. https://doi:10.1111/jonm.12707.

Polit, DF & Beck, CT. 2014. *Essentials of nursing research: appraising evidence for nursing practice*. 9th Edition. Philadelphia. Wolters Kluwer.

Polit, DF & Beck, CT. 2017. *Nursing research: generating and assessing evidence for nursing practice*. Philadelphia: Wolters Kluwer.

Portney, LG & Watkins, MP. 2014. *Foundations of clinical research: applications to practice. Pearson new international edition*. 3rd edition. London: Pearson.

Prentice, JJ, Weatherall, M, Grainger, R & Levack, W. 2019. “Tell someone who cares”: Participatory action research of motivation and workplace engagement among caregivers in aged residential care, New Zealand. *Australasian Journal on Ageing*, 40(2):e109-e115.

Rathert, C, Wyrwich, M & Boren, S. 2013. Patient-centered care and outcomes: a systematic review of the literature. *Medical Care Research and Review*, 70(4):351-379. https://doi. org/10.1177/1077558712465774.

Reeves, S, Xyrichis, A & Zwarenstein, M. 2018. Teamwork, collaboration, coordination and networking: why we need to distinguish between different types of interpersonal practice. *Journal of Interprofessional Care*, 32(1):1-3. doi: 10.1080/13561820.2017.1400150.

Republic of Kenya. 2016. Human resource policies and procedures manual for the public service. Nairobi: Government Printer.

Rispel, LC & Blaauw D. 2015. The health system consequences of agency nursing and moonlighting in South Africa. *Global Health Action*, 8(1):26683.

Rispel, LC. 2015. Transforming nursing policy, practice and management in South Africa. *Global Health Action*. 8:28005. http://dx.doi.org/10.3402/gha.

Rupprecht, S, Koole, W, Chaskalson, M, Tamdjidi, C & West, M. 2019. Running too far ahead? Towards a broader understanding of mindfulness in organisations. *Current Opinion in Psychology*, 28:32-36.

Rybowiak, V, Garst, H, Frese, M & Batinic, B. 1999. Error orientation questionnaire (EOQ): reliability, validity, and different language equivalence. *Journal of Organizational Behavior*, 20(4):527-547.

Salas-Rueda, RA, Salas-Rueda, ÉP & Salas-Rueda, RD. 2020. Analysis and design of the web game on descriptive statistics through the ADDIE model, data science and machine learning. *International Journal of Education in Mathematics, Science and Technology*, 8(3):245-260.

Salman, W & Hassan, Z. 2016. Impact of effective teamwork on employee performance. *International Journal of Accounting & Business Management*, 4(1):76-85.

Santana, MJ, Manalili, K, Jolley, RJ, Zelinsky, S, Quan, H & Lu, M. 2018. How to practice person-centred care: a conceptual framework. *Health Expectations*, 21(2):429-440.

Shahid, A & Azhar, SM. 2013. Gaining employee commitment: linking to organisational effectiveness. *Journal of Management Research*, 5(1):250-268. http://www.macrothink.org/journal/index.

Shklarov, S, Marshall, DA, Wasylak, T & Marlett, NJ. 2017. "Part of the team": mapping the outcomes of training patients for new roles in health research and planning. *Health Expectations*, 20(6):1428-1436.

Slater, P, McCance, T & McCormack, B. 2017. The development and testing of the Person-centred Practice Inventory–Staff (PCPI-S). *International Journal for Quality in Health Care*, 29(4):541-547. https://www.doi.org/10.1093/intqhc/mzx066.

Sørensen, M, Stenberg, U & Garnweidner-Holme, L. 2018. A scoping review of facilitators of multi-professional collaboration in primary care. *International Journal of Integrated Care*, 18(3): 13. https://doi.org/10.5334/ijic.3959

South Africa Borgen project. 2020. *Poverty on the rise in South Africa*: 14 August https://borgen project.org. Pretoria: Borgen project.

South Africa (Republic). 1996. *Constitution of the Republic of South Africa Act, 108 of 1996*. Pretoria: Government Printers. Government Gazette, 378.

South Africa (Republic). 1996. *South African Qualifications Authority Act, 58 of 1995*. Pretoria: Government Printers.

South Africa (Republic). 1997. *Higher Education Act, 101 of* 1997. Pretoria: Government Printers.

South Africa (Republic). 2005. *Nursing Act, 33 of 2005.* Pretoria: Government Printers.

South Africa (Republic). 2008. National Qualifications Framework Act, 67 of 2008. Pretoria: Government Printers.

South African Nursing Council (SANC). 1985. *Regulations relating to the approval of and the minimum requirements for the education and training of a nurse (general, psychiatric and community) and midwife leading to registration (R425 of 22 February 1985).* Pretoria: SANC.

South African Nursing Council (SANC). 2013. *Regulations relating to the accreditation of institutions as Nursing Education Institutions.* Government Notice no. R173 of 8 March 2013. Pretoria: SANC.

South African Nursing Council (SANC). 2014. *Competencies for a nurse educator*. Pretoria: SANC. www.sanc.co.za (Accessed 25 October 2017).

South African Nursing Council (SANC). 2016. Growth in registers and rolls 1996-2005. Pretoria: SANC. www.sanc.co.za (Accessed 24 October 2017).

South African Nursing Council (SANC). 2017. *Competencies for a nurse educator*. Pretoria: SANC. www.sanc.co.za (Accessed 25 October 2017).

South African Nursing Council (SANC). 2019. *Report: Distribution by province of nursing manpower versus the population of South Africa*. Pretoria: SANC.

South African Nursing Council (SANC). 2021. circular 3 of 2021/2022 annual fee.

Statistics South Africa (statssa). 2016. *Community survey 2016*. Pretoria: statssa.

Statistics South Africa (statssa). 2018. *General household survey*. Pretoria: statssa.

Statistics South Africa (statssa). 2018. *Statistics South Africa in terms of Section 14 of the promotion of access to information Act 2 of 2000*. Pretoria: statssa.

Stevens, A. 2019. *The 'ontological politics of drug policy': a critical realist approach*. Paper presented at the 13th Annual Conference of the International Society for the Study of Drug Policy. Kent. University of Kent.

Stouten, J, Rousseau, DM & De Cremer, D. 2018. Successful organizational change: integrating the management practice and scholarly literatures. *Academy of Management Annals*, 12(2):752-788.

Swart, B. 2013. A community service: reflections of a community service clinical psychologist. *South African Journal of Psychology*, 43(1):105-115.

Thomson, K, Outram, S, Gilligan, C & Levett-Jones, T. 2015. Interprofessional experiences of recent healthcare graduates: a social psychology perspective on the barriers to effective communication, teamwork, and patient-centred care. *Journal of Interprofessional Care*, 29(6):634-640.

Thon, CC, Feng, PKJ & Lian, CW. 2016. Risk factors of low back pain among nurses working in Sarawak General Hospital. *Health*, 7(1):13-24.

Tiffany, HM, Adger, AN, Brown, K, Lemons, MC, Huitema, D & Hughes, TP. 2017. Mitigating and adaptation in polycentric systems: sources of power in the pursuit of collective goals. *WIREs Climate Change*, 8:1-16.

Tompos, A & Ablonczy-Mihalyka, L. 2018. The sustainability of cultural diversity in the workforce: cultural values and intercultural mindset. *European Journal of Sustainable Development*, 7(1):298-306.

Topp, SM & Chipukuma, JM. 2015. *A qualitative study of the role of workplace and interpersonal trust in shaping service quality and responsiveness in Zambian primary healthcare*. London. Oxford University Publishers.

Topp, SM, Chipukuma, JM. 2016. A qualitative study of the role of workplace and interpersonal trust in shaping service quality and responsiveness in Zambian primary health centres. *Health*

Policy Plan. 31(2):192-204. doi: 10.1093/heapol/czv041. Epub 2015 May 20. PMID: 25999586; PMCID: PMC4748128.

Trede, F & Hill, B. 2012. *Intercultural communication. In Communicating in the health and social sciences*, edited by J Higgs, R Ajjawi, L McAllister, F Trede and S Loftus. 3rd edition. South Melbourne: OUP.

Trede, F & Titchen, A. 2012. Transformational practice development research in the healthcare professions: a critical-creative dialogue. *International Practice Development Journal*, 2(2):1-20.

Turnnidge, J & Côté, J. 2017. Transformational coaching workshop: applying a person-centered approach to coach development programs. *International Sport Coaching Journal*, 4(3):314-325.

Uğurlu, F, Yıldız, S, Boran, M, Uğurlu, Ö & Wang, J. 2020. Analysis of fishing vessel accidents with Bayesian network and Chi-square methods. *Ocean Engineering*, 198:106956.

Uys, LR & Klopper, HC. 2017. What is the ideal ratio of categories of nurses for the South African public health system? *South African Journal of Science*, 109(5/6):1-4 http://dx.doi.org/10.1590/sajs.2013/a0015. (Accessed 24 October 2017).

van der Meer, CAI, te Brake, H, van der Aa, N, Dashtgard, P, Bakker, A & Olff, M. 2018. Assessing Psychological Resilience: Development and Psychometric Properties of the English and Dutch Version of the Resilience Evaluation Scale (RES). *Front. Psychiatry* 9:169. doi: 10.3389/fpsyt.2018.00169.

Vanderstukken, A, Schreurs, B, Germeys, F, Van den Broeck, A & Proost, K. 2018.
Should supervisors communicate goals or visions? The moderating role of subordinates psychological distance. *Journal of Applied Social Psychology*, 49(11):671-683.

Vaske, JJ, Beaman, J & Sponarski, CC. 2017. Rethinking internal consistency in Cronbach's alpha. *Leisure Sciences*, 39(2):163-173.

Walsh, D & Evans, K. 2013. *Critical realism: an important theoretical perspective for midwifery research*. London: Elsevier.

Wareing-Jones, S. 2016. *Whispers and song: a phenomenological inquiry to discover nurses' lived experiences of person-centred dementia care*. Edinburgh: Queen Margaret University.

Wedding, JS. 2020. *Designing leadership: using design thinking to create, practice, and implement a formal leadership development program*. Master's dissertation. Sacramento. University of the Pacific. Retrieved from https://scholarlycommons.pacific.edu/uop_etds/3663.

Welch, CD, Check, J & O'Shea, TM. 2017. Improving care collaboration for NICU patients to decrease length of stay and readmission rate. *BMJ Open Quality*, 6(2):1-6.

Westphal, J, Marnocha, S & Chapin, T. 2016. A pilot study to explore nurse educator workforce issues. *Nursing Education Perspectives*, 37(3):171-173.

Wikipedia contributors. 2021. March 24. Healthcare in South Africa. In Wikipedia, The Free Encyclopedia. 2:1-2. Retrieved 09:29, April 20, 2021, from https://en.wikipedia.org/w/index.php?title=Healthcare_in_South_Africa&oldid=1013926403.

Wilson, V, Dewing, J, Cardiff, S, Mekki, TE, Øye, C & McCance, T. 2020. A person-centred observational tool: devising the Workplace Culture Critical Analysis Tool®. *International Practice Development Journal*, 10(1):1-15. https://doi.org/10.19043/ipdj.101.003.

Wilson, V & Solman, A. 2017. *Person-centred health services for children. In Person-centred practice in nursing and health care: theory and practice,* edited by B McCormack and T McCance. 2nd Edition. Oxford: Wiley-Blackwell.

World Health Organization (WHO). 2015. *WHO Global Strategy on People-centred and Integrated Health Services: Interim Report*. Geneva: WHO. http://apps.who.int/iris/bitstream/10665/155002/1/WHO_HIS_SDS_2015.6_eng.pdf?ua=1&ua=. (Accessed 4 February 2016)

World Health Organization. (WHO). 2016. *Nurse educator core competencies*. Geneva: WHO. http://who.int/hrh/nursing_midwifery/nurse_educator050416.pdf.

Wu, S, Singh-Carlson, S, Odell, A, Reynolds, G & Su, Y. 2016. Compassion fatigue, burnout, and compassion satisfaction among oncology nurses in the United States and Canada. *Oncology Nursing Forum*, 43(4):E161-E169.

Xie, K, Hensley, VL & Sun, Z. 2019. Self-regulation as a function of perceived leadership and cohesion in small group online collaborative learning. *British Journal of Educational Technology*, 50(1):456-468. https://doi.org/10.1111/bjet.12594.

Young, M. 2016. *Private vs. public healthcare in South Africa*. Kalamazoo. Western Michigan University.https://scholarworks.wmich.edu/cgi/viewcontent.cgi?article=3752&context=honors_theses. (Accessed on 29 April 2020); 2016 .

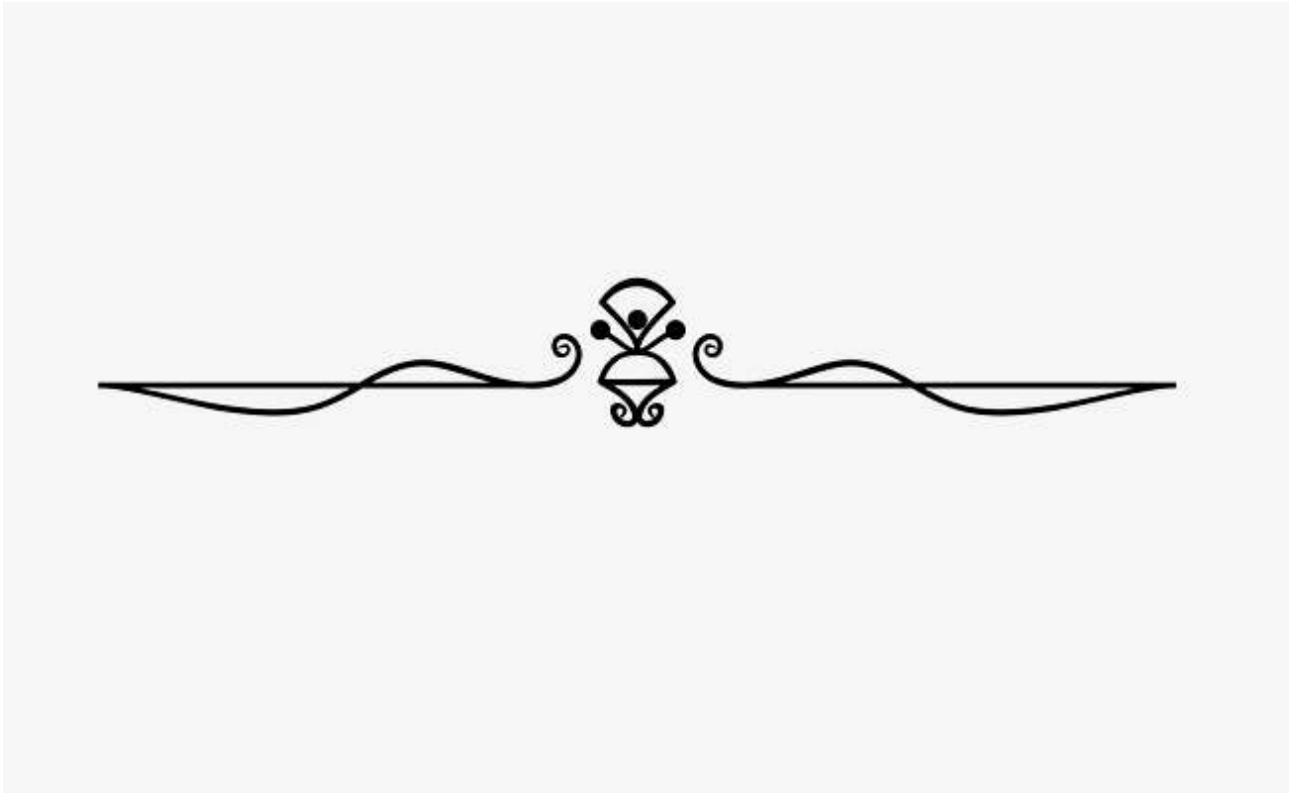
Zak, PJ. 2017. The neuroscience of trust. *Harvard Business Review*, 95(1):84-90.

Ziglar, Z & Ziglar, T. 2012. *Born to win: find your success code*. Seattle. Amazon.

Zwane, ZP & Mtshali, NG. 2019. Positioning public nursing colleges in South African higher education: stakeholders' perspectives. *Curationis*, 42(1):e1–e11. https://doi.org/10.4102/curationis.v42i1.1885.

ANNEXURE A1

APPROVAL FROM IN-HOUSE COMMITTEE



Queen Khanyisile Masimula

ANNEXURE A1: APPROVAL FROM IN-HOUSE COMMITTEE

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

Faculty of Health Sciences
Department of Nursing Science

Enquiries: Dr. Ramadimetja Mogale
Tel: 0123563156
Mobile: 0715591327
Email: Shirley.mogale@up.ac.za

1st October 2018

The Chair: Post Graduate Committee

Dear Prof,

Letter of approval from Departmental In-house committee

The proposal of PhD student Queen Khanyisile Masimula (18390863) served before the In-house committee of the Department of Nursing Science and was approved for submission to the Post Graduate School Committee.

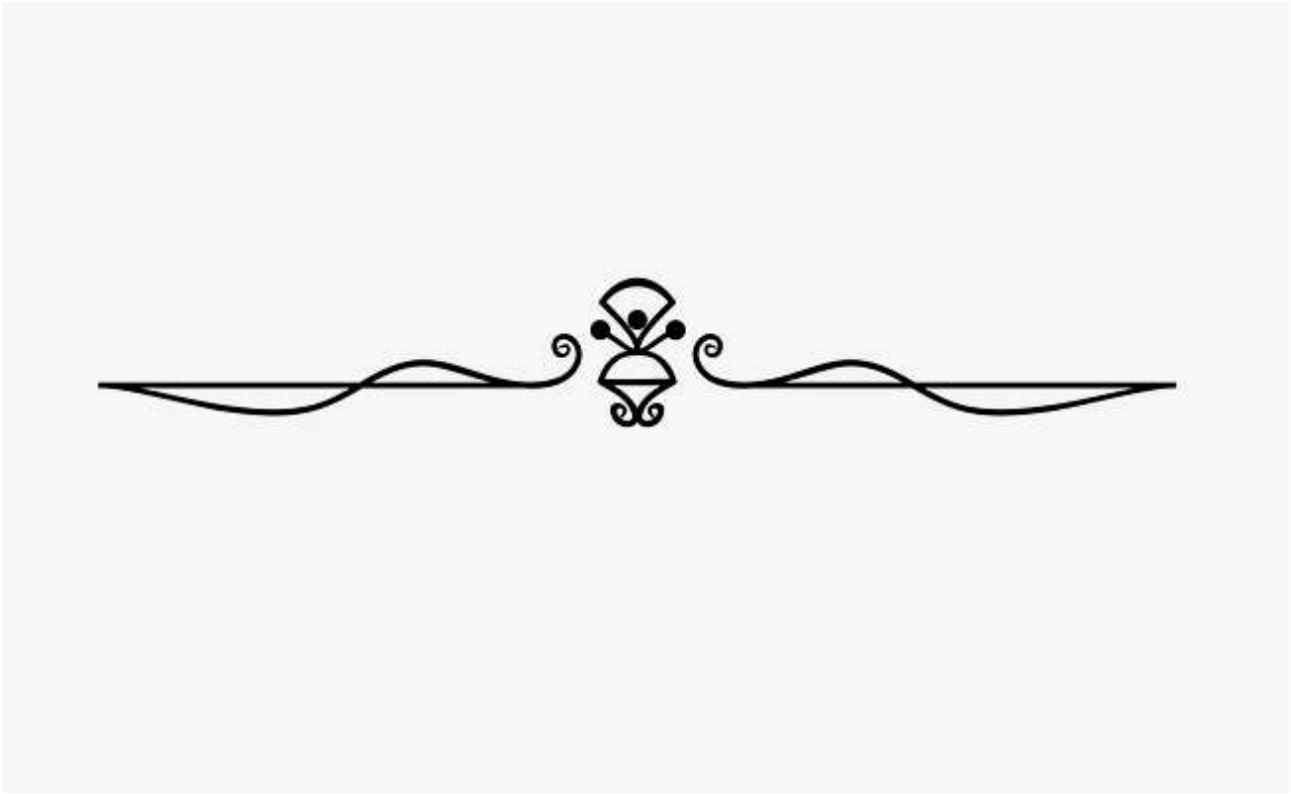
Internal reviewers: Prof N. van Wyk, Prof C. Maree and Dr R. Rikhotso.

Yours sincerely

Dr RS Mogale
Senior Lecturer
Department of Nursing Science
University of Pretoria
Cell phone: +27715591327
Office: (012) 356-3156
Email: Shirley.mogale@up.ac.za

ANNEXURE A2

RESEARCH ETHICS COMMITTEE APPROVAL



Queen Khanyisile Masimula

ANNEXURE A2: RESEARCH ETHICS COMMITTEE APPROVAL

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

Faculty of Health Sciences

The Research Ethics Committee, Faculty Health Sciences, University of Pretoria complies with ICH-GCP guidelines and has US Federal wide Assurance.

- FWA 00002567, Approved dd 22 May 2002 and Expires 03/20/2022.
- IRB 0000 2235 IORG0001762 Approved dd 22/04/2014 and Expires 03/14/2020.

1 February 2019

Approval Certificate
New Application

Ethics Reference No.: 760/2018
Title: Transforming workplace culture towards person centredness in a Nursing Education Institution in South Africa

Dear Mrs QK Masimula

The **New Application** as supported by documents received between 2019-01-23 and 2019-01-30 for your research, was approved by the Faculty of Health Sciences Research Ethics Committee on its quorate meeting of 2019-01-30.

Please note the following about your ethics approval:

- Ethics Approval is valid for 1 year and needs to be renewed annually by 2020-02-01.
- Please remember to use your protocol number (760/2018) on any documents or correspondence with the Research Ethics Committee regarding your research.
- Please note that the Research Ethics Committee may ask further questions, seek additional information, require further modification, monitor the conduct of your research, or suspend or withdraw ethics approval.

Ethics approval is subject to the following:

- The ethics approval is conditional on the research being conducted as stipulated by the details of all documents submitted to the Committee. In the event that a further need arises to change who the investigators are, the methods or any other aspect, such changes must be submitted as an Amendment for approval by the Committee.

Additional Conditions:

- Approval is conditional upon the Research Ethics Committee receiving letter from the statistician.

We wish you the best with your research.

Yours sincerely

Dr R Sommers
MBChB MMed (Int) MPharmMed PhD
Deputy Chairperson of the Faculty of Health Sciences Research Ethics Committee, University of Pretoria

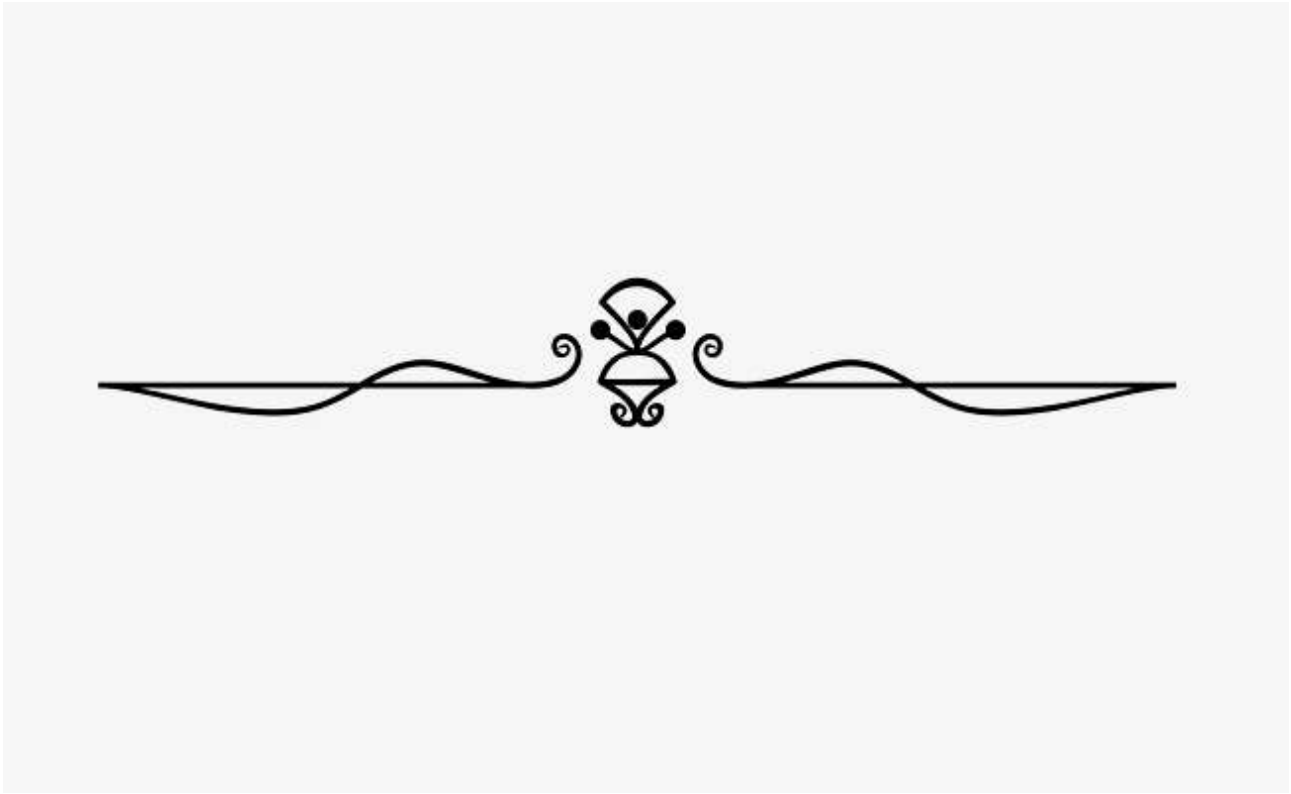
The Faculty of Health Sciences Research Ethics Committee complies with the SA National Act 61 of 2003 as it pertains to health research and the United States Code of Federal Regulations Title 45 and 46. This committee abides by the ethical norms and principles for research, established by the Declaration of Helsinki, the South African Medical Research Council Guidelines as well as the Guidelines for Ethical Research: Principles Structures and Processes, Second Edition 2015 (Department of Health).

Research Ethics Committee
Room 4-60, Level 4, Tswelopele Building
University of Pretoria, Private Bag X323
Arcadia 0007, South Africa
Tel +27 (0)12 356 3084
Email deepeka.behari@up.ac.za
www.up.ac.za

Fakulteit Gesondheidswetenskappe
Lefapha la Disaense tša Maphelo

ANNEXURE A3

PROVINCIAL PROTOCOL REVIEW COMMITTEE APPROVAL



Queen Khanyisile Masimula

ANNEXURE A3: PROVINCIAL PROTOCOL REVIEW COMMITTEE APPROVAL

GAUTENG PROVINCE
HEALTH
REPUBLIC OF SOUTH AFRICA

OUTCOME OF PROVINCIAL PROTOCOL REVIEW COMMITTEE (PPRC)

Researcher's Name (PI)	Masimula QK
Organization / Institution	University of Pretoria
Research Title	Transforming workplace culture towards person centredness in a Nursing Education in South Africa
Contact number	072 204 6903
Protocol number	GP 201812 003
Sites	SG Lourens Nursing College

Your application to conduct the abovementioned research has been reviewed by the Province and permission has been granted.

We request that you submit a report after completion of your study and present your findings to the Gauteng Health Department.

☑ Permission granted

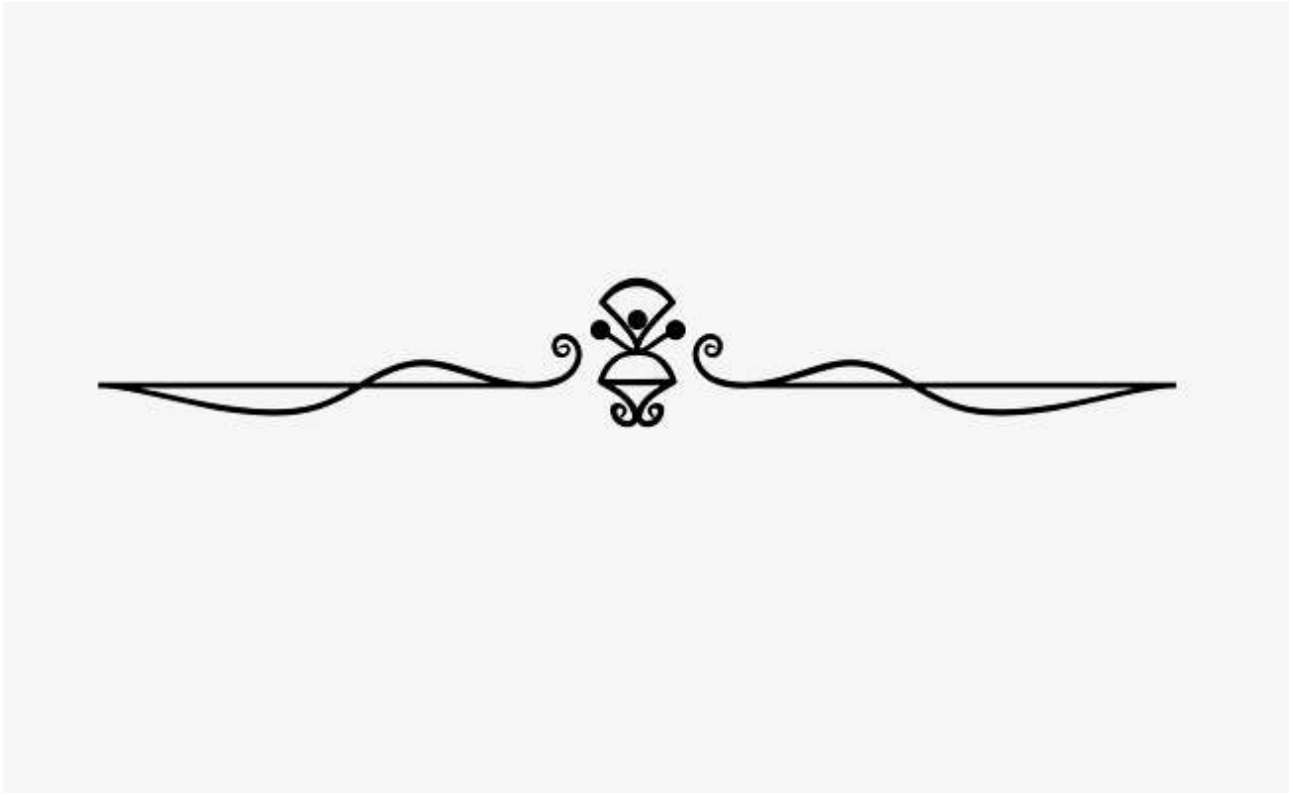
☐ Permission denied

Recommended by

Mr R Ramahlafi
Acting Director: Nursing Education & Training
Date 20/02/2019

ANNEXURE A4

APPROVAL FROM PUBLIC NURSING COLLEGE



Queen Khanyisile Masimula

ANNEXURE A4: APPROVAL FROM PUBLIC NURSING COLLEGE

Permission to access information from Nurse Educators and Managers at SG Lourens Nursing College

TO: MP Tjale[Name]
Chief Executive Officer/Manager

SG Lourens Nursing College
College

FROM : QK Masimula[Name]
Investigator

SG Lourens Nursing College
College

Re: Permission to do research at SG Lourens Nursing College

TITLE OF STUDY: Transforming workplace culture towards person centredness in a Nursing Education Institution in South Africa

This request is lodged with you in terms of the requirements of the Promotion of Access to Information Act. No. 2 of 2000.

I am a researcher / student at the Department of Nursing at the University of Pretoria.

I am working with DR Annatjie van der Wath and Prof Isabel Coetzee. I herewith request permission on behalf of all of us to conduct a study on the above topic on the college grounds.

We intend to publish the findings of the study in a professional journal and/ or to present them at professional meetings like symposia, congresses, or other meetings of such a nature.

We intend to protect the personal identity of the Nurse Educators and Managers by assigning each individual a random code number.

We undertake not to proceed with the study until we have received approval from the Faculty of Health Sciences Research Ethics Committee, University of Pretoria.

Yours sincerely

Signature of the Principal Investigator

Permission to do the research study at this College and to access the information as requested, is hereby approved.

Principal MP Tjale
Lourens Nursing College

Date: 7/12/2018

GAUTENG DEPT. VAN GESONDHEID
Official Stamp
2018 -12- 07
S.G. LOURENS NURSING COLLEGE
GAUTENG DEPARTMENT OF HEALTH

ANNEXURE A5

PERMISSION TO USE THE PERSON-CENTRED PRACTICE INVENTORY

Queen Khanyisile Masimula

ANNEXURE A5: PERMISSION TO USE THE PERSON-CENTRED PRACTICE INVENTORY

Queen Margaret University
EDINBURGH

Professor Brendan McCormack,
Head of the Division of Nursing; Head of QMU Graduate School;
Associate Director CPCPR
Queen Margaret University,
Queen Margaret University Drive,
Musselburgh,
East Lothian,
EH21 6UU
Tel: 0131 474 0000 (Voice activated recording - ask for Brendan McCormack)
Email: BMcCormack@QMU.ac.uk

September 12, 2018

Dear Professor Coetzee

I can confirm that I give my permission for yourself and your PhD student Ms Q Masimula to use and adapt the Person-centred Practice Inventory-Staff [PCPI-S].

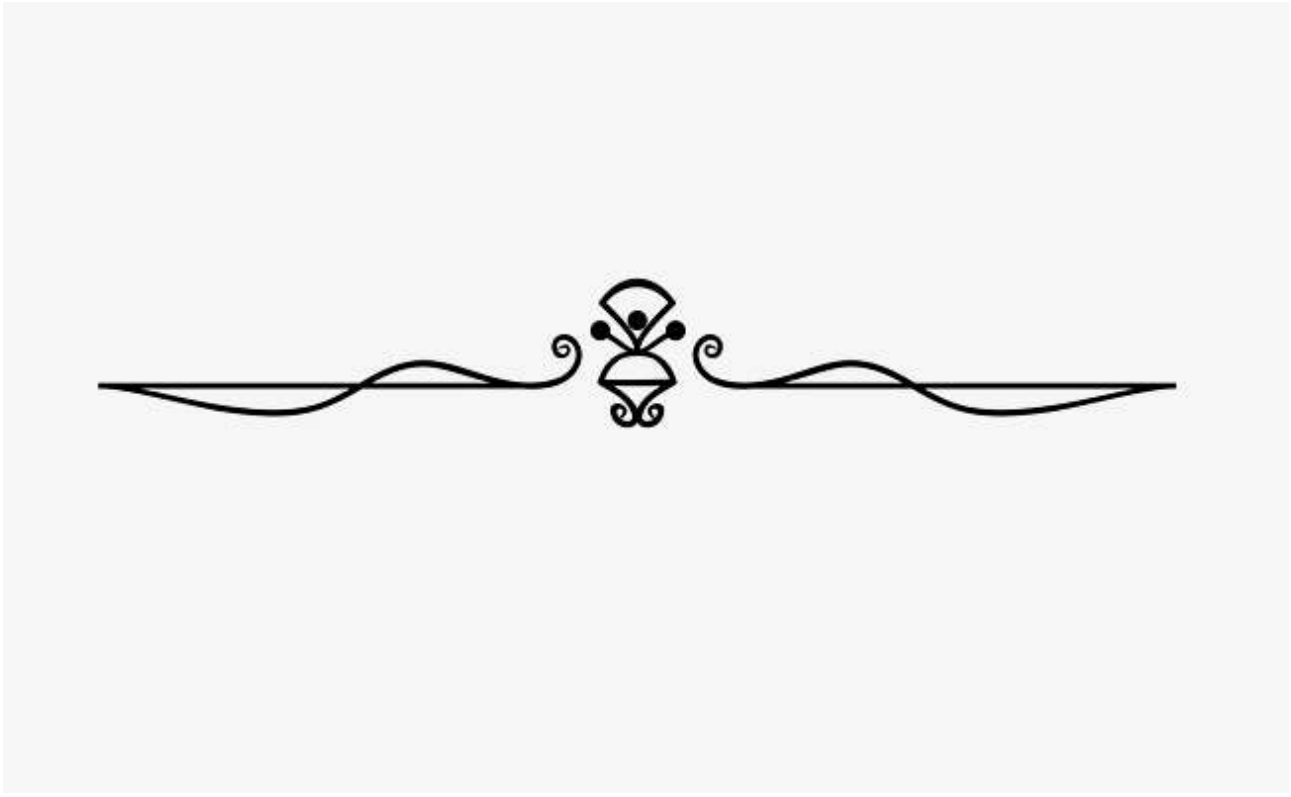
Yours sincerely

Professor Brendan McCormack

Head of the Division of Nursing/
Head of QMU Graduate School
Associate Director, Centre for Person-centred Practice Research

ANNEXURE B1

PROPOSAL PRESENTATION



Queen Khanyisile Masimula

UNIVERSITY OF PRETORIA

TRANSFORMING WORKPLACE CULTURE TOWARDS PERSON CENTREDNESS IN A PUBLIC NURSING EDUCATION INSTITUTION IN GAUTENG PROVINCE

Student: QK Masimula

Supervisors: Prof A van der Wath
Co-supervisors: Prof IM Coetzee

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

Introduction and Background

- Public Nursing Education Institutions (PNEIs) in South Africa are approved and accredited to provide nursing education and training for student nurses. Governance and regulation of PNEIs is provided by:
  - The South African Nursing Council (SANC) a nursing regulatory body.
  - The Department of Health (DoH) provides governance for PNEIs to ensure quality nursing education.
  - The Nursing Act (Act no. 33 of 2005) controls and regulates nursing practice for all NEIs in South Africa.
  - There are four PNEIs in Gauteng Province; only one PNEI will be the context of this study. The PNEI refers to a nursing college that provides nursing education to student nurses to become professional nurses in accordance with the National Qualification Act (Act no 67 of 2008).

Introduction and Background

- The PNEI under study produces around 200 professional nurses per year. The PNEI recruits, admits and trains around 250-300 student nurses in the first year of the nursing programme.
- Policy mandates of high student nurse numbers lead to high nurse educator-student ratios and an unmanageable workload for nurse educators. These workload challenges are believed to contribute to nurse educator shortages (DoH 2013: 22, 23; Mkhize 2009: 63).
- The nurse educator workload challenges produce experience of an unconducive workplace culture at the PNEIs due to lack of participation and support in policy formulation and results in difficult implementation across all levels of authority from top to the lowest categories of instruction.

Introduction and Background

- In Southern Indian nursing schools, a similar situation like in South Africa occurred in which, Garner, Prater and Putturaj (2014: 389) found that an imbalance in resource diversity policies and lack of collaboration, inclusion and participative management decisions contributed to nursing education workforce shortages.
- In Italy, at the University of Udine, Palese, Falomo, Brugnolli, Mecugni, Marognolli, Montalti, Tameni, Gonella and Dimonte (2017:100) reported that nurse educators felt satisfied to work in a working environment, that is economically balanced, where there is growth, trust, honor, support, respect between workers, possibility of working with less mobbing nursing teams, empowered participatory leadership styles and advanced technologies.

Introduction and Background

- In this study, the researcher aims to transform a person centred workplace culture for the PNEI in Gauteng Province.
-

Background

- PNEIs are faced with workplace culture challenges that emanate from a non-participative approach that affects nurse educator outcomes and organisational goals for student nurse training.
- The challenges with the "top-down" non-participative (Mkhize, 2009:161-162) leadership approach in team work that takes place at different levels of Authority ascending down to the lower staff category.
- There is lack of active participation in leadership teams from top – to bottom that contributes to lack of collaboration efforts in policy formulation and makes implementation of nursing education mandates difficult (Mkhize: 89).
- The lack of a bottom up approach for teams leads to staff complaints, limited compliance, poor staff relations and resistance in buying-in to most of the "top-down" or "talked down" academic policies and mandates for nursing education practice in the midst of an unmanageable workload of high student numbers (Mkhize, 2009: 89).

6

Background

- In African continent, statistics showed that 18.8% of nurse educators in Tanzania, 26.5% in Malawi and 41.4% in South Africa were faced with unconducive workplace cultures due to work overload, and were looking for better remuneration and job satisfaction (Blaauw, Ditlopo, Maseko, Chirwa, Mwisongo, Bidwell, Thomas & Normand, 2013:127).
- The above performance indicators showed that other African countries just like South Africa, experience challenges of an unconducive workplace culture due to lack of leadership collaboration, inclusion and participation following limited resources in nursing education practice .

7

Background

- In Canada, a nursing education institution also faced similar challenges of top-down leadership approach that lacked academic staff collaboration and suffered participative management issues, from lack of responsible resources that lacked bottom-up inputs.
- The lack of participative management resulted in poor staff attitudes, poor work relations, poor compliance to nursing education policies and activity standards, lack of teamwork, burnout and high staff turnover that caused nurse educator shortages.
- The institution mentioned opted to engage in different methods to facilitate transformation of the workplace culture for better outcomes (Sayah, Szafran, Robertson, Bell & Williams, 2014:2968).

8

Introduction and background

- According to Topp and Chipukuma (2016:197,198) the possible solution to solve workplace challenges that threaten organisational outcomes is to transform a workplace culture of person centredness to improve organisational practice.
- Reeves, Xyrichis and Zwarenstein (2018: 1-3), argued that collaboration, inclusion and participation (CIP principles) could best solve problems of the top-down leadership approach. Participative leadership blended with team approach improves job satisfaction, team compliance and staff retention.
- In study, outcomes harvested will be used to transform the workplace culture of the PNEI to improve student, nurse educator and organisational outcomes for job satisfaction

Problem Statement

- Public Nursing Education Institutions Academic staff employees has an unconducive workplace culture
- The PNEI unconducive workplace culture is evidenced by lack of participatory leadership in team work (Mkhize, 2009: 93; DoH, 2013: 23), and a "top-down" leadership approach ascending from all levels of nursing education practice (Mkhize, 2009: 161-162; Mutea & Cullen, 2012: 417-418).

Problem Statement

- The nursing education training mandates comes with implementation of increased student nurse numbers with limited populated resources (DoH, 2013: 22, 23), that lead to increased nurse educator - student ratios and unmanageable nurse-educator work-overload.
- The PNEIs in the Gauteng Province reported a lack of participation in policy mandates and formulation, difficulty in the implementation of student nurse training mandates, limited power and authority in the management of PNEIs and experiences of being unsupported (Mkhize, 2009: 89, 93; DoH, 2013: 23, 33; Mutea & Cullen, 2012: 417-418).

Problem Statement

- Public Nursing Education Institutions suffer lack of adequate supportive resources (financially, materially, infrastructural and human resources) that hinder the training of student nurses at a larger scale of numbers (Mkhize, 2009: 89) and (DoH, 2013:27,41).

Problem Statement

High student numbers policy mandates led:

- to increased nurse educator workload (DoH, 2013: 23),
- resistance to compliance, poor work relations, nurse educator turnover (Carolyn & Fong, 2016: 102,107),
- lack of teamwork and burnout (Kol, ilaslan & Turkay, 2017: 2-3),
- nurse educator disengagement,
- increased absenteeism,
- and decreased job satisfaction (Boamah, Read & Laschinger, 2017:1183).

Problem Statement

- The challenges mentioned face the PNEI :
  - directly affects nursing education practice,
  - could cause a decrease in the optimal teaching and learning milieu,
  - impacting negatively on student nurse outcomes, nurse educator outcomes and organisational goals if not addressed (Flott & Linden, 2016:501; DoH, 2013: 38,47).
- According to McCormack (2010: 10,63), the best solution to address workplace culture challenges is to adopt and implement a person centred approach.

It is also not clear how nursing educators and other employees view the workplace culture in the PNEI under study.

Significance of the study

- Contribution to nursing education knowledge and practice.
- Provide guidance to PNEIs towards transforming the workplace culture of person centredness.
- Contribute towards achievement of positive student nurse, nurse educator and organisational outcomes.
- Facilitate execution of a participative team approach through CIP principles.
- facilitate the use of a coordinated “bottom-up” approach.
- Inform policy markers to widen the scope of participation and inputs in policy formulation forums
- Address policy implementation challenges facing DoH and National Nursing educational strategy (Mkhize, 2009, :89).
- To provide a source of references to other scholars

AIM OF THE STUDY

The aim of this study will be to transform the workplace culture of a PNEIs in Gauteng Province towards person centredness

Research questions

How can the workplace culture of the PNEI in Gauteng Province be transformed towards person centredness?

Research objectives

Phase 1

- Assess the current workplace culture of the PNEI in Gauteng Province.

Phase 2

- Implement the Transformative Practice Development Program (TPDP)

Phase 3

- Evaluate the Transformative Practice Development Program to transform the workplace culture of person centredness

PARADIGM PERSPECTIVE

- The paradigmatic perspective using critical realism within a blend of a mixed method research design of Transformative Practice Development methodology will guide the ontological, epistemological and methodological assumptions that underpins this study.

Ontology

- In critical realism, critical realist explain how we come to know what we know in the world by gaining a deeper understanding of the causes and causalities (Walsh & Evans, 2014:4) and best answers the research question.
- Gaining a deeper understanding of the causes and causalities will be discovered through the use of a mixed method design within the Transformative Practice Development methodology, use of multiple data collection methods and data analysis
- To gain deeper understanding the researcher will use:
  - Quantitative method - questionnaires and descriptive statistical analysis
  - Qualitative method - "creative arts" data collection, hermeneutics data analysis and,
  - Consensus meeting and data analysis through ranking and voting to meet consensus.

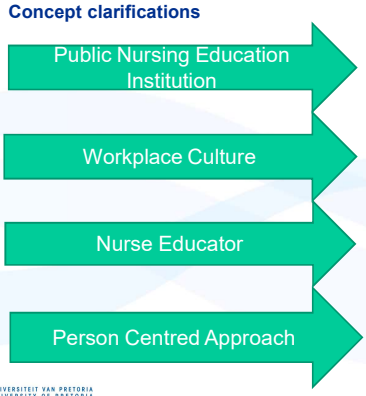
Epistemological assumptions

- In Critical realism, knowledge is subjective and bound by place and time. Rich knowledge is optimized when the researcher interact with those being researched (Walsh & Evans, 2014:3).
- The researcher will employ diverse approaches to gain knowledge through:
  - **questionnaires** to gain knowledge and be able to explain the workplace culture currently and after evaluation of the TPD program.
  - **"Creative arts"** and **consensus meeting** data collection will assist to generate knowledge by exploring the workplace culture.
- The TPD program will be implemented for six months by the researcher and PDFs through an interactive process.

Methodological assumption

- Critical realism in transformative research believe that knowledge and understanding could be constructed by using more than one method to investigate complex and wide range of views in order to enlarge more classifications and concepts (Creswell, 2014: 37).
- Critical realism challenge transformative researchers to vacate their professional silos and go out to collaborate, include and participate across disciplines to holistically examine phenomena using different research methods Walsh & Evans, 2014:3)
- The searcher will use a combination of quantitative method through questionnaire and qualitative method through creative arts and consensus meetings for data collection and a combination of data analysis method.
- The researcher will merge, map and evaluate the outcomes of Phase 1 and 3 of TPDP implementation to transform the workplace culture of the PNEI in Gauteng in South Africa.

Concept clarifications



Research Method and Design

Phase 1 - Quantitative Stance

Objective 1 – To assess the current workplace culture

Step 1: Adaptation of the assessment tool to the South African context
Step 2: Orientation session of PDFs
Step 3: Assessment of current workplace culture

Processes: Appointment and Presentation of study, obtaining informed consent, distribution of questionnaire and collection, confidentiality.

Data collection	Population	Sampling	Data Analysis	Rigor
Questionnaire	Principal, Vice Principal, HODs, Nurse Educators	**Type**: Total population **Size**: +/- 92	Descriptive analysis	Validity Reliability

Research Method and Design

Phase 2 - Qualitative Stance

Objective 2 – To implement the Transformative Practice Development Program (TPDP)
Step 1: Planning session: Co-construct the TPDP with Transformative Practice Development Facilitators (TPDFs)
Step 2: Implementation session: Action TPDP with TPDFs using CIP principles

Processes: Get volunteers to be TPDFs, obtain informed consent, conduct workshop for TPDFs for role clarification, create groups for facilitation, use Phase 1 outcome to plan a full TPDP for emancipation by TPDFs for six months.

Data collection	Population	Sampling	Data Analysis	Trustworthiness
----------	Participants from: Principal, Vice Principal, HODs, Nurse Educators	**Type**: Total population **Size**: +/- 15 TPDFs	----------	Credibility, Dependability. Conformability, Transferability, Authenticity, Prolong engagement

Research Method and Design

Phase 3 - Quantitative and Qualitative Stance

Objective 3 – To evaluate the workplace culture after implementing the Transformative Practice Development Program (TPDP)
Step 1: Evaluate the workplace culture after TPDP implementation
Step 2: Evaluate TPDFs' experiences
Step 3: Evaluate managers

Processes: Merge, map and evaluate outcomes from Phase 1 and Phase 3

Data collection	Population	Sampling	Data Analysis	Trustworthiness
Step 1 – questionnaire **Step 2** – creative art **Step 3** – consensus meeting	**Step 1** - Principal, Vice Principal, HODs, Nurse Educators **Step 2** – TPDFs **Step 3** - managers	**Step 1**- Total population **Step 2**- purposive **Step 3**- total population	**Step 1**- Descriptive analysis **Step 2**- creative hermeneutics **Step 3**- voting , ranking and coding	Credibility, Dependability. Conformability, Transferability, Authenticity, Prolong engagement

Ethical considerations

- Informed consent
- The right to privacy
- confidentiality
- Ethical approval

Dissemination of Results

- The results will be disseminated as a thesis,
- Publication of the results in an accredited journal,
- Findings will be presented in conferences and research days,
- Will be made available to research participants,
- Gauteng Department of Health,
- National Department of Health,
- Will be made available at the Faculty of Health Sciences, University of Pretoria as a thesis of reference for other scholars for life-long learning and further in the future,
- Department of Higher Education.

PROPOSED BUDGET		
ITEM	**PRICE**	**TOTAL**
Information leaflets and Informed consents	4 pages per participant = 92x2=184pages + (15+9=24pages x R1/page=R208xR1.00	R208.00
PCPI tool copies	2 pages x 92x2=184x2pages=R368xR1/page= (R368x2)	R736.00
Internet	R2 000	R1 000.00
Travelling costs	37.5L/100km x120km x R15.99/L	R719.55
Language Editing	R80 x 250 pages	R20 000.00
Independent co-coder	Independent co-coder fees for phase 3 x R5 000 each for group x 2 (PDFs x 15) and (Group of Managers x 9)	R15 000.00
Printing of final work	R800 x 4 copies	R3 200.00
Binding	R360 x 4 copies	R1440.00
Laptop (replace out-dated)	R13000	R13 000
Data collection materials	hand diaries and reflective note handbooks, creative art materials for phase 3 x 24 participants = R100 x 24	R2400.00
Data bundles for PDFs	Watsapp bundlesx15xR50	R750.00
Thank you cards	Thank you cards for Nurse Educator Experts R50 each x 3	R150.00
Registration fees	Annual registration fees	R7500.00
Editing fees	Editing 250 pages, PDFs and Managers x R10 000 each	R20 000.00
Statician costs	For descriptive statistics coding of x 92 participants	R15 000.00
Workshop costs	Three workshops refreshments R250 x 3	R750.00
Total		**R101,853.55**

Conclusion

The researcher provides a layout on how the study will be conducted in order to achieve the aim and objectives of the study.

The lack of a participatory approach in teamwork from both leadership and academic staff in PNEIs in South Africa could lead to an unconducive workplace culture compromising organisational outcomes and job dissatisfaction.

The "top-down" leadership approach used lack compliance in policy implementation from lack of dedicate funding and resources for student nurse training.

The aim of the study is to transform the workplace culture of person centredness for the PNEI in Gauteng Province. South Africa

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

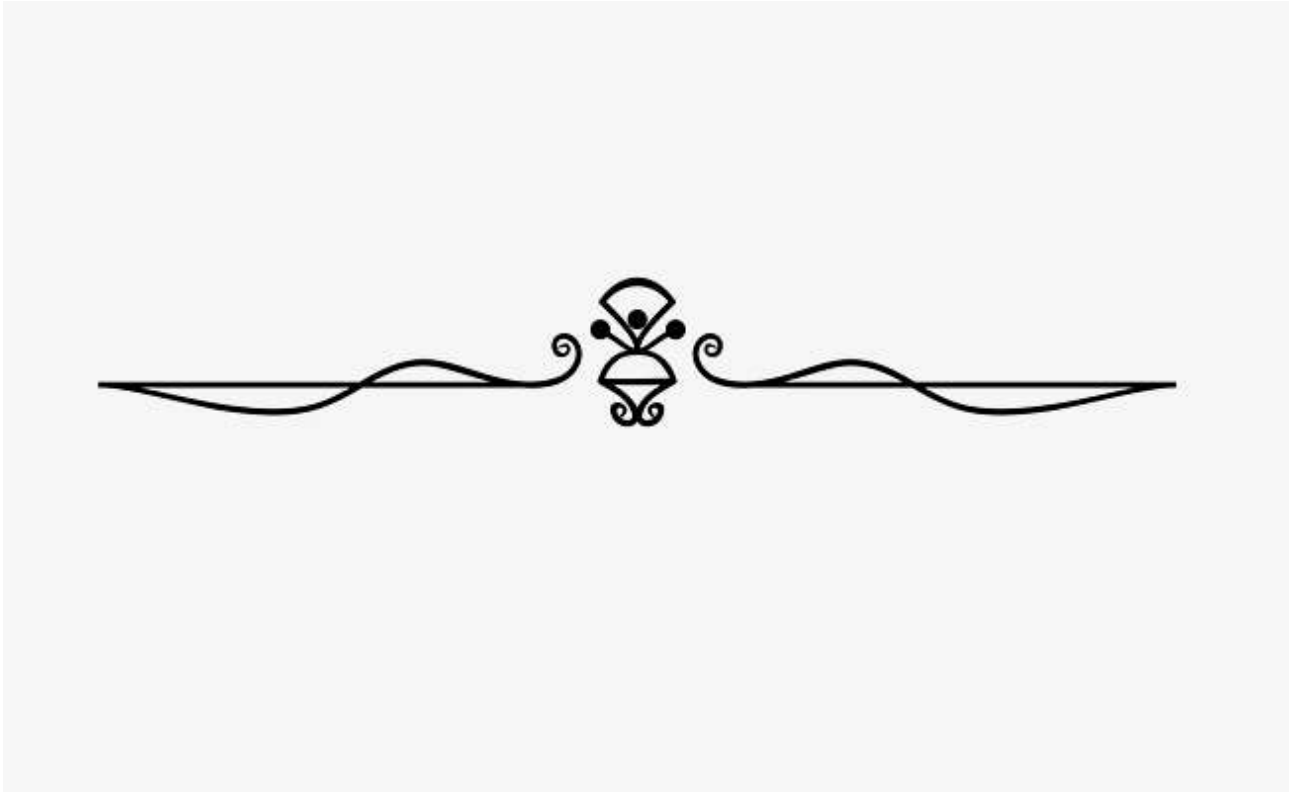
30

THANK YOU FOR LISTENING

QUESTIONS AND COMMENTS

ANNEXURE B2

INVITATION TO ACADEMIC STAFF TO ATTEND RESEARCH PRESENTATION



Queen Khanyisile Masimula

ANNEXURE B2: INVITATION TO ACADEMIC STAFF TO ATTEND RESEARCH PRESENTATION

All academic staff are kindly invited to attend a research presentation topic on "transforming the workplace culture towards person centredness at the NEI in South Africa".

Attendance is voluntary and a consent form will be signed to volunteer to participate in the study.

Date: 12 February 2019

Time: 08:00-12:00

Venue: Room A5

Research Presenter: Researcher

Agenda:

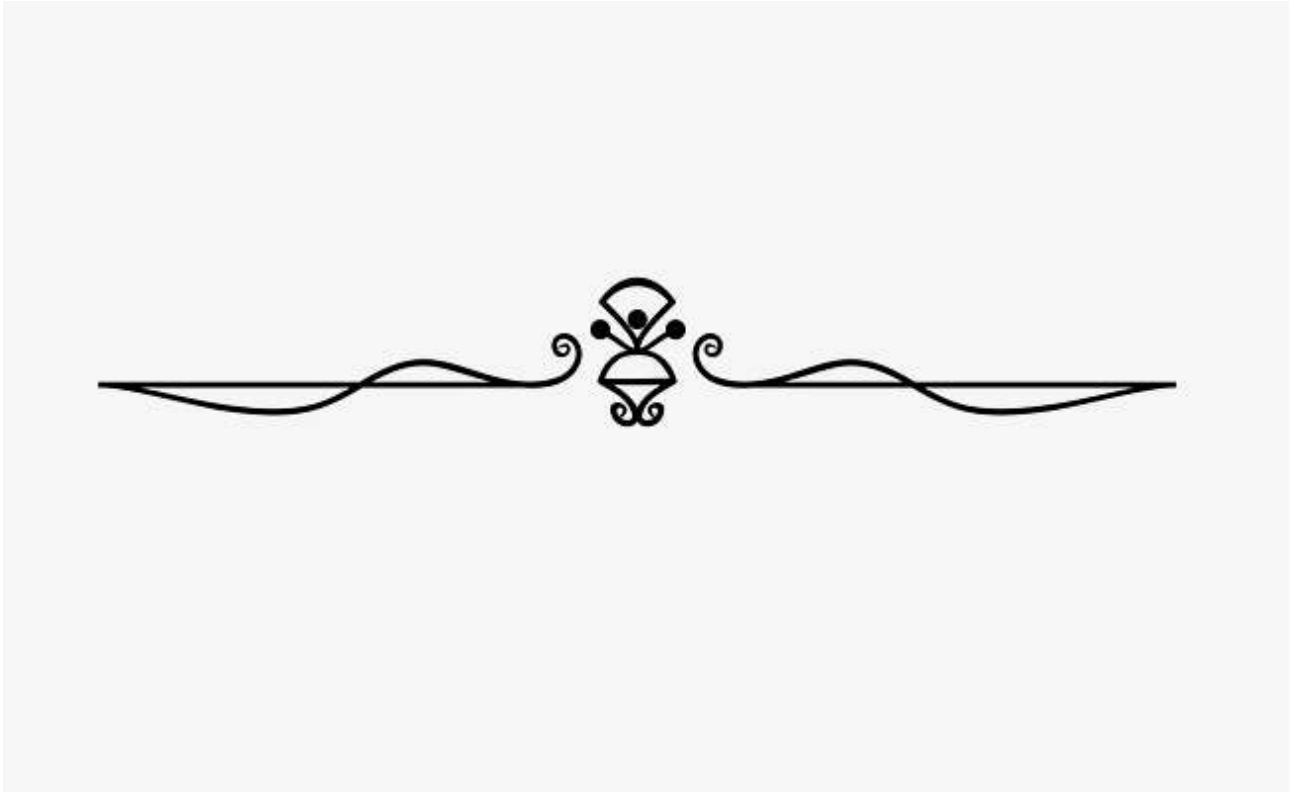
- Opening and welcome:
  Facilitated by Participant No. 1 (Research Chairperson)
- Presentation of research briefing note topic:
  Facilitated by Researcher
- **Signing consent forms of participants who volunteer to participate:** *Facilitated by Participants No. 12, 32, 23, 31.*
- **Signing of attendance register of participants:**
  Facilitated by Participants No. 9, 27.
- **Introduction of Programme facilitators**:
  Facilitated by Researcher and Nurse Educator Experts
- **Vote of thanks**:
  Facilitated by Participant No. 7 (Research Deputy Chairperson)
- **Closure:**
  Facilitated by Main Researcher
- **Serving of refreshments:**
  Facilitated by Main Researcher
- **By Order:**

  Research Chairperson and Researcher

Slogan of the day: Change starts with us

ANNEXURE C1

PARTICIPATION INFORMATION AND CONSENT DOCUMENT FOR ACADEMIC STAFF



Queen Khanyisile Masimula

ANNEXURE C1: PARTICIPATION INFORMATION AND CONSENT DOCUMENT FOR ACADEMIC STAFF

STUDY TITLE:

TRANSFORMING WORKPLACE CULTURE TOWARDS PERSON CENTREDNESS IN A NURSING EDUCATION INSTITUTION IN SOUTH AFRICA

Principal Investigators: Queen K. Masimula

Institution: University of Pretoria

DAYTIME AND AFTER-HOURS TELEPHONE NUMBER(S):

Daytime numbers: **072 204 6903**

Afterhours: **072 204 6903**

DATE AND TIME OF FIRST INFORMED CONSENT DISCUSSION:

dd	**mmm**	**ivy**

:
Time

Dear Participant

Dear Mr. / Mrs. ..... date of consent procedure …...../…...../…...

1) INTRODUCTION

You are invited to volunteer for a research study. This information leaflet is to help you to decide if you would like to participate. Before you agree to take part in this study you should fully understand what is involved. If you have any questions, which are not fully explained in this leaflet, do not hesitate to ask the investigator. You should not agree to take part unless you are completely happy about all the procedures involved. Please take note that no remuneration will be awarded for participation in this study

2) THE NATURE AND PURPOSE OF THIS STUDY

You are invited to take part in a research study. The aim of this study will be to transform the workplace culture towards person centredness in a Nursing Education Institution in South Africa. You are considered as being a very important source of information and are thus requested to volunteer to take part in this study. The following three (3) objectives are proposed in order to achieve the aim of this study:

- Assess the current workplace culture of the PNEI in South Africa.
- Implement the Transformative Practice Development Program
- Evaluate the outcomes of Transformative Practice Development Program to transform the workplace culture to person centredness

3) EXPLANATION OF PROCEDURES TO BE FOLLOWED

Participation of academic staff members working at the PNEI in South Africa are requested to participate in three ways. At first you are requested to participate in a self-administered assessment questionnaire that takes 30 minutes to answer in English to assist in assessing the current workplace culture of person centredness. Secondly to participate in the implementation of the Transformational Practice Development Programme intervention activities towards transforming the current workplace culture of the PNEI to a more person-centred workplace culture. Thirdly, you will be requested to participate in an evaluation of the Transformational Practice Development Program using another second round of self-administered assessment questionnaire, creative art and consensus meeting data collection methods. All participants will be considered as important role players of the change process by being engaged in different academic activities that will take place. Participative discussions will be held and actions plans implemented in order to move towards a culture of person-centeredness using collaborative,

inclusion, participative and reflective principles of the Transformative Practice Development Program.

Your agreement to participate will be important so that you may participate in the implementation of the Transformative Practice Development Program intervention within daily activities in the PNEI. Facilitators and group of managers' data collection and collaborative data analysis sessions will be recorded and transcribed verbatim. Participation is voluntary and as such you will be allowed to withdraw at any stage of the study without any penalties.

4) RISK AND DISCOMFORT INVOLVED.

The identity of participant will be kept confidential throughout the transformative process. The TPD program takes very long for a period of six months which will also require some of your time, patience and will need a lot of efforts during the six months of implementing the program.

5) POSSIBLE BENEFITS OF THIS STUDY.

Possible benefits of the study will include participatory decision making leadership, employment of a facilitated person centred participative leadership approach, enhanced collaborative teamwork, improved workplace culture and improved work relations. It could enhance compliance to diverse stakeholder participative policy mandates and improve student outcomes. It will contribute towards a person centred workplace culture where employees could flourish as persons, improve job satisfaction, reduce staff shortages, turn-over rates and improve organisational outcomes.

6) WHAT ARE YOUR RIGHTS AS A PARTICIPANT?

Your participation in this study is entirely voluntary. You will be allowed to withdraw from participation in the study or stop at any time during the transformative process without giving any reason. You will not incur any penalty from withdrawal from the study.

7) ETHICAL APPROVAL

The Faculty of Health Sciences' Research Ethics Committee at the University of Pretoria and your Nursing Education Institution has given written approval for this study. A copy of the Declaration may be obtained from the investigator should you wish to review it.

Please feel free to contact the Research Ethics Committee, if you need any clarification pertaining to ethical approval.
Faculty of Health Sciences University of Pretoria's Office:
Tel: 012 354 1330 or 012 354 1367
Fax: 012 354 1367

8) INFORMATION

If you have any questions concerning your participation in this study, you should feel free to contact the principal researcher: Queen K. Masimula

Cell: 072 204 6903

Email address: queenmasimula@yahoo.com

Or Contact my supervisors	: Dr A van der Wath	084 506 3142
	: Prof I Coetzee	071 158 9045

9) CONFIDENTIALITY

All records obtained whilst in this study will be regarded as confidential. Your input into this study will also be kept strictly confidential. Results and reports will be published in accredited scientific journals and presented in such a manner that your identification as a participant will remain anonymous.

10) CONSENT TO PARTICIPATE IN THIS STUDY.

The content and meaning of this information leaflet have been explained to me. I agree that the person asking my consent to take part in this study has told me about the nature, process, risks, discomforts and benefits of the study. I have also received, read and under ` the above written

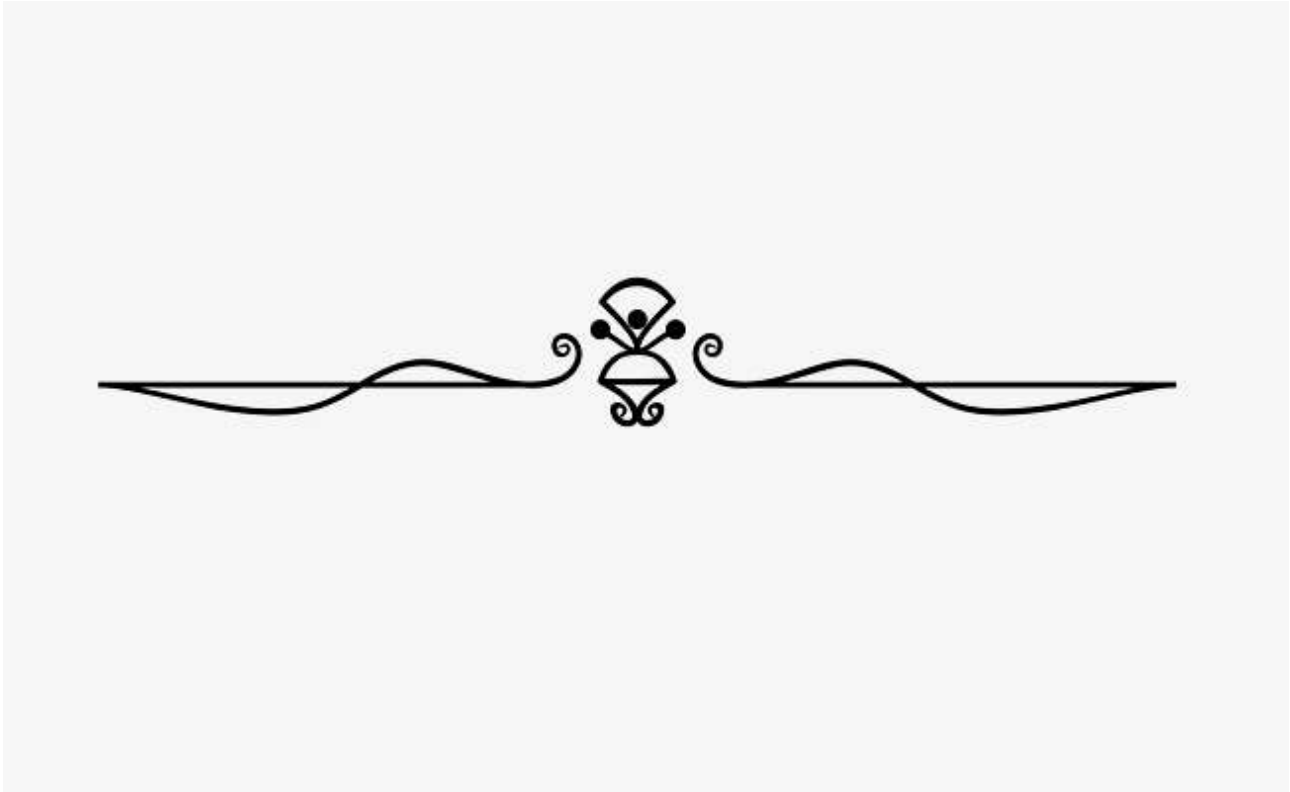
information (Information Leaflet and Informed Consent) regarding the study. I am aware that the results of the study, including personal details, will be anonymously managed into study reports. I am participating willingly. I have had time to ask questions and have no objection to participate in the study. I understand that there is no penalty should I wish to discontinue with the study and my withdrawal will not affect me in any way. I hereby volunteer to take part in this study.

I have received a signed copy of this informed consent agreement.

.....	.....
Participant's name	Date
.....	.....
Participant's signature	Date
.....	.....
Investigator's name	Date
.....	.....
Investigator's signature	Date
.....	.....
Witness's name	Date
.....	.....
Witness's Signatures	Date

ANNEXURE C2

GROUND RULES FOR CONSENSUS AND FEEDBACK MEETINGS



Queen Khanyisile Masimula

ANNEXURE C2: GROUND RULES FOR CONSENSUS AND FEEDBACK MEETINGS

RESEARCH TOPIC: TRANSFORMING WORKPLACE CULTURE TOWARDS PERSON CENTREDNESS IN A NURSING EDUCATION INSTITUTION IN SOUTH AFRICA

DEVELOPMENT OF GROUND RULES BY PARTICIPANTS FOR CONSENSUS AND FEEDBACK MEETINGS RESEARCH FOR ACTIVITIES CONDUCTED.

The researcher and participants jointly developed ground rules before starting the workshop. The ground rules were developed as follows:

- Respect all inputs of participants
- Listen respectfully, without interrupting other participants
- Listen actively to understand other' views.
- Commit in order to share information, not to persuade your ideas of interest
- Avoid blame, speculation, and inflammatory language
- Allow everyone a chance to speak
- Avoid assumptions about any member of the group or generalisations
- Be culturally sensitive
- Cell phones on silence
- Provide a safe place:
  - Psychological safety
  - Non-judgemental environment
  - Non-prejudice
- Safe use of language
- No fun of other participants inputs
- Do not answer cell phones in the meeting or ask for an excuse to attend important calls
- Do not laugh at others members
- Do not just talk, raise a hand to be noted
- Keep up time in all scheduled research activities

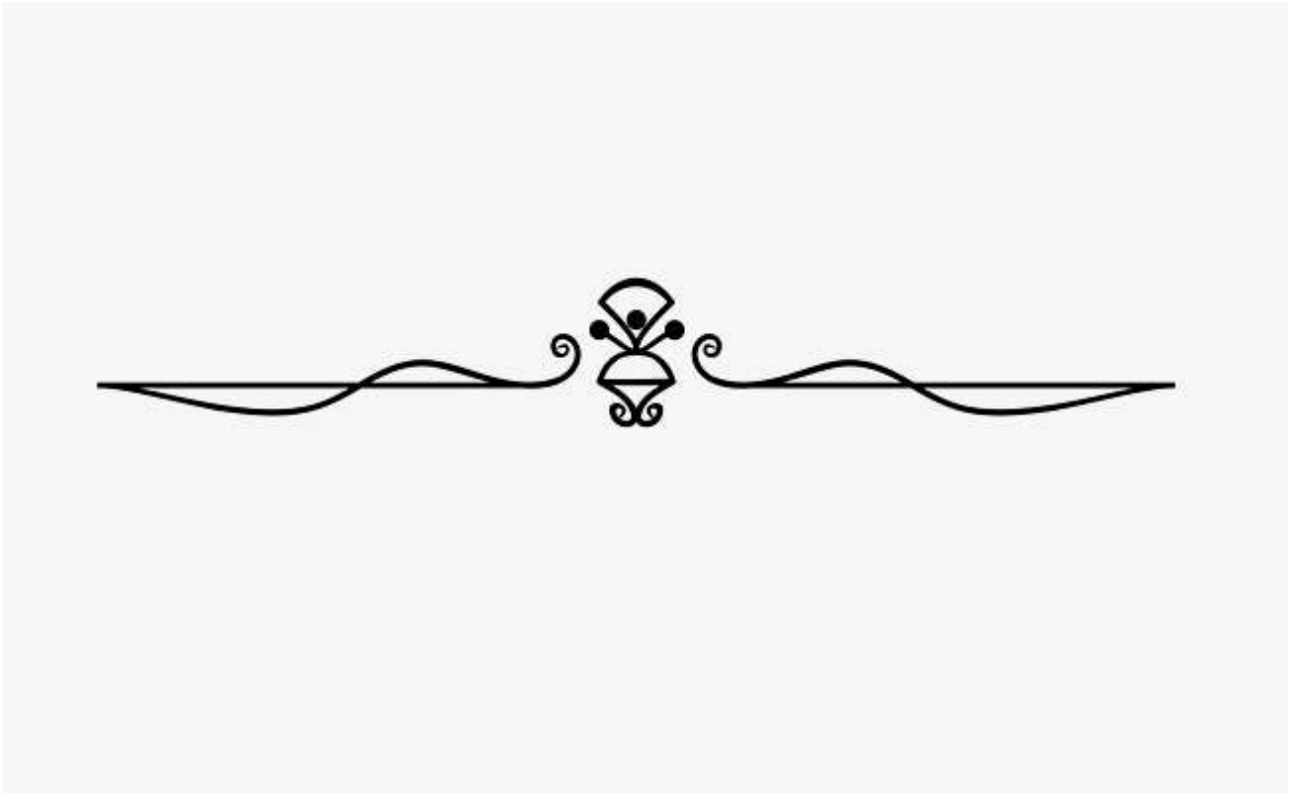
Ground rules developed and accepted by all 46 members for consensus and feedback meetings.

By order: Researcher

12 February 2019

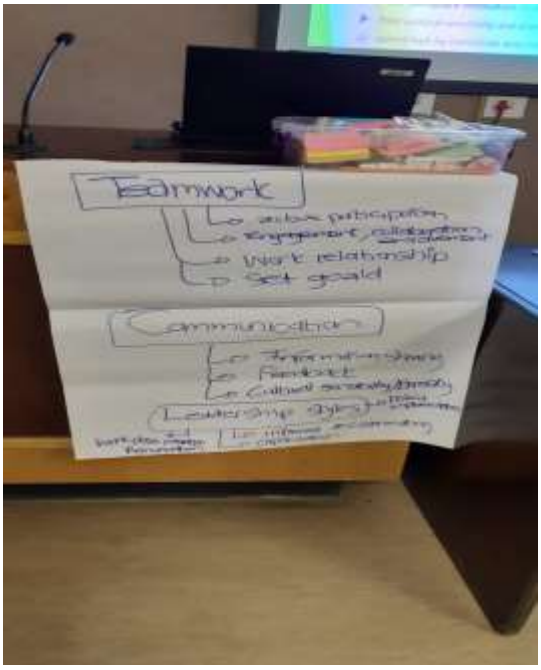
ANNEXURE C3

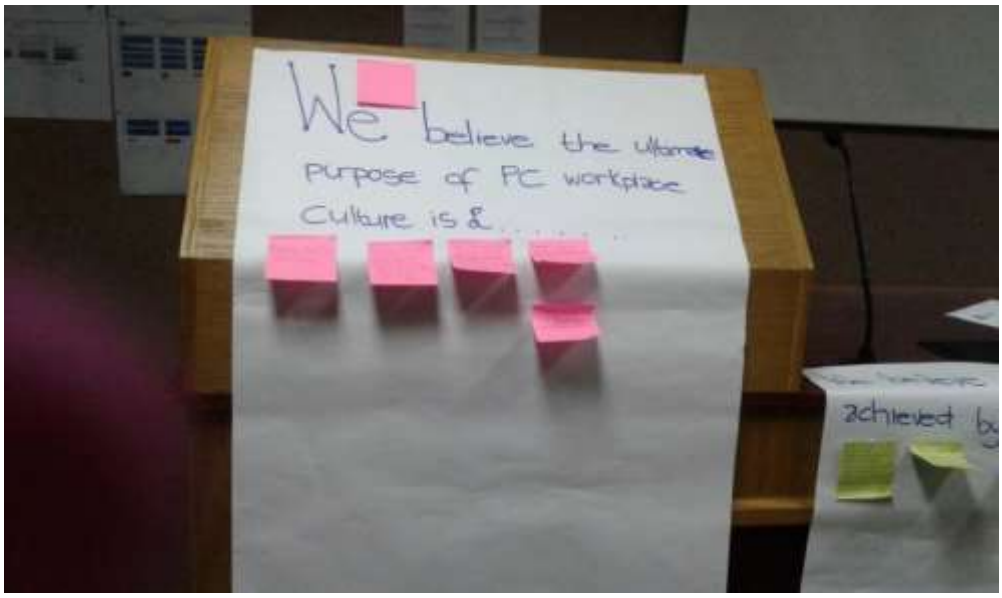
EXAMPLE OF CONSENSUS MEETING

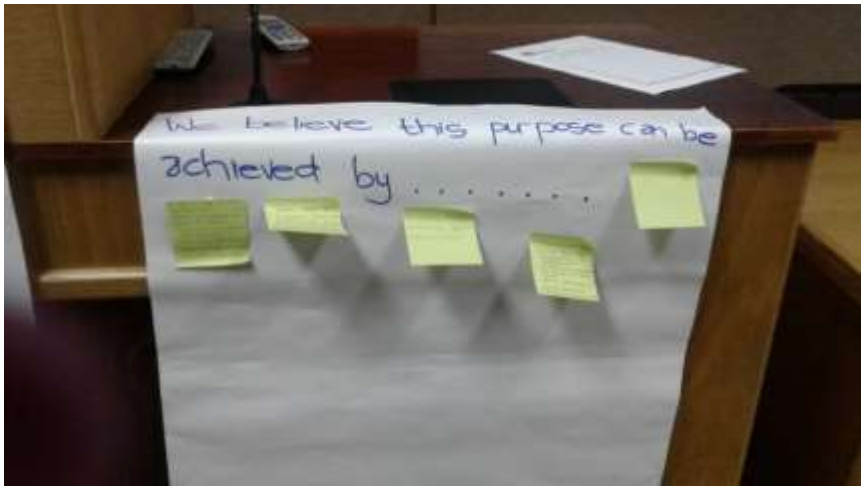


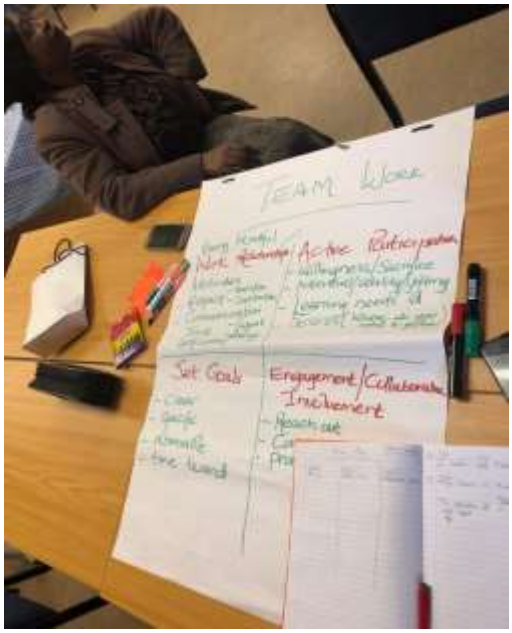
Queen Khanyisile Masimula

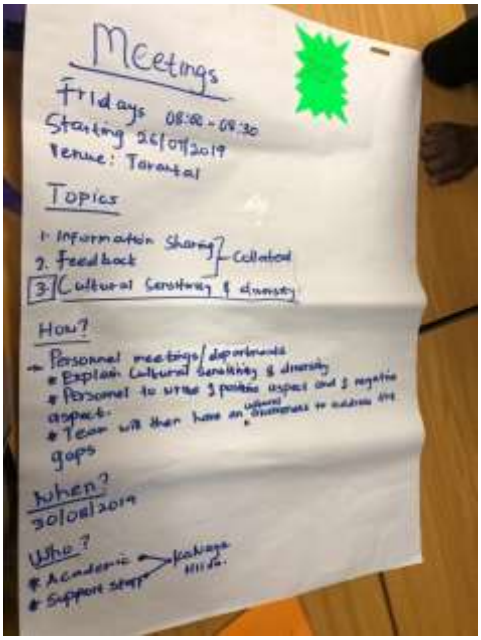
ANNEXURE C3: EXAMPLE OF CONSENSUS MEETING











COLLATED AND COMPUTED WHITE BOARD CLIPS OF PARTICIPANTS

ANNEXURE C4

EXAMPLE OF FEEDBACK SESSION NOTES

Queen Khanyisile Masimula

ANNEXURE C4: EXAMPLE OF FEEDBACK SESSION NOTES

Workshop conducted for the academic staff under communication as a theme.

Date: 8 August 2019

Time: 08:00-12:30

Venue: A5

Name of Facilitators: #change starts with us

(Facilitators for Communication team)

Attendees: 32 participants plus researcher

Topic: cultural sensitivity and diversity.

The academic team was divided into three groups according to age groups

Group 1: 30-40 years.

Positives	Things you would change
• Annual cultural celebration where individuals are allowed to wear their cultural attire and share traditional food. • Older people are respected regardless of qualifications	• Individuals should be allowed to wear their traditional clothes to work, as long as they look presentable. • Christianity is more dominantly practiced making other people feel outcasted. • Doeks for spiritual / cultural reason should not be questioned (there shouldn't be motivational letters for permission.) • Individuals should be allowed to wear moaning attire.

Group 2: 40-50 years

Positives	Things you would change
• Meetings every month; Academic, Research days, committees. • English to accommodate everyone. • Team building activities: year-end function, Heritage days, woman's day celebrations, tekkie Friday. • I care 4 u- wellness for employees, medical surveillance. • Religiously – given time to pray once a month and during meetings. • Corporate image- gives positive reputation.	• Noise levels are very high • Language switch in meetings. • Males not fully supported • Not all religions are supported, mostly Christianity is recognised. • No accommodation for disabled. • Negative attitude- others not responding to greetings. • Late coming to meetings**.**

Group 3: >50 years

Positives	Things you would change
• Cultural diversity • Learn different values. • Assisting each other. • Appreciate different religions**.**	• Insensitivity to other racial groups. • Respect / have knowledge of each other's culture. • Dress code imposed on certain days. • Different values from age groups eg. Baby shower, religion. • Imposed religious beliefs. • Personality traits differ and offend others.eg. speaking loud and hugging.

Comments:

The group really enjoyed the session and got a chance to express their feelings about Cultural diversity and gave feedback to Program Facilitators.

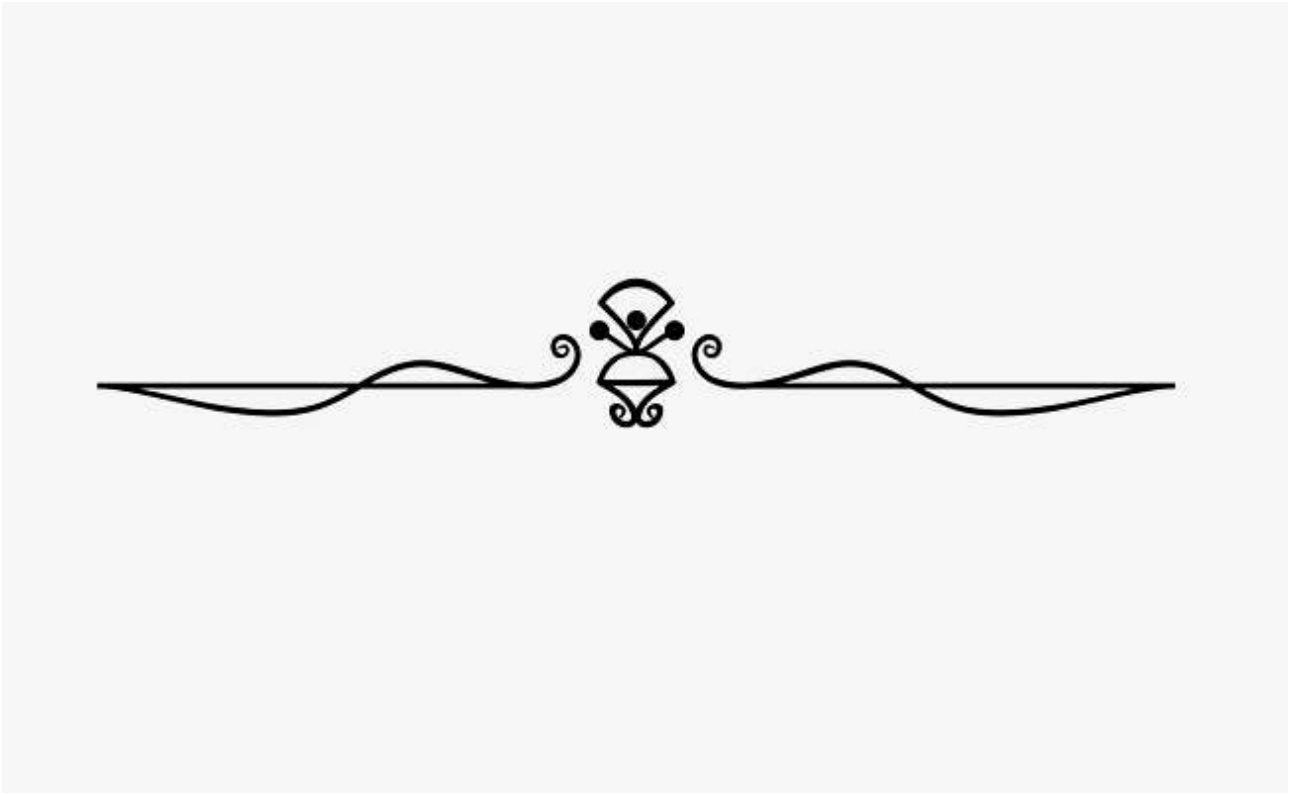
The participants worked together to come-up with the above collated data in their 3 age groups.

Compiled by: Program Facilitators facilitating the feedback sessions.

Host: Main Researcher

ANNEXURE C5

PCPI QUESTIONNAIRE



Queen Khanyisile Masimula

ANNEXURE C5: PCPI QUESTIONNAIRE

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

Section A: Demographic profile

A1. Age

18- 28 years	
29 - 38 years	
39 - 48 years	
49 - 58 years	
59 an older	

A2. Gender

Female		**Male**	

A3. Highest level of education

Bachelor`s degree	
Master`s degree	
PhD	
Tertiary	
Others (specify)	

A4. Years of experience as Nurse Educator_____

Section B: Person-centred practice inventory

Please indicate how much you agree or disagree with each of the following statements:

Number	Question	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
1	I have the necessary skills to negotiate educational options					
2	When I teach I pay attention to more than the immediate task					
3	I actively seek opportunities to extend my professional competence					
4	I ensure I hear and acknowledge others perspectives					
5	In my communication with others I demonstrate respect for others					
6	I use different communication techniques to find mutually agreed solutions					
7	I pay attention to how my non-verbal cues impact on my engagement with others					
8	I strive to delivwer high quality education to students					
9	I seek opportunities to get to know my students in order to provide holistic care/support					
10	I go out of my way to spend time with my students					
11	I strive to delivers quality education that is evidence informed					
12	I continously look for opportunities to improve the education experience for students					
13	I take time to explore why I react as I do in certain situations					
14	I use refelction to check out if my actions are consistant with my ways of being					
15	I pay attention to how my life experiences influence my teaching practice					
16	I actively seek feedback from others about my teaching practices					

17	I challenge colleagues when their teaching practices is inconsistant with our team`s shared values and beliefs					

Please indicate how much you agree or disagree with each of the following statements

Number	Question	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
18	I support colleauges to develop their teaching practice to reflect the team`s shared values and beliefs					
19	I recognise when there is a deficit in knowledge and skills in the team and its impact on teaching and learning					
20	I value the input from all team members and their contribution to teaching and learning					
21	I actively participate in team meetings to inform my decision-making					
22	I participate in organisational decision-making forums that impact on teaching practice to inform					
23	I am able to access opportunities to actively participate in influencing decision in my division					
24	My opinion is sought in decision making forums (eg staff meetings)					
25	I work in a team that value my contribution to care					
26	I work I a team that encourges everyone`s contribution to person centred care					
27	My colleauges positivly role model the development of effective relationships					
28	The contributions of colleuage is recognised and acknowledge					
29	I actively contribute to the development of shared goals					
30	The leader (HOD) facilitates participation on all levels of the organisation					
31	I am supported to do things differently to improve my teaching practice					
32	I am encouraged and supported to lead developments in teaching practice					
33	I am able to balance the use of evidence with taking risks					

34	I am committed to enhance learning by challeging teaching practices					
35	I pay attention to the impact of the physical environment on students/lecturers dignity					

Please indicate how much you agree or disagree with each of the following statements

Number	Question	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
36	I pay attention to the impact of the physical environment on students/lecturers dignity					
36	I challenge other to consider how different elements of the physical environment impact on person-centredness					
37	I seek out creative ways of improving the physical environnet					
38	In my team we take time to celebrate our achievements					
39	My organisation recognises and rewards success					
40	I an recognised for the contribution that I make to students having a good experience of teaching and learning					
41	I am supported to express concerns about an aspect of teaching and learning					
42	I have the opportunity to discuss my practice and professional development on a regular basis					
43	I intergrate my knowledge of the person into teaching and learning					
44	I work with the student within the context of their family and carers					
45	I seek feedback on how students make sence of their learning expereince					
46	I include students in teaching and learning decisions where appropriate					
47	I work the students to set goals for their future					
48	I enable students to seek information about their teaching and learning					
49	I try to understand the students perspectives					

50	I engage students in teaching and learning processes where appropriate					
51	I actively listen to to students to idently unmet needs					
52	I gather additional information to help me support students					

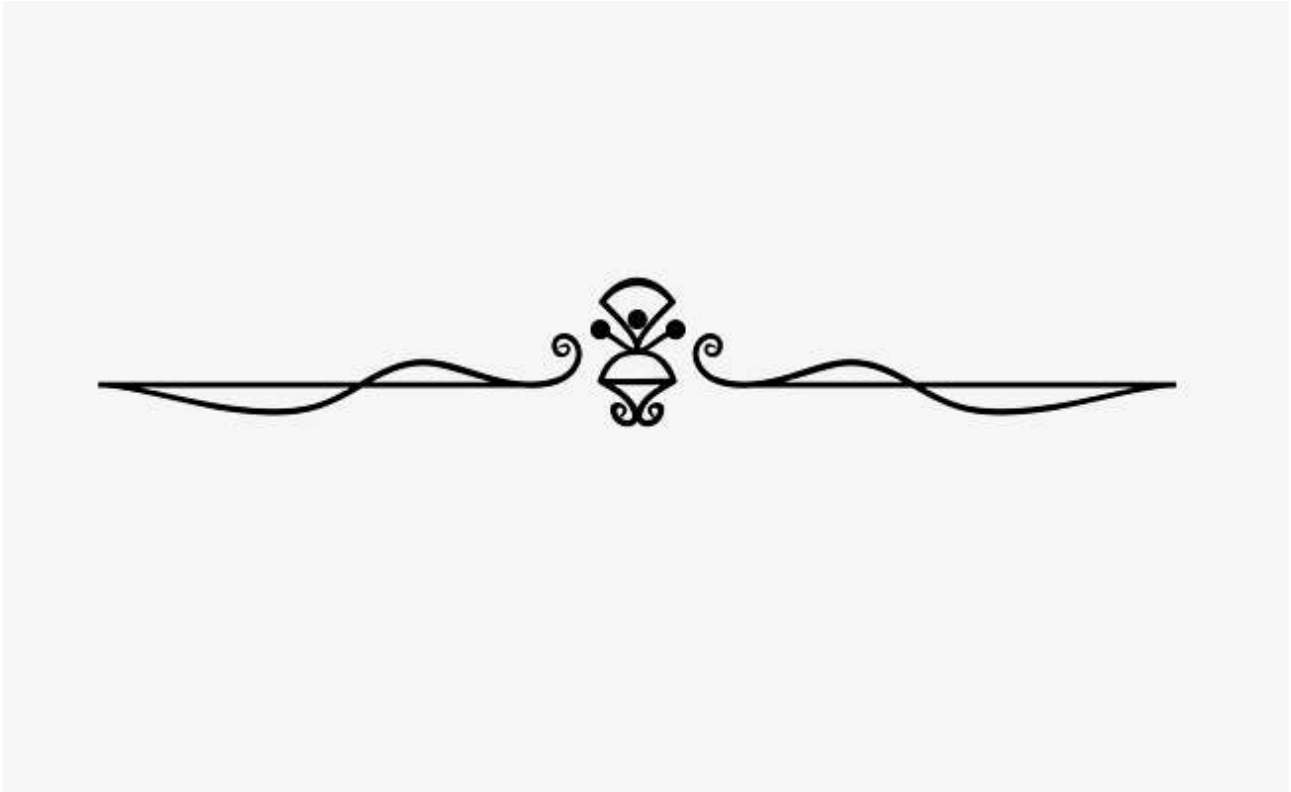
Please indicate how much you agree or disagree with each of the following statements

Number	Question	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
53	I seek to reslove issues when my goals for students differs from theirs perspectives					
54	I ensure my full attention is focussed on the student when I am with them					
55	I strive to gain a sense of the whoe person (student)					
56	I assess the needs of students, taking into account all aspects of their lives					
57	I teach in a manner that takes account of the whole person (student)					

Thank you for participating it is highly appreciated

ANNEXURE D1

TRANSFORMATIVE PRACTICE DEVELOPMENT PROGRAM PLANNING



Queen Khanyisile Masimula

ANNEXURE D1: TRANSFORMATIVE PRACTICE DEVELOPMENT PROGRAM PLANNING

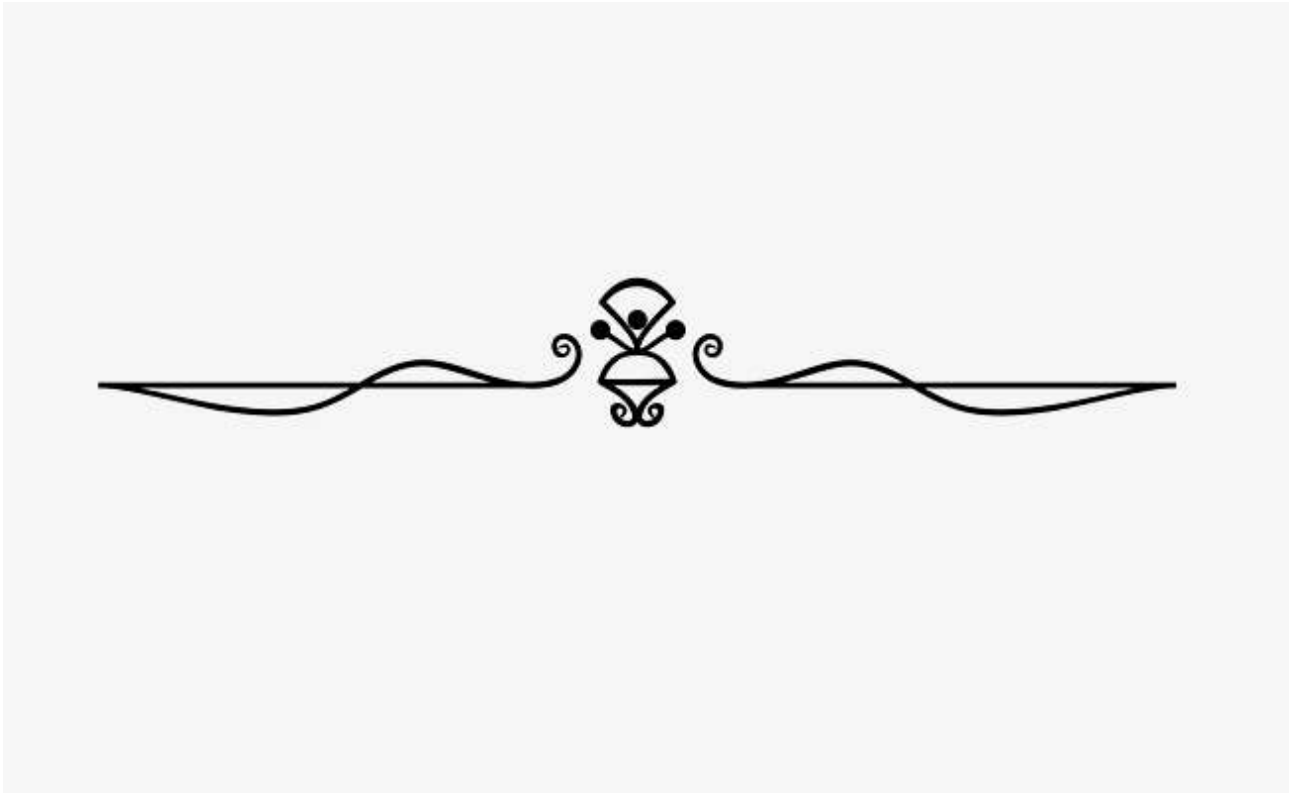
TABLE 3 Co-construction of the Transformative Practice Development program for creating a person-centred workplace culture in a public nursing education institution

Questions	**Actions**	**Responsible person** ***Timelines***
What must be done? *Who does what?* *When should the TPD program be presented?*	Develop and present sub-topics from the three main topics that emerged from the consensus meetings (positive work relations, communication and leadership). Facilitate group discussions Send invitations to the workshops Book venues. Ensure participants sign informed consent and attendance registers Facilitate feedback sessions	Program facilitators *Three workshops per month, three hours per workshop.* Researcher *Every session* *After each workshop*
What are the key concepts that guide the TPD program implementation?	Transformation, workplace culture, persons centredness, practice development, collaboration, inclusion, participation and reflection	Research team
What values will guide the program facilitators?	Adherence, compliance, integrity, faithful replication, completeness and compliance to protocols	Research team
What satisfaction indicators will guide the TPD program?	Attendance, feedback/ comments, representativeness of target population, engagement, attendance and retention.	Research team
How should quality be ensured during implementation of the TPD program?	The topics and the plan should achieve the TPD program outcomes. Monitor the TPD program delivery, ensure that program protocols are observed, and capture participant comments and feedback during the workshops and feedback sessions.	Research team Researcher
Which resources are needed for the TPD program?	Stationary, laptops, overhead projector, microphone, refreshments.	Researcher

Adapted from Beukes (2011)

ANNEXURE D2

TRANSFORMATIVE PRACTICE DEVELOPMENT PROGRAMME



Queen Khanyisile Masimula

ANNEXURE D2: TRANSFORMATIVE PRACTICE DEVELOPMENT PROGRAMME

TABLE 2 Transformative Practice Development programme

Topic	Date and time[a]	Overview of content covered	Presenter	Feedback from participants (examples of direct quotations in italics)
Positive work relations				
Effective teamwork to transform the workplace culture towards person centredness	Consensus meetings 18022019 25022019	• Positive attitude: knowing self and others, respecting self and others, trusting self and others and mindfulness • Effective communication: sharing information, cultural sensitivity and diversity • Group cohesion: active participation, adherence to work plans, collective vision of goals, collective decision making and clear roles and responsibilities.	Facilitator N	*Management to involve all stakeholders when forming strategic initiatives to achieve effective teamwork.* *Needs more active engagement of person-centred activities to promote workplace transformation through effective teamwork.* *It's all about teamwork - sometimes you are the star, but sometimes you help the star* *Develop the mindset to volunteer to help others towards building effective teams for person centredness.*
Workplace values and beliefs to achieve a person-centred workplace culture	Workshop: 22032019 Feedback session: 29032019	• What are values and beliefs? • Development of values and beliefs • Examples of person-centred values: respect, love, care, acknowledging others.	Facilitator M	*The values and beliefs were unpacked well and clear for understanding.* *Appreciated the awareness on the need to develop workplace values and beliefs to support transformation.* *Appreciated the person-centred activities applied during the workshop related to workplace values and beliefs.*
Factors affecting a conducive workplace culture (Overcoming challenges for all to flourish)	Workshop: 26042019 Feedback session: 30042019	• Factors affecting the workplace culture of person centredness: poor leadership styles, toxic working relationships, negative attitudes, lack of policy implementation, lack of respect, ack of information sharing and knowledge - incapacitation • Challenging factors to be addressed in a loving and caring way	Facilitator L	*No one could have addressed our workplace challenges better, continue to teach us.* *I appreciated this workshop that addressed poor workplace relationships and how to address them in a loving manner.* *Incapacitation was addressed very well and the objectives of employee capacitation was outstanding*
Facilitating healthy work relations for a person-centred workplace culture	Workshop: 06062019 Feedback session: 20062019	Healthy workplace relations to transform towards person centredness: Be strong but not rude, kind but not weak, bold but not a bully, thoughtful but not lazy, humble but not timid, proud but not arrogant, have humour but without folly	Facilitator K	*We have started to capacitate our colleagues in our departments on healthy workplace relations so that we are all in this transformation, everyone must know and join in for our happiness.* *The factors needed to establish healthy workplace relations were addressed well and thought provoking.*

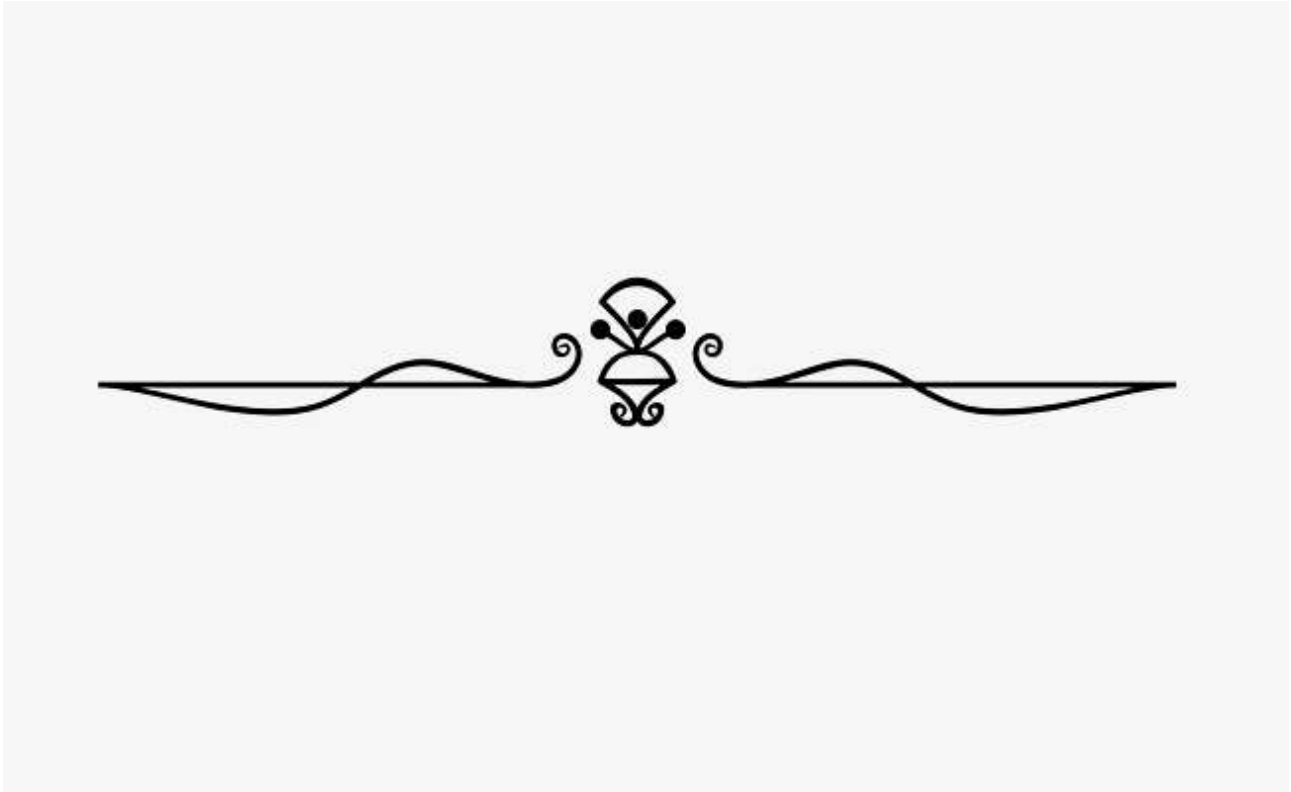
				Appreciated how the facilitators engaged participants into self-introspection activities in a non-provoking manner.
Transformation of the workplace culture through effective teamwork	Workshop: 17072019 Feedback session: 26072019	Effective teamwork: know self and others, respect self and others, acknowledgement where due, share knowledge and information, open communication, positive attitudes and support, collective decision making	Facilitator D	*Many questions were asked on effective teamwork and guidance on how to deal with some workplace issues was well clarified.* *Enjoyed informative role plays.* *Facilitator creativity and confidence was eye catching and realistic.* *We appreciated the facilitators walking the talk of effective teamwork.*
Communication				
Investing in cultural diversity for a person-centred workplace culture	Workshop: 12082019 Feedback session: 23082019	Person-centred attention to cultural diversity, different race groups and religions through sensitive use of language, dress codes and religion.	Facilitator F	*Celebrate each other's strong points /success and support each other's culture.* *Embrace cultural days.*
Transformational values and beliefs for person centredness	Workshop: 09092019 Feedback session: 27092019	• Participation in organisational decision-making forums • Respect for student's/lecturer's dignity • Creative ways to develop the self, others and the organisation • Personal and professional development	Facilitator C	*How can each person improve workplace practice for person centredness? Was answered well in activities.* *Participants were actively involved in activities that demonstrated their understanding and interest of the topic.*
Building a person-centred workplace culture through communication, feedback and information sharing.	Workshop: 17092019 Feedback session: 30092019	Effective communication at the workplace through: open communication, continuous feedback, effective information sharing, attention to medium of communication	Facilitator I	*The workshop was relevant and need to be repeated and monitored that the proposed activities are implemented effectively.* *There is a need to develop a policy on communication to facilitate the objectives of this workshop in the future for continuity.*
"Not a workplace, but a wow place"	Workshop: 04102019 Feedback session: 18102019	Transformation is complex and risky and brings changes to: various dimensions of the organisation, work procedures and values Employees must find peace, satisfaction and flourish at work despite challenges.	Facilitator J	*Found the topic to be informative and want a follow-up as we didn't exhaust all what we had to address.* *Repeat the topic as colleagues that were not present need to hear it.*
Factors that will help to achieve a person-centred workplace culture	Workshop: 25102019 Feedback session:	Feedback reports Flexibility for "self" and "others" Motivation, dedication and commitment Positive attitude	Facilitator E	*Actively engaged in group work sessions and asked a lot of questions that were well addressed.*

	31102019	Embracing each other's differences Collective decision making Collaboration, inclusion and participation		*The factors to achieve a person-centred workplace was informative and outstanding as practical examples for understanding were used.*
Transform the workplace culture through skills diversity and relevance	Workshop: 01112019 Feedback session: 15112019	Nurse educators to embrace skills diversity and relevance through: • Continuous development and capacitation • Mentorship and evaluation • Healthy working relationships (respect and trust)	Facilitator A	*Were very pleased and appreciated the boldness of the facilitators when addressing workplace issues that were real but could not be touched*.
Leadership				
Developing person centred leadership to transform the workplace culture to person centredness	Consensus meetings 03052019	Person-centered leadership: leadership skills, leading change, collaborative decision making, workplace motivation.	Facilitator M	*Enjoyed the workshop group session that mimicked a real work situation.* *As a leader, you don't build a business, you build people – and then people build a business.* *A dream written down with a date becomes a goal to inspire followers.* *A goal broken down into steps becomes a plan backed up by collaborative decision making.* *A plan backed down by action makes your dreams becomes true in a person centred leadership approach.*
Leading yourself before leading others to achieve a person-centred workplace practice	Workshop: 13052019 Feedback session: 31052019	Based on the book: "Who said elephants can't dance" (Gerstner 2002) • Everyone has the potential to change towards person centredness for all to flourish. "And that which you thought can't change can still change" (Gerstner 2002:1)	Facilitator B	*The participants were motivated to see the elephants dancing on the power point giving the lesson that there is nothing you cannot do.* *More lessons needed to revive others on how you can be coached to lead yourself first before leading others.*
Transformational leadership traits and person-centred leadership	Workshop: 21082019 Feedback session: 30082019	Transformational leadership and learning are related to each other. Transformational leadership traits include: inspiring others, teaching others, learning from others, mentoring and coaching others, be bold, be humble, listen to others.	Facilitator H	*Appreciated the topic and wanted a repeat before the college could close as everyone needs to learn.* *Learned in the work sessions and self-presentation during active work groups that we participated in.* *During transformation everyone learns new things.*

[a]3 hours per workshop and 2 hours per feedback session

ANNEXURE D3

PARTICIPANT INFORMATION AND CONSENT DOCUMENT FOR PROGRAM FACILITATORS



Queen Khanyisile Masimula

ANNEXURE D3: PARTICIPANT INFORMATION AND CONSENT DOCUMENT FOR PROGRAM FACILITATORS

PARTICIPANT'S INFORMATION & CONSENT DOCUMENT FOR PRACTICE DEVELOPMENT PROGRAMME FACILITATORS

STUDY TITLE:

TRANSFORMING WORKPLACE CULTURE TOWARDS PERSON CENTREDNESS IN A NURSING EDUCATION INSTITUTION

Principal Investigators: Queen Khanyisile Masimula

Institution: University of Pretoria

DAYTIME AND AFTER HOURS TELEPHONE NUMBER(S):

Day time numbers: 072 204 6903

Afterhours: 072 204 6903

DATE AND TIME OF INFORMED CONSENT PROCEEDINGS:

Date	**Month**	**Year**

:
Time

Dear PDF Participant

Dear Mr. / Mrs. _____ date of consent procedure _____./_____./_____

1) INTRODUCTION

You have volunteered to participate as a Practice Development Facilitator at the PNEI in the Gauteng Province in South Africa to implement the Transformative Practice Development Program intervention activities that will take place over a period of six months. This participant information leaflet contains information that will help you understand your role in the study. If there is any need for further clarification, please feel free to contact the researcher, Queen Khanyisile Masimula at any time.

2) THE NATURE AND PURPOSE OF THIS STUDY

Improving the workplace culture towards person centredness is important for human flourishing of all academic staff members through transformative processes of Transformative Practice Development Program research. You as the academic staff member working in PNEI

in South Africa will assist to transform the workplace culture of the PNEI by facilitating the implementation of the Transformative Practice Development Program activities while executing your normal daily duties.

The aim of the study will be to transform the workplace culture of a PNEI in South Africa towards person centredness.

3) EXPLANATION OF PROCEDURES TO BE FOLLOWED

The researcher is requesting you to participate as a facilitator in the PNEI during the transformative process of moving towards a person centred workplace culture to achieve student nurse, nurse educator and organisational outcomes.

The researcher together with nurse education experts will meet with all facilitators for the first time for a period of three hours to discuss the procedures and preparations of the study. The transformative practice development program facilitators will employ the collaborative principles collaboratively with the researcher to implement a participative transformative practice development program at the PNEI under study on different communication avenues. The objective is to ensure that all facilitators will be continuously informed of the plans, activities procedures and results.

Transformative practice development program assessment, planning, implementation and evaluation of the whole processes for six months will be done collaboratively and documented.

You will be trained to become a practice development facilitator to be empowered on how to execute your facilitation roles and responsibilities for the duration of six months. Your role and functions will be negotiated with you as I need your help to do the research. The researcher will agree with facilitators' team on the meeting platforms and dates for support and feedback, but preferably every 4 weeks towards transforming the workplace culture.

In every scheduled meeting every four weeks you will be expected to evaluate the outcomes experienced from implementation of the transformative practice development program intervention activities and processes. You will be guided and coached on how to feedback your findings during the four-weekly meetings. The transformative practice development program intervention activities will be collaboratively structured as outlined below in a participative decision making process.

Transformative practice development program implementation of intervention processes

- Introduction and overview of the transformative practice development program implementation for person-centredness
- First session for three hours workshop for managers on overview of transformative practice development program facilitation processes
- Overview of the transformative practice development program for six months
- Clarify and explain the transformative practice development program research, person centredness and workplace culture
- Values clarification

Transformative Practice Development Program implementation of intervention processes

- Management reflecting on their workplace culture of the PNEI
- Developing a transformational culture of workplace changes

Transformative Practice Development Program implementation of intervention processes

- PNEI Managers roles and responsibilities in supporting transformative practice development program activities and facilitators
- Second session for three hours workshop for facilitators to clarify, develop and compile their role and responsibilities regarding facilitation skills
- Overview of the transformative practice development program research programme for six months
- Clarify and explaining transformative practice development program, person centeredness and workplace culture
- Clarification of values for the facilitator
- Facilitators reflecting on their workplace culture of the PNEI
- Facilitation skills and empowerment
- Roles and responsibilities as a facilitator
- Values and beliefs of Academic staff members
- Using CIP principles towards development of a shared vision
- Visiting phase 1 assessment outcomes as an introduction towards measuring and evaluating claims, concerns and issues.
- Facilitators collaboratively get started by establishing through measuring and evaluating where the PNEI is currently standing in terms of a workplace culture of person centredness experiences and phase 1 assessment outcomes.
- The researcher and facilitators collaboratively engage in the development of practice development plan

• Establish the transformative practice development program for six months – plan, act, evaluate and learn from self and others • Give feedback on data collected; make collaborative analysis using pocket diaries, reflective notes of field experiences for six months. • Conduct self-reflection sessions and share, make data analysis and code themes of practice development during meetings.
Third session for three hours workshop to finalize the programme according to the time preference of the facilitators • To emphasize continuous development of facilitation skills and team empowerment • Facilitators continuous team spirit and reflection on further planning as necessary and applicable

4) RISK AND DISCOMFORT INVOLVED.

There is no discomfort involved in participating in the study as a practice development facilitator. There is however a risk of being facilitator identification during facilitators meetings for feedback and support, meaning, your identity as a practice development facilitator will be known to the other participants in the study. However your identity as a practice development facilitator will be kept strictly confidential during sharing and dissemination of the research results. Your input as a facilitator in the transformative practice development program implementation will require some of your time and effort for a period of six months.

5) POSSIBLE BENEFITS OF THIS STUDY.

Possible benefits of the study will include a transformed workplace culture, participatory decision making leadership, employment of a facilitated and coordinated top-down and "bottom-up" participatory leadership approach, enhanced teamwork, improved working relations with respect and improved colleague morale. It may enhance compliance to participative policy mandates and improve student outcomes.

You will be developed as a practice development facilitator that could enable you to be a positive change agent in.

6) YOUR RIGHTS AS A PARTICIPANT

Your participation in this study is entirely voluntary. You can refuse to participate or stop at any time during the study without giving any reason or penalty.

7) ETHICAL APPROVAL

The Faculty of Health Sciences' Research Ethics Committee at the University of Pretoria and your Nursing Education Institution has given written approval for this study. A copy of the Declaration may be obtained from the investigator should you wish to review it.

Please feel free to contact the Research Ethics Committee, if you need any clarification pertaining to ethical approval.
Faculty of Health Sciences University of Pretoria's Office:
Tel: 012 354 1330 or 012 354 1367
Fax: 012 354 1367

8) INFORMATION

If you have any questions about your participation in this study, you should contact the researcher, Mrs Queen Khanyisile Masimula
Cell phone: 072 204 6903
Email address: queenmasimula@yahoo.com
Alternatively you may contact her supervisors:
Dr A. vanderWath: 084 506 3142 and Prof I. Coetzee: 071 158 9045

9) CONFIDENTIALITY

Your input into this research will be kept confidential. Results will be published and presented in such a manner that you as a facilitator will strictly remain anonymous during all dissemination of research findings and reports.

10) COMPENSATION

Your participation is voluntary. No compensation will be given for your participation.

11) CONSENT TO PARTICIPATE IN THIS STUDY: INFORMED CONSENT

I confirm that the person asking my consent to take part in this study has told me about nature, process, risks, discomforts and benefits of the study. I have also received, read and understood the above written information (Information Leaflet and Informed Consent) regarding the study. I am aware that the results of the study, including personal details, will be anonymously processed into research reports. I am participating willingly. I have had time to ask questions and have no objection to participate in the study. I understand that there is no penalty should I wish to discontinue with the study and my withdrawal will not affect me in any way. I hereby volunteer to take part in this research.

I have received a signed copy of this informed consent agreement.

Participant's name: ……..... (Please print)

Participant's signature: .....…… Date.....

Investigator's name .....……...(Please print)

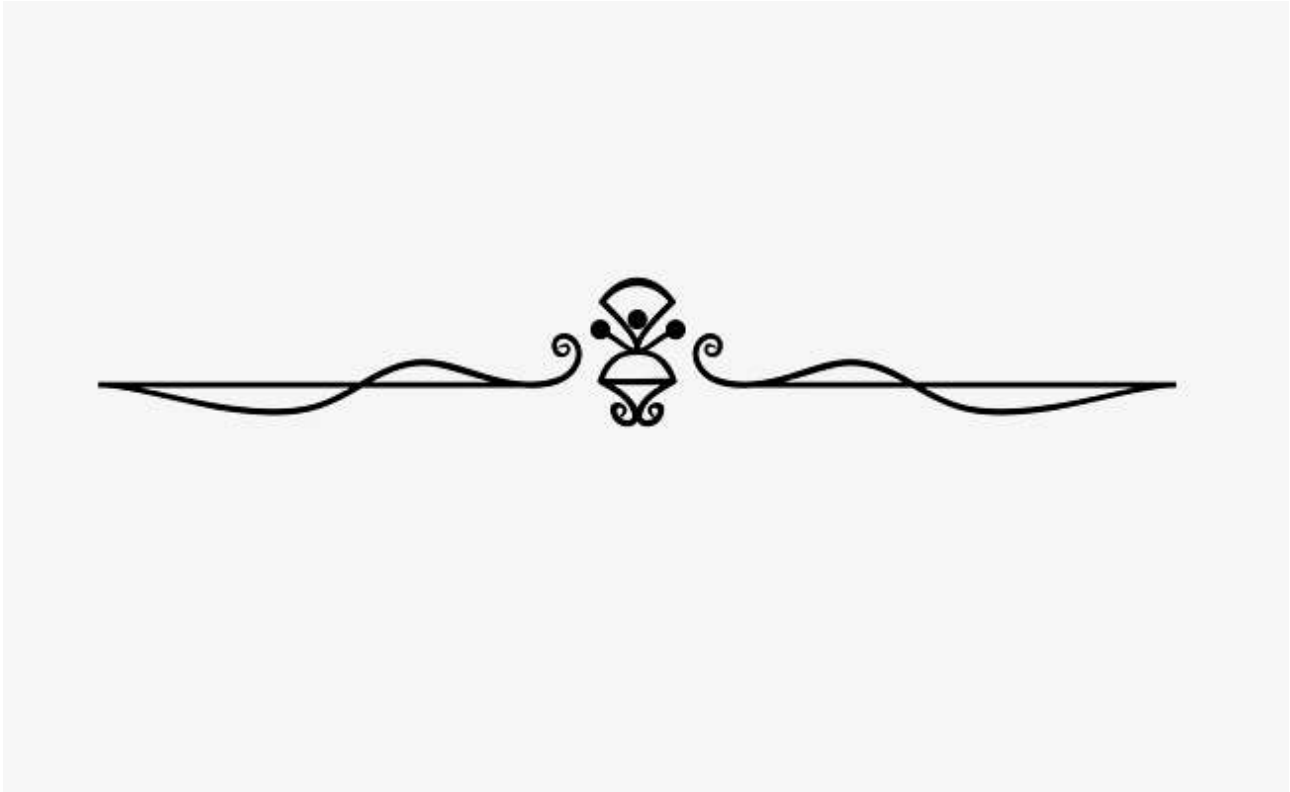
Investigator's signature .....…… Date.….....

Witness's Name .....……..... .(Please print)

Witness's signature .....…….. Date.….....

ANNEXURE D4

PARTICIPANT INFORMATION AND CONSENT DOCUMENT FOR MANAGERS



Queen Khanyisile Masimula

ANNEXURE D4: PARTICIPANT INFORMATION AND CONSENT DOCUMENT FOR MANAGERS

PARTICIPANT'S INFORMATION & CONSENT DOCUMENT FOR MANAGERS

STUDY TITLE:

TRANSFORMING WORKPLACE CULTURE TOWARDS PERSON CENTREDNESS IN A NURSING EDUCATION INSTITUTION

Principal Investigators: Queen Khanyisile Masimula

Institution: University of Pretoria

DAYTIME AND AFTER HOURS TELEPHONE NUMBER(S):

Day time numbers: 072 204 6903

Afterhours: 072 204 6903

DATE AND TIME OF INFORMED CONSENT DISCUSSION:

				:
Date	**Month**	**Year**		**Time**

Dear Participant Manager / HOD

Dear Mr. / Mrs. _____ date of consent management meeting _____./_____./_____

1) INTRODUCTION

You have volunteered to participate as a Transformative Practice Development program Facilitator at the PNEI in South Africa to implement the TPD program intervention activities that will take place over a period of six months. This participant information leaflet contains information that will help you understand your role in the study. If there is any need for further clarification, please feel free to contact the researcher, Queen Khanyisile Masimula at any time.

2) THE NATURE AND PURPOSE OF THIS STUDY

Improving the workplace culture towards person centredness is important for human flourishing of all academic staff members through transformative processes of TPD research. You as the academic staff member working in PNEI in South Africa you will assist to transform

the workplace culture of the PNEI by sharing your experiences and making contributions through participation. You will work with the researcher collaboratively towards transforming the workplace culture in the PNEI for a person-centred workplace culture in a consensus meeting. The aim of the study will be to transform the workplace culture of a PNEI in South Africa towards person centredness. This means that I will be conducting research together with you during the implementation of TPDP intervention in a consensus meeting of transforming the workplace culture

3) EXPLANATION OF PROCEDURES TO BE FOLLOWED

You as a Manager and or Head of Department in the PNEI are requested to participate in a management consensus meeting for the managers group regarding the above mentioned objective. The management group will be used to gather information to help achieve the aim of the study. The management consensus management meeting data collection will take approximately three hours. The interview will be audio recorded and transcribed after the management consensus meeting group.

4) RISK AND DISCOMFORT INVOLVED.

There is a risk involved in this study that your identity will be identified in the management consensus meeting with your group members. However, your identity as a participant will be kept confidential during dissemination and sharing of findings and reports. Your input into this project will also require some of your time and effort in your busy schedule.

5) POSSIBLE BENEFITS OF THIS STUDY.

Possible benefits of the study will include a transformed workplace culture, improved attitudes, participatory decision making leadership, employment of a facilitated and coordinated top-down and “bottom-up” participative leadership approach, enhanced teamwork, improved working relations with respect and improved colleague morale. It will enhance compliance to participative policy mandates and improve student outcomes.

6) YOUR RIGHTS AS A PARTICIPANT

Your participation in this study is entirely voluntary. You can refuse to participate or stop at any time during the study without giving any reason or penalty.

7) ETHICAL APPROVAL

The Faculty of Health Sciences' Research Ethics Committee at the University of Pretoria and your Nursing Education Institution has given written approval for this study. A copy of the Declaration may be obtained from the investigator should you wish to review it.

Please feel free to contact the Research Ethics Committee, if you need any clarification pertaining to ethical approval.

Faculty of Health Sciences University of Pretoria's Office:

Tel: 012 354 1330 or 012 354 1367

Fax: 012 354 1367

8) INFORMATION

If you have any questions about your participation in this study, you should contact the researcher, Mrs Queen Khanyisile Masimula, Cell phone: 072 204 6093

Email address: queenmasimula@yahoo.com

Alternatively, you may contact my supervisors: Dr A. van der Wath: 084 506 3142 and Prof I. Coetzee: 071 158 9045

9) CONFIDENTIALITY

Your input into this research will be kept confidential. Results will be published and presented in such a manner that you as a participant will remain anonymous.

10) CONSENT TO PARTICIPATE IN THIS STUDY: INFORMED CONSENT

I confirm that the person asking my consent to take part in this study has told me about nature, process, risks, discomforts and benefits of the study. I have also received, read and understood the above written information (Information Leaflet and Informed Consent) regarding the study. I am aware that the results of the study, including personal details, will be anonymously processed into research reports. I am participating willingly. I have had time to ask questions and have no objection to participate in the study. I understand that there is no penalty should I wish to discontinue with the study and my withdrawal will not affect me in any way. I hereby volunteer to take part in this research.

I have received a signed copy of this informed consent agreement.

Participant's name: ……..... (Please print)

Participant's signature: .....…… Date.....

Investigator's name .....……...(Please print)

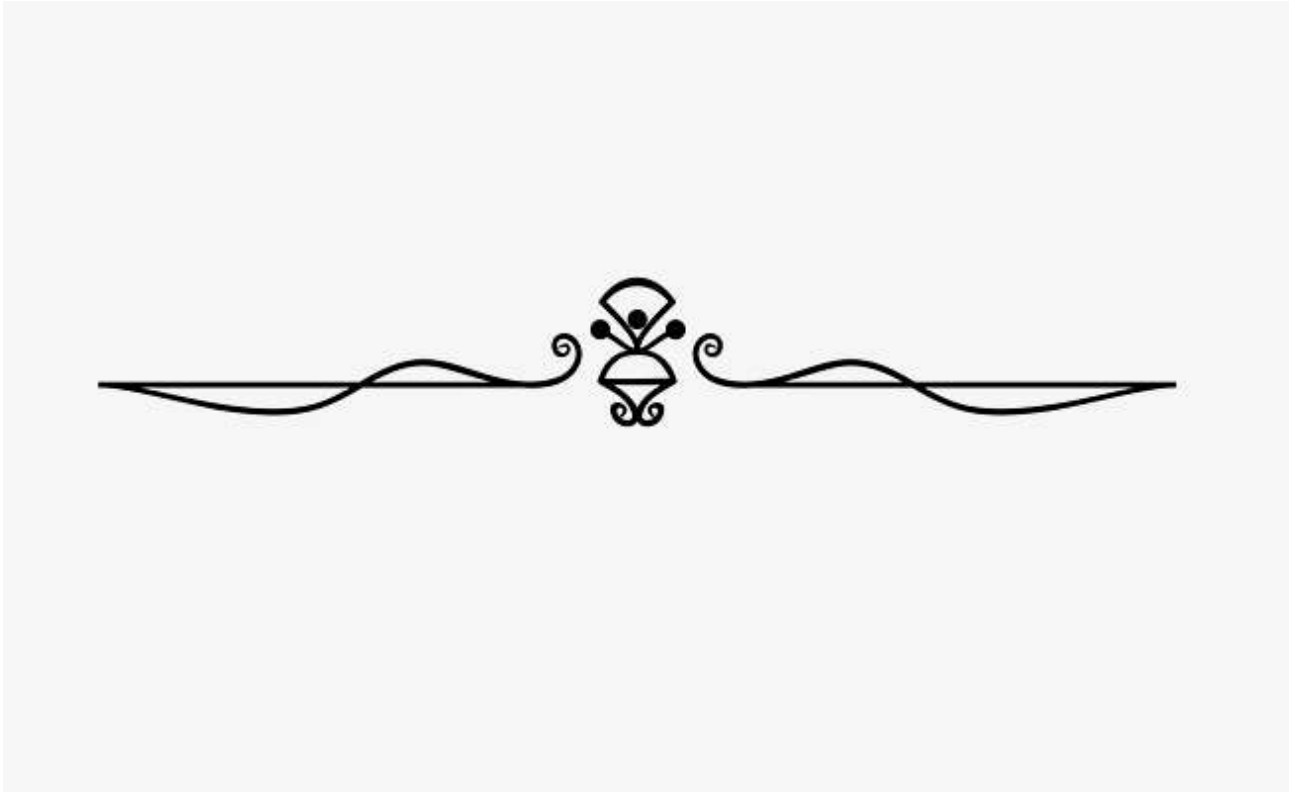
Investigator's signature .....…… Date….....

Witness's Name .....……..... .(Please print)

Witness's signature .....……... Date.….....

ANNEXURE D5

TRANSFORMATIVE PROGRAM DEVELOPMENT PROGRAMME PROCESSES



Queen Khanyisile Masimula

ANNEXURE D5: TRANSFORMATIVE PROGRAM DEVELOPMENT PROGRAMME PROCESSES

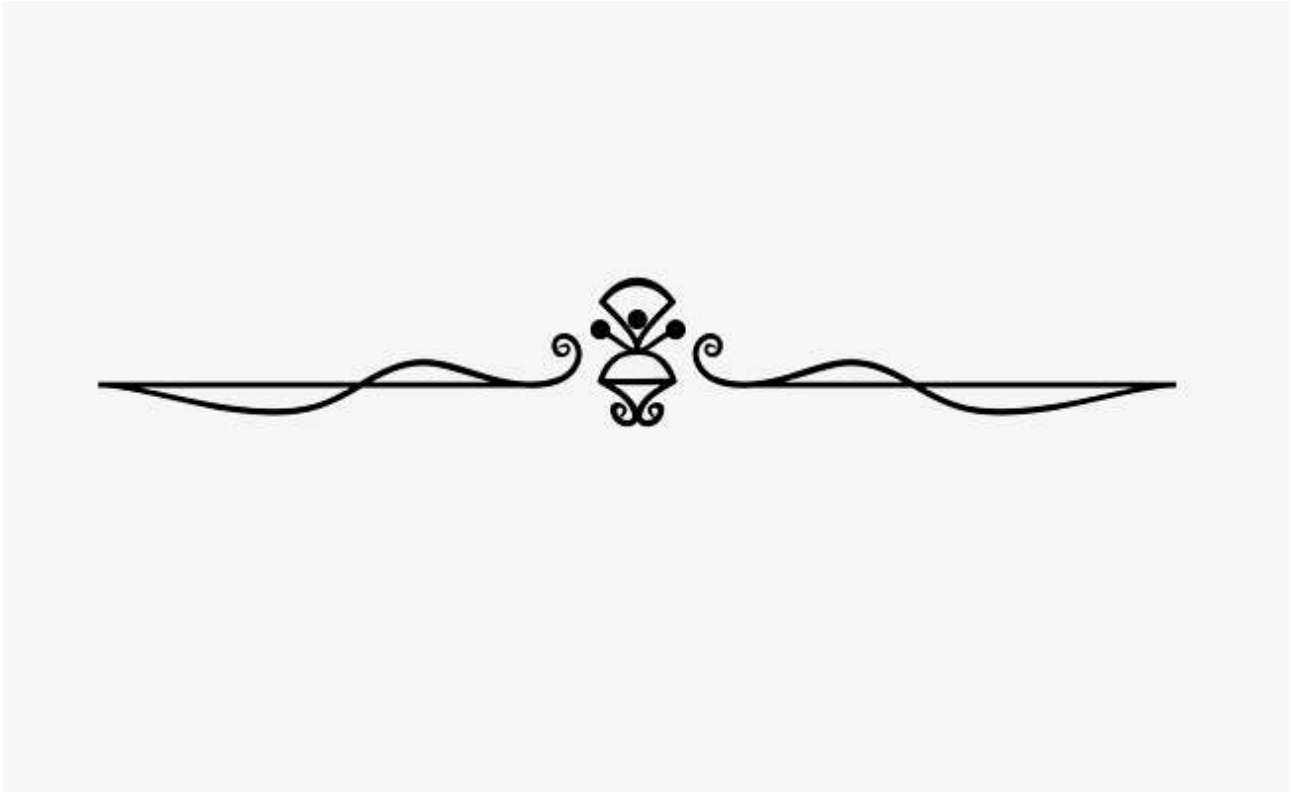
Summary of transformative practice development program implementation of intervention activities and processes

- Introduction and overview of the transformative practice development program implementation for person-centredness
- First session for three hours workshop for managers on overview of transformative practice development program facilitation processes
- Overview of the transformative practice development program for six months
- Clarify and explain the transformative practice development program research, person-centredness and workplace culture
- Values and beliefs clarification
- Management reflecting on their workplace culture of the PNEI
- Developing a transformational culture of workplace changes
- PNEI Managers roles and responsibilities in supporting transformative practice development program activities and facilitators
- Second session for three hours workshop for facilitators to clarify, develop and compile their role and responsibilities regarding PDF facilitation skills
- Overview of the transformative practice development program for six months
- Clarify and explaining transformative practice development program, person-centredness and workplace culture
- Clarification of values for the facilitators
- Facilitators reflecting on their workplace culture of the PNEI
- Facilitation skills and empowerment
- Roles and responsibilities as a facilitator
- Values and beliefs of Academic staff members
- Using CIP principles towards development of a shared vision
- Utilising phase 1 assessment outcomes as an introduction towards measuring and evaluating claims, concerns and issues.
- Facilitators collaboratively get started by establishing through measuring and evaluating where the PNEI is currently standing in terms of a workplace culture of person centredness experiences and phase 1 assessment outcomes.
- The researcher and facilitators collaboratively engage in the development of practice development plan

- Establish the transformative practice development program for six months – plan, act, evaluate and learn from self and others
- Give feedback on data collected; make collaborative analysis using pocket diaries, reflective notes of field experiences for six months.
- Conduct self-reflection sessions and share, make data analysis and code themes of person-centredness during meetings.

ANNEXURE E1

PROPOSAL PRESENTATION



Queen Khanyisile Masimula

ANNEXURE E1: DECLARATION FROM EDITOR

Cell/Mobile: 073-782-3923

53 Glover Avenue
Doringkloof
0157 Centurion

26 November 2021

TO WHOM IT MAY CONCERN

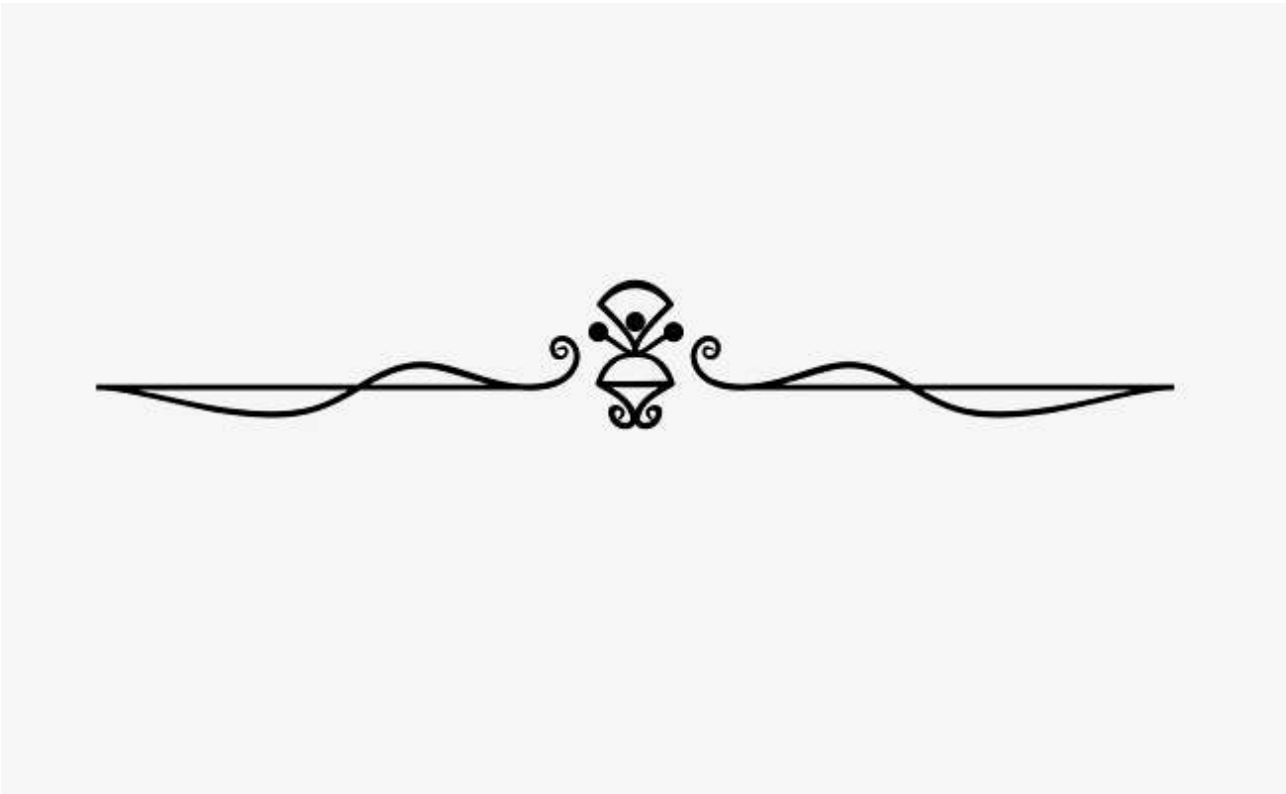
I hereby certify that I have edited Queen Masimula's doctoral dissertation, **Transforming the workplace culture of a selected public nursing education institution (PNEI) in South Africa towards person centredness**, for language and content.

IM Cooper

Iauma M Cooper
192-290-4

ANNEXURE E2

DECLARATION FROM STATISTICIAN



Queen Khanyisile Masimula

ANNEXURE E2: DECLARATION FROM STATISTICIAN

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA
Denkleiers • Leading Minds • Dikgopolo tša Dihlalefi

DEPARTMENT OF STATISTICS

LETTER OF STATISTICAL SUPPORT

Date: 26 March 2019

This letter is to confirm that **Ms QK Masimula**, studying at the University of Pretoria, discussed the project with the title "**Transforming workplace culture towards person centredness in a nursing education institution in South Africa**" with me.

I hereby confirm that I am aware of the project and undertake to assist with the statistical analysis of the data generated from the project.

The researcher is an employee at one of the six Public Nursing Education Institutions in Gauteng Province and she will ask permission from this PNEI to involve its academic staff members in the study. All the academic staff members employed at this PNEI will be contacted and requested to participate in Phase 1 and Phase 3 of the study. Participation will be strictly voluntary. Currently, the PNEI has approximately 91 academic staff members.

The data analysis will consist of frequencies and descriptive statistics such as means and standard deviations. Cronbach alphas will be computed to assess the internal reliability of the scales. Composite scores will be calculated for scales. If the data come from a normal distribution, ANOVAs will be performed to compare the mean scores across demographic variables. If not, non-parametric tests can be applied to compare the scores across the demographic variables.

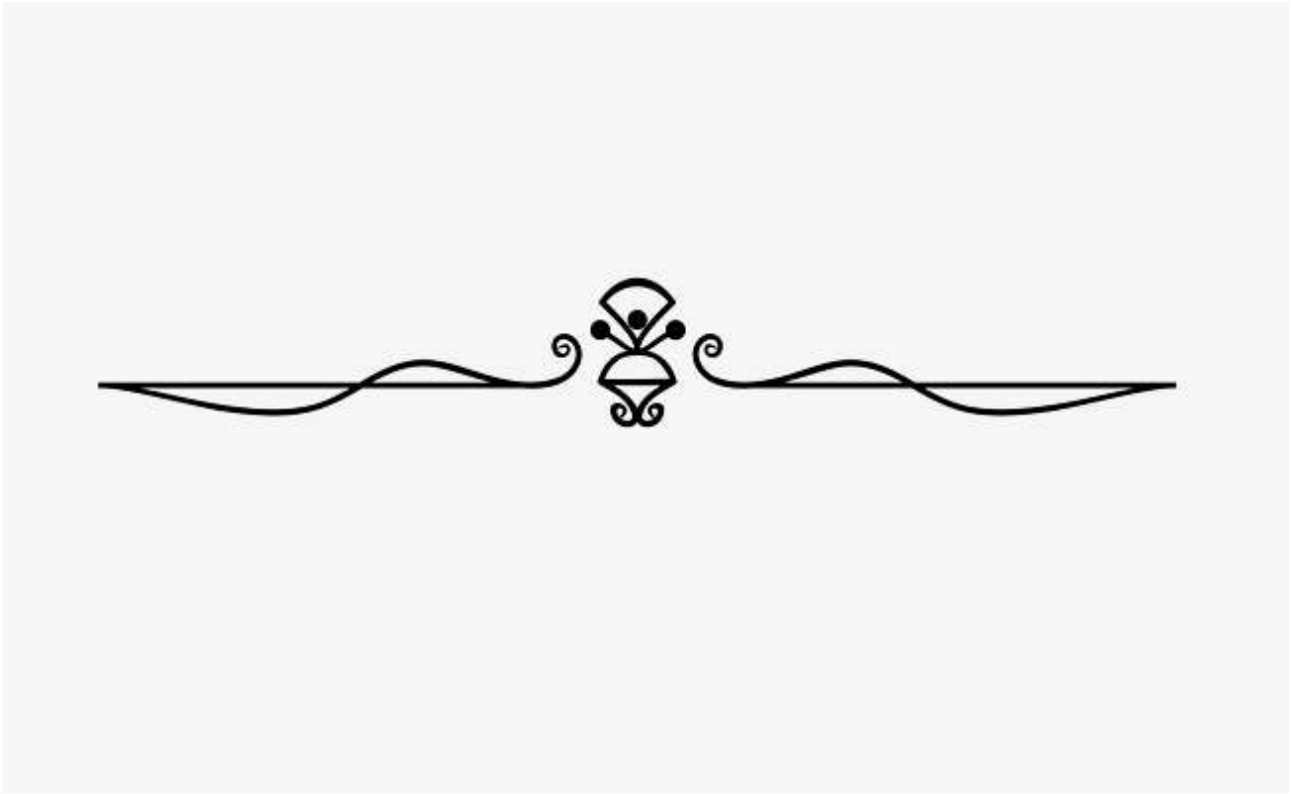
J C Jordaan

Ms JC Jordaan
Research consultant
Internal Statistical Consultation Service
Department of Statistics
E-mail address: joyce.jordaan@up.ac.za

ANNEXURE F1

ARTICLE 1

NURSE EDUCATION IN PRACTICE



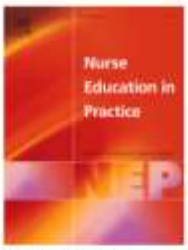
Queen Khanyisile Masimula

ANNEXURE F1: ARTICLE 1 NURSE EDUCATION IN PRACTICE

NURSE EDUCATION IN PRACTICE

AUTHOR INFORMATION PACK

TABLE OF CONTENTS



ISSN: 1471-5953

DESCRIPTION

Nurse Education in Practice aims to publish leading international research and scholarship on the practice of nurse and midwifery related education. The remit of the journal, therefore, spans education and clinical practice. We publish empirical studies and systematic reviews with a view to contributing to the evidence base of nurse and midwifery education in practice.

Nurse Education in Practice is a peer reviewed journal which promotes diversity in terms of country, culture, sexual orientation and lifestyle. Submissions to the journal should be theoretically based, methodologically sound and of interest to an international readership. We promote open science and encourage the pre-printing of manuscripts, registration of studies and sharing of data.

IMPACT FACTOR

2020: 2.281 © Clarivate Analytics Journal Citation Reports 2021

ABSTRACTING AND INDEXING

Scopus
EMCARE
PubMed/Medline
PubMed/Medline
CINAHL
Science Citation Index Expanded
Journal Citation Reports - Science Edition
Social Sciences Citation Index
Social Sciences Citation Index
Current Contents - Clinical Medicine
Current Contents - Social & Behavioral Sciences

EDITORIAL BOARD

Editor-in-Chief

Roger Watson, University of Hull, Hull, United Kingdom

GUIDE FOR AUTHORS

INTRODUCTION

Nurse Education in Practice (YNEPR) provides an international forum for research and scholarship on the practice of **nurse and midwifery related education**. *YNEPR* aims to support evidence informed policy and practice by publishing research, systematic reviews, critical discussion, and commentary of the highest standard. Studies should address issues of international interest and concern and present the study in the context of the existing international research base on the topic. Studies that focus on a single country should identify how the material presented might be relevant to a wider audience and how it contributes to the international knowledge base.

Types of papers and word limits

YNEPR publishes original research, reviews, and discussion papers.

Research Papers - 5,000 words

YNEPR publishes original research that matches the aims and scope of the journal. Research papers should adhere to recognised standards for reporting (see guidance below and the Author Checklist). Instrument development or validation papers are only considered if accompanied by a copy of the full instrument, included as a supplementary file at submission stage so it can be published as an appendix online if accepted.

Reviews and Discussion Papers - 6,000 words

We publish systematic reviews (addressing focused research questions) and broader literature reviews (such as scoping reviews). We also publish discussion papers, which are scholarly articles of a debating or discursive nature. In all cases, there must be engagement with and critical analysis of a substantive body of research or other scholarship. Systematic reviews should adhere to recognised standards for reporting (see guidance below and the Author Checklist). We welcome papers that introduce or elaborate on novel or under used methods or approaches to analysis with substantial significance for the discipline. Such papers can be submitted as a review or discussion paper as appropriate and should represent significant advances and / or be authoritative accounts of the 'state of the art'.

Letters to the editor - up to 1000 words

Designed to stimulate academic debate and discussion, the Editor invites readers to submit letters that refer to and comment on recent content in the journal, introduce new comment and discussion of clear and direct relevance to the journal's aims and scope.

Editorials

All editorials are commissioned, and we do not invite submissions under this category. Editorials in YNEPR are not reviewed and are published at the discretion of the Editor-in-Chief

General guidance and preferred article types

Selection of papers for publication is based on their scientific excellence, distinctive contribution to knowledge (including methodological development) and their importance to contemporary nursing and midwifery education.

We are unlikely to publish studies of new instruments unless the instrument is useful for directly guiding clinical practice (e.g. diagnostic/ screening instruments) and there is validation against a robust criterion. Preliminary instrument development studies indicating the need for further development, translations from one language to another and other pilot studies are unlikely to be accepted. We do not publish studies undertaken on animals.

Submission system

Submission to this journal is online here.

Elsevier Researcher Academy

Researcher Academy is a free e-learning platform designed to support early and mid-career researchers throughout their research journey. The "Learn" environment at Researcher Academy offers several interactive modules, webinars, downloadable guides and resources to guide you through the process of writing for research and going through peer review. Feel free to use these free resources to improve your submission and navigate the publication process with ease.

BEFORE YOU BEGIN

Ethics in publishing

YNEPR is a supporter of the Recommendations for the Conduct, Reporting, Editing and Publication of Scholarly Work in Medical Journals, issued by the International Committee for Medical Journal Editors (ICMJE), and to the Committee on Publication Ethics (COPE) code of conduct for editors. Our guidelines should be read in conjunction with this broader guidance. The ICJME requirements can be found here and the COPE's guidelines here.

The work to be described in your article must have been carried out in accordance with The Code of Ethics of the World Medical Association for experiments involving humans (Declaration of Helsinki) and research on health databases (Declaration of Taipei). Further information on Ethics in Publishing and Ethical guidelines for journal publication can be found here.

Reporting guidelines

The editors require that manuscripts adhere to recognized reporting guidelines relevant to the research design used and require authors to submit a checklist verifying that essential elements have been reported for all primary research and systematic reviews. We suggest that you consult the guidelines at an early stage of preparing your manuscript. You can search for the correct guideline for your study using the tools provided by the EQUATOR Network. The guideline used must be indicated in the journal's Author Checklist, which is to be submitted with every paper.

Study Registration

We strongly encourage the prospective registration of studies and suggest that authors use either the Open Science Framework or the Center for Open Science.

Informed consent and ethical approval

Informed consent must be sought from participants who are able to give it and this should be documented in the paper. Where informed consent is not obtained, consistent with recognised ethical principles and local legal frameworks this must also be documented in your paper. Ethical approval must be stated at an appropriate point in the article. The approving body and approval number should be identified in the manuscript. If the study was exempt from such approval the basis of such exemption and the regulatory framework must be described.

Participant details

The personal details of any participants included in any part of a study and in any supplementary materials (including all illustrations and videos) must be removed before submission. Where an author wishes to include case details or other personal information or images of participants or any other individuals in an Elsevier publication, appropriate consents, permissions, and releases must be obtained by the author. Written consents must be retained by the author, but copies should not be provided to the journal unless specifically requested. More information, please review the Elsevier Policy on the Use of Images or Personal Information of Patients or other Individuals can be found here.

Copyright

If excerpts from other copyrighted works are to be included, the author(s) must obtain written permission from the copyright owners and credit the source(s) in the article. This includes permission to translate scales where a third party holds the copyright.

Multiple, redundant or concurrent publication

Submission of an article implies that the work described has not been published previously (except in the form of an abstract), a published lecture or academic thesis that it is not under consideration for publication elsewhere, and that, if accepted, it will not be published elsewhere in the same form, in English or in any other language, including electronically without the written consent of the copyright holder. To aid editorial decisions about distinctiveness and to avoid redundant or duplicate publication, we ask that you provide full references of any publications drawing on the same data in the journal's Author Checklist. If the sources are not readily available, please upload a copy of the manuscript as supplementary material for editors to consider. If other publications are under review or in preparation this should be mentioned in your letter to the Editor. If the sources are not readily available, please upload a copy of the manuscript as supplementary material for editors to consider.

Relevant results from the wider study must be referred to in the paper and the relationship between this and other publications from the same study must be made clear. It is not sufficient to simply cite a prior publication, rather text must clearly state that results are from the same study.

Preprints
Preprints can be shared anywhere at any time, in line with Elsevier's sharing policy. Sharing your preprints e.g. on a preprint server will not count as prior publication (see 'Multiple, redundant or concurrent publication' for more information).

Authorship, contributors and acknowledgements
All authors should have made substantial contributions to all the following: (1) the conception and design of the study, or acquisition of data, or analysis and interpretation of data; (2) drafting the article or revising You will be asked to confirm this on submission critically for important intellectual content; and (3) final approval of the version to be submitted. Everyone who meets these criteria should be listed as an author. You will be asked to confirm this on submission. And please list these contributions-using initials only-at the end of the manuscript. Other individuals who made substantial contributions (e.g., collecting data, providing language help, writing assistance, or proofreading the article, etc.) should not be listed as authors but should be acknowledged in the paper. Those who meet some but not all the criteria for authors can be identified as 'contributors' at the end of the manuscript with their contribution specified. For papers with ten or more authors, we ask that you give a collective name for the research group (e.g. ATLAS Research Group) to appear at the front of the article and list all authors at the end of the paper.
For transparency, we encourage authors to submit an author statement file outlining their individual contributions to the paper using the relevant CRediT roles: Conceptualization; Data curation; Formal analysis; Funding acquisition; Investigation; Methodology; Project administration; Resources; Software; Supervision; Validation; Visualization; Roles/Writing - original draft; Writing - review & editing. Authorship statements should be formatted with the names of authors first and CRediT role(s) following (more details and an example).

Changes to authorship
Authors are expected to consider carefully the list and order of authors **before** submitting their manuscript and provide the definitive list of authors at the time of the original submission. It is important that all authors agree this. Any addition, deletion or rearrangement of author names in the authorship list should be made only **before** the manuscript has been accepted and only if approved by the journal Editor. To request such a change, the Editor will require from the **corresponding author**: (a) the reason for the change in author list; and (b) written confirmation (e-mail, letter) from all authors that they agree with the change. In the case of addition or removal of authors, this includes confirmation from the author being added or removed.

Conflict of interest
All authors must disclose any financial and personal relationships with other people or organizations that could influence their work. Potential conflicts of interest do not necessarily preclude publication and authors are advised to err on the side of transparency and openness in declaring any relevant relationships. Examples of potential conflicts of interest include employment, consultancies, stock ownership, honoraria, paid expert testimony, patent applications/registrations, and grants or other funding. Details must be included at the end of your manuscript and in a file that must be uploaded on submission. We recommend you use the ICMJE standard form to help you prepare this declaration. If there are no conflicts of interest. then please state this: 'Conflicts of interest: none'. More information can be found here.

Role of the funding source
You are requested to identify who provided financial support for the conduct of the research and/or preparation of the article and to briefly describe the role of the sponsor(s), if any, in study design; in the collection, analysis and interpretation of data; in the writing of the report; and in the decision to submit the article for publication. If the funding source(s) had no such involvement, then this should be stated. If you received no external funding (i.e. other than your main employer) please state 'no external funding'. More information can be found here.

PREPARATION

Documents required for submission (overview).
Author Checklist - a brief checklist to ensure that you have provided all essential information. The Author Checklist is available as a word file.
Declaration of interests statement - detailing any actual or potential competing interests that could have appeared to influence the work reported in this paper. Please complete and upload the Declaration of Interest template is available as a word file.

Title page (with author details) - This should include the title, authors' names and affiliations, and a complete address for the corresponding author including telephone and e-mail address. Twitter handles for one, or all, authors may also be included on the Title Page if they wish for these to be published. A template word file to help guide you is available.
Blinded manuscript (no author details) - The main body of the paper including where relevant the abstract, contribution statements, references, figures, tables and any acknowledgements. This should not include any identifying information, such as the authors' names or affiliations. Please ensure that the manuscript includes page numbers for ease of reference during the review process. A template word file to help guide you is available.
Use of word processing software Regardless of the file format of the original submission, at revision you must provide us with an editable file of the entire article. Keep the layout of the text as simple as possible. Most formatting codes will be removed and replaced on processing the article. The electronic text should be prepared in a way very similar to that of conventional manuscripts (see also the Guide to Publishing with Elsevier). See also the section on Electronic artwork.
To avoid unnecessary errors, you are strongly advised to use the 'spell-check' and 'grammar-check' functions of your word processor.
Covering letter - to the Editor (optional) in which you address any matters you may wish the editors to consider (for example requests for exceptions to policy or the relationship of this work to other studies, elaboration on potential conflicts of interest). *Additionally, the following are required for all full papers (excluding letters and editorials)*
Reporting guideline checklist - Additional reporting guidelines checklist for the relevant research design. For discussion papers and non-systematic reviews, where no checklist applies, upload a file with 'reporting guideline not applicable'.

Title page

The title page should include the following. It will not be seen by reviewers. Title. The title should be concise and informative. The journal requires titles for research and review papers to be in the format Topic (or question): method (e.g. Nurse staffing in intensive care units: a systematic review). The country in which the study was conducted should not normally be named in the title unless it is an essential element (for example a national survey). **Author names**. Please clearly indicate the given name(s) and family name(s) of each author and check that all names are accurately spelled. You can add your name between parentheses in your own script behind the English transliteration.
Affiliations. Give the authors' affiliation addresses (where the actual work was done) below the names. Indicate all affiliations with a lower-case superscript letter immediately after the author's name and in front of the appropriate address. Provide the full postal address of each affiliation, including the country name and the e-mail address of each author. **Corresponding author**. Clearly indicate who will handle correspondence at all stages of refereeing and publication. This responsibility includes answering queries about the research that may arise after publication. **Present/permanent address**. If an author has moved since the work described in the article was done, or was visiting at the time, a 'Present address' (or 'Permanent address') may be indicated as a footnote to that author's name. The address at which the author actually did the work must be retained as the main affiliation address. Use superscript Arabic numerals for such footnotes.

Blinded manuscript

It is the authors' responsibility to ensure that the manuscript file contains no details that readily identify them to prospective reviewers. However, we recognise that on occasion essential information or the nature of the work itself may make it impossible to guarantee anonymity to authors. Authors may exercise discretion in relation to redacting details of prior research. Authors who reveal their identity in the manuscript will be deemed to have declined anonymity and the review will be single blind (i.e. authors do not know reviewers' identities). You can choose to submit your manuscript as a single file to be used in the refereeing process. It should contain high enough quality figures for refereeing. If you prefer to do so, you may still provide all or some of the source files for tables and figures at the initial submission. Please note that individual figure files larger than 10 MB must be uploaded separately.
The blinded manuscript must include the following essential elements (except as noted above):

Abstract
All submissions (except letters and editorials) should include an abstract of 400 words or less. In general, the following detail is required: Aim; Background; Design; Methods; Results; and Conclusions, which should relate to study aims and hypotheses. Abstracts for Discussion Papers should provide a concise summary of the line of argument pursued and conclusions. When reporting

quantitative results in the abstract report parameter estimates and confidence intervals in preference to p-values (e.g. "risk of death was reduced [Odds ratio 0.9, 95% confidence interval 0.87-0.92]" rather than "risk of death was significantly reduced [p=0.001]").
Study registration details should be included in the title page and - if the manuscript is accepted - should be moved to the end of the abstract. Abstracts should not include references or abbreviations other than standard system international (SI) units. Abstracts of research papers must be structured and should adopt the headings suggested by the relevant reporting guidelines.

Tweetable abstract
Optionally authors may add a `tweetable abstract? to the end of the abstract as a final section. The tweetable abstract should be 280 characters or fewer (to allow people using it to add additional hashtags, links to the article and other twitter handles). Tweetable abstracts should provide the main conclusions or the key message of a paper in a way that is easily understood.

Keywords
Provide between four and ten key words that accurately identify the paper's subject, purpose, method and focus. Use the Medical Subject Headings (MeSH) or Cumulative Index to Nursing and Allied Health (CINAHL) headings where possible.
Give keywords in alphabetical order.

Main manuscript text
Up to 5000 words for original manuscripts and 6000 words for reviews and discussion papers.
Structure: The following structure should be followed: Abstract; Introduction; Methods; Results; Discussion; Conclusion should be used. Authors should consult the relevant reporting guidelines for their methods and complete the relevant checklist to ensure essential detail is included (see our Author Checklist and the Equator Network.
As part of the discussion, authors should describe limitations of the work. A sub-heading before the final conclusions is recommended.
Word limits: Full papers up to 5000 words for original manuscripts and 6000 words for reviews and discussion papers (excluding tables, figures, and references, letters up to 1000 words. Shorter papers are preferred.
Tables and figures: Up to five in total. The corresponding caption should be placed directly below the figure or table. Additional tables / figures (including large tables) can be included as supplementary material.
Ethical approval and informed consent: details must be given in the methods as specified above
Abbreviations: No abbreviations should be used other than as specified below in our general notes on style.

References
There are no strict requirements on reference formatting at submission. References can be in any style or format as long as the style is consistent, and references are complete and accurate. Where applicable, author(s) name(s), journal title/book title, chapter title/article title, year of publication, volume number/book chapter and the article number or pagination must be present.
Use of DOI is highly encouraged. The reference style used by the journal will be applied to the accepted article by Elsevier at the proof stage.

Revised submissions
At revision stage the following documentation is required: a separate **"Response to Reviewers"** file, which responds point by point to the reviewers' and editors' comments and highlights the changes made. **a revised blinded manuscript** with changes clearly highlighted. Unless revisions are minor do not simply use your word processor's 'track changes' - your aim is to help reviewers identify revised sections AND to read / review the revised manuscript.
If you provided low-resolution artwork for review, you should also add files suitable for publication at this stage (see below):

Style and specific requirements

Language (usage and editing services)
Please write your text in good English (American or British usage is accepted, but not a mixture of these). Authors who feel their English language manuscript may require editing to eliminate possible grammatical or spelling errors and to conform to correct scientific English may wish to use the English Language Editing service available from Elsevier's WebShop.

Use of inclusive language
Articles should make no assumptions about the beliefs or commitments of any reader, should contain nothing that might imply that one individual is superior to another on the grounds of ethnic background, sex, culture or any other characteristic, and should use inclusive language throughout. We ask authors to consider that the term 'race' is closely associated with ideologies of scientific racism and has no clearly defined scientific meaning.
We recognise that the recipients of healthcare are firstly people. In many cases, it is not appropriate to refer to them as "patients". For example, "people with diabetes" is preferable to "diabetes patients" although recipients of health care in general might be referred to as patients in some circumstances. Never refer to people as 'sufferers' or 'victims' of a condition.
Authors should ensure that writing is free from gender bias, for instance by using 'he or she', 'his/her' instead of 'she' or 'her', and by making use of job titles that are gender neutral (e.g. 'chairperson' instead of 'chairman' and 'flight attendant' instead of 'stewardess'). Nurse is a gender neutral term.

Abbreviations, acronyms and initialisms
YNEPR does not permit the use of abbreviations, acronyms and initialisms (abbreviations for brevity). We make a limited number of exceptions, but we do not allow the use of any abbreviations that are not widely recognised.
The limited exceptions include cases where the abbreviated form has near universal recognition (e.g. USA), statistical terms and tests (e.g. df, t, ANOVA) and instruments and products that are generally identified by their initials or an abbreviation (e.g. SF36, SPSS). For additional guidance, see the editorial policy/style on abbreviations, initialisms and acronyms.
Any abbreviations which the authors intend to use in the body of your paper should be written out in full, followed by the letters in brackets the first time they appear. Thereafter only the letters should be used. Please note that SPSS is the full name of the product, not an abbreviation. Abbreviations used in tables need to be fully defined at the foot of each table where the abbreviation is used.

Tables
Please submit tables as editable text and not as images. Tables can be placed next to the relevant text in the article. Number tables consecutively in accordance with their appearance in the text and place any table notes below the table body. Be sparing in the use of tables (maximum 5 tables and figures in the body text) and ensure that the data presented in them do not simply duplicate results described elsewhere in the article. Additional tables can be submitted as online supplemental material, but these must be referred to in the text (supplemental material table X etc.). Please avoid using vertical rules. Abbreviations used in tables need to be fully defined at the foot of each table where the abbreviation is used.

Footnotes
Do not use footnotes other than where abbreviations or other symbols have been used in a table, in which case the notes should be below the table, not the foot of the page.

Statistics
Standard methods of presenting statistical material should be used. Where methods used are not widely recognised explanation and full reference to widely accessible sources must be given. Identify the statistical package used (including version).
Wherever possible give both point estimates and 95% confidence intervals for all parameters estimated by the study (e.g. group differences, frequency of characteristics). Exact p values should be given to no more than three decimal places. Do not interpret non-significant results as evidence that there is no difference #/relationship. Please refer to the *International Journal of Nursing Studies* position paper on reporting statistical significance and p-values to which we adhere.

Citations and references
In text citations and reference lists will be reformatted to journal style if the article is accepted. The journal uses an author (date) citation style. Please ensure that every reference cited in the text is also present in the reference list (and vice versa). When copying references, please be careful as they may already contain errors. Use of the DOI is highly encouraged.
Unpublished results and personal communications are not to be included the reference list but may be mentioned in the text. Citation of a reference as 'in press' implies that the item has been accepted for publication.

Web references. As a minimum, the full URL should be given and the date when the reference was last accessed. Any further information, if known (DOI, author names, dates, reference to a source publication, etc.), should also be given. Web references can be listed separately (e.g., after the reference list) under a different heading if desired or can be included in the reference list.
Data references. This journal encourages you to cite underlying or relevant datasets in your manuscript by citing them in your text and including a data reference in your Reference List. Data references should include the following elements: author name(s), dataset title, data repository, (where available), year, and global persistent identifier. Add [dataset] immediately before the reference so we can properly identify it as a data reference. The [dataset] identifier will not appear in your published article.

Use of reference management software
We encourage the use of templates available in Mendeley Desktop and EndNote.
Using plug-ins to word processing packages, authors only need to select the appropriate journal template when preparing their article. The list of references and citations to these will be formatted according to the journal style.

Funding sources
List funding sources in this standard way to facilitate compliance to funder's requirements for example: "This work was supported by the National Institutes of Health [grant numbers xxxx, yyyy]; the Bill and Melinda Gates Foundation, Seattle, WA [grant number zzzz]; and the United States Institutes of Peace [grant number aaaa]"
It is not necessary to include detailed descriptions on the program or type of grants and awards. When funding is from a block grant or other resources available to a university, college, or other research institution, submit the name of the institute or organization that provided the funding. If no funding has been provided for the research, please include the following sentence: "This research did not receive any specific grant from funding agencies in the public, commercial or not-for-profit sectors."

Supplementary material
Supplementary material such as applications, images and sound clips, can be published with your article to enhance it. Please submit your material together with the article and supply a concise, descriptive caption for each supplementary file. Submitted supplementary items are published exactly as they are received (Excel or PowerPoint files will appear as such online). If you wish to make changes to supplementary material during any stage of the process, please make sure to provide an updated file. Do not annotate any corrections on a previous version. Please switch off the 'Track Changes' option in Microsoft Office files.
For papers reporting the development of scales, measures, questionnaires or other instruments we will only publish if authors are willing and able to provide a copy of the scale in the original language and (where relevant) in English. Authors may retain copyright and if they wish to do so should include a copyright line. They can also give details on permissions and restrictions for use and/or add a creative commons license.
Where authors do not own the copyright, they are responsible for gaining permission from the copyright holder and giving full acknowledgement. This includes permission to translate scales where a third party holds the copyright.

Appendices
Normally there should be no appendices although in the case of papers reporting tool development or the use of novel questionnaires authors may include a copy of the tool as an appendix as an alternative to providing it as supplementary material if it is short.

Use of word processing software
Regardless of the file format of the original submission, at revision you must provide us with an editable file of the entire article. Keep the layout of the text as simple as possible. Most formatting codes will be removed and replaced on processing the article. The electronic text should be prepared in a way very similar to that of conventional manuscripts (see also the Guide to Publishing with Elsevier). See also the section on Electronic artwork. To avoid unnecessary errors, you are strongly advised to use the 'spell-check' and 'grammar-check' functions of your word processor.

Artwork
General points
Make sure you use uniform lettering and sizing of your original artwork. Preferred fonts: Arial (or Helvetica), Times New Roman (or Times), Symbol, Courier. Number the illustrations according to their sequence in the text. Use a logical naming convention for your artwork files. Indicate per figure if it is

a single, 1.5 or 2-column fitting image. For Word submissions only, you may still provide figures and their captions, and tables within a single file at the revision stage. Please note that individual figure files larger than 10 MB must be provided in separate source files.
Regardless of the application used, when your electronic artwork is finalized, please 'save as' or convert the images to one of the following formats (note the resolution requirements for line drawings, halftones, and line/halftone combinations given below): EPS (or PDF): Vector drawings. Embed the font or save the text as 'graphics'. TIFF (or JPG): Color or grayscale photographs (halftones): always use a minimum of 300 dpi. TIFF (or JPG): Bitmapped line drawings: use a minimum of 1000 dpi.
TIFF (or JPG): Combinations bitmapped line/half-tone (color or grayscale): a minimum of 500 dpi is required. A detailed guide on electronic artwork is available.

Figure captions
Ensure that each illustration has a caption. A caption should comprise a brief title (not on the figure itself) and a description of the illustration. Keep text in the illustrations themselves to a minimum but explain all symbols and abbreviations used.

Colour artwork
If, together with your accepted article, you submit usable colour figures then Elsevier will ensure, at no additional charge, that these figures will appear in colour online (e.g., ScienceDirect and other sites) regardless of whether or not these illustrations are reproduced in colour in the printed version. For colour reproduction in print, you will receive information regarding the costs from Elsevier after receipt of your accepted article. Please indicate your preference for colour: in print or online only.
Because of technical complications that can arise by converting colour figures to 'gray scale' (for the printed version should you not opt for colour in print) please submit in addition usable black and white versions of all the colour illustrations. For further information on the preparation of electronic artwork, please see here.

Illustration services
Elsevier's WebShop offers Illustration Services to authors preparing to submit a manuscript but concerned about the quality of the images accompanying their article. Elsevier's expert illustrators can produce scientific, technical and medical-style images, as well as a full range of charts, tables and graphs. Image 'polishing' is also available, where our illustrators take your image(s) and improve them to a professional standard. Please visit the website to find out more.

Data visualization
Include interactive data visualizations in your publication and let your readers interact and engage more closely with your research. Follow the instructions here to find out about available data visualization options and how to include them with your article.

Research data
This journal encourages and enables you to share data that supports your research publication where appropriate and enables you to interlink the data with your published articles. Research data refers to the results of observations or experimentation that validate research findings. To facilitate reproducibility and data reuse, this journal also encourages you to share your software, code, models, algorithms, protocols, methods and other useful materials related to the project. Below are several ways you can associate data with your article or make a statement about the availability of your data when submitting your manuscript. If you are sharing data in one of these ways, you are encouraged to cite the data in your manuscript and reference list. Please refer to the "References" section for more information about data citation. For more information on depositing, sharing and using research data and other relevant research materials, visit the research data page.

Mendeley Data
This journal supports Mendeley Data, enabling you to deposit any research data (including raw and processed data, video, code, software, algorithms, protocols, and methods) associated with your manuscript in a free-to-use, open access repository. During the submission process, after uploading your manuscript, you will have the opportunity to upload your relevant datasets directly to Mendeley Data. The datasets will be listed and directly accessible to readers next to your published article online. For more information, visit the Mendeley Data for journals page.

Data linking
If you have made your research data available in a data repository, you can link your article directly to the dataset. Elsevier collaborates with several repositories to link articles on ScienceDirect with relevant repositories, giving readers access to underlying data that gives them a better understanding of the research described.

There are different ways to link your datasets to your article. When available, you can directly link your dataset to your article by providing the relevant information in the submission system. For more information, visit the database linking page.
For supported data repositories a repository banner will automatically appear next to your published article on ScienceDirect.
In addition, you can link to relevant data or entities through identifiers within the text of your manuscript, using the following format: Database: xxxx (e.g., TAIR: AT1G01020; CCDC: 734053; PDB: 1XFN).

Data statement
To foster transparency, we encourage you to state the availability of your data in your submission. This may be a requirement of your funding body or institution. If your data is unavailable to access or unsuitable to post, you will have the opportunity to indicate why during the submission process, for example by stating that the research data is confidential. The statement will appear with your published article on ScienceDirect. For more information, visit the Data Statement page.

Submission and review

Our online submission system guides you stepwise through the process of entering your article details and uploading your files. All correspondence, including notification of the Editor's decision and requests for revision, is sent by e-mail.

Submit your article

Please submit your article here.

Review process

The decision to publish a paper is based on an editorial assessment and peer review. Initially all papers are assessed by an editorial committee consisting of members of the editorial team. The prime purpose is to decide whether to send a paper for peer review and to give a rapid decision on those that are not.
Editorials and Letters may be accepted at this stage but in all other cases the decision is to reject the paper or to send it for peer review. Papers which do not meet basic standards or are unlikely to be published irrespective of a positive peer review, for example because their novel contribution is insufficient or the relevance to the discipline is unclear, may be rejected at this point to avoid delays to authors who may wish to seek publication elsewhere.
Occasionally a paper will be returned to the author with requests for revisions to assist the editors in deciding whether or not send it out for review.
Manuscripts going forward to the review process are reviewed by members of an international expert panel. This journal uses double-blind review, which means that both the reviewer and author name(s) are not allowed to be revealed to one another for a manuscript under review. The identities of the authors are concealed from the reviewers, and vice versa. For more information, please check here.
We take every reasonable step to ensure author identity is concealed during the review process, but it is up to authors to ensure that their details of prior publications etc. do not reveal their identity.
The decision to publish is made by the senior editor with advice from one of more associate editors and the reviewers. The Editor-in-Chief reserves the right to the final decision regarding acceptance and, on occasion, we may choose not to published despite recommendations from reviewers (or vice versa).

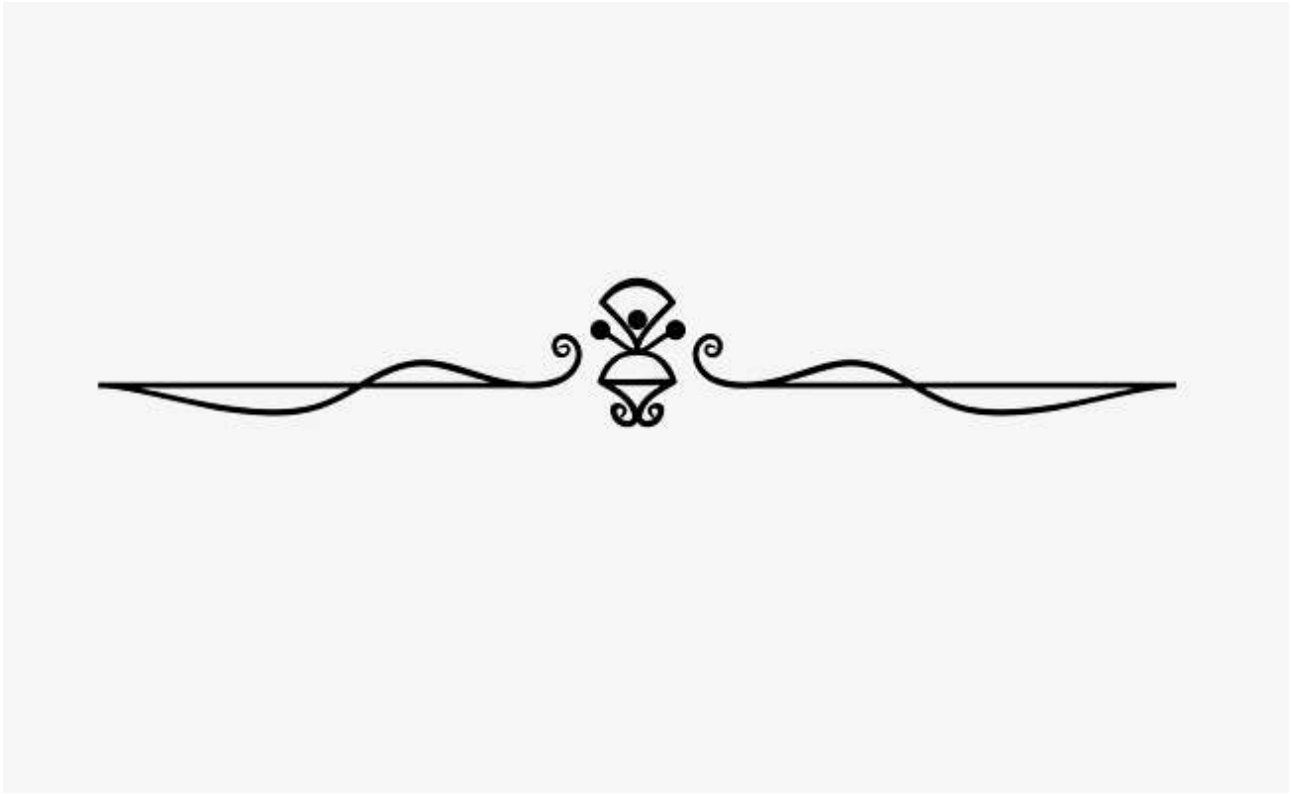
Referees

During submission, authors may suggest the names and institutional e-mail addresses of three potential referees. This can be helpful in facilitating timely and high-quality peer review.
Note that the Editor retains the sole right to decide if the suggested reviewers are used.
Suggested reviewers should not be from the same institution as any of the authors and authors should avoid suggesting reviewers who might be seen to have a conflict of interest, for example because of ongoing close collaboration with the author.

ANNEXURE F2

ARTICLE 2

NURSE EDUCATION TODAY



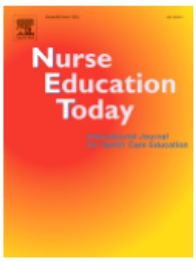
Queen Khanyisile Masimula

ANNEXURE F2: ARTICLE 2 NURSE EDUCATION TODAY

NURSE EDUCATION TODAY

AUTHOR INFORMATION PACK

TABLE OF CONTENTS



ISSN: 0260-6917

DESCRIPTION

Nurse Education Today is the leading international journal providing a forum for the publication of high quality original research, review and debate in the discussion of **nursing**, **midwifery** and interprofessional **health care education**, publishing papers which contribute to the advancement of educational theory and pedagogy that support the evidence-based practice for educationalists worldwide. The journal stimulates and values critical scholarly debate on issues that have strategic relevance for leaders of health care education.

The journal publishes the highest quality scholarly contributions reflecting the diversity of people, health and education systems worldwide, by publishing research that employs rigorous methodology as well as by publishing papers that highlight the theoretical underpinnings of education and systems globally. The journal will publish papers that show depth, rigour, originality and high standards of presentation, in particular, work that is original, analytical and constructively critical of both previous work and current initiatives.

Authors are invited to submit original research, systematic and scholarly reviews, and critical papers which will stimulate debate on research, policy, theory or philosophy of nursing and related health care education, and which will meet and develop the journal's high academic and ethical standards.

The journal employs a double blind peer review process for all submissions and its current Impact Factor is 2.533 making it one of the leading nursing education journals (2016 Journal Citation Reports, Clarivate Analytics 2017).

IMPACT FACTOR

2018: 2.442 © Clarivate Analytics Journal Citation Reports 2019

ABSTRACTING AND INDEXING

Scopus
PubMed/Medline
Current Contents - Social & Behavioral Sciences
ASSIA
CINAHL
Referativnyi Zhurnal VINTI-RAN (Russian Academy of Sciences)
BDLIC
SIIC Data Bases
Silver Platter
ENB Health Care Database
UMI Microfilms
EMCARE

EDITORIAL BOARD

GUIDE FOR AUTHORS

Introduction

The Editors of *Nurse Education Today* welcome the submission of papers for publication in the form of research findings, systematic and methodological reviews, literature reviews and Contemporary Issue pieces that contribute to, and advance, the knowledge of, and debate within, international nursing, midwifery and healthcare education

For enquiries relating to the submission of articles (including electronic submission) please visit this journal's homepage. Contact details for questions arising after acceptance of an article, especially those relating to proofs, will be provided by the publisher. You can track accepted articles at https://www.elsevier.com/trackarticle. You can also check our Author FAQs (https://www.elsevier.com/authorFAQ) and/or contact Customer Support via https://service.elsevier.com.

Page charges

This journal has no page charges.

BEFORE YOU BEGIN

Ethics in publishing

Please see our information pages on Ethics in publishing and Ethical guidelines for journal publication.

The work described in your article must have been carried out in accordance with The Code of Ethics of the World Medical Association (Declaration of Helsinki) for experiments involving humans http://www.wma.net/en/30publications/10policies/b3/index.html EU Directive 2010/63/EU for animal experiments http://ec.europa.eu/environment/chemicals/lab_animals/legislation_en.html Uniform Requirements for manuscripts submitted to Biomedical journals http://www.icmje.org This must be stated at an appropriate point in the article.

Declaration of interest

All authors must disclose any financial and personal relationships with other people or organizations that could inappropriately influence (bias) their work. Examples of potential competing interests include employment, consultancies, stock ownership, honoraria, paid expert testimony, patent applications/registrations, and grants or other funding. Authors must disclose any interests in two places: 1. A summary declaration of interest statement in the title page file (if double-blind) or the manuscript file (if single-blind). If there are no interests to declare then please state this: 'Declarations of interest: none'. This summary statement will be ultimately published if the article is accepted. 2. Detailed disclosures as part of a separate Declaration of Interest form, which forms part of the journal's official records. It is important for potential interests to be declared in both places and that the information matches. More information.

Submission declaration and verification

Submission of an article implies that the work described has not been published previously (except in the form of an abstract, a published lecture or academic thesis, see 'Multiple, redundant or concurrent publication' for more information), that it is not under consideration for publication elsewhere, that its publication is approved by all authors and tacitly or explicitly by the responsible authorities where the work was carried out, and that, if accepted, it will not be published elsewhere in the same form, in English or in any other language, including electronically without the written consent of the copyright-holder. To verify originality, your article may be checked by the originality detection service Crossref Similarity Check.

Other/multiple and parallel publications

NET seeks to provide full transparency to its readers on every study it publishes. The journal seeks to publish original papers that make a substantial novel contribution. Generally NET's word limits permit authors to publish all aspects of a study within a single paper. However we recognize that this is not always possible. To aid editorial decisions about distinctiveness and to avoid inadvertent duplication please upload copies of all previous, current and under review publications from the single study being submitted for consideration of publication and / or give full details in the Covering Letter to the editorial office. Seehttps://www.elsevier.com/__data/assets/pdf_file/0009/163719/ETHICS_SS01a.pdf

Preprints

Please note that preprints can be shared anywhere at any time, in line with Elsevier's sharing policy. Sharing your preprints e.g. on a preprint server will not count as prior publication (see 'Multiple, redundant or concurrent publication' for more information).

Use of inclusive language

Inclusive language acknowledges diversity, conveys respect to all people, is sensitive to differences, and promotes equal opportunities. Articles should make no assumptions about the beliefs or commitments of any reader, should contain nothing which might imply that one individual is superior to another on the grounds of race, sex, culture or any other characteristic, and should use inclusive language throughout. Authors should ensure that writing is free from bias, for instance by using 'he or she', 'his/her' instead of 'he' or 'his', and by making use of job titles that are free of stereotyping (e.g. 'chairperson' instead of 'chairman' and 'flight attendant' instead of 'stewardess').

Contributors and Acknowledgements

All authors should have made substantial contributions to all of the following: (1) the conception and design of the study, or acquisition of data, or analysis and interpretation of data, (2) drafting the article or revising it critically for important intellectual content, (3) final approval of the version to be submitted.

All those individuals who provided help during the research (e.g., providing language help, writing assistance or proofreading the article, etc.) that do not meet criteria for authorship should be acknowledged in the paper.

Author contributions

For transparency, we encourage authors to submit an author statement file outlining their individual contributions to the paper using the relevant CRediT roles: Conceptualization; Data curation; Formal analysis; Funding acquisition; Investigation; Methodology; Project administration; Resources; Software; Supervision; Validation; Visualization; Roles/Writing - original draft; Writing - review & editing. Authorship statements should be formatted with the names of authors first and CRediT role(s) following. More details and an example

Authorship

All authors should have made substantial contributions to all of the following: (1) the conception and design of the study, or acquisition of data, or analysis and interpretation of data, (2) drafting the article or revising it critically for important intellectual content, (3) final approval of the version to be submitted.

Changes to authorship

Authors are expected to consider carefully the list and order of authors **before** submitting their manuscript and provide the definitive list of authors at the time of the original submission. Any addition, deletion or rearrangement of author names in the authorship list should be made only **before** the manuscript has been accepted and only if approved by the journal Editor. To request such a change, the Editor must receive the following from the **corresponding author**: (a) the reason for the change in author list and (b) written confirmation (e-mail, letter) from all authors that they agree with the addition, removal or rearrangement. In the case of addition or removal of authors, this includes confirmation from the author being added or removed.

Only in exceptional circumstances will the Editor consider the addition, deletion or rearrangement of authors **after** the manuscript has been accepted. While the Editor considers the request, publication of the manuscript will be suspended. If the manuscript has already been published in an online issue, any requests approved by the Editor will result in a corrigendum.

Copyright

Upon acceptance of an article, authors will be asked to complete a 'Journal Publishing Agreement' (see more information on this). An e-mail will be sent to the corresponding author confirming receipt of the manuscript together with a 'Journal Publishing Agreement' form or a link to the online version of this agreement.

Subscribers may reproduce tables of contents or prepare lists of articles including abstracts for internal circulation within their institutions. Permission of the Publisher is required for resale or distribution outside the institution and for all other derivative works, including compilations and translations. If

excerpts from other copyrighted works are included, the author(s) must obtain written permission from the copyright owners and credit the source(s) in the article. Elsevier has preprinted forms for use by authors in these cases.

For gold open access articles: Upon acceptance of an article, authors will be asked to complete an 'Exclusive License Agreement' (more information). Permitted third party reuse of gold open access articles is determined by the author's choice of user license.

Author rights
As an author you (or your employer or institution) have certain rights to reuse your work. More information.

Elsevier supports responsible sharing
Find out how you can share your research published in Elsevier journals.

Role of the funding source
You are requested to identify who provided financial support for the conduct of the research and/or preparation of the article and to briefly describe the role of the sponsor(s), if any, in study design; in the collection, analysis and interpretation of data; in the writing of the report; and in the decision to submit the article for publication. If the funding source(s) had no such involvement then this should be stated.

Open access
Please visit our Open Access page for more information.

Elsevier Researcher Academy
Researcher Academy is a free e-learning platform designed to support early and mid-career researchers throughout their research journey. The "Learn" environment at Researcher Academy offers several interactive modules, webinars, downloadable guides and resources to guide you through the process of writing for research and going through peer review. Feel free to use these free resources to improve your submission and navigate the publication process with ease.

Language (usage and editing services)
Please write your text in good English (American or British usage is accepted, but not a mixture of these). Authors who feel their English language manuscript may require editing to eliminate possible grammatical or spelling errors and to conform to correct scientific English may wish to use the English Language Editing service available from Elsevier's Author Services.

Authors who require information about language editing and copyediting services pre- and post-submission please visit http://webshop.elsevier.com/languageediting or our customer support site at https://service.elsevier.com for more information.

Informed consent and patient details
Studies on patients or volunteers require ethics committee approval and informed consent, which should be documented in the paper. Appropriate consents, permissions and releases must be obtained where an author wishes to include case details or other personal information or images of patients and any other individuals in an Elsevier publication. Written consents must be retained by the author but copies should not be provided to the journal. Only if specifically requested by the journal in exceptional circumstances (for example if a legal issue arises) the author must provide copies of the consents or evidence that such consents have been obtained. For more information, please review the Elsevier Policy on the Use of Images or Personal Information of Patients or other Individuals. Unless you have written permission from the patient (or, where applicable, the next of kin), the personal details of any patient included in any part of the article and in any supplementary materials (including all illustrations and videos) must be removed before submission.

Permission
Permission to reproduce previously published material must be obtained in writing from the copyright holder (usually the publisher) and acknowledged in the manuscript.

Submission
Our online submission system guides you stepwise through the process of entering your article details and uploading your files. The system converts your article files to a single PDF file used in the peer-review process. Editable files (e.g., Word, LaTeX) are required to typeset your article for final publication. All correspondence, including notification of the Editor's decision and requests for revision, is sent by e-mail.

For questions about the editorial process (including the status of manuscripts under review) please contact the editorial office jtyldsley@jtyldsley.karoo.co.uk. For technical support on submissions please contact https://service.elsevier.com

Submit your article
Please submit your article via https://www.evise.com/profile/api/navigate/NET.

Review process
All manuscripts are initially assessed by an editorial team who will decide whether to send a paper for peer review and to allow a rapid response to authors for those that are not. The decision to publish a paper is based on assessment via a double-blind peer review process by an international panel of experts and the Editors reserves the right to the final decision regarding acceptance. Papers which do not meet the journal's standards or do not provide a novel contribution to the literature already published in the field, may be rejected at this point in order to avoid delays to authors who may wish to seek publication elsewhere. Occasionally a paper will be returned to the author with requests for revisions prior to additional peer review.

Submitted papers should be written in a way that is relevant to an international audience and authors should not assume knowledge of national and local practices, organisations and professional bodies. Authors should therefore avoid the use of acronyms when referring to such and should use terminology that is internationally acceptable. Authors should consult a recent issue of the journal for style and structure if possible.

Nurse Education Today is a signatory journal to the Uniform Requirements for Manuscripts Submitted to Biomedical Journals, issued by the International Committee for Medical Journal Editors (ICMJE), and to the Committee on Publication Ethics (COPE) code of conduct for editors. We follow COPE's guidelines

Additional information

PREPARATION

Article structure

Presentation of Manuscripts

Abbreviations - Avoid the use of abbreviations unless they are likely to be widely recognised. In particular you should avoid abbreviating key concepts in your paper where readers might not already be familiar with the abbreviation. Any abbreviations which the authors intend to use should be written out in full and followed by the letters in brackets the first time they appear, thereafter only the letters without brackets should be used.

Statistics - Standard methods of presenting statistical material should be used. Where methods used are not widely recognised explanation and full reference to widely accessible sources must be given.

Exact p values should be given to no more than three decimal places.

Wherever possible give both point estimates and confidence intervals for all population parameters estimated by the study (e.g. group differences, frequency of characteristics). Identify the statistical package used.

Identify the statistical package used.

Word Length
Contemporary Issues - 2,000-2,500 words.

Papers that discuss contemporary issues within nursing, midwifery and health profession education, and stimulate scholarly debate, are welcomed. Authors who have ideas which address issues of substantive concern to the disciplines, particularly those of a controversial nature, should consider submitting a Contemporary Issue piece. The issues must be current and, although they can be of national agenda, they must have international implications or be of relevance to an international audience.

Contemporary Issues should consist of editorial-style. No abstract is required, but Keywords and up to 8 references should be included (following the style as outlined in this Guide). References and Keywords are included in the word count. Contemporary Issues should be submitted online in the usual way for the journal.

Research Papers - 3,500-5,000 words.

Papers reporting original research are welcomed between 3,500-5,000 words, including abstract/ summary and references. Please check your text carefully before you send it off, both for correct content and typographic errors. You will increase the chances of acceptance if you draw on the experience of previously published colleagues where possible. It is not possible to change the content of accepted papers during production. Research papers should adhere to recognised standards for reporting (see Guidance below - Considerations to specific types of research design).

Reviews - 3,500-4,500 words.

Reviews are welcomed by the journal editors including, 1.systematic reviews, 2. literature reviews, which provide a thorough analysis of the literature on a topic.The word count includes abstracts and keywords but excludes references.

Big Ideas - 1,500-2,000 words.

You are invited to submit a review essay of a book (including works of fiction) or 'big idea' from the arts, sciences or humanities that has guided or influenced you as a practitioner, educator and/or academic. The review should normally focus on a book or idea from outside the immediate scope of nursing, midwifery and healthcare, and might include an overview, a critical appraisal and some thoughts about how it could be applied to practice and/or education. Critical commentaries of previously published contributions to the 'Big Ideas' series are also welcome. Abstracts and key words are not required, and papers of approximately 1500-2000 words (excluding references) should be submitted in the usual way, indicating that they are intended for the 'Big Ideas' section.

Do not use 'he', 'his' etc where the sex of the person is unknown, say 'the nurse' etc. Avoid inelegant alternatives such as 'he/she'. Nurses and doctors should not be automatically designated as 'he/she'. In terms of style, try to avoid artificially objective language such as 'the author thought that' or 'the researcher' where this person is yourself. 'I' or 'we' are acceptable when related to matters concerning the author(s) themselves or their opinions.

Editorials - Editorials are brief commentaries which should be no more than 1500 words, with a maximum of 10 references. Editorials do not contain an abstract, figures or tables.

Supporting Documentation
A Covering letter to the editor in which you detail authorship contributions and other matters you wish the editors to consider.

- The title page should be provided as a separate file .
- Your **title page** should give the **title** in capital letters, below which should be the **authors' names** (as they appear) in lower-case letters.
- For each author you should give one first name as well as the family name and any initials
- Authors' addresses should be limited to the minimum information needed to ensure accurate postal delivery; these details should be on the title page below the authors' names and appointments
- Authors should also provide a daytime contact telephone number, fax number and e-mail address. Author's may include their Twitter handles on the Title Page if they wish to.
- The title should explicitly describe the topic and type of paper and should be in the format "Topic/ question: Design/type of paper" (e.g. Student nurse perceptions of risk in relation to international placements: A phenomenological research study).
- All Acknowledgements/Contribution/Funding statements should be listed on the author 'Title Page' file and not in the Manuscript (to avoid disclosure to reviewers). There should be no author details appearing in the 'Manuscript' file or the 'Response to Reviewers' file for revised submissions

Highlights

Highlights are optional yet highly encouraged for this journal, as they increase the discoverability of your article via search engines. They consist of a short collection of bullet points that capture the novel results of your research as well as new methods that were used during the study (if any). Please have a look at the examples here: example Highlights.

Highlights should be submitted in a separate editable file in the online submission system. Please use 'Highlights' in the file name and include 3 to 5 bullet points (maximum 85 characters, including spaces, per bullet point).

Abstract

An **abstract** of your paper, a maximum of **300 words** summarising the content, must be included in your manuscript file and copied into a text box during the online submission process - the two version must be identical. The abstract should not include references or abbreviations.

Abstracts of Research Papers must be structured. As guidance they should include Background;*Objectives; Design; Settings ; Participants; Methods; Results; and Conclusions.*

Abstracts for Reviews should provide a summary under the following headings, where possible: *Objectives, Design, Data sources, Review methods, Results, Conclusions.*

Abstracts are not required for Editorials and Contemporary Issues.

Keywords

Include 4-8 keywords. The purpose of these is to increase the likely accessibility of your paper to potential readers searching the literature. Therefore, ensure keywords are descriptive of the study. Refer to a recognised thesaurus of keywords wherever possible, for example refer to the Medical Subject Headings (MeSH®) thesaurus or Cumulative Index to Nursing and Allied Health (CINAHL) headings (see http://www.nlm.nih.gov/mesh/meshhome.html).

Headings

The content of your paper should determine the **headings** you use. If yours is a quantitative research paper the headings should follow the usual layout, such as:**Introduction, Background/Literature, Methods, Data/Results, Discussion, Conclusions.** If your paper takes another form, theoretical or qualitative for example, you should use the appropriate headings, but do bear in mind that headings should facilitate reading and understanding. You should use only two kinds of headings, major headings should be indicated by underlined capital letters in the centre of the page whereas minor headings should be underlined, have lower-case letters (beginning with a capital) and begin at the left hand margin.

Formatting of funding sources

List funding sources in this standard way to facilitate compliance to funder's requirements:

Funding: This work was supported by the National Institutes of Health [grant numbers xxxx, yyyy]; the Bill & Melinda Gates Foundation, Seattle, WA [grant number zzzz]; and the United States Institutes of Peace [grant number aaaa].

It is not necessary to include detailed descriptions on the program or type of grants and awards. When funding is from a block grant or other resources available to a university, college, or other research institution, submit the name of the institute or organization that provided the funding.

If no funding has been provided for the research, please include the following sentence:

This research did not receive any specific grant from funding agencies in the public, commercial, or not-for-profit sectors.

Artwork

Electronic artwork

General points

- Make sure you use uniform lettering and sizing of your original artwork.
- Embed the used fonts if the application provides that option.

• Aim to use the following fonts in your illustrations: Arial, Courier, Times New Roman, Symbol, or use fonts that look similar.
• Number the illustrations according to their sequence in the text.
• Use a logical naming convention for your artwork files.
• Provide captions to illustrations separately.
• Size the illustrations close to the desired dimensions of the published version.
• Submit each illustration as a separate file.
• Ensure that color images are accessible to all, including those with impaired color vision.

A detailed guide on electronic artwork is available.
You are urged to visit this site; some excerpts from the detailed information are given here.
Formats
If your electronic artwork is created in a Microsoft Office application (Word, PowerPoint, Excel) then please supply 'as is' in the native document format.
Regardless of the application used other than Microsoft Office, when your electronic artwork is finalized, please 'Save as' or convert the images to one of the following formats (note the resolution requirements for line drawings, halftones, and line/halftone combinations given below):
EPS (or PDF): Vector drawings, embed all used fonts.
TIFF (or JPEG): Color or grayscale photographs (halftones), keep to a minimum of 300 dpi.
TIFF (or JPEG): Bitmapped (pure black & white pixels) line drawings, keep to a minimum of 1000 dpi.
TIFF (or JPEG): Combinations bitmapped line/half-tone (color or grayscale), keep to a minimum of 500 dpi.
Please do not:
• Supply files that are optimized for screen use (e.g., GIF, BMP, PICT, WPG); these typically have a low number of pixels and limited set of colors;
• Supply files that are too low in resolution;
• Submit graphics that are disproportionately large for the content.

Color artwork
Please make sure that artwork files are in an acceptable format (TIFF (or JPEG), EPS (or PDF), or MS Office files) and with the correct resolution. If, together with your accepted article, you submit usable color figures then Elsevier will ensure, at no additional charge, that these figures will appear in color online (e.g., ScienceDirect and other sites) regardless of whether or not these illustrations are reproduced in color in the printed version. **For color reproduction in print, you will receive information regarding the costs from Elsevier after receipt of your accepted article**. Please indicate your preference for color: in print or online only. Further information on the preparation of electronic artwork.

Illustration services
Elsevier's Author Services offers Illustration Services to authors preparing to submit a manuscript but concerned about the quality of the images accompanying their article. Elsevier's expert illustrators can produce scientific, technical and medical-style images, as well as a full range of charts, tables and graphs. Image 'polishing' is also available, where our illustrators take your image(s) and improve them to a professional standard. Please visit the website to find out more.

Illustrations

A detailed guide on electronic artwork is available on our website: https://www.elsevier.com/authors and below.

Figure captions, tables, figures, schemes
Submit these as separate files and not in the manuscript. They are described in more detail below. High-resolution graphics files must always be provided separate from the main text file (see Preparation of illustrations).

Tables
Each table needs a **short descriptive title** above it, and a **clear legend or key** and, if necessary, suitably identified **footnotes** below. When drawing up the tables take care to include all the units of measurement. **Make sure that each table is cited in the text.** Number tables consecutively in accordance with their appearance in the text. Avoid vertical rules. Be sparing in the use of tables and ensure that the data presented in tables do not duplicate results described elsewhere in the article. Tables should be presented in separate files

References

Citation in text
Please ensure that every reference cited in the text is also present in the reference list (and vice versa). Any references cited in the abstract must be given in full. Unpublished results and personal communications are not recommended in the reference list, but may be mentioned in the text. If these references are included in the reference list they should follow the standard reference style of the journal and should include a substitution of the publication date with either 'Unpublished results' or 'Personal communication'. Citation of a reference as 'in press' implies that the item has been accepted for publication.

Reference links
Increased discoverability of research and high quality peer review are ensured by online links to the sources cited. In order to allow us to create links to abstracting and indexing services, such as Scopus, CrossRef and PubMed, please ensure that data provided in the references are correct. Please note that incorrect surnames, journal/book titles, publication year and pagination may prevent link creation. When copying references, please be careful as they may already contain errors. Use of the DOI is highly encouraged.

A DOI is guaranteed never to change, so you can use it as a permanent link to any electronic article. An example of a citation using DOI for an article not yet in an issue is: VanDecar J.C., Russo R.M., James D.E., Ambeh W.B., Franke M. (2003). Aseismic continuation of the Lesser Antilles slab beneath northeastern Venezuela. Journal of Geophysical Research, https://doi.org/10.1029/2001JB000884. Please note the format of such citations should be in the same style as all other references in the paper.

Web references
As a minimum, the full URL should be given and the date when the reference was last accessed. Any further information, if known (DOI, author names, dates, reference to a source publication, etc.), should also be given. Web references can be listed separately (e.g., after the reference list) under a different heading if desired, or can be included in the reference list.

This journal encourages you to cite underlying or relevant datasets in your manuscript by citing them in your text and including a data reference in your Reference List. Data references should include the following elements: author name(s), dataset title, data repository, version (where available), year, and global persistent identifier. Add [dataset] immediately before the reference so we can properly identify it as a data reference. This identifier will not appear in your published article.

Example:
[dataset] Oguro, M., Imahiro, S., Saito, S., Nakashizuka, T., 2015. Mortality data for Japanese oak wilt disease and surrounding forest compositions. Mendeley Data, v1. http://dx.doi.org/10.17632/xwj98nb39r.1.

Reference management software
Most Elsevier journals have their reference template available in many of the most popular reference management software products. These include all products that support Citation Style Language styles, such as Mendeley. Using citation plug-ins from these products, authors only need to select the appropriate journal template when preparing their article, after which citations and bibliographies will be automatically formatted in the journal's style. If no template is yet available for this journal, please follow the format of the sample references and citations as shown in this Guide. If you use reference management software, please ensure that you remove all field codes before submitting the electronic manuscript. More information on how to remove field codes from different reference management software.

Users of Mendeley Desktop can easily install the reference style for this journal by clicking the following link:
http://open.mendeley.com/use-citation-style/nurse-education-today
When preparing your manuscript, you will then be able to select this style using the Mendeley plug-ins for Microsoft Word or LibreOffice.

Reference formatting
There are no strict requirements on reference formatting at submission. References can be in any style or format as long as the style is consistent. Where applicable, author(s) name(s), journal title/book title, chapter title/article title, year of publication, volume number/book chapter and the article number or pagination must be present. Use of DOI is highly encouraged. The reference style used by

the journal will be applied to the accepted article by Elsevier at the proof stage. Note that missing data will be highlighted at proof stage for the author to correct. If you do wish to format the references yourself they should be arranged according to the following examples:

Reference style
In the text references should state the author's surname and the year of publication (Garrett, 2006). If there are two authors you should give both surnames (Warne and McAndrew, 2008). When a source has more than two authors, give the name of the first author followed by 'et al.'. Where a quotation is used within your paper the author, date and page number should be given, e.g. 'has a beginning and an end; that it is best separated from the rest of our activities and that it is as a result of teaching.' (Wenger, 1998, p.3) A list of all references in your manuscript should be typed in alphabetical order. Each reference to a paper needs to include the authors' surnames and initials, year of publication, full title of the paper, full name of the journal, volume number, issue number and first and last page numbers. Do not add unnecessary punctuation.

For example:
Henderson, A., Creedy, D., Boorman, R., Cooke, M., Walker, R., 2010. Development and psychometric testing of the Clinical Learning Organisational Culture Survey (CLOCS). Nurse Education Today 30 (7), 598-602.
References to Books should be given in a slightly different form, as in these examples: Billings, D., Halstead, J., 2005. Teaching in Nursing: A Guide for Faculty, 2nd ed. Elsevier Saunders, St Louis, MO.
Heron, J., Reason, P., 2006. The practice of co-operative inquiry: research "with" rather than "on" people. In: Reason, P., Bradbury, H. (Eds), Handbook of Action Research. Sage Publications, London, pp. 145-154.

Video

Elsevier accepts video material and animation sequences to support and enhance your scientific research. Authors who have video or animation files that they wish to submit with their article are strongly encouraged to include links to these within the body of the article. This can be done in the same way as a figure or table by referring to the video or animation content and noting in the body text where it should be placed. All submitted files should be properly labeled so that they directly relate to the video file's content. In order to ensure that your video or animation material is directly usable, please provide the file in one of our recommended file formats with a preferred maximum size of 150 MB per file, 1 GB in total. Video and animation files supplied will be published online in the electronic version of your article in Elsevier Web products, including ScienceDirect. Please supply 'stills' with your files: you can choose any frame from the video or animation or make a separate image. These will be used instead of standard icons and will personalize the link to your video data. For more detailed instructions please visit our video instruction pages. Note: since video and animation cannot be embedded in the print version of the journal, please provide text for both the electronic and the print version for the portions of the article that refer to this content.

Further Considerations
Considerations specific to types of research designs

The journal editors recommend that authors adhere to recognized reporting guidelines relevant to the research design used in their manuscripts. These are not quality assessment frameworks and your study need not meet all the criteria implied in the reporting guideline to be worthy of publication in the journal.

Reporting guidelines endorsed by the journal are listed below:

Observational cohort, case control and cross sectional studies - STROBE - Strengthening the Reporting of Observational Studies in Epidemiology http://www.equator-network.org/index.aspx?o=1032

Quasi-experimental/non-randomised evaluations - TREND - Transparent Reporting of Evaluations with Non-randomized Designs http://www.equator-network.org/index.aspx?o=1032

Randomised (and quasi-randomised) controlled trial - CONSORT - Consolidated Standards of Reporting Trials http://www.equator-network.org/index.aspx?o=1032

Study of Diagnostic accuracy/assessment scale - STARD - Standards for the Reporting of Diagnostic Accuracy Studies http://www.equator-network.org/index.aspx?o=1032

Systematic Review of Controlled Trials - PRISMA - Preferred Reporting Items for Systematic Reviews and Meta-Analyses http://www.equator-network.org/index.aspx?o=1032

Systematic Review of Observational Studies - MOOSE - Meta-analysis of Observational Studies in Epidemiology http://www.equator-network.org/index.aspx?o=1032

Qualitative researchers might wish to consult the guideline listed below:

Qualitative studies - COREQ - Consolidated criteria for reporting qualitative research. Tong, A., Sainsbury, P., Craig, J., 2007. Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. International Journal for Quality in Health Care 19 (6), 349-357. http://dx.doi.org/10.1093/intghc/mzm042

Data visualization

Include interactive data visualizations in your publication and let your readers interact and engage more closely with your research. Follow the instructions here to find out about available data visualization options and how to include them with your article.

Research data

This journal encourages and enables you to share data that supports your research publication where appropriate, and enables you to interlink the data with your published articles. Research data refers to the results of observations or experimentation that validate research findings. To facilitate reproducibility and data reuse, this journal also encourages you to share your software, code, models, algorithms, protocols, methods and other useful materials related to the project.

Below are a number of ways in which you can associate data with your article or make a statement about the availability of your data when submitting your manuscript. If you are sharing data in one of these ways, you are encouraged to cite the data in your manuscript and reference list. Please refer to the "References" section for more information about data citation. For more information on depositing, sharing and using research data and other relevant research materials, visit the research data page.

Data linking

If you have made your research data available in a data repository, you can link your article directly to the dataset. Elsevier collaborates with a number of repositories to link articles on ScienceDirect with relevant repositories, giving readers access to underlying data that gives them a better understanding of the research described.

There are different ways to link your datasets to your article. When available, you can directly link your dataset to your article by providing the relevant information in the submission system. For more information, visit the database linking page.

For supported data repositories a repository banner will automatically appear next to your published article on ScienceDirect.

In addition, you can link to relevant data or entities through identifiers within the text of your manuscript, using the following format: Database: xxxx (e.g., TAIR: AT1G01020; CCDC: 734053; PDB: 1XFN).

Mendeley Data

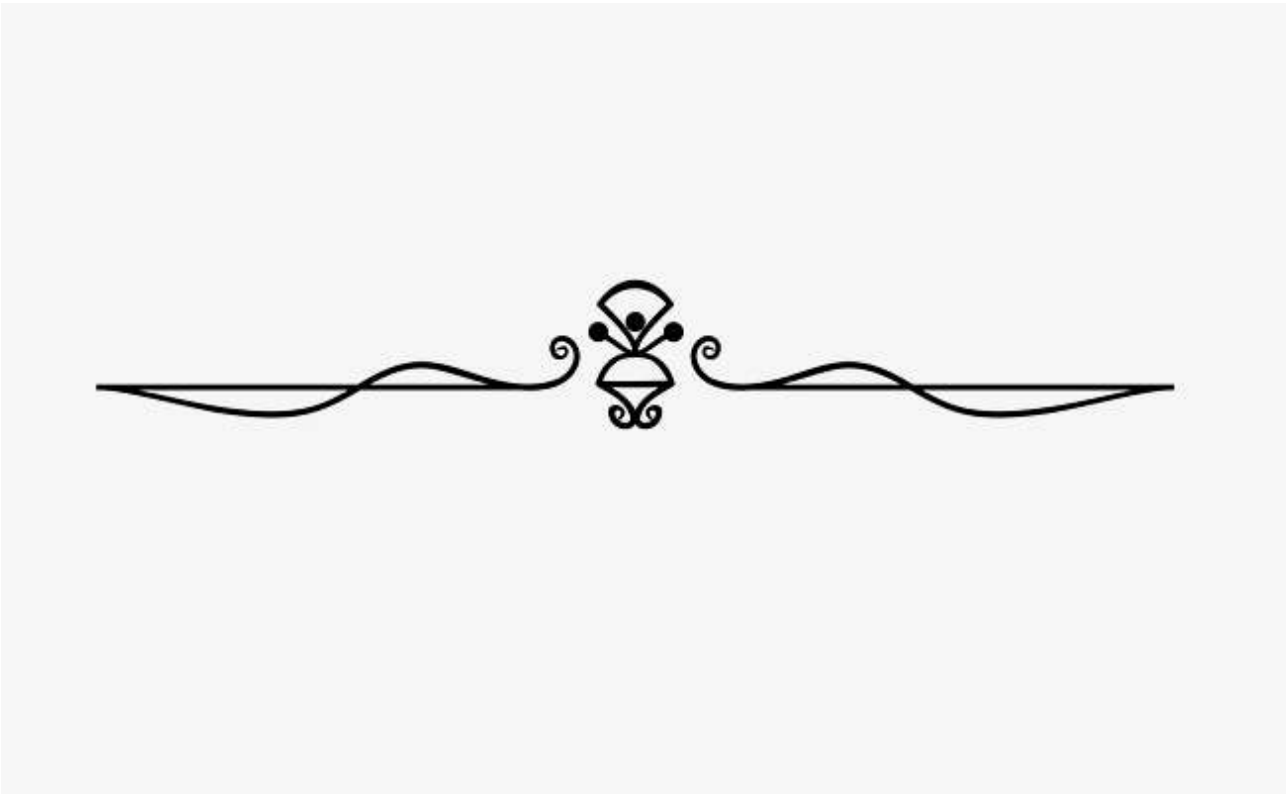
This journal supports Mendeley Data, enabling you to deposit any research data (including raw and processed data, video, code, software, algorithms, protocols, and methods) associated with your manuscript in a free-to-use, open access repository. During the submission process, after uploading your manuscript, you will have the opportunity to upload your relevant datasets directly to *Mendeley Data*. The datasets will be listed and directly accessible to readers next to your published article online.

For more information, visit the Mendeley Data for journals page.

ANNEXURE F3

ARTICLE 3

GENDER & BEHAVIOUR



Queen Khanyisile Masimula

ANNEXURE F3: ARTICLE 3 GENDER & BEHAVIOUR

CONTRIBUTORS' INFORMATION

Content: GENDER & BEHAVIOUR welcomes scholarly manuscripts from authors all over the world on a wide array of subjects concerning psychological and behavioural aspects of gender in general. All manuscripts **MUST** respect the dignity of **HUMANITY.** Articles published or submitted for publication elsewhere are not accepted. Authors are solely and fully responsible for the statements and views contained in their articles. Neither the Editorial board nor the Ife Centre for Psychological Studies/Services accepts responsibility for author's views and statements.

Book Review: Two copies of the book/manuscript to be reviewed are to be submitted to the Project coordinator. Gender and Behaviour Ife Centre for Psychological Studies / Services. P.O. Box 1548 Ile-Ife, Osun State, Nigeria. Or through Emails: ifepsy@yahoo.com or wanawake2002@yahoo.com

Manuscript Preparation: Prepare manuscripts according to the Publication manual of the American Psychological Association (6th Edition, 2002; APA 750 First Street, NE, Washington, 20002-4242). Follow "Guidelines to reduce Bias in Language (pp. 46-60)
Limit manuscripts to maximum of 20 pages of text, including references. **On page 1, type article title, author name(s), affiliation(s) address phone and fax numbers, e-mail address(es), running head (abbreviated title, no more than 45 characters and space) name and address of the person to whom requests for reprints should be address; on page 2, type an abstract of no more than 150 words; type author notes/acknowledgements at the end of the article (just before references section). All copies must be double-spaced**: The author name(s) should appear only on the title sheet.

Permissions: Authors are responsible for all statements made in their work and for obtaining permission from copyright owners to reprint or adapt a table or figure or to reprint a quotation of 599 words or more. Authors should write to original author(s) and publisher to request nonexclusive world right in all languages to use the material in the article and in future editions.

Cover Letter: On a cover letter, include the contact author's address and telephone and fax numbers and state that the manuscript includes only original materials that has not been published and that is not under review for publication elsewhere.
Manuscript submission: Send manuscript by **Emails:** ifepsy@yahoo.com; wanawake2002@yahoo.com
Please make sure that the content of the files exactly matches that of the printed, accepted, finalized manuscripts (**provide revised printout).** Submit camera ready figures.
Assumption: it is assumed that the copyright of papers submitted and accepted are transferred to Ife Centre for Psychological Studies/Services.

Production Notes: Files of accepted manuscripts are copyedited and typeset into page proofs. Author will receive a copy of the issue in which his/her article appears. **Production costs will be shared with authors.**
Submission of articles through our electronics mail addresses (most preferred).

INVITATION TO SUBSCRIBE

Please enter my/our subscription of GENDER & BEHAVIOUR

Name:……

Address:……
……

City:……

E-mail:……

Telephone:……..

Subscription rates: ₦5,000.00 per copy (Five Thousand naira) in Nigeria & ($100) postage fee.

Return to:

Project Coordinator: Gender & Behaviour

Ife Centre for Psychological Studies/Services

P.O. Box 1548

Ile-Ife, Osun State

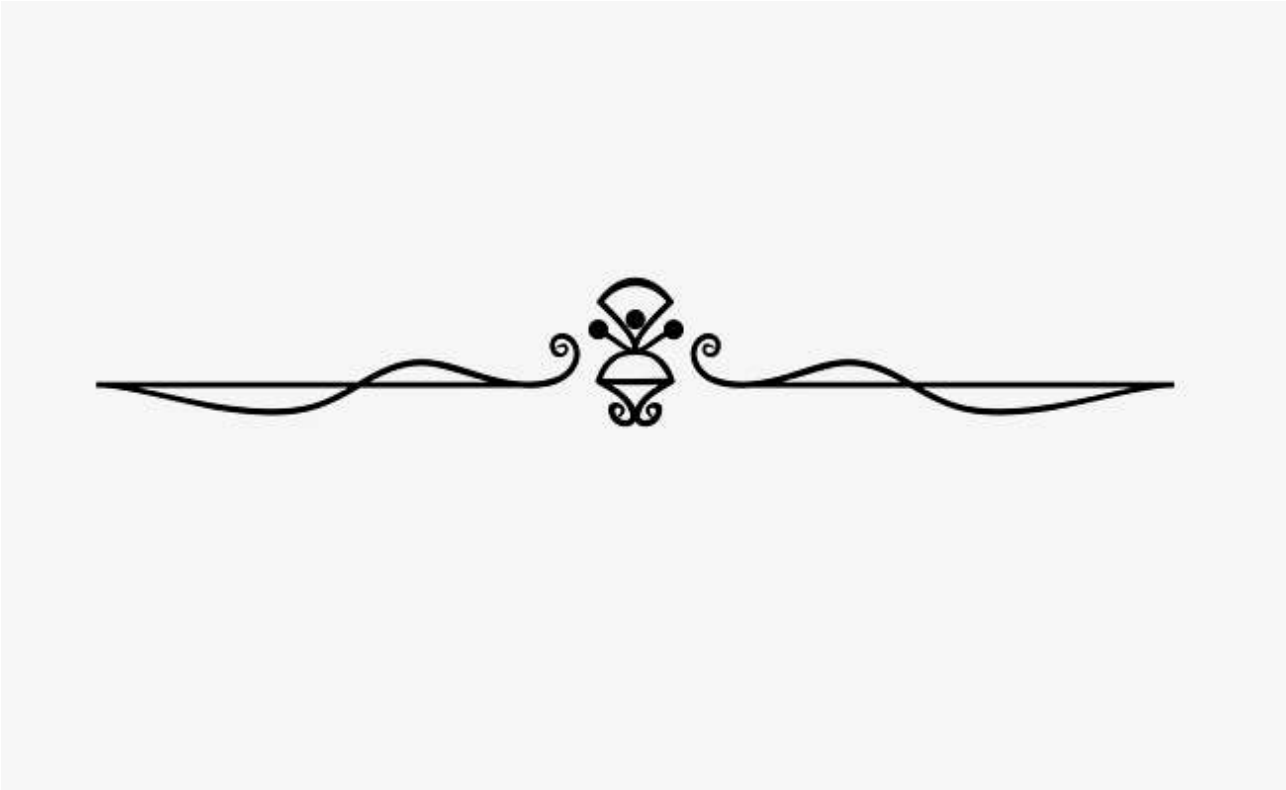
Or any member of the Editorial Board near you.

Phones: +234 803-711-6382
+234 0805-634-3255

ANNEXURE F4

ARTICLE 4

INTERNATIONAL JOURNAL OF AFRICA NURSING SCIENCES



Queen Khanyisile Masimula

ANNEXURE F4: INTERNATIONAL JOURNAL OF AFRICA NURSING SCIENCES

INTERNATIONAL JOURNAL OF AFRICA NURSING SCIENCES

AUTHOR INFORMATION PACK

TABLE OF CONTENTS

ISSN: 2214-1391

DESCRIPTION

International Journal of Africa Nursing Sciences (IJANS) is an international scientific open access journal published by Elsevier. The broad-based journal was founded on two key tenets, i.e. to publish the most exciting research with respect to the subjects of **Nursing** and **Midwifery** in **Africa**, and secondly, to advance the international understanding and development of **nursing** and **midwifery** in **Africa**, both as a profession and as an academic discipline.

The fully refereed journal provides a forum for all aspects of **nursing** and **midwifery sciences**, especially new trends and advances. The journal call for original research papers, systematic and scholarly review articles, and critical papers which will stimulate debate on research, policy, theory or philosophy of **nursing** as related to **nursing** and **midwifery** in **Africa**, technical reports, and short communications, and which will meet the journal's high academic and ethical standards. Manuscripts of **nursing practice**, education, management, and research are encouraged. The journal values critical scholarly debate on issues that have strategic significance for educators, practitioners, leaders and policy-makers of **nursing** and **midwifery** in **Africa**. The journal publishes the highest quality scholarly contributions reflecting the diversity of **nursing**, and is also inviting international scholars who are engaged with **nursing** and **midwifery** in **Africa** to contribute to the journal. We will only publish work that demonstrates the use of rigorous methodology as well as by publishing papers that highlight the theoretical underpinnings of **nursing** and **midwifery** as it relates to the **Africa** context. The journal employs a double blind peer review process for all submissions and is working towards inclusion of the journal on the Thomson Reuters Journal Citation Reports.

ABSTRACTING AND INDEXING

Scopus
Directory of Open Access Journals (DOAJ)

EDITORIAL BOARD

GUIDE FOR AUTHORS

INTRODUCTION

Dr Hester Klopper, Editor, welcomes manuscripts for consideration for publication in the journal.

Submission checklist

You can use this list to carry out a final check of your submission before you send it to the journal for review. Please check the relevant section in this Guide for Authors for more details.

Ensure that the following items are present:

One author has been designated as the corresponding author with contact details:
- E-mail address
- Full postal address

All necessary files have been uploaded:
Manuscript:
- Include keywords
- All figures (include relevant captions)
- All tables (including titles, description, footnotes)
- Ensure all figure and table citations in the text match the files provided
- Indicate clearly if color should be used for any figures in print

Graphical Abstracts / Highlights files (where applicable)
Supplemental files (where applicable)

Further considerations
- Manuscript has been 'spell checked' and 'grammar checked'
- All references mentioned in the Reference List are cited in the text, and vice versa
- Permission has been obtained for use of copyrighted material from other sources (including the Internet)
- A competing interests statement is provided, even if the authors have no competing interests to declare
- Journal policies detailed in this guide have been reviewed
- Referee suggestions and contact details provided, based on journal requirements

For further information, visit our Support Center.

BEFORE YOU BEGIN

Ethics in publishing

Please see our information pages on Ethics in publishing and Ethical guidelines for journal publication.

The IJANS is a signatory journal to the Uniform Requirements for Manuscripts Submitted to Biomedical Journals, issued by the International Committee for Medical Journal Editors (ICMJE), and to the Committee on Publication Ethics (COPE) code of conduct for editors. Our guidelines should be read in conjunction with this broader guidance. The ICJME requirements can be found at http://www.icmje.org/ and the COPE's guidelines at http://publicationethics.org/files/u2/New_Code.pdf.

Studies in humans and animals

If the work involves the use of human subjects, the author should ensure that the work described has been carried out in accordance with The Code of Ethics of the World Medical Association (Declaration of Helsinki) for experiments involving humans. The manuscript should be in line with the Recommendations for the Conduct, Reporting, Editing and Publication of Scholarly Work in Medical Journals and aim for the inclusion of representative human populations (sex, age and ethnicity) as per those recommendations. The terms sex and gender should be used correctly.

Authors should include a statement in the manuscript that informed consent was obtained for experimentation with human subjects. The privacy rights of human subjects must always be observed.

All animal experiments should comply with the ARRIVE guidelines and should be carried out in accordance with the U.K. Animals (Scientific Procedures) Act, 1986 and associated guidelines, EU Directive 2010/63/EU for animal experiments, or the National Research Council's Guide for the Care and Use of Laboratory Animals and the authors should clearly indicate in the manuscript that such guidelines have been followed. The sex of animals must be indicated, and where appropriate, the influence (or association) of sex on the results of the study.

Informed consent and patient details

Studies on patients or volunteers require ethics committee approval and informed consent, which should be documented in the paper. Appropriate consents, permissions and releases must be obtained where an author wishes to include case details or other personal information or images of patients and any other individuals in an Elsevier publication. Written consents must be retained by the author but copies should not be provided to the journal. Only if specifically requested by the journal in exceptional circumstances (for example if a legal issue arises) the author must provide copies of the consents or evidence that such consents have been obtained. For more information, please review the Elsevier Policy on the Use of Images or Personal Information of Patients or other Individuals. Unless you have written permission from the patient (or, where applicable, the next of kin), the personal details of any patient included in any part of the article and in any supplementary materials (including all illustrations and videos) must be removed before submission.

Declaration of competing interest

All authors must disclose any financial and personal relationships with other people or organizations that could inappropriately influence (bias) their work. Examples of potential conflicts of interest include employment, consultancies, stock ownership, honoraria, paid expert testimony, patent applications/ registrations, and grants or other funding. All authors, including those *without* competing interests to declare, should create a declaration of competing interest statement (which, where relevant, may specify they have nothing to declare). To do so, authors should use this tool and upload to the submission system at the Attach Files step. **Please do not convert the .docx template to another file type. Author signatures are not required.**

Submission declaration and verification

Submission of an article implies that the work described has not been published previously (except in the form of an abstract or as part of a published lecture or academic thesis or as an electronic preprint, see 'Multiple, redundant or concurrent publication' section of our ethics policy for more information), that it is not under consideration for publication elsewhere, that its publication is approved by all authors and tacitly or explicitly by the responsible authorities where the work was carried out, and that, if accepted, it will not be published elsewhere in the same form, in English or in any other language, including electronically without the written consent of the copyright-holder. To verify originality, your article may be checked by the originality detection service CrossCheck.

Acknowledgements

One or more statements should specify (a) contributions that need acknowledging, but do not justify authorship (b) acknowledgments of technical support (c) acknowledgments of financial and material support, specifying the nature of the support. Persons named in this section must have given their permission to be named. Authors are responsible for obtaining written permission from those acknowledged by name since readers may infer their endorsement of the data and conclusions. Authors should include Acknowledgments in the Conflict of Interest statement at original submission stage, and will be required to transfer the Acknowledgments into the manuscript file for revised articles.

Preprint posting on SSRN

In support of Open Science, this journal offers its authors a free preprint posting service. Preprints provide early registration and dissemination of your research, which facilitates early citations and collaboration.

During submission to Editorial Manager, you can choose to release your manuscript publicly as a preprint on the preprint server SSRN once it enters peer-review with the journal. Your choice will have no effect on the editorial process or outcome with the journal. Please note that the corresponding author is expected to seek approval from all co-authors before agreeing to release the manuscript publicly on SSRN.

You will be notified via email when your preprint is posted online and a Digital Object Identifier (DOI) is assigned. Your preprint will remain globally available free to read whether the journal accepts or rejects your manuscript.

For more information about posting to SSRN, please consult the SSRN Terms of Use and FAQs.

Use of inclusive language

Inclusive language acknowledges diversity, conveys respect to all people, is sensitive to differences, and promotes equal opportunities. Content should make no assumptions about the beliefs or commitments of any reader; contain nothing which might imply that one individual is superior to another on the grounds of age, gender, race, ethnicity, culture, sexual orientation, disability or health condition; and use inclusive language throughout. Authors should ensure that writing is free from bias, stereotypes, slang, reference to dominant culture and/or cultural assumptions. We advise to seek gender neutrality by using plural nouns ("clinicians, patients/clients") as default/wherever possible to avoid using "he, she," or "he/she." We recommend avoiding the use of descriptors that refer to personal attributes such as age, gender, race, ethnicity, culture, sexual orientation, disability or health condition unless they are relevant and valid. When coding terminology is used, we recommend to avoid offensive or exclusionary terms such as "master", "slave", "blacklist" and "whitelist". We suggest using alternatives that are more appropriate and (self-) explanatory such as "primary", "secondary", "blocklist" and "allowlist". These guidelines are meant as a point of reference to help identify appropriate language but are by no means exhaustive or definitive.

Author contributions

For transparency, we encourage authors to submit an author statement file outlining their individual contributions to the paper using the relevant CRediT roles: Conceptualization; Data curation; Formal analysis; Funding acquisition; Investigation; Methodology; Project administration; Resources; Software; Supervision; Validation; Visualization; Roles/Writing - original draft; Writing - review & editing. Authorship statements should be formatted with the names of authors first and CRediT role(s) following. More details and an example

Changes to authorship

Authors are expected to consider carefully the list and order of authors **before** submitting their manuscript and provide the definitive list of authors at the time of the original submission. Any addition, deletion or rearrangement of author names in the authorship list should be made only **before** the manuscript has been accepted and only if approved by the journal Editor. To request such a change, the Editor must receive the following from the **corresponding author**: (a) the reason for the change in author list and (b) written confirmation (e-mail, letter) from all authors that they agree with the addition, removal or rearrangement. In the case of addition or removal of authors, this includes confirmation from the author being added or removed.

Only in exceptional circumstances will the Editor consider the addition, deletion or rearrangement of authors **after** the manuscript has been accepted. While the Editor considers the request, publication of the manuscript will be suspended. If the manuscript has already been published in an online issue, any requests approved by the Editor will result in a corrigendum.

Reporting Clinical Trials

Registration in a public trials registry is a condition for publication of clinical trials in this journal in accordance with International Committee of Medical Journal Editors recommendations. Trials must register at or before the onset of patient enrolment. The clinical trial registration number should be included at the end of the abstract of the article. A clinical trial is defined as any research study that prospectively assigns human participants or groups of humans to one or more health-related interventions to evaluate the effects of health outcomes. Health-related interventions include any intervention used to modify a biomedical or health-related outcome (for example drugs, surgical procedures, devices, behavioural treatments, dietary interventions, and process-of-care changes). Health outcomes include any biomedical or health-related measures obtained in patients or participants, including pharmacokinetic measures and adverse events. Purely observational studies (those in which the assignment of the medical intervention is not at the discretion of the investigator) will not require registration.

Authors should include the Clinical Trial Registration number in the Conflict of Interest statement (see above) at original submission stage, and will be required to transfer the number into the manuscript file for revised articles.

Registration of clinical trials
Registration in a public trials registry is a condition for publication of clinical trials in this journal in accordance with International Committee of Medical Journal Editors recommendations. Trials must register at or before the onset of patient enrolment. The clinical trial registration number should be included at the end of the abstract of the article. A clinical trial is defined as any research study that prospectively assigns human participants or groups of humans to one or more health-related interventions to evaluate the effects of health outcomes. Health-related interventions include any intervention used to modify a biomedical or health-related outcome (for example drugs, surgical procedures, devices, behavioural treatments, dietary interventions, and process-of-care changes). Health outcomes include any biomedical or health-related measures obtained in patients or participants, including pharmacokinetic measures and adverse events. Purely observational studies (those in which the assignment of the medical intervention is not at the discretion of the investigator) will not require registration.
Authors should include the Clinical Trial Registration number in the Conflict of Interest statement (see above) at original submission stage, and will be required to transfer the number into the manuscript file for revised articles.

Copyright

Upon acceptance of an article, authors will be asked to complete an 'Exclusive License Agreeement' (for more information see https://www.elsevier.com/OAauthoragreement). Permitted reuse of open access articles is determined by the author's choice of use license(see https://www.elsevier.com/openaccesslicenses).

Retained author rights
As an author you (or your employer or institution) retain certain rights; for details you are referred to https://www.elsevier.com/OAauthoragreement).

Elsevier supports responsible sharing
Find out how you can share your research published in Elsevier journals.

Open access

Please visit our Open Access page for more information.

Elsevier Researcher Academy
Researcher Academy is a free e-learning platform designed to support early and mid-career researchers throughout their research journey. The "Learn" environment at Researcher Academy offers several interactive modules, webinars, downloadable guides and resources to guide you through the process of writing for research and going through peer review. Feel free to use these free resources to improve your submission and navigate the publication process with ease.

Language (usage and editing services)
Please write your text in good English (American or British usage is accepted, but not a mixture of these). Authors who feel their English language manuscript may require editing to eliminate possible grammatical or spelling errors and to conform to correct scientific English may wish to use the English Language Editing service available from Elsevier's Author Services.

Submission

Our online submission system guides you stepwise through the process of entering your article details and uploading your files. The system converts your article files to a single PDF file used in the peer-review process. Editable files (e.g., Word, LaTeX) are required to typeset your article for final publication. All correspondence, including notification of the Editor's decision and requests for revision, is sent by e-mail.

Revised Submission
Submission of a revised article implies that all authors are confirming that they have been involved with, and have agreed to, any revisions made. At revision stage the following documentation is required: a separate "Response to Reviewers" file - Responses to the reviewers' and editors' comments in a table format that shows the original comments and the responses made. a revised blinded manuscript with changes clearly highlighted in yellow/or using alternative coloured text to the rest of the article a "clean", blinded version of the revised manuscript without any highlights or comments. Revised submissions should be accompanied by the table file which responds, point by point, to the reviewers' and editors' comments, and changes to the revised paper should be highlighted so they can

be spotted easily by the editors and reviewers during further review. A "clean" copy of the manuscript without any identifying information or highlights should also be submitted. Any revisions missing any of the above elements/files may be returned to authors.

Submit your article

Please submit your article via https://www.editorialmanager.com/IJANS/default.aspx

PREPARATION

Queries

For questions about the editorial process (including the status of manuscripts under review) or for technical support on submissions, please visit our Support Center.

Peer review

This journal operates a double anonymized review process. All contributions will be initially assessed by the editor for suitability for the journal. Papers deemed suitable are then typically sent to a minimum of two independent expert reviewers to assess the scientific quality of the paper. The Editor is responsible for the final decision regarding acceptance or rejection of articles. The Editor's decision is final. Editors are not involved in decisions about papers which they have written themselves or have been written by family members or colleagues or which relate to products or services in which the editor has an interest. Any such submission is subject to all of the journal's usual procedures, with peer review handled independently of the relevant editor and their research groups. More information on types of peer review.

Double anonymized review

This journal uses double anonymized review, which means the identities of the authors are concealed from the reviewers, and vice versa. More information is available on our website. To facilitate this, please include the following separately:
Title page (with author details): This should include the title, authors' names, affiliations, acknowledgements and any Declaration of Interest statement, and a complete address for the corresponding author including an e-mail address.
Anonymized manuscript (no author details): The main body of the paper (including the references, figures, tables and any acknowledgements) should not include any identifying information, such as the authors' names or affiliations.

Use of word processing software
It is important that the file be saved in the native format of the word processor used. The text should be in single-column format. Keep the layout of the text as simple as possible. Most formatting codes will be removed and replaced on processing the article. In particular, do not use the word processor's options to justify text or to hyphenate words. However, do use bold face, italics, subscripts, superscripts etc. When preparing tables, if you are using a table grid, use only one grid for each individual table and not a grid for each row. If no grid is used, use tabs, not spaces, to align columns. The electronic text should be prepared in a way very similar to that of conventional manuscripts (see also the Guide to Publishing with Elsevier). Note that source files of figures, tables and text graphics will be required whether or not you embed your figures in the text. See also the section on Electronic artwork.
To avoid unnecessary errors you are strongly advised to use the 'spell-check' and 'grammar-check' functions of your word processor.

Article structure
Double-blind peer review - This journal uses double-blind review, which means that both the reviewer and author name(s) are not allowed to be revealed to one another for a manuscript under review. The identities of the authors are concealed from the reviewers, and vice versa. To facilitate anonymity, the author's names and any reference to their addresses should only appear on the title page.
Blinded manuscript (no author details): The main body of the paper (including the references, figures, tables and any Acknowledgements) should not include any identifying information, such as the authors' names or affiliations. Authors should also ensure that the place of origin of the work or study, and/or the organization(s) that have been involved in the study/development are not revealed in the manuscript - "X" can be used in the manuscript and details can be completed if the manuscript is processed further through the publication process.

Full length original research articles and reviews:

Headings
Headings in the article should be appropriate to the nature of the paper. Research papers should follow the standard structure of: Introduction (including review of the literature), Methods, Findings and Discussion.

Introduction
State the objectives of the work and provide an adequate background, avoiding a detailed literature survey or a summary of the results.

Material and methods
Provide sufficient details to allow the work to be reproduced by an independent researcher. Methods that are already published should be summarized, and indicated by a reference. If quoting directly from a previously published method, use quotation marks and also cite the source. Any modifications to existing methods should also be described.

Results
Results should be clear and concise.

Discussion
This should explore the significance of the results of the work, not repeat them. A combined Results and Discussion section is often appropriate. Avoid extensive citations and discussion of published literature.
Please note that the Title Page should be provided as a separate file.

Essential title page information

• ***Title.*** Concise and informative. Titles are often used in information-retrieval systems. Avoid abbreviations and formulae where possible.
• ***Author names and affiliations.*** Please clearly indicate the given name(s) and family name(s) of each author and check that all names are accurately spelled. Present the authors' affiliation addresses (where the actual work was done) below the names. Indicate all affiliations with a lower-case superscript letter immediately after the author's name and in front of the appropriate address. Provide the full postal address of each affiliation, including the country name and, if available, the e-mail address of each author.
• ***Corresponding author.*** Clearly indicate who will handle correspondence at all stages of refereeing and publication, also post-publication. **Ensure that the e-mail address is given and that contact details are kept up to date by the corresponding author.**
• ***Present/permanent address.*** If an author has moved since the work described in the article was done, or was visiting at the time, a 'Present address' (or 'Permanent address') may be indicated as a footnote to that author's name. The address at which the author actually did the work must be retained as the main, affiliation address. Superscript Arabic numerals are used for such footnotes. Authors are also encouraged to include their personal Twitter handles on the Title Page if they wish for these to be published.

Highlights

Highlights are optional yet highly encouraged for this journal, as they increase the discoverability of your article via search engines. They consist of a short collection of bullet points that capture the novel results of your research as well as new methods that were used during the study (if any). Please have a look at the examples here: example Highlights.

Highlights should be submitted in a separate editable file in the online submission system. Please use 'Highlights' in the file name and include 3 to 5 bullet points (maximum 85 characters, including spaces, per bullet point).

Abstract

A concise and factual abstract is required. The abstract should state briefly the purpose of the research, the principal results and major conclusions. An abstract is often presented separately from the article, so it must be able to stand alone. For this reason, References should be avoided, but if essential, then cite the author(s) and year(s). Also, non-standard or uncommon abbreviations should be avoided, but if essential they must be defined at their first mention in the abstract itself.

Keywords

Immediately after the abstract, provide a maximum of 6 keywords.

Electronic artwork
General points

• Make sure you use uniform lettering and sizing of your original artwork.
• Embed the used fonts if the application provides that option.
• Aim to use the following fonts in your illustrations: Arial, Courier, Times New Roman, Symbol, or use fonts that look similar.
• Number the illustrations according to their sequence in the text.
• Use a logical naming convention for your artwork files.
• Provide captions to illustrations separately.
• Size the illustrations close to the desired dimensions of the published version.
• Submit each illustration as a separate file.
• Ensure that color images are accessible to all, including those with impaired color vision.

A detailed guide on electronic artwork is available.
You are urged to visit this site; some excerpts from the detailed information are given here.
Formats
If your electronic artwork is created in a Microsoft Office application (Word, PowerPoint, Excel) then please supply 'as is' in the native document format.
Regardless of the application used other than Microsoft Office, when your electronic artwork is finalized, please 'Save as' or convert the images to one of the following formats (note the resolution requirements for line drawings, halftones, and line/halftone combinations given below):
EPS (or PDF): Vector drawings, embed all used fonts.
TIFF (or JPEG): Color or grayscale photographs (halftones), keep to a minimum of 300 dpi.
TIFF (or JPEG): Bitmapped (pure black & white pixels) line drawings, keep to a minimum of 1000 dpi.
TIFF (or JPEG): Combinations bitmapped line/half-tone (color or grayscale), keep to a minimum of 500 dpi.
Please do not:
• Supply files that are optimized for screen use (e.g., GIF, BMP, PICT, WPG); these typically have a low number of pixels and limited set of colors;
• Supply files that are too low in resolution;
• Submit graphics that are disproportionately large for the content.

Figure captions
Ensure that each illustration has a caption. Supply captions separately, not attached to the figure. A caption should comprise a brief title (**not** on the figure itself) and a description of the illustration. Keep text in the illustrations themselves to a minimum but explain all symbols and abbreviations used.

Tables

Please submit tables as editable text and not as images. Tables can be placed either next to the relevant text in the article, or on separate page(s) at the end. Number tables consecutively in accordance with their appearance in the text and place any table notes below the table body. Be sparing in the use of tables and ensure that the data presented in them do not duplicate results described elsewhere in the article. Please avoid using vertical rules and shading in table cells.

References

Citation in text
Please ensure that every reference cited in the text is also present in the reference list (and vice versa). Any references cited in the abstract must be given in full.

Web references
As a minimum, the full URL should be given and the date when the reference was last accessed. Any further information, if known (DOI, author names, dates, reference to a source publication, etc.), should also be given. Web references can be listed separately (e.g., after the reference list) under a different heading if desired, or can be included in the reference list.

Data references
This journal encourages you to cite underlying or relevant datasets in your manuscript by citing them in your text and including a data reference in your Reference List. Data references should include the following elements: author name(s), dataset title, data repository, version (where available), year, and global persistent identifier. Add [dataset] immediately before the reference so we can properly identify it as a data reference. The [dataset] identifier will not appear in your published article.

Reference management software
Most Elsevier journals have their reference template available in many of the most popular reference management software products. These include all products that support Citation Style Language styles, such as Mendeley. Using citation plug-ins from these products, authors only need to select the appropriate journal template when preparing their article, after which citations and bibliographies will be automatically formatted in the journal's style. If no template is yet available for this journal, please follow the format of the sample references and citations as shown in this Guide. If you use reference management software, please ensure that you remove all field codes before submitting the electronic manuscript. More information on how to remove field codes from different reference management software.

Users of Mendeley Desktop can easily install the reference style for this journal by clicking the following link:
http://open.mendeley.com/use-citation-style/international-journal-of-africa-nursing-sciences
When preparing your manuscript, you will then be able to select this style using the Mendeley plug-ins for Microsoft Word or LibreOffice.

Reference style
Text: Citations in the text should follow the referencing style used by the American Psychological Association. You are referred to the Publication Manual of the American Psychological Association, Sixth Edition, ISBN 978-1-4338-0561-5, copies of which may be ordered from http://books.apa.org/books.cfm?id=4200067 or APA Order Dept., P.O.B. 2710, Hyattsville, MD 20784, USA or APA, 3 Henrietta Street, London, WC3E 8LU, UK.

In-text citations: In-text citations consist of the surname(s) of the author(s) and the year of publication. For citations of two or more works by different authors, order alphabetically in the same order they appear in the reference list eg. Several studies (Miller, 1999; Shafranske & Mahoney, 1998)

Arrange two or more works by the same author by year of publication. Place In Press citations last eg. Past research (Gogel, 1990, 2006, in press)

Identify works by the same author (or by the same two or more authors in the same order) with the same publication date by the suffixes a, b, c, and so forth, after the year; repeat the year, eg. Several studies (Derryberry & Reed, 2005a, 2005b, in press-a; Rothbart, 2003a, 2003b)

Reference List: references should be arranged first alphabetically and then further sorted chronologically if necessary. More than one reference from the same author(s) in the same year must be identified by the letters 'a', 'b', 'c', etc., placed after the year of publication.
Examples: Reference to a journal publication: Van der Geer, J., Hanraads, J. A. J., & Lupton, R. A. (2010). The art of writing a scientific article. *Journal of Scientific Communications*, 163, 51-59.

Data references
For reference style 5 APA:[dataset] Oguro, M., Imahiro, S., Saito, S., Nakashizuka, T. (2015). Mortality data for Japanese oak wilt disease and surrounding forest compositions. Mendeley Data, v1. http://dx.doi.org/10.17632/xwj98nb39r.1.
Reference to a book: Strunk, W., Jr., & White, E. B. (2000). The elements of style. (4th ed.). New York: Longman, (Chapter 4).
Reference to a chapter in an edited book: Mettam, G. R., & Adams, L. B. (2009). How to prepare an electronic version of your article. In B. S. Jones, & R. Z. Smith (Eds.), *Introduction to the electronic age* (pp. 281-304). New York: E-Publishing Inc.

Journal abbreviations source
Journal names should be abbreviated according to the List of Title Word Abbreviations.

Supplementary material

Supplementary material such as applications, images and sound clips, can be published with your article to enhance it. Submitted supplementary items are published exactly as they are received (Excel or PowerPoint files will appear as such online). Please submit your material together with the article and supply a concise, descriptive caption for each supplementary file. If you wish to make changes to supplementary material during any stage of the process, please make sure to provide an updated file. Do not annotate any corrections on a previous version. Please switch off the 'Track Changes' option in Microsoft Office files as these will appear in the published version.

Research data

This journal encourages and enables you to share data that supports your research publication where appropriate, and enables you to interlink the data with your published articles. Research data refers to the results of observations or experimentation that validate research findings. To facilitate reproducibility and data reuse, this journal also encourages you to share your software, code, models, algorithms, protocols, methods and other useful materials related to the project.

Below are a number of ways in which you can associate data with your article or make a statement about the availability of your data when submitting your manuscript. If you are sharing data in one of these ways, you are encouraged to cite the data in your manuscript and reference list. Please refer to the "References" section for more information about data citation. For more information on depositing, sharing and using research data and other relevant research materials, visit the research data page.

Data linking

If you have made your research data available in a data repository, you can link your article directly to the dataset. Elsevier collaborates with a number of repositories to link articles on ScienceDirect with relevant repositories, giving readers access to underlying data that gives them a better understanding of the research described.

There are different ways to link your datasets to your article. When available, you can directly link your dataset to your article by providing the relevant information in the submission system. For more information, visit the database linking page.

For supported data repositories a repository banner will automatically appear next to your published article on ScienceDirect.

In addition, you can link to relevant data or entities through identifiers within the text of your manuscript, using the following format: Database: xxxx (e.g., TAIR: AT1G01020; CCDC: 734053; PDB: 1XFN).

Mendeley Data

This journal supports Mendeley Data, enabling you to deposit any research data (including raw and processed data, video, code, software, algorithms, protocols, and methods) associated with your manuscript in a free-to-use, open access repository. During the submission process, after uploading your manuscript, you will have the opportunity to upload your relevant datasets directly to *Mendeley Data*. The datasets will be listed and directly accessible to readers next to your published article online.

For more information, visit the Mendeley Data for journals page.

Data statement

To foster transparency, we encourage you to state the availability of your data in your submission. This may be a requirement of your funding body or institution. If your data is unavailable to access or unsuitable to post, you will have the opportunity to indicate why during the submission process, for example by stating that the research data is confidential. The statement will appear with your published article on ScienceDirect. For more information, visit the Data Statement page.

AFTER ACCEPTANCE

Online proof correction

To ensure a fast publication process of the article, we kindly ask authors to provide us with their proof corrections within two days. Corresponding authors will receive an e-mail with a link to our online proofing system, allowing annotation and correction of proofs online. The environment is similar to MS Word: in addition to editing text, you can also comment on figures/tables and answer questions from the Copy Editor. Web-based proofing provides a faster and less error-prone process by allowing you to directly type your corrections, eliminating the potential introduction of errors.

If preferred, you can still choose to annotate and upload your edits on the PDF version. All instructions for proofing will be given in the e-mail we send to authors, including alternative methods to the online version and PDF.

We will do everything possible to get your article published quickly and accurately. Please use this proof only for checking the typesetting, editing, completeness and correctness of the text, tables and figures. Significant changes to the article as accepted for publication will only be considered at this

stage with permission from the Editor. It is important to ensure that all corrections are sent back to us in one communication. Please check carefully before replying, as inclusion of any subsequent corrections cannot be guaranteed. Proofreading is solely your responsibility.

Offprints

The corresponding author will be notified and receive a link to the published version of the open access article on ScienceDirect. This link is in the form of an article DOI link which can be shared via email and social networks. For an extra charge, paper offprints can be ordered via the offprint order form which is sent once the article is accepted for publication. Both corresponding and co-authors may order offprints at any time via Elsevier's Author Services.

AUTHOR INQUIRIES

Visit the Elsevier Support Center to find the answers you need. Here you will find everything from Frequently Asked Questions to ways to get in touch.
You can also check the status of your submitted article or find out when your accepted article will be published.