THE LEADERSHIP POTENTIAL OF GENERATION Y PRACTITIONER NURSES: BASIS FOR A DEVELOPMENTAL FRAMEWORK

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Declaration

This is to certify that the work is entirely my own and not of any other person, unless explicitly acknowledged (including citation of published and unpublished sources). The work has not previously been submitted in any form to the Durban University of Technology or to any other institution for assessment or for any other purpose.

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Signature of student Date

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Dedication

To Mike and Jono.

Your love and encouragement means the world to me.

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Abstract

Background

This study addresses the global leadership crisis in healthcare. Generation Y nurses are the face of the future for the nursing profession and they will soon form the majority cohort of nurses worldwide. Leaders look similar all over the world, and Filipino nurses are now working in most countries. Their leadership ability will no doubt impact on healthcare worldwide. There has been a lack of academic research focusing on the leadership needs of Generation Y nurses, and in particular a lack of mixed methods research in this field.

Aim

The aim of the study was to develop a sustainable, structured, Generation Y appropriate leadership framework for practitioner nurses, incorporating the knowledge, skills and abilities required so that they are adequately prepared to fulfil leadership at the bedside.

Methodology

The study design was a multistage mixed methods advanced framework, with concurrent and sequential phases. The design suitably addressed the quantitative and qualitative research questions. Integration occurred at multiple levels. The Relationship-Based Care (RBC) model was adapted to serve as the theoretical framework. Data was collected on Generation Y Filipino nurses working at a hospital in Saudi Arabia. The data collection methods included the online VIA-24 strengths survey, the American Organization of Nurse Executives (AONE) leadership survey on 'the leader within' using Benner's rating scale, and semi-structured face-to-face interviews. The quantitative data was analysed using statistical measures, while the qualitative data was analysed using Tesch's coding and thematic analysis.

Findings

The three sets of data revealed insights into the perceptions, leadership needs and leadership development of Generation Y nurses. The significant

findings were that Generation Y nurse's rate 'fairness' as the most important character strength and they want equal opportunity to take on leadership roles. The character of a leader determines leadership ability and effectiveness, and they believe they have leadership ability, and that anyone can lead. Generation Y nurses are keen to take the lead, but they need further personal and professional development, and a clear career plan. They value collaborative teamwork, relationships and good communication. They have a clear leadership vision, and strongly desire leadership education that is creative, innovative, technology-driven and fun. They want to learn through active learning and reflective practice. The outcome of the study led to the development of a leadership framework for practitioner nurses that can be used to prepare them for future leadership roles.

Key words: Bedside leader, character strengths, clinical leadership, Filipino nurse, Generation Y, leadership, Millennials, nursing leadership.

Table of Contents

List of Tables

List of Figures

List of Appendices

Glossary of terms

Bachelor of Science in Nursing

A Bachelor of Science in Nursing (BSN) refers to a four-year college degree providing entry into practice as a qualified professional/registered nurse. Nurses who have undertaken a BSN are also referred to as baccalaureate-prepared nurses (Megginson 2008: 47).

Coordinator

In this study a coordinator refers to a registered nurse (staff nurse) who coordinated activities in the ward during the commissioning stage of the hospital where data was collected, before the arrival of the nurse manager.

Licensing

Licensing refers to the statutory system whereby authorities ensure healthcare organisations are permitted to operate, in order to ensure safe, quality patient care. These authorities control the training, fit for practice, standards, conduct and licence renewal of professional healthcare providers (Whittaker et al. 2011: 60).

Practice environment

The practice environment refers to the characteristics of the workplace setting that either promotes or decreases the ability of nurses to effectively practice the professional art and science of nursing (Lake 2002: 178).

Practitioner nurse

In this study, a practitioner nurse is a BSN-qualified registered nurse, who will be referred to as a staff nurse. A practitioner nurse works clinically at the bedside as a primary nurse, providing care to patients.

Preceptee

A preceptor is defined as a staff nurse who supervises new or inexperienced nursing peers in the clinical practice setting, to bridge the gap between theory and practice (Carlson 2012: 457). In this study, the term preceptor refers to

the staff nurse providing the clinical supervision, and the term preceptee refers to the staff nurse receiving the clinical supervision.

Registered nurse

A registered nurse refers to a qualified professional nurse, who has either undergone nurse training at a nursing school, nursing college or university. A registered nurse can hold a nursing diploma, Bachelor of Nursing degree, master's degree or a doctoral degree (Megginson 2008: 48). All registered nurses (staff nurses) who participated in this study hold BSN degrees.

Shift leader

A shift leader is a staff nurse to whom the nurse manager has assigned authority in terms of some managerial functions for a specific shift, to oversee patient care and staff control. This authority is limited to a given shift (Goldblatt et al. 2008: 46). In some healthcare organisations a shift leader is referred to as a team leader or a charge nurse.

Staff nurse

In this study a staff nurse is a qualified registered nurse. Registered nurses are often employed and referred to as staff nurses in healthcare organisations (Rogers et al. 2004: 202), in many countries of the world, including Saudi Arabia.

Strengths

In this study a strength is defined, according to Park, Peterson and Seligman (2004: 603), as a positive attribute which is echoed in beliefs, a state of mind and behaviour of an individual.

List of Acronyms

Acronym	Full word/sentence
AMP	Applied Measurement Professionals, Incorporated
AONE	American Organization of Nurse Executives
AHA	American Hospital Association
BSN	Bachelor of Science in Nursing
DUT	Durban University of Technology
EBP	Evidence-Based Practice
EI	Emotional Intelligence
GAPFON	Global Advisory Panel on the Future of Nursing and Midwifery
HR	Human Resources
ICN	International Council of Nurses
IOM	Institute of Medicine
IRB	International Research Board
IT	Information Technology
LMIC	Low-middle income countries
MDGs	Millennium Development Goals
MOH	Ministry of Health
NHS	National Health Service
OFW	Overseas Filipino Workers
POEA	Philippines Overseas Employment Agency
PWC	Price Waterhouse Cooper
RBC	Relationship-Based Care
RN	Registered Nurse
SCFHS	Saudi Commission for Healthcare Specialties
SDGs	Sustainable Development Goals
SNB	Scientific Nursing Board
SPSS	Statistical Package for Social Sciences
UK	United Kingdom
UN	United Nations

Acronym	Full word/sentence
USA	United States of America
VIA	Values in Action
WHO	World Health Organisation

CHAPTER 1: ORIENTATION TO THE STUDY

1.1 INTRODUCTION

Healthcare delivery relies on effective leadership and a lack thereof can have an enormous impact on patient outcomes. The healthcare workforce is currently unprepared for the ever-increasing healthcare needs, due to a multiplicity of factors. The nursing profession is being urged by the World Health Organization (WHO) to transform the current state of healthcare and properly plan and prepare the workforce according to the needs of each country (World Health Organization [WHO] 2016: 12). For the first time in history, organisations are experiencing a multigenerational workforce, with four generations of people working together (Nelsey and Brownie 2012: 197; Stanley 2010: 846). Many current leaders will be retiring in the next decade, leaving a gap in competent nursing leadership (Dyess et al. 2016: Para. 1 line 1; Holland 2015a: 8; Nelsey and Brownie 2012: 197). By 2020 50% of the global workforce will comprise the younger generation (Generation Y), born between 1980 and 2000 (Chung and Fitzsimons 2013: 1173). Their value in the workforce cannot be ignored and measures need to be put in place to retain these nurses, help them to reach their full potential, and keep them satisfied. In addition, nurses who enjoy their work perform better (Stanley 2010: 846; Wieck, Dols and Landrum 2010: 17).

Nurses play a pivotal role at the bedside ensuring that patients receive excellent care (Koloroutis 2004: 20). The focus of this study will be on the leadership development of the practitioner nurse, no matter how junior, because decisions requiring good leadership ability are made by all practitioner nurses on a day-to-day basis. This study must not be confused with the traditional leadership of nurses who assume high positions in the nursing hierarchy; it is about developing the practitioner nurse who cares for the patient at the bedside in his/her clinical nursing role. Leadership should be developed at all levels, even at the level of the most inexperienced nurse.

However, it stands to reason that preparing Generation Y nurses now means that there will be adequately prepared future leaders waiting in the wings to substitute those who resign or retire. This study takes place in a hospital in Saudi Arabia, and the participants are Filipino nurses employed in this hospital.

1.2 BACKGROUND OF THE STUDY

Globally there is a critical shortage of nurses, which has been highlighted by the International Council of Nurses (ICN) in their report titled 'Nurses: A Force for Change Care Effective, Cost Effective' (International Council of Nurses [ICN] 2015: 4). In particular, this shortage extends to nurses who are inadequately prepared to meet the ever-expanding healthcare needs of ailing populations (Nelsey and Brownie 2012: 197; Sherman, Dyess and Prestia 2013: 18). The WHO has labelled this situation a 'crisis' (WHO 2015: 1). Because nurses make up 40-50% of the global healthcare workforce (Stanley 2010: 847), they are the backbone of any healthcare organisation. This means that the success of healthcare organisations is dependent on future nurse leaders. The future workforce needs to be prepared at a more practical level to meet emerging healthcare needs and the organisation urges healthcare to improve the underperformance and strengthen the capacity of the current workforce (WHO 2015: 3; WHO 2016: 8). A global strategy is needed to motivate better collaboration of efforts in healthcare organisations, one focus being human resources for health, to meet the goals of the sustainable development goals (SDGs) 2016-2030 (WHO 2015: 4). Nurses have a key role to play in policy-making (ICN 2015: Para. 3 line 13) yet they are not fully utilised in care delivery, management and policy settings, which is a shame, since they have much to offer. Putting effort and focus into the strategic approach to workforce development is a "return on investment" according to the ICN (2015: Para. 3 line 20).

According to Stanley (2010: 850), there is a link between leadership and generational workforce success, and between leadership and outcomes (Kelly 2008: 13). There also appears to be a positive relationship between

leadership development and organisational growth and success (Amanchukwu, Stanley and Ololube 2015: 6; Hogan and Kaiser 2005: 178; Joiner and Josephs 2007: 36). Since by 2020 Generation Y nurses will make up 50% of the workforce and 75% by 2030, it is imperative that strategies to meet their expectations are put in place to prepare them to lead the future of nursing, according to the American Hospital Association (AHA) (American Hospital Association [AHA] 2014: 8; Hewitt and Upkere 2012: 6002). Furthermore, in the next twenty years, millions of baby boomers will retire, many of whom are the current nurse leaders (Dyess et al. 2016: Para. 1 line 1; Sherman, Dyess and Prestia. 2013: 18). This exit will be a great loss of experience for the profession (Kuhl 2014: 26). If nursing departments do not prepare for this deficit by developing a pool of future leaders from Generation Y, this will be catastrophic for the healthcare sector (Sherman, Dyess and Prestia 2013: 18).

This research focused on the development of leadership skills in practitioner nurses, thereby growing them to reach their full potential, in terms of everyday practice. This research was aimed at preparing practitioner nurses who are at the patients' bedside, because these nurses also need to take the lead in situations such as day-to-day decision-making. According to Byers (2017: 449), there is a need for organisations to support the optimisation of the leadership potential of nurses at the point of care. The focus of this research should not be confused with the preparation of nurses for formal leadership positions. This study will ensure that nursing takes its rightful place in healthcare, alongside other healthcare professions, which is not the case right now. In many organisations nurses are seen as subordinate to doctors (Schneider 2015: 1). If every nurse was well prepared it would create the impression that nurses are independent enough to stand alone as competent practitioners in a multidisciplinary healthcare team. This impression of nurses not being autonomous provides good reason for the development of leaders amongst practitioner nurses and this study will contribute to further advance the nursing profession globally.

Because care is at the heart of healthcare, good relationships between nurses, patients/families and the multidisciplinary team are paramount. According to Koloroutis (2004: 4), relationship-based caring has a positive impact on patient outcomes and thus organisational success. This research is about fulfilling the leadership potential of Generation Y practitioner nurses. It is the belief of the researcher that to apply a theoretical model, such as the relationship-based care model (RBC) which is about relationships, makes sense in healthcare. Although the RBC model focuses on patient care delivery, elements can be appropriately applied to the leadership development of nurses. This study used the RBC model as a foundation and a guide throughout all stages, namely the research design, problem, questions, aim, significance, literature review, results, and development of a leadership framework.

The RBC model is based on six dimensions, namely: a) leadership, b) teamwork, c) professional nursing practice, d) patient care delivery, e) resource driven practice and f) outcomes measurement. For the aim of this study, only four of the dimensions mentioned above were used, namely: leadership, teamwork, professional nursing practice and resource driven practice. This model is developed around the central needs of the patient and family and it lends itself to the development of leadership in practitioner nurses. In this model, the nurse is portrayed as an important component of the resource dimension, and the leadership and teamwork dimensions in a relationship-based context can be well integrated in the study to contextualise the findings and discussion, as well as guide the development of the leadership framework itself (Koloroutis 2004: 14).

1.3 RESEARCH QUESTIONS

Research questions are central to a mixed methods study. They evolve and are interconnected to various parts of a study (Onwuegbuzie and Leech 2006: 478). In this study there is a complementary relationship between the literature review, research questions, objectives, theoretical framework and methodologies. Leadership is complicated and multidimensional (Sutherland

and Cameron 2015: 365). Complex problems often need a clear and assimilated set of mixed methods research questions (Lavelle, Vuk and Barber 2013: 273). The research questions in this study, which were generated from a number of sources, set the stage for constructing a rigorous study plan. At the outset of the study the researcher was interested in the topic of nursing leadership, and in developing the youngest layer of qualified nurses who have recently joined the profession. After a thorough review of the available literature, the researcher noted a lack of current information regarding ways to prepare young nurses to become effective leaders, which then formed the overarching question. After reviewing theories to serve as the framework for the study, the researcher selected the RBC model, because it was felt it would be the most suitable to guide the study in answering the research questions. More details on the theoretical framework can be found in Chapter 3.

There is one main overarching question and three sub-research questions, comprising two quantitative and one qualitative type question. In mixed methods research, Tashakkori and Teddlie (2003 cited in Lavelle, Vuk and Barber 2013: 273) advise researchers to have one main question acting as an umbrella for several sub-questions. Creswell (2008: 41) suggests having separate quantitative and qualitative questions followed by a mixed methods question, which integrates the findings of both strategies. The approach in this study starts with three sub-questions (two quantitative and one qualitative), and ends with one overarching mixed approach question.

1.3.1 Sub-research questions

- Quantitative question: Which character strengths are important to Generation Y nurses?
- Quantitative question: How do Generation Y nurses rate their leadership skills?
- Qualitative question: What are the leadership experiences and needs of Generation Y nurses?

1.3.2 Main research question

- Mixed question: How can the nursing profession prepare Generation Y nurses to become effective leaders?

1.4 PROBLEM STATEMENT

The problem statement is one of the most critical elements of research (Grant and Osanloo 2014: 18). The problem that inspired this study is that nurses are inadequately prepared for leadership, which is a serious situation in healthcare, where quality of care and patient safety are of paramount importance. In addition, healthcare problems are often complex and have many dimensions that need to be considered (Lavelle, Vuk and Barber 2013: 273). The responsibility of ensuring optimal patient outcomes, to a large extent, falls on the shoulders of nurses. With reports of a lack of leadership globally, it is a concern that this will affect the future success and sustainability of healthcare organisations (Sherman, Dyess and Prestia 2013: 18). In addition, a lack of leadership affects the work satisfaction of nurses, their retention in the workforce as well as their performance, which ultimately impacts negatively on patient outcomes.

Anecdotal evidence suggests that nurses generally are not adequately prepared to take the lead in meeting the changing needs of healthcare and it is proposed that measures be put in place to prepare nurses for this role, focusing on the leadership needs of Generation Y nurses. Dr Margaret Chan, the Director General of the WHO, urges each country to reform the health sector, since nurses form the pillar of healthcare provision in almost every country, and their input is crucial (ICN 2015: 1; Mitchell 2015: 283; White 2015: Para. 25 line 1; WHO 2015: 1). The mission of the Institute of Medicine (IOM) in the United States of America (USA) is to advance and spread scientific knowledge to improve health for all. In 2011 they issued a report which urged the country to transform its healthcare. In the third key message of the IOM report, reference is made to the need to promote leadership at all levels, from the local bedside to the executive level boardroom (Institute of

Medicine [IOM] 2011: 221). According to their report, the public does not usually consider nurses to be leaders, and furthermore, when nurses embark on their nursing career, the thought of someday becoming a leader is not foremost in their minds. The IOM (2011: 228) makes a plea for action regarding the nursing profession in their challenging statement “A call for nurses to lead”.

The development of nurses is likely to impact the quality of healthcare. Competent nurses with leadership skills are needed at the bedside and not only in formal leadership positions. However, many of the current nursing leaders are retiring, and younger generations of nurses, including the many Generation Y nurses, will need to fill this gap. To date, most leadership development has targeted nurses already in formal leadership/management positions. Since at least half for the nursing workforce will soon comprise Generation Y nurses, many of whom are close to the point of care, the opportunity to develop their leadership must be embraced as a matter of urgency. Previous studies show that Generation Y people have unique characteristics and needs (Nelsey and Brownie 2012: 197; Stanley 2010: 846). A lot of previous Generation Y research tends to centre on their unique characteristics, but there is little research on effective strategies to manage this cohort of nurses (D’Netto 2012: 1). How these unique characteristics translate into leadership development was of specific interest to the researcher. Nursing departments globally have not taken this into consideration in developing leadership in practitioner nurses (Huston 2006 cited in Marquis and Huston 2009: 62).

Generation Y will be handling nursing leadership from early in the next decade, and little preparation has been made in organisations thus far. In order to advance nursing, nursing practice must be transformed. New ways in which to prepare this generation of nurses must be considered, because current methods are no longer suitable (Hewitt and Upkere 2012: 6002). If nursing departments do not step up to the plate and prepare a pool of future leaders from Generation Y, this will be catastrophic for the future of the healthcare sector (Sherman, Dyess and Prestia 2013: 18).

In summary, the root of the problem is that there are global reports of a lack of good leadership in nursing, which calls for further research. Additionally, many current leaders will soon be retiring, and with Generation Y nurses expected to become the majority in the workforce in the next few years, action needs to be taken now to prepare this cohort for their imminent leadership roles.

1.5 AIM OF THE STUDY

The aim of the study was to develop a sustainable, Generation Y appropriate leadership framework for practitioner nurses, incorporating the knowledge, skills and abilities required for nurses to be adequately prepared to fulfil leadership roles at the bedside. This framework is intended for Generation Y nurses across the world. The framework will develop the leadership ability of bedside nurses, which will in turn contribute to their ability to be effective leaders in formal positions in the future.

This study views the world through a pragmatic lens, which includes the belief that people are interconnected. This research is justified by its uniqueness, because, to the researcher's knowledge, no previous research exists on leadership frameworks designed specifically for the younger generation, including Generation Y nurses. Furthermore, no existing leadership framework has been developed for nurses using the RBC model as a theoretical framework. Previous authors acknowledge that relationships are crucial to effective leadership and optimal outcomes (Dyess et al. 2016: Para. 36 line 12; Kouzes and Posner 1989: 503; Stodgill and Coons 1957 cited in Uhl-Bien 2006: 654), and the RBC model appears to have been previously applied mostly in the clinical setting, focusing on nursing practice (Field 2015; Heindel 2015; Steele-Moses, Koloroutis and Ydarraga 2011; Roberts 2016: 92; Rodney 2015; Winsett and Hauck 2011).

This study employed the RBC model as the theoretical framework to obtain first-hand experiences and ideas from Generation Y practitioner nurses at the bedside, in order to develop a nursing leadership framework for this cohort of nurses. The data collected on them will help researchers to take the findings

further. This study will also assist organisations with Generation Y employees to understand them better as a cohort, as well as to hear their perspectives and needs in terms of leadership development. By developing practitioner nurses, new strategies could emerge that will transform the care of patients. This research will add to the plethora of existing work on leadership development across all sectors falling inside and outside of healthcare, but more especially, this study will uniquely speak to the future leaders in the nursing profession who are keen to take the lead, because the past alone will not prepare them for the future.

1.6 RESEARCH OBJECTIVES

The objectives of the study were to:

- Determine strengths with which Generation Y nurses enter the workforce.
- Determine the leadership skills of Generation Y practitioner nurses.
- Identify skills that are likely to prepare Generation Y nurses in the workplace.
- Develop a sustainable framework for practitioner leadership skills, to prepare nurses for the future workforce.

Table 1.1 displays the link between the research questions and the objectives of the study.

Table 1.1: Aligning the research questions to the objectives

	Research questions	Objective
Sub-research questions	1. Quantitative question: Which character strengths are important to Generation Y nurses?	1. To determine strengths with which Generation Y nurses enter the workforce.
	2. Quantitative question: How do Generation Y nurses rate their leadership skills?	2. To determine the leadership skills of Generation Y practitioner nurses.
	3. Qualitative question: What are the leadership experiences and needs of Generation Y nurses?	3. To identify skills that are likely to prepare Generation Y nurses in the workplace.
Main research question	4. Mixed question: How can the nursing profession prepare Generation Y nurses to become effective leaders?	4. Develop a sustainable framework for practitioner leadership skills, to prepare nurses for the future workforce.

1.7 SIGNIFICANCE OF THE STUDY

The potential value of this study cannot be underestimated because it positions itself as a solution to the current healthcare leadership crisis. The topic is of great importance to the nursing profession and should attract the attention of a wide audience including practitioner nurses, nurse leaders, nurse managers, nurse educators and researchers. The importance lies in the applied methodology, the theoretical framework, and the findings and outcomes of this study because they impact on the nursing profession and its future leaders. In addition, elements of the study can also be applied to non-healthcare related organisations who employ Generation Y individuals requiring leadership development.

Leadership as a science and art is a complex, multifaceted phenomena (Sutherland and Cameron 2015: 365). This study addresses the issue of relatively weak study designs which appear to have been used previously in leadership studies, yielding limited evidence on how to increase the effectiveness of leadership. The significance of this study from a research design perspective is that it may be the first multistage advanced framework study of leadership in any discipline, certainly in nursing. Single method approaches, in particular quantitative, are probably the most typical approach to leadership research (Stentz, Plano Clark and Matkin 2012: 1173). This study is significant in that it advances leadership through approaching the inquiry from an innovative mixed methods perspective, with integration at multiple levels. Mixed methods are known to elicit more valid information, especially in complex inquiries such as those found in behavioural and social science research such as healthcare (Creswell 2009: 203). Theories that have commonly been used in nursing leadership arose having been translated from studies in sociology and psychology, and appear to have been applied more liberally to corporate business. Theories such as transformational leadership and emotional intelligence (EI) have directed much of the research and development strategies designed to promote nursing leadership. This study is unique in that it utilised a theoretical framework, namely RBC, created for

healthcare, by experts in the profession. The RBC theory has predominately been applied to clinical practice and not leadership development.

It is generally acknowledged that good nursing leadership yields better patient outcomes (West et al. 2014: 2). There are many situations that practitioner nurses face on a daily basis, where they need to use leadership skills to make safe and effective decisions for their patients and colleagues This is a significant study because development of future nursing leaders is imperative to ensure that countries offer care to their patients that is effective, safe and of an excellent standard. Although there are many leadership studies both in nursing and out of nursing, this study is significant because it directs the inquiry to leadership development in Generation Y nurses working as practitioner nurses in hospitals. This study is timely, because it addresses the current pleas from nursing associations such as the ICN, WHO and the IOM to transform nursing through encouraging leadership at every level.

This study is a strategic-thinking study because it focuses on the future and establishes the leadership needs of Generation Y nurses, as identified by them. There appears to be a lack of research on effective strategies to manage Generation Y, making this study significant. It is not known how much emphasis is put on leadership education of nurses, nor the current level of leadership knowledge of Generation Y nurses. It is also not known whether Generation Y nurses aspire to be leaders and whether they perceive leadership development to be useful to their professional journey. It would appear that there is little literature to date on the unique needs, motivations and expectations of this young generation of nurses, who have only recently embarked on their nursing careers. In fact much of the previous research on generations is not related to nursing. Rather, a great deal of previous literature has focused on the work ethic, characteristics and leadership styles of the four generations in the workplace in general, and furthermore, most of these studies took place in developed countries. This study is significant because it addresses these unknown issues.

This study is important to healthcare because it remedies the underrepresentation of minority groups such as Filipino nurses, who practice in both high and low-middle income (LMI) countries around the globe, which makes this a very significant study. Leaders around the world have more similarities than differences (Posner 2016: 585), implying that the nationality of study participants is not important, and that data provided from this cohort can inform leadership development across the globe. Yet distinct differences have been found between the characteristics and the requirements of different generations of people (Mannheim 1952; Woodward, Vongswasdi and More 2015), strengthening the need for further research on Generation Y individuals.

Although there has been a small burst of recent research on Filipino nurses, little if any empirical studies have been undertaken on their leadership development or their perceptions of leadership, which is significant because these nurses are now staffing hospitals all over the world. There is also little research available on leadership in developing countries such as Saudi Arabia and the Philippines. The findings of this study are significant because they add to the body of knowledge that already exists on nursing leadership. The opinion of Generation Y nurses matters and therefore research conducted on them and for them is more valuable and credible.

This research is significant in that it approaches nursing leadership integrally, meaning that emphasis is placed on both the behavioural science as well as the professional skills required in complex unpredictable environments such as healthcare. Deliberate application of the study methods is expected to lead to advancements in leadership which will not be limited to theory progression only, but also to the theoretical understanding of the phenomena of nursing leadership itself. While the study explores nursing leadership in the context of a single generational cohort and in the profession of nursing, the researcher proposes that these same perceptions may also emerge elsewhere, in other fields.

1.8 STRUCTURE OF THE THESIS

Chapter 1: Orientation to the study.

Chapter 2: Literature review.

Chapter 3: Theoretical framework.

Chapter 4: Research methodology.

Chapter 5: Methodology of integration.

Chapter 6: Presentation of results.

Chapter 7: Discussion of results.

Chapter 8: A leadership framework for practitioner nurses.

Chapter 9: Limitations, conclusions, recommendations and potential outputs.

1.9 SUMMARY OF THE CHAPTER

This chapter introduced the reader to the background of the study and revealed the structure of the thesis. It also justified the significance of the study and the problem in nursing leadership that this research addresses, namely, concerns about the lack of adequate leadership and more specifically the need for preparation of Generation Y nurses for the future. Chapter 2 will present the literature review.

CHAPTER 2: LITERATURE REVIEW

2.1 INTRODUCTION

A review of the literature was conducted to explore different aspects of leadership, particularly as it applies to the Generation Y cohort of nurses in the healthcare sector. The literature review explored the researcher's field of interest, which helped the researcher identify gaps, which led to the formation of the research questions. Literature was sourced on the healthcare situation globally, in Saudi Arabia, and in the Philippines. The concept of self-awareness and character strengths was studied as it applied to performance in the workplace. Leadership and generations also formed part of the search.

In addition to this chapter serving to address the elements and scope of the study, it should be noted that previous literature was also reviewed to justify the researcher's choice of theoretical framework and the choice of instruments utilised for data collection. Previous literature focusing on the four dimensions of the RBC theoretical framework, namely: leadership, teamwork, professional practice and resources. The gaps in the available literature will be revealed towards the end of the chapter, after the literature review has been presented. Figure 2:1 outlines the organisation of the literature review.

Figure 2.1: Framework for literature review

2.2 SOURCES OF LITERATURE

Search engines: Google Scholar, EBSCOhost, Cumulative Index to Nursing and Allied Health Literature, Sabinet, Science Direct, Summon. Peer-reviewed journal articles and online sources were considered for the study, as well as books. The key words used when searching included: bedside leader, character strengths, clinical leadership, Filipino nurse, Generation Y, leadership, Millennials, nursing leadership.

2.3 THE HEALTHCARE SITUATION

Healthcare will be discussed from a global perspective, followed by healthcare in Saudi Arabia and the Philippines.

2.3.1 Healthcare globally

The current nursing workforce remains inadequate to meet future healthcare demands, despite a recent increase in global recruitment into health sectors. Between high staff turnover, an inability to attract talented nurses and the fact

that many of the current nurse leaders are about to retire, the health sector is struggling to respond appropriately to the healthcare needs of their communities (Holland 2015a: 8; Nelsey and Brownie 2012: 197). With the imminent retirement of many of the older, experienced, nurses, a significant loss of knowledge and experience will be felt, which is not easily replaced (Sherman 2008: 45). Nurse Managers therefore need to consider several strategies such as acknowledging the need for change and being prepared to undertake change in their healthcare setting. This starts with self-awareness and education regarding the characteristics and core values of each generation in the workplace (Hendricks and Cope 2012: 720).

There is no dispute that, globally, nurses form the backbone of any healthcare organisation (Barney 2002: 154). Nurses make up 40-50% of the healthcare workforce (Stanley 2010: 847) and therefore have a key role to play in the provision of universal health coverage (Mitchell 2015: 283; WHO 2013: iii), especially at the point of care (Sherman and Pross 2010: Para. 1 line 4). Nurses are on the frontline and are the first providers of care in any healthcare organisation (Alghamdi and Urden 2016: E95). The blame for the perception that healthcare systems are inefficient and unprepared has been placed partly on a lack of good leadership (Sherman, Dyess and Prestia 2013: 18). In the nursing profession, it has been predicted that by the end of this decade, there will be a worldwide shortage of nursing leaders, which will be a key challenge to rectify (Dyess et al. 2016: Para. 1 line 1; Holland 2015a: 8; Sherman Dyess and Prestia 2013: 18).

In response to the need to revitalise healthcare, the ICN, a global organisation, have set as their motto for a 2017-2019 campaign as “Nurses: A Voice to Lead”, which focuses on the fact that nurses need to participate and speak out more in the development and implementation of policy (ICN 2017: Para. 4 line 3). Another response comes from the United Nations (UN). In the year 2000, the UN developed eight millennium development goals (MDGs) which aimed to create a better world through three global dimensions of development namely economic, social, and environmental. These goals were not fully achieved by the target date of 2015, although a great deal of

progress was made. Building on this success, the UN reacted to the global healthcare needs by extending the MDGs and creating 17 SDGs to be achieved over the next 15 years until the target date of 2030 (WHO 2015: 6). These new goals are unique in that they call for global action by all WHO member states (rich, poor and middle-income) to promote prosperity through building economic growth and by addressing a range of social needs including health. One of the goals is to strengthen health systems through building effective health leadership (WHO 2015: 6). Pierre Théraulaz said in the ICN Global Leadership Institute report that nursing leadership should be strengthened if the profession want their voice to be heard (ICN 2016: Para. 2 line 1).

The WHO is a 194 member organisation that includes the countries of Saudi Arabia and the Philippines. The WHO supports global health matters and advises countries accordingly. The organisation is calling on nurses to contribute to achieving the SDGs through the 'WHO global strategy on Human Resources for Health (HRH): Workforce 2030 requirements' (WHO 2015: Para. 4 line 4). According to White (2015: Para. 1 line 7), the world needs adequate numbers of appropriately trained nurses on the workforce to match healthcare needs. Nursing must contribute to this by developing a country-level plan. In support of this goal, Dr Margaret Chan, the Director General of the WHO, urges each country to focus on evidence-based policy as a way to reform the health sector. Since there are more than 16 million nurses practising worldwide, nurses form the pillar of healthcare provision in almost every country and their input is crucial (ICN 2014: Para. 2 line 4).

The nursing profession needs transformation and nurses need to be scaled-up at all levels (Mitchell 2015: 283). One way to achieve this is through effective and appropriate leadership (Medyanik 2016: 3). In the Robert Wood Johnson Foundation-funded IOM report, *The Future of Nursing: Leading Change, Advancing Health* (IOM 2011: 172), it is plainly stated that nurses need advanced levels of innovative education and training in order to meet the increasing healthcare demands. In support of this statement, a study by Aiken et al. (2012: 5) concluded that improvement of hospital work

environments might be a relatively low cost strategy to improve safety and quality in hospital care which could also increase nurse retention and satisfaction. This notion is further backed by American Chief Clinical Officer Marcia Faller (2015) who said in a radio interview with *The Health News* that it is the responsibility of healthcare systems to use innovative approaches to attract and retain their nurses while keeping them satisfied and competent. Innovative solutions in the nursing workforce could make a dramatic impact on patient outcomes and could transform the healthcare industry.

2.3.2 Healthcare in Saudi Arabia

The kingdom of Saudi Arabia, one of the largest countries in the Middle East, is an Islamic county, abiding by the Islamic traditions that are evident in all aspects of life, including work life (El-Gilany and El-Wehedy 2001: 35). It is considered a LMIC and its healthcare is categorised as being a national healthcare system. This means that the Ministry of Health (MOH) controls healthcare for the entire population of 28.29 million people (UNICEF 2014 cited in Aghamdi and Urden 2016: E96), through the Council of Health Services, as decided by Royal Decree in 2002. In addition is the increase in life expectancy of Saudi nationals from 69 years in 1990 to 76 years in 2012 (WHO 2013). Healthcare is provided in private and government healthcare organisations, although the vast majority of citizens use the government system (Alghamdi and Urden 2016: E96). The MOH provides primary, secondary and tertiary levels of healthcare to people living in Saudi Arabia (AlYami and Watson 2014: 10). Anyone nursing in Saudi Arabia needs to belong to the Saudi Commission for Healthcare Specialties (SCFHS), whose responsibility it is to oversee and evaluate all education programmes, as well as to set minimum requirements and standards of practice for health professions to follow (Alghamdi and Urden 2016: E97).

Formal one-year nurse training commenced in Saudi Arabia in 1954. In 1976 the first Bachelor of Science in Nursing (BSN) was offered for women and in 2004 the BSN was offered to men. Due to the poor image of nursing in the country, the enrolment numbers are low. Saudi nurses are able to enrol

abroad for Bachelor, Master's and doctoral degrees through international scholarships, since Master's studies are only offered to women in Saudi Arabia (AlYami and Watson 2014: 11).

The global nursing shortage is well known, and the kingdom of Saudi Arabia has not been left unscathed by this situation (Aiken 2007: 1300; Alghamdi and Urden 2016: E98; Al Hosis, Plummer and O'Connor 2012: 19; AlYami and Watson 2014: 10; Mitchell 2009: 167). In Saudi Arabia, this shortage is related to a number of factors, including the ever-increasing annual Saudi population growth rate (Alghamdi and Urden 2016: E98). According to the United Nations Children's Fund (2014 cited in Alghamdi and Urden 2016: E98), the population growth rate in Saudi Arabia increased by 2.5% each year from 1990 to 2012. Another factor is that people are living longer with an increase in the life expectancy of Saudi nationals from 69 years in 1990 to 76 years in 2012 (WHO 2013 cited in Alghamdi and Urden 2016: E98). These factors have resulted in an increased demand for health care. While hospitals in Saudi Arabia are generally well-equipped with state-of-the-art consumables and machinery using the latest technology, their healthcare is not supported by a local, experienced and specialised nursing workforce. In Saudi Arabia, the majority of any nursing workforce is staffed by expatriates. According to one study, the Saudi Arabian nursing workforce is made up of only 34% Saudi nurses (AlYami and Watson 2014: 10). Thus, it is evident there is a shortage of qualified Saudi nurses. The nursing profession is not viewed as a profession of high status in Saudi Arabia, and in addition, many female nurses refuse to nurse male patients. According to the Islamic tradition, it is forbidden that men and women work together (El-Gilany and El-Wehedy 2001: 35). The researcher observed while working in Saudi Arabia, that some hospital administrative offices have 'Female Office' signage, indicating that these traditions are still evident to some degree.

The Saudi government has made an effort to draw Saudi nurses into the nursing profession, more recently through the National Transformation Program (2016: 27) 'Saudi Arabia Vision 2030', which includes the MOH. The fifth strategic objective for health is to increase the attraction of nursing as a

career of choice National Transformation Program 2020 (2016: 27). However, nursing is not viewed in a positive light by the nationals (Almutairi and McCarthy 2012: 71; AlYami and Watson 2014: 11). Other reasons why more Saudi's do not work as nurses are the unattractive conditions such as working shifts, working over weekends, night shift and the inability to balance work and family responsibilities (AlYami and Watson 2014: 11).

Saudi nurses are usually given the advantage of being able to choose the most comfortable and suitable place and role (El-Gilany and El-Wehedy 2001: 34). Having a majority Saudi national workforce will bring challenges to the profession because, according to Gazzaz (2009: 119), female Saudi nurses prefer:

- Not to work on weekends (in Saudi Arabia, the weekend falls on Friday and Saturday);
- Not to work long hours or late shifts;
- Not to work night shift.
- Not to gender mix

El-Gilany and El-Wehedy (2001: 33), report that female Saudi nurses prefer to work:

- Single shifts, preferably morning;
- No Thursdays;
- No shifts;
- Fewer hours per day;
- The majority of nurses would prefer not to work with males.

It is no wonder that there is a shortage of nurses in Saudi Arabia. In addition to the cultural issues described above, and the number of graduating nurses annually is insufficient to meet the needs of the population and the expanded healthcare services offered. There has also been a drop in the number of expatriate recruited nurses as a consequence of the first Gulf War of 1991 as well as the political unrest in the Middle East ever since (Gazzaz 2009: Para. 2 line 2). As a result of the obstacles resulting in nursing shortages, the Saudi

government is forced to recruit nurses internationally from poor countries such as the Philippines and India, because it is a convenient and economical solution to their healthcare problem (Alghamdi and Urden 2016: E98; Al Hosis, Plummer and O'Connor 2012: 19). Further, the regulation of the profession is lacking, management tends to be centralised in healthcare organisations, and there is a shortage of nurses like most countries are experiencing (Alghamdi and Urden 2016: E95).

2.3.3 Healthcare in the Philippines

The Philippines is an archipelagic country in Southeast Asia, consisting of over 7000 islands (Tanalgo and Hughes 2018: Para. 1 line 4) with a total land area of approximately 300,000 square kilometres. It is described as comprising three main island groups: Luzon, Visayas and Mindanao (Philippine Statistics Authority 2011 cited in United Nations Children's Fund 2016: 79).

The healthcare system in the Philippines is cash-strapped, especially in the government sector where nurses experience poor working conditions (Lorenzo et al. 2007: 1406). These hardships include poor quality of care, shortages of consumables and inferior medical supplies which are considered the norm in healthcare settings. Horrific stories emerged in a Filipino study by Lin (2009: 72). The study relays experiences of Filipino nurses compensating for the many healthcare shortfalls, for example a nurse within the last decade spoke of recycling consumables. This included washing and reusing gloves, and boiling needles and syringes before reusing them. These shortages result in Filipino nurses being very frugal, resourceful and creative in their bid to prevent wastage of inadequate supplies. Another told of a situation where a patient could not afford ventilation at a hospital. The options given were to either extubate the patient or the patient could hire a 'bagger' to provide manual ventilation via an ambu-bag at a cost equivalent to $1.00 a day (Lin 2009: 70).

The Philippines graduates many more nurses than there are jobs, resulting in a large number of newly qualified nurses volunteering their services or alternatively seeking employment in other countries across the world, more especially the Middle East, United Kingdom (UK), Canada, Australia and the USA (IOM 2011: 590). For those who volunteer as nurses in the Philippines, they take full responsibility as a registered nurse (RN), and the purpose is to gain experience and hopefully be hired at that organisation when a post becomes available. Volunteering on average spans between two months and two years and many either do not get paid or they pay the organisation to work as a volunteer. Another alarming comment from that study was that one nurse's volunteer stint was where she learned the basics of her nursing knowledge and skills. They now deemed themselves competent to practice as a nurse in the USA after this experience in the Philippines (Lin 2009: 67).

2.4 LEADERSHIP

In this section, the definitions of the term 'leadership' will be discussed, the difference between a leader and a manager will be shown. In addition leadership will be discussed with regards to healthcare, generations, with special emphasis on Generation Y leadership, as well as the practitioner as a bedside leader. Because data was collected using a self-rating tool, the acquisition of leadership skills will be discussed with reference to the Dreyfus and Patricia Benner's rating.

2.4.1 The leadership conundrum

Leadership is a multifaceted phenomenon which is not easily defined, but in action it is readily recognised (Northouse 2004: 2). Sutherland and Cameron (2015: 365) agree, and state further that when it comes to leadership, a universal schema does not exist. These authors inform that evolution of leadership theory is happening at a fast pace, and that the focus has moved from leader-centred, to leadership-centred, specifically with regards to a sharper focus on the two-way relationship between the leader and follower. Simultaneously, due to the fact that leadership is complex and

multidimensional, there has been a demand for a shift from the traditional quantitative research paradigm to one inclusive of multiple theories and multiple methodological approaches. According to Ladkin (2010 cited in Sutherland and Cameron 2015: 365), leadership is far too complex to be understood through statistical analysis alone. Despite years of discussion and debate, one single definition of the term ‘leadership’ has not been reached.

Leadership and followers are usually mentioned in the literature as being a unit. Some researchers say that the most important element in leadership is the relationship between leader and follower (Kouzes and Posner 1989: 503; Medyanik 2016: 1), whereas Kowalski and Yoder-Wise (2003: 27), on the other hand, postulate that the most important core element of a leader is character. One group of authors defines leadership as the ability to influence the thoughts, actions and opinions of others (Spector 2006 cited in Curtis de Vries and Sheerin 2011: 306). Another author defines leadership as the procedure of influencing a group of people to work together towards a mutual goal (Northouse 2004: 3), whereas an earlier statement by this author (Northouse 2004: 3) defines leadership as involving a process, through influence, in groups, with a focus on goals, and classifies leadership according to personality, process or behaviour. Booyens (1998: 418) expands on this by describing leadership as having three domains, namely, leaders, follows and the context. Ulrich and Smallwood (2012: 10) differentiate further between leaders and leadership by asserting that a leader should prove competence by visualising and planning the future, and then following through by managing the process and the people to realise the vision. In this way, the leader shows belief in his/her followers.

According to Northouse (2004: 4) leadership can be classified by type: those who believe a person is a natural born leader fit the classification of ‘personality trait leadership’, those who believe that anyone can be a leader fit the description of ‘process leadership’ and those who believe that leadership is defined by the actions of a person in a situation fit the description of ‘behavioural leadership’.

The World Bank (2007: 5) characterises an effective leader as someone who is commitment to integrity, ethics and accountability for one's acts and omissions. This raises the topic of leaders and managers. There are distinct differences between the two, and these need to be clarified. According to Kotter (2013: Para. 5 line 2), management and leadership are different concepts, and one cannot replace the other. Both are crucial for organisational success (Kotter 2013: Para. 5 line 2). In general, managers deal with the day-to-day control of operations, whereas leadership is all about behaviours. Managers are in formal leadership positions, higher up the hierarchy, whereas leaders are found at every level. Table 2.1 shows the differences between a manager and a leader, according to Kotter (2013: Para. 8 line 1).

Table 2.1: Differences between a manager and leader

Manager	Leader
Deals with processes	Takes an organisation into the future
Produces products and services	Creates vision
Plans and budgets	Finds opportunities and grasps them
Measures performance	Gets the buy-in of the people
Deals with staffing	Empowers others
Solves problems	Produces useful change

There are many different styles of leadership, the examination of which is beyond the ambit of this study and not in keeping with the aim of the study. However, it would be negligent not to discuss leadership style where and when it relates to the context. There is no optimal leadership style, as the personality of the leader, followers and the environment can all impact on leadership effectiveness (Mullins 2006 cited in Lin et al. 2015: 2). Traditional leadership models, which tend to be based on the individual leader's communication, style and actions, are not sustainable. Relying solely on one style, for example the charismatic leadership style, is a mistake (Ferlie and Shortell 2001: 291), because different situations call for different styles. The healthcare environment, for example, is a system with multiple stakeholders, making it extremely complex to lead with one style only.

Many authors have identified a global leadership crisis (Barrett 2011: 1), which exists in the healthcare sector as well (Hewitt and Upkere 2012: 6002). According to Barrett (2011: 3), only the most resilient organisations will prosper. Organisations need to develop new leadership strategies which support employees to achieve self-actualisation, build united teams and establish a culture for the mutual benefit of all employees. In response to the global leadership crisis a new leadership paradigm has evolved consisting of four elements: leading self, leading a team, leading an organisation and leading in society. But one may ask if the leadership needs of one culture are the same for another, or if utilising leadership strategies from one country will be effective in another. Posner (2016: 573) has revealed answers to these questions in a study comparing the national impact of leadership in India, Pakistan, Ethiopia and the Philippines. This study provided insights on how leaders behave across the world, by exploring the leader's constructs of model, inspire, challenge and enable followers. The findings of this study were that although each country practiced leadership uniquely, their impact within their countries was in fact very similar. This implies that research findings from leadership data collected in one culture or nationality could be beneficial to other countries around the world with different cultures.

2.4.2 Leadership in healthcare

The WHO (2015: 1) reports inefficiency in the global healthcare system. Writing from a USA perspective, Yoder-Wise and Kowalski (2006 cited in Al Hosis, Plummer and O'Connor 2012: 20) note that even those nurses who hold formal positions of frontline and middle management leadership are often ill-prepared and poorly skilled, due to the limited number of suitable candidates for recruitment. A global lack of good leadership and management is at the heart of the problem and by the end of this decade will cause a healthcare crisis (Sherman, Dyess and Prestia 2013: 18). Besides a current lack of effective leaders, new ways of leading are required to meet the unrelenting pace of change in healthcare systems (Careau et al. 2014: 39) which will mean new leadership development initiatives. In the UK, the public health service provided by the National Health Service (NHS) states that it is

during these times of change that healthcare leadership needs to develop capacity from within healthcare, to optimise leadership potential across the healthcare profession as a whole (NHS 2011: 5).

The importance of focusing on nursing leadership globally, including the Middle East, was supported during a meeting of the Global Advisory Panel on the Future of Nursing (GAPFON) chaired by the Sigma Theta Tau Institute (Klopper and Hill 2015: 3). Leaders from around the world met and agreed that one of the top priorities requiring strategic planning is global nursing leadership, which is congruent with the UN SDGs (Wilson et al. 2016: 3). GAPFON is a catalyst for the future of nursing and the panel includes nursing leaders who share the vision for nursing and healthcare advancement globally. GAPFON's aim is to add to the body of knowledge about the value of nursing and to provide input on policies regarding healthcare, leadership and nursing practice, in pursuit of global health and global nursing (Klopper and Hill 2015: 3). Kelly (2008: 24) further suggests that in order to bring about a better leadership culture in healthcare, practices must adapt to employees who show initiative and promise.

Within healthcare organisations the nursing hierarchy is changing. Having four generations working together is not new, but this has produced a more flattened chain of command. In the traditional tiered organisational structure, older workers supervise younger novice workers. The changing hierarchy means that now younger inexperienced nurses are bolder and make their voices heard. Whereas a multigenerational workforce could lead to disharmony and reduced productivity, the diversity and skills mix fits in well with the nursing profession, where teamwork drives the practice of nursing (Stanley 2010: 849). The new hierarchical system lends itself to team-based management which has increased the interaction and shared decision-making between all levels on the organisational structure, making the younger generations of nurses less dependent on the older more experienced nurses (Hendricks and Cope 2012: 720). Shared decision-making identifies and develops leadership at the point of care (Honour 2013: 127).

According to Chief Clinical Officer Marcia Faller (2015), the fact that nearly one third of the older generation will be retiring by 2025 is a serious problem for healthcare since they are the nurses with many years of experience. She stated that it would appear that many of the nurses who are put in leadership positions lack experience and in addition the older nurses are not always willing to mentor the younger nurses. Many nurses are contemplating leaving the profession because of this lack of leadership, and, according to Marcia, because the nursing profession is not always kind to new and inexperienced nurses. This reiterates the need for the older nurses to get the younger nurses up to speed by transferring their knowledge to them.

Hill (cited in Larkin 2012: Para.13 line 1) argues that it takes talent, energy and innovation from all disciplines, including nursing, to significantly accomplish reform within the healthcare system. Because nurses have been managing patient care since the nursing profession began, they are in a unique position to lead healthcare to success. In the next ten years 30 million Baby Boomers will be over 55 years (Lancaster 2004: Para. 5 line 4); many of them are the current nurse leaders (Nelsey and Brownie 2012: 197; Sherman, Dyess and Prestia 2013: 18). The future leaders of the nursing profession will therefore be made up of many Generation Y nurses since it is predicted that by 2020 they will form half of the total workforce (Cheng, Filzah and Warangkana 2015: 39; Martin and Martin 2014: 137; Stanley 2010: 847).

2.4.3 Leadership skill acquisition

Nurses need to be competent in leadership skills in order to perform optimally. Benner's 'novice to expert' theory, adapted from the 1980 Dreyfus and Dreyfus model on skill acquisition, is often used in nursing and demonstrates how people gain knowledge or skills through a five level process (Benner 1982: 402). Benner applied the Dreyfus model to the nursing profession by outlining the same five levels of clinical competency, namely novice, advanced beginner, competent, proficient and expert. These five levels echo changes in skills performance from abstract principles to concrete experience, from seeing a situation as fragmented pieces to a complete whole and from

merely being an observer to becoming engaged in the situation. Skill acquisition of nurses is through formal instruction and practising. These five levels represent an overall change in two aspects of a nurse's skills: increased independence from reliance on abstract ideas and principles and an increase in critical thinking. As one collects more concrete experiences, they are then able to use these as paradigms rather than abstract principles, which also leads to an increase in critical thinking. Experiences gained over time enable a change in perception. Such a change in perception then opens up a new level of thinking that is based on each situation and is more holistic, rather than abstract and pieced-together knowledge that a novice might have. The five levels are awarded 1 to 5 points as follows:

- 1 = Novice – beginners who have had no experience of the situation in which they are expected to perform.
- 2 = Advanced beginner – those who can demonstrate marginally acceptable performance, ones who have coped with enough real situations to note the recurring meaningful situational components that are termed “aspects of the situation” in the Dreyfus model.
- 3 = Competent – typified by the nurse who has been on the job in the same or similar situations for 2 to 3 years; develops when the nurse begins to see his or her actions in terms of long-range goals or plans of which he or she is consciously aware.
- 4 = Proficient – perceives situations as wholes rather than in terms of aspects, and performance is guided by maxims. Proficient nurses understand a situation as a whole because they perceive its meaning in terms of long-term goals.
- 5 = Expert – the expert nurse, with an enormous background of experience, now has an intuitive grasp of each situation and zeroes in on the accurate region of the problem without wasteful consideration of a large range of unfruitful, alternative diagnoses and solutions (Benner 1982: 403).

2.4.4 Generational leadership

The term generational leadership, in the context of the study, refers to leadership as it applies to the different generations working in healthcare organisations. With appropriate leadership, great effectiveness can be achieved in a multigenerational workforce. A healthy working environment can be created through leadership adjustment for each generation to ensure harmony for all nurses, regardless of age (Hendricks and Cope 2012: 720; Hewitt and Upkere 2012: 6002; Jobe 2014: 307). It is important for nurse leaders to know the generational differences and what is important to them, so that they can synergise and work as a team, to produce service excellence.

Links have been found between leadership and nurse retention for all generations (Kowalski 2006 cited in Stanley 2010: 850). The American Association of Nurse Assessment Coordination has identified a connection between the values of the generations and the way they prefer to be managed (Association of Nurse Assessment Coordination 2014: 6), which is supported by Salahuddin (2010: 1). It is often said in the working world that employees do not leave because of organisations, they leave because of bad leaders (Medyanik 2016: 33). This is supported by Buckingham (2006 cited in Fung 2011: 17) who states that the most significant influence on employee performance is the relationship between worker and immediate manager.

There appears to be a lack of literature on nursing leadership relating to generational needs. It seems there are unique leadership needs for younger generations (Woodward, Vongswasdi and More 2015: 70) and leadership development will need to be adapted appropriately to suit Generation Y individuals, because the literature tells us they are known to be more complex to lead (Hewitt and Upkere 2012: 6000; Nelsey and Brownie 2012: 197).

2.4.5 Generation Y leadership

With Generation Y forming the largest generational cohort, leaders face the challenge of finding unique ways to lead this generation (Savage 2012: iv). The fact that, according to Stanley (2010: 850), Generation Y are keen to 'take the lead', means that the time is right to start developing them as leaders. Generation Y need strong leadership (Tulgan 2009: 9) and it is said that they prefer to be 'led' rather than 'managed' (Holt, Marques and Way 2012: 92; Tulgan 2009: 1). Literature on Generation Y leadership in nursing supports the development of nurse leaders at the bedside, even before they assume formal leadership positions (Sherman, Dyess and Prestia 2013: 19). Organisations need to accommodate talented staff and develop their leadership strength for the future workforce (Cheng, Filzah and Warangkana 2015: 39). This means that hospitals need to focus on developing effective leaders, especially within the Generation Y cohort (Dyess et al. 2016: Para. 38 line 2; Holt, Marques and Way 2012: 82; Nelsey and Brownie 2012: 197), since Generation Y will form as much as 50% of the workforce by 2020 (AHA 2014: 8; Hewitt and Upkere 2012: 6002).

The profession and healthcare institutions need to focus on ways to lead and motivate Generation Y because their influence on the future of healthcare will be significant and cannot be ignored (Stanley 2010: 846). The nursing profession has a great responsibility in accommodating their unique needs to ensure talented nurses are attracted to organisations and retained on the workforce (Salahuddin 2010: 1; Lavoie-Tremblay et al. 2010: 2; Wieck, Dols and Landrum 2010: 7). Furthermore, leaders should foster a working environment that is able to withstand constant change, by evolving and responding to the growing needs of the workforce (Lapeña et al. 2017: 66).

2.4.6 Bedside leadership

Bedside leadership, sometimes referred to as clinical leadership, is pivotal in establishing healthcare that has safety and quality at its core (NHS 2011: 5). Anyone can lead; leadership is a process and the ability to lead can be found

within every person (Muller, Bezuidenhout and Jooste 2013: 415; Koloroutis 2004: 71). Benne (1948: 203) had a similar view as reflected in the book title: Leaders Are Made, Not Born. In the 'Leadership Matters' programme on leadership development, the World Bank (2007: 12) sees value in developing leadership in the youth and in so doing they support Benne (1948: 203) and Koloroutis (2004: 71), by moving from the idea that only exceptional people can lead, to one of anyone and everyone can be a leader. Furthermore, a nurse can be a leader even if not in a formal position of authority (Grossman and Valiga 2017: 22; Kelly 2008: 12). Leadership is an obligation to others and in the nursing profession, it embodies the element of care (Buxton 2016: 22). Kelly (2008: 4) points out that the ability for leadership is found in all nurses, not only a select few, due to the fact that they are knowledge experts who provide and coordinate patient care, even as new nurses. Robin Sharma (2008: 45) encourages organisations to develop leaders at all levels as a matter of urgency, because if all employees think and act like leaders, their performance will be optimal. The nursing profession should focus on leadership development, because it impacts positively on staff satisfaction and performance (Lapeña et al. 2017: 67).

The study title informs the reader that the research target for leadership development is the nurse practitioner, who is a BSN graduate, and the primary provider of bedside care. Developing bedside leadership in nurse practitioners could have an enormous impact on the workforce (Stanley 2010: 846; Wieck, Dols and Landrum 2010: 17), because high levels of staff satisfaction result in optimal patient outcomes (Sherman and Pross 2010: Para. 1 line 1). Collaborative, shared leadership at the bedside should be developed because leadership occurs at all levels in an organisation, unlike management, which is usually higher up the hierarchy (Koloroutis 2004: 79). The IOM (2011: 223) reports that although bedside nurses have critical knowledge about the patient, they do not speak up as often as they should. Practitioner nurses should, therefore have more influence than they currently do. With the rapid increase in complexity of healthcare and modern health technology, there is a demand for nurses to assume leadership roles at all levels, including at the bedside (Lippincott, Williams and Wilkins 2003: 2).

2.5 TEAMWORK

Teams are defined as “a distinguishable set of two or more people who interact, dynamically, interdependently, and adaptively toward a common and valued goal/objective/mission” (Salas et al. 1992: 4). This implies that teams are made up of a number of people, who share a common goal, are interdependent on one another; yet remain in a collaborative relationship which ensures inclusivity of all members.

Nursing is a group effort job by description. Nurses do not work in isolation, but rather, in collaboration with multidisciplinary healthcare professionals and ancillary workers. In the context of the study, teamwork will be discussed with regard to relationships within the team, self-awareness and character strengths, deemed necessary to work congenially with others. Successful teamwork is known to improve staff and patient satisfaction (Koloroutis 2004: 112), thus its relevance in the leadership development of practitioner nurses at the bedside is crucial.

Teamwork will now be discussed in the context of relationships between members, self-aware leaders and working with others, as well as the importance of knowing one’s character strengths.

2.5.1 Relationships and leadership within the team

In the context of the study, relationships within the team speak directly to the core of the RBC model which guided the study (Koloroutis 2004: 112). Teamwork is about relationships, which are not only important between nurses, but between all stakeholders who form part of the patient care team. In addition, healthy relationships are crucial to optimal patient and staff outcomes. Failure to acknowledge and understand the unique group dynamics within a hospital make it very difficult to create and sustain a desirable working environment (Kelly 2008: 76).

Within a team, leaders emerge, thus leadership and teamwork are closely linked. The idea of relationship-based leadership is not new (Stodgill and

Coons 1957 cited in Uhl-Bien 2006: 654). Traditionally it refers to people who enjoy connecting with other people (Lipman-Blumen 1996: 165). Leadership is viewed as an exclusive relationship of trust between a leader and his/her subordinates. This relationship needs to be nurtured and requires full focus (Kouzes and Posner 1989: 503), especially within nursing teams. Relationships formed by a leader should be central to establishing and sustaining great teams and they should be part of the culture in any organisation. Relationships are the glue that hold an organisation together (Kowalski and Yoder-Wise 2003: 29).

With the shift towards a relationship-age leadership paradigm, comes a less structured hierarchical management structure. Relationship-age leadership refers to the relationship between the leader and followers. Younger generations resist the traditional style of tiered hierarchies and would rather work in a flattened hierarchy (Chung and Fitzsimons 2013: 1173; Ramirez 2012: 36), where shared decision-making takes place.

Regardless of the generation, effective leaders need to be able to work with others because teamwork is part of nursing. Leaders need to build trusting relationships with others and show understanding and offer support to nursing staff (NHS 2011: 3). Leadership in the 21st century is looking toward a leadership approach that is grounded in a solid relationship between leader and follower. With Generation Y emerging as the future leaders, this is important because they are known to have high expectations of relationships (Medyanik 2016: 1). We also know that Generation Y seek working environments that fosters creativity and that offers them daily inspiration, while they enjoy working in a team (Pendergast 2009; Tulgan 2009). In a book on nursing leadership, relationship-based leadership is succinctly summarised as the ability to adjust to a multitude of unpredictable changes, and relationships are the central force to this process (Porter-O'Grady and Malloch 2015 cited in Sherman et al. 2015: 9). In order for a person to effectively lead others, they should be self-aware (Northouse 2004: 235). When working in a team, it is important for members to demonstrate self-awareness and

limitations of their own strengths, so as to acknowledge their own potential in order to contribute effectively within the team (Cronenwett et al. 2007: 125).

2.5.2 Self-aware leaders and working with others

Self-awareness relates to all individuals, including Generation Y and practitioner nurses, as well as leaders. Self-awareness is associated with effective leadership ability (Ashley and Reiter-Palmon 2012: 2). Previous research confirms the idea that effectively leading oneself is positively related to leading others (Furtner, Baldegger and Rauthmann 2013: 436; Furtner and Rauthmann 2013: 27; Northouse 2004: 236). Shakespeare once said “To thine own self be true” which is reflected in the description by Eckroth-Bucher (2001: 39) that people who are self-aware are in a position to better understand their own personal philosophy and worth. Self-awareness has been defined as thinking about one’s own thoughts and affective processes which means being aware of oneself in the moment, devoid of judgement (Fung 2011: 11). A strong leader should focus on their personal strengths rather than on their weaknesses (Kowalski and Yoder-Wise 2003: 31).

Although there are many skills needed to be an effective leader, human skill is essential to leadership ability. Human skill refers to the ability to work with other people such as peers, subordinates and supervisors. Leaders need these people-skills to work together within organisations, to reach common goals (Northouse 2004: 37). In order to relate to others, one must be self-aware (Furtner and Rauthmann 2013: 27) and be able to translate the value of leadership into effective leadership behaviours (George et al. 2007: 4). Effective leadership requires individuals to tap into their strengths and values in order to deliver optimal patient care, so nurses need to develop self-awareness as well as the ability to grow from their own experiences (NHS 2011: 12). Previous research has observed the benefit of self-awareness in leadership. It is often associated with the style known as authentic leadership, which has self-awareness as one of its four elements (Harvath 2013: iv).

The construct of self-awareness began with the focus on the self as a vehicle of change in the psychotherapeutic process, and was introduced by Rogers in the 1930s (1961:51). The structure of the self relates to an individual's experiences and their awareness of being, and is formed because of their interaction with the environment and more specifically their interaction with others (Rogers, 1961: 489). In his earlier works, Rogers (1959: 223) explains that awareness is the self-experience that results in personal growth, realised through experiences. Thus, being and functioning grows as a result of interaction with the environment, particularly with significant others. This experience becomes a continuous self-view (Rogers 1959: 223).

When 75 leaders were asked to recommend the most crucial competency required by an effective leader, they unanimously nominated self-awareness (George et al. 2007: 3). Self-awareness leads a person to understand their own strengths and weaknesses, values and needs at their deepest level. By knowing one's traits, one is able to be open and honest about presenting the true self to others and this creates a solid anchor on which to base future judgements or actions (Labrague et al. 2016: 4; Northouse 2004: 21). This awareness also allows a person to identify behaviours they desire to change (Fung 2011: 15). Self-awareness is positively and notably correlated with effective relationships with others (Fung 2011: iii). The foundation of our character is derived from our values learned from our family upbringing, experiences and faith. Based on these values, we react to situations accordingly. An example is that we may judge others on our own personal values; for example we may expect others to follow through on promises they make if 'integrity' is one of our values.

It is also believed that leadership skills start when a leader understands him/herself (Sherman and Pross 2010: Para. 18 line 1) and that in order to achieve excellence, one must know one's strengths (Clifton and Harter 2003: 4; Drucker 2009: 17; Peterson and Seligman 2004; Sosik 2006: vii). According to Koloroutis (2004: 31) it is the responsibility of a care provider to be self-aware, since this awareness aligns our perceptions with other people, namely patients and their families as well as colleagues (Koloroutis 2004: 31). Self-

awareness and understanding yourself is essential to being an effective leader as it allows one to fully understand the viewpoints and motivations of others (Bach and Ellis 2011 cited in Billington 2013: 45). It can therefore be said that self-awareness improves decision-making and ultimately optimises patient outcomes (Billington 2013: 45). Since decision-making is crucial in nursing, this is especially relevant to Generation Y practitioner nurses who make decisions on a daily basis.

Northouse (2004: 15) discusses the individual traits of the leader in terms of leadership effectiveness. In his book Leadership Theory and Practice, Northouse (2004) agrees with the importance of self-awareness, but criticises the limitations of many researchers' self-awareness approach because they exclude the influence of the followers and the influence of the unique situation in the leadership process. However, he does acknowledge that taking tests to identify strengths and weaknesses helps people gain valuable insight and gives direction to aspiring leaders. Chung and Fitzsimons (2013: 1176) urge managers to know the strengths and weaknesses of their Generation Y nurses because this may reduce turnover rates.

Self-awareness is linked to EI (Goleman 1998b: 26). Leadership traits are sometimes evaluated through the notion of EI, referring to an individual's affective or emotional characteristics. Goleman (1998b: 56), in his book on EI, explains that the ability to align work with personal aspirations and beliefs builds on self-awareness and that EI increases with self-awareness. Egan (1973 cited in Fung 2011: iii) goes further to say that self-awareness helps develop the ability to understand others and empathise with them, which becomes the foundation for building strong relationships. Goleman's model of EI consists of four elements, one of which is self-awareness, described as the ability to recognise one's own emotions as they occur. He argues that self-awareness is the basis for EI and that when a person deeply understands their own emotions, they are better able to have relationships with others. This notion is supported by Fung's (2011: iii) study on self-awareness that showed positive correlations with self-acceptance and interpersonal relationships, implying that self-awareness supports teamwork and optimises the ability of

individuals to reach their full potential. High-quality relationships, in turn, can lead to enhanced performance. Translated to healthcare, the literature supports the thesis that employees will perform better if they are self-aware. There appears to be a paucity of research on self-awareness as it relates to nursing leadership, so focusing on this under-researched field could make a significant difference to healthcare transformation.

2.5.3 Character strengths

The researcher believes that if Generation Y practitioner nurses are aware of their personal strengths, they can be more effective leaders. Quantitative data was collected in the study, using a strengths survey. Character strengths, believed to be universal, are defined by Park, Peterson and Seligman (2004: 603) as positive attributes which are echoed in beliefs, state of mind and behaviour. Additionally, strengths are characteristics a person owns and uses frequently (Littman-Ovadia, Lavy and Boiman-Meshita 2016: 527). According to Ruch et al. (2014: 53), character strengths are positive, valued qualities which correlate with a number of optimistic outcomes in life.

Rogers (1961: 494), writing in the early days of the self-awareness movement, suggests that the best way to understand the behaviour of people is by looking at their internal value system. Many years later the concept of ‘positive psychology’ emerged, in search of the state of happiness (Seligman 2003: 126). The health science of positive psychology is the study of psychological strengths and positive emotions (Snyder and Lopez 2007 cited in Linley et al. 2010: 6). This new aspect represented a shift in pattern from a focus on ‘what is wrong with people’, to a more positive ‘what is right with people’ (Linley et al. 2010: 6). Crossan, Mazutis and Seijts (2013: 579) found a link between an individual’s strengths and decision-making and this is important in a healthcare setting where practitioner nurses make decisions in their day-to-day care of patients.

Strengths are associated with personal values (Linley et al. 2010: 13). The values approach to motivation assumes that people will be motivated by

activities and outcomes that they personally value (Maslow 1943: 395). Strengths have also been found useful in goal-achievement, improved well-being and success in college students in the UK. Solid empirical evidence supports the assertion that employers who are utilising strengths approaches in the workplace improve outcomes (Linley et al. 2010: 14).

The Values in Action (VIA) Institute on Character is a non-profit organisation dedicated to the development of a scientific knowledge-base of human strengths, established by the Manuel and Rhoda Mayerson Foundation in the USA. Positive psychology's 24 character strength VIA survey, known as the VIA-120 survey, is considered reliable across a consistent question and response format and is also reported to be the primary tool for measuring the virtues and character strengths of individuals (Linley et al. 2007: 343; Littman-Ovadia, Lavy and Boiman-Meshita 2016: 535). Studies of the tool scales have been conducted signifying adequate internal and test/retest reliability, and validity is supported through the use of ratings by significant others and markers of well-being (Peterson and Seligman 2004: 132; Proyer, Ruch and Buschor 2012: 275; Ruch et al. 2014: 53). The VIA classification consists of six core virtues and 24 strengths. The strengths are measured by means of an online survey, where a statement is made and the respondent selects one option for each, from a 5-point scale range of 'very much like me' to 'very much unlike me'. The measure allows researchers to assess each of the 24 strengths in relation to each other, and for many of the strengths, provides the first specific self-report measure of the strength available. Based on this, the tool seems to contribute positively to the list of researchers and practitioners who are interested in the effective assessment of a person's character strengths (Linley et al. 2007: 343). Table 2.2 describes the 24 character strengths and the six virtues that categorise them.

Table 2.2: VIA classification of character strengths and virtues

1. Wisdom and Knowledge – Cognitive strengths that entail the acquisition and use of knowledge

- **Creativity** [originality, ingenuity]: Thinking of novel and productive ways to conceptualise and do things; includes artistic achievement but is not limited to it.
- **Curiosity** [interest, novelty-seeking, openness to experience]: Taking an interest in ongoing experience for its own sake; finding subjects and topics fascinating; exploring and discovering
- **Judgement** [critical thinking]: Thinking things through and examining them from all sides; not jumping to conclusions; being able to change one's mind in light of evidence; weighing all evidence fairly.
- **Love of Learning:** Mastering new skills, topics, and bodies of knowledge, whether on one's own or formally; obviously related to the strength of curiosity but goes beyond it to describe the tendency to add systematically to what one knows.
- **Perspective** [wisdom]: Being able to provide wise counsel to others; having ways of looking at the world that make sense to oneself and to other people.

2. Courage – Emotional strengths that involve the exercise of will to accomplish goals in the face of opposition, external or internal

- **Bravery** [valour]: Not shrinking from threat, challenge, difficulty, or pain; speaking up for what is right even if there is opposition; acting on convictions even if unpopular; includes physical bravery but is not limited to it.
- **Perseverance** [persistence, industriousness]: Finishing what one starts; persisting in a course of action in spite of obstacles; “getting it out the door”; taking pleasure in completing tasks.
- **Honesty** [authenticity, integrity]: Speaking the truth but more broadly presenting oneself in a genuine way and acting in a sincere way; being without pretence; taking responsibility for one's feelings and actions.
- **Zest** [vitality, enthusiasm, vigour, energy]: Approaching life with excitement and energy; not doing things halfway or half-heartedly; living life as an adventure; feeling alive and activated.

3. Humanity - Interpersonal strengths that involve tending and befriending others

- **Love**: Valuing close relations with others, in particular those in which sharing and caring are reciprocated; being close to people.
- **Kindness** [generosity, nurturance, care, compassion, altruistic love, "niceness"]: Doing favours and good deeds for others; helping them; taking care of them.
- **Social Intelligence** [emotional intelligence, personal intelligence]: Being aware of the motives and feelings of other people and oneself; knowing what to do to fit into different social situations; knowing what makes other people tick.

4. Justice - Civic strengths that underlie healthy community life

- **Teamwork** [citizenship, social responsibility, loyalty]: Working well as a member of a group or team; being loyal to the group; doing one's share.
- **Fairness**: Treating all people the same according to notions of fairness and justice; not letting personal feelings bias decisions about others; giving everyone a fair chance.
- **Leadership**: Encouraging a group of which one is a member to get things done, and at the same time maintaining good relations within the group; organising group activities and seeing that they happen.

5. Temperance- Strengths that protect against excess

- **Forgiveness**: Forgiving those who have done wrong; accepting the shortcomings of others; giving people a second chance; not being vengeful.
- **Humility**: Letting one's accomplishments speak for themselves; not regarding oneself as more special than one is.
- **Prudence**: Being careful about one's choices; not taking undue risks; not saying or doing things that might later be regretted.
- **Self-Regulation** [self-control]: Regulating what one feels and does; being disciplined; controlling one's appetites and emotions.

6. Transcendence - Strengths that forge connections to the larger universe and provide meaning

- **Appreciation of Beauty and Excellence** [awe, wonder, elevation]: Noticing and appreciating beauty, excellence, and/or skilled performance in various domains of life, from nature to art to mathematics to science to everyday experience.
- **Gratitude**: Being aware of and thankful for the good things that happen; taking time to express thanks.
- **Hope** [optimism, future-mindedness, future orientation]: Expecting the best in the future and working to achieve it; believing that a good future is something that can be brought about.
- **Humour** [playfulness]: Liking to laugh and tease; bringing smiles to other people; seeing the light side; making (not necessarily telling) jokes.
- **Spirituality** [faith, purpose]: Having coherent beliefs about the higher purpose and meaning of the universe; knowing where one fits within the larger scheme; having beliefs about the meaning of life that shape conduct and provide comfort.

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In a study of nearly 10,000 workers in New Zealand, it was found that those with high self-awareness of their character strengths were nine times more likely to flourish than those with low awareness, and those with high strengths usage were 18 times more likely to flourish than those with low usage of their strengths (Hone et al. 2015: 979). When it comes to leadership styles, authentic leaders are encouraged to commit to self-development through self-awareness of experiences as opposed to merely passively experiencing life. They propose that leadership should be based on solid values and principles as the foundation for moral reasoning and actions. This can be achieved by practising their values and balancing their motivations in order to be driven as much by inner values as external recognition (George et al. 2007: 2; Woodward, Vongswasdi and More 2015: 45). Jim Whittaker, the first American to summit Mount Everest, learned that he could not conquer a mountain because mountains cannot be conquered; rather, in order to succeed in his mission, he had to conquer himself. This view is supported by a study which asserts that self-mastery begins with establishing your personal set of values such as integrity and honesty, which are true leadership characteristics (Kouzes and Posner 1989: 504).

When a leader shows exemplary behaviour in line with their values, the followers will trust that leader (Kouzes and Posner 1989: 503). Generation Y worry that they will fail as leaders because they are concerned about whether their personal value system is aligned with leadership roles, based on the feedback they receive from current leaders. The inclusion of personal strengths, when developing leadership, is becoming a popular approach in order to progress from being an average leader to becoming a great leader (Welch et al. 2014: 20). Strengths training could be useful in developing nursing leaders at all levels of healthcare, including practitioner nurses at the bedside.

2.6 PROFESSIONAL PRACTICE

The importance of professional practice in nursing will be discussed in relation to personal and professional accountability, career planning and personal

journey disciplines. Practitioner nurses need to provide nursing care in a professional manner, which is an important element in the RBC model.

2.6.1 The importance of professional practice in nursing

According to the University Health Network (2005 cited in Kooker, Shoultz and Codier 2007: 30), essential elements in professional nursing practice include independent thinking and decision-making, trust and integrity, as well as accountability and relationships. They explain further that the goal of professional practice is to provide a high standard of nursing care to individuals and their families through processes and organised structures. Other outcomes of professional nursing practice include professional satisfaction and autonomy in the practice of nursing.

Each country has its own statutory bodies that govern and regulate practice standards to ensure patient safety. The nursing profession is vested in these professional regulators who ensure that the staff are fit to practice in the nursing field (NHS 2011: 6). Nurses practice and make decisions according to the code of professional standards of practice, and within legal and ethical parameters (Howatson-Jones 2013: 4).

In the context of this study, professional practice will be discussed according to the categories found in the leadership survey tool (Appendix 7), namely personal and professional accountability, career planning and personal journey disciplines. The researcher searched the available literature to ensure that the content of the tool was suitable for the study. Each category on the tool has two or three sub-categories, which are described below.

2.6.2 Personal and professional accountability

2.6.2.1 Personal growth and development

The nursing practice environment refers to the characteristics of the workplace setting that either promote or decrease the ability to practice the professional art and science of nursing (Lake 2002: 178). The quality of the

professional practice environment is critical in ensuring that safe, quality care is rendered, and nursing staff retained (Kelly 2008: 75). The practice environment must be supportive, high-performing and show evidence of high quality and safety. This requires investment of time, energy and resources. In the highly competitive healthcare environment, professional teams exist, and members must respect the unique qualities that each person contributes, inclusive of their professional experience and accountabilities (Cronenwett et al. 2007: 125). Creating a much sought-after working environment in healthcare is quintessential to positively influencing the attitude, behaviour and performance of staff (Kelly 2008: 76).

2.6.2.2 Ethical behaviour

Ethics is the part of philosophy that distinguishes right from wrong. This distinction is not based on opinion, but on a body of knowledge (Kelly 2008: 518). Ethics provides a much-needed framework to guide nurses in each situation in the form of ethical principles which influence behaviour, practice and relationships that nurses are accountable for in their professional duties (Kelly 2008: 518).

2.6.2.3 Professional associations

All professionals need the knowledge, skills and abilities associated with the work they do, and their cultivation is dependent on the organisation in order to generate positive outcomes. In addition to the organisation affording nurses with opportunities to grow, there are many professional associations that nurses are encouraged to subscribe to, in order to keep knowledge relevant and skills honed (Kelly 2008: 76). In nursing, professional associations are identified as mediums to offer nurses educational opportunities as well as the chance to develop their leadership (Ross et al. 2014: 201). Professional associations also provide opportunities for professional development including continuing education hours, webinars and web-based media formats to provide members with new information relevant to the profession (Matthews 2012: Para. 29 line 2). Through these professional associations as well as

through experienced nurse leaders, the leadership development of nurses can take place at all levels, including novices at the bedside. Mentoring programmes can accomplish this which will ultimately improve outcomes and engage members (Hassmiller and Reinhard 2011 cited in Ross et al. 2014: 205). Nurses are encouraged to join professional associations so as to contribute to the profession, as expected by society.

2.6.3 Career planning

In the context of the leadership survey, the sub-categories include ‘know your role’, ‘know your future’ and ‘position yourself’. These sub-categories refer to the nurse being aware of their role in the healthcare team, being instrumental in planning their career and positioning themselves within the organisation. Through mentoring, supervisors must encourage nurses working under them to create a career plan to ensure their continued development in the profession. This plan should be guided by the assessment of the nurse’s strengths and fields of interest within the profession. Goals should be identified according to their desires and needs (Shermont, Krepcio and Murphy 2009: 432).

2.6.4 Personal journey disciplines

2.6.4.1 Action learning

The essence of action learning is that it is a learning approach where people learn from one another in real time. By definition it is a continuous process of learning, where a supportive group of six or more colleagues, from different levels of an organisation, work voluntarily on finding a solution to a problem. Action learning is not for small petty problems, it is applied to organisation-wide problems. Reflection is a crucial part of this approach to learning and requires collaboration and support from all group members. The idea of this method of problem-solving is to get input from a number of sage stakeholders and at the same time the less experienced group members learn to solve complex problems in the real world, from the more experienced members (Marquardt 2004: 1; Yeadon-Lee 2013: 985). Action learning definitely has a

place in the education of managers (Hay 2011: 38) and it therefore lends itself as an appropriate approach for leadership development education.

2.6.4.2 Reflective practice

According to the leadership survey used in this study, knowledge and practice of active reflection is desirable leadership behaviour. Reflective practice is about reflective thinking. According to Kelly (2008: 484) we have two selves, the active one and the reflective one. The role of the reflective self is to observe and offer advice to the active self. Reflective thinking is related to critical thinking, and to be good at the latter, one must be good at the former. Practising reflective thinking builds confidence in making effective clinical decisions. Reflecting on practice influences issues of patient safety and accountability and can therefore enhance professional knowledge. A nurse should reflect on his or her own practice and discuss any concerns with other team members, to enhance learning from the experience (Howatson-Jones 2013: 5). Johns (2017: Para. 3 line 7) refers to the importance of nurses reflecting on experience as the ticket to professional development, through conscious practice which leads to wisdom.

2.7 RESOURCES

When referring to resources in the context of the study, the literature review will include nursing resources, such as frontline practitioner nurses. The multigenerational workforce will also be discussed with regard to their differences, with a special emphasis on Generation Y, who were the study participants. Because the study sample was nurses from the Philippines, they will be discussed with regard to their background, character and their migration across the world, especially into Saudi Arabia.

2.7.1 Nursing resources

Resource management is more important now than ever before. In healthcare, resources are defined as staffing, equipment and finance, although people are the most important of all. Resource management enables

healthcare organisations to obtain, maintain and allocate their resources effectively in order to function optimally (Koloroutis 2004: 205). With the shift in organisational management from labour-centeredness to knowledge-based, there has been growing emphasis on human capital, encompassing people's knowledge, skills, training and expertise (Muller, Bezuidenhout and Jooste 2013: 43). It is true that organisations cannot ignore material resources such as technology and money, but they certainly cannot ignore the human element, namely the people and the teams who carry out the daily work, which, in healthcare organisations, is patient care (Kelly 2008: 76). Human resource development is crucial in any organisation, but in nursing it ensures competent practitioners who deliver safe, quality care to patients. Human resource management acknowledges that employees need to develop new and better skills for their personal benefit as well as for the benefit of the profession, and this includes development in leadership. Human capital management is thus considered a strategic approach to bring about high performance (Muller, Bezuidenhout and Jooste 2013: 241).

The study topic refers to practitioner nurses. A practitioner nurse, in the context of the study, is a BSN-qualified registered nurse who is known as a staff nurse in Saudi Arabia. A practitioner nurse works clinically at the bedside as a frontline primary nurse, providing care to patients. The practitioner nurse is a human resource, who managed by human resources (HR) with regard to recruiting talented staff, paying their salaries, identifying and implementing their training needs, and developing strategies to motivate and retain them. It is a challenge for organisations to align human capital development with the personal needs of the employee as well as the organisation. Once hired, staff need to be given the training to ensure they perform optimally and to allow for continuous development, for example through communication and team building development strategies (Osmani 2016: 117). This would include the provision of opportunities to ensure practitioner nurses are developed as leaders.

2.7.2 The generations

Since the study topic is centred on Generation Y nurses, the generations will now be discussed. The matter of generations is important enough to be afforded earnest consideration, because according to Mannheim (1952: 163), understanding the generations will go a long way to enhancing social and intellectual processes. A generation is an identifiable cohort who share birth years and important life events at critical developmental phases of life (Beutell and Wittig-Berman 2008: 507; Jamieson et al. 2015: 52). The best definition applicable to this study is that a generation is a group of people who were raised in the same context socially and historically, and as such have shared similar experiences. These experiences differentiate them from other age groups in terms of values and beliefs (Woodward, Vongswasdi and More 2015: 9). Generational cohorts usually span about 15-20 years, and those born close to the edge of a generation often share characteristics with both generations, to varying extents (Jamieson et al. 2015: 52; Lavoie-Tremblay et al. 2010: 3; Woodward, Vongswasdi and More 2015: 10).

The four current generations, born roughly 20 years apart, are known by varying names: Veterans (born 1950-1960), Generation X/Xers (born 1960-1980), Generation Y (born 1980-2000) and Generation Z (born 2000-2020). There are many definitions of the birthdates of each generation in the literature, so for the purpose of this study, Generation Y will be referred to as those individuals born between the years of 1980-2000. This definition of era reflects the writings of Chung and Fitzsimons (2013: 1173).

2.7.2.1 Generational differences

Mannheim (1952: 167) wrote that a generation of people is based on them having a common year of birth, and a shared social and historical location. This means different generations may view life differently to other generations because of when they were born. This supports those researchers who state that the experiences of each generation are unique. Because each generation is born in the same 20 year-span, they share similar backgrounds and

experiences which may affect subsequent experiences (Woodward, Vongswasdi and More 2015: 10). According to Beutell and Wittig-Berman (2008: 508), the generational model identifying generational differences, is generally ascribed to Mannhein. This model stresses the importance of social factors in human development. Generations are distinguished by the major historical events around them and this may partly determine the way people think, perceive things and behave in life (Beutell and Wittig-Berman 2008: 515; Conger 2001 cited in Cheng, Filzah and Warangkana 2015: 39; Hewitt and Upkere 2012: 6003; Scott 2000: 356; Zemke 2001:1). In addition to the generational differences, there are factors such as generational diversity which includes elements of cultural norms, ethnicities, races and religions (DeLellis 2000 cited in Ramirez 2012: 38).

2.7.2.2 Generation Y

This generation was born between 1980 and 2000, close to the turn of the 21st century. This generation is known by many different names including “Generation Y, the Millennials, Echo Boomers, Linked Generation, Era of the Child, Generation Net, Nexters, the Younger Portion of Gen X, the Plugged In Generation, the Second Baby Boom, Boomlets, the Internet Generation, I Generation, Generation ME and Generation WHY“ (Jamieson 2009 cited in Chung and Fitzsimons 2013: 1173). Although this cohort goes by many different names, the term ‘Generation Y’ was coined in 1993 by the American Chicago magazine *Advertising Age* (Chung and Fitzsimons 2013: 1173). In the USA there is estimated to be about 81 million people in this generation, identifying them as the second-largest cohort. It is also believed that they may be the most influential generation since World War II (Mannion 2009 cited in Chung and Fitzsimons 2013: 1173).

Generation Y are known to be self-indulgent, narcissistic and to expect immediate feedback, recognition and promotion. However, this is outweighed by their positive attributes such as loyalty (Alexander and Sysko 2012: 64), although this loyalty usually extends to their individual managers (not organisations). They are known to be committed to the vision, mission and

values of companies and they have a reputation of being hard workers (Alexander and Sysko 2013: 127). They have been greatly influenced by modern technology and they have an exclusive view of ethics, feedback and teamwork; they are known to be rather demanding on their superiors and peers (Medyanik 2016: iii). Generation Y are the youngest working generation in organisations today and have begun to take on leadership roles. Although they agree that nursing leadership is important for the profession, they have reservations about whether they will receive adequate support if they do take on leadership roles (Sherman et al. 2015: 5).

2.7.2.3 Multigenerational workforce

The workplace consists of a diverse mix of age groups and for the first time in history four different generations are working together. Each generation has a unique set of values, behaviours, expectations, habits and motivational buttons. The personal values and responses of people are affected by the generation in which they were born and raised (de Run and Ting 2013 cited in Medyanik 2016: 4). Understanding generational diversity is a necessity, in order for the survival of health care organisations. This will result in creating harmony at work, talent recruitment, staff retention and the positive spin-off of drawing prospective clients. Embracing generational diversity should be seen as a crucial strategic goal (Peck, Kleiner and Kleiner 2011: 54).

Some of the many descriptions assigned to Generation Y are that they appear to group together and prefer to work in collaboration with co-workers which is in contrast to Generation X people who prefer to work more independently. Generation X's intense desire for autonomy and independence may be why they spend less energy on workplace professionalism, because it is too closely associated with styles of interaction with others. However, previous studies show that there are in fact misconceptions about how the different generations are perceived. An example is the stereotypical profile perceived by younger generations that older generations place less emphasis on flexibility, technology and fun. Conversely, older generations perceive the younger generation to value participation, authority, face-to-face interaction,

and lifelong learning to a lesser degree than Generation Y acknowledge (Lester et al. 2012: 351). Older generations are regarded as rigid, whereas younger generations are regarded as entitled and irresponsible; and those in between are misunderstood by both generations either side of them. Perhaps the truth lies in the fact that there are more similarities than differences after all. A study in New Zealand revealed that Generation Y is not that different from other generations with regard to work values (Cennamo and Gardner 2008: 904). Cucina et al. (2018: 246) agrees with those researchers who claim there are more similarities than differences between Generation Y and other generations. These authors are less convinced about stereotyping any generations because age does not make a difference. Being a unique person makes a difference. The individuality of each employee should be taken into account, not their age, and the world should not accept these broad generalisations which are misleading to say the least (Cucina et al. 2018: 246). Deal, Altman and Rogelberg (2010: 196) have similar sentiments when they alert readers to be aware that although there definitely are differences between the generations, at best these are modest.

In a nursing study, it was found that employees from any generation have five main needs: respect and recognition, opportunity for organisational advancement, work/life balance, decent salary/benefits, and opportunities for learning and development (Stanley 2008: 519). The literature on organisational responsibility is increasing and provides the reader with powerful facts through which generational differences amongst nurses can be viewed. The strengths and weaknesses that many individuals from Generation Y display will be carried into their roles as leaders and it is therefore important to understand their differences. These factors should be noted and taken seriously as they can be helpful in developing strategic goals to improve staff performance and patient outcomes. Faced with a global nursing shortage, management should expand their understanding of generational diversity and tap into the individual strengths of their nursing staff which can have positive results (Carver and Candela 2008: 984). Leveraging the strengths of a generation is beneficial for organisations (Lancaster and Stillman 2002 cited in Woodward, Vongswasdi and More 2015: 11).

This can be seen in current healthcare environments where four generations of nurses are working side by side. Due to the fact that many nurses have delayed their retirement, many have changed careers and joined nursing later in life, some have returned to work after a career break and a because there is a smaller but significant number of younger graduates, the nursing workforce now comprises four generations of nurses working simultaneously, namely, Veterans, Baby Boomers, Generation X and Generation Y (Kapoor and Solomon 2011: 308).

Relevant to this study, are reports that each generation brings with it an age diversity with a unique brand of strengths and values, expectations and employment needs (Nelsey and Brownie 2012: 197; Stanley 2010: 846). In addition to these differences is the unique way in which the different generations communicate. In order to foster optimal team output, an effective leader should dedicate time at the outset of a project to identify how the team members wish to communicate, since each generation has unique communication preferences. The literature reveals that some authors believe that organisations should focus on the expectations and needs of the younger generations, in particular on the development of the interpersonal relationship skills of Generation Y (Martin and Martin 2014: 138).

2.7.2.4 Challenges in generational literature/research

There is a plethora of literature available on the generations, each with their own definitions, generational differences, generational characteristics as well as generations at work from all over the world including:

- South Africa (Beutell and Wittig-Berman 2008; Hewitt and Upkere 2012; Martin and Martin 2014);
- USA (Alexander and Sysko 2013; AONE 2015; Douglas et al. 2015; Gomel 2015; Jobe 2014; Kaifi et al. 2012: 88; Rasmussen 2015; Salahuddin 2010; Thompson 2015; Tolbize 2008; Twenge et al. 2010; Weston 2006; Wieck, Dols and Landrum 2010: 7);
- Canada (Lavoie-Tremblay et al. 2010);
- UK (Chung and Fitzsimons 2013; Mannion 2009);

- Australia (Hendricks and Cope 2012; Stanley 2010; Woodward, Vongswasdi and More 2015);
- New Zealand (Cennamo and Gardner 2008; Jamieson et al. 2015);
- Malaysia (Cheng, Filzah and Warangkana 2015);
- Mexico (O'Reilly 2012);
- Turkey (Aydemir, Dinç and Çağlar 2016).

A variety of professions have highlighted the different characteristics, values and needs of Generation Y people, compared with their predecessors. However, it seems researchers cannot agree on whether there are indeed great differences between the generations or not, with one study revealing that differences may also exist across countries, within a single generation. This could pose a challenge for organisations, because recommendations from one country may not be appropriate to another (Cogin 2011: 2268). Posner (2016: 585) however, suggests from the findings of a study comparing leadership between four countries: India, Pakistan, Ethiopia and Philippines, that leadership looks "much more similar than different" all over the world. Woodward, Vongswasdi and More (2015: 3) feel that there is still a great deal of value in studying the generational differences as they pertain to the workplace. This is supported by other researchers such as Constanza et al. (2012: 390) who undertook a meta-analysis on generational differences about attitudes at work, who state that further research is needed to understand generational differences (Martin and Martin (2014: 129) found similarities in the generations, but they also found significant differences in some areas.

Some argue that there are more similarities than differences, such as in a nursing study where it was found that generational differences in work ethic are more fiction than fact (Jobe 2014: 307). Deal, Altman and Rogelberg (2010: 191) wrote that the rather sparse number of empirical studies written on Generation Y are at best befuddling, and at worst conflicting. Constanza et al. (2012: 391) go further to say that it would be more applicable if a generational needs assessment was done to identify strategic interventions, rather than relying on studies that stereotype the generations.

2.7.3 Migration of Filipino nurses

The expatriate Generation Y Filipino staff nurses formed the majority of the nursing workforce at the hospital in Saudi Arabia where data collection took place. When countries experience periods of nursing shortages, healthcare organisations utilise many strategies to meet their needs for RNs, including hiring nurses internationally (Lin 2009: vii). The Philippines is reportedly the largest exporter of nurses worldwide (Lorenzo et al. 2007: 1406; Marquis and Huston 2009: 62), and furthermore, in the Philippines, nurses form the largest sector of professional overseas Filipino workers (OFW). The Philippines trains large numbers of nurses in the BSN degree every year. This has resulted in a net surplus of qualified RN's, yet due to migration the country is losing skilled nurses which threatens the health sector countrywide (Aiken 2007: 1299; Lorenzo et al. 2007: 1408). It is interesting to note that a recent study revealed that nearly three quarters of the respondents in a study admitted selecting a career in healthcare because of the potential opportunity to work abroad (Castro-Palaganas et al. 2017: 10).

For decades the Philippines has been exporting nurses to the USA and Saudi Arabia, and in more recent years to the UK, Netherlands and Ireland (Lorenzo et al. 2007: 1407). In the USA alone; 30% of the foreign-educated nurses are from the Philippines (Aiken 2007: 1299). The exact figures of OFW are difficult to ascertain, because many of the statistics are taken purely from the recruiting agency lists, which could result in gross under-reporting (Lorenzo et al. 2007: 1407). These lists are incomplete because many Filipino's obtain jobs privately and not through the Philippines Overseas Employment Agency (POEA). In the 2011 annual report of the POEA, 1,318,727 new hire and rehire contracts were processed for land-based deployment of OFW's. Of this total, 316,736 Filipino's were deployed to Saudi Arabia, which is consistently the number one destination for Filipino's (POEA 2011: 8). As a requirement for working as a RN in Saudi Arabia, a nurse must have a minimum of two years' experience in a tertiary hospital (IOM 2011: 594).

There appears to be conflicting evidence of reasons why so many Filipino nurses leave the Philippines to take up employment in other countries. Some studies report that hospitals in the Philippines are closing down due to a shortage of skilled nurses, caused by migration to more prosperous jobs (Lorenzo et al. 2007: 1406), yet other studies report that there are not enough jobs for the nurses of the Philippines (Lin 2009: 67). Either way, there are many reported reasons why Filipino nurses work outside their country of birth. There are work-related reasons such as underemployment, unemployment, poor working conditions and opportunities for career advancement, and there are personal reasons such as safety concerns, poverty, and seeking a better life for their children and families (Castro-Palaganas et al. 2017: 1). One thing is certain though, Filipino nurses earn much better salaries in Saudi Arabia than they ever could in the Philippines (Castro-Palaganas et al. 2017: 6).

Ortiga (2014: 64), in her study on 'global' Filipino nurses, concludes that countries such as the Philippines knowingly educate their workers for export because this is a viable economic strategy. Such irrational usage of the concept 'human capital' further exacerbates the nursing shortage in the Philippines, the very country where education took place, because money is wasted on educating nurses in the Philippines, because other countries reap the fruits of their labour, further burdening the government (Lin 2009: 19). More than just training nurses for export, migration has meant that the Philippines has undertaken a great deal of retraining of physicians to become nurses in other countries, further burdening the healthcare system (Lorenzo et al. 2007: 1406). These findings are congruent with the findings of another study on the high cost of migration of skilled health personnel from the Philippines, revealing that the expansion in training of healthcare workers is designed specifically for 'outmigration' instead of for the underserved Philippine healthcare services (Castro-Palaganas et al. 2017: 11). The loss of skilled healthcare workers through migration leaves the Philippines with a struggle to meet the needs of the people, particularly the neediest people in remote rural areas (Castro-Palaganas et al. 2017: 1).

Migration experiences are frequently negative for Filipino healthcare workers who are often subjected to unequitable treatment in foreign countries, for example poor wages compared to other nationalities, discrimination, alienation, exploitation, deskilling and racism (Castro- Palaganas et al. 2017: 11; Lin 2009: 150). Adapting to the host organisation's culture, included putting the patient at the centre of care, apparently unlike in the Philippines, is also challenging for Filipino's who are used to making decisions for patients back home (Lin 2009: 102).

With many foreign nurses staffing hospitals in Saudi Arabia, good leadership development is necessary, because besides the nursing profession needing effective leadership, the foreign nurses experience cultural, professional and psychological discord due to being anxious, home-sick, feeling isolated as well as coping with their patients being Arabic speaking. In addition to this diversity is the generation diversity inherent in all hospitals around the world (Marquis and Huston 2009: 62). Although working abroad is a lucrative option for Filipino nurses, those working in the USA reportedly experience social and emotional anguish as they try to adapt to a foreign country where they are challenged by working with a new culture of patient, in a foreign language, with multicultural colleagues (Aldossary, While and Barriball 2008: 128), as well as needing to learn new clinical practice methods (Almutairi, Gardner and McCarthy 2013: 188; Lin 2009: 150; Lovering 2006: 389; Smith 2011: 146). This is supported by a study on Filipino nurses working in the USA, whereby they refer to 'role transitioning' from the Philippines to America being a complex process, fraught with exploitation and alienation. In this study, several participants referred to adapting to the new country as a "culture shock" (Lin 2009: 85). This calls for organisations to support Filipino nurses, which is congruent with the suggestion of a study on leadership amongst Filipino nurses, and that nurse managers should take an active interest in meeting the needs of their nurses (Lapeña et al. 2017: 74).

2.7.4 Character of Filipino nurses

Filipino nurses are known to be caring, patient, dedicated, attentive and respectful. They are also known to go out of their way to be culturally sensitive by adopting the cultural values and practices in the country they are working in (Spangler 1992 cited in Lin 2009: 22). They are sensitive to criticism, patient and enduring, have an inner strength, a sense of humour, and show sensitivity to others (Sanchez and Gaw 2007: 813). According to these authors, their personal growth may be impeded, which would delay their ability to adjust in a host society.

Filipino nurses working in the USA were described as valuing good relationships with their colleagues, which compliments the process of acculturation into the host organisation (Lin 2009: 104). They found that this improved their work performance and fostered good teamwork amongst the nursing staff. They have also been found to have a high work ethic which is evidenced through the high value they place on their work and the fact that they are seldom absent from work (Ordonez and Gandeza 2004 cited in Lin 2009: 23). With regard to assertiveness, they are known to avoid confrontation, disagreement and complaining. Although this might mean they are easy to manage, it could have negative implications on their image as confident and good communicators. It could also imply that they may be lacking in leadership ability, although no previous literature was found on Filipino nurses and their leadership effectiveness.

2.8 GAPS IN THE LITERATURE

Leadership has been studied across broad fields including psychology, education, management, the military, and healthcare. In recent years, leadership research has also included the nursing profession (Cummings et al. 2008: 240). At the outset of this study the researcher was interested in the topic of nursing leadership, with a special interest in developing the youngest layer of qualified nurses who have recently joined the profession. There is a lack of previous research on Filipino nurses. Little, if any, research has been

conducted on leadership and the Filipino nurse, let alone the leadership needs of the Filipino nurse, yet Filipino's are working in healthcare organisations in most countries across the globe. Additionally, no literature could be found on Generation Y Filipino's, let alone Filipino nurses. There is also a lack of research on the character strengths of Filipino nurses.

After a thorough analysis of the available literature in these areas, gaps were identified, and several questions remained unanswered by the literature. The gaps relate to how the nursing profession can prepare generation Y nurses, what character strengths are important to them, how they self-rate their leadership skills and what their leadership experiences and needs are. These gaps formed the basis for the development of the research questions.

In order to address the gaps, the researcher used the literature to make the research plan. The literature influences the researcher's choice of topic, methodologies, theoretical framework, sampling methods and choice of instrument/s for data collection. Based on the limitations in the literature, a researcher will often choose a specific methodology or topic for the study, in order to make the research significant, to answer the research questions, and to bridge the gap in the literature. These will now be discussed.

2.8.1 Topics

Much of the previous literature on leadership centres on the behaviour and practices of individual leaders, for example transformational leaders. The traits and characteristics of leaders, as well as leaders in different contexts and setting are other areas where a great deal of attention has been directed. The future of nursing needs more rigorous theory and research on interventions that develop and promote leadership in less experienced nurses, in order to satisfy both patients and staff.

2.8.2 Methodologies

Leadership researchers appear to have applied a diverse range of research methods, although until recently the majority has been dominated by a single approach to data collection, that of quantitative research, usually in the form of self-administered surveys. Quantitative research is weak in interpreting the situation or setting in which an individual speaks from, because the voice of the participant is not directly heard in quantitative research. Researchers need to broaden the field of leadership methodologies by instilling the idea that leadership is best studied by diverse approaches. Although mixed methods in leadership research appears to have gained a great deal of traction in the past five to ten years, much of the qualitative research takes a subsidiary role, mainly because qualitative data played a supporting role to quantitative data, rather than qualitative being given the privilege of holding its own. Mixed methods are likely to suggest new ways of thinking about leadership, considering that research designs that include multiple measures of perspectives, mixed methods and longitudinal studies are probably better suited to providing scientific revelations about the leadership development process.

2.8.3 Sampling

Most previous leadership studies appear to have used convenience sampling and it is possible that probability sampling could increase the strength of study designs in leadership research. Quasi-experimental designs with matched or random allocation to control and intervention groups could also be effectively applied to future leadership research.

2.8.4 Instruments

In this study, the researcher's field of interest in leadership included self-awareness, leadership skills and first-hand experiences and needs of the target population. Following the literature review, a mixed methods approach was deemed most appropriate, since it is an underrepresented method used in leadership research, and would best answer the research questions.

Hence, both quantitative and qualitative instruments were sought to collect data for the mixed methods approach.

To collect data about leadership skill needs, a number of quantitative instruments were examined for use in the study. Most instruments found were self-rated survey-type tools. The following quantitative instruments were considered for the study:

- The Leadership Practices Inventory (Kouzes and Posner 1995: 69) is a 30-item self-assessment survey that measures the frequency of leadership behaviours on a 10-point Likert Scale (Fardellone et al. 2014: 509).
- The 1997 Multifactor Leadership Questionnaire developed by Bass and Avolio concerns leadership effectiveness and adaptability description (Cummings et al. 2008: 246).
- The Clinical Nurse Leader Self-Efficacy Scale, developed and tested in 2011, is a 35-item tool used to assess the perceptions of nurses on their ability to function effectively as practitioner leaders (Gilmartin and Nokes 2015: 133).
- The American Organization of Nurse Executives (AONE) nurse manager's competencies tool was found to be most suitable for the leadership skills survey (AONE 2015: 3).

To answer the research question about character strengths, in relation to self-awareness in leadership, a number of instruments were found and examined for appropriateness in the study:

- The VIA-120 online survey measures character strengths, fundamental positive attributes for feeling, thinking, and behaving in ways that benefit both themselves and others.
- The Myers-Briggs Type Indicator personality type test, measures how people perceive their world.
- The Business and Industry Advisory Committee Character Qualities for the Workplace Survey aims to understand, from an employer's perspective, which character traits are considered important for an

employee to be successful (Business and Industry Advisory Committee 2015: Para. 4 line 2).

- Clifton Strengths Finder 2.0 (Rath and Conchie 2008: 5).
- Realise2 (Linley and Dovey 2012: 4).

To address the inquiry regarding the leadership needs and experiences of the target population, qualitative interview questions were sought in the course of the literature review. As discussed in Chapter 4, no interview guide tool was found to perfectly pose the questions, however the following were considered:

- Appreciative Inquiry questions (Havens, Wood and Leeman 2006: 463).
- RBC model questions for self-assessment (Koloroutis 2004: 80).
- Bedside leadership interview questions (Dyess et al. 2016: Para. 9 line 13).
- Self-awareness and relationship interview questions (Fung 2011: 85).
- Generation Y leaders interview questions (Ramirez 2012: 175).

2.9 SUMMARY OF THE CHAPTER

The literature review scrutinised previous research relevant to the study topic, and was structured around the four elements of the adapted RBC theoretical framework and the healthcare situation globally, in Saudi Arabia, and in the Philippines. There were challenges associated with the lack of consensus throughout a variety of professions, as to whether or not differences do indeed exist between the generations, and within Generation Y itself. The previous literature has painted a picture of the global healthcare workforce, and multigenerational workforce worldwide. In addition, the chapter described the future nursing leadership challenge and the value of self-awareness associated with the development and effectiveness of leadership. The literature review also reported on healthcare and Filipino nurses who form a large part of the nursing workforce in hospitals in Saudi Arabia.

Despite the growing body of literature extracted about leadership from both developed and developing countries, there is a paucity of evidence around the

topic of nursing leadership for the youngest generation of qualified nurses. Previous studies show that there is a need for adequate leadership training and knowledge, which is imperative to prepare Generation Y practitioner nurses in order to transform the future quality of nursing care. There appears to be a scarcity of information available on suitable methods and frameworks on how this leadership development should take place within the nursing profession. The next chapter will present the theoretical framework that was used to underpin the study.

CHAPTER 3: THEORETICAL FRAMEWORK

3.1 INTRODUCTION

A theoretical framework is used in a study to assist the researcher to systematically place the study in context, so as to explore a problem and manage the gathered data (Brink, van der Walt and van Rensburg 2012: 26). All research is theoretical (Grant and Osanloo 2014: 14) and every study has a framework (Polit and Beck 2012: 128). A framework or conceptual reasoning underpins every sound study and is the foundation from which all knowledge is constructed (Polit and Beck 2012: 128). A framework can be likened to a blueprint because it gives a clear vision for the study (Grant and Osanloo 2014: 12).

This chapter describes how and why the chosen RBC theoretical framework was selected for the study, based on the researcher's epistemological views, the literature review, as well as its appropriateness to the research problem. A brief overview is given of other frameworks and models that were discounted for use in the study. The RBC model is discussed in detail, describing the six dimensions.

3.2 A THEORETICAL FRAMEWORK THAT GUIDED THE STUDY

It is important that the researcher selects a solid, descriptive existing theory that fits as closely as possible to the study (Brink, van der Walt and van Rensburg 2012: 26; Grant and Osanloo 2014: 19). In addition to suiting the study, the framework should reflect important personal views of the researcher and his/her understandings about the nature of knowledge. The researcher therefore considers his/her epistemological beliefs which are influenced by personal postulations, ideals and ethics (Grant and Osanloo 2014: 19). In the case of this study, the researcher views the world pragmatically, through a lens of interconnectedness of human beings.

Koloroutis (2004: 14) claims the RBC model leads to practitioner nurses who have better leadership skills, which facilitates better decision-making, which in turn will lead to optimal and sustainable patient-centred health. The research problem led the researcher to identify the most appropriate theoretical framework which is aligned to her personal beliefs, and which appears to address many of the leadership deficits mentioned in the research problem.

Theories that have commonly been used in nursing leadership arose from, and were translated from, studies in sociology, psychology, and corporate business. These include theories of transformational leadership and EI, which have directed much of the research and development strategies proposing to promote nursing leadership (Cummings et al. 2008: 240). This study is unique in that it utilised a theoretical framework (RBC), created for healthcare by experts in the profession (Koloroutis 2004: ix). Its suitability for nursing is evidenced by the fact that the model was written and coordinated by Creative Health Care Management, which is an international healthcare consulting firm with a history of 25 years of excellence in transforming health care (Koloroutis 2004: ix).

Prior to selecting a framework for the study, a number of theoretical and conceptual frameworks were considered in relation to the various dimensions of this study namely generations, leadership, self-awareness, development and human relations. Frameworks that were considered, but not utilised in the study, are summarised in Table 3.1.

Table 3.1: Theoretical frameworks that were considered, but not utilised, to guide the study

Theory	Outline of the theory
Generations	
Kaleidoscope career model for generations	The model describes how individuals change the patterns of their careers by rotating the varied aspects of their lives in order to arrange their relationships and roles in new ways (Sullivan et al. 2009: 284).
Leadership	
Theory U	Helps people better understand the origins from which all social action regularly comes into being, and relates to collective leadership. It explores a new territory of scientific research and personal leadership, one that is grounded in real life experience and shared practices (Sharmer 2009: 13).
The New Leadership Paradigm	This paradigm is a response to the global leadership crisis; Leading Self, Leading a Team, Leading an Organisation and Leading in Society. It is a shift from being the best in the world to the best for the world; a shift from what's in it for me to what's best for the common good (Barrett 2011: 1).
Contingency theory	Founded by Fielder, it suggests three major situational variables determine whether a given situation is favourable to leaders, which includes their personal relations with the members of their group, known as leader-member relations. According to this theory, no leadership style is best in all situations (Blanchard, Zigarmi and Nelson 1993: 24).
Situational leadership theory	Based on Fielder's contingency theory, Hersey and Blanchard (1969) addressed the characteristics of the subordinates in relation to effective leader behaviour (Blanchard, Zigarmi and Nelson 1993: 24).
Transformational leadership	This leadership theory originated in the work of Downton and was later developed by Burns. It is a process where the leader empowers subordinates to higher levels of achievement and morality. It is complex but has a positive effect on communication and team building (Burns 1978: 21).
Transformational and transactional leadership	Bass and Avolio (Cummings et al. 2008: 246).
Theory of leadership motivation	McLelland (Cummings et al. 2008: 243).
Three-circle model of strategic	This is a democratic model of leadership, with three elements: the needs of the task, the individual, and the team. It values people, their knowledge, experience and skills and

leadership	individuals/groups are involved in decision-making processes concerning their work (Adair 1990: 25).
Employee-centered leadership	This is a behavioural approach, focusing on the human needs of subordinates (Moorhead and Griffin 2001 cited in Kelly 2008: 15).
Other: Self-awareness/ Development/ Motivation	
Appreciative inquiry	The theory was developed in 1980, and at its heart is seeking the best in people and their organisations. It is strengths-filled and creates opportunities in the world (Cooperrider, Whitney and Stavros 2008: vi).
Motivation and personality	Reflects the belief that a hierarchy of needs motivates people beginning with the most basic needs to ultimate self-actualisation (Maslow 1943: 383).
Path-goal theory	The leader's aim is to motivate subordinates and influence them to goal achievement. The subordinates believe that the rewards for their efforts are valued and meaningful (House 1971: 323).
The emotional competence framework	Goleman's three personal competencies: self-awareness, self-regulation, motivation; and two social competencies: empathy and social skills (Goleman 1998b: 26).

This study addresses the problem of a lack of effective leadership training and subsequently a lack of leadership effectiveness in nursing. The study aim was to develop a suitable leadership framework for Generation Y practitioner nurses, to help them reach their full potential. The significance of the study is that it addresses unanswered questions, following a thorough review of available literature. The design of the study is that of mixed methods. After careful consideration of a number of existing theories mentioned above, the RBC model for transforming practice (Koloroutis 2004: 14) was found to be the best fit to address the study problem, aim, significance and design. In addition, this model is also in line with the beliefs of the researcher, which are congruent with the statement in RBC that care is the essence of nursing. The meaning and essence of care are experienced in the moment when one human being connects with another (Koloroutis 2004: viii). The researcher agrees with the RBC model that providing care occurs through relationships. There are three important relationships that occur when providing care, namely the provider's relationship with patients and their families, the provider's relationship with self and thirdly the provider's relationship with co-workers (Koloroutis 2004: 4).

This study revolves around self-awareness and the strengths of Generation Y nurses. Watson, in support of RBC, postulates that if nurses have a good understanding of themselves they will be better equipped to handle the relationships with their patients and with co-workers. It also considers leadership skills required for developing the 'leader within', an important component of being an effective leader. Jean Watson wrote the foreword in the RBC book (Koloroutis 2004: viii) and states that care providers' knowledge of self and self-care are fundamental requirements for quality care and healthy interpersonal relationships.

The leadership survey used to collect data included the competencies of career planning, knowing your role and future, and engaging in reflective practice. Successful leaders in a RBC system will maintain an unwavering focus on what matters most: caring and healing relationships at the point of care (Koloroutis 2004: 7). The RBC is rooted in care. This model highlights

important issues regarding the ever-changing healthcare environment and is recommended as a guide to transform health care (Koloroutis 2004: viii). In the RBC model, personal development and professional growth are considered to be an integrated whole, through continuing education focusing amongst other things on self-awareness, fostering healthy relationships and leadership development (Koloroutis 2004: 8). Through relationships leadership is developed at all levels of an organisation.

The RBC model is well integrated into the study. At the outset, the researcher found the RBC to be an effective way in which to structure the study inquiry on Generation Y nursing leadership and the model was referred to when identifying the study problem, aim and significance. It was used when developing the research questions which are closely aligned and carefully intertwined to serve as the foundation to guide the research design and data analysis. It was also used when structuring the literature review, selecting a study design, data analysis and contextualising the findings. The RBC is recommended for transforming practice through six dimensions, in a healing and caring environment, as depicted in Figure 3.1. This model was selected because it is suitable for healthcare organisations striving to transform their culture through effective leadership. RBC provides essential direction for success, leading to quality patient outcomes (Roberts 2016: 96).

Figure 3.1: The Relationship-Based Care (RBC) model
Source: Koloroutis (2004)

Nursing care is provided to patients through care delivery systems. The RBC model places the person and relationships at the central focus of all interactions in healthcare. This encourages relationship development as well as professional development (Koloroutis 2004: 15). The RBC model postulates that health care is provided through relationships formed while performing activities related to providing care. It regards the individual nurse's significant value in contributing to care with an emphasis on the pivotal impact on patient satisfaction and outcomes (Koloroutis 2004: 14). The six dimensions of the model are: leadership, teamwork, professional nursing, care delivery, resources and outcomes.

The researcher selected four of the six dimensions for the study because they were best suited to use as a theoretical framework to guide all aspects of the research process. The researcher's adapted RBC framework can be seen in Figure 3.2. Each dimension will now be discussed in more detail.

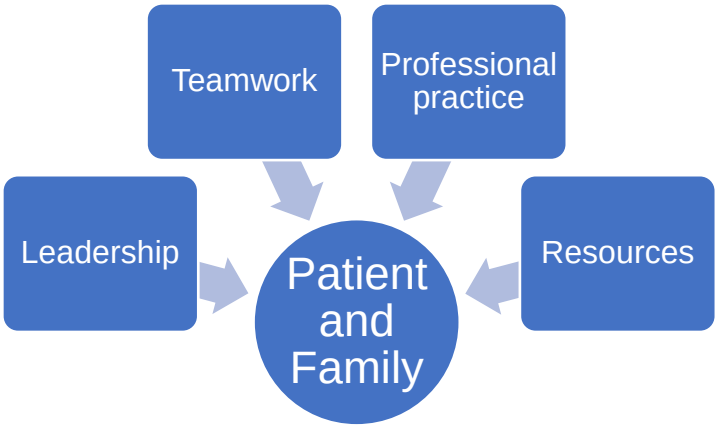

Figure 3.2: Researcher's adapted RBC framework

3.2.1 Leadership

Koloroutis (2004: 53) defines leadership as not only the ability of a person in a position of authority, but as the capacity to lead, implying that leadership ability is found within everyone. In a relationship-based culture, leaders inspire development of people to reach their full potential. It is thus their responsibility to create an environment in which people consciously desire to own their work and the goals of the organisation. Leaders are found at all levels of an organisation and they play a central role in all aspects of optimising the service offered to patients. Caring leaders create environments where caring relationships happen between staff members and with their patients. Leaders who care facilitate the development of others through experiences and they support opportunities for their growth and development through teaching, mentoring and coaching.

3.2.2 Teamwork

Teamwork is critical to ensuring the safety and quality of patient care (Polis et al. 2017: 19). Interdisciplinary teamwork is clearly reflected in the RBC. Interdependent teamwork predicts the quality of patient outcomes. Relationships in teams are crucial to safe, effective patient care and therefore it is essential that multidisciplinary team members work together collaboratively towards a common goal. A healthy team allows all members to

share decision-making as well as to contribute their knowledge, ideas and skills to provide well-coordinated care in a culture of responsibility, accountability and authority. The concept of ‘it takes a village’ is embedded in the teamwork element of the RBC model. No individual or ward is an island, and this is exemplified through the teamwork promoted by the RBC. Group interaction and collaboration is essential and relationships between disciplines as well as with patients must be encouraged through effective communication. The patient must be included in the teamwork approach, because s/he is part of the team and his/her plan of care (Koloroutis 2004: 91).

3.2.3 Professional practice

The therapeutic relationship between a nurse and a patient is a privilege and based on duty-bound trust (Koloroutis 2004: 17). The aim of professional practice is to ensure that compassionate care is provided to patients and their families. This is achieved through more than the knowledge and skills acquired in training. In caring for patients nurses play many roles, including that of leader. Professional practice also encompasses nursing staff using evidence-based practice (EBP) to create quality improvement projects to ensure improved patient outcomes, for example creating guidelines on prevention of falls (Koloroutis 2004: 148).

Healthcare demands caring – towards the patient and towards any person one forms a relationship with in the day-to-day work of a nurse. Displaying a caring attitude and actions is an expression of compassion in the form of an act of kindness, showing concern for another (Adams 2016: 1). In a hospital, the nurse forms a relationship with patients and colleagues. Nurses must be aware of their own strengths and limitations, they must know how to provide compassionate care within a caring relationship (Watson and Foster 2003 cited in Steele-Moses, Koloroutis and Ydarraga 2011: 43).

3.2.4 Resources

Managing resources should be a shared responsibility between nurse managers and practitioner nurses, because frontline workers provide the care and manage the day-to-day activities at the bedside. These activities involve staffing, delegation, critical thinking, reflection and decision-making, to name a few elements that influence the provision of care (Koloroutis 2004: 183).

The nurse is portrayed as an important component of resources. Human capital is a hospital's greatest resource. Nurses can be taught how to be more effective at the bedside. Hospital administration, nursing management and practitioner nurses are responsible for the allocation of resources. Nursing management must provide education for nurses to facilitate their ability to think critically and creatively and to learn reflection skills. This will develop their ability to assess situations effectively and to use common sense in prioritising and problem solving. This training will also enable nurses to apply learned skills in complex situations (Koloroutis 2004: 206).

3.3 SUMMARY OF THE CHAPTER

The nurse is portrayed as an important resource when it comes to leadership. In a relationship-based context the RBC model can be well integrated in the study to contextualise the findings and discussion, using the four domains of leadership, teamwork, professional practice and resources. The next chapter will describe the research methodology applied in the study.

CHAPTER 4: RESEARCH METHODOLOGY

4.1 INTRODUCTION

The previous chapter focused on a literature review of work by other researchers in this area of study. This chapter sets out to describe the methodology used in this study so as to provide an understanding of how the study was undertaken to ensure methodological rigour. The following sections will be covered: the research methodology that was used based on previous studies; the research design; the setting, population and sample selection; survey methods and materials; the pilot study; analysis of the data as well as the consent and ethical considerations employed in this study.

4.2 PARADIGM THAT GUIDED THE STUDY METHODS

A paradigm is a world view or general perspective which breaks down the complexities of reality into simpler more understandable constructs (Brink, van der Walt and van Rensburg 2012: 24). In research, paradigms are used to structure reality because they function as a set of assumptions about the fundamental types of entities in the world and how they interact, as well as a method to construct and test theories about these entities. Scotland (2012: 10) asserts that since all paradigms are conjecture, their rationale cannot be empirically verified as true or untrue. However, it is essential that the worldview of the researcher is revealed, because awareness of philosophical assumptions increases the quality of the study and can contribute to the creativity of the researcher. All research is driven by the theories and assumptions that researchers bring to their studies. The theoretical perspectives mirror the researcher's personal standpoint on the topic under study (Creswell et al. 2003: 176).

According to Scotland (2012: 10), it is not possible for a researcher to participate in any form of research without committing, often tacitly, to positions of ontology and epistemology. Creswell (2008: 22) identifies four

worldviews: post-positivism, constructivist, pragmatism, and participatory. Researchers can use these worldviews either singly or, according to Greene (2007 cited in Creswell 2008: 22), as multiple paradigms referred to as a dialectic perspective. This researcher's investigation was influenced and guided by the paradigm assumptions of ontology, epistemology, methodology and axiology (Guba and Lincoln 2005 cited in Creswell 2008: 23). The researcher has a pragmatic philosophy, and believes that knowledge should be applied and practised, and that people are viewed within their surroundings through a lens of interconnectedness. This led to the choices being made regarding the research topic and methodologies, including data collection methods and the interpretation and integration of the study results. Leadership is a socially constructed phenomenon (Berger and Luckmann 1966 cited in Sutherland and Cameron 2015: 365), and is both complex and multifaceted. The challenge is how to capture and study it (Stentz, Plano Clark and Matkin 2012: 1173; Sutherland and Cameron 2015: 366).

4.2.1 Ontology

Ontology is defined as a group of assumptions about reality (Brink, van der Walt and van Rensburg 2012: 24). Crotty (2003:10) defines ontology as the study of existence. Pragmatically, the researcher views the social world as one made up of meanings, assuming the world under investigation is filled with human beings with their own thoughts, ideas and interpretations. Reality is constantly renegotiated, debated and interpreted in new and unpredictable situations, because that is the reality of healthcare. Healthcare is in crisis and effective nursing leadership is lacking, hence, the best method to use is the one that solves the problem.

In addition, Generation Y nurses, who form a large percentage of the nursing workforce, have their own unique views, opinions and needs, and they therefore require a suitable leadership framework to meet their needs. This generation of nurses may be the answer to the crisis in that they could transform healthcare through generation-specific effective leadership development. The study is about leadership amongst the study sample; they

are the key informants who can tell us their perspectives, and the findings are for their benefit as well as the broader profession. In light of all these factors, the researcher believed that collecting both quantitative and qualitative data would do the study the most justice.

4.2.2 Epistemology

Epistemology refers to a person's knowledge of reality (Brink, van der Walt and van Rensburg 2012: 24). Scotland (2012: 10) defines epistemology as a means of explaining and comprehending how new knowledge can be generated or acquired. In other words, how we come to be understand the knowledge we acquire (Crotty 2003:3). The epistemological assumption in this study was that there is an inadequate understanding of the unique needs of Generation Y nurses and that practitioner nurses could be the major breakthrough required by healthcare, if only we knew what it was that they need to know. The unanswered question about leadership is 'what is it that Generation Y nurses need to know in order to be effective leaders'; and 'how can this knowledge be transmitted to them?' The best method for finding solutions to the research problem and aim of the study is to change the way leadership is developed, because current methods do not appear to be working.

4.2.3 Methodology

Creswell et al. (2011: 20) clearly state that when deciding on the study design, researchers should consider the best way to address the research problem. The theoretical perspective of the study is about which strategies, including instruments and techniques, should be used to obtain the best results to answer the research questions. It includes what data should be collected from the sources. The methodology was selected based on a thorough literature review of existing knowledge. Deficits in the literature left the researcher with unanswered questions which generated the aim and strategies for the study, so as to be able to go about finding out whatever is needed to be known regarding the leadership development needs of Generation Y nurses. A

pragmatist places the most importance in the research problem, valuing both the objective and the subjective in order to obtain answers (Morgan 2007 cited in Creswell, Plano Clark and Smith 2011: 4). The researcher believed that the best way to answer the research inquiry was through a strategy of mixed methodologies. The mixed methods design allows for creativity, and it is an approach commonly used by researchers who hold a pragmatic philosophy. The inclusion of both quantitative and qualitative data, and the choice of RBC as the theoretical framework for the study, fits with the worldview of the pragmatic researcher. Mixed methods research is commonly used by researchers who hold a pragmatic philosophy.

4.2.4 Axiology

In research, axiology refers to the value or worthiness of the inquiry paradigm or the nature of ethics and what is valued by individuals (Biddle and Schafft 2015: 321). In order for humans to thrive, they practice social interaction in which there is a reciprocal relationship of support and autonomy. All individuals are part of the decisions made, which promotes their ability to succeed (Heron 1996: 11). The researcher believes the value of the study to be good and useful for the nursing profession and the social good of those in it. Through the use of mixed methods, the study's value is based on the fact that the outcomes will result in a leadership framework derived from the perceptions, experiences and needs of Generation Y nurses. In addition, the framework can be used for the development of nurse leaders at all levels in healthcare organisations. The researcher does not trust hegemonic methods used by the majority of previous leadership researchers, namely quantitative surveys, because they inadequately address all aspects of leadership inquiry. Rather, the researcher employed mixed methods, further evidencing axiological commitment through the showcasing of the relationship between the researcher and the methods chosen as well as the conclusions the study produced to bring about social good.

4.3 RESEARCH DESIGN

Polit and Beck (2012: 58) describe the research design as the architectural backbone of the study, meaning it is the overall plan of how to conduct research. The design of a study dictates specific strategies and techniques required to ensure that evidence is accurate and interpretable. It is crucial that the researcher expresses a clear logic for using mixed methods and bases this argument on the theory behind it. Mixing or integrating two methods (quantitative and qualitative) allows for addition of depth in understanding the issue under study and the various components of the research enquiry (Halcomb and Hickman 2015: 2). The design used in the study was a fixed one (Creswell et al. 2011: 7), in that the methods were predetermined from the outset of the research process, and the researcher had precise intent to mix the quantitative and qualitative approaches from the study's inception.

Creswell (2008: 25) suggests the mixed methods researcher makes a simple, elegant illustration of the chosen design. The study design used was one identified by Fetters, Curry and Creswell (2013: 2136) and falls under their category of 'advanced frameworks'. Comprehensive methodology was developed by the researcher, to approach the complex, multidimensional phenomena of nursing leadership. A simple outline of the research design, showing the phases and the quantitative and qualitative components, is illustrated in Figure 4.1.

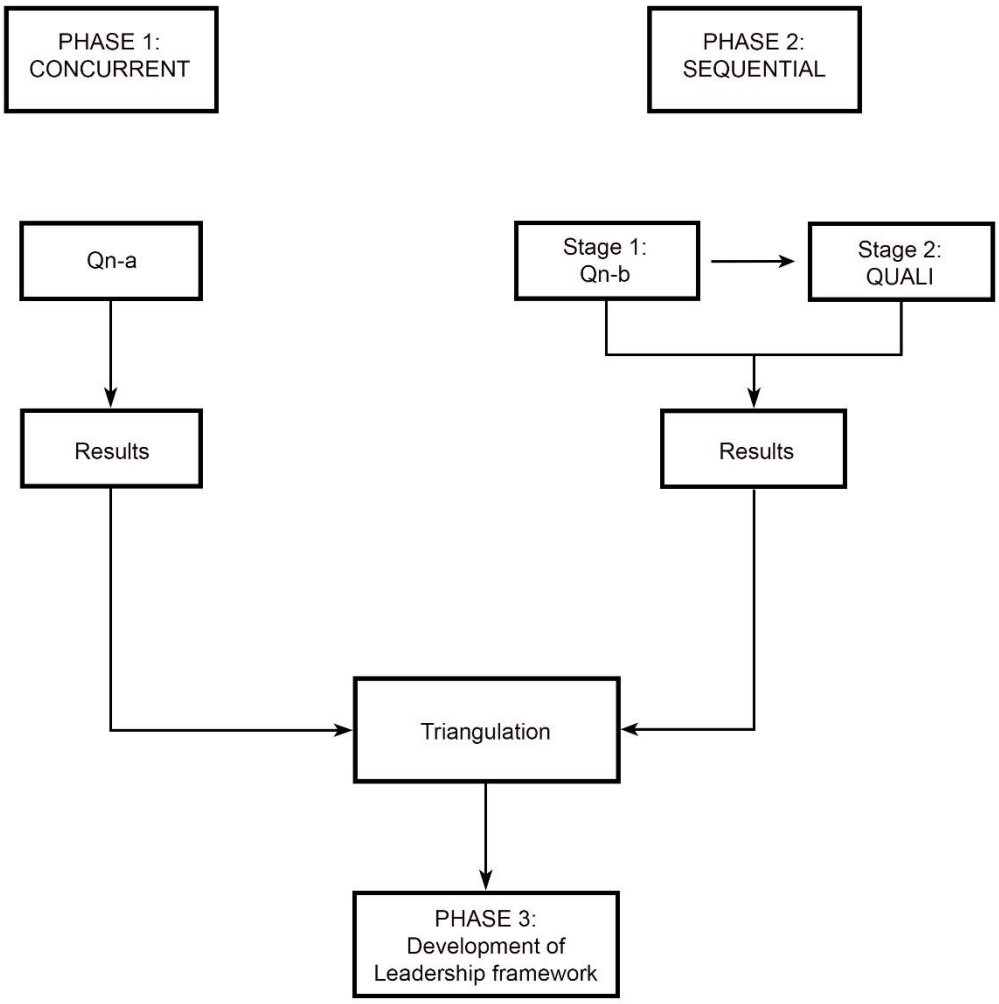

Figure 4.1: Research design

When describing the research design, it is important for the researcher to present every detail in order to enhance the quality of the study findings. Guidelines proposed by O'Cathain, Murphy and Nicholl (2008: 97) were employed to present the research design details that follow.

4.3.1 Applying the multistage mixed methods framework

The mixed methods framework guided the sequence of events during the research process, from the aim of the study to the finale, when the results provided information used to develop the leadership framework. The study design included sequential and concurrent elements (Fetters, Curry and Creswell 2013: 2136). There were three phases to the study. The first phase

(concurrent) comprised the collection of quantitative data using an online strengths survey. The second phase (sequential) comprised the collection of data in two sequenced stages. Stage one (quantitative) made use of a leadership survey, followed by phase two (qualitative) which used a semi-structured face-to-face interview. The third and final phase of the study was when the findings of the quantitative and qualitative data collected in two phases that were integrated, triangulated and interpreted to develop the leadership framework.

4.3.2 Rationale for using a mixed methods approach

The research method refers to the strategies and techniques that the researcher uses to gather data (Polit and Beck 2012: 733). The type of research question drives the choice of methods (Fetters, Curry and Barber 2013: 2135). Quantitative methods are most commonly used to answer quantitative research questions about causality, generalisability or the magnitude of effects. By contrast, qualitative methods address qualitative research questions to develop theories, to describe the experiences of individuals or to explore how or why phenomena occur.

Applying traditional research methodologies, mainly quantitative, to some extent could result in limited views on the inquiry. This is where mixed methods finds its traction in research. Mixed methods is where the researcher combines or merges quantitative and qualitative research techniques, methods, approaches, concepts or language into a single study or set of related studies (Johnson, Onwuegbuzie and Turner 2007: 120). Mixed methods research is also defined as research where data is collected and analysed, followed by integration and interpretation, using both qualitative and quantitative approaches in a single research study (Creswell and Plano Clark 2007: 5). The central assumption in this study was that combining the strengths of both quantitative and qualitative research would yield better understanding of the research problem, which would be more valuable than either research approach alone (Creswell 2008: 9), because a single source

of data may produce subjective outcomes that are doubtful and unfounded (Zohrabi 2013: 258).

The mixed methods approach has seen a surge in popularity in health sciences and its role in this field should not be underestimated (Fetters, Curry and Creswell 2013: 2134; Lavelle, Vuk and Barber 2013: 272). Health science research lends itself to methodologies that combine both quantitative and qualitative components, because healthcare professionals frequently find themselves facing complex problems that are often not addressed when utilising a single research perspective (Fetters, Curry and Creswell 2013: 2134; Lavelle, Vuk and Barber 2013: 272). Mixed methods research allows the investigator to apply diverse and creative methods to address complex present-day issues so often found in healthcare (Fetters, Curry and Creswell 2013: 2134).

Creswell et al. (2011: 6) recommend a list of reasons to use mixed methods research. The researcher's reasons for selecting a mixed methods design were as follows:

- The researcher sought to view the research problem from many perspectives to enhance and enrich the meaning of an otherwise single viewpoint;
- By merging of the quantitative and qualitative methods, a more holistic understanding of the research problem would develop;
- Triangulation would substantiate the findings thus would help to identify patterns or trends reflective of the study population.

Collecting different sets of data and following a quantitative method alongside a qualitative data collection method allowed integration and analysis of the data, in order to provide optimal insight into the research problem (Creswell 2008: 9). The overarching aim was to conduct a thorough investigation into the leadership experiences and needs of the study population so as to develop strategies to enhance their leadership ability. This was achieved through the collection of multiple sets of data to get factual evidence in the

form of surveys as well as interviews, to hear leadership experiences, past and expectant, that were identified by the target population themselves. Triangulation of this pertinent data increased the scope and range of the inquiry and led to the discovery of new dimensions in the field. It enabled the development of an evidence-based leadership framework that most effectively meets the needs of Generation Y practitioner nurses.

The research inquiry was complex because it included multiple facets of culture, generations, developing countries, nursing and leadership as well as the researcher's paradigm, which is why the mixed method approach was suitable. Once the study method had been decided, the researcher did an in-depth literature review of the different types of mixed methods approaches available, to find the one that best fit the research questions.

4.3.3 Rationale for the selection of multistage mixed methods approach

Once the researcher has decided to use a mixed methods approach for the study, the next stage is to decide on the specific mixed methods design that will be most suitable in addressing the research problem (Creswell and Plano Clark 2007: 58). There is no particular research design that is considered superior to another. Selection must be based on the one that will best answer the research problem, aim, questions and objectives (Brink, van der Walt and van Rensburg 2012: 128). While the researcher acknowledges that there are other ways to gather data on nursing leadership, and there are many other studies that have used other designs to gather this information, the creative mixed methods design used in this study was felt to be the best fit for the research inquiry as well as being in keeping with the researcher's worldview. Sutherland and Cameron (2015: 366) would see this study as an answer to the call for more diverse and innovative approaches to studying leadership (Sutherland and Cameron 2015: 366).

Those researchers who are considered connoisseurs of mixed methods research tend not to agree on the wording or number of types of mixed method designs available. Tashakkori and Teddlie (2003 cited in Creswell and

Plano Clark 2007: 59) report 40 types, while Creswell et al. (2011: 8) subsequently refer to four (concurrent, sequential, embedded and multiphase). Later still, Fetters, Curry and Creswell (2013: 2136) propose three basic mixed methods designs (a) exploratory sequential, b) explanatory sequential and c) convergent) as well as four advanced frameworks (a) multistage, b) intervention, c) case study and d) participatory). Creswell and Plano Clark (2007: 2) warn that reducing research to phases runs the risk of making processes oversimplified, which suggests a single-minded approach to research. The authors do, however, add that the process should not be seen as a series of lock-step procedures, but as a wide-ranging scaffold that might be useful in undertaking and appraising mixed methods research. A broader-minded view is suggested by the authors, through their statement that specific research problems may require the researcher to choose to use the phases in an alternative way that makes more sense to the study.

The researcher acknowledges that the mixed methods design utilised in the study is not a basic design. It is not one of the four basic designs offered by Creswell et al. (2011: 8), nor one of the three basic designs suggested by Fetters, Curry and Creswell (2013: 2136). Yet, this study is certainly not a multimethod design, which is well supported by the clear differentiation between mixed method and multimethod in the excerpt below:

> Mixed methods further is not simply the collection of multiple forms of qualitative data such as (for example interviews and observations), nor the collection of multiple types of quantitative data (for example, survey data, experimental data). It involves the collection, analysis and integration of 'both' quantitative and qualitative data. In this way, the value of the different approaches to research (for example the trends as well as the stories and personal experiences) can contribute more to understanding a research problem that one form of data collection (quantitative or qualitative) could on its own. When multiple forms of qualitative data (or multiple forms of quantitative data) are collected, the term is 'multimethod'. (Creswell 2015: 2 cited in Anguera et al. 2018: Para. 35 line 15).

There appears to be a great deal of confusion about the difference between mixed methods research and multimethod research (Anguera et al. 2018: Para. 42 line 5). In addition, the nomenclature creates further challenges. Many of those considered mixed method experts would like to see standardisation of this type of research, but Teddlie and Tashakkori (2012: 776) caution that if the community of mixed methods is to flourish, it must remain open to diverse and new ideas in the domains of theory, methodology and application. The researcher contends, along with some experts in the field of mixed methods, that as long as the research meets the criteria for mixed methods research according to the criteria offered by various experts in this field (Creswell 2007: 39; O'Cathain, Murphy and Nicholl 2008: 97), which this study does, then it is a mixed methods study. Additionally, if the mixed method design is creative in that it has many stages, yet does not perfectly fit those designs often referred to as 'basic designs' offered by various experts in the field (Creswell et al. 2003: 179; Fetters, Curry and Creswell 2013: 2136), then the current study is that of a 'multistage' mixed method design classified under 'advanced frameworks', as articulated by Fetters, Curry and Creswell (2013: 2136). Furthermore, Creswell et al. (2011: 8) are generous in their encouragement of researchers to have freedom in considering examples of specific designs, by suggesting that stated design possibilities are not intended to be limiting but rather they are meant to suggest a number of possible approaches that have previously been applied in health science research. Depending on the specific research inquiry and study aim, designs that are more complex should be commonly used (Creswell et al. 2011: 8).

It is interesting to read a recent statement made by the editors of the *Journal of Mixed Methods Research* on the issue of where mixed method research fits into multiple method/multimethod research. The focus of this journal is to address the unique challenges and possibilities of integration of qualitative and quantitative approaches. The editors, Fetters and Molina-Azorin (2017: 5), make the following statement:

> After 10 years, it also is timely to revisit the language of mixed methods as well. As editors of Journal of Mixed Methods Research, we make the following distinctions. Multiple methods research refers to all the various combinations of methods that include in a substantive way more than one data collection procedure. Multiple methods research can include two or more exclusively qualitative approaches, Qualitative plus Qualitative; two or more quantitative approaches, Quantitative plus Quantitative; or a combination of qualitative and quantitative approaches, Qualitative plus Quantitative, hence mixed methods research. In our view, mixed methods is one category of multimethods or multiple methods research.

The aim of the study was to develop a sustainable leadership framework suitable for Generation Y practitioner nurses. The researcher attempted to collect data that best answered the research questions set, and it was felt that multiple perspectives would render better results, hence multistage data collection methods were used when developing the methodology. It is important for researchers to justify the use of a design in accordance with the research questions, objectives and data collection methods. Table 4.1 displays support for the choice of research methods utilised in the study, to answer the research questions and achieve the study objectives.

Table 4.1: The appropriateness of multistage mixed methods design

	Research questions	Objective	Research orientation	Data collection methods
Sub-research questions	1. Quantitative question: Which character strengths are important to Generation Y nurses?	1. To determine strengths with which Generation Y nurses enter the workforce.	Quantitative	Strengths survey tool
	1. Quantitative question: How do Generation Y nurses rate their leadership skills	2. To determine the leadership skills of Generation Y practitioner nurses.	Quantitative	Leadership survey tool
	2. Qualitative question: What are the leadership experiences and needs of Generation Y nurses?	3. To identify skills that are likely to prepare Generation Y nurses in the workplace.	Qualitative	Semi-structured face-to-face interviews
Main research question	3. Mixed question: How can the nursing profession prepare Generation Y nurses to become effective leaders?	4. To develop a sustainable framework for practitioner leadership skills, to prepare Generation Y nurses for the future workforce.	Mixed: Quantitative and qualitative	Development of a leadership framework

4.3.4 Purpose of the design

The heterogeneous and comprehensive approach to research design served the purpose of answering the research questions meaningfully and enriching the data derived from the participants. As such, these factors enhanced the validity of the study. Using the mixed methods approach broadened the horizons of the study in that it created meaning that would not have been possible using any single method alone. In mixed methods research, integration of the two sets of data distinguishes the study from multimethods research. This study applied integration of the approaches at many stages, as can be seen in Chapter 5.

4.3.5 Relative priority

Some, but not all, researchers assign a certain amount of priority to either quantitative or qualitative data. Priority refers to the relative importance or weight that is given by the researcher to one of the methods. Some studies assign equal priority to both methods, but it depends on the nature of the study and the best way to answer the research questions (Creswell et al. 2011: 7). Because there is limited existing literature on Generation Y nurses, and in particular regarding their leadership, the study sought to explore what this cohort of nurses felt about leadership, and their views on how they could be developed as leaders. Hence, priority was given to the qualitative data, because it was the personal views and experiences of the target population that the researcher was particularly interested in gaining knowledge about. Allowing dominance of one approach can also prove useful when results of two sets of data are found to be contradictory (Halcomb and Hickman 2015: 7). In Figure 4.1 above, the priority assigned to the qualitative approach can be seen in Phase 2.

4.4 SETTING DESCRIPTION

The setting is defined as the specific physical place and the conditions in which the data is collected (Polit and Beck 2012: 743). The 300-bed general hospital where data collection took place is a governmental hospital under the

umbrella of the MOH, situated in a city in Saudi Arabia. The hospital is new, fully air-conditioned and in a state of good repair. The study sample were fulltime staff nurses employed at the hospital.

In Saudi Arabia, the majority of any nursing workforce is made up of expatriates. Qualified Indian and Filipino staff nurses make up 66% of the healthcare workforce in the country (Alghamdi and Urden 2016: E98; Al Hosis, Plummer and O'Connor 2012: 19). The hospital under study has on-site accommodation for all nurses working in the hospital, and they are taken to and from work by buses provided by the organisation. At the time of data collection, the hospital had a young nursing workforce made up of 96% Filipino staff nurses, both male and female. The Filipino nurses all have a BSN degree, obtained in the Philippines. In addition, it is a mandatory requirement that each staff nurse has at least two years' fulltime clinical experience post-graduation, prior to being offered a job. The data was collected within the hospital itself.

4.5 POPULATION

The study population (n = 218) met the sample criteria in that they were nationals of the Philippines and because they were from the Generation Y cohort, born between 1st January 1980 and 31st December 2000. The study population consisted of females 76% (n = 166) and males 24% (n = 52). The population or target population is the total group of people who share characteristics, that the researcher is interested in studying (Brink, van der Walt and van Rensburg 2012: 133). In August 2016, the HR nursing liaison representative was consulted to assist the researcher identify the study population. This was accomplished by using the nursing database to determine dates of birth, nationality, names and gender data of all nurses in the workforce. At that time the total nursing workforce was 295 staff nurses. By the time data was collected in June 2017, the nursing workforce numbers had reduced to 269, due to resignations, dismissals and the slow process of recruiting more nurses from other countries. In preparation for sampling, lists

were printed of each of the 16 clinical areas. The lists contained the names of staff nurses from the study population, each with their assigned clinical area.

4.6 SAMPLING METHOD

Sampling is the researcher's process of choosing subjects from the study population, to participate in the study (Brink, van der Walt and van Rensburg 2012: 132). It is important that the sample represents the study population as closely as possible, so that inferences drawn can be generalised to the target population (Polit and Beck 2012: 742). Purposive sampling was utilised in the study.

In order to find the study population, the researcher used the workforce lists. The names of those nurses who did not meet the study criteria were removed, resulting in a study population of 218 Filipino nurses from the Generation Y cohort, comprising females (76%) and males (24%). The study population was working in the 16 clinical areas at the hospital. Most of them were working 12-hour shifts, rotating between day and night shift to cover in-patient nursing care 24 hours a day, and a small number were working regular office hours in clinical areas offering ambulatory healthcare services. The number of nurses allocated in each ward differed according to the number of operational beds and patient acuity.

4.6.1 Sampling of the study population

The researcher had access to the entire study population, since they worked at the same hospital as the researcher. It was expected that some of the population would be absent from work at some point during the seven month period of data collection. To reduce the possibility of objectivity bias, the researcher did not personally recruit participants for the study. A nurse manager, who will be referred to as the 'recruiting assistant' and who had no authority over the study population, assisted the researcher by inviting nurses to participate in the study, arranging the signing of consents, and collecting the surveys. A non-disclosure agreement was signed by the recruiting

assistant (Appendix 11). Gaining access to the study population commenced prior to data collection, after the researcher had obtained all the necessary permissions.

In June 2017, an email was sent by the researcher to nurse managers of all clinical areas, with attachments of ethical clearance (Appendix 1) from Durban University of Technology (DUT), permission from the hospital's affiliated university International Research Board (IRB) (Appendix 2b) and permission from the department of nursing at the hospital, informing them of the study and that data collection would begin the next week. The researcher explained that she would not personally approach the study population but that a recruiting assistant would invite them to participate. The researcher also repeated this explanation to the clinical nurse managers at a leadership gathering, and answered any questions they had.

In mixed methods studies, a combination of sampling methods can be used in creative ways to enhance the study (Polit and Beck 2012: 614). There were two phases of data collection, each with a different sampling method. The first phase (concurrent) employed a quota sampling method, for collecting data from a retrospective free online strengths survey. The second phase (sequential) applied a random sampling method, for collecting data from a survey (quantitative) followed by an interview (qualitative).

The sampling process is illustrated in Figure 4.2.

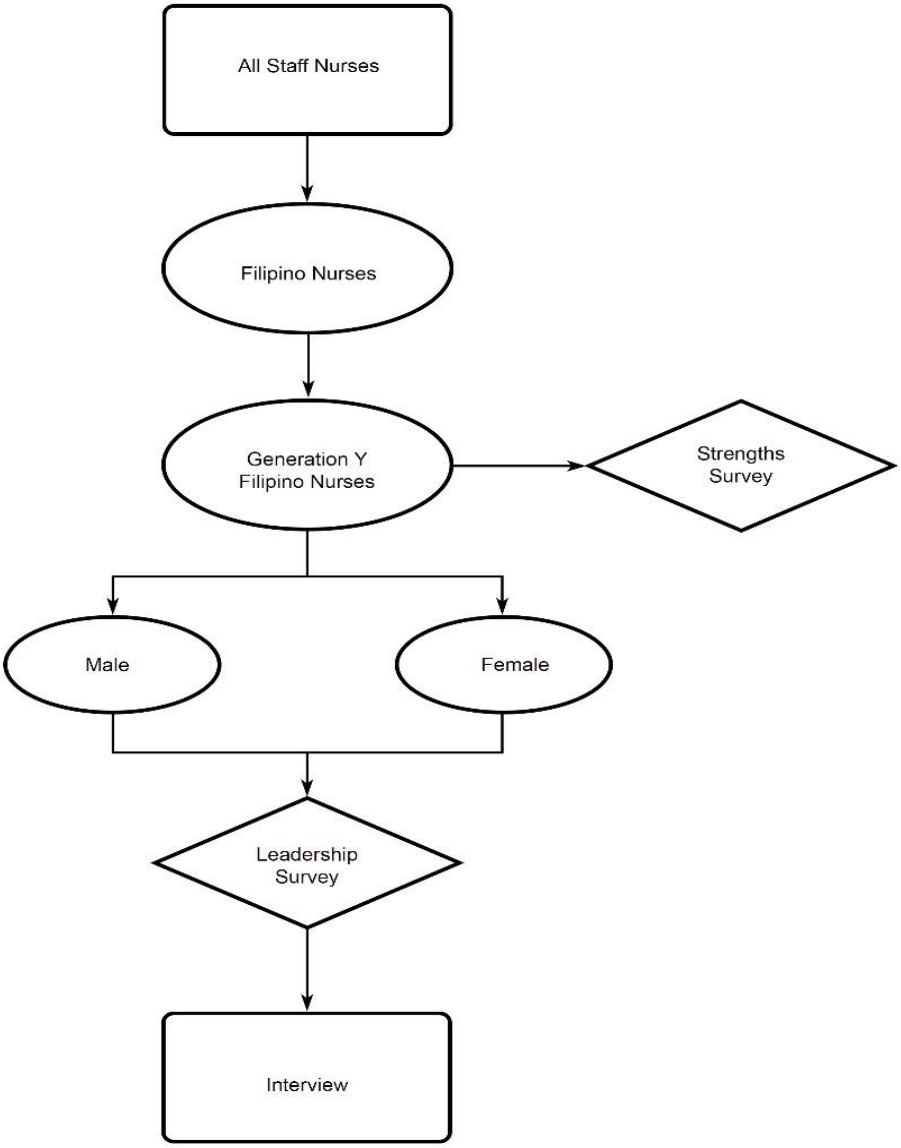

Figure 4.2: Sampling flow process

4.6.2 Phase 1 sampling: Strengths survey (retrospective)

Phase 1 concerned a quantitative online strengths survey which had already been completed by the study population, making the data retrospective. Because the surveys had already been completed, the researcher planned to apply a saturation sample to the study, by inviting all to participate, to get a measure of what the overall strengths rating was for the population. However,

the saturation sample did not materialise, because only 61% of the population responded, despite numerous attempts to encourage more participants.

The statistician was consulted, and after calculating, a sample size of at least 140 was required, using the formula proposed by Bartlett, Kotrlik and Higgins (2001: 43):

$$384/(1+\frac{384}{218}) = 140$$

Once permission had been granted to collect data, the researcher sent an email to all nurse managers of the 16 clinical areas, informing them that data collection would be commenced on nurses in their units. Attachments of ethics approval accompanied this email as well as letters of permission to collect data from the researcher's university, the hospital affiliated university and the nursing department. The recruiting assistant then physically visited each clinical area to explain the study and recruiting process and to invite participation. Because most of the study population worked irregular hours, the recruiting assistant repeated the visit more than once to ensure as many nurses as possible were aware of the need for participating in the study. At the time of the visits, the population was issued with a letter of information about the study which they could read at their convenience. The nurses who were willing to participate in the study were invited to visit the recruiting assistant to sign the consent form and hand in their survey results.

The strengths survey is completed as a mandatory requirement for all nurses in the month of hire. In order to obtain basic demographic details to describe the population in the study, each participant was requested to hand-write, on the survey result, their age and years of post-graduation experience at the time of completing the survey. To ensure confidentiality and anonymity, the recruiting assistant also ensured that the nurse removed his/her name from the results, by cutting it off with a pair of scissors, prior to submission.

4.6.3 Phase 2 sampling: Leadership survey and interview

Phase 2 concerned the sequential collection of quantitative and qualitative data, using the identical sample. The leadership survey (quantitative) was followed by a face-to-face interview (qualitative). Onwuegbuzie and Collins (2007 cited in Polit and Beck 2012: 614) have grouped mixed methods sampling designs according to the relationship between the qualitative and quantitative elements. The approach in this study is considered an identical relationship, where exactly the same people are in both quantitative and qualitative elements of the study. Polit and Beck (2012: 614) explain that overlapping participants in a study can enrich the study, because having the same people in both parts of a mixed methods study allows for integration (convergence and comparison) of data collected in the two parts.

Because the qualitative component of the study was privileged with greater priority, the size of the study sample was based on the qualitative research requirements. The principle of data saturation was used to decide when the sample was adequate. Random sampling was applied using the fish bowl approach described by Brink, van der Walt and van Rensburg (2012: 135). Random samples are more likely to be representative of the population and to reflect its unique characteristics (Brink, van der Walt and van Rensburg 2012: 135).

The lists of 218 names of nurses in the study population described earlier were cut into strips and placed in two separate bowls to keep the genders separate. The bowls were shaken well. The recruiting assistant then did random selection in the presence of the researcher, ensuring that the percentage of male/female nurses was as close as possible to that of the population. One paper was pulled out of the female bowl at a time and the name written down in position one on a blank study sample list. The piece of paper was then returned to the fish bowl so that statistically each nurse still had a one in 218 chance of being selected. The next piece of paper was selected from the female bowl and written down in position two on the study sample list. This process was also repeated for the selection of male nurses.

For convenience, a list was created with 10 female and five male nurses. These numbers were estimated to be maximum numbers of potential interviewees. The reason why a single name was not drawn before each single interview was purely for convenience and to reduce the data collection time. It was thus possible that not all names on the list would become participants, depending on when data saturation was reached.

The sequence of names on the list was strictly applied as this was the random selection order in which the names had been drawn from the bowl. Recruitment was done by the recruiting assistant who then invited the first nurse on the list to participate in the study by informed consent. The participant was asked to complete the leadership survey and to participate in a face-to-face interview with the researcher. The participant selected a suitable time for the interview. The researcher personally conducted each interview and data collection occurred concurrently with analysis. The process described above was then repeated to select the next participant, ensuring that the correct proportion of male/female nurses was maintained. This process continued until the threshold of data saturation was reached and no new data emerged from the thematic analysis. The sample size was determined by the principle of data saturation described by Polit and Beck (2012: 614), which occurred when no new themes arose during analysis and when data became repetitive and redundant in subsequent interviews. At that point recruiting ceased. Only 12 of the 15 names on the list were interviewed, eight female nurses and four male nurses.

4.6.4 Inclusion criteria

- All Generation Y Filipino male and female nurses working in the hospital where the research took place were included in the study population.

4.6.5 Exclusion criteria

- Nurses who were not from Generation Y, meaning those born after 31 December 2000 were excluded.

- Nurse who were not nationals of the Philippines.
- Nurses who did not consent or who were not willing to participate or who chose to withdraw from the study at any time.
- Nurses who were in the pilot study.

4.7 RESEARCH INSTRUMENTS

An instrument is selected to examine a specific variable in a study (Brink, van der Walt and van Rensburg 2012: 166). According to these authors, quantitative approaches propose the use of a predetermined instrument such as a self-reporting questionnaire or survey, designed to obtain information through the written responses of a participant (Brink, van der Walt and van Rensburg 2012: 153). On the other hand, qualitative approaches often use a face-to-face interview as a means of collecting data, because interviews are useful in mixed methods research where in-depth data is desired. Data was collected using the following three research instruments:

- Retrospective results of an online strengths survey (Appendix 6)
- A leadership survey (Appendix 7)
- An interview guide (Appendix 8).

4.7.1 The strengths survey

The VIA-120 online survey was used in the study. The VIA-120 online survey of ranked personal character strengths was selected by the researcher to answer the quantitative research question: "Which character strengths are important to Generation Y nurses?". The survey achieved the first objective: To determine strengths with which Generation Y nurses enter the workforce.

The idea of using a strengths survey in this study was because the researcher believes that knowing your personal strengths supports leadership ability in general, as also stated by Furtner, Baldegger and Rauthmann (2013: 436). More specifically, as revealed in the literature surveyed, self-knowledge is known to develop leadership within the healthcare environment, where nurses are key members of interdisciplinary teams and need to work harmoniously

with others. The VIA-120 tool used to collect data to answer the first research question and achieve objective one is an existing scientifically validated self-administered survey on character strengths, offered free online by the VIA Institute on Character. This tool is considered the most widely used positive psychology tool in use today (Linley et al. 2010: 7).

The survey is known as the VIA-120 because it consists of 120 multiple choice statements (Appendix 6). Each question is a Likert Scale type question relating to 24 character strengths: leadership, creativity, teamwork, self-regulation, curiosity, honesty, perseverance, judgement, bravery, zest, love, kindness, love of learning, social intelligence, fairness, forgiveness, perspective, prudence, appreciation of beauty and excellence, gratitude, hope, humility, humour and spirituality. When taking the survey, each statement offers five response options ranging from a score of 1 being 'very much like me' to a score of 5 being 'very much unlike me'.

An example of a survey statement can be seen in Table 4.2.

Table 4.2: Example of strengths survey statement

STATEMENT	**RATING**				
	1 Very much like me	2 Like me	3 Neutral	4 Unlike me	5 Very much unlike me
I like to think of new ways to do things					

The participants' answers are analysed online by the VIA Institute on Character and the results are emailed directly to the personal email address of the participant. The scale scores are averaged across items, yielding rank order scores, reflecting the participant's ratings of each of the 24 strengths. The survey results summary is presented as a list of the strengths with one being the most important and 24 being the least important of the set. A brief explanation is given with the result of each strength.

4.7.2 The leadership survey

The leadership survey was selected by the researcher to answer the quantitative research question: “How do Generation Y nurses rate their leadership skills?” The survey accomplished the second objective: To determine the leadership skills of Generation Y practitioner nurses. Written permission to use this portion of the tool in the study was obtained from the AONE (Appendix 13). According to Neu (2017: 16) the tool was developed through the combined effort of the AONE, AACN, and AORN. However, it is found online through the AONE (2015: 3). The AONE claim the tool establishes reliability and validity through its development. Further details can be found in the quantitative rigour section of the study (4.16).

The researcher sought a tool that could be used by nurses to identify the status of their leadership skills. The desire to find a tool that linked self-development with leadership led to the use of an existing instrument recommended by the AONE (2015: 3) (Appendix 7). The 2015 version used in the current study was an update of the previous 2005 version. According to the AONE this instrument titled ‘Nurse Manager Competencies Assessment’ was designed for nurse managers who are nurse leaders, responsible and accountable for providing 24-hour healthcare services. There are three domains in the tool, namely the science, the art and the leader within. The AONE believes that in order for a nurse leader to be successful, expertise is required in all three domains, because together the domains encompass the knowledge, skills and attributes that direct the practice of nurse leaders.

Based on the value of the tool, the researcher believed it to be appropriate for the collection of useful data from the study population of nurses, toward their progressive growth as leaders. A work study found this tool to be appropriate, after a small panel studied the topics on the tool and identified them as being needed by current nursing leaders (Fabrey and Traynor 2014: 1). For the purpose of this study, only the third section ‘Creating the leader within’ was used, which consisted of three categories, namely personal and professional accountability, career planning and personal journey disciplines.

A previous study applied all three sections of the previous 2005 version of the AONE leadership survey to nurses, before and after leadership intervention (Titzer, Shirey and Hauk 2014: 43). The post-test showed a statistically significant increase on 54 of the 81 statements ($p < 0.05$). The results demonstrated a statistically significant increase in the participants' perception of their management skills in 67% of the competency statements. A panel of experts was used in another study, and they agreed that the instrument appropriately measured the self-rated leadership skills (Johnson 2015: 5). In addition, this study claims the tool also proved its validity by showing post-assessment growth in every category on the tool (Johnson 2015: 9).

This is a self-administered tool which requires the participant to rate each leadership skill according to a five-point scale ranging from novice to expert, where 1 = novice and 5 = expert. Responses inform the researcher of the leadership skill level of the participant, as per the self-evaluation survey. Further details about Benner's rating scale can be found in the literature review Section 2.3.3. Table 4.3 shows an example of a statement in the leadership survey:

Table 4.3: Example of leadership survey statement

CAREER PLANNING	**1 (Novice)**	**2 (Advanced beginner)**	**3 (Competent)**	**4 (Proficient)**	**5 (Expert)**
Know your role: understand current job description/ requirements and compare those to current level of practice					

KEY:
Novice = Demonstration of behaviour is absent
Advanced Beginner = Minimal demonstration of behaviour
Competent = Solid demonstration of behaviour at a basic level
Proficient = Significant demonstration of behaviour
Expert = Demonstrates role model behaviour

4.7.3 The interview guide

The tool of semi-structured interview was selected by the researcher to answer the qualitative research question: “What are the leadership experiences and needs of Generation Y nurses?” The interviews achieved the third objective: To identify skills that are likely to prepare Generation Y nurses in the workplace. The purpose of conducting interviews is to obtain facts from the target population about their beliefs, feelings, experiences, preferences and what they value (Brink, van der Walt and van Rensburg 2012: 157). The list of questions asked during the semi-structured face-to-face interviews was typed in an interview guide (Appendix 8). These questions were developed by the researcher, using a number of sources, namely the RBC book (Koloroutis 2004: 80); interview questions created by Sherman, Dyess and Prestia (2013: 21); the knowledge of the researcher as an experienced nurse leader; other expert nursing leaders; and the study objectives. Input was also sought from Generation Y nurses who undertook a pilot study.

There were nine open-ended interview questions, designed to answer the research questions. The first eight questions were semi-structured, and the ninth open question asked: “Is there anything else that you would like to share?” These questions led to the sub-themes that emerged from the responses by participants.

Below is an example of an interview question:
Question 2: “Do you believe nurses can lead at the bedside”?

4.8 PRE-TESTING OF THE DATA COLLECTION INSTRUMENTS

If a new instrument is developed for a study, it is important to pilot it prior to use, to ensure validity and reliability. A pre-test of the data collection instruments was applied to a small sample before applying it to the main study, as recommended by Brink, van der Walt and van Rensburg (2012: 56). This takes time and effort, but it determines the feasibility and highlights

possible errors and potentially problematic questions that may need to be addressed.

Phase 1

Because the VIA strengths survey was an existing, validated and reliable online tool, and it had already been completed by the study population at the hospital where the study took place, it was not pre-tested by the researcher. In addition, the respondents had already completed this survey as part of the orientation programme to the hospital.

Phase 2

Stage 1: Because the leadership survey tool was not developed by the researcher, nor was evidence of validation available, it was piloted on five Generation Y nurses from the study population, who were not part of the main study. The researcher explained the need for them to report if they had any difficulties in understanding the content, considering English was not their home language. In addition to piloting the instruments they also read the letter of information and consent to ensure it was easily understood. The feedback from the pilot study participants was that the instruments and letter of information and consent were easily understood and thus there was no need to make amendments.

Stage 2: The interview questions were devised by the researcher and therefore had not been previously tested. This tool was piloted by the same five Generation Y nurses mentioned in Stage 1 above. Considering English was not their home language, the researcher was particularly interested to see if they found it easy to understand. None of the pilot participants had difficulty interpreting and communicating the content and thus no amendments were made.

4.9 DATA COLLECTION PROCESS

Permission was obtained from the department of nursing to collect data on the sample at the hospital (Appendix 3b). Phase 1 data collection took place over a period of seven months, between 13 June and 15 January 2018. Phase 2 data collection took place between 13 June 2017 and 15 July 2018, a period of just over one month. As mentioned earlier, data was collected from three sources: a strengths survey, a leadership survey and an interview. The data collection methods can be seen in Table 4.4.

Table 4.4: Data collection methods

Phase	Approach	Orientation	Tool
Phase 1	Concurrent	Quantitative	Strengths survey
Phase 2	Sequential	Stage 1: Quantitative	Leadership survey
		Stage 2: Qualitative	Interview

4.9.1 Phase 1: Concurrent

This phase of data collection is referred to in Figure 4.1 as 'Qn-a'. Applying a concurrent phase to a study refers to the timing of when the data is collected (Creswell et al. 2011: 7). Concurrent data collection occurs either at exactly the same time, or more or less the same time as another phase. In this study the concurrent data collection phase began simultaneously with the sequential phase (June 2017), but only ended in January 2018. The concurrent data was collected from a mandatory online strengths survey that had already been completed by all nurses in the hospital in their month of hire, thus the data was retrospective data. The summary results, emailed by the VIA Institute on Character directly to each person were submitted to the recruiting assistant, after signing consent to take part in the study. The recruiting assistant ensured that the participant had removed his/her name and had entered by hand his/her age and years of post-graduation experience at the time of completing the survey. The survey results were captured on a prepared spreadsheet by the researcher.

4.9.2 Phase 2: Sequential

Stage 1: Quantitative: This stage of data collection is referred to in Figure 4.1 as ‘Qn-b’. After random selection sampling with the researcher and recruiting assistant, the recruiting assistant invited the randomly selected nurses to participate in this phase of the study. After signing consent the participant was given a copy of the leadership survey to complete. The participant was instructed not to write his/her name on the survey tool. Because the completed leadership survey was to be used by the participant in the interview, the participant was given the option of either keeping the survey until the interview or it could be safely kept by the recruiting assistant and handed to the researcher for use during the interview. The researcher felt that by the participant completing the survey prior to the interview, the participant would have a feel for the content in the tool, and would have a good idea of her/his competency level of each skill in the tool. This would make the participant more comfortable with its content when referring to it during the interview, and not cause undue stress. In addition, when the researcher analysed the leadership survey ratings, it was of interest to find out what the competency level of the participant was for comparing the data during merging.

Stage 2: Qualitative: This phase of data collection is referred to in Figure 4.1 as ‘QUALI’. The same participants who completed the survey (Qn-b) also participated in the semi-structured interviews. The interview followed the leadership survey (Qn-b). Following a quantitative method with a qualitative data collection method allows integration and analysis of the data, in order to provide optimal insight. The purpose of this form of research is that a combination of both quantitative and qualitative research yields better understanding of a research problem, which is more valuable than either research approach alone.

The researcher personally conducted the individual face-to-face interviews with consenting participants. The researcher arranged the use of an unused lounge within the hospital, so as to provide privacy, quietness, comfortable

seating and no interruptions. Water and tissues were provided if they were required. In keeping with the advice offered in Polit and Beck (2012: 310), the researcher made a concerted effort to ensure the environment was relaxed so that the interviewee was able to openly answer the questions honestly and fully. The researcher was always punctual, courteous, friendly and unbiased. Before the interview questions started, the researcher built a rapport with the participant.

The recruiting assistant ensured that at each interview, the participant's completed leadership survey was readily available. The researcher had prepared an interview orientation guide which was personally read to each participant before the interview began (Appendix 9), with statements such as "This interview is voluntary; you may stop at any time", and "If you feel at any stage that you are not comfortable answering a particular question, please tell me". The participants were informed about the fact that the interviews would be audio-taped during the interview orientation prior to commencement of questioning. A Sony recorder was used to record all interviews (A10 Linear Recorder A-Series). This device was tested before use for quality functionality prior to each interview, and was found to be reliable with excellent audibility.

When the participant agreed to start the interview, the researcher switched on the audio-recorder and read out a code. This code was congruent with the sequence of interviews, for example, the first participant interviewed was coded '001' and the second was '002' and so forth. The completed leadership survey was given a matching code for integration during analysis.

The interview guide contained nine interview questions which were used to guide the researcher when asking participants questions. The guide was also used by the researcher to make field notes during the interview, and this was made known to the participants by the researcher prior to commencing the interview questions. This was a semi-structured interview so the researcher tried to ask the questions in a conversational tone aimed at increasing the chance of being offered insightful information. Because the tool had been pre-tested, signifying it was easily understood, and participants were able to

answer all the questions without difficulty. Adequate time was given to participants to fully answer each question.

During the interview, the participant was informed that s/he may use the completed leadership survey form when answering question seven “What would you hope to gain from leadership education? You can use your leadership survey to identify skills you need”. The interview added depth to the information on the leadership survey, by uncovering deeper needs of this generation of nurses during the discussion. Merely completing a survey of skills, although useful for statistical measurement, can be limiting because it does not allow for explanation or clarification of the survey content. The interview also allowed for integration of the data during analysis. After the interview, the researcher kept the leadership survey, for independent analysis as well as for merging during further data analysis.

At the commencement of data collection, it was not known how many interviews would be conducted. The researcher chose to use the principle of data saturation, described by Polit and Beck (2012: 521), whereby the researcher continues to conduct interviews until data saturation, or data satisfaction, has been reached. In this study, the researcher did a preliminary analysis during each interview, and thematic analysis was done to establish data saturation, after which no further interviews took place. This led to data being collected from 12 interview participants, eight females and four males.

4.10 DATA STORAGE

Study data was contained in multiple forms, namely hard copies, electronic records and audio-recordings that contained confidential information that needed to be safely kept by the researcher in order to protect the study sample. The categories of data were stored as follows:

Paper documents and hard copies: The two survey documents, the interview guides, on which the researcher wrote field notes during each interview, as well as printed hard copies of the interview transcripts and the letters of

information and consent were sealed in an envelope and locked in a code-protected electronic safe installed in the home of the researcher. The code is known only to the researcher. After five years the documents will be destroyed.

Electronic data: The data kept on the researcher's personal laptop is password protected, and the password is known only to the researcher. The data will be permanently deleted after five years.

Dictaphone audio-recordings: Immediately after each interview, the researcher saved the recording onto her personal computer and permanently deleted it off the recording device. After transcribing the interview recordings, the session was deleted from the Dictaphone. The transcripts of the interviews will be permanently deleted from the researcher's computer after five years.

4.11 DATA ANALYSIS

Because this was a mixed methods study, both quantitative and qualitative data analysis took place. Quantitative data analysis involves manipulating numerical data using statistical procedures in order to describe phenomena to enable researchers to organise, interpret and communicate the data (Polit and Beck 2012: 556).

Qualitative inquiry is more exploratory in nature, with strong emphasis on the description of, understanding of, the central phenomena. Researchers analyse these data for a rich description of the phenomenon so as to identify themes to develop a detailed version of the complexity of the problem, leading to a personal interpretation made by the researcher (Creswell et al. 2003: 174). Qualitative data analysis involves the organising and interpretation of narrative data in order to glean important meaning from the data. It is a time-consuming exercise and in the case of interviews, it requires coding to elicit themes (Polit and Beck 2012: 739).

4.11.1 Quantitative data analysis

For the quantitative data, statistical analysis was performed using the Statistical Package for Social Sciences (SPSS) version, 22.0. A statistician was consulted (Appendix 10). Two types of statistical analyses were applied to the quantitative data: descriptive statistics and inferential statistics. Descriptive statistics were used to describe the sample and included relevant tables and graphs showing frequencies and percentages and, where applicable, means (measure of central tendency) and standard deviations (measure of spread) were also calculated.

Inferential statistical analysis included both parametric and non-parametric tests to help draw conclusions about the population characteristics based on the study sample. These tests objectively reveal trends in the data (Brink, van der Walt and van Rensburg 2012: 190). In order to identify predictors of performance in nursing, and to explore other relationships in the data, regression analysis was applied. Throughout the analysis, p-values of < 0.05 were used to measure statistical significance. Where conditions for parametric tests were not met, equivalent non-parametric tests were used.

The following tests were used in the quantitative analysis:

- Chi-square goodness-of-fit, test to assess which competency rating category/categories is/are selected significantly more than others.
- Friedman's non-parametric tests were used to determine if there were significant differences across multiple constructs.
- Binomial tests were applied to test if a significant proportion of respondents select one of a possible two responses. This can be extended when data with more than two response options is split into two distinct groups.
- Cronbach's alpha is applied to test whether combining the items from a construct will yield a reliable measure for that construct. Alpha > 0.7 indicates a reliable measure of internal consistency.
- Independent samples t-test: A test that compares two independent groups of cases.

Analysis of the strengths survey

Quantitative analysis was done on the retrospective data by the researcher, in consultation with a statistician. The analysis of the survey was to determine the strengths of Generation Y, the results of which were taken into consideration in the development of the leadership framework. Descriptive and inferential analysis was done to identify trends and correlations in the data, to describe the character strengths of Generation Y nurses.

Analysis of the leadership survey

The leadership survey was dual-purpose in the study. It was analysed statistically to determine the leadership competency level of Generation Y nurses, and it was used during the interviews to enrich the data collected when participants were asked the question relating to their leadership needs, as a means of integrating the quantitative and qualitative data. The analysis of the leadership survey was only done once all the interviews were individually undertaken, transcribed and analysed. This quantitative analysis by the researcher was used to gauge the perceived needs in leadership skills required by Generation Y participants. In addition the data from the two approaches was compared, integrated and interpreted to elicit the leadership development needs and experiences of Generation Y nurses.

4.11.2 Qualitative data analysis

Analysis of the interview

It is imperative that the analysis process is described in as much detail as possible (Elo and Kyngäs 2008: 110). The details of how the analysis was done must be clearly stated in order to use a universal language in research (Hsieh and Shannon 2005: 1286). The researcher applied an inductive approach for the analysis of the qualitative data. This approach is grounded in social sciences to interpret data that answers research questions. The organisation of the qualitative data is an important step in inductive content analysis and it is through this process that the themes or categories are derived from the data (Cavanagh 1997 cited in Elo and Kyngäs 2008: 110).

This method involves open coding, creating themes and abstraction. The purpose of creating themes is to provide a means of describing the phenomenon, to increase understanding and to generate knowledge. The trustworthiness of the research results is also determined by how adequately the themes cover the collected data (Graneheim and Lundman 2004 cited in Elo and Kyngäs 2008). Links between the results and the data are required to enhance the study's reliability (Polit and Beck 2004 cited in Elo and Kyngäs 2008: 112).

In this study, a preliminary thematic analysis was conducted by the researcher during each interview, as an initial approach to identify information and themes. This entailed the researcher writing field notes on the interview guide. Thereafter the researcher transcribed the interview recordings into text, using Microsoft Word (Appendix 9). The field notes were compared with the transcripts to ensure the data was congruent, especially when a word was difficult to hear clearly. The researcher then re-coded the transcribed interviews for referencing during the presentation of results for example 'RN01-W'. In this example, the participant is a qualified RN. The '01' refers to the fact that this was the first participant interviewed. The 'W' refers to a code assigned to the specific clinical area where the participant worked in the hospital.

The researcher then prepared the data for deep thematic analysis by fully engaging with the content, achieved through the researcher personally having conducted the interviews and listening to the recordings several times to 'feel' the content. According to DeSantis and Ugarriza (2000: 362), thematic analysis assigns meaning to the data by bringing it together to form a meaningful whole. The steps used to analyse the qualitative data into themes are described by Tesch (1990: 142-145) and have been summarised in Table 4.5.

Table 4.5: Tesch's coding steps

1	Carefully read all data to gain a sense of the whole and jot down any idea that springs to mind.
2	Read one document at a time, and while reading, asks yourself 'What is this about?' Write down any ideas that might answer this question.
3	Repeat as above for several documents. Make a list of topics and enter them in a blank table with enough columns for each interview.
4	Go back to the data with the table and write codes next to the corresponding sections in the text. Check for new categories that might emerge. Jot down any ideas (analytic memos).
5	Turn the topics into categories by allocating a descriptive code to each topic. Try to reduce the number of categories by grouping related ones. Look for sub-categories (20-50), which become the organising system for the data.
6	Finalise the abbreviation of each category and alphabetise the codes to ensure that no duplication occurs.
7	Group common data categories together and perform an initial analysis. Study the material in one category at a time, focusing on the content. Discard any irrelevant data that does not answer the research question.
8	Re-code the existing data where necessary.

Following the steps described above, the printed transcripts were then read and re-read to gain deep understanding of the data and their overall value. Several generalised notions were written in the margins of the document and important phrases were highlighted in different colours to elicit common themes. Some pertinent phrases were highlighted to be quoted in the results. The four elements of the adapted RBC model formed the main themes, and after rigorous analysis through the application of Tesch's coding, eight salient sub-themes emerged.

The above steps were followed for each interview of transcribed data. After analysis of the first interview, the next participant was invited. This analysis process continued with all subsequent participants until data saturation was reached and no further themes emerged from the analysis. Once all 12 interviews were complete, the data was re-read and further analysed to amalgamate the findings and revise the list of themes that emerged. The researcher's supervisors, considered experts at qualitative research, reviewed the thematic analysis and provided input.

4.11.3 Linking data analysis with the study

It is important that the researcher shows the link between data analysis to the research questions and data collection in the study (Lavelle, Vuk and Barber 2013: 274). Table 4.6 displays the connection between the methods that were used to analyse the data so as to answer the research questions.

Table 4.6: Linking data analysis to research questions

Research questions	Data collection	Data analysis
1. Quantitative question: Which character strengths are important to Generation Y nurses?	Strengths survey	Statistical
2. Quantitative question: How do Generation Y nurses rate their leadership skills?	Leadership survey	Statistical
3. Qualitative question: What are the leadership experiences and needs of Generation Y nurses?	Face-to-face interviews	Coding and thematic analysis

4.12 MERGING SEQUENTIAL QUANTITATIVE AND QUALITATIVE DATA

In mixed methods research, when and how merging takes place must be carefully planned and explicitly specified by the researcher (Creswell et al. 2011: 22). In the current study the data from the concurrent and sequential phases of data collection were analysed independently. The quantitative data was statistically analysed, whereas the qualitative data was analysed using coding and thematic analysis, guided by the four RBC elements. The data from the two sequential data sets was then merged to compare and substantiate the quantitative findings with the qualitative findings. Further analysis included methodological triangulation when interpreting and synthesising the results of Phases 1 and 2.

4.13 TRIANGULATION OF DATA

Triangulation refers to the use of more than one approach to the investigation of a research question in order to enhance confidence in the ensuing findings (Bryman 2011: 11420; Teddlie and Tashakkori 2009: 32). Using multiple

sources of data in a study can optimise its dependability, trustworthiness and interpretation (Zohrabi 2013: 254), but care must be taken to reduce threats to validity which can unintentionally lead to inaccurate conclusions being made by the researcher (Bergman 2008: 24). The purpose of using triangulation in this study was to compare and substantiate certain elements of the study, thereby adding depth to the findings, as well as to generate complimentary data in the study. Denzin (1970), as cited by Bryman (2011: 11420), distinguishes four forms of triangulation:

a) Data triangulation, which entails gathering data through several sampling strategies so that slices of data at different times and in different social situations as well as on a variety of participants are gathered.
b) Investigator triangulation, which refers to the use of more than one researcher in the field to gather and interpret data.
c) Theoretical triangulation, which refers to the use of more than one theoretical position in interpreting data.
d) Methodological triangulation, which refers to the use of more than one method for gathering data.

This study used data and methodological triangulation. There were three sets of data collected in Phases 1 and 2. Two sets were quantitative surveys and one was a qualitative interview. In Phase 1, data was collected using a strengths survey tool. In Phase 2, sequential data was collected using a leadership survey, followed by an interview. The sequential phase allowed the researcher to compare certain aspects of the leadership survey findings with those of the interview, to enrich the understanding of the study inquiry and enhance the outcome. The third phase of the study was achieved through objective four, which depended on the triangulation and interpretation of outcomes from the first three objectives. The results of the methodological triangulation are presented in Chapter 6 and discussed in Chapter 7.

4.14 INTERPRETATION OF DATA

This is a process whereby the researcher describes the results and interprets the findings as clearly as possible so that sense can be made of the entire study (Zohrabi 2013: 261). After the data analysis stage of the research had been completed, the researcher studied the findings of all three sets of data as well as the integrated findings so as to interpret them and make inferences and meta-inferences. This involved the researcher thoroughly examining the quantitative and qualitative results, to evaluate whether the findings had adequately addressed the main mixed research question. Tashakkori and Teddlie (2008: 101) refer to the result of interpretation as the drawing of conclusions to allow for the identification of certain inferences and meta-inferences, which are discussed in Chapter 7.

4.15 DEMONSTRATING RIGOUR IN THE MIXED METHODS

It is the researcher's responsibility to build validity into all stages of the research process (Zohrabi 2013: 258). When two different instruments are used to collect data, it is crucial that their quality is exceptional, because conclusions are drawn from the results of their use (Fraenkel and Wallen 2003 cited in Zohrabi 2013: 258). While the use of mixed methods in research is known to increase its validity, there is no excuse for omitting to demonstrate systematic rigour in both the qualitative and quantitative components. Other authors agree that rigour is vitally important to validate the findings of a study (Brink, van der Walt and van Rensburg 2012: 126; Lavelle, Vuk and Barber 2013: 274), and this occurs when the findings of both approaches are amalgamated into a clear conceptual framework that answers the research question (Teddlie and Tashakkori 2009: 286). Although mixed methods research is rapidly gaining attention and becoming more widespread in its use, establishing its rigour remains poorly defined (Halcomb and Hickman 2015: 11).

Rigour can be achieved through the researcher detailing every activity and decision made in the research process (O'Cathain, Murphy and Nicholl 2008:

94), to show a crystal clear picture to justify how and why each activity took place (Creswell et al. 2011: 21; Lavelle, Vuk and Barber 2013: 274). Researchers must endeavour to prove rigour as they would when using either quantitative or qualitative methods in a study.

The researcher went to great lengths to ensure an undisputable case to justify the decisions made regarding all aspects of the study. In the current study there was a concurrent and sequential phase, and to ensure rigour, the researcher applied the principles regarding these designs to the concurrent and sequential phases in the multistage design. Brink, van der Walt and van Rensburg (2012: 126) recommend using different methods to establish rigour in quantitative and qualitative studies, because the process and outcomes of the two approaches are quite different, and as such are discussed using different criteria. In quantitative research, the criteria used to establish rigour focuses on validity and reliability, whereas in qualitative research the criteria used focuses on trustworthiness.

4.16 QUANTITATIVE RIGOUR

The data for the quantitative component of the study was collected using a survey tool during each of the first two phases in the study. The first phase (concurrent) collected data from an online strengths survey, the second phase (sequential), collected data with a survey which was followed by the qualitative data collection on the identical sample. The third and final stage was when the proposed leadership framework was developed.

4.16.1 Validity

Establishing validity through face, content, construct and external validity are important in ensuring rigour in a study (Polit and Beck 2012: 336). In qualitative research, validity seeks to establish whether an instrument measures what it is designed to measure. Quantitative validity was established for the methods used for data collection and analysis. Validity determines how well an instrument effectively represents all aspects of the

variable it is measuring (Brink, van der Walt and van Rensburg 2012: 165). In other words, validity establishes the trustworthiness of the choice and use of the tool.

Face validity determines if the instrument actually measures what it is supposed to (Polit and Beck 2012: 336). If face validity is not demonstrated, the results of the study are regarded as weak or worse still, meaningless. Content validity refers to the degree to which the items on a tool represent all that is known about the construct being measured and verifies that the instrument actually measures the desired contents for the study (Polit and Beck 2012: 336). The researcher did a thorough review of all literature available, as presented in Chapter 2, before selecting the use and choice of instruments in the study. Construct validity of instruments refers to the degree to which it measures the construct under inquiry (Polit and Beck 2012: 723).

Validity of the strengths survey

The research question "Which character strengths are important to Generation Y nurses?" was answered through the objective 'Determine the strengths of Generation Y nurses'. In order to do this the researcher used an online strengths tool. Although there are a number of instruments that measure character strengths, such as the Clifton Strengths Finder 2.0 (Rath and Conchie 2008: 5) and the Realise2 (Linley and Dovey 2012: 4), the VIA strengths survey is considered valid in that it is the most widely used positive psychology tool in use today, according to Linley et al. (2010: 7). One advantage of using this particular survey is that it links strengths with occupation (Peterson et al. 2009 cited in Linley et al. 2010: 7), and thus the researcher recognised this as increasing its validity in this study on the development of the nursing workforce. In line with the literature review Chapter 2, the content of the VIA-120 survey is congruent with character strengths identified in positive psychology. Previous research has found that the application of signature strengths generally correlates the most positively with behavioural outcomes, validating its use of the tool (Littman-Ovadia, Lavy and Boiman-Meshita 2016: 544). Construct validity was established because

the VIA strengths survey is a validated tool, and the measuring is done online by the VIA Institute on Character as soon as the survey has been completed. The analysis on the results was done in consultation with a statistician, to increase validity.

Validity of the leadership survey

The research question “How do Generation Y nurses rate their leadership skills?” was achieved through the objective ‘Identify skills that are likely to prepare Generation Y nurses in the workplace’. Data was collected using a leadership survey. According to the AONE its reliability and validity has been established because, firstly, it was developed by Applied Measurement Professionals, Incorporated (AMP) as part of a job-related certification examination, and secondly, it was developed with the input of the target population. The AMP organisation that provide healthcare certification by means of testing services and they assist healthcare organisations achieve and maintain accreditation by third parties, including the National Commission for Certifying Agencies and the Accreditation Board for Specialty Nursing Certification.

The AMP organisation was requested to design and conduct a study upon which the content valid certification examination could be developed (Fabrey and Traynor 2014: 1). AONE set up an advisory committee to provide data for the development of the tool. This committee comprised experienced nurse managers and leaders who were actively working in the nursing profession at the time and were thoroughly familiar with the duties of being a leader. The committee was tasked with developing a sampling plan, identification of the tool content and categories, determining the rating scales as well as taking the relevant demographic variables into consideration. The data was collected using a web-based analysis survey which was distributed to nurse managers and leaders. Data from the 328 respondents were analysed and revealed reliability regarding the use of the rating scales and in addition, all respondents agreed that the tool content at least adequately addressed the duties of a nurse leader.

Face validity was established by asking nurse leader experts to review the leadership survey tool to approve its usefulness in gathering data within the context of this study. Once they had agreed that the tool was appropriate, it was tested in a pilot study to gather any recommendations for revisions. Content validity was established because data was collected from key informants who are the only population who can offer unbiased leadership competency ratings for their cohort. Construct validity was established because the existing tool was approved for use by the supervisor and was piloted to ensure it was easily understood by those using it in the study. Expert nurse leaders also approved that the tool was suitable for measuring the constructs in the study. The statistician was satisfied that the tool was appropriate for statistical measurement. Construct validity was established through the analysis on the results which was done in consultation with a statistician.

4.16.2 Reliability

Reliability refers to the extent to which the tool can be trusted to return the same results if used again and again by either the same researcher or by more researchers (Polit and Beck 2012: 331). The reliability of an instrument is expressed by a numerical correlation measure that varies between 0 and 1. A reliable instrument will measure a higher correlation closer to 1 (Brink, van der Walt and van Rensburg 2012: 169).

Reliability of the strengths survey

For the purpose of this study, previous literature was examined on the reliability of using the strengths surveys to bring about positive goals. In searching for suitable instruments for the study, to fit with the researcher's worldview as well as the literature, the VIA-120 tool, which is a character strengths survey offered online by the VIA Institute on Character, was selected. Internal consistencies of the 24 scales were satisfactory.

This survey was appropriate for the study because a previous study that used the VIA strengths survey revealed that the use of personal character strengths appears to be intrinsically harmonious with the self, and therefore leads to positive feelings and better goal achievement (Linley et al. 2010: 14; Littman-Ovadia, Lavy and Boiman-Meshita 2016: 527). The latter study provides a concrete pragmatic foundation to support employers who are using character strength approaches in their work.

The reliability of a tool gives rigour to a study. A Cronbach's α value of >.70 indicates acceptable internal consistency (Huber et al. 2019: Para. 16 line 6). The VIA-120 strengths survey was found to have internal consistencies for the 24 scales, with Cronbach's α-coefficients of 0.70 to 0.88, evidencing the reliability of the tool for use in the study (Littman-Ovadia, Lavy and Boiman-Meshita 2016: 535).

Reliability of the leadership survey

The AONE is a globally acclaimed organisation of nursing leaders, and is a subsidiary of the AHA, which claims to be the only organisation dedicated to the specialised field of nursing leadership. Development of the leadership skills competencies tool was initiated in 2004, and again in 2006. The AONE claim the tool to be reliable, which is established by conducting periodic job analysis/role delineation studies to ensure the results are consistent when used repeatedly (Fabrey and Traynor 2014: 1).

4.17 QUALITATIVE RIGOUR (TRUSTWORTHINESS)

Quantitative research is often criticised because it is less objective than quantitative research, lending itself to the risk of subjectivity (Polit and Beck 2012:174). The principles of qualitative research are built on the extent to which the researcher and other interested parties assess the credibility, reliability and usefulness of the study (Zohrabi 2013: 258). It is therefore, very important to provide evidence of rigour to render the findings trustworthy since they were used to develop a leadership framework in this study. The

qualitative component of the multistage design was part of a sequential stage of the study, where data was obtained through interviews, and was integrated with survey data collected from the same participants. Methods applied by the researcher to enhance trustworthiness of the study's qualitative component follow. Lincoln and Guba (1985: 289 cited in Polit and Beck 2012: 584) suggest several criteria for developing the trustworthiness of a qualitative inquiry. To ensure trustworthiness in this study, the criteria outlined below were used.

4.17.1 Credibility

Credibility is the number one goal of qualitative research (Lincoln and Guba 1985 cited in Polit and Beck 2012: 584). Credibility is the degree of confidence in the truth of the data collected and the interpretations made about the data (Polit and Beck 2012: 175). In the study, credibility was achieved through a number of factors: sound sampling methods, creating a suitable set of interview questions, sound data collection decisions, methodological triangulation of the data collected, recording of the interviews and using their quotes in the presentation of results. The content of the leadership questions were developed from a previous tool used in interviews regarding development of bedside nurse leaders. (Sherman, Dyess and Prestia 2013: 21). In addition, examples of self-assessment questions from the RBC book were incorporated (Koloroutis 2004: 80) and, additionally, the draft interview guide was given to experienced nurses to review prior to its use in the study.

The researcher personally conducted each interview, and was aware from the previous literature, that in face-to-face interviews the researcher has a great deal of influence on the outcome (Brink, van der Walt and van Rensburg 2012: 141). The researcher's gender, ethnicity, attire and manner of speaking can affect the responses of the participants. Before each interview, the researcher attempted to build a rapport with the participant in the hope that this would lead to a more relaxed climate to promote conversation that would yield deep and richer information. During each interview the researcher

endeavoured to remain as unobtrusive as possible so as not to intimidate or influence the participant's responses, yet at the same time was friendly and engaging so as to encourage participants to share information freely during their responses. Data saturation was reached only when no new information arose from subsequent interviews, thus increasing credibility that adequate data was obtained (Brink, van der Walt and van Rensburg 2012: 141). The researcher transcribed each interview into text painstakingly replaying them to ensure accuracy. In addition, the analysis was done personally by the researcher by immersing herself in the data so as to get a feel for the content. When interpreting the interview data, the researcher remained as objective as possible and refrained from the temptation of making assumptions from the data.

Anthropologists point out that the researcher is an instrument in research (Polit and Beck 2012: 492). In this study, the input of the researcher as an instrument was not overlooked. The researcher has a vast amount of nursing leadership experience, with almost four decades of fulltime nursing in hospitals during which time she has held positions as a clinical instructor, lecturer, manager, and director, making her a credible tool in the collection, analysis and interpretation of data. In addition, the researcher has completed a master's degree in nursing and is passionate about education and leadership and the development of nurses, which add to the credibility of the study. Furthermore, the researcher's supervisors are highly experienced nurse leaders as well as academics, who supervise degrees at postgraduate level, and were actively involved in the research process.

4.17.2 Generalisability

External validity, also known as transferability, refers to the extent to which study findings can be applied to other contexts or samples (Brink, van der Walt and van Rensburg 2012: 127). This is achieved through the presentation of the thesis, which is a database of rich description, which other researchers and professionals can learn from and extrapolate in other settings. Ample detail has been provided in the study, so that others can assess its use

elsewhere. The data collection and analysis was robust enough to safely project the results onto a different population, although the researcher herself cannot stipulate whether the findings were externally valid, since this has not been proven. She has however, provided the results needed should another interested party want to project it onto other groups or within another context (Lincoln and Guba 1985 cited in Polit and Beck 2012: 584). The findings of this study will also shape future research which can build upon it.

4.17.3 Creativity

The framework developed by Whittmore and colleagues (2001 cited in Polit and Beck 2012: 585) posits that creativity challenges traditional ways of thinking and encourages innovative ideas to collecting, analysing and giving meaning to data. In this study the researcher demonstrated her creativity by utilising a non-traditional mixed methods design, to fit with her philosophical beliefs and to best answer the research questions, while at the same time ensuring that the quality of the study was not in any way compromised. The researcher also used creativity in opting to use only a portion of the original leadership survey, with permission from the AONE.

4.17.4 Authenticity

Authenticity refers to the degree of reality which emerges in the mind of the reader when reading the research study. An authentic study conjures up feelings about the context of the participants' lives (Lincoln and Guba 1985 cited in Polit and Beck 2012: 585). This has been encouraged in the study through using quotations from the interview transcripts, to reveal their inner thoughts, for example on their experiences at work and their perception of whether they are being treated fairly. Authenticity was also achieved by the researcher observing the participants during the interviews and taking field notes on their facial expressions and affect when responding to questions. In addition, when the researcher listened to the tapes repeatedly, the tone of voice was noted to enrich the authenticity of the data.

4.17.5 Dependability

Dependability refers to the reliability of the data over time and when applied to other conditions (Polit and Beck 2012: 175), and can include auditing of the processes and procedures used in the study (Brink, van der Walt and van Rensburg 2012: 127). Credibility is reliant on dependability, in that it cannot be achieved without it. The study methodology increases its dependability. In this study the minute details of the methods used, including the design, context of the study, the data collection and analysis as well as sample population description were disclosed to the reader. The sample is an important factor in claiming that a study is dependable. In this study the key informants were from the cohort that the study was aimed at: Generation Y nurses. No other sample can answer questions about their leadership perceptions, but them.

Dependability has also been guaranteed through the fact that the doctoral supervisors have kept track of the research process at all stages. Tesch's coding and the thematic analysis was done independently by the researcher, and the sub-themes were then verified independently by the supervisors. The researcher kept track of all documents during the study and an audit trail was kept of all data collected such as surveys and interview transcripts. Rich and vivid descriptive data was produced from the data. Triangulation of all collected data further increased dependability of the findings, because there was some overlap of data collected during the sequential phase occurred, and this allowed for confirmation of the findings. Congruency of the different aspects of the study also increases dependability on the results of the study, such as between the research questions and the methods, (Whittmore and colleagues' framework 2001, cited in Polit and Beck 2012: 586). Rigorous triangulation during the third phase ensured that the proposed leadership framework was an accurate reflection of the study findings.

4.17.6 Confirmability

Confirmability refers to the extent to which the study findings are gleaned from the participants' characteristics, and not the researcher's biases (Polit and Beck 2012: 175). Confirmability also verifies that the study results and recommendations are supported in the data collected, and that the interpretations made by the researcher are congruent with the original evidence (Brink, van der Walt and van Rensburg 2012: 127). This was achieved by checking the interview transcripts repeatedly to ensure no relevant points were missed, and to ensure that interpretation of the results remained congruent with the findings.

Integrity plays an important role in confirmability, for example, that the researcher does not invent or manipulate the findings. Scientific honesty includes falsifying data and plagiarism (Brink, van der Walt and van Rensburg 2012: 45). The researcher did not falsify documents at any stage and when quoting from the writings of other researchers, inverted commas were used and direct references were provided. The integrity of the researcher was high throughout the study, and even when obstacles were reached, she sought to address them without compromise. In accordance with Whittmore and colleagues' framework (2001 cited in Polit and Beck 2012: 585) the researcher ensured the auditability of the study by maintaining impeccable records and accurate results. Further, confirmability was achieved through the collection of qualitative data from the key informants which rested on the threshold of saturation, after which the thematic analysis was conducted independently by the researcher and again by the supervisors. The secure storage of the study data as described in Section 4.10 above, added to the confirmability of the qualitative portion of the study.

4.18 ETHICAL CONSIDERATIONS

A researcher has the right to seek the truth in the most rigorous manner, however this should never be at the expense of the rights of the study sample (Babbie and Mouton 2001: 518). In nursing research, truth and integrity are

vitally important, and expert systematic processes must be diligently applied to ensure studies that are ethically sound (Burns and Grove 2011: 228). It was important that the researcher ensured ethical guidelines were diligently adhered to during the research process.

Permission to conduct the study was given by an accredited research ethics committee when they approved the proposed research plan. Full ethical approval clearance was received prior to commencing the study (Appendix 1). In addition, the researcher was required to undergo a Bioethics online training course, which took place on 4 May 2017, prior to approval being given by the affiliated university's Institutional Review Board in Saudi Arabia. Written permission was also obtained from the hospital's affiliated university IRB (Appendix 2b) where data collection took place.

A statistician was consulted by the researcher to guide the sample size and the statistical analysis of the quantitative component of the first phase of the study. This was to make sure that the sample was scientifically representative of the target population, and to increase the transferability of the findings to other groups or contexts.

4.18.1 Informed consent

Informed consent means that the researcher has met the participants right to full exposure about the study, and that they have the ability to understand the information, so that they are able to make an informed consent, or they can refuse to voluntarily take part (Polit and Beck 2012: 157). The researcher ensured that informed consent (Appendix 5) was obtained from all participants who took part in the study, for both the quantitative and qualitative component. Informed consent was guaranteed by the provision of a letter of information given to each participant by the recruiting assistant prior to consenting (Appendix 4). The same study sample who completed the leadership survey were interviewed and the researcher personally conducted all face-to-face interviews with the participants, to ensure confidentiality. By signing consent forms the participants acknowledged that data collected

would be processed in a computerised system by the researcher, and that they had been offered sufficient opportunity to ask question.

The recruiting assistant, who had signed a non-disclosure agreement, was the only person besides the researcher, who knew which participants had consented to take part in the study. To maintain anonymity, participants' names did not appear on any documents, but rather codes were used on the documents so that they could not be linked to the study in any way. Participants were informed that the researcher and a statistician would analyse the results. Because the researcher worked at the hospital where the participants worked, they were also informed that the results of this study would not affect their employment in any way.

4.18.2 Beneficence and non-maleficence

Beneficence refers to the researcher's responsibility in research to minimise harm and non-maleficence refers to the researcher's responsibility to maximise benefits for the participants and others (Polit and Beck 2012: 152). Furthermore, this ethical principle secures the physical, emotional, psychosocial, spiritual, legal and economic security of those who participate in research studies (Brink, van der Walt and van Rensburg 2012: 35). This principle was addressed by having the research proposal reviewed by the Faculty of Health Science and Higher Degrees Committee and ethical clearance was requested from the Institutional Research Ethics Committee (23/2017) (Appendix 1). Institutional Review Board approval was obtained from the affiliated university and the department of nursing at the hospital where data was collected. The participation and results of the study did not affect the employment of the participants, nor will the results of the study do so in the future, thus the participants were not exploited in any way. The participants were not subjected to harm, fear or emotional discomfort, nor to financial loss.

4.18.3 Respect for human dignity

Respect for human dignity refers to the right of self-determination, and the right to a full explanation and the right to ask questions, as well as the right to withdraw from the study at any time (Brink, van der Walt and van Rensburg 2012: 35). Respect also refers to not influencing participation by offering generous rewards (Burns and Grove 2011: 233). The researcher treated the participants with the utmost respect during all interactions. All participants were given adequate time to read a letter of information regarding the research and a written informed consent was signed, which included that there would not be any remuneration for participating (Appendix 4). Participants were treated with the utmost respect throughout all interactions regarding the study.

4.18.4 Justice

According to Brink, van der Walt and van Rensburg (2012: 35), justice in research concerns the right to privacy, anonymity and confidentiality, as well as the right to fair treatment. From the outset by way of the letter of information, the participants understood that participation was voluntary and that their anonymity and confidentiality would be maintained throughout the study. Privacy was maintained during the interviews by using a dedicated room as described in the study setting above. Sampling methods ensured that the participants were objectively and equitable selected, and not according to the personal preference of the researcher. In addition, the random sampling was done with the recruiting assistant, who had read the methodology of the study sample selection process beforehand. Recruiting and obtaining of consent for the study was not personally done by the researcher, but by a recruiting assistant, to further protect the participants from biasedness and intimidation. The recruiting assistant was asked to sign a non-disclosure agreement.

The researcher personally entered the survey data onto the spreadsheet in preparation for analysis. For all instruments, the names of the participants did

not appear on any documents containing data collected from participants, to ensure anonymity and confidentiality. The leadership survey was coded to match the survey with the interview records. The researcher personally analysed the interview data, to ensure confidentiality. Completed data collection instruments are being kept in an electronic safe and will be destroyed by shredding after five years. Electronic data is being stored in the researcher's personal computer, secured with a password known only to the researcher. This data will be deleted after 5 years. Audio-recordings were permanently deleted from the recording device immediately after each interview once they had been saved to the researcher's computer.

4.19 SUMMARY OF THE CHAPTER

The methodology is the most important chapter in research. Data analysis is the most difficult and a crucial aspect, especially the analysis of qualitative research. In this chapter the methodology of the study was described. The various steps in the research process, objectives and ethical considerations were explained as well as the type of analyses applied. The next chapter will present the methodology of integration of research methods used in the study.

CHAPTER 5: METHODOLOGY OF INTEGRATION

5.1 INTRODUCTION

This chapter will provide details regarding the methodology of mixing or integration of the research methods throughout the study. It should be noted that this chapter deals specifically with the integration methodology, and not the actual findings of the study, which are presented in the appropriate chapters. Integration has also been briefly discussed, where it applies, within other chapters of the study, namely Chapters 4, 6 and 7.

5.2 RATIONALE FOR INTEGRATION OF MIXED METHODS

Integration is the intentional combining of multiple forms of data, both quantitative and qualitative, using systematic procedures (Creswell et al. 2011: 5). Integration can radically enhance the value of mixed methods research. Merging is the mixing of quantitative and qualitative data, often done after analysis has occurred (Fetters, Curry and Creswell 2013: 2140), as was the case in the current study. In this study, merging of the qualitative strand complemented and substantiated the quantitative strand, because in-depth explanations are known to be more easily achieved through qualitative methods.

Timing

The study aim dictates the extent of integration and exactly when and how integration occurs (Creswell et al. 2003: 175). In mixed methods research, the timing of integration refers to both the time of data collection as well as the order in which the data is utilised by the researcher. Differentiation is made between concurrent, sequential and multiphase combination timing (Creswell, et al. 2011: 65). The timing of data collection has been described in Chapter 4 as being concurrent in the first phase, and sequential in the second phase. The aim of the study was to obtain first-hand experiences and ideas from

Generation Y practitioner nurses at the bedside, in order to develop a nursing leadership framework for this cohort of nurses. Because the researcher was interested in knowing the competency level of their leadership skills, and what their leadership development needs were, two different sets of data were required. The researcher decided that the best way to do this was through a mixed methods design comprising three phases. The integration of the three sets of data collected is shown in Figure 5.1. The dotted lines show the integration of the data collected.

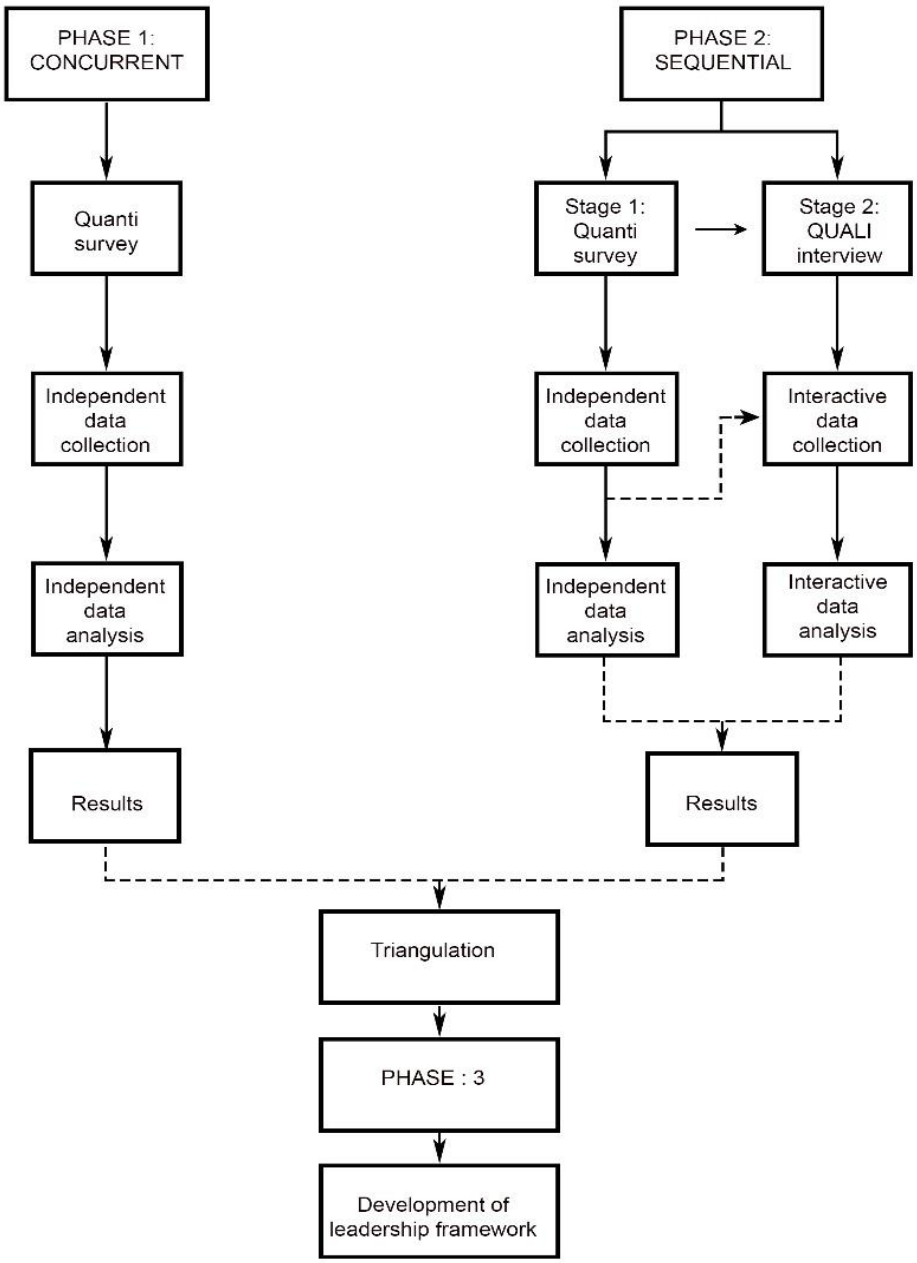

Figure 5.1: Integration of study data

5.3 INTEGRATION LEVELS IN THE STUDY

Fetters, Curry and Creswell (2013: 2135) specify levels where integration can occur, namely, the design, methods, interpretation and reporting levels of research. In fact, integration begins even earlier than this, within the research questions, if there are both quantitative and qualitative questions.

Interpretation also occurs when examining the results to integrate the findings (Creswell et al. 2003: 173). The researcher carefully planned when and how the data would be integrated at the outset of the research study, congruent with a fixed design. Table 5.1 displays the four levels of integration applied to this study, and each level will be explained in more detail thereafter.

Table 5.1: Multi-level integration in the study

Integration level	**Approach explained**
Design level	**Multistage mixed methods framework**: Using multiple sets of data better describes the nature of an individual's experience of a complex phenomenon such as leadership.
Methods level	**Sequential phase**: One data set connects with another through the identical study sample. The two sets of data (quantitative and qualitative) are merged or brought together after analysis, to combine, compare and substantiate results. After independent analysis of the different sets of data, the quantitative data was embedded in the qualitative.
Presentation of results level	**Sequential phase**: Quantitative and qualitative results are presented separately using statistical and staged narrative approaches respectively. Findings of both sets are then merged to compare and substantiate findings.
Discussion of findings level	**Narrative weaving approach**: This approach is used to link concurrent and sequential findings after analysis. Findings are discussed together using qualitative (priority) themes and sub-themes as the framework.

5.3.1 Integration at study design level

At the conceptualisation stage of the research study, based on the research questions and objectives, the researcher decided that a mixed methods study was better suited for the complexity of a leadership inquiry. Of the three basic mixed methods designs, the researcher felt none would accomplish as much as an advanced mixed method design known as the 'multistage advanced framework' (Fetters, Curry and Creswell 2013: 2136). This multistage advanced framework incorporates multiple stages of data collection, with merging and integration of the data. The researcher used a combination of both concurrent and sequential approaches, resulting in three stages of data

collection, which took place in the first two phases of the study. Table 5.2 summarises how the data was collected.

Table 5.2: Data collection methods

Phase	Approach	Orientation	Tool
Phase 1	Concurrent	Quantitative	Strengths survey
Phase 2	Sequential	Stage 1: Quantitative	Leadership survey
		Stage 2: Qualitative	Interview

5.3.2 Integration at methods level

Ideally, at the design stage, the researcher develops a plan for collecting both sets of data in such a way as to facilitate the smooth integration of the data. Integration at the methods level is invariably related to the choice of research design used in the study, because the study design dictates the decision for when and how integration should occur. Integration at the methods level links the methods of data collection and data analysis in several ways, namely through connecting, merging and embedding (Creswell et al. 2011: 5). In the sequential phase, the same sample was used for both stages, quantitative and qualitative. Both sets of data were merged after independent analysis and the quantitative findings were embedded in the qualitative data.

Connecting

According to Fetters, Curry and Creswell (2013: 2137), connecting occurs when one type of data connects with the other through the sampling frame. Methodological integration occurred in the second phase, which was a sequential phase of the study (Creswell 2008: 33), through connecting the study population who were Generation Y Filipino nurses working in a hospital in Saudi Arabia. This was the same population used for both phases of data collection. In the first phase, which was concurrent, the entire study population was invited to submit their strengths surveys. In the second phase, which was sequential, participants were selected through random sampling. The same identical study sample provided data for both stages of the sequential data

collection, namely the leadership survey (quantitative) and the interview (qualitative).

Merging

Merging refers to combining or bringing together the results of more than one set of data (Creswell et al. 2011: 5). This process typically occurs after the statistical analysis of the quantitative data and once the qualitative data has been analysed (Fetters, Curry and Creswell 2013: 2140), although it can also occur during data collection (Creswell et al. 2011: 7). In sequential studies, merging usually occurs after the statistical analysis so that the findings of the quantitative data inform the qualitative data (Creswell et al. 2011: 6), however this study was not a traditional sequential mixed methods design, although it did have a sequential element in Phase 2. In the current study, the results of the quantitative data did not inform the qualitative data, but rather helped to further explain the study phenomenon by merging the content of the quantitative data in order to render deeper understanding of the experiences and leadership needs from the study population. Hence, merging occurred in the sequential phase of the study, during data collection and again after independent analysis when the results were compared and substantiated. The statistical analysis of the quantitative data only took place after the interviews.

As discussed in the data collection process in Chapter 4, the participants were required to complete the leadership survey before the interview, so that they had a feel for the content of the survey and their self-rated belief in their ability to perform the leadership skills that appeared in the survey. The leadership skills data was merged with the interview data during each interview, where the completed leadership survey was used by participants as a reference when answering question about potential leadership education. Because the participants were already familiar with the leadership survey content prior to the interview, it gave them a quantitative idea of their competency level. Additionally, this process allowed greater probability that they would speak more comfortably and openly during the interview, thereby increasing the chance of generating richer information than had they only seen the survey

tool for the first time in the interview session. After each interview, both sets of data were analysed independently. The quantitative data was analysed to get a scientific picture of the level of leadership skill competencies as self-rated by the study sample. The qualitative data was analysed after each interview to gauge when data saturation had been reached, after which all the interview transcripts were studied in greater detail to confirm and adjust the themes with the salient sub-themes.

Embedding

Embedding refers to the inserting of secondary data from one method into the larger priority set of data (Creswell et al. 2011: 6). In this study the qualitative data was assigned greater priority. Embedding at methods level occurred when the quantitative data results from both the sequential phase and the concurrent phase were embedded in the qualitative data in the final integration, to interpret the findings. When a researcher merges the data during a concurrent design, the findings may conflict or be contradictory (Creswell et al. 2011: 9). This is discussed in Chapter 7.

5.3.3 Integration at results level

Fetters, Curry and Creswell (2013: 2142) suggest a staged approach to reporting results in multistage mixed methods studies, where the results of each stage are reported separately. Accordingly, the results of the three sets of data collected were presented separately using the study objectives as a guide, as presented in Chapter 6. The researcher first presents the quantitative data results which had been statistically analysed, and then the qualitative data, using excerpts and sub-themes that emerged during analysis. Merging of the results from data collected sequentially then took place and is presented in Chapter 6 in Section 6.9.

5.3.4 Integration at interpretation level

The three sets of collected data were interpreted after data analysis. A discussion of the findings was presented in a single report, using a weaving narrative form of reporting. Fetters, Curry and Creswell (2013: 2142) discuss the option of using a narrative approach when reporting integration in a study. The discussion of the quantitative and qualitative results can occur in a single or succession of reports. A weaving narrative reporting option can be adopted, which involves writing both quantitative and qualitative data together according to themes. The researcher interpreted the results in the context of relevant existing research. When discussing the sequential phase findings, the researcher presented the discussion according to the qualitative themes and sub-themes, thereby embedding the quantitative findings in the qualitative data. This was done because priority was assigned to the qualitative method in this study. To achieve study Phase 3, the merged, triangulated and interpreted data became the foundation for the development of the leadership framework, to achieve the main aim of the study as articulated by the fourth and final objective. The discussion and interpretation of the findings are presented in Chapter 7.

5.4 "FIT" OF DATA INTEGRATION

When integrating mixed methods data, the question of coherence of the quantitative and qualitative results may arise (Fetters, Curry and Creswell 2013: 2143). Evaluating the fit is established through the study findings. Further details can be found in Chapter 7.

5.5 SUMMARY OF THE CHAPTER

This chapter provided the integration of the study on multiple levels, namely design, methods (data collection and analysis), presentation of results, and interpretation and discussion of results. The explanation of the integration approaches that were adopted in the study enhanced the quality of the research procedures and strengthened the rigour of the evidence generated in the study.

CHAPTER 6: PRESENTATION OF RESULTS

6.1 INTRODUCTION

Chapter 4 described the methodology of how the surveys and interviews were conducted, including how data was collected and analysed. This chapter will answer the first three study objectives, through presentation of the study findings. This chapter will also reveal how the data was collated to achieve the third and final stage of the study. Firstly, the demographic profile of the participants will be presented, followed by the results which will be organised according to the first two phases of the study and the first three objectives related to the phases. Phase 1, a concurrent approach, used quantitative data collection from a survey. Phase 2, a sequential approach, used quantitative data collection from a survey, followed by qualitative data from an interview. The qualitative data has been organised using the researcher's adapted RBC model as a framework for the themes, and the related sub-themes identified during thematic analysis. Thereafter the results of integration and methodological triangulation of the two phases is presented in Phase 3.

The qualitative results use tables, figures and graphs and are presented scientifically after statistical analysis, which, according to Brink, van der Walt and van Rensburg (2012: 201), is the norm. The qualitative results are presented quite differently because of the nature of the data, which allows for a fair amount of flexibility. Qualitative reporting is usually narrative and descriptive in nature as opposed to a scientific report. The RBC model provided the themes and the interview data elicited eight related sub-themes. Pertinent quotes were used as evidence of the findings. Using the interview as a means to collect data provided a glimpse of the world as seen through the eyes of the participants, hence it is crucial that the researcher communicate the results as clearly and honestly as possible. Generally speaking, reporting should be done according to the pre-planned aim and objectives, as stated at the outset of the study.

The framework for the presentation of results can be viewed in Figure 6.1.

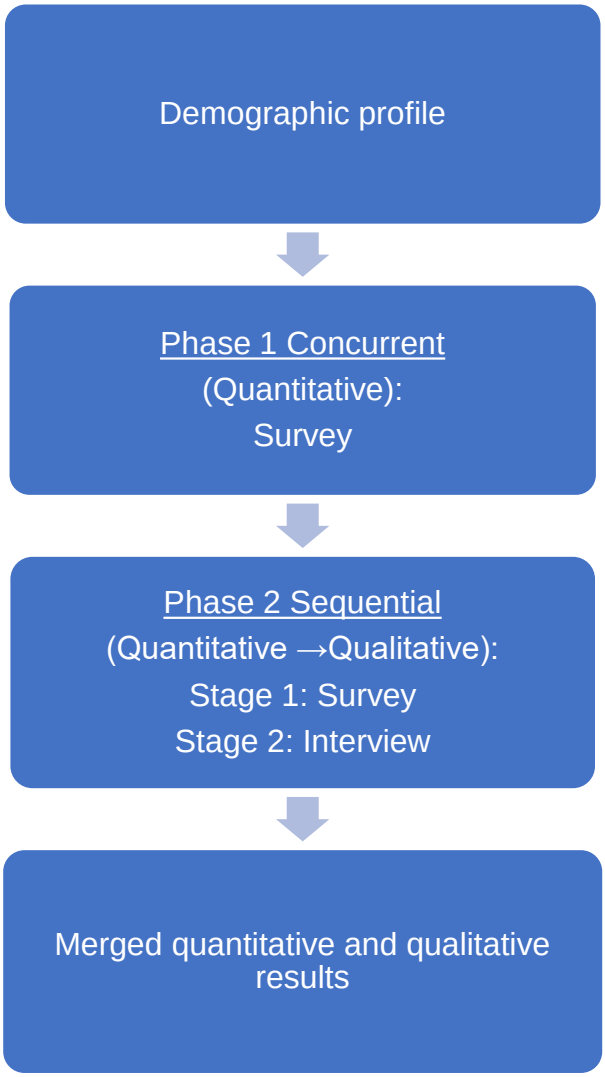

Figure 6.1: Framework for presentation of results

6.2 DEMOGRAPHIC PROFILE OF SAMPLE

6.2.1 The study sample

In total there were 269 nurses working in the hospital at the time of data collection, as explained in Chapter 4. The study population (n = 218) met the sample criteria in that they were nationals of the Philippines and because they were from the Generation Y cohort, born between 1st January 1980 and 31st December 2000. The study population consisted of females 76% (n = 166) and males 24% (n = 52). The study sample for Phase 1 was n = 134 and the study sample for Phase 2 was n = 12.

6.2.2 Ages

The ages of the study sample were between 22 and 35 years, with an average age of 27.6 years. Just under half (47.3%, n = 62) of the nurses were aged between 22 and 27 years and just over half (51.5%, n = 69) between the ages of 28 and 35 years. The age distribution is shown in Figure 6.2.

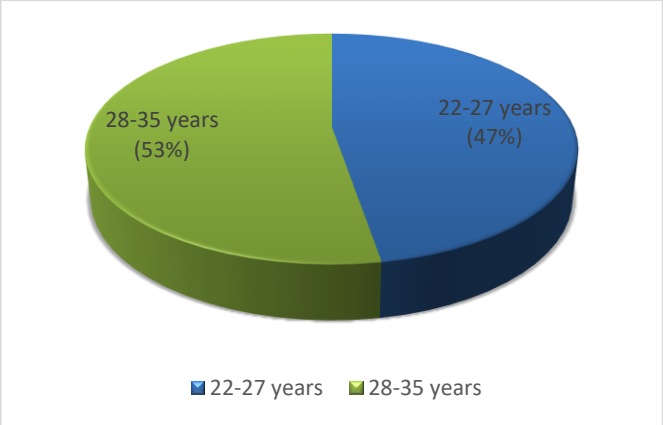

Figure 6.2: Age distribution of study sample

6.2.3 Gender

For the sequential phase of the study, a smaller sample was drawn from the original sample so that the same sample was used for both the quantitative and qualitative data collection. The gender of respondents for Phase 2 (n = 134) was a random mixed sample, with no specific ratio required for the study aim. The gender of participants for Phase 2 (n = 12) was females n = 8 and males n = 4, which was representative of the study population.

6.2.4 Education

All nurses working at the hospital were qualified RNs, with a minimum number of two years' experience post-qualification in a tertiary hospital. The Generation Y nursing sample had between 2-11 years of experience, with an average of 6.69 years. There were just under a quarter (24%, n = 32) with up to 5 years' experience and 70% (n = 94) with 6-11 years' experience.

6.2.5 Professional licensing

The participants in the study need to be licensed to practice nursing in both their country of origin where they did their training (the Philippines), and in the country where they are working (Saudi Arabia). It is therefore a mandatory requirement for all Filipino nurses working in Saudi Arabia to be licensed with both the Professional Regulations Commission and the SCFHS.

6.2.6 Language

The study sample all speaks Filipino as their home language, yet they practice nursing in Saudi Arabia in English. The study was conducted in English as the language of communication in Saudi Arabian hospitals is English.

6.3 PHASE 1: CONCURRENT (QUANTITATIVE)

6.3.1 Objective 1: Determine strengths with which Generation Y nurses enter the workforce

This phase consisted of data gathered from the VIA-120 strengths survey.

6.3.1.1 Sample realisation

Of the study population (n = 218), the total number of strengths surveys received were n = 134 (61%). Despite a number of attempts to obtain further surveys, only 134 nurses responded. The exception was for the age-related analyses, where 131 surveys were used, because three respondents did not indicate their age. For the experience-related analyses, 126 surveys were used, because eight respondents did not indicate their years of experience.

6.3.1.2 Analysis of data collected

Descriptive statistics were used to analyse the response frequency. Means and standard deviations were calculated and frequency tables and graphs have been used to illustrate the results. During the analysis of the collected

data, various tests were used, as described in Chapter 4. The data was entered into an SPSS version 22.0 spreadsheet, and various inferential analyses were applied to render results. Analysis of the age and experience of the sample is reflected in Table 6.1.

Table 6.1: Average age and experience of study sample (n=134)

	n	Minimum	Maximum	Mean	Std. Deviation
Age	131	22	35	27.69	2.393
Experience	126	2	11	6.69	1.729

Table 6.1 shows that the study sample was composed of nurses aged between 22 and 35 years, with an average age of 27.6 years. There were n = 62 (47.3%) nurses aged between 22-27 years and n = 69 (51.5%) between the ages of 28-35 years. The years of nursing experience post-registration of the sample was between 2-11 years, with an average of 6.69 years. There were n = 32 (23.9%) with up to 5 years' experience and n = 94 (70.1%) with 6-11 years' experience.

6.3.1.3 Character strengths of Generation Y nurses

Table 6.2 ranks the 24 character strengths in order of importance. The respondents rated 'Fairness' as the highest ranked character strength and 'Love of learning' as the lowest ranked strength.

The binomial test was applied to test if a significant proportion rated any of the strengths in the top 'n'.

Table 6.2: Top ‘n’ strengths rating (n = 134)

n	Strength rated in top n	% of people	p-value
5	None rated in top 5 by a sig proportion		
6	None rated in top 6 by a sig proportion		
7	Fairness	69	<.0005
	Honesty	63	.004
8	+ Gratitude	59	.047
	Hope	66	<.0005
	Teamwork	62	.007
9	No more added		
10	+ Kindness	60	.019
	Love	61	.012
	Perseverance	60	.030

Although no strengths were voted top 5 by a significant proportion, the character strength ‘Fairness’ was rated in the top 7 by a significant 69% of the respondents ($p < 0.0005$) and ‘Honesty’ by a significant 63% ($p = 0.004$). ‘Gratitude’ was voted in the top 8 by a significant 59% ($p = 0.047$), as were ‘Hope’ by a significant 66% ($p < 0.0005$) and ‘Teamwork’ by a significant 62% ($p = 0.007$). Voted in the top 10 were the strengths ‘Kindness’ by a significant 60% ($p = 0.019$, ‘Love’ by a significant 61% ($p = 0.012$) and ‘Perseverance’ by a significant 60% ($p = 0.030$) of respondents. Since this study was about leadership, it is worth reporting that although the results are not significant, the strength ‘Leadership’ did not feature as a highly rated character strength in this sample.

Table 6.3: Character strengths in order of importance (n = 134)

Strength	Average rank
1. Fairness	6.01
2. Honesty	6.94
3. Hope	7.57
4. Gratitude	7.91
5. Teamwork	8.30
6. Kindness	8.97
7. Perseverance	9.40
8. Love	9.92
9. Spirituality	10.07
10. Leadership	11.19
11. Appreciation of beauty and excellence	11.96
12. Curiosity	12.40
13. Prudence	12.67
14. Humour	12.75
15. Judgement	12.88
16. Zest	13.78
17. Humility	15.10
18. Social intelligence	15.59
19. Forgiveness	16.13
20. Creativity	16.23
21. Perspective	17.05
22. Bravery	17.92
23. Self-regulation	19.12
24. Love of learning	19.33

Table 6.3 above shows all 24 strengths rated in order of importance according to the Generation Y respondents. Of interest is that ‘Fairness’ was rated highest and ‘Love of learning’ was rated lowest.

6.3.1.4 Strengths by age of Generation Y nurses

The participants’ ages were split into two groups by age: 22-27 years and 28-35 years. The results in the Tables 6.4 and 6.5 below show the rankings for the different age groups. There were 134 respondents who participated in the study, however the data of only 131 respondents was used in this section of the results, because not all respondents submitted their age.

Table 6.4: Sequence of character strengths of participants 22-27 years of age (n = 62)

Strength	Average rank
1. Fairness	6.19
2. Hope	7.29
3. Gratitude	7.29
4. Honesty	7.63
5. Teamwork	8.34
6. Kindness	8.60
7. Spirituality	9.81
8. Love	9.89
9. Perseverance	9.98
10. Leadership	11.00
11. Curiosity	11.61
12. Judgement	11.87
13. Appreciation of beauty and excellence	12.42
14. Humour	12.92
15. Prudence	12.98
16. Zest	13.27
17. Social intelligence	15.89
18. Creativity	16.05
19. Humility	16.24
20. Forgiveness	16.66
21. Perspective	17.56
22. Love of learning	18.06
23. Bravery	18.92
24. Self-regulation	19.34

Table 6.4 above shows that out of the 24 character strengths, ‘Fairness’ was rated the highest for participants aged 22-27 years. The strength ‘Self-regulation’ was found to be rated the lowest character strength for this group.

Table 6.5: Sequence of character strengths of participants 28-35 years of age (n = 69)

Strength	Average rank
Fairness	5.78
Honesty	6.35
Hope	7.83
Teamwork	8.33
Gratitude	8.46
Kindness	9.12
Perseverance	9.32
Spirituality	10.04
Love	10.04
Leadership	11.09
Prudence	12.16
Appreciation of beauty and excellence	12.50
Humour	12.58
Curiosity	12.79
Judgement	13.48
Zest	14.12
Humility	14.50
Social intelligence	15.00
Forgiveness	15.48
Perspective	16.38
Creativity	16.73
Bravery	16.87
Self-regulation	18.80
Love of learning	20.85

Table 6.5 above shows that out of the 24 character strengths, ‘Fairness’ was rated the highest by participants aged 28-35 years. The strength ‘Love of learning’ was found to be rated the lowest character strength by this age group.

When an independent samples t-test was applied to test if the average ranking for each strength differed by age group or by experience group, the results revealed that ‘Love of learning’ was rated significantly differently by the two age groups (22-27 years and 28-35 years), t (100.809) = -2.870, p = 0.005. The younger age group rate this at 18.06, on average, which is

significantly higher than the average rating of 20.85 given by the older age group.

6.3.1.5 Strengths by years of experience of Generation Y nurses

The participants' years of experience were split into two groups: 2-5 years and 6-11 years. The results in Tables 6.6 and 6.7 below show the rankings for the two groups. The data of only 126 respondents was used in this section of the results, because not all respondents submitted their number of years of experience.

Table 6.6: Sequence of character strengths of participants with 2-5 years' experience (n = 32)

Strengths	Average rank
Fairness	4.91
Hope	6.13
Honesty	7.66
Teamwork	7.84
Kindness	8.19
Gratitude	8.78
Perseverance	9.94
Love	10.09
Spirituality	10.56
Leadership	10.56
Curiosity	11.78
Prudence	12.16
Judgement	12.56
Humour	12.91
Appreciation of beauty and excellence	13.29
Zest	13.41
Humility	15.90
Perspective	16.13
Social intelligence	16.28
Creativity	16.35
Forgiveness	17.44
Love of learning	18.16
Bravery	18.48
Self-regulation	19.28

Table 6.6 above shows that out of the 24 character strengths, ‘Fairness’ was rated the highest by participants with 2-5 years’ experience. The strength ‘Self-regulation’ was found rated the lowest character strength by this group.

Table 6.7: Sequence of character strengths of participants with 6-11 years’ experience (n = 94)

Strengths	Average rank
Fairness	6.09
Honesty	6.70
Gratitude	7.72
Hope	8.02
Teamwork	8.50
Spirituality	9.15
Perseverance	9.22
Kindness	9.48
Love	10.24
Leadership	11.15
Appreciation of beauty and excellence	11.53
Curiosity	12.62
Judgement	12.73
Humour	12.84
Prudence	13.12
Zest	13.95
Forgiveness	14.90
Humility	15.46
Social intelligence	15.49
Creativity	16.39
Perspective	17.14
Bravery	17.75
Self-regulation	19.05
Love of learning	19.95

Table 6.7 above shows that out of the 24 character strengths, ‘Fairness’ was rated the highest strength by participants with 6-11 years’ experience. The strength ‘Love of learning’ was rated the lowest character strength by this age group. The results revealed that there are no significant differences in the average rating of each character strength across the two categories of experience.

Table 6.8: Highest and lowest rating of character strengths for all four categories

Strength rating	Age		Experience	
	22-27 years n = 62	28-35 years n = 69	2-5 years n = 32	6-11 years n = 94
Highest	Fairness	Fairness	Fairness	Fairness
Lowest	Self-regulation	Love of learning	Self-regulation	Love of learning

The results in Table 6.8 revealed that for all four categories of age/experience, Generation Y nurses rate the character strength 'Fairness' highest. The strength 'Love of learning' was shown to be rated the lowest with the older and more experienced Generation Y nurses, whereas the younger and less experienced Generation Y nurses rated the strength 'Self-regulation' as the lowest strength.

6.4 PHASE 2: SEQUENTIAL (QUANTITATIVE → QUALITATIVE)

6.4.1 Objective 2: Determine the leadership skills of Generation Y practitioner nurses

Stage 1: Leadership survey

The completed leadership surveys were used by participants during the interviews. This was a self-administered leadership survey using Patricia Benner's novice to expert range rating scale (Appendix 7). Rating levels were from 1-5, where a score of 1 = Novice, 2 = Advanced beginner, 3 = Competent, 4 = Proficient and 5 = Expert. The survey consisted of three categories:

- Personal and professional accountability
- Career planning
- Personal journey disciplines

The results will be presented using the three categories above.

6.4.1.1 Sample realisation

The sample was made up of 12 RN participants who completed the self-assessment survey on their perceived level of competence for specified leadership skills. The same participants (i.e. the same sample) were also interviewed.

6.4.1.2 Analysis of data collected

Descriptive statistics were used to analyse the response frequency. Means and standard deviations were calculated. The results are illustrated with frequency tables and graphs. Various tests were used to analyse data, as described in Chapter 4. The data was entered into an SPSS 22.0 spreadsheet, and various inferential analyses were applied to render results.

6.4.1.3 Personal and professional accountability

Figure 6.3 shows the results of the data collected during the leadership survey, revealing the self-rating frequency (%) of either novice, advanced beginner, competent, proficient and expert of each skill.

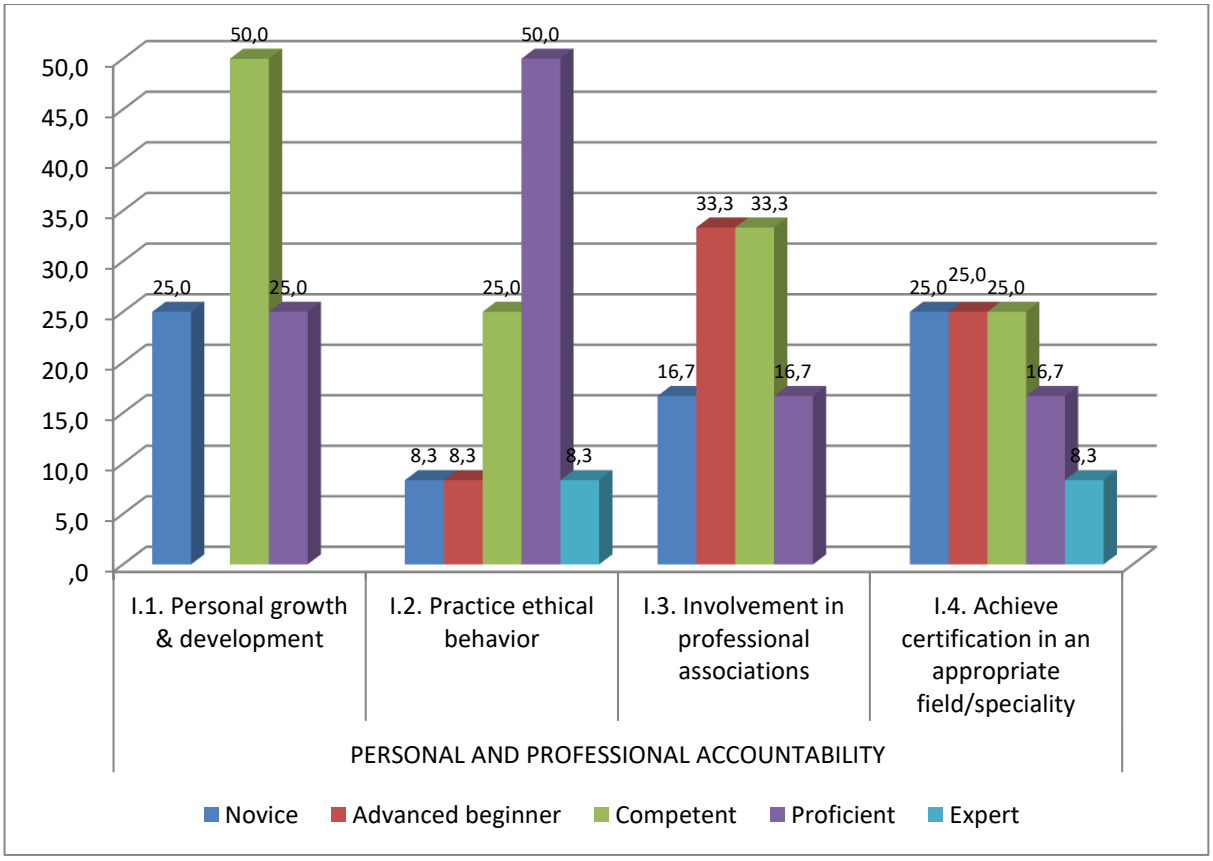

Figure 6.3: Personal and professional accountability (n = 12)

Analysis regarding personal and professional accountability shows the results of a binomial test with a cut-off of 2 (advanced beginner) which was applied to test if a significant proportion of participants are at most advanced beginner/ competent. The analysis revealed that a significant proportion (83%) rated themselves as competent for 'Practice ethical behaviour', p = .039. When applying the same test with a cut-off of 1 (novice versus at least advanced beginner) results showed that a significant percentage (83%) were at least advanced beginners for 'Involvement in professional associations', p = .039.

6.4.1.4 Career planning

Figure 6.4 shows the results of the data collected during a self-assessment leadership survey regarding 'Know your role', 'Know your future' and 'Position yourself'.

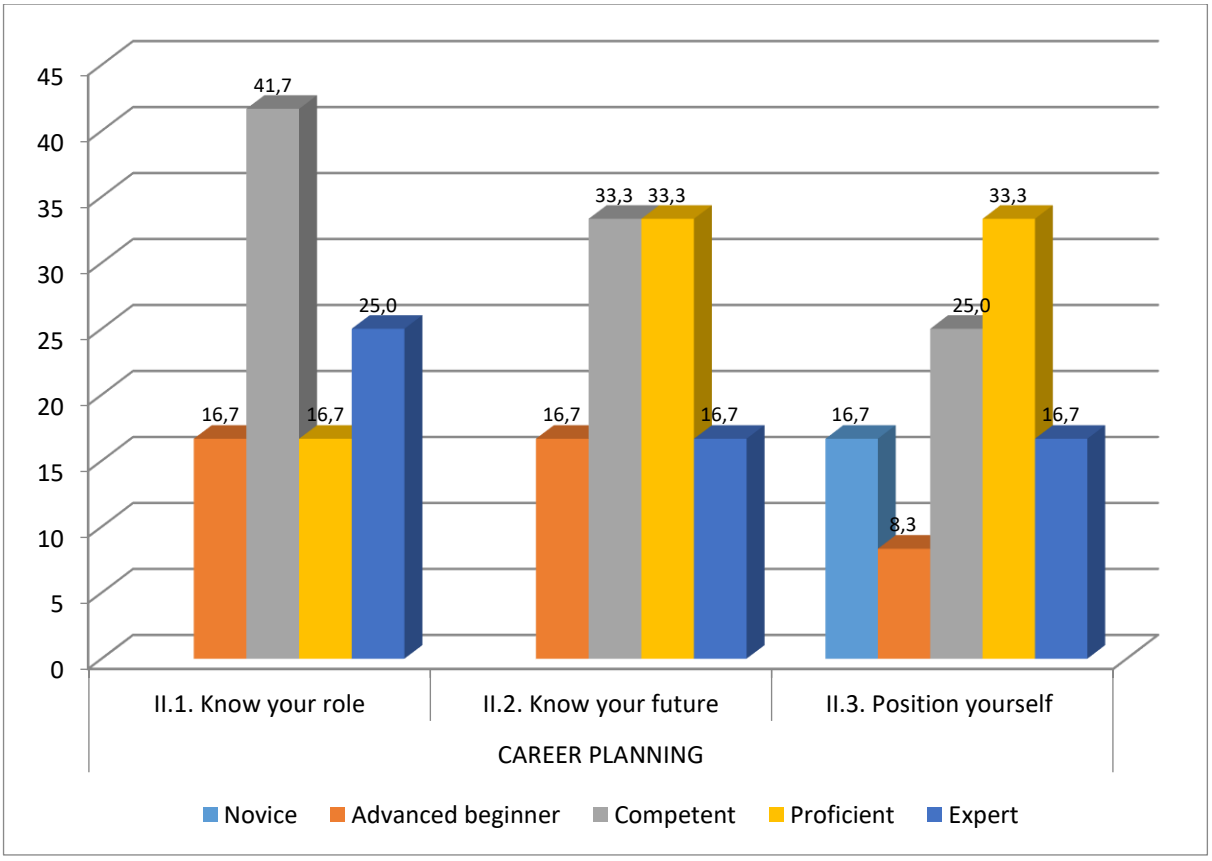

Figure 6.4: Career planning (n = 12)

When the binomial test with a cut-off of 2 was applied, it showed a significant proportion (83%) were rated at least competent for both 'Know your role', p = 0.039 and 'Know your future', p = 0.039. When the binomial test with a cut-off of 1 was applied, a significant percentage (83%) rated themselves at least advanced beginners (better than novice) for the item 'Position yourself', p = 0.039.

6.4.1.5 Personal journey disciplines

Figure 6.5 shows the results of the data collected during a self-assessment leadership survey, showing the frequency (%) of 'Apply action learning' and 'Engage in reflective practice'.

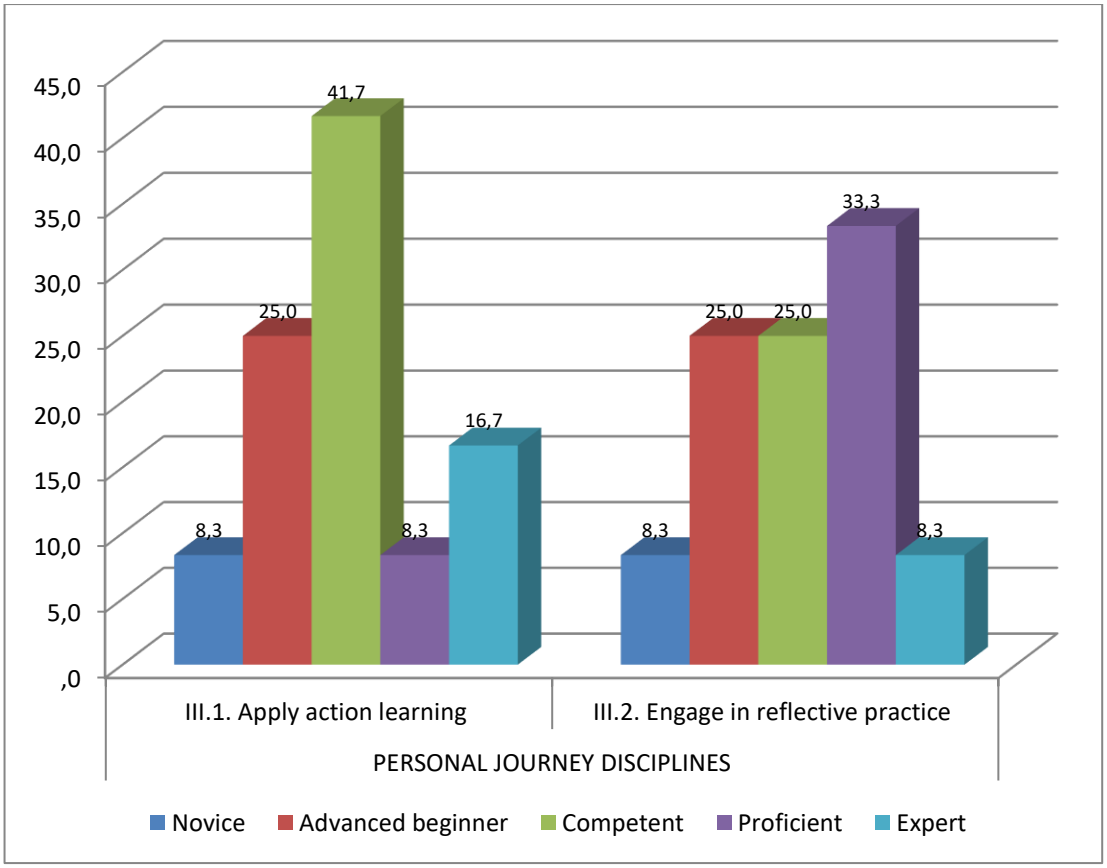

Figure 6.5: Personal journey disciplines (n = 12)

The binomial test with a cut-off of 1 was applied and the analysis of the skill 'Apply action learning' showed that a significant proportion (92%) are at least advanced beginners (better than novice), p = 0.006. In addition, a significant percentage (92%) rated themselves at least a novice for the item 'Engage in reflective practice', p = 0.006.

6.4.1.6 Reliability testing

In order to compare results across the three categories ('Personal and professional accountability', 'Career planning' and 'Personal journey disciplines'), single measures for each category were obtained by averaging responses for all items in a category. In order to ensure that these three measures are reliable, Cronbach's alpha was applied. For each category it was found that alpha > 0.7, indicating that the single measures, as formed, are reliable. These single measures were then used in further analysis.

Means, standard deviations and alpha values for these three categories scores are presented in Figure 6.6.

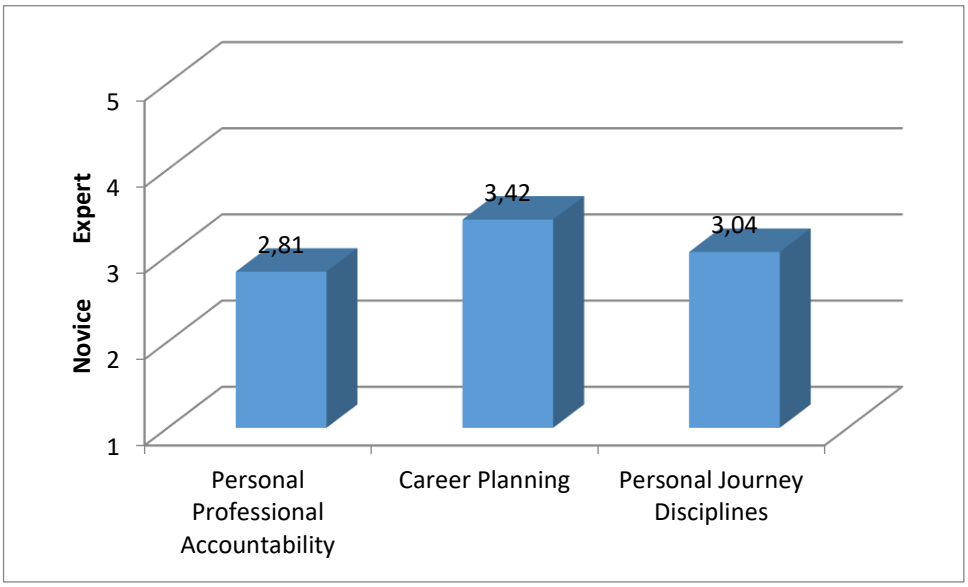

Figure 6.6: Self-assessment for all three competency categories (n = 12)

In order to test if there is a significant difference across the three categories, Friedman's test was applied. Results of this test showed that significant differences are evident across the three categories, $\chi 2$ (2) = 10.711, p = 0.005. Specifically, competencies are higher/greater for 'Career planning' than for the other two categories, namely 'Personal and professional accountability' and 'Personal journey disciplines'.

6.4.2 Objective 3: Identify skills that are likely to prepare Generation Y nurses in the workplace

In the qualitative phase of the research, the researcher used the audio-recorded interviews then transcribed the data into written text, before categorising them into themes according to the theoretical framework that guided the study. The four dimensions of the researcher's adapted RBC model became the four themes, and the Tesch's coding process identified sub-themes, as shown in Table 6.9 below. The qualitative results will be presented using the themes and sub-themes as a framework.

Stage 2: Interview

6.4.2.1 Sample realisation

The participants who were interviewed were the identical sample to that used for the quantitative leadership survey mentioned above in Section 6.2.2.1. An interview guide was used. The mixed method of data analysis strengthened the study in that it allowed for triangulation of the findings from the participants, to obtain richer information to strengthen the results. Thematic saturation led to a total of 12 interviews being conducted.

6.4.2.2 Thematic analysis of data collected

A thorough data analysis process was used as described in Chapter 4: In preparing the collected data for presentation, the researcher sought to arrange it in a meaningful and organised manner, using the theoretical framework as a guide.

The researcher used the four dimensions of the RBC model as the main themes, namely leadership, teamwork, professional practice and resources. After repeated scrutiny of the interview transcripts, and coding by the researcher to achieve thematic analysis, eight sub-themes emerged for the four themes. For each theme, two sub-themes were formed based on the analysis. The results will now be presented according to the RBC themes and related sub-themes, as can be seen in Table 6.9 below. The ‘Code’ column refers to the unique code assigned by the researcher to the sub-theme when applying the steps of Tesch’s coding to analyse the raw data.

Table 6.9: Framework for presentation of qualitative results

	Theme		Sub-themes	Code
1	Leadership	1.1	Leaders and leadership	L = Leadership
		1.2	Bedside leaders	BL = Bedside leader
2	Teamwork	2.1	Knowing self	S = Self-awareness
		2.2	Relationships with others	R = Relationships
3	Professional Practice	3.1	Current practice environment	E = Environment
		3.2	Professional growth, career plans	PG = Professional growth
4	Resources	4.1	Previous experiences that developed leadership	Ex = Experience
		4.2	Future expectations to develop leadership	E = Expectations

6.5 THEME 1: LEADERSHIP

Table 6.10: Sub-themes for theme 1

Sub-themes
• 1.1 Leaders and leadership
• 1.2 Bedside leaders

Table 6.10 above has been provided for ease of reference when reading the findings of the first theme. It should be noted that during the interviews, some of the study participants refer to the researcher as ‘ma’am’, the short expression for ‘madam’, as a display of respect.

6.5.1 Sub-theme 1.1: Leaders and leadership

Participants provided many perceptions about how they defined leaders and leadership. Some participants answered this question as though the term ‘leader’ and ‘leadership’ were synonymous. The explanation of their understanding of ‘leaders’ included thoughts on the appointment as a leader, with some saying “anyone can become a leader”, to those who felt it was an appointed position. Below are some statements from the participants on their view of the term ‘leader’:

> For me leaders are the one who lead like they have differentiations on being a leader and a boss. A leader is a more assertive type of person wherein you lead by your strengths. [RN08-NE]
>
> It doesn't mean that you have to be a senior or a junior – anyone can become a leader. [RN011-N]
>
> For me I believe that leaders have the authority to set rules … [RN012-P]
>
> I think a leader should be knowledgeable especially with her career or with her expertise because you are not just responsible for yourself, you're also responsible for others and the outcome they will input to like the society or the organisation. [RN07-G]
>
> About leaders, they are those people; for me they are the appointed ones; by their colleagues or by a nation, who have that capability to lead. They are highly influential in a way that people knows they can decide they can rule over them; someone whom they can respect. A leader is a person who has been identified. [RN05-G]
>
> Leaders are the ones who have the ability to influence others, the ability to touch lives of the others and the ability to lead. And have the power to lead the mass or other people or the group. [RN04-G]

When discussing leaders, participants mentioned a wide range of positive characteristics of a leader, while others mentioned negative attributes. A significant skill mentioned frequently was decision-making. So important was decision-making to the participants that the word was used 23 times during the interviews, mostly with regard to it being a crucial leadership skill. Examples are that a leader needs to be confident to make decisions, a leader must get input from team members before making a final decision, and a leader must be non-judgemental when a decision has been made.

Many participants mentioned that they lack confidence and would like to improve this skill. The word confidence was mentioned 35 times in the interviews, by 6 participants. They felt this was an important leadership skill.

A number of participants (n = 5) mentioned that a leader should be a good 'role model' (RN05-G; RN06-G; RN08-NE; RN09-E and RN10-O). Four participants explained that a leader should be 'positive', using words "positiveness", "be positive" (RN09-E), "positive vibes" (RN06-G), "Positive attitude" (RN02-G). Others mentioned a leader should inspire others, be a role model, set an example, have integrity and have the ability to lead change, to name a few. Below are their statements showing their perceptions about leaders:

> My current belief about being a leader and leadership is once you are a leader you should be an inspiration to others and you would lead change to others, not only to yourself. And being a leader doesn't mean that once you lead a team or you lead someone or an organisation it doesn't mean that they should also complement you. Like it's something from inside; no need for reward or no need for positive complements from others. [RN011-N]

> … and then she must be a role model to everyone, to the members. [RN06-G]

> … leaders are the one who lead the people around them by example. They do what the policy says, with or without their superiors. They do things with integrity. [RN10-O]

> Personally, I believe that to be a leader you have to be a doer first. You have to do, you have to be a doer, because how can you say that you want to lead someone if you don't know what a leader is supposed to do? … so that the members or the other staff can rely to you. [RN01-I]

> My current beliefs about leader, leader is the one who leads the team, leader … should have a positive attitude towards any incidents or situations, and should be confident also. [RN02-G]

> I always admire world war documentaries especially my role model Winston Churchill. I always admire his leadership style because he is very outspoken but much loved by the people. [RN03-E]

> Assertive in a way that you are not bulldozing through people, you're not judging their decisions. Assertive that you are accepting all the information that might be helpful when dealing with these scenarios or certain situations … like especially for us as a nurse. [RN08-NE]

> What I believe about leaders is that they are those that empower people and don't impose, but rather transform them into something … people should be given choices, not to be dictated. [RN09-E]

When explaining their thoughts on 'leadership', some explained it as the manner in which a leader carries out the act of leading, while others referred to leadership as the skills a leader should possess, as can be read from their excerpts below:

> About leadership, it's a way how you lead people, an organisation. Relating to our nursing experience, someone who can guide the colleagues who will also lead the team, to organise the team, to manage it effectively, to coordinate it to every department … is a good representative of the unit. [RN05-G]

> Leadership is the way how you lead or how you manage your group for the members … [RN06-G]

> I think leadership should not be taken lightly because like I said it really has a lot of responsibilities not just for yourself but it really affects a lot of people and a lot of other aspects as well. [RN07-G]

> I believe in the type of leadership transformational leadership. Because I know that leadership doesn't dictate but it changes people. And we all know the different types of leadership ma'am, the laissez faire leadership as well as dictatorship. [RN09-E]

> …leadership is the style that they possess, for example they let their colleagues or co-staff to give suggestions on certain things which for me it's very important because it is a way to let your colleagues knows that their suggestions are being addressed. [RN10-O]

> Leadership for me, you are authorised as being leader but you have also to see to it that your members are, they have the democracy to do their own thing as long as they are abiding to the rules. [RN12-P]

> Leadership is about, they say don't please everyone, but leader has to do that, like they tell me you cannot always please everyone ... but leadership starts with harmony because leaders do not divide people, they unite people…leadership is communication. [RN03-E]

> Leadership is a skill that the leader should possess … be confident because you will lead your team, so your team members should see to the leader that she's confident on the decision-making for a positive outcome and should have a positive attitude also the leader should listen to all the concerns. [RN02-G]

> Leadership is doing things by example and letting people look up you as a role model for each and every one. [RN08-NE]

> Leadership should have, I believe that in leadership you should have skills like intelligence, communication, being proactive, you should have integrity and others; a lot of skills. [RN11-N]

6.5.2 Sub-theme 1.2: Bedside leaders

When participants were asked if they believe nurses can lead at the bedside, all participants (100%) unanimously responded positively. Two excerpts that strongly showed this finding follow:

> … the bedside nurses can lead also … everything that we do, in every aspect or position that we are in, I think that we can be a leader. [RN10-O]

> … bedside experience is a foundation of being a good leader for all of us … It's a potential that a bedside nurse can be a good leader. [RN08-NE]

A number of situations were cited as leadership opportunities. One explanation given by participants was that bedside nurse's practise leadership when teaching or guiding other nurses, as demonstrated in the excerpts below:

> … it's like the preceptor/preceptee relationship, the preceptor will be the one who lead the preceptee, at the bedside, like making nursing skills for example simple vital signs. We can lead by instructing the preceptee about using the equipment … [RN02-G]

> … in preceptorship, for example your buddy nurse is your preceptee, so of course you will be the one to lead your preceptee in doing ordinary patient care at the bedside. [RN03-G]

> For my colleagues I can be an effective leader at the bedside if I can teach novice nurses, for example when we do preceptorship. [RN04-G]

> … also to your colleagues if you have some knowledge that they didn't know you can share it … for example the newby that is new or less experienced than you, you can teach them experiences that you have had … especially at the bedside for the patient because you are the leader on the side of the patient, you are their leader ... [RN06-G]

> … bedside nurse are the ones who are gaining too much knowledge or enough knowledge to lead by example and then once we have those incoming staff nurses who are just beginning their professional life they can share even more things and lead and inspire others by example … because if you are developed or have been a bedside nurse for several years, for example ten years or above; experience tells it all. [RN08-NE]

One participant described how, as a junior nurse, she had shown leadership by influencing the sequence of the ward routine to improve patient outcomes. She went on to say that she had been a bedside preceptor to younger nurses, new nurses and students; how she had translated knowledge into practice. She believed that junior nurses can even show leadership when they influence the practice of more experienced nurses, because sometimes older nurses are more "bookish" and they cannot always translate what they read in books into reality. But that perhaps a young nurse knows of a new practice and s/he could teach other nurses. Another referred to the seniority of the nurse as not being of importance in leadership. Below are the excerpts from the participants:

> I do believe that at some instances the youngsters or the juniors … they acquire new knowledge on giving care on bedside, because sometimes … if older nurses, sometimes they are too like, it's good to be bookish, but sometimes you cannot do all that things in reality, you cannot really apply those things in the book in reality. [RN01-I]

> I don't consider the senior and junior thing, anyone can lead. As a junior nurse, for example there are new nursing practices that the senior nurses don't know, so at least the junior nurses can share to others what are these new nursing practices that was not being practised by senior nurses, especially research practices that could improve the patient's condition. [RN11-N]

Some participants explained that as bedside nurses they are leaders because as primary nurses they lead their patients, make decisions for them and collaborate regarding their plan of care. They also educate their patients on healthcare matters. Their explanations follow:

> ... at the bedside you can lead your patient about how to involve themselves to your plan of care, to the treatment. [RN06-G]

> … if you're going to take care of the patient, you have to be the leader first for that patient to obey you … you have to explain everything, give the patient an opportunity to express herself, and inform her that you are doing everything for the patient. [RN01-I]

> … primary nurse is the one who is planning for their patient and decision-making also, and is also the leader for the patient. The primary nurse is the one who is also orientating the patient inside the room and collaborating with the doctors regarding what is the plan, and you will be the one who will lead the nursing care plan for our patient. [RN02-G]

> Nurses at the bedside can lead also because, for example we have preceptorship programme, so when there is a new one or a newby in the unit we stand on the newcomer as their leader so they watch us and see how to perform the basic things in the ward, so I think that's an example that the bedside nurses can lead also. [RN10-O]

> … you can do the leadership to your patient, more especially at the bedside, so your follower is the patient, for example when you are doing health teaching to your patients. [RN04-E]

> Me as a primary nurse, I can say that I can lead in a way through the patient-nurse relationship. I can be a leader by educating my patient on health education purposes to give her knowledge. So, when you speak of something like: this is how you wash your wounds, this is how you take care of yourself … if they follow it means you are an effective leader. [RN05-G]

> … nurses are part of the patient's plans and how they want their health to be carried out, so we are the ones who are responsible and how will they achieve that, so we are planning things for them … because we are the ones directly interacting with the patient so we are in the first line that is accountable for what they will achieve in their hospitalisation. [RN07-G]

> As a primary nurse, you are responsible for that patient so you are the one on lead for that patient; you know the case, you know how to organise which task you are going to do first; the important one for the safety of the patient. You know essential for the patient. When it comes to referrals for example you have many referrals for that patient and those doctors came altogether at the same time and you know how to deal with them. Management of your time, like that. [RN12-P]

When participants were asked if they thought they had leadership ability, none refuted this. Seven (58.3%) out of twelve participants interviewed spoke with outright confidence that they had leadership ability and one participant [RN08-NE] did not directly state he had leadership ability, but he was very confident in his response and in fact throughout the interview. The researcher perceived him to be modest in the words he used. A number explained that their leadership skills needed development to reach their full potential. Below are some comments from the participants:

> Yes of course, I think I also have leadership ability. We all have different styles of leadership. There are times that we go into the dictatorship, we go into the liaise faire, but that's an experience so that when we realise that we should be the transformational type of leadership … I think I should strive hard in order for me to let them see the role model that is within me, so that is a peculiar one, that is a unique one that nobody will be able to compare, because leadership should not be compared, it should be exercised. But I think I'm a leader in my own way. [RN09-E]

> Yes … I don't only consider myself but anyone does have leadership abilities. The only problem is that some of the skills are not well developed as a leader. You have to develop it. For me, anyone can be a leader, anyone has the skills; they only need to be developed. They should have initiative, the interest to learn. They should devote their time also and effort if they want to improve as a leader. [RN11-N]

> Yes … I do think I have a leadership ability … because now I was allocated before as team leader, because I did the team leader well and any problem we encounter I, we solved it, we made solutions … problem-solving, and I worked before here in Saudi Arabia, so I also lead my colleagues regarding the culture here. I teach them, I guide them and I give them information about the practice here in Saudi compared to nursing in the Philippines. [RN02-G]

> I do think that I have the leadership ability … I do believe that I can be a leader. I am able to of course make the decisions for the unit and of course we all want to give what's best. When the team leader is going on break, then sometimes she is handing me the narcotics … and of course I also have experience in precepting the new staff ... I'm able to share the things that I've learned at the bedside, and of course what are the things that can help them, especially for the first time abroad … especially in dealing with Arabs. [RN01-I]

> Yes I have, but maybe I have to enhance it, practice it; develop it. Currently we are allocated as team leaders in the unit that's how we practice, we take turns in our staff schedule, we also take turns whenever our nurse manager's on leave, we are acting as nurse managers. We are really involved here at this hospital. [RN12-P]

> I think so … because in our ward we have the team leader, the exchanging of role...as a team leader I do my job well, my staff follow me when I am the team leader. I gain their respect. [RN06-G]

> I may have the leadership ability! ...(laughs confidently) … and I'm leading by example … And for me, bedside experience is a foundation of being a good leader for all of us. [RN08-NE]

The remaining five participants revealed that they thought they had the ability to lead but they were not that confident as conveyed by either their tone of voice when responding, or in what they stated. One participant felt she had leadership ability to lead patients but that she was "not yet fully effective" to lead colleagues or a group because of a lack of opportunity. But what was noted by the researcher is that all participants were keen to develop their leadership skills, as can be seen in the following quotations:

Somehow, but I think it is not yet that effective or that whole. I mean for the patient yes, because I already have the patient, but for example when it comes to a group or your colleagues, I am not that used to leading them yet, maybe it's because of lacked opportunities. [RN04-G]

I'm not that sure, but I tried, because in some of our committees here I've been appointed by our chairman in the medication room to handle the committee if they go for vacation or I replace them. So, I think they trust me enough to lead the group. I'm confident enough that I can impart knowledge ma'am. In a way what I have learned from the task I think I can share it, so I can lead the group; I know my direction, I know that I can lead people. [RN05-G]

Not quite yet because I think that my experience is not that well-equipped enough to handle such a big responsibility like a nurse manager or something. But in a way I think there are maybe circumstances that I can lead, like today ma'am, I'm the team leader so I have to be responsible in my core nurses if they do their job well, if they do it correctly and if they do everything to let the patient be safe so that the patient will get better or be discharged, according to the doctor's plan or the plan of care with the healthcare team. [RN07-G]

For honestly speaking ma'am, I'm not that confident you know, (blushes), but I think I have (sic leadership ability), because what makes me feel not that confident is every time I speak in front of people … my facial expression will get red or blush and when the people start to see they look at me and say he's … I tend to forget the things I need to say or deliver. That's why I'm not confident enough to lead. I was the acting nurse manager before, and Alhamdulillah, my experience, when your colleagues follows you not because of the position, but because you lead them better or the best way you can, that's the best prize you can receive, even without the position itself, even if it is temporary. [RN10-O]

I hope so, I hope so, I'm trying ma'am. I'm trying ma'am every day, I always think of my father how he led my family too, from poverty to having a good education. Your role model should be inside your home … I want to become the leader. [RN03-E]

6.6 THEME 2: TEAMWORK

Table 6.11: Sub-themes for theme 2

Sub-themes
• 2.1 Knowing self
• 2.2 Working with others

Table 6.11 above has been provided for ease of reference when reading the findings of the second theme.

6.6.1 Sub-theme 2.1: Knowing self

Participants also mentioned the importance of having self-awareness which in turn would enhance their ability to work with others. Self-awareness included knowing yourself, self-reflection, managing emotions and building self-confidence, as evidenced by the following quotations:

> … I think if you study your own self … when I go home, I think of before what happened and I think what is the best thing to do and, okay, then I say I will try to help, so I reflect. [RN10-O]

> I would love to have a leadership programme that inspire us to be leaders so not force us but makes us see who we are, makes us find the uniqueness in us, and transform ourselves so that we can transform other people … the greatest thing we need to learn first is about yourself. Confucius said “Know thyself first”. Because if you don’t know about yourself, how can you share your uniqueness with others, how can others see you if you can’t see yourself. [RN09-E]

> … sometimes if I hear something negative it will affect me and then I will react negatively also, so I want like to learn to how handle my feelings also because sometimes negative vibes, my emotions also will be high like that … so I want to manage how is that, emotions. [RN02-G]

> Self-confidence … because it is my weakness. [RN02-G]

> … my confidence, I have low self-esteem ma’am that is why I cannot really accept a leadership position since before. [RN05-G]

> That's my main focus when leadership workshop arises: focus on my confidence. [RN08-NE]

> And for me it's most important that you be gaining continual knowledge, dealing with your patient, dealing with your staff, managing their emotions and how you will be dealing with several types of staff. [RN08-NE]

6.6.2 Sub-theme 2.2: Working with others

Although there was not an interview question specifically about teamwork, most participants brought it into their explanations, indicating that good teamwork is integral to effective leadership. In their responses, teamwork appears to encompass the relationship between team members and the communication within the team, influenced by the leader. Some mentioned knowing yourself as being important so that you can lead others. Participants said that the responsibilities of a leader included managing groups of people or teams to attain order and functioning in a non-punitive way. Some mentioned supporting and advising members, creating trust within the team. Four participants mentioned a leader should have good communication where everyone is heard. Statements included "Listen to all the nurses" and "Leaders should listen" (RN02-G), "People listen" when referring to a good leader (RN03-E), "We are not heard enough" (RN05-G) and "So that everyone is heard" (RN12-P). Some quotations from the participants regarding this sub-theme can be read below:

> … a leader is the decision maker, if you did the right way the patient will be satisfied. The credit is not only for the leader, it's for the whole team … the people that lead us in our department help us because they support us also ... if anything happens the leader should support the other members to gain the confidence. [RN02-G]

> I think without a leader there will be chaos or a certain organisation or even just a certain family or team won't function well without a person who is going to at least guide them in their goals or plans. [RN07-G]

> … to give guidelines and to organise or to supervise the members of the group or people in the unit. [RN12-P]

I've been in bad organisations; I've seen people who always care about themselves that they forget how to love the people. [RN03-E]

… should have a positive attitude also the leader should listen to all the concerns. [RN02-G]

You have to assume your responsibilities as a team leader and you also have to be open to whichever information that was given to you by not judging people's beliefs or thoughts and ideas. Assertive that you are accepting all the information that might be helpful when dealing with these scenarios or certain situations … like especially for us as a nurse. [RN08-NE]

A leader is the one who will lead not only to delegate a task but to help the other member about the task that they need to do. [RN06-G]

… I always think that communication with patient is the most important and leadership comes with it ma'am … because leadership is communication. [RN03-E]

I feel great ... we have teamwork. [RN02-G]

6.7 THEME 3: PROFESSIONAL PRACTICE

Table 6.12: Sub-themes for theme 3

Sub-themes
• 3.1 Practice environment
• 3.2 Professional growth

Table 6.12 above has been provided for ease of reference when reading the findings of the third theme.

6.7.1 Sub-theme 3.1: Practice environment

When asked their perceptions on the current practice environment where patient care is provided and whether they felt leadership influences the environment, eight participants stated that their current working environment was positive, referring to terms such as healthy, teamwork and learning and

sharing as reasons for the good working environment. Below are the positive responses:

> … in my unit, there is teamwork and respect. And I really appreciate that … it's good for improvement. [RN01-I]
>
> I feel great, because we practice what we learn ... we have teamwork. [RN02-G]
>
> … somehow we learn how to work with each other, in a good way … [RN03-E]
>
> Yes, so far it is good however we are still adjusting to the situations we are having in the unit and most especially there are lots of changes, for example the scope of practice … [RN04-G]
>
> I cannot say that it is 80% or 100% a healthy working environment … I can say that maybe 75 to 80% ... [RN10-O]
>
> … we have the healthy environment, the sharing environment, learning and sharing. [RN11-N]
>
> It is good for every one of us, it is a great opportunity for us. [RN12-P]

The remaining four participants felt the practice environment was negative, citing reasons of poor leadership, unclear policies and processes, many changes, high pressure and chaos as the reasons. Their responses are shown below:

> … I'm not that comfortable with our current environment ma'am. I don't want to disclose anything more, but I think leadership needs reinforcement … [RN05-G]
>
> I can say that it's not good … [RN06-G]
>
> … the work is really not yet that smooth because of the processes and the policies that are not that clear, and there are so many changes … [RN07-G]
>
> … high-pressured environment so the atmosphere is very … what would I term it … chaotic, in a sense … [RN09-E]

When asked if they believed leadership influences nursing practice, the environment and the outcomes, all 12 participants agreed that leadership was

positively correlated to the environment. According to the findings, good leadership is supportive and has clear expectations, and produces staff who feel confident and cared for, a team of good followers who are united. In addition, good leadership creates a strong foundation and inspires and influences the team. A well led ward is organised, has smooth processes and excellent patient and staff outcomes. Excerpts describing the environment can be found below:

> … if you have good leaders you have good followers of course, and if we trust our leaders, all will flow, just the way it leads the group. It also unites the group. Good leadership influences the environment. [RN05-G]

> ... it really affects it because if you don't have an organised team or an organised unit, which a leader is the one responsible to lead them, there won't be a clear … I mean an excellent outcome, because we're not sure where to go and there is no clear plan and there might be misunderstandings or there won't be any clarification for certain issues that will be addressed, and so that's why a leader should be in charge of a certain unit or a certain team … because if a unit is united or really has good team work, which the leader is the one responsible for, then the patient will really have good outcomes with each person's practice. [RN07-G]

> Leadership contributes a lot, it brings a more structured way of handling this type of situations and the department will be more established, more recognised if strong, if the foundation is strong. [RN08-NE]

> The leadership affects the patient outcome because if the patient is satisfied it means that the leadership skills you have shown to them are good and for that … a leader is the decision maker. If you did something the right way, the patient will be satisfied … the people that lead us in our department help us because they support us also ... if anything happens, the leader should support the other members to gain their confidence. [RN02-G]

> … leadership influences nursing practice, one good example is if I'm … at the bedside and I make a mistake, my leader or the people who is on top of me will not embarrass me in front of the patient. He or she will correct me privately from the patient. [RN10-O]

… as a leader you are influencing people and affecting each other in the same way, for example if I'm a negative kind of leader … so that will pave a way to experience negative emotions and a negative atmosphere … So as a leader it is very important to have an attitude that fosters positivity, because the way people see you influences their job, influences how they act and how they implement those tasks as well as the outcomes of the patient, because the patient will be able to see how those nurses will perform. [RN09-E]

… once you have a proactive leader, once you have a leader who inspires others, like I have said with the first question, everything changes; it influences a lot. Even from a very little thing … [RN11-N]

Yes, it influences, for example we know whom to talk to when we have these concerns regarding our unit; if there's a suggestion to improve the flow process; if there's a new event or incident that we need to sort out so that it will not happen again. And the communication is also good; you're trying to communicate so that everyone will be heard. It improves the patient's outcome. [RN12-P]

6.7.2 Sub-theme 3.2:Professional growth

Two aspects arose from the participants' responses regarding their professional growth: their personal aspirations and leadership vision. Although participants were not directly asked what their personal career plans and aspirations were, many of them referred to clinical and academic goals. Feeling bored and wanting to be challenged at work was mentioned. Clinical goals included developing self-confidence (three participants), becoming a team leader or a nurse manager (four participants). Academic goals included master's degree, nursing administration, information technology (IT) and computer science. One participant expressed not being afforded the opportunity to practice leadership skills while some participants did not even mention future formal leadership positions. The excerpts follow:

Just leadership … in nursing. I want to become the leader. [RN03-E]

In 2020 … personally, I want to be a team leader that's why I applied before, I also want to enrol in master's degree to … for professional growth. [RN01-I]

I want to know my path ma'am or my future plan. Maybe I just want to be exposed with some work that I never got used to; maybe something different; a challenge ma'am. Just for a change, because I don't want to get old without an experience. Sometimes I feel a bit bored but when things get rough I think I just become; just turning but without career advancement. [RN05-G]

I am looking for really, a permanent team leader position. [RN06-G]

Well I'm hoping I can get a master's in nursing and maybe I can be a charge nurse if ever that situation allows me. And I hope that it really develops my personality in terms of my career because my plan kind of … really low-key and I really don't engage much in leadership but I know that someday I will really encounter some leadership situations. So I will have to learn it. I'm not that confident and I'm kind of intimidated with others. [RN07-G]

… for my leadership I want to be a role model for most here in the hospital and I want to give a legacy for my name itself and one day they will tell that when I am not here anymore that "he (sic) is that funny guy that gives more information to all of us". I must have those type of identity that wherein they will look up to my practice, not from the bad side but the good side and it leaves an impression for me that I have served as an inspiration for them and also … when we combine learning and sharing in a fun way … not … in a structured way like in school. For personal growth … I'm not aspiring for a higher position right now; because being a clinical nurse I am more on hands-on … to continue where I can have an access with the patient, I can have access with the staff. Because on a managerial basis ... you set aside bedside nursing … In a year or two I want to get my masters, hopefully in God's time, I'll be taking my masteral degree, because I know there are several things I need to prioritise, but that is one on my bucket list. And I think it's also ideal for my practice. [RN08-NE]

I am studying informatics and I am also planning to study diploma computer science because I want to use technology with nursing so I know that there are certain software as well as hardware that will really be able to help nursing. [RN09-E]

I am planning to be more confident in public speaking and what are the things the qualities that I have, I want to polish it because in the near future I want to become an entrepreneur. [RN10-O]

> Yes ma'am, honestly, I'm dreaming of becoming a, I don't want to be so boastful or what, but there's nothing wrong with dreams … becoming like a nurse manager or a clinical head of a unit. A leader that would inspire others to become leaders also, and a leader who is open-minded and honest to the team members. And also, a leader, especially if you are a head nurse or nurse manager, a leader who possesses a lot of nursing skills, knowledgeable. I only just have one issue about becoming a leader, I notice this when other leaders, not considering myself, other leaders they wanted to be reminded, I mean, complemented all the time. Like they also wanted to be known by others. And for me, I consider it as a negative or a wrong motion as a leader. A humble leader, you don't need to be called by this, you don't have to have a high position; you can be quiet but a very good leader. Because with our generation I really noticed that one. Others really like to be, "she's the boss" or "she's the leader. [RN11-N]

Participants gave a variety of explanations for their future leadership vision, mentioning basic desires of having a non-punitive working environment, to bigger visions such as innovative initiatives, as seen in the following excerpts:

> My vision for leadership … That's my vision to have an environment that's no one to blame where we are free, free to do…as long as we are on the rules, we are abiding by policies and everything. And everyone is heard ma'am. That's all. [RN12-P]

> … for my colleagues I want them to think that even though they're in this position, it's not the end you know, it's not all about the position. It's all about who you are and how you will influence other people. [RN01-I]

> I think leaders in 2020, they should listen to all the nurses all the concerns and before making final decisions should inform us like that ma'am, and then they will ask our opinion also. Our voice. Because if not, at the end ma'am, there will be negative feedback so it will be better to involve all … the nurses. [RN02-G]

> … the innovation, because now it's 2017 maybe three years more innovation of a good leader will come out yes, for example the research on the nursing for example how the one procedure will become more easier for example for nursing side nursing some procedure will become more easier than before … more like that. So, they will do more research, more discoveries … [RN06-G]

Leadership for the younger ones; research is a great help because it is always continuous and still improving. [RN04-G]

Leadership now is for the 2020. I think leadership has become broader, I mean you are not only a leader, those leaders are not only as a leader but also a good member and follower. Then they collaborate, they cooperate not only to give commands, to delegate a task but also, they will do it together with the members. Then on the 2020 I think more leaders will become more critical thinking, more innovative. [RN06-G]

Wow, describe the leadership, well we all know that technology is fast growing nowadays, so I think technology will by then help in leading. [RN04-G]

Actually, I have a big dream for the organisation … I want to contribute something, wherein as part of 2 or 3 years … 2020 I will be able to graduate from computer science and I want to create a software that will be able to help nursing. Actually, I don't know what that software will be, but deep inside me I want to really create something unique. Because we are not stuck in diverse because the nursing field is really developing because life is in our hands so we need technology enhancement and innovation. … having staff that are performing to the maximum, using their uniqueness … working together as a team. [RN09-E]

6.8 THEME 4: RESOURCES

Table 6.13: Sub-themes for theme 4

Sub-themes
• 4.1 Previous experiences that developed leadership
• 4.2 Future expectations to develop leadership

Table 6.13 above has been provided for ease of reference when reading the findings of the sub-themes for the fourth theme.

6.8.1 Sub-theme 4.1: Previous experiences that developed leadership

When participants were asked to give examples of activities they had been exposed to that had developed their leadership skills, they volunteered a wide

variety. One participant spoke of being given deadlines for tasks which enhanced their time management skills.

Eight participants (66.6%) spoke about the experience of being in the role of team leader, or acting as unit manager or coordinator during their shift. They felt this enhanced their leadership skills. Statements from the participants follow:

> … when I be the team leader of the day I think it's developed because the decision-making, because sometimes there's a decision you don't know if it's good or right but you think as a leader you are liable for this decision so if the staff nurse asked me so (name) what will I do here. So, okay me I will think what is good for the staff; what is good for the patient so I will balance it so I will come with a decision so I will know if the result is good for all of us. Mostly the team leader in our unit is the one who developed my leadership. [RN06-G]

> When I'm being the team leader for the shift … it's like forcing me to be more hands-on with all the things that's going on in the unit, because I know that I'm the one who's responsible and I will be the one who is scolded if something goes wrong. So that kind of forces me, but it's a good thing. [RN07-G]

> One concrete example that I can tell you is when I was this coordinator before, so for me I can see this is a heavy responsibility in that time because they consider you as next to the nurse manager so you should know everything, you should know things that is happening in the unit. They approach you every time they need something regarding the unit. So for me it was a great experience also especially for my social skills because I'm a very, how will I say that, introvert person. Yes, honestly, I'm an introvert person, when I joined this organisation it improved my social skills because I was meeting different kind of leaders with different attitudes, with different skills. And I learned from them, so it really improved my communication skills because before you couldn't even approach me because I'm too quiet. That's why honestly my husband was also shocked with the changes that I have because he said "oh now you are talking to your colleagues, you're going to other departments to talk". It's not that I don't want, it's just I'm not the type ... the quiet person. [RN11-N]

One of the ways that participants felt their leadership skills had been developed was through being a member of a committee and attending meetings. Six participants (50%) mentioned this exposure. Below are some of the responses:

> … before I'm one of the medication committee, once also the narcotic … and the team leader rotational duty. [RN02-G]

> I attended a meeting, then after the meeting I discussed this meeting to the whole unit so everyone must know … their feedback about that meeting so I am getting their suggestion, what they are thinking about this meeting. [RN06-G]

> … number one that I can say to you, I became the chairman of the seminars and training committee, yes, I can say it really enhanced my leadership capability, because before I'm not really familiar on how to set up things and when I became the leader, chairman of that TFO I'm able to learn a lot of things, I'm able to explain what they should or they shouldn't do, I'm able to attend meetings … if there is a good feedback it means that you are able to handle that your, task formation order and your membership in a good way because it reflects on how you do your work. [RN01-I]

> … one of the most challenging tasks that I have is to be a chairman of the task formation order of the nursing informatics because although I am already good at IT, I'm not that good, I'm not the best at the IT, but I was really challenged by the nursing informatics because I was able to see a different kind of view in nursing, the nursing informatics, that's why I also enrolled in the university; I was gelled by that. [RN09-E]

Three participants mentioned precepting and teaching new nurses on their ward had developed their leadership ability, which can be seen in the statements below:

> The number one for me is the preceptorship (course) because it somehow touched the leadership. [RN04-G]

> In my previous institution, being preceptors to the students and to the new staff being the second in charge I can say that I'm able to share my leadership skills and also enhance my leadership skills. [RN01-I]

> I'm the clinical expert in our unit so at that time I became the one who do the competency to them so I think this is the one who developed my leadership because I can handle them, I can teach them for example especially in the clinical aspect I teach them how to do this one how to…what is the progress … what is the sequence of this particular procedure and then I'm the one who evaluate them … [RN06-G]

Four participants spoke of the leadership development they had acquired through standing up in front of others to present a lecture or a report, or when they gave an update at an informal 'huddle'. Some of the responses follow:

> Presentation, there is a lot of presentation … I did presentations on for example jaundice and the clinical cases. [RN04-G]

> … when I'm given responsibility by my manager like launching a workshop, performing this different programmes, up-skilling programmes wherein you are the one who is managing and you will be formulating your schedules, how you will be dealing with your staff, the management and also performing competencies. [RN08-NE]

> … in the huddles because it develops us. I'm a shy type of person but through huddles I was able to express myself because if those leaders would be able to mould you as a person. I have only been standing in front of those persons who are of my age. There are those that are younger than me so I was able to stand up for myself because I don't know actually … because I don't know how to speak in front of those people like … directors of nursing … because I have this fear of speaking and expressing myself. Because I didn't have a choice that's why I'm very thankful. [RN09-E]

> … as a team leader you lead the huddle you will be the one who will handover to all the nurses … incoming nurses what happened and how many patient if any problem we encounter then about the solution that we made also and we also as a team leader if you encounter a new process or a new procedure then on handover give information to other nurses. [RN02-G]

> We have this in-service in our unit and then our nurse manager assigned one in-service to be lectured in our unit so we have to prepare the modules, the slides to present; it's monthly we are taking turns with that. [RN12-P)

> … I think when I presented a lecture; not totally presented a lecture, but when explaining about consumables. When I speak in nursing admin and all the nursing staff here … At first I was so nervous … But when I started and get along, I managed to finish mine. I think on the speaking skill side, more exposure. I did a talk in my department on otitis media I presented in our department; that is one of the projects of the nursing education. They applauded because I am not totally red, so I managed well. I think we need to have seminars on nursing leadership, we have already, but I think not all staff has the opportunity to attend; only selected a few of us. [RN10-O)

Another six participants (50%) mentioned projects, developing policies and processes and participating in team building games as being experiences that developed their leadership skills. Their responses are set out below:

> … process flow development policies and the Unit- Based Councils. We have before the team building activities with the nursing affairs. In each game they assigned one leader to coordinate, to organise things. We learned from that, we were able to make friends with other departments. [RN12-P)

> … when we are developing our process in our unit ma'am, I guide them through what is the process, what it's like to handle this case. [RN05-G]

> Through our games ma'am maybe … example the Cluedo … we were the champions there. Because of the game, I became more confident. [RN05-G]

> Go-Green project I'm involved in that but I am not the speaker who did that … I'm just setting the structure to see how it goes … I was in charge of planning, which activities we will make, how did the staff go and how they will be accepting their specific roles. [RN08-NE]

> Go-Green (fun project) because if, well I'm not actually the one that said that "you're the leader", but because no one is doing anything to have … to make our Go-Green; I'm the one who initiated "why don't we do this". [RN07-G]

> Also being part of evidence-based practice, I was on the pressure ulcer project, getting exposure. We also have a schedule who will be assigned to the next research project [RN12-P]

> We have these breastfeeding seminars – we are encouraged to give our ideas in doing the pamphlets, like that. [RN12-P]

6.8.2 Sub-theme 4.2: Future expectations to develop leadership

The participants listed many skills they desire for personal and professional growth including career-pathing and preparation for a formal leadership position. Four participants expressed their desire to hold a formal leadership position in the future. Below are some excerpts from the data that was collected:

> Personal and professional growth. That is the main thing that I want to gain in attending those leadership programmes because we all want to grow professionally as a nurse, not just grow professionally; I'm aiming to be in a position or being a team leader or being a nurse manager but in yourself you know you have achieved something it will reflect on how you do things, how you handle things if you able to achieve that. [RN01-I]

> Flexibility maybe … so when a nurse is put in another position for him or her to work beyond their comfort zone, because if we are only staying in our comfort zone, we will not grow. [RN02-G]

> I'm a novice here where items are not practised or lack of opportunities to apply these, for example personal growth and development, manage through advanced education, career planning and self-assessment action plans. [RN04-G]

> Maybe because I'm kind of scared of having such a big responsibility, so if there is a training for leadership it might help me to face my fears and be more accepted of being a leader. And I think it is a good learning as well because I'm not going to be just a staff nurse, but in my career, I don't want to be a staff nurse all the time … so it's a step forward. [RN07-G]

> If I get exposed to leadership, maybe I'm planning to take nursing administration. I need direction because I don't see any improvement with me ma'am … I'm just stuck being a staff nurse. I'm afraid to get position, leadership role in the administration. If I'm given a chance, but I think I need more trainings, more exposure ma'am. If someone was not given a chance to be a leader, she or he cannot prove … maybe if he doesn't try he just doesn't know his capabilities. Maybe he just needs to try it. Because up to now I don't know if I can do it. Maybe I just need that break to try. Because not all are given the chance, or only those that have high confidence. [RN05-G]

Participants revealed leadership skills they required including three who referred to wanting to improve their communication skills. Another spoke of wanting to develop responsibility and accountability, whereas another participant felt well prepared for this. Yet another participant feared the “big responsibility” of being a leader. The excerpts can be seen below:

> And of course I want to gain the accountability on everything … that I do because for me if you are a leader you’re not only accountable for yourself but you also accountable to your members so it should be being a leader you should have the responsibility and accountability on how you do things because one mistake if you’re a nurse, do no harm to the patient that’s the number one. [RN01-I]

> Responsibility-wise I don’t have any issues with it … [RN08-NE]

Management skills such as critical thinking, decision-making, problem-solving, people management, conflict management and time management were identified by many participants. The following statements support this:

> I think the evidence-based nursing ma’am, it’s really helpful in how to handle situations that are not within the normal like some encounters where we have to deal with ethics and I think it’s really important to make the right decision because as nurses we are handling a life. [RN07-G]

> I have learned about the decision-making especially. Decision-making you cannot decide it as here you decide within a short period of time but you need to think a lot of times before you decide. Before making your decision, the final decision. You need to balance anything if it’s good for you, if it’s good for everybody. Not only good for you but to other people also, if it will affect the other people or where work like that. And sometimes making a decision is very hard because sometimes I will ask my colleagues “is it good?” “Is it better?” like that so sometimes you need by your own, you need critical thinking for that. I’m always asking for their opinions, suggestion. [RN06-G]

> … dealing with difficult people, like that, sometimes there’s some people they hardly understand, maybe the way I also communicate with them. [RN12-P]

> How to think advanced ma'am, like consequences … leadership decision-making also ma'am, so we should see the consequences. So that you know how to approach them how to sort the issue, like if you make mistake maybe like worry only like punishment, you should first know her side if maybe personal problems you should consider her feelings … the team members they did well or not good we should know how to approach them. [RN02-G]

Participants also mentioned areas of self-development that they felt would enhance their ability to be effective leaders. These self-awareness skills include knowing yourself, self-reflection, managing emotions, building self-confidence, self-improvement and performance improvement, as evidenced by the following quotations:

> Maybe more involvement in the practice because I'm not really exposed into leadership. [RN05-G]

> … how to manage also my colleagues … I want to manage … emotions. [RN02-G]

In addition, participants mentioned approaches to leadership education that would enhance the learning experience, such as technology, innovation team-building activities, simulation, pre-examinations and fun, by stating:

> Team-building activities … technology … Apply techniques of action learning to problem solve. [RN012-P]

> … when we combine learning and sharing in a fun way … not, what do you call this … in a structured way like in school. Because for me, my idea of learning is that it must be fun. It must not have any barriers. [RN08-NE]

> Actually in this programme I think as I told earlier, they need to know their capabilities as well as their unique talents so I think if there is certain, for example in the Philippines ma'am, interview as well as written exam before you will proceed with a course that you like in life, you will take that kind of exam ... I want to see the staff performing simulations as of now ma'am, I want to see them performing series of simulations, because if we will not do some series of simulations, we will get stuck. [RN09-E]

> … the innovation … because now it's 2017, maybe in three year more innovation of a good leader will come out. [RN06-G]

> I don't yet have that particular idea but we all know that technology is improving nowadays and it is part of our everyday lives that is why I thought of technology. For example, in the leadership workshop by the time there will be lots of activities involved, like that'. [RN04-G]

Another issue raised by a number of the participants was their fear and poor skills in addressing a group of people. Some related this to their perceived poor English language proficiency in reading, writing, speaking; in particular "public speaking" which made them lack confidence. They would like this to be included in future leadership education as can be read in their excerpts below:

> I think the barrier also is my language, because I'm also not confident with my English … my ability to speak or write, I'm always shy I get distracted when I speak. That's why I don't do the International English Language Testing System … I'm scared of the speaking. [RN05-O]

> For myself I will be more confident because that is my number one weakness and the reason also … is the English language … I cannot really express … I cannot find exact word that I want to tell, that's a problem … by practising more, talking more, by conversation and reading maybe reading more, because I am not a reader. [RN02-G]

> For me number one priority is public speaking because if you cannot speak in front of the crowd, you cannot clearly disseminate information the message that you wanted. [RN11-N]

> I want to learn public speaking and communication skills because for me I'm not that confident talking in a crowd, just like this even on one-on-one, I don't know why, maybe my language. [RN12-P]

6.9 MERGING RESULTS OF THE QUANTITATIVE AND QUALITATIVE DATA

The analysed quantitative data collected for achievement of study Objective 2 and the analysed qualitative data collected for study Objective 3 were compared. As explained in Chapter 5, in order to bring about complementarity

of the two methods used in this study, integration of the results occurred after the quantitative and qualitative analysis had been independently analysed.

6.9.1 Embedding data collected during sequential phase

The qualitative data in the study took priority over the quantitative data, and hence the leadership skills results were merged and embedded into the qualitative themes.

6.9.1.1 Career planning and growth and development

The quantitative leadership surveys were analysed, and as was reported above (section 6.2.2.6) when further testing was applied to the data (Friedman's test), it was noted that there was a significant difference between the three leadership skill categories. To be specific, competencies were self-rated higher for 'Career planning' than for the other two categories.

When integrating the two methods of data collection, the researcher delved deeper into combining the results of both methods to compare. The categories were presented in an integrative way as opposed to the presentation in the quantitative method above (section 6.2.2). In the leadership survey the category 'Personal growth and development' includes an example of 'career planning' and thus when analysing the qualitative data, any responses made on growth and development were considered together with career planning. Through merging the results, the researcher was better able to see the relationship perceived by the participants between career planning and growth and development.

The quantitative data on the category 'Career planning' for the constructs 'know yourself', 'know your future' and 'position yourself' as well as for the first construct 'personal growth and development' of the category 'Personal and professional accountability' allowed the researcher to compare and link the data to the appropriate participant when reviewing interview excerpts. Although the results of the construct 'Personal growth and development' were

not significant, they have been merged with the career planning category, because of the links noted by the researcher in the qualitative data. It is acknowledged by the researcher that because the sample was small (n = 12), the statistical analysis of the quantitative data did not show significance for this construct and thus cannot be projected onto the population with much confidence. However, the data cannot be ignored because it was the first stage of a sequential phase and was thus integrated during the qualitative data collection. The findings of the categorical constructs are summarised together in Table 6.14.

Table 6.14: Ratings of all participants for career planning and personal and professional growth and development

Career planning	**Rating**				
	1 Novice	**2 Advanced beginner**	**3 Competent**	**4 Proficient**	**5 Expert**
Know your role		RN04-G RN12-P	RN02-G RN05-G RN08-NE RN09-E RN10-O	RN01-I RN11-N	RN03-E RN06-G RN07-G
Know your future		RN04-G RN12-N	RN02-G RN05-G RN08-NE RN10-O	RN01-I RN06-G RN09-E RN11-N	RN03-E RN07-G
Position yourself	RN04-G RN10-O	RN12-N	RN02-G RN05-G RN09-E	RN01-I RN06-G RN08-NE RN11-N	RN03-E RN07-G
Personal and professional accountability	**Rating**				
	1 Novice	**2 Advanced beginner**	**3 Competent**	**4 Proficient**	**5 Expert**
Personal growth and development	RN04-G RN10-O RN12-N		RN01-I RN02-G RN05-G RN08-NE RN09-E RN11-N	RN03-E RN06-G RN07-G	

These findings led the researcher to move back and forth between the quantitative and qualitative data, leading to further integration of the two methods of data collection. When re-examining the qualitative interview results more deeply for explanations specifically on the three categories for 'career planning' and the construct of 'growth and development', it was found that during the 12 interviews, the word 'career' was mentioned eight times, by four participants (RN01-I, RN04-G; RN05-G and RN07-G) and the term 'growth and development' was discussed by three participants (RN04-G; RN08-NE and RN11-N). Although the statistical results for 'personal growth and development' were not significant, these were areas in which these participants expressed in the interviews the need for more education and development. Excerpts taken from the interview recordings of some of the participants follow:

> Of course I want to plan a career path for myself, because you will be motivated to achieve more will be equipped, you will be more challenged to do, to improve yourself … to have the desire to achieve more. [RN01-I]

> I'm a novice here where items are not practised or lack of opportunities to apply these, for example personal growth and development, manage through advance education, career planning and self-assessment action plans. [RN04-G]

> Sometimes I feel a bit bored but when things get rough I think; just turning … but without career advancement. Sometimes you feel you just need to earn, but sometimes you want to get to that point. [RN05-G]

> … in my career I don't want to be a staff nurse all the time in my own career, so it's a step forward. [RN07-G]

> For me it is personal growth and development (when referring to the leadership survey form). [RN08-NE]

One participant (RN12-P) who self-rated level 2 (Advanced beginner) for all three categories elaborated on this when discussing growth and development in the interview. Below is the participant's response to the question on leadership development needs:

> Personal growth and development through education advancement, continuing education … [RN11-N]

6.9.1.2 Personal and professional accountability

The quantitative data on the category 'Personal and professional accountability' for the two significant findings in categories 'practice ethical behaviour' and 'involvement in professional associations' are summarised together in Table 6.15, which allowed the researcher to compare and link the data to the appropriate participant when reviewing interview excerpts.

Table 6.15: Summary of significant ratings for personal and professional accountability

Personal and professional accountability	**Rating**				
	1 Novice	**2 Advanced beginner**	**3 Competent**	**4 Proficient**	**5 Expert**
Practice ethical behaviour	RN04-G	RN12-N	RN02-G RN09-E RN11-N	RN01-I RN03-E RN05-G RN07-G RN08-NE RN10-O	RN06-G
Involvement in professional associations	RN10-O RN12-N	RN01-I RN02-G RN04-G RN11-N	RN05-G RN07-G RN08-NE RN09-E	RN03-E RN06-G	

The majority (83%) rated themselves at least competent for 'Practice ethical behaviour' and this category was not mentioned by any participants during the interviews.

6.9.1.3 Personal journey disciplines

The quantitative data on the construct 'Personal journey disciplines' for the categories 'apply action learning' and 'engage in reflective practice' are summarised together in Table 6.16 below, which allowed the researcher to compare and link the data to the appropriate participant when reviewing interview excerpts. For the construct 'Involvement in professional association',

although the statistical results were significant, no participants raised this as a leadership development need in the interviews.

Table 6.16: Summary of significant ratings for personal journey disciplines

Personal journey disciplines	Rating				
	1 Novice	2 Advanced beginner	3 Competent	4 Proficient	5 Expert
Apply action learning	RN04-G	RN02-G RN10-O RN12-N	RN01-I RN06-G RN08-NE RN09-E RN11-N	RN05-G	RN03-E RN07-G
Engage in reflective practice	RN04-G	RN02-G RN10-O RN12-N	RN05-G RN06-G RN08-NE	RN01-I RN07-G RN09-E RN11-N	RN03-E

Although the majority of participants chose at least advanced beginner (level 2) for the construct ‘Applies action learning’, only one mentioned action learning in the interview, but this participant used it in the context of learning how to make decisions, which is more significant since decision-making was mentioned as a leadership skill by many of the participants (n = 6) in their interviews, as presented in the qualitative results above (section 6.4.1).

The statistical results for the construct ‘engage in reflective practice’ revealed that the participants rated themselves as at least a novice (level 1). In the interviews, n = 4 participants mentioned reflection as an important practice, explaining that good feedback is a reflection that your job performance is effective, and that self-reflection will tell you if you have achieved something (RN01-I). Another explained that when learning from other leaders, you look at the desired principles and you reflect and decide if you are doing things correctly (RM03-E). Yet another participant discussed that your behaviour reflects how you handle your emotions, your colleagues and your patients (RN06-G). One participant (RN10-O) reflected on his actions when he arrives home after working, especially if he thinks he could have done things better at work that day.

6.10 SUMMARY OF THE CHAPTER

This chapter presented the results of the mixed methods study and interpreted the data collected from the three instruments. The results satisfied the researcher that the first three objectives were met as they pertained to data collected during the strengths survey, leadership survey and the interviews. The quantitative and qualitative data were presented separately, after which merged results were offered for the sequential phase of the study. Frequency tables, graphs, and figures were used to show quantitative results for objectives one and two. Thematic analysis, after using Tesch's coding, was used to elicit eight sub-themes, related to the RBC framework which formed the themes. The themes and sub-themes were used to present the results of the qualitative interviews in narrative form to achieve Objective 3.

A combination of all these findings provided the researcher with the necessary information to guide the development of the leadership framework for Generation Y nurses in the workplace for the achievement of the fourth mixed research question and objective. The triangulated data results will now be interpreted for the discussion in Chapter 7, along with contributions that they made to the literature.

CHAPTER 7: DISCUSSION OF RESULTS

7.1 INTRODUCTION

The results of the quantitative and qualitative data analyses were presented in Chapter 6. The data pertained to the character strengths, leadership skills and leadership development needs of Generation Y Filipino nurses at a hospital in Saudi Arabia, where the study took place.

The discussion will begin with the demographic data, followed by a discussion of the how the integration of the quantitative and qualitative data occurred, and will finish by consideration of the study findings in relation to the relevant literature. The researcher's adapted RBC framework, described in detail in Chapter 3, as well as the sub-themes that were revealed in the previous chapter, will be used as the framework for the discussion.

7.2 SUMMARY OF SIGNIFICANT FINDINGS

A summary of the significant findings presented in the previous chapter, aligned to the first three study objectives, can be seen in Table 7.1.

Table 7.1: Summary of significant findings

Objective	Research orientation	Findings of Generation Y nurses
Objective 1: To determine the strengths with which Generation Y nurses enter the workforce.	Quantitative	**From strengths survey** -The character strength 'Fairness' was rated highest out of 24 strengths. Honesty, Gratitude, Hope, Teamwork, Kindness, Love and Perseverance were in the top 7. -'Self-regulation' was rated lowest for Generation Y nurses under the age of 28, and those with less than six years' experience. -The strength 'Love of learning' was rated lowest for Generation Y nurses aged between 28-35 years and those with more than six years' experience.
Objective 2: To determine the leadership skills of Generation Y practitioner nurses.	Quantitative	**From leadership survey** **1. Personal and professional accountability**: Although a significant proportion rated themselves competent for 'Practice ethical behaviour', a significant proportion were slightly less confident in their ability at 'Involvement in professional associations'. **2. Career planning**: Generation Y want a clear career path, although a significant proportion rated themselves at least competent for both 'Know your role' and 'Know your future', however they were less confident of their ability to 'Position yourself' within the organisation. **3. Personal journey disciplines**: Generation Y need further development through action learning and reflective practice.

Table 7.1: Summary of significant findings (continued)

Objective	Research orientation	Findings of Generation Y nurses
Objective 3: To identify skills that are likely to prepare Generation Y nurses in the workplace.	Qualitative	**From Interviews** **Theme 1: Leadership** Leaders and leadership: Believe that the characteristics of a leader determine leadership ability and effectiveness. Believe anyone can lead. Bedside leaders: Strongly believe that nurses can lead at the bedside, regardless of years of experience. Believe anyone can lead and that they have leadership ability. They are keen to take the lead and want equal opportunity to practice leadership skills. **Theme 2: Teamwork** Knowing self: Effective leaders are self-aware. Leadership skills, people management skills and ability to speak well will increase their self-confidence to lead. Relationships with others: Value collaborative teamwork and good communication, specifically listening skills. Relationships and getting to know subordinates are important. **Theme 3: Professional practice** Current practice environment: Believe leaders influence the practice environment. A non-punitive environment is desirable. They want to be heard and to be part of decision-making. They want their leader to support them. Professional growth: Have leadership vision that includes their individualised career plan, equal opportunity to lead. Want to be challenged and do not want to be bored. **Theme 4: Resources** Previous experience: Have gained leadership experience through a number of activities such as team-building games, projects, evidence-based activities, precepting new staff, taking turns to be shift leader, being a committee member, doing presentations in front of others, developing policies and processes. Future expectations: Education must include leadership skills for personal development- to improve self-confidence, self-awareness, management of self (emotions). Need skills to manage others (conflict, decision-making) for personal and professional development. Strongly desire leadership education and that it must be creative, innovative, technology-driven and fun.

7.3 SOCIO-DEMOGRAPHIC FACTORS

It is important to describe the socio-demographic profile of the nurses. These variables cannot be influenced by the researcher, and include inherent characteristics such as age, gender, education level and home language to help create an image of the sample (Brink, van der Walt and van Rensburg 2012: 91). As described in Chapter 4, the same population was used throughout the study, although the sampling methods were different for the two phases.

7.3.1 Study population

There were 269 nurses working in the hospital at the time of data collection, as explained in Chapter 4. The study population was 218 nurses who were from the Generation Y cohort and who were nationals of the Philippines. According to El-Sanabary (1993 cited in Al-Mahmoud, Mullen and Spurgeon 2012: 369) expatriate nurses make up 76% of the total nursing workforce in Saudi Arabia, as recorded in the 2005 Saudi MOH Annual Report. This figure differs from another report of a slightly lower number of expatriate nurses in healthcare in the Gulf countries, particularly, Saudi Arabia, which states that expatriate nurses account for 67.7% of the total number of nurses (Almutairi and McCarthy 2012: 71). Either way, the figures are high. Most of the expatriate nurses working in Saudi Arabia come from India and the Philippines (Alghamdi and Urden 2016: E98; Al Hosis, Plummer and O'Connor 2012: 19). Filipino nurses migrate to more developed countries perceived to be 'the land of milk and honey' in order to have better opportunities for their families. It is claimed that they have become the world's 'dominant migrant group' of female health care providers, nurses in particular (Castro-Palaganas et al. 2017: 3). Besides working in their home country of the Philippines, Filipino nurses are working in most countries in the world. Between 2008 and 2012, it was estimated that 90 382 Filipino nurses went to Saudi Arabia, while 15 701 migrated to the UK and 14 895 to the USA (Castro-Palaganas et al. 2017: 2), and large numbers have also migrated to Singapore, the United Arab Emirates, the Netherlands and Ireland (Lorenzo et al. 2007: 1407).

7.3.2 Ages

The study sample comprised young nurses with an average age of 27.6 years. Just under half were between 22 and 27 years old, and the balance between the ages of 28 and 35 years. As defined in Chapter 2, Generation Y are individuals born between the years of 1980 and 2000. According to Savage (2012: iv), Generation Y comprises the largest generation, with 81 to 95 million members, thus it can be predicted that this cohort will soon form the majority of healthcare employees (Snethen 2018: 1). At the time of data collection (2017), the generation known as Generation Y would have been between the ages of 17 and 27 years. The Philippines has a young population of more than 92 million, with a median age of 23 years, which is in the Generation Y age category. Thus, it is not surprising that the hospital in the current study had a young nursing workforce.

7.3.3 Gender

The gender of the study sample was majority female, with only 21% being male. The gender ratio in the current study is close to the global norm, if not marginally lower than that of the global nursing workforce (Manson 2014: 90). It is well known that nursing is female dominant (Limiñana-Gras et al. 2013: 135; Ross 2017: 4; Shah, Parpio and Zeb 2013: 1), and the situation in Saudi Arabia is no different although it is definitely more complex and requires further explanation. There appears to be a lack of Saudi women willing to be nurses and work in healthcare organisations. In general, nursing is not viewed as a profession suitable for Saudi women. Some of the reasons include cultural values such as issues of gender integration, and other reasons are the poor image of the nursing profession and family pressure to not work irregular shifts, and if shifts are unavoidable, to not work night shifts (Al-Homayan et al. 2013: 2588; AlYami and Watson 2014: 11).

7.3.4 Education

The hospital where the study took place only recruited RN's with a minimum of two years' post-qualification experience. The average number of years'

experience was 6.69 years, with just under a quarter having up to five years' experience and the majority having between six and eleven years' experience.

All Filipino nurses working in the hospital have BSN degrees. This is consistent with the recommendations of Rosseter (2017: 1) that healthcare organisations should increase the number of baccalaureate-prepared nurses to 80% in order to respond to the ever-increasing demands of the health care system and the changing needs of the patients, in order to improve outcomes. This requirement is supported by a recommendation of the IOM in the report of 2011 initiated by the Robert Wood Johnson Foundation about the future of nursing, that the USA nursing workforce should increase the number of RN's with BSN degrees to 80% for entry into nursing practice, because it reduces patient safety issues and improves outcomes (IOM 2011: 173). Prior to employment in Saudi Arabia, all expatriate nurses must pass the Saudi Arabia Prometric 'nurse technician' examination with a minimum of 50%.

7.3.5 Professional licensing

The participants in this study were licensed to practice nursing in both their country of origin where they did their training (the Philippines) and in the country where they were working at the time of data collection (Saudi Arabia). It is a mandatory requirement for all nurses working in Saudi Arabia to be licensed with the SCFHS. The Scientific Nursing Board (SNB) was formed in 2002 as a subsidiary to the SCFHS (Miller-Rosser et al. 2006 cited in Almalki, FitzGerald and Clark 2011: 307). The SNB serves to monitor and control professional development and accreditation of the nursing profession. Professional development encompasses many areas including ethical practice, scope of practice, core standards for education, and nursing research. Accreditation refers to the formal approval and control of nursing education, the content of the programmes, and the institutions where nursing is taught. It also incorporates verification of qualifications obtained outside Saudi Arabia (Almalki, FitzGerald and Clark 2011: 307).

7.3.6 Language

The study sample participants all spoke Filipino as their home language. A home language is defined as the language one learns first and uses in the home; the language one is most comfortable communicating in (Mashiya 2010: 94). In the Philippines, the national language is Filipino, while English is the official international language. Although English is in many cases their second language, most people from the Philippines have a fairly good command of English (Martin 2015: 116). Many developed countries require international workers to pass an English proficiency examination prior to employment. Although this is not a requirement for working in Saudi Arabia, it is well known that most nurses are expatriates who speak a home language other than English (Almalki, FitzGerald and Clark 2011: 309).

7.4 INTEGRATION OF THE QUANTITATIVE AND QUALITATIVE DATA

As discussed in Chapter 4 and Chapter 5, this study applied a multistage mixed methods framework design and, therefore, merging of the quantitative and qualitative data occurred at various levels. The qualitative data, collected through face-to-face semi-structured interviews, dominated the study. When data was merged and contrasting findings were revealed between the two sets of data, the qualitative data took preference.

In mixed methods research the integration ‘fit’ can be evaluated through the study findings. The three possible conclusions are: confirmation, expansion and discordance of the study results (Fetters, Curry and Creswell 2013: 2143). When integrating results, the two sets of data fell mainly in the confirmation and expansion category; however, the researcher did identify one instance of discordance. Integration of the findings is discussed below:

- Confirmation signifies that the findings from both types of data in the sequential phase are mostly consistent with one another. The quantitative data indicated that respondents did not rate themselves highly in the career development leadership competency, and this was

reiterated during the interviews, when participants spoke of wanting to advance their career and develop themselves professionally.

- Expansion signifies that the findings that arose from the quantitative data converge with the findings of the qualitative data. This was the case in two of the four constructs for the category ‘Personal and professional growth and development’ which were seen as a skill in need of enhancing in both the qualitative and the quantitative data. The findings of the two sets of data increased insights by addressing different aspects of the research inquiry, which added to the knowledge found in the literature.
- Discordance occurs when the quantitative and qualitative data contradict one another. In Phase 1, the strength ‘Love of learning’ was rated lowest on the list, yet in the qualitative stage of the sequential phase, the participants spoke of their desire to grow personally and professionally, which requires learning. There are different ways to manage discordant results. A strategy which can be employed to resolve data differences needs to be considered, such as revisiting the databases. When this discordance occurred, the researcher revisited the data, going back and forth to ensure effective understanding of why there may have been a difference. The qualitative data took preference over the quantitative since it held more value in this study (Creswell et al. 2011: 9). This is discussed later in Section 7.5.3.2.

7.5 DISCUSSION OF THE RESULTS

The adapted RBC model was used as the theoretical framework to guide the study (further details can be found in Chapter 4). Figure 7.2 directs the reader to this framework.

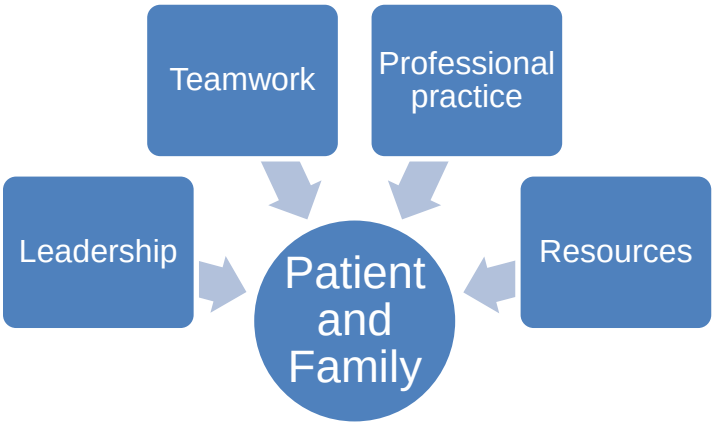

Figure 7.1: Researcher's adapted RBC framework

The discussion and interpretation of the results will be framed around the four BC themes and the eight sub-themes that emerged during analysis of the interviews. It should be noted that although both mixed methods results were presented separately in the previous chapter, the quantitative results will be integrated within the dominant qualitative findings during the discussion of the findings in this chapter. The results will now be collated and examined in comparison to other related studies, as recommended by Zohrabi (2013: 260). Table 7.2 displays the framework for the discussion of the results.

Table 7.2: Framework for discussion of results

	Theme		**Sub-theme**
1	Leadership	1.1	Leaders and leadership
		1.2	Bedside leaders
2	Teamwork	2.1	Knowing self
		2.2	Relationships with others
3	Professional Practice	3.1	Current practice environment
		3.2	Professional growth
4	Resources	4.1	Previous experiences that developed leadership
		4.2	Future expectations to develop leadership

7.5.1 Theme 1: Leadership

7.5.1.1 Sub-theme 1.1: Leaders and leadership

There was a range of perceptions about leaders and leadership amongst the nurses who were interviewed. Many of the Generation Y nurses in the study

used the terms ‘leader’ and ‘leadership’ synonymously. Some participants perceived it as an appointed position, while others said “anyone can become a leader”. Northouse (2004: 5) asserts that appointed leaders differ from emergent leaders. Emergent leadership is acquired when other people in the organisation accept the ideas or behaviours of that person and subsequently treat them as a leader.

One participant said “there is a difference between a boss and a leader”. A previous study revealed that Generation Y individuals prefer to be led than managed and that they rate practical experience more highly than title or rank (Holt, Marques and Way 2012: 92). Gomel (2015: 83) agrees that Generation Y people are less concerned about titles and consider them as having diminished value. Previous literature also points to the fact that Generation Y employees prefer hierarchies that are flattened as opposed to tiered, which should support the notion that Generation Y are better suited to organisations that eliminate bureaucracy and hierarchical structures within the workplace (Zemke, Raines and Filipczak 2000 cited in Rasmussen 2015: 7).

Adair (1990: 53) differentiates between managers and leaders: managers are people who run routine activities in organisations, for example equipment, and are content when things are running smoothly, while leaders are people that seem to emerge amidst change. Leaders deal with the human resources, not just the activities. By interpretation, this means that the unrelenting pace of a constantly changing healthcare environment today calls for leaders who can inspire and motivate others. Ferlie and Shortell (2001: 292) believe that researchers who believe strong leadership is all that is needed to ensure success are wrong, because leadership is multi-conceptual and is dependent on many factors. Furthermore, healthcare is a multidisciplinary system which relies on input from all disciplines and all stakeholders within a hospital. This means that without multidisciplinary teamwork, the healthcare system cannot be optimised.

The study sample of Generation Y nurses discussed the link between leaders and followers. Their perceptions of a good leader included the ability to create

good followers and unite the group, as a means of establishing trust in the team. They also stated that leaders must be good team members and followers themselves. This finding corresponds with previous research. According to Northouse (2004: 3), leadership always involves followers, and leaders are not better than their followers. It is natural for subordinates to want to follow the example set by their leaders. The example a leader sets, both behaviourally and attitudinally, must have a positive influence on others, because the example of a leader not only leads others, but also develops the leadership ability of the followers who want to be like their leader (Klann 2007: 55; Medyanik 2016: 89).

When describing leaders, the study participants named the many characteristics which they felt a leader should possess, including influencing and inspiring others, being a role model, setting an example, having integrity, and having the ability to transform people. According to Kelly (2008: 15), many people remain reliant on personality attributes in describing and defining leadership characteristics, despite the fact that no list of traits has been agreed upon to decide on who is a leader or who is an exceptional leader. The virtue known as ‘honesty’ is about speaking truthfully, but applied in a broader context, honesty is about integrity, about feeling and acting sincerely, being true to oneself and presenting oneself without pretence. Integrity encompasses taking responsibility for one’s actions (VIA Institute on Character 2018: Para. 2 line 8).

Leaders who clearly demonstrate their defined values and integrity will create followers who respond to them (Bennis and Thomas 2007: 144), because there is a direct link between leadership and inspiration (Adair 1990: 58). The characteristics of a leader are behaviours that positively influence others, because being a leader comes with the responsibility to be influential, and great leaders have the ability to inspire and motivate those around them (Klann 2007: 5). Character communicates stability and drive to followers (de Braine and Verrier 2007: 8) and these characteristics are synonymous with leadership. In particular, having a role model is crucial to Generation Y,

because role models are highly influential to this generation (Holt, Marques and Way 2012: 92).

It seems that if organisations want to get the best out of their employees, some authors recommend that organisations should adapt to the unique needs of their employees, which is in line with the perceptions of Generation Y nurses (Chung and Fitzsimons 2013: 1179; Woodward, Vongswasdi and More 2015: 44). In order to develop leadership ability amongst Generation Y nurses they need those who are senior to them to be positive role models, with effective leadership characteristics. This will set a good example for them to follow and to help them achieve their full potential as bedside leaders. Good bedside leaders will in turn result in some Generation Y nurses taking up formal leadership positions in the future. However, leadership development is not restricted to those in formal leadership positions (NHS 2011: 6); merely holding the position of manager and having this power does not make a manager a good leader (Muller, Bezuidenhout and Jooste 2013: 415).

When merging the two types of data collected, a summary of the significant quantitative findings was that Generation Y nurses rated the following character strengths highest: Fairness, Honesty, Gratitude, Hope, Teamwork, Kindness, Love and Perseverance (refer to Table 6.2). It would appear from the findings that these top strengths are important characteristics for nurses. According to Sample (2002: 8), in order to be effective, a leader should be consciously aware of his/her own moral core. Leadership is a process whereby leaders need to exert their knowledge, skills, attitude, character, views and ethics (Muller, Bezuidenhout and Jooste 2013: 415).

The character strength ‘Gratitude’ is defined as being conscious and thankful for one’s good fortune or the opportunities afforded them. To be grateful means making the effort to give thanks for these blessings (VIA Institute on Character 2018: Para.6 line 5). The researcher interpreted this finding as possibly related to working in a country that offers the Filipino nurse a better salary and opportunities that would not be offered in the Philippines.

The fact that participants in the current study rated the character strength 'Perseverance' highly is promising. Perseverance relates to diligence, being productive, and taking pride and pleasure in completing tasks. People who persevere will achieve their objectives regardless of the obstacles they encounter (VIA Institute on Character 2018: Para. 2 line 6). Other authors agree that this generation of nurses is hardworking, committed and dedicated (Tolbize 2008: 5) with a 'can-do' attitude (Chung and Fitzsimons 2013: 1176) and they are determined (Reynolds 2005 cited in Savage 2012: 41).

According to Gilmartin and Nokes (2015: 133), self-confidence is a significant forecaster of job performance, job satisfaction and how effectively an employee transitions into other roles. Although many of the Generation Y participants listed 'self-confidence' as a characteristic needed by leaders, some of them voiced their personal lack of confidence which caused them to fear taking a leadership role. This finding is surprising in light of the fact that most previous research describes Generation Y individuals as confident (Cheng, Filzah and Warangkana 2015: 40; Chung and Fitzsimons 2013: 1176; Skiba 2008: 174), sometimes overly so (Jamieson et al. 2015: 53), and thus they are not afraid to take on more responsibility (D'Netto 2012: 2), and are rarely fearful (Medyanik 2016: 91). Thompson (2015: 33) refers to the 'self-esteem movement' as increasing the confidence of Generation Y individuals. But what was clearly expressed by all participants is that they were eager to develop their leadership skills. Some felt that anyone has the ability to lead, and if their skills are not well developed then they should be further advanced. Gomel (2015: 83) reports that leadership development needs must be met to retain Generation Y, because if not, they will resign.

During the discussions on leadership, some participants referred to the need to avoid negative leadership approaches, such as "bulldozing" people. They favoured a leadership approach that does not dictate or impose, where a leader does not only delegate, but empowers and transforms the individual delegated to. This type of thinking informs managers that they need to limit, as far as possible, a dictator-type of leadership style with Generation Y individuals. They should rather build on interpersonal relationships within the

team so as to foster a positive working environment with optimal outcomes (Colvin et al. 2007 cited in Cheng, Filzah and Warangkana 2015: 41), because leadership is so much more than just knowing all the answers Gentry et al. (2011: 39) makes the general observation that Baby Boomers as well as Generations X and Generation Y have similar leadership development needs that specifically include building and mending relationships.

7.5.1.2 Sub-theme 1.2: Bedside leaders

All participants unanimously stated that nurses can lead from the bedside, because as primary nurses they are in a unique frontline position to directly interact with the patient. Practitioner nurses have the power to make important decisions for patients and can influence others in the multidisciplinary team. Generation Y nurse participants felt that from the bedside they could make a powerful impact on patient outcomes. As practitioner nurses they lead their patients, make collaborative multidisciplinary decisions for their care, and educate them on healthcare matters. The participants mentioned that being a bedside nurse was an experience that laid a solid foundation for being a good leader and that all activities undertaken by senior or junior bedside nurses are opportunities for leadership. This implies that age or experience does not necessarily equal more knowledge, and that a nurse at any experience level can impart opinions on best practice in a ward. In addition to leading patients, the participants gave other examples where a practitioner nurse practices other forms of leadership such as teaching or guiding other nurses. These findings are in line with studies referring to the rapid increase in complexity of healthcare and modern health technology resulting in a demand for nurses to assume leadership roles at all levels, including at the bedside (Honour 2013: 127; Klann 2007: 4; Lippincott, Williams and Wilkins 2003: 2; NHS 2011: 5; Porter-O'Grady 2011: 33). In fact, Generation Y individuals want to be afforded leadership opportunities and they believe others should see them as leaders (Alexander and Sysko 2012: 65). Outside of healthcare, in the corporate world, organisations are encouraged to develop leaders at a fast pace and to foster a leadership culture at all levels, because if all employees think and act like leaders, their performance will be optimal (Sharma 2008:

45). This will suit Generation Y, because they apparently want leadership fast-tracked (Chung and Fitzsimons 2013: 1176).

All participants unanimously affirmed their interest in being a leader and most said they believed that they had leadership ability, but they desired leadership exposure and development to improve their ability. This finding is congruent with a study by Medyanik (2016: 91) on Generation Y leaders who found that they expressed that they felt able to lead. However, not all researchers agree that Generation Y nurses are keen to take on leadership roles, because although they do view themselves as leaders (Sherman, Dyess and Prestia 2013: 19), some are reluctant to hold leadership roles because they fear they may not be supported, and they fear failing in the leadership role (Sherman et al. 2015: 5). Based on the findings of the current study, all nurses, no matter how experienced they are, or how confident they are, should be afforded the opportunity to reach their full potential through leadership development.

In merging the results of the mixed methods data, it is worth mentioning that the quantitative findings of the strengths survey revealed that Generation Y nurses do not rank highly the character strength ‘Leadership’. Nevertheless, during the qualitative interviews a significant number of the nurses indicated that they believed they had leadership ability and that they are interested in taking on leadership roles. These qualitative findings are echoed in studies by Stanley (2010: 850) that Generation Y are keen to take over the reins and lead, and Gomel (2015: 83) that Generation Y value leadership opportunities within the organisation. Given the high number of Generation Y employees currently working in healthcare workforces, and with the predicted increase in these figures, it makes sense to assume that a great portion of Generation Y nurses will be future leaders (Cheng, Filzah and Warangkana 2015: 39; Martin and Martin 2014: 137; Snethen 2018: 1; Stanley 2010: 847). According to the VIA Institute on Character (2018: Para. 4 line 6), leadership is about team members encouraging a group while establishing and maintaining good relations within the group. The fact that Generation Y nurses are willing and feel they have the potential to effectively take leadership roles is a positive factor to bear in mind for future nursing workforce planning.

7.5.2 Theme 2: Teamwork

7.5.2.1 Sub-theme 2.1: Knowing self

The participants in the current study expressed their preference for working in teams. The younger generations prefer self-focused leadership (Woodward, Vongswasdi and More 2015: 44) and with this comes self-knowledge, which not only develops the self but because of it, can improve clinical practice (Labrague et al. 2016: 2). Leadership development is a continual process involving the acquisition of self-awareness and the ability to form good relationships (Gardner et al. 2005: 1). Holt, Marques and Way (2012: 84) agree that Generation Y want personal growth, and an effective way to become self-aware is to be aware of one's character strengths. During the interviews in the current study, participants mentioned phrases such as "lead by your strengths" and "know thyself", indicating that these findings are congruent with previous studies.

There is a strong positive link between awareness of personal strengths and the use thereof, as evidenced in research that reveals that people who are aware of their strengths and use them appropriately have higher levels of goal-achievement (Linley et al. 2010: 6), which also applies to Generation Y (Chung and Fitzsimons 2013: 1176). This supports attempts to establish more effective relationships through self-awareness. Self-awareness allows a person to build on their strengths and minimise their weaknesses (Fung 2011: 17) and helps a person to understand their own strengths and weaknesses, values and needs at the deepest level. Littman-Ovadia, Lavy and Boiman-Meshita (2016: 545), while agreeing that using one's signature strengths at work is the strongest way to improve performance, go on to say that using one's weaknesses may contribute even further to work performance. In agreement with previous researchers, it is believed that self-awareness is crucial to effective leadership and that if one is self-aware, one is in a better position to lead oneself, which enhances one's ability to lead others and respect their perspectives (Ashley and Reiter-Palmon 2012: 2; Bach and Ellis 2011 cited in Billington 2013: 45; Furtner, Baldegger and Rauthmann 2013: 436).

It is not easy to describe and measure virtues; however, the individual character strengths that reflect these virtues in action are quantifiable and measurable (Sosik and Cameron 2010 cited in Harvath 2013: 49), as is proven with the VIA Strengths Survey (Linley et al. 2007: 343). Peterson and Park (2006: 1149) observe that many organisations neglect to use character strengths, yet they are a crucial resource for organisational success. Character is important because it encourages people to make moral decisions, which can be advantageous from a performance and financial point of view (Peterson and Park 2006: 1149). Leenerts (2003: 158), arising from a study on nursing students, recommended that they be taught how to know themselves because this is the foundation for relationships, which is the core of the therapeutic relationship between the nurse and patient. In addition to the nurse-patient relationship, there is also the relationship between the nurse leader and subordinate. According to de Braine and Verrier (2007: 8), it is a person's character that influences the relationship between leader and follower, and ultimately the outcome of this relationship.

Participants mentioned many management skills that they felt needed to be included in their development as leaders, such as critical thinking, decision-making, problem-solving, people management, conflict management and time management. Previous researchers agree with these points. According to Goleman (1998a: 93), although self-awareness and social skills are critical to leadership development, technical skills cannot be ignored when developing leaders. This is supported by Conger and Fulmer (2003: 1) who refer to leadership development as incorporating general management expertise.

Participants discussed the importance of a leader working well with others and that they should be "loved by the people". When comparing this finding to the quantitative results of the strengths survey, the virtue 'Love' was rated in the top 10. Love is described as having close relationships with other people and caring for them (VIA Institute on Character 2018: Para. 3 line 2). Nursing is a caring profession, and love and kindness are crucial characteristics for a nurse to possess. The virtue 'Kindness' goes hand-in-hand with altruism which is a desirable characteristic for people in caring professions. Kind

people show nurturing and compassion, they give of themselves and help others, they do good deeds, care for their fellow human beings, and are generous with their time and devotion when serving others (VIA Institute on Character 2018: Para. 3 line 4). Whereas a previous study claimed that Generation Y nurses are more altruistic in nature (Chung and Fitzsimons 2013: 1176), other researchers question whether differences exist between generations regarding their caring towards others (Cennamo and Gardner 2008: 898; Hansen and Leuty 2012: 41; Twenge et al. 2010: 1117). Even when a systematic review of generational differences at work was undertaken, the findings were inconclusive (Woodward, Vongswasdi and More 2015: 36).

Character strengths are related to relationships in general, and more specifically to leadership relationships. According to Bass and Steidlmeier 1999: 193), when it comes to leadership the leader's character has a substantial influence. When applying character strengths to leadership, a study on the development of leadership asserts that previous studies do not show evidence that leaders are always aware of their personal character strengths (Eckstein 2017: iv). A leader's character is important to their leadership effectiveness (Sankar, 2003; Sarros and Cooper 2006; Thompson et al. 2008; Wright and Huang 2008: 981) and the character strengths of a leader inform their moral conscience to guide the leader and influence their relationship with their followers (Bass and Steidlmeier 1999; de Braine and Verrier, 2007). However, it should be noted that a person's character or attributes are able to undergo development, even as an adult, meaning that they can and must be personally enhanced, which is crucial in leadership growth (de Braine and Verrier 2007: 1; Klann 2007: 2). However, it should be noted that each character strength is different and as a result could require different interventions in order to bring about development (Riggio et al. 2010: 247). Thus, it is advisable for nursing departments to encourage nurses to develop self-awareness in order to improve their relationships and leadership effectiveness. Mutually respectful relationships which start with an understanding of one another's values and differing strengths are critical (Kuhl 2014: 29).

The current study survey found the strength ‘Fairness’ to be the most important to Generation Y, regardless of their age or nursing experience. In addition, the notion of ‘equity’ was mentioned in the interviews regarding having equal opportunities to practice in a leadership role, maintaining that it is often the confident people who are given the opportunity to lead. These findings are significant yet are not new scholarship. To ensure there is no generational dominance, and to ensure that all team members’ views are regarded as important, equity and fairness are paramount (Moore, Everly and Bauer 2016: Para. 24 line 3). A study by Medyanik (2016: 83) reveals similar findings, as do Harmoinen et al. (2014: 69) who state that good management involves equality, according to the perceptions of young adult nurses from Finland. This is further supported by a study on the expectations of newly recruited Filipino nurses in London, which revealed that equal opportunity was one of the factors that affected their adjustment when it came to training and promotion opportunities (Daniel, Chamberlain and Gordon 2000: 254). Furthermore, it appears there is good reason for Filipino nurses to value fairness, because one study reported that Filipino nurses working overseas are often subjected to discrimination and wage differentials (Castro-Palaganas et al. 2017: 11).

It should also be remembered that this generation has been pushed by their parents to excel and to be assertive, to the point of that they are often viewed as questioning authority in an attempt to be treated fairly (Crappell 2012 cited in Medyanik 2016: 23). However, not all researchers agree that fairness is unique to the Generation Y, suggesting that it is also important to other generations, as disclosed in a multigenerational nursing study (Jobe 2014: 305) and important to the job satisfaction of Filipino nurses (Lapeña et al. 2017: 66).

According to the VIA Institute on Character (2018: Para. 4 line 4), ‘Fairness’ as a strength is linked to the virtue ‘Justice’, which is defined as communal strengths that form the basis of a healthy community life. Fairness and justice is about treating everyone equally, disallowing personal feelings to influence decisions, and providing equal opportunities to everyone (Park, Peterson, and

Seligman (2004: 605). De Braine and Verrier 2007: 1) agree that fairness is one of the fundamental ethical values of character which is desired in leaders. This implies that this generation wants equal opportunity and feel they should not be overlooked as potential leaders.

The current study revealed that Generation Y participants under the age of 28 and with less than six years' experience, rated the strength 'Self-regulation' as the lowest strength. This is a significant finding because according to Park, Peterson, and Seligman (2004: 605) self-regulation refers to being disciplined and having control over one's actions and feelings, as well as having the ability to control one's emotions. Some participants in the current study did mention their need to manage their own emotions. Sheldon and Kasser 2015: 1329) are of the view that people with better social and self-regulatory skills achieve their goals more often than those without such skills. The reason the participants in this current study scored this strength low on the list could be because of their age. Personal traits relate to virtues which can be developed through applying them in practice, implying that character strengths can be developed over time because they are not set in stone (Klann 2007: 2); in fact it is a lifelong process and as one matures and gains more life experience, one's emotions develop (de Braine and Verrier 2007: 8).

The current study revealed that a significant percentage of Generation Y nurses rated themselves at least novice for the skill of engaging in reflective practice, which refers to knowledge and the practice of reflection as a leadership behaviour. For the category regarding the application of action learning, a significant percentage of participants rated themselves at least advanced beginners. According to Benner (1982: 404), the ability of a novice and an advanced beginner to digest a situation is limited because their skill ability is too new and undeveloped, which is reflected in the findings of this study, considering that participants were young professionals. In merging the findings of the survey with the interviews, participants interviewed mentioned reflection as an important practice for nurses, explaining that good feedback is a reflection that your job performance is effective, and that self-reflection will gauge your performance. When learning from other leaders, one looks at the

principles they display that are desirable, then reflect and consider whether one is doing things correctly and how to improve future decision-making. According to Joiner and Josephs (2007: 41) reflective action is also called action learning. These authors believe that leaders can be developed through this approach to become agile leaders. This can be accomplished by engaging in developmental activities that specifically emphasise reflective action, which is a cyclical process of defining objectives, developing action plans to reach these goals, and reflecting on the experience. Reflective practice enhances self-awareness and includes techniques to solve problems and reflect personally on decisions, which are skills necessary for an effective leader (Billington 2013: 45). Leadership development is a continual process of growth in self-awareness, which happens effectively through self-reflection on one's strengths and weaknesses, as well as learning to adjust one's leadership approach to unique situations (Hernez-Broome and Hughes 2004: 28).

With regard to action learning, Generation Y nurses would benefit from this approach to learning and gaining experience in problem-solving. Action learning is defined as an instrument used to solve problems in a team-based way, which is highly successful in developing successful leaders, teams and organisations. The problem referred to could be a project or a challenge that is of interest to the organisation. Its resolution needs to be urgent and significant to the organisation, because action learning is not used for minor issues (Marquardt 2004: 1). This could be a useful strategy for leadership development in complex environments such as hospitals, although it would possibly require the involvement of other levels and disciplines within an organisation.

7.5.2.2 Sub-theme 2.2: Relationships with others

The findings of the current study included the preference of Generation Y nurses for team-based approaches at work, which implies that team-based leadership is definitely an area of development that needs sharp focus in the 21st century. For this cohort, the world is one of collaboration and networking

with a preference for a collective team-based approach to tasks (Alexander and Sysko 2013: 130; Tolbize 2008: 11; VanMeter et al. 2012: 93) and they enjoy social connections with their peers (Cennamo and Gardner 2008: 904). In fact, out of the four generations of nurses who are currently working together, as far as being team players goes, Generation Y individuals are apparently better at it (Jamieson et al. 2015: 52; Tulgan 2004 cited in Wieck, Dols and Landrum 2010: 14), and they enjoy the opportunity to develop their teamwork ability (Alexander and Sysko 2012: 65). In addition, individuals from younger generations want to be managed by someone who is a good team player themselves; someone who values their input in the team, and who sincerely recognises and appreciates their efforts at work (Wieck, Dols and Landrum 2010: 10). It is thus crucial to develop the teamwork skills of this generation to enhance their productivity (Behrens 2009 cited in D'Netto 2012: 5).

Teamwork is being able to work congenially with others within a team and doing one's fair share of the teamwork. Generation Y, with their inclination towards teamwork, will most likely favour a leadership approach that is participative in nature, where the leader acts more as a group facilitator than a leader in the traditional sense (Medyanik 2016: iv). Any future leadership training approaches should bear this in mind and apply a democratic approach for Generation Y nurses, because the findings of the current study were that Generation Y nurses like to get input from all team members before making a decision. Some might label this as a lack of accountability on their part; this study found that Generation Y nurses prefer working collectively, but this does not necessarily equate to a lack of accountability. In order to ensure that this generation's need to work collectively are met, and to ensure that each nurse is accountable for his or her practice, future leadership should include building accountability into teamwork training.

When merging the quantitative data of the strengths survey on teamwork with the findings of the qualitative interview data, the findings support one another. In terms of coherence of the two sets of data, integration confirmation applies here (Fetters, Curry and Creswell 2013: 2143). The strength 'Teamwork' was

rated high on the list of 24 strengths by a significant percentage of Generation Y nurses. This confirms that team-based work is held in high regard by this cohort of nurses. The VIA Institute on Character (2018: Para. 4 line 2) defines teamwork as being a social responsibility that demands loyalty towards fellow group members, working well with others, and sharing the workload equitably.

Adair (1990: 58) claims that a leader thinks naturally in terms of 'teams', and teams in turn tend to seek leaders rather than managers. In other words, team-based work lends itself more towards leaders than managers. In support of the findings of this study, there is strong evidence and consistent reporting that team-based work is important to Generation Y. A number of studies point to the fact that Generation Y prefer to work in teams or have a close team surrounding them (Boag 2009 cited in Cheng, Filzah and Warangkana 2015: 40; Carver and Candela 2008: 984; Mangold 2007: 21; Medyanik 2016: 1; Sherman et al. 2015: 9).

Leading through relationships was an important finding in the current study, highlighting the importance that Generation Y nurses place on relationships. According to Muller, Bezuidenhout and Jooste (2013: 141), the management of professional leadership and relationships is vitally important in the process of health transformation, as is the impact that teamwork has on the success of the outcome. This implies that the chemistry within a nursing team is important in predicting its success. Participants in the present study mentioned how leadership influences team functioning through relationships and open communication, in a non-judgemental environment. Participants also said that people skills "touch the lives of others" and that the responsibilities of a leader included personal management and group or team management in order to create order and ensure the functioning of teams. This is congruent with the findings of a study on Generation Y leaders who believe in leading through relationships (Medyanik 2016: 84). It would seem that with Generation Y nurses, management must get out of their comfort zones, consider the unique needs of each team member, compromise, and be flexible with all individuals in the team to get optimal output.

In the healthcare environment, there are a number of relationships: between team members, between the nurse and manager or leader, as well as between the nurse and patient. Indeed, results from this study suggest that good relationships within the team are integral to effective leadership and outcomes. Generation Y seeks organisations that offer an environment with good relationships between team members (Gomel 2015: 83; VanMeter et al. 2012: 103) and they have high expectations of these relationships (Medyanik 2016: 1). Undoubtedly all employees seek happiness in the workplace, and supporting this is a previous study that proved staff engagement and positive relationships were effective strategies to increase the well-being of employees (Gander, Proyer and Ruch 2016: 11). Brunetto et al. (2013: 827) discuss the fact that management must focus their attention on improving the quality of relationships in the workplace in order to retain skilled nurses and reduce the global nursing workforce shortage. As a way of building relationships within in the team, Generation Y nurses stated their preference for working on the same ward for longer periods (Lavoie-Tremblay et al. 2010: 5).

Generation Y like to be led through relationships and positive reinforcement (Medyanik 2016: 32). They prefer relationship-orientated leadership (Medyanik 2016: 32; Woodward, Vongswasdi and More 2015: 44). This was evidenced by Kuhl (2014: 27) who was successful in leading Generation Y when she adopted a management style aligned to promoting relationships. Furthermore, Generation Y individuals value the relationship with their immediate manager (D'Netto 2012: 4) which they like to be nurturing (McDonald 2008 cited in Savage 2012: iv) and supportive, as proven by most individuals in this cohort who rated autonomy highly, although they desire support and reassurance in their work. Price Waterhouse Cooper (PWC) (PWC 2013: 9) report consistent findings that this generation expects the organisation to offer them support and appreciation in return for their involvement in the team. It is said that employees do not leave because of organisations, they leave because of bad leaders (Medyanik 2016: 33), which means that the relationship between Generation Y nurses and their managers is more important than ever. Generation Y staff value the empowerment they

feel when they are allowed to have access to their managers (Behrens 2009 cited in D'Netto 2012: 5).

Generation Y individuals like to work in an interactive environment (Holt, Marques and Way 2012: 92), with open, collaborative lines of communication, which will require leaders to relook at their current communication approaches (Savage 2012: 112). Generation Y employees believe they are good listeners and they therefore want to be listened to and to not be treated in a condescending way (Tolbize 2008: 8). In a study on multicultural nursing environments in Finland, it was found that Generation Y expected their managers to have good interactive skills, especially in understanding their cultural communication and values (Harmoinen et al. 2014: 69). Communication is not only about talking, but listening too. In the current study, Generation Y nurses stated they want to be heard; they want people to listen to their opinions and include them in decisions because they are part of the team. Nurses have long complained that they feel their voices fall on deaf ears. According to Baggett (1997: 111) people considered to be effective communicators are effective listeners. Previous researchers have found consistently that nurses at all levels want their voices to be heard and they want to be included in decision-making (Kreitzer and Koithan 2015: 53); in fact they expect it, regardless of how junior they may be in the workplace (Gomel 2015: 86). Other studies suggest that key nurse leadership competencies should include the communication skill of listening (Eddy et al. 2009: 1). Good leadership requires a variety of strengths, including willingness to listen to the opinions of others (McGrath 2014: 12). When dealing with team members, a leader should listen to each side of the story, take personal problems into consideration, and know how to approach each person (Medyanik 2016: 89). Administrators and managers can no longer simply say they are listening and hope the problem will disappear (Wieck, Dols and Landrum 2010: 17). It is therefore vital for nurse managers to augment their people skills in an endeavour to retain staff and ensure each individual nurse reaches their full potential (Wieck, Dols and Landrum 2010: 8). These findings are congruent with a study that asserts that over and above clinical competence and EI,

bedside leaders need proficiency in communication, cooperation and efficiency, in order to influence others (Grindel 2016: 13).

Participants in the study revealed their appreciation of team-building activities. According to Moore, Everly and Bauer (2016: Para. 24 line 5) strategies to build teams result in positive outcomes. Successful teams acknowledge that each team member brings personal expertise to the group. In an optimally functional team, relationships are created and each member knows the scope of his/her responsibility and role within the team, as well as what can be expected from other members. In successful teams, relationship management is the key (Koloroutis 2004: 99). The four fundamental characteristics upon which healthy teams are built are trust, mutual respect, consistent and visible support, and open and honest communication. Team-building improves problem-solving and team spirit which in turn leads to a healthier practice environment. Working well with others also increases the chance of generating new knowledge, new ways of thinking, and better patient care methods (Gonzalez and Rolman 2010 cited in Moore, Everly and Bauer 2016: Para. 26 line 6).

7.5.3 Theme 3: Professional practice

7.5.3.1 Sub-theme 3.1: Current practice environment

The practice environment was discussed by the participants interviewed in the current study. They all had a leadership vision, which included working in a non-punitive working environment, where everyone has a voice and freedom to practice within policy parameters. The participants said that an effective leader creates a positive, non-punitive environment for members. According to Benton (2012: Para. 15 line 7), research on nursing leadership repeatedly highlights the need for nurse leaders to be proficient, of high integrity and able inspiring other people with their vision. It seems the participants in the current study are correct, that the work environment is definitely influenced by the leader. Good leadership results in a strong foundation in a ward, with well-organised and structured work flow processes and clear plans. It is the leader

who is responsible for excellent outcomes. This is supported by the findings in an American study which concludes that leaders should offer strong and effective leadership in order to transform the environment at work (Holland 2015b: 8). Quality care and patient and staff satisfaction are factors that affect nurse retention (Holland 2015b: 8). The participants in the current study described the results of good leadership as being patient satisfaction, confident staff, staff who are good followers, smooth workflow in the ward, a united team, sound decisions, good team support, efficient ward organisation, excellent patient outcomes and clear work expectations. These findings are important for effective performance in healthcare, where upward progress in nursing leadership competency can lead to better patient outcomes for patients and will go a long way in building teams who are high-performing (West et al. 2014: 2).

According to the IOM (2011: 234), there is no substitute for the abilities of an outstanding nurse to develop another nurse into becoming equally outstanding (IOM 2011: 234). This implies that a more experienced or knowledgeable peer is the right person to teach a new or inexperienced peer at the bedside. Orientation and precepting are effective ways to ensure clinical competence and staff satisfaction. The transition period, when a new staff nurse begins working in a ward, is very important. Nurses with little experience post-graduation are known to have the lowest retention rates, hence their development needs should receive particular focus (Hillman 2010: 50). An Australian study found that nurses in their first year post-graduation experienced dissatisfaction with their support in the practice environment and this had a significant impact on their future career directions (Parker et al. 2012: 1). Preceptorship is a type of experiential approach where an experienced nurse is partnered with a newly recruited or inexperienced nurse, to offer support and education in the clinical setting. There is a reciprocal relationship between the preceptor and the preceptee (Bott, Mohide and Lawlor 2011: 35). Over 50% of nurses began their clinical experience post-graduation, in a hospital setting (Horton et al. 2012: E1). Newly qualified nurses as well as nurses transferred from other wards need orientation and facilitation in transitioning in the new environment. Orientation benefits both

the nurse through the provision of psychological support, and the patient through the provision of safe, quality care.

The nursing practice environment influences the ability of nurses to apply the act of caring when carrying out their nursing duties (Lake 2002: 178). Participants mentioned the leader's role in creating a positive working environment. When comparing the quantitative results to this comment, it was found that Generation Y participants rated 'Hope' in the top 10 of the strengths. Hope is a positive characteristic that shows optimism and future-thinking. A person who is hopeful expects the best in the future and works to achieve it, and believes that a good future is something that can be brought about (VIA Institute on Character 2018: Para. 6 line 6). Previous research is consistent with the findings that Generation Y people are an optimistic group of people (D'Netto 2012: 2; Kersten 2002 cited in Tolbize 2008: 4; Ramirez 2012: 23; Reynolds 2005 cited in Savage 2012: 41), ambitious (Cheng, Filzah and Warangkana 2015: 39) and hopeful (Reynolds 2005 cited in Savage 2012: 41).

Person-centeredness is absolutely critical for professionalism. The patient and family should be the centre of healthcare, and this should be promoted throughout the healthcare environment (Swensen et al. 2013: 10). The findings of the current study are that Generation Y nurses value the quality of the work environment, which is congruent with the results of other studies (D'Netto 2012: 3). According to Lavoie-Tremblay et al. (2010: 6), Generation Y nurses perceive that in any job the team and the working climate matter the most, and they will go so far as to select a work environment based on its reputation. Aiken et al. (2012: 4) conducted a multi-country study on whether hospital environments effect outcomes. Although the causality cannot be absolutely sure because the study data was cross-sectional, the findings revealed that the working environment in the many European and USA hospitals under study was consistently and positively associated in each country with regards to both the patient and nurse outcomes.

The findings of the current study revealed that Generation Y nurses believe that leadership influences the practice environment and ultimately impacts patient outcomes. The majority of participants reported a positive and healthy working environment where learning and sharing took place. As practitioner nurses, they were accepting of responsibility and saw the workplace as a great opportunity where they enjoyed good teamwork. However, some did report poor working environments due to poor leadership, unclear policies and processes, many changes, high pressure and chaos. We now live in a dramatically transformed environment which is more socially connected, and where change is constant, rapid and inevitable as well as unpredictable. Chaotic, turbulent environments are common place in healthcare nowadays, so much so that they are being referred to as 'volatile, uncertain, complex and ambiguous' also known as VUCA, an acronym coined by the USA military (Whiteman 1998: 15). Providing agreeable working conditions is a way to show Generation Y employees that they are important to the organisation, and as one participant put it, the team dynamics and work environment forms the security of the job (Lavoie-Tremblay et al. 2010: 5). It seems that when nurses are happy with their career, employer and themselves, they contribute more fully to the workforce, implying that it is in the best interests of organisations to ensure a climate that keeps their staff engaged and satisfied (Holland 2015b: 8).

7.5.3.2 Sub-theme 3.2: Professional growth

Professional nursing practice is the provision of compassionate, collaborative care with sound ethical values. There is a significantly positive relationship between professional nursing values and levels of self-esteem in nursing students (Iacobucci et al. 2012: 479). Professional practice involves lifelong learning to ensure nurses are accountable and responsible when practising safe, quality patient care (Fletcher 2016: 71; Girard, Linton and Besner 2005: 3; Masters 2017: xv; IOM 2011: 31). According to Masters (2017: xvi), the science of professional practice is encompassed in a number of core competencies namely, patient safety, quality improvement, leadership, collaboration and teamwork, communication, informatics, system-based

practice, ethics, EBP, patient-centred care and professionalism. In healthcare, the working environment is professional in nature, and nurse leaders are responsible for creating this professionalism and fostering a culture where interdisciplinary team members from all disciplines are able to contribute to optimal patient outcomes and grow professionally at all levels (AONE 2015: 3).

It was expected that most, if not all, leadership skills listed in the leadership survey would be mentioned in the interviews; however, most participants honed in on their need for career planning and personal and professional development. The results showed clear evidence that Generation Y nurses perceive a relationship between career planning and personal growth and development. The merging of the quantitative and qualitative findings could be interpreted as inconsistent or could be viewed as significant. The significant findings for the career planning category were that Generation Y nurses rated themselves at least competent for knowing their role and their future. However, they felt less confident about positioning themselves in the hospital, rating themselves at least advanced beginner only (level 2). This could indicate that they require this skill to be developed because it is desirable for them to be at least competent (level 3). The researcher interpreted this as significant because the qualitative data confirmed their desire to grow in the profession, and specifically in nursing leadership. The findings are consistent with those of a previous study which concluded that professional development is necessary to enhance leadership skills in all areas of nursing practice (Fardellone et al. 2014: 512). In their second key message, the IOM (2011: 31) urges the healthcare industry to transform nursing education by promoting lifelong learning throughout a nurse's professional career.

When integrating the quantitative data from the leadership survey into the qualitative data from the interviews, it was found that although the majority of participants in the current study considered themselves to be less than competent (only advanced beginners) for the category on involvement in professional associations, most expressed a desire for leadership education and training that included professional development. Professional association

includes being a member or being involved in an appropriate professional association that provides a professional network and resultant professional development. By joining a professional association of interest within the nursing field, the member is declaring themselves as a career professional. It demonstrates commitment and a desire to advance skills in a specific field. Benefits include having access to networks, conferences, connecting with like-minded intelligent individuals and being offered learning opportunities. Discussions with other individuals who share an interest can lead to contributing to new ideas and developing or enhancing theories. It can also offer the opportunity to showcase and develop leadership ability (Harley 2015: 9). Nursing associations are also viewed as key drivers for influencing policy, not only within country, but worldwide (Benton 2012: Para. 7 line 1).

A possible reason why the study sample did not feel competent in their association with professional organisations could be that the participants were all expatriates from the Philippines, a developing country, and were perhaps reluctant to spend money on membership fees when the purpose of working in Saudi Arabia was to make money for their families back home (Castro-Palaganas et al. 2017: 1).

Lavoie-Tremblay et al. (2010: 2) suggest creating a plan for the future of Generation Y within organisations. The findings of the current study are congruent with those of Tolbize (2008: 14) who reports that younger the generation desires leadership training compared to the older generation who prefers to receive training in their field of expertise.

Lifelong learning is recognised as crucial for the nursing profession (Gomel 2015: 78; Qalehsari, Khaghanizadeh and Ebadi 2017: 5541). The NHS (2011: 5) states that leadership development is a lifelong process. Researchers are largely in agreement with the findings of the current study that Generation Y desire continued professional growth (Cheng, Filzah and Warangkana 2015: 39; Gomel 2015: 83; Harmoinen et al. 2014: 69; Holt, Marques and Way 2012: 92). Although the Generation Y cohort highly values jobs that offer them ongoing education (McCrindle 2006 cited in Jamieson et al. 2015: 52), Shaw and Fairhurst (2008 cited in D'Netto 2012: 4) noticed a trend amongst this age

group to not take personal accountability for their development, but rather to place the blame on others when they fail to progress within the organisation. It is interesting and somewhat confusing to note that in the current study, the strength 'Love of learning' was rated last out of the 24 VIA strengths of Generation Y nurses aged between 28-35 years with more than six years' experience. Despite this, participants expressed a desire for professional development which comes partly through learning. The low rating of this strength could be attributed to the fact that this cohort recently completed their studies and perhaps were not ready to take on further studies at this stage. It should also be emphasised that there are only 24 character strengths in the VIA survey. Ranking 'Love of learning' last on the list does not necessarily indicate that it was not important, but that it was least important of the 24 strengths listed at this stage of their lives.

Again, mention should be made that the purpose of merging the results in the current study was to further enrich the study because additional clarity and detail elicited from the interviews would otherwise not have been evident from the survey alone. During the interviews the participants spoke frequently of their desire for personal and professional development, which includes the learning process. Because the qualitative component of the study was assigned priority over the quantitative, the qualitative data was considered more important. Discordance occurs when the two sets of data are inconsistent (Fetters, Curry and Creswell 2013: 2143). The data was revisited for possible reasons in keeping with the suggestion by Creswell et al. (2011: 9) in this regard. The strategy employed was to consider the qualitative results as being more reliable. This finding was none the less surprising and has been refuted by many previous research studies which found that this generation expect continued learning throughout their careers (Gomel 2015: 83; Jamieson et al. 2015: 52). In fact, they are eager to learn (Cheng, Filzah and Warangkana 2015: 40; Medyanik 2016: 85).

PWC claim to have conducted the biggest study ever on Generation Y. The study found that Generation Y individuals in developed countries expect development opportunities, and furthermore, they expect their employers to

create a work environment that allows them personal and professional growth (PWC 2013: 9). Porter-O'Grady (2011: 34) asserts that it is the responsibility of organisations to make sure that people at all levels of leadership reach their potential, including clinical practice environments, for the benefit of the nursing profession and the community. These contradictions in the literature suggest that organisations such as hospitals, and the nurses who work there, should share the responsibility of professional development. Organisations could provide development opportunities and the nurses themselves should be intrinsically motivated for their own development. With professional maturity comes the responsibility to be motivated to grow within the profession; to seize the opportunities afforded to them as they arise.

Participants in the current study reported the need for a career path, which is supported by Medyanik (2016: 25). Apparently, Generation Y nurses are more interested in gaining knowledge when it applies directly to their career plan and feeds their desire to climb the ladder. Some healthcare organisations have implemented clinical ladder programmes (Fardellone et al. 2014: 508) which provide nurses at the point of care an opportunity for advancement while remaining at the bedside. If all nurses were in formal leadership positions this would exacerbate the leadership problem. It is thus important for the profession to develop the leadership of practitioner nurses and still keep them at the bedside. Management is well advised to show an interest in the career plans of Generation Y; one participant in a Canadian study reported that s/he resigned when s/he was refused study leave (Lavoie-Tremblay et al. 2010: 5). This attitude is typical of Generation Y. They have no issue with job-hopping if it meets their personal needs (Chung and Fitzsimons 2013: 1173). They are ambitious (Cheng, Filzah and Warangkana 2015: 39) and they expect rapid career advancements every one to three years (Kuhl 2014: 25; Lavoie-Tremblay et al. 2010: 3) or they will move on to another organisation (Gomel 2015: 83). This is more about fast career advancement than ego and arrogance (Kuhl 2014: 29). Not all researchers agree that Generation Y will leave organisations if their development needs are not met, disputing the implication that this cohort are not loyal employees (Medyanik 2016: 85).

Generation Y nurses in the current study were not very confident about developing a flexible career plan designed to offer direction and coping strategies for the future. However, they expressed their desire for broadening their skills to increase their flexibility in the workplace. It would appear from these findings that this generation needs assistance with creating flexible career plans in order to build resilience in the nursing profession, because as a group they enjoy change and appreciate variety at work (Jamieson et al. 2015: 52; Lavoie-Tremblay et al. 2010: 6). An Australian HR study concludes that the talents of Generation Y employees will benefit organisations that provide them with interesting work and greater flexibility in a congenial environment with supportive leaders (D'Netto 2012: 7).

It would appear that work flexibility is key to work satisfaction amongst Generation Y employees (PWC 2013: 9). This is consistent with the findings of another large study on 3 200 accounting professionals across 122 countries. This study revealed that accountants from Generation Y need new career pathways and that they value flexible career plans with a wide variety of work options. This can be accomplished by their desire to increase their knowledge by continuing to study, either in a certified field of specialisation or by returning to college while working (Martin 2005 cited in Hess 2012: 42). Fletcher (2016: 71) recommends access to career counsellors who can coach nurses to pursue their personal and professional goals. It is worth mentioning that previous research suggests that the need for flexibility may not be unique to Generation Y. Employees from other generations were also found to have similar values in that they also place a high priority on workplace flexibility (Snethen 2018: 1).

Keeping Generation Y satisfied and fully productive could include a strategy of rotation and cross-training within the workplace (Zemke, Raines and Filipczak 2000 cited in Rasmussen 2015: 8). According to the Association of Chartered Certified Accountants (ACCA), flexible career paths should include learning opportunities and job rotation which are important considerations for Generation Y when job-hunting. They view a job as a gateway to career development, and the path they choose may not necessarily be confined to

the initial profession itself (Lyon, Filmer and McDougall 2010: 10). Current leaders now face the challenge of finding ways to introduce flexibility into the nursing environment, in order to meet the needs of Generation Y nurses (Snethen 2018: 1).

Leaders and managers are urged to adjust their leadership approach to accommodate younger generations (Chung and Fitzsimons 2013: 1179; Martin and Martin 2014: 129). As one of the study participants said, perhaps the younger generation can teach the older generation new ways of providing care for patients. This is supported by Adelman-Mullally et al. (2012: 31) who recognise that at times leaders need to challenge the status quo, because the traditional way of doing something may no longer be effective. Even though Generation Y has unique characteristics and quirky ways that differ from other generations, and are often frowned upon by older generations, perhaps it is time for organisations to accept them and adjust accordingly. After all, Generation Y are here to stay, have a lot to offer, and soon will lead the way.

When it comes to practising ethical behaviour, the findings of the current study showed that the majority of Generation Y nurses rated themselves at least competent in the scope and standard of their nursing practice. This generation is known to prefer a leader with a strong work ethic (Horenczy et al. 2012: para. 21 line 6), which hopefully will be mirrored in their leadership attributes as they develop. Although there are limited studies supporting generational differences in work ethics amongst nurses, one study (Jobe 2014: 304) used a 65-item inventory tool called the Multidimensional Work Ethic Profile. This tool measures seven dimensions of work ethic: self-reliance, morality/ethics, hard work, leisure, centrality of work, delay in gratification, and wasted time (Miller et al cited in Jobe 2014: 304). The results showed that there were more similarities than differences in dimensions of work ethic of the three generations, and furthermore, Generation Y scored the highest mean score overall (Jobe 2014: 305). This indicates that Generation Y nurses may not have weak work values and ethics as suggested by Daloğlu (2013 cited in Aydemir, Dinç and Çağlar 2016: 80; Medyanik 2016: 47). They have been found to be hardworking (Chung and Fitzsimons 2013: 1176; Gomel 2015: 83;

Medyanik 2016: 31). The good news for hospitals is that apparently Generation Y may just be the best generation so far. They are motivated by the opportunity to take a meaningful role in their career by doing work that is of value in helping others and they want to have a positive impact in the workplace (Holt, Marques and Way 2012: 84).

7.5.4 Theme 4: Resources

7.5.4.1 Sub-theme 4.1: Previous experiences that developed leadership

The current study revealed a wide variety of experiences that Generation Y nurses had been exposed to in their nursing careers, which they perceived to have enhanced their ability to lead. These experiences included: being assigned to work on a special taskforce team or project; being a member of a committee, attending meetings and providing feedback to others; attending development courses such as preceptorship courses; taking on temporary leadership roles such as precepting new nurses or acting as shift leader; delivering public presentations or education sessions, and participating in team-building games.

The findings of the current study revealed that Generation Y nurses consider people management skills such as conflict management, “handling difficult people”, to be vital for effective leadership. Decision-making was also repeatedly mentioned as an important leadership skill. Generation Y nurses enjoy being included in the decisions that are made. They also desire leadership training that will develop their conflict management, decision-making and problem-solving ability. The IOM (2011: 234) refers to the need for a new culture in healthcare working environments which supports clinical leaders, and where all interdisciplinary team members hold one another accountable for the success of the team’s outputs. As nurse leaders who are equal partners in the healthcare team, nurses must be competent at conflict resolution as well as have the ability to negotiate and communicate effectively. The younger generations enjoy making decisions and prefer shared decision-making (Woodward, Vongswasdi and More 2015: 44). This finding is not

surprising because they have become accustomed to being included in decision-making while growing up (Holt, Marques and Way 2012: 82). However, one research study on Generation Y revealed that although this group of individuals enjoy problem-solving, they lack effective problem-solving skills (Medyanik 2016: 91). Holland (2015b: 8) highlights the importance of engaging with team members when making decisions regarding patient care or the functioning of the ward to ensure that the culture of the environment is healthy. Participants in the current study said that critical thinking is part of decision-making, as is getting input from team members in the ward before taking a decision. In nursing, decisions are often ethical in nature. The IOM (2011: 479) recommends that future nursing education should include critical thinking skills, in order to advance the nursing profession.

Conflict management is seen as a crucial training topic for all nurses (Erdenk and Altuntaş 2017: 366). This finding is consistent with the findings of a study by Salahuddin (2010: 3) that Generation Y individuals lack experience when it comes to managing difficult situations. Conflict is regarded as an unavoidable issue that arises from time to time within nursing teams. Although training in positive conflict resolution is important, conflict situations will still arise due to interpersonal relationships of team members and poor leadership. New staff members need to be supported and engaged in order to establish positive and healthy working environments where mutual respect is the norm. This can only be achieved if there is effective leadership, a nurturing culture and good communication (McKibben 2017: Para. 1 line 8). Future leadership development should include this as a strategic approach to establishing and maintaining a positive working environment where optimal patient care can take place.

A finding of the current study was that Generation Y nurses believe that their leadership skills were enhanced when doing a public presentation. Some mentioned that they lacked confidence in public speaking, and that their English proficiency was poor which affected their self-confidence. English proficiency is the ability to read, write, speak and listen with understanding (Doley 2010: 1807). To be proficient enough to take instruction in English

takes between five to seven years whereas fluency in conversational English only takes about two years (Abedi and Gandara 2006; Stephen, Welman and Jordaan 2004). It is common for a group of people to converse in their mother tongue when they share a home language other than English, (Njobe 2007: 28). This naturally reduces the opportunity to practice English, thus impeding proficiency. Some of the study participants had only been working in the hospital for a short while, indicating that their use of English may not have been frequent. The hospital in which the study took place is an English medium hospital, and the majority of the non-nursing hospital staff are Arabic-speaking. The researcher also observed while working in the hospital that many of the Saudi staff have a poor command of English and seldom speak English, even during meetings in the presence of non-Arabic speaking staff. This appeared to be because their command of English was poor, but even those who were fluent often chose not to speak English which made it very difficult for non-Arabic speaking staff to follow what was being said in meetings. This further challenges communication and it is no surprise that Filipino nurses lack confidence in speaking English in this setting.

The IOM consensus report (2011: 587) found that nurses in the USA, for whom English is a second language, consistently complain that they are perceived to be incompetent by patients and other healthcare providers. They believe this is related to their lack of proficiency in English. It is claimed that English language proficiency has been cited as the most critical skill for foreign nurses who have migrated to work in the USA (Davis and Kritek 2005 cited in IOM 2011: 587). Hartman and McCambridge (2011: 22) found that although Generation Y university students have been described as technology experts, their communication skills are lacking insofar as verbal, written and interpersonal skills is concerned.

Considering that the participants in the current study were Filipino, a suggestion is that diverse learning styles should be adopted to include multicultural elements when educating Filipino nurses. This approach yields better academic performance at all levels (Dunn and Griggs 1995: 40). These factors should also be taken into consideration when providing leadership

training. Another study adds that teaching strategies must match the goal, for example when attempting to develop transformative leaders, faculty must use transformative teaching strategies, especially when the content includes complex issues such as diversity (Young, Mountford and Skrla 2006: 264).

In the current study, the importance of receiving support and feedback was mentioned by a number of the participants. It has been claimed that Generation Y individuals value feedback and this finding is consistent with data collected during the literature review. A big part of mentoring is providing feedback to the mentee (Gomel 2015: 86), and Generation Y desire this feedback to be immediate and regular (Holt, Marques and Way 2012: 82; Kuhl 2014: 29; Lavoie-Tremblay et al. 2010: 4; Martin 2005 cited in Hess 2012: 43; Medyanik 2016: 22; Tolbize 2008: 8), within a healthy relationship with their manager because they value their guidance and encouragement (D'Netto 2012: 6). In fact, Generation Y people are dependent on feedback (O'Reilly 2012: 10). Specific, constructive feedback, both positive and negative, is essential to the retention and motivation of Generation Y employees (Holt, Marques and Way 2012: 91; Shih and Allen 2007 cited in D'Netto 2012: 5). The Generation Y cohort experienced over-protective parents who encouraged them and guided them intensely (Schullery 2013: 253), to the point sometimes of impeding their sense of responsibility and independence (Alexander and Sysko 2012: 64). The feedback they yearn for is much like that received from their parents while growing up (Dupont 2014: 75). An Australian study found that instead of trusting their own judgement, they expect continual feedback not only from their friends and families, but from their employers too (Crumpacker and Crumpacker 2007 cited in D'Netto 2012: 2). Through this relationship, the responsibility for coaching and mentoring Generation Y falls on the shoulders of the managers, who develop these young employees for taking on future leadership roles (Ferri-Reed 2012: 18; Medyanik 2016: iii).

7.5.4.2 Sub-theme 4.2: Future expectations to develop leadership

According to the World Bank (2011: 6) there is a significant demand for leadership training that is appropriately timed and relevant to those for whom it applies. Klann (2007: 4) argues that good leadership is a rare and precious commodity and as such it has the potential to become the most valuable resource in an organisation. Lapeña et al. (2017: 66) advises leaders to drive the organisation's response to the needs of the workforce. Organisations nowadays are facing increasing challenges, but there is no need to despair because great leaders can be developed (Klann 2007: 4). Generation Y nurses themselves have expressed their need for continuous training and updates (Lavoie-Tremblay et al. 2010: 5). This need should be taken seriously, since besides increasing work performance, training could encourage this cohort to be more loyal and perform even better (Solnet, Kralj and Kandampully 2012: 44). Holland (2015b: 8) agrees that attention must focus on leadership development, education and training and retention of the nursing workforce, so that talented nurses are retained and become experts. With the reputation Generation Y workers have with regard to job-hopping, organisations who invest in leadership development will need to include individual career planning in their development, because unless they retain this cohort, they will likely be left with leadership gaps.

With reference to the unique leadership needs of Generation Y, a Malaysian study by Cheng, Filzah and Warangkana (2015: 41) tries to remedy what D'Netto (2012: 1) refers to as a lack of research on effective methods to manage Generation Y, by suggesting a modern-day leadership programme that includes relationship development, teamwork and self-awareness. This suggestion is congruent with the findings of the current study. All healthcare professionals should be educated in inter-professional teamwork so as to enhance collaboration in the context of patient-centred care (IOM 2003: para. 3 line 2). Exposure to leadership education should begin early, because as stated by the IOM (2011: 227), not all nurses begin their nursing career with thoughts of becoming a leader.

The participants in the current study expressed a desire to try something new at work. Generation Y do not want to be bored (D'Netto 2012: 2), and apparently it does not take much for them to reach a state of boredom (Arhin and Cormier 2007 cited in Lavoie-Tremblay et al. 2010: 4). This generation craves stimulation (Woodward, Vongswasdi and More 2015: 42) and they like to be challenged (Alexander and Sysko 2013: 130; Cheng, Filzah and Warangkana 2015: 39; Chung and Fitzsimons 2013: 1176; Lavoie-Tremblay et al. 2010: 5). They enjoy diversity and new challenges that help them attain their potential and they perform at their best when their unique talents are identified and matched to the job (Martin and Tulgan 2006 cited in D'Netto 2012: 2). Generation Y should be assigned challenging tasks in order for them to showcase their technological expertise, even if it comes with the possibility of failure (Ferri-Reed 2012: 18). It is interesting to read that as far back as the 1950s and 1960s, Frederick Herzberg, the clinical psychologist known for his work on motivation theory, found that what satisfies employees is not the opposite of what dissatisfies them. Rather, employees are satisfied by intrinsic factors such as doing interesting, challenging work and being given increased responsibility, which feeds their innate need for growth and success (Herzberg 1968: 7).

The leadership development ideas identified by the participants in the current study (see 6.5.4.1) are supported by other researchers. Klann (2007: 74) describes a variety of professional experiences that could be instrumental in cultivating leadership behaviours, for example leading a particular project, being a member of a task force, committee or team or serving in an acting position. Generation Y also enjoy visual learning through game-based approaches (Prensky 2001 cited in Hess 2012: 35).

As explained in Section 6.8.1 a number of Generation Y nurses who participated in the study mentioned experiences they felt developed their leadership skills including being involved in meaningful and interesting activities such as projects, developing policies and processes, being a member of a committee and attending meetings and providing feedback to others. Some mentioned how participating in team-building games had

developed their leadership ability, as did taking on a temporary or rotational leadership role such as acting shift leader. Attending a preceptorship course and precepting new staff on their ward had boosted their confidence in leading others. As a result of the findings of the current study that Generation Y nurses like to be challenged at work, a possible strategy would be to offer interesting assignments to them, in order to keep them engaged and motivated. Gander, Proyer and Ruch (2016: 11) who did a study on positive psychology agree with the findings of the current study. Keeping staff engaged in the business results in staff satisfaction. Supervisors can allow this cohort of nurses to work on different assignments to allow them to bring new and fresh ideas to the organisation (Meier and Crocker 2010 cited in D'Netto 2012: 3).

Direct superiors should fulfil the ambitious and performance-driven streak of Generation Y individuals by setting challenges for them (Cheng, Filzah and Warangkana 2015: 39; Holt, Marques and Way 2012: 82). When it comes to leadership character-building, Klann (2007: 68) suggests giving Generation Y assignments that stretch them out of their comfort zone in order to accelerate their growth. Ed Zander, chairperson and Chief Executive Officer of Motorola, supports the idea of setting challenging assignments to develop leadership. He speaks of applying originality by moving junior leaders and others around. He sees this as crucial to organisational success, because it allows different employees to collaborate with one another, which allows novel ideas to emanate, take form, and be shared (Zander 2005 cited in Klann 2007: 74).

Erroneous assumptions result in nurses not being considered knowledgeable, educated, experienced or critical thinkers, who can make independent decisions (Porter-O'Grady 2011: 35). This notion is supported in an American study which reports that nursing leaders need to devise competencies for nurses in the field of EBP where it affects patient care in clinical settings (Porter-O'Grady 2011: 37). EBP can be used to enhance professional practice (Roberts 2016: 94) but it could also be used to create leadership programmes as a means to develop staff at all levels of the organisation (Koloroutis 2004). The 21st century is an information age, where nursing leadership will have a

profound impact on the advancement of the profession. Research into the science of nursing has increased significantly, and has been translated into practice, through reliable evidence that improves the clinical art of nursing.

Section 6.8.2 discussed the finding that Generation Y nurses in the current study value a clear career path. In the interviews the participants expressed a desire for leadership education and training that includes career planning, although the leadership survey results found that the majority of Generation Y nurses considered themselves to be competent at career planning. This contradiction may simply be that they over-reported their competence in the survey, which further justifies the mixed methods design to get a deeper understanding of their perceptions through the interviews which followed the survey. In the interviews, the participants articulated their need for education on how to develop a career plan because they value clear and individualised career direction (D'Netto 2012: 4; Lavoie-Tremblay et al. 2010: 7).

Education on how to develop a career plan will help to keep Generation Y in the organisation as well as motivate them to grow. As a potential leader, having career direction can enhance their leadership ability and increase their confidence in their field of choice. Succession planning is also a much-needed strategy in ensuring a workforce that is well prepared for any eventuality (Holmes 2017: 88; Trepanier and Crenshaw 2013: 980), in which is very appropriate in healthcare organisations. Succession planning is a process which brings about continuity of services within organisations, and facilitates talent management, retention of knowledge and skills and development through experiences. Marbury and Mayer (2013: 58) point out that succession planning is a future investment in leadership development and that it should not only be aimed higher up the workforce ladder, but at the bottom rungs too. Growing leaders from within hospitals will ensure that a pool of successors is readily available. Having a formal succession plan for nursing departments will remedy the deficit in nurses' ability to position themselves within the organisation. Knowing their future plans and those of the nursing department will give them a clear picture of their future opportunities.

Participants were of the opinion that self-development would enhance their ability to be effective leaders. These skills included knowing yourself, self-reflection, managing emotions, building self-confidence, self-improvement and performance improvement. Some Generation Y nurses in the current study reported that they lacked confidence or had low self-esteem, and that a leader needed to have confidence. This finding was surprising in light of the fact that other authors believe this generation to have high self-esteem (D'Netto 2012: 2; Thompson 2015: 33). This discrepancy could be attributed to the fact that the participants in the current study were Filipino, now in a foreign country with an extremely different culture to their own or that of the western world. In addition, the fact that they are practising their profession in English which is not their home language could also reduce their self-confidence (Almalki, FitzGerald and Clark 2011: 309). In Saudi hospitals, interpreters only translate from Arabic to English between the patient and the nurse/physician (Almutairi and McCarthy 2012: 74). These authors believe that the language barrier could be an obstacle to optimising health care provision for Saudi people because most of the nurses are expatriates who do not speak Arabic. The fact that the Generation Y nurses in this study felt they lacked confidence is an important finding, because Filipino nurses from Generation Y have infiltrated the healthcare sector globally. Leadership development should be adapted to suit Filipino nurses' unique needs and this will help raise their self-esteem.

All countries should approach transforming healthcare as part of a global strategy. The Philippines trains more nurses than they can employ, as part of a 'global production' scheme (IOM 2011: 590). Since most countries around the world employ Filipino nurses, the intellectual capital of the nurses should be expanded, for the economic benefit of the countries they migrate to as well as the country they came from. Nurses that come from the Philippines are helping to address nursing shortages in other countries; therefore their education and competence is of great importance to countries which import nurses. Energy and capital should be invested in their development as practitioner leaders, even if they might move on for better opportunities than they are able to get in their home country. Their development will also benefit

the Philippines, because many Filipino nurses will return to work in their home country at some point.

Because the 21st century is technology-driven (Manson 2014:139), with Generation Y being technologically connected from birth (Dupont 2014: 75), future leadership will become more technology efficient. The influence of technology is changing leadership (Medyanik 2016: 3), and therefore building skills through working with technology is a good idea (Hulett, 2006 cited in D'Netto 2012: 3).

The literature agrees that Generation Y are experts in the field of technology (Alexander and Sysko 2012: 64; Holt, Marques and Way 2012: 82; Lavoie-Tremblay et al. 2010: 4; Tulgan 2009: 9; Weston 2006: 27). Generation Y were influenced by the technology revolution (Thompson 2015: iv) and grew up with technology (Kuhl 2014: 26). They were 'technology-born'; they did not know a time without the internet and text messaging. They have always had access to information at their fingertips (Lavoie-Tremblay et al. 2010: 4) and are instinctively able to gather information faster than individuals from older generations. This is supported by a study that finds that Generation Y relies heavily on technology, and organisations should embrace this by supporting innovation and technology (Gomel 2015: 83).

Generation Y are known to be innovative and creative individuals (Cheng, Filzah and Warangkana 2015: 39; Gomel 2015: 83). Creativity is defined as the thought behind the innovative action (Holt, Marques and Way 2012: 90); because Generation Y are both creative and innovative they thrive on new challenges which feeds their desire for job satisfaction (Cheng, Filzah and Warangkana 2015: 39). Because Generation Y are the emerging leaders they will fashion an environment of anticipation and creativity which will put a new spin on problem-solving. Koloroutis (2004: 80) agrees that new leaders help to foster a creative environment, and through this, possible solutions can be put into action. Generation Y like to make a positive contribution to the organisation and they want their ideas to be heard. They prefer a working

culture that promotes creativity and organisations that value their time and effort (Gomel 2015: 83).

The study revealed that Generation Y nurses form a significant component of the new nursing era which is steeped in creativity and technology. This is not a new revelation; it is well known that Generation Y like to be creative, challenged and innovative (Cheng, Filzah and Warangkana 2015: 39; Chung and Fitzsimons 2013: 1173; Holt, Marques and Way 2012: 91; Ramirez 2012: 3). In healthcare organisations, Generation Y should be encouraged to establish innovative practices in order to transform healthcare (Booth, Strudwick and Fraser 2017: 138). This is supported by Porter-O'Grady (2011: 37) who states that all levels of nursing leadership should be permeated with innovation as a means of contributing to healthcare reform in the USA. In fact, the older generations should encourage novice nurses to mentor them in technology, since their technology skills are less developed than those of Generation Y (Moore, Everly and Bauer 2016: Para. 21 line 6).

An innovative way of building skills is through simulation, as suggested by a participant in the study. This approach meets the needs of Generation Y because of their interest in new and innovative ways of learning. Generation Y enjoy learning through simulation probably because they are visual learners, and they are motivated to learn when trained through simulation (Skiba 2008: 174). IOM (2011: 472) recommends including simulation as a teaching strategy in future nursing education. Simulation has proven to be an effective learning approach which can translate theory into practice within a safe and realistic environment, regardless of the level of prior experience. In simulation, learning can be enhanced through the process of reflective practice and by using videography to enhance the results (Flanagan, Nestel and Joseph 2004: 56). Simulation is considered a learning method through 'teaching with technology'. This method was supported by a study on interdisciplinary, collaborative simulation where nurses and physicians were taught simultaneously, which is not the norm (McCallin cited in Reese, Jeffries and Engum 2010: 33). Simulation as a learning method allows for reflection and

feedback, and growth in self-confidence (Reese, Jeffries and Engum 2010: 33), important according to the findings of the current study.

The present study revealed that Generation Y nurses suggest combining learning and sharing in a creative and fun way, as opposed to the traditional methods at school. Generation Y enjoys an element of fun in the workplace (D'Netto 2012: 3; Lester et al. 2012: 348; Tew, Michel and Allen 2014: 923). They desire creative organisations, which can be explained by their enjoyment of work that is unique, interesting, fun and challenging (Gomel 2015: 83). This is further supported by a study that reveals they like humour, silliness and even impudence at work (Holt, Marques and Way 2012: 92). Another study that took place in the hospitality industry found that promoting fun at work for Generation Y employees results in positive attitudes, increased teamwork, job satisfaction and optimal job performance (Choi, Kwon and Kim 2013: 410).

Studies about this generation have found that humour is an important aspect of the work culture which enables the ideas and knowledge of Generation Y to flow freely. This work culture enables interpersonal relationships to thrive, which in turn increases staff performance (Romerot and Cruthirds 2006 cited in Choi, Kwon and Kim 2013: 421). A number of simple things that could contribute to this, such as casual dress days and company-provided food and refreshments (Karl et al. 2005 cited in D'Netto 2012: 3), as well as inclusion of non-work-related interests into the job through sponsoring sporting activities or getting involved in volunteer work (Hulett 2006 cited in D'Netto 2012: 3). Porter-O'Grady (2011: 35) suggests that when fun is incorporated into leadership this provides opportunities for innovation across all levels of nursing. McDonald (2008 cited in Savage 2012: 27) suggests that this generation values a nurturing work experience that incorporates fun and informality. However, Goleman (1998b: 249) cautions that entertainment should never be valued over education. Having fun does not guarantee excellence; this should be considered when applying rigour to the evaluation of training programmes.

When the findings of this study's qualitative and quantitative data were compared, the virtue 'Humour' was located within the top 10 strengths of Generation Y nurses, which was further confirmed by the consistency shown during the interviews. Humour as a virtue refers to being playful and finding time to enjoy oneself through folly, laughing, teasing or joking. People who are fun-loving bring smiles to people's faces through making (but not necessarily telling) jokes. They are often positive in their outlook and tend to see the brighter or lighter side of situations (VIA Institute on Character 2018: Para. 6 line 8).

The desire of Generation Y nurses to grow professionally, their expectation of a close relationship with their manager, and the value of developing the character of a leader has been discussed previously in Section 6.5.1. The leader's character is important to their leadership effectiveness (Wright and Huang 2008: 981) and feedback is an effective approach to building the character of a leader (Klann 2007: 20). From the early stages of their career, Generation Y nurses need help with their personal and professional development (Cheng, Filzah and Warangkana 2015: 39; Lavoie-Tremblay et al. 2010: 5), and they expect their managers to provide this help.

Because they treasure a close, friendly and supportive relationship with their manager (Gomel 2015: 86), this need for development goes hand-in-hand with the development approach of participative mentoring and coaching, which is critical to their development and retention (Holt, Marques and Way 2012: 92) and an important strategy to develop the expertise of Generation Y individuals (Baker 2009 cited in D'Netto 2012: 5). One-on-one coaching is considered an effective approach to developing Generation Y individuals (Lyon, Filmer and McDougall 2010: 25; D'Netto 2012: 4; Douglas et al. 2015: 12; Hendricks and Cope 2012: 722; Kuhl 2014: 28).

Mentoring is defined as a developmental relationship where a senior person provides coaching, guidance and emotional support to their protégé in order to contribute to their personal and professional growth (Northouse 2004: 280). In organisations today, work environments are increasingly varied and success

depends on the quality of the relationship between the manager and the subordinate (Lester et al. 2012: 352). This type of relationship is referred to as a coaching relationship, which is related to strengths-based coaching (MacKie 2014: 118) and should happen over an extended time (Lavoie-Tremblay et al. 2010: 6). It is interesting that Generation Y individuals want to sit down and talk with their mentors, because although this generation are drawn to technology and generally prefer electronic communication, when it comes to discussions with their supervisors about their future career planning, they prefer traditional methods of face-to-face communication (Holt, Marques and Way 2012: 89; PWC 2013: 9).

7.6 SUMMARY OF THE CHAPTER

This chapter presented a discussion of the findings from data on the perceptions of Generation Y Filipino nurses at a hospital in Saudi Arabia. The researcher's interpretation of the data contributes to the existing literature presented in Chapter 2 and makes recommendations for future research which appear in Chapter 9. The discussion satisfied the first three objectives of the study, which were to determine the strengths with which Generation Y nurses enter the workforce, to determine the leadership skills of Generation Y practitioner nurses, and to identify skills that are likely to prepare Generation Y nurses in the workplace. The RBC theoretical framework was used to present the discussion. The next chapter will present the proposed leadership framework that was created based on the findings of the study.

CHAPTER 8: A LEADERSHIP FRAMEWORK FOR PRACTITIONER NURSES

8.1 INTRODUCTION

The aim of the study was to explore the needs of Generation Y practitioner nurses who care for patients at the bedside, and to develop a framework to develop their leadership potential. This mixed methods study addresses the global leadership crisis in healthcare. Because Generation Y nurses will form 75% of the nursing workforce by 2030, their leadership ability will impact on healthcare worldwide. The proposed framework is based on the findings of the study which were presented in Chapter 6 and discussed in Chapter 7.

The proposed leadership framework presented in this chapter responds to the main mixed research question: “How can the nursing profession prepare Generation Y nurses to become effective leaders?”. This accomplishes study Objective 4: To develop a sustainable framework for practitioner leadership skills, to prepare nurses for the future workforce.

8.2 PHASE 3 OF THE STUDY

Phase 1 (concurrent) and Phase 2 (sequential) of the study were detailed in Chapter 4. Using mixed methods to investigate the research topic, and gathering three sets of diverse data from the target population, was an ideal approach in terms of designing a framework for practitioner nurses to facilitate their development as leaders in challenging times.

Phases 1 and 2 achieved the aim of the study through the following:

- The research problem was addressed;
- The main mixed research question was answered through the findings that addressed the other three research questions;
- The gaps in the available literature were addressed.

The study objectives were to:

- Determine strengths with which Generation Y nurses enter the workforce.
- Determine the leadership skills of Generation Y practitioner nurses.
- Identify skills that are likely to prepare Generation Y nurses in the workplace.
- Develop a sustainable framework for practitioner leadership skills, to prepare nurses for the future workforce.

Through meeting the first three objectives, the results of the study enabled the meeting of the fourth and final objective: to develop a framework for practitioner leadership skills, to prepare nurses for the future workforce.

This objective was aligned with the aim of the study which was the development of a framework which would incorporate the knowledge, skills and abilities required by Generation Y nurses, to ensure that they are adequately prepared to fulfil their potential as leaders in nursing. The triangulation, interpretation and synthesis of the different sets of data led to the development of the framework presented below.

8.3 CONCEPTS USED TO DEVELOP THE FRAMEWORK

The personal pragmatic worldview of the researcher and the belief in developing people through relationships contributed to the development of the framework. This worldview and belief led to the topic of research, the theoretical framework and the related study methods. When developing the leadership framework, the researcher incorporated a variety of data, which will now be discussed.

8.3.1 The theoretical framework

The RBC model was used as a theoretical framework throughout the study. It helped identify the study problem, aim and significance. It was used when developing the research questions, which are closely aligned and carefully

intertwined in order to serve as the foundation to guide the research design and data analysis. It was also used when structuring the literature review and selecting a study design. In addition, four of the RBC domains formed the themes for the qualitative analysis and presentation of results.

8.3.2 The strengths survey

Data from the strengths survey revealed Generation Y nurses' ranking of the 24 character strengths, and calculated patterns in how these were ranked (highest/lowest) by the cohort. The significant findings contributed to the design of the framework, in that they were incorporated into the domains.

8.3.3 The leadership survey

Data from the leadership survey regarding 'the leader within' revealed the self-rated competency level of Generation Y nurses with regards to personal and professional accountability, career planning and personal journey disciplines. The findings of these competencies were incorporated into the development needs which are reflected in the framework.

8.3.4 The semi-structured interview

Data from the face-to-face interviews identified the leadership perceptions and development needs of Generation Y staff nurses who are practitioners at the bedside. The findings were revealed through eight sub-themes that emerged from the interview data. These themes were intertwined in the proposed framework.

8.4 DEVELOPING THE FRAMEWORK

The three strands of the data collected in Phases 1 and 2 of the study were utilised. The merged sequential data from Phase 2 was triangulated with the concurrent data collected during Phase 1, so that the researcher could interpret the findings. The integrated findings formed the foundation for the development of the leadership framework. The findings have revealed many

perceptions regarding the development needs of this cohort of nurses, including evidence that they believe they have leadership ability and are keen to reach their leadership potential. The participants indicated areas that are lacking in their development as nurses who do not hold formal leadership positions, and various approaches and suggestions of ways to address these deficits were highlighted.

Once the significant results from the three sets of data were interpreted, significant elements were considered for inclusion in the framework. When merging the data, any relationships that emerged between the quantitative and qualitative data were used towards developing the leadership framework, to ensure it was appropriate for this cohort of nurses. Six domains arose from the significant results after statistical quantitative analysis and thematic qualitative analysis.

Once the framework had been developed, the researcher and supervisors sent a copy to eight experienced nurse leaders. Two clinical leaders and two academic leaders responded. Their recommendations were considered and incorporated into the leadership framework.

8.5 A PROPOSED LEADERSHIP FRAMEWORK

Leadership is the pivotal element of healthcare success, because its aim is to meet the expectations of the people it serves. Leadership resides in the next generation of leaders, who are shaped by a clear definition of leadership, and regular processes for the assessment and development of future leaders. Nurses are an integral part of any healthcare team, especially as frontline nurses, where they should be actively and respectfully involved in all decisions in order to fully embrace the term ‘shared decision-making’. Nursing leadership requires the ongoing development of nurses in order to reach the overarching aim of ensuring safe and high-quality patient care. In addition to needing to be confident and competent, future leaders need to experience job satisfaction, because they are on a clearly-defined journey towards reaching their full potential, and this will result in the provision of excellent care.

The sustainability of the framework is established because it is not limited to once-off leadership development; it is intended to form part of a process that can be expounded upon as the personal and professional growth of each nurse unfolds. Sustaining anything takes will, energy and discipline. The leadership framework is intended for nurses to use interdependently (with their supervisors' guidance), to gauge progress and identify any obstacles that may be hindering. The supervisor should provide feedback on leadership performance regularly. Figure 8.2 provides an illustration of the proposed leadership framework, comprising six core domains.

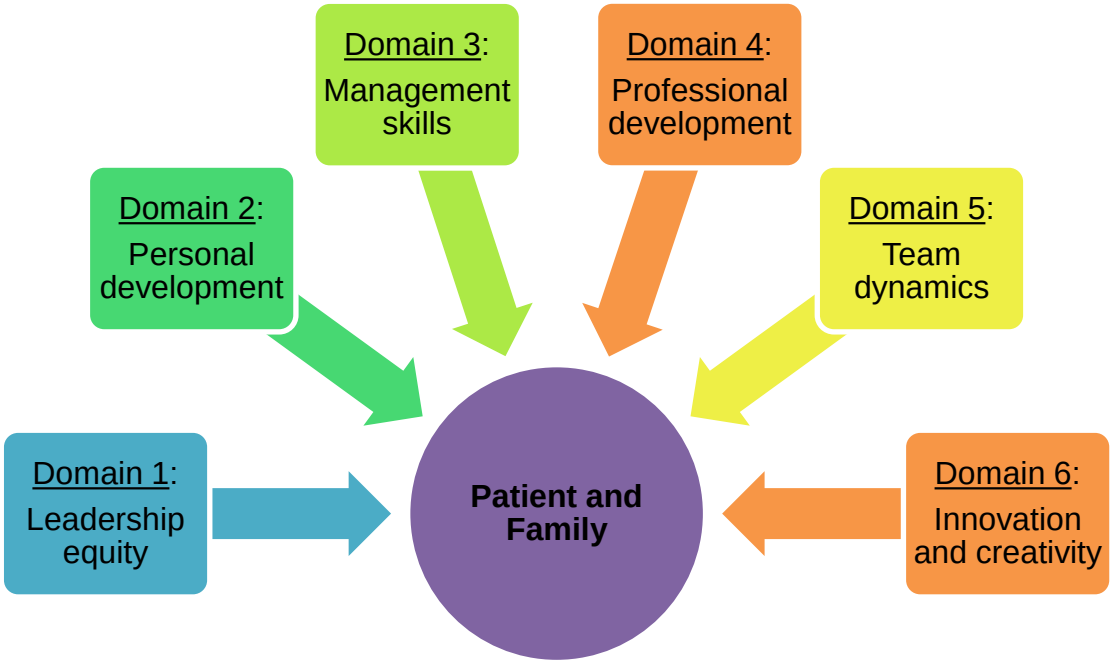

Figure 8.1: Proposed leadership framework for practitioner nurses

8.5.1 The design of the framework

Central to the framework is the 'patient and family'. The patient includes all individuals, from the public as well as within the organisation, who seek and receive healthcare from the organisation, be it primary, secondary or tertiary healthcare. The six core domains, in no particular order, encompass concepts of leadership competency and personal growth.

8.5.2 The domains

8.5.2.1 Domain 1: Leadership equity

- **Leadership exposure**: Every staff nurse should be afforded equal opportunity to practice leadership skills. This can be achieved through many avenues such as rotation of leadership roles, scheduling shift leader roles or rotating as committee members.
- **Leadership education**: Training in the form of a workshop or 'boot camp' day away from the clinical setting, or even over a weekend. Global video conferencing is a good way to grow leaders, where sessions are held once a week with small groups of nurses. Nurses should be encouraged to undertake online leadership courses and attend leadership conferences to create an interest in the art of leadership.
- **Preceptor training**: Each nurse should be trained as a preceptor, as this is a good initiation into taking on a leadership role.
- **Public speaking**: Teaching or sharing knowledge is an excellent way to develop confidence in public speaking and confidence in imparting skills to colleagues. In healthcare there are many committees that require nursing representation, where nurses can gain confidence in speaking to an audience.

8.5.2.2 Domain 2: Personal development

- **Strengths awareness**: All nurses should complete a strengths survey as part of their orientation on entrance to the nursing department, as a way of becoming self-aware.
- **Coaching**: The strengths of each nurse should be on the agenda of one-on-one coaching sessions with their immediate supervisor. They should discuss how to maximise performance through using these strengths and how to use them to promote character-building. This will develop skills in self-regulation and emotional management.
- **Reflective practice**: Encourage the use of reflective practice, such as keeping a daily diary, to improve outcomes and learn from previous

experience. Reflective practice can be used to debrief as well as during coaching or bi-annual performance reviews.

- **Personal development plan**: Included in the bi-annual individual personal development plan should be at least one personal goal, even if non-nursing related. A nurse is more than his/her profession. It is important for nurses to be developed holistically. When supervisors know their staff well, they can better facilitate their all-round development.

8.5.2.3 Domain 3: Management skills

- **Strategic skills**: Every nurse at every level must know the vision, mission and values of the organisation and the nursing department. They must feel part of the team in achieving common goals.
- **Management skills**: Skills such as dealing with difficult people, conflict management, time management, decision-making, and problem-solving. These skills can be taught through action learning and simulations.
- **Communication skills**: Healthcare environments are tumultuous and unpredictable and thus require excellent communication skills. The ability to communicate well is critical for any leader, and this includes the vitally important skill of listening.
- **Change management**: Change is constantly happening in healthcare, necessitating leaders to be not only competent at managing change, but optimistically leading the change. Remaining positive amidst resistance to change is a not easy, but effective leaders need to practice and hone this skill.

8.5.2.4 Domain 4: Professional development

- **Professional development plan**: Each nurse must devise an individual plan with professional actionable goals. These goals must enhance flexibility and resilience in the ever-changing environment of healthcare. These action plans must accompany the professional plan,

and these must be used at the bi-annual evaluation to assess developments and address any obstacles hindering progress.

- **Career planning**: Facilitate individual career planning which includes role identification and future career planning. Position each nurse on the career ladder algorithm to plan their future, and on the succession plan to ensure equity.
- **Accountability development**: Encourage development of personal and professional accountability, which includes ethical behaviour and involvement in professional associations and partnerships, to ensure continual professional growth.
- **Feedback**: Direct supervisors must give regular and immediate feedback on performance and ensure debriefing as required.

8.5.2.5 Domain 5: Team dynamics

- **Fun**: Ensure fun is included in the workplace. An element of light-heartedness must be structured into the strategies for the nursing department. This could be in the form of a celebration in honour of Nurses' Day, celebrating achievements, competitions or prize-giving ceremonies.
- **Team-building**: Use games to develop the ability of nurses to work with others and to get to know each other, in order to enhance working relationships.
- **Interdisciplinary training**: Arrange formal simulation activities with members from all disciplines involved in providing services, in order to promote collaboration and shared decision-making. This will also develop the perception of equal importance of each member of the multidisciplinary team.

8.5.2.6 Domain 6: Innovation and creativity

- **Clinical practice**: Encourage innovation and change in order to improve the patient experience, for example: develop an innovative strategy to reduce a lengthy process such as waiting times for patients.

Introduce a ‘creativity and innovation’ category award for a nurse who has proposed a new idea.

- **Creative thinking**: Involve nurses in community-based, hospital-wide or unit-based projects that allow them to express their creativity and enhance global intelligence.
- **Technology**: Introduce technology into all aspects of the nursing profession, be it clinical practice or education, in order to allow the technology-wise nurses to apply the skills with which they are comfortable and expert.
- **Learning and sharing**: Incorporate innovative contemporary approaches to professional skill development, for example: simulations and online modules.

8.6 IMPLEMENTATION OF THE PROPOSED FRAMEWORK

Leadership development should begin as soon as possible after a nurse qualifies and commences work in a healthcare organisation. The notion that everyone is a leader means that fairness (equal opportunity) should be applied. The opportunity to be exposed to leadership roles should be afforded each nurse, through the guidance of the proposed framework. This framework was not developed for single use; the researcher intends that it form part of the central foundation to guide professional development training for young nurses, but could be implemented in the development of nurses at all levels. Nursing education, whether pre- or post-graduate should be aligned with the principles of the leadership framework.

8.7 VALIDATION OF THE PROPOSED FRAMEWORK

This leadership framework is proposed as being appropriate for the development of Generation Y practitioner nurses, and as such has not yet been validated. It is recommended that the framework be piloted so that adjustments can be made if necessary, because the measurement of success will be important in establishing its effectiveness.

8.8 SUMMARY OF THE CHAPTER

The results of both the quantitative and qualitative phases of the study and their integration, as well as the theoretical framework selected for this study, led to the accomplishment of Phase 3 in the study. The aim of the chapter was to produce a leadership framework that sheds light on the leadership development needs of Generation Y nurses, as expressed by them through the results of the data which was collected. The primary activity required of all hospital leaders, managers and staff is to ensure that they continue to develop the younger generation of nurses working in their midst, through the application of the proposed leadership framework. The framework is expected to contribute to the much-needed transformation of healthcare across the world. Conclusions and limitations of the study will be discussed in the next chapter, as well as recommendations for application, further research opportunities and potential outputs.

CHAPTER 9: LIMITATIONS, CONCLUSIONS, RECOMMENDATIONS AND POTENTIAL OUTPUTS

9.1 INTRODUCTION

The research aim was to develop a sustainable, structured, Generation Y appropriate leadership framework for practitioner nurses, incorporating the knowledge, skills and abilities required so that nurses are adequately prepared to fulfil informal leadership roles as the need arises. This framework will also prepare a second line of leadership defence to build a solid resilience for the uncertainty of future healthcare challenges. This chapter summarises the limitations, conclusions, potential outputs and recommendations that arise from the study.

9.2 LIMITATIONS OF THE STUDY

The researcher acknowledges that the study was not exempt from limitations. Firstly, the sample size for the strengths survey was marginally less than the minimum requirement, reducing the confidence level when projecting the results to others. However the saturation of data supports the noteworthiness of the findings, and the findings were significant enough to assume that even if more surveys were included, they may have made little difference.

It is acknowledged that the scope of the study was limited to one nationality; however previous literature reveals that a significant number of Filipino nurses are working in most countries around the world, especially those countries considered to be LMIC. This implies that the findings would be useful to other countries as well, and to nurses who are subject to the leadership crisis in healthcare. Data was collected on Filipino nurses, from a LMIC who were working in Saudi Arabia, which is also a LMIC. This in itself could be seen as limiting, however the findings could well be applied to other developing countries who have nurses with similar backgrounds and ethnicity.

Reflecting on what the researcher could have done differently in the study, the first thought is that the study could perhaps have included other ethnic groups working in other hospitals in Saudi Arabia. Secondly, it may have been easier for the researcher to apply one of the simpler basic mixed methods designs offered by those researchers considered experts in the field. However, a basic design may not have elicited such significant and diverse findings as did the multistage design utilised in the study. Thirdly, the leadership skill competence tool utilised was not scientifically validated, but the researcher could not find a more suitable tool in the available literature. The researcher could have applied the basic sequential mixed methods design to develop a more suitable tool, but this would have extended the study timeline. The findings of this study could well inform the development of a more suitable instrument for future use.

9.3 CONCLUSIONS DRAWN FROM THE STUDY

This study has generated new information about the leadership development of Generation Y nurses. The empirical evidence of this study suggests significant leadership needs of Generation Y nurses in a hospital setting, which validates the generational construct as a worthwhile and important concept in leadership development. Both the empirical evidence and the generational construct hold important implications for how today's youngest generation in the nursing workforce are uniquely experiencing and influencing nursing. In turn, it may inform nursing management and leaders interested in leveraging the needs of this generation in order to maximise their potential in leading the future of the nursing profession.

The results of this study suggest that Generation Y nurses have unique needs that must be addressed in order to ensure they practice at their full potential and as effective leaders. To begin with, it is necessary to recognise their needs and to collaboratively create an individualised development path for them.

A discussion of the key findings of the research, aligned to the study objectives, follows.

RESEARCH OBJECTIVE 1: Determine strengths with which Generation Y nurses enter the workforce.

It was found that Generation Y nurses rated the character strength '**Fairness**' highest out of 24 strengths. 'Self-regulation' was rated lowest for those nurses under the age of 28, and those with less than six years' experience. The strength 'Love of learning' was rated lowest for nurses aged between 28-35 years and those with more than six years' experience.

RESEARCH OBJECTIVE 2: Determine the leadership skills of Generation Y practitioner nurses.

Need further development in ethical behaviour and professional associations: As part of personal and professional accountability, although they perceive that they are competent at practicing ethical behaviour, a significant proportion felt slightly less confident to be involved with professional associations. Further development is required to strive for expertise in these areas.

Need a clear career plan: Generation Y want a clear career path, although a significant proportion rated themselves at least competent for both knowing their role and future at work, a significant proportion were less confident in their ability to position themselves within the organisation.

Desire leadership development through action learning and reflection: As part of their personal journey disciplines, Generation Y believe further development through action learning and reflective practice will enhance their leadership ability.

RESEARCH OBJECTIVE 3: Identify skills that are likely to prepare Generation Y nurses in the workplace.

Significant findings for the qualitative data were that Generation Y nurses:

Believe that the characteristics of a leader determine leadership ability and effectiveness: Effective leaders are self-aware and get to know their

subordinates. Additionally, that leadership skills, people management skills, and public speaking will increase their self-confidence to lead.

Value collaborative teamwork, relationships and good communication: They want to be heard and to be part of decision-making. They want their leader to support them.

Believe that formal leaders influence the practice environment, which affects outcomes, harmony and positivity at work: A non-punitive environment is desirable.

Need further development to manage others: Need skills in decision-making and managing conflict.

Believe they have leadership ability; that anyone can lead and they are keen to take the lead: They want equal opportunity to practice leadership skills. They strongly believe that practitioner nurses can lead at the bedside, regardless of years of experience.

Have gained leadership experience through a number of activities such as team-building games, projects, evidence-based activities, precepting new staff, taking turns to be shift leader, being a committee member, doing presentations in front of others, as well as developing policies and processes.

Strongly desire leadership education: This must be creative, innovative, technology-driven, and fun. Education must include leadership skills to improve self-confidence, self-awareness, management of self (emotions) and others (conflict, time, critical thinking and decision-making), personal development and professional development.

Have clear leadership vision that includes their individualised career plan, equal opportunity to lead, being heard. They want to be challenged and do not want to be bored at work.

RESEARCH OBJECTIVE 4: To develop a sustainable framework for practitioner leadership skills, to prepare nurses for the future workforce. In line with the data collected using both quantitative and qualitative methods, the leadership needs of Generation Y are met through the proposed leadership framework. It was designed to develop Generation Y nurses to reach their full leadership potential.

9.4 RECOMMENDATIONS

The findings of this study must be brought to the attention of nurse educators and healthcare organisations so that appropriate strategies can be put in place to secure effective future leadership of nurses. The impact of bedside leaders should not be underestimated; they could shape the future of unaddressed healthcare outcomes. Hospitals should waste no time in developing bedside leaders as this will enhance the leadership at all levels and bring about the much-needed transformation of healthcare. In addition, the findings of this study are applicable not only to nurses, but to any organisation that has Generation Y individuals in its workforce. This study also forms a foundation to stimulate the proliferation of further research. The recommendations are made for the categories of nursing education, management and further research.

9.4.1 Nursing education

With the aim of improving leadership ability across all sectors of healthcare, leadership awareness should be a focus much earlier in the nursing career than it currently is, preferably at the inception of a nurse's career. Leadership education should hold more importance and focus during the training of student nurses, because grooming future leaders is often only initiated later in the professional career, which maybe too late. It is recommended that the study findings be considered for curriculum development, and the proposed framework could be embedded into undergraduate and postgraduate education programmes.

With regard to training for postgraduate nurses who are already qualified RNs; not only do Generation Y nurses need leadership training, but so do the older generations. It is recommended to create managers who are role models through developing a system to identify potential managers and put them through manager training and leadership development early in their tenure. Older nurses also need leadership training on how to embrace and get maximum performance out of Generation Y. They need to learn how to lead

the younger generation, to develop them into effective leaders. The proposed framework could be applied to leadership education training courses, and additionally it could also be incorporated as part of continuing professional education.

Generation Y nurses are in their first and second decade of nursing experience, which is an impressionable stage in any career. Career planning and professional development are high on the agenda of strategic Generation Y nurses. Strong mentors, formal career algorithms and dynamic leadership development education are required during this phase to get Generation Y nurses to the level needed to effectively lead the nursing profession.

Career-pathing should also be included in the student nurse curriculum, so that young nurses have a good idea of where they want to focus their professional energy. Not that this pathing is set in stone, but knowing what paths are available and of interest to the individual appeals to Generation Y nurses who like a clear route. Much like the motto of Tom-Tom, the global leader in navigation, one should always be aware of the most direct path and easily coordinate your places of interest.

The career pathway for nursing needs to be expanded for the profession to be able to advance. Current leaders need to continue to be part of generating solutions by partnering to create and expand development programmes to raise the number of nurses with postgraduate certifications. This applies to newly minted graduate nurses at entry level, those at middle level and all the way to executive level, and includes preparation of advanced practice nurses, masters and doctoral preparation. The proposed framework could be utilised as a foundation for advanced practice education in leadership for nurses.

Leadership education should include technology, which appeals to Generation Y individuals. There are now nursing positions in healthcare organisations such as IT nurses which many nurses from the Generation Y cohort would most probably find attractive. In addition, leadership development should include contemporary approaches such as e-learning, because electronic

communication is the way this cohort of people are accustomed to learning and communicating.

9.4.2 Nursing management

The young nurses working in the current nursing workforce represent the future of nursing. The researcher recommends that formal planning for their takeover as leaders is imperative to ensure the success of the healthcare system in any country, because failing to plan leadership will be a case of planning to fail for the nursing profession. The formidable task of keeping Generation Y nurses motivated rests within organisations. They are key players in the legacy which their organisations will create, and their innovative talents could set the world alight by their sheer numbers. They need to be gainfully employed while having their creativity tapped into, and they must be afforded the opportunity for personal and professional growth, including appropriate leadership development. Furthermore, in keeping with the nurturing they received from their parents, they should be offered support and frequent feedback. This will only succeed if organisations are broad-minded and look at the bigger picture. Generation Y nurses have a great deal to offer the healthcare industry; the industry should stop trying to change them, but rather be flexible to their distinctive needs, and it will be a win-win for both parties.

The formidable task of keeping Generation Y nurses motivated rests within organisations. They are key players in the legacy which their organisations will create, and their innovative talents could set the world alight by their sheer numbers. They need to be gainfully employed while having their creativity tapped into, and they must be afforded the opportunity for personal and professional growth, including appropriate leadership development. Furthermore, in keeping with the nurturing they received from their parents, they should be offered support and frequent feedback. This will only succeed if organisations are broad-minded and look at the bigger picture. Generation Y nurses have a great deal to offer the healthcare industry; the industry should

stop trying to change them, but rather be flexible to their distinctive needs, and it will be a win-win for both parties.

The future of nursing will see big strides in introducing technology in all areas, and this cohort is considered expert in technology skills. It is recommended that nursing management take these notions into consideration when setting up nursing departments, because their application will lead to Generation Y being attracted to work and stay in the hospitals they consider to be ‘most desirable hospitals to nurse at’.

Nursing management needs to be aware of the unique traits of each generation in their team. They need to accept these traits, warts and all, if they are to retain and attract talented nurses. Without adapting to the unique needs of the different generations in the team, the workplace could be the poorer for it and management will be forever frustrated. Working in a multigenerational environment requires a mind-set change to broader thinking to ensure optimal output from each individual staff member. In addition, mentoring and leadership training must be part of the daily routine in the life of a manager if organisations want to create healthy environments at work. Ongoing relationship-building must be consciously addressed between managers and nurses. Mentors need to customise a career plan for each nurse, with incentives and responsibilities aligned with their individual needs. Frequent feedback and encouragement should be scheduled.

Role model managers must be created through strategies defined by nursing departments. Firstly, all nurses should be developed leadership-wise. But as part of succession planning, hospitals must develop a system for identifying potential managers and put them through manager training and development early in their tenure. In addition, current managers should receive training on generation awareness and positive reinforcement which is in line with the needs of Generation Y individuals. Managers themselves should also develop a culture of positive feedback reinforcement, for example: sending emails of praise or thanks to those under their authority as a means of encouraging good work performance or behaviour.

It is recommended that employees take a strengths survey to identify their signature strengths. This will enable them to use their personal strengths positively when dealing with themselves and others. It will also enhance employee awareness of their personal strengths as well as those of their co-workers. Strengths-awareness within a team is also important because if leaders know the strengths of their team members, they can draw on their individual strengths in a collaborative way so as to get optimal outcomes.

Generation Y likes to see the significance and value of their work and they like to feel appreciated. If they feel that their job has a sense of purpose, they are motivated. Healthcare organisations need to be transformed in order to appeal to the younger generation. This can be achieved through investment in education and training to bring about leadership development. The style of management and the culture created within organisations will go a long way in retaining and satisfying Generation Y nurses.

9.4.3 Further research

The contribution this study makes to literature and practice suggests future research possibilities. The study makes a significant contribution to the literature in the field of mixed methods research and has extended the theory on leadership. Early patterns have emerged in the study that could be useful to build on in future research on nursing leadership. This study is possibly the first study employing a multistage design in the field of nursing. The researcher recommends that creativity in designs should not be stifled, provided threats to rigour are addressed by ensuring that the study meets the criteria that define mixed methods research.

Healthcare research, and in particular leadership research, is well suited to the application of mixed methods and as such the researcher recommends that further mixed methods research be undertaken in health sciences. In addition, within all higher education institutions, a panel of experts in this field of research should be appointed and adequately developed, so that nurse researchers can be guided to produce mixed methods research of an

excellent quality. This will put nursing at the forefront of mixed methods research, which will advance the profession through new knowledge as a result of this diverse and creative body of research.

The nomenclature surrounding designs using more than one approach creates a great deal of confusion and uncertainty and the researcher suggests that this either be standardised or more open to creativity and innovation in selecting the best mix of approaches to render optimal outcomes for the study phenomenon. In addition, mixed method terminology and criteria for ensuring quality research for nursing would be a real help for prospective researchers wanting to undertake research employing both qualitative and quantitative methods. However, care should be taken not to limit the creativity of research.

Since this study focused on nursing leadership development, it is recommended that further research should be conducted, incorporating the unique characteristics of Generation Y nurses as presented in this and previous studies. These unique characteristics beg for the inclusion of humour, fun, creativity, innovation and technology in the nursing profession, because Generation Y value a healthy working environment with limitless potential. As leadership research incorporating qualitative data grows and strengthens, it is likely that the awareness of the potential of this and other underrepresented methods will arouse researchers to consider leadership from other angles and hence suggest new research questions.

It is recommended that this leadership framework be tested on the Generation Y nursing cohort, by whom and for whom it was designed. Further research on its implementation will be useful for the nursing profession and may contribute towards the much-needed transformation of healthcare. A future study could apply the framework on Generation Y nurses, to measure its success. A coaching programme could be applied prior to and after the framework has been implemented, to ascertain if the participants perceive any beneficial contribution to their leadership development.

There is little agreement on generations across the globe, and further research should be conducted to verify findings cross-culturally. This study offers multiple opportunity for follow-up studies. For example, it would be interesting to compare the findings of this study with a similar study of the same generation in another country. It would also be interesting to study the unique learning styles of nurses in the different generational groups. Future research could also address how younger generations communicate and interact and how they affect other generations in nursing teams. Leadership certainly calls for continued research interest, not only in the theoretical and empirical areas, but also in the transformation of leadership science and initiatives into rigorous action in the practice of healthcare.

9.5 POTENTIAL OUTPUTS

In addition to the recommendations above, the study has the potential to generate the following outputs:

- Publications in accredited journals concerning global nursing leadership, mixed methods research and ethnic research;
- Conference presentations on nursing leadership and mixed methods;
- Forums for professional/registered nurse leaders;
- National and international recognition for the research and contribution of research outputs to building the global knowledge base on leadership development in nursing practice for the future of nursing;
- Application of research results through consultancy in hospitals on how to improve performance of the nursing workforce;
- Expected effects of research results which is to strengthen the nursing workforce globally at practitioner level and beyond.

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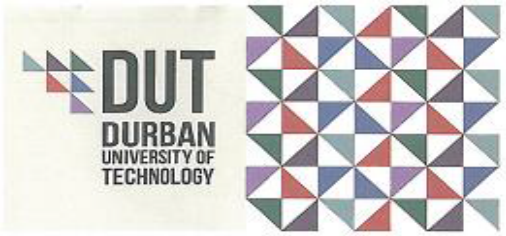
APPENDICES

Appendix 1: University Ethics clearance



Institutional Research Ethics Committee
Research and Postgraduate Support Directorate
2nd Floor, Berwyn Court
Gate 1, Steve Biko Campus
Durban University of Technology

P O Box 1334, Durban, South Africa, 4001

Tel: 031 373 2375
Email: lavishad@dut.ac.za
http://www.dut.ac.za/research/institutional_research_ethics

www.dut.ac.za

1 June 2017

IREC Reference Number: **REC 23/17**

Ms T A Manson
P O Box 13628
Cascades
3202

Dear Ms Manson

THE LEADERSHIP POTENTIAL OF GENERATION Y PRACTITIONER NURSES: BASIS FOR A DEVELOPMENTAL FRAMEWORK

The Institutional Research Ethics Committee acknowledges receipt of your notification regarding the piloting of your data collection tool.

Kindly ensure that participants used for the pilot study are not part of the main study.

In addition, the IREC acknowledges receipt of your gatekeeper permission letter.

Please note that FULL APPROVAL is granted to your research proposal. You may proceed with data collection.

Yours Sincerely,

Professor C E Napier
Chairperson: IREC (Acting)

Appendix 2a: Letter of permission to the Hospital Ethics Committee

13th March 2017

The Institutional Review Board

Dear IRB members,

RE: PERMISSION TO COLLECT DATA AT HOSPITAL

I am currently studying for a Ph.D through Durban University of Technology, South Africa. I have obtained ethical approval from the Institutional Research Ethics Committee, and I hereby request permission to collect data from nurses in the Department of Nursing at the Hospital.

Your positive response will be highly appreciated.

Best regards,

Theresa Manson

Appendix 2b: Approval letter from the Hospital Ethics Committee

Kingdom of Saudi Arabia
Ministry of Education
Princess Nourah Bint Abdulrahman University
(048)

المملكة العربية السعودية
وزارة التعليم
جامعة الأميرة نورة بنت عبدالرحمن
(٠٤٨)

Institutional Review Board

مجلس المراجعة المؤسسي

IRB Registration Number with KACST, KSA: H-01-R-059

May 18, 2017
IRB Log Number: 17-0099
Project Title: The leadership potential of generation Y practitioner nurses: Basis for a developmental framework
Category of Approval: EXEMPT

Dear Ms. Theresa Anne Manson,

Thank you for submitting your proposal to the PNU Institutional Review Board. Your proposal was evaluated considering the national regulations that govern the protection of human subjects. The IRB has determined that your proposed project poses no more than minimal risk to the participants. Therefore, your proposal has been deemed ***EXEMPT*** from IRB review. Please note that this approval is from the research ethics perspective only. You will still need to get permission from the head of the department in PNU or an external institution to commence data collection.

Please note that the research must be conducted according to the proposal submitted to the PNU IRB. If changes to the approved protocol occur, a revised protocol must be reviewed and approved by the IRB before implementation. For ***any*** proposed changes in your research protocol, please submit a Request for Modification form to the PNU IRB. Please be aware that changes to the research protocol may prevent the research from qualifying for exempt review and require submission of a new IRB application or other materials to the PNU IRB. In addition, if an unexpected situation or adverse event happens during your investigation, please notify the PNU IRB as soon as possible. If notified, we will ask for a complete explanation of the event and your response.

Please be advised that regulations require that you submit a progress report on your research every 6 months. Please refer to the protocol number denoted above in all communication or correspondence related to your application and this approval. You are also required to submit any manuscript resulting from this research for approval by IRB before submission to journals for publication.

We wish you well as you proceed with the study. Should you have additional questions or require clarification of the contents of this letter, please contact me.

Sincerely Yours,

Dr. Ebtisam AlMadi
Chairman, Institutional Review Board (IRB)
Princess Nourah bin Abdulrahman University, Riyadh, KSA
Tel: + 966 11 824 0861
E-mail: irb@pnu.edu.sa

جامعة الأميرة نورة بنت عبدالرحمن
مجلس المراجعة المؤسسي
Institutional Review Board (IRB)

Appendix 3a: Letter of permission to the Department of Nursing

03 May 2017
Hospital
Department of Nursing

Dear Ms. Amira,

RE: PERMISSION TO COLLECT DATA

I am currently studying for a Ph.D in nursing through Durban University of Technology (DUT). I have received provisional ethics approval to collect data, subject to a pilot study and obtaining gatekeeper permission (see attached letter IREC REF: 023/17). I hereby request written permission to collect data on Generation Y Filipino Staff Nurses at XXX Hospital.

The title of my research is: THE LEADERSHIP POTENTIAL OF GENERATION Y NURSES: BASIS FOR A DEVELOPMENTAL FRAMEWORK.

Outline of data collection:
The study population is Generation Y Filipino nurses working at XXX Hospital. Participation is voluntary and by consent only. Data collection will take place in three stages:

Stage 1:	All Filipino nurses from Generation Y will be invited to participate by submitting the results of their VIA on-line strengths.
Stages 2 and 3:	Random selection of participants will be required to complete a questionnaire followed by an interview. The sample size will be determined by thematic saturation.

I would appreciate being afforded the opportunity to collect data on the nurses and look forward to your favourable response.

Theresa Anne Manson

Persons to Contact in the Event of Any Problems or Queries:

Researcher:	Mrs Theresa Manson	Mobile: 00966 05 808 3397
Supervisor:	Prof MN Sibiya	Tel: 0027 31-373 22704
Co-supervisor:	Prof. Zerish Zethu Nkosi	Mobile: 0027 83 645 7899
Institutional Research Ethics Administrator:		Tel: 0027 31 373 2375

Complaints can be reported to the Director: Research and Postgraduate Support, Prof. S. Moyo on 0027 31 373 2577 or moyos@dut.ac.za.

Appendix 3b: Approval letter from the Department of Nursing

مستشفى الملك عبدالله بن عبدالعزيز الجامعي
King Abdullah bin Abdulaziz University Hospital

Executive Director of Nursing
King Abdullah bin Abdulaziz
University Hospital (KAAUH)
Riyadh

22 May 2017

Dear Theresa,

RE: APPROVAL TO COLLECT DATA

Thank you for your letter regarding your research study and for requesting permission to collect data from the nurses at King Abdullah bin Abdulaziz University Hospital (KAAUH). I have pleasure in informing you that I hereby grant permission for you to collect data and I wish you well in your studies.

Best regards,

Anne Blunden
Executive Director of Nursing

المرفقات | التاريخ | الرقم

Appendix 4: Letter of information

LETTER OF INFORMATION

Dear colleague,

I am currently undertaking research towards a Ph.D. in Health Sciences at the DUT. The title of my research as shown below requires me to determine the leadership potential in nurses. Therefore you are kindly requested to participate in this study.

Title of the Research Study: The leadership potential of Generation Y practitioner nurses: Basis for a developmental framework

Principal Investigator/researcher:	Mrs. Theresa Anne Manson (M. Tech)
Supervisor:	Prof MN Sibiya (D. Tech: Nursing)
Co-Supervisor:	Prof ZZ Nkosi (PhD)

Brief Introduction and Purpose of the Study: Leadership skills in healthcare workers are important to move healthcare towards meeting the ever-changing healthcare demands. Younger nurses must be prepared to take their place as leaders regardless of their roles in the healthcare workforce, to improve patient outcomes. Generation Y nurses will form 50% of the workforce by 2020 and therefore they must be adequately prepared to take the lead in healthcare. The purpose of this study is to develop a leadership framework for practitioner/bedside nurses, which is suitable for the younger generation's needs.

Outline of the Procedures: You are invited to participate in this study. Participation is voluntary. If you choose to participate, you will be asked to sign a consent form. Data collection will take place in three stages. For the first stage, all Filipino nurses from Generation Y will be invited to participate by submitting the results of their VIA on-line strengths to Ms……, so that the researcher can determine the overall strengths of Generation Y nurses (born between 01.01.1980 – 31.12.1999). Your name must not appear on the survey results. For the next stages of data collection, only some of you will be randomly selected and then invited to complete a leadership questionnaire followed by an interview to determine your views on leadership qualities in nurses.

Risks or Discomforts to the Participant: Your anonymity will be maintained at all times as your name will not appear on in any documents. The results of this study will not affect your employment in any way.

Benefits: The outcome of this study may be used to improve the development of practitioner /bedside nurses. Publications from this study may advance the nursing profession as well as the professional growth of the researcher.

Reason/s why the Participant May Be Withdrawn from the Study: Participation is voluntary and by consent only. You may withdraw at any time and will not be penalized should you choose to withdraw.

Remuneration: None.

Costs of the Study: None.

Confidentiality: The VIA strengths survey results will be handed to XXX, who will sign a confidentiality agreement. The survey results will be kept under lock and key until handed to the researcher. Only the researcher will have access to the survey results, and codes will be used on the documents so that your name cannot be linked to the study. The researcher will analyse the results.

Research-related Injury: Not applicable.

Persons to Contact in the Event of Any Problems or Queries:

Researcher: Mrs Theresa Manson. Mobile: 00966 05 808 3397
Supervisor: Prof. MN Sibiya, Tel: 0027 31-373 2704
Co-supervisor: Prof. ZZ Nkosi, Mobile: 0027 83 645 7899
Institutional Research Ethics Administrator, Tel: 0027 31-373 2375 -

Complaints can be reported to the Director: Research and Postgraduate Support, Prof S. Moyo on 031 373 2577 or moyos@dut.ac.za.

Appendix 5: Consent form

CONSENT

Statement of Agreement to Participate in the Research Study:

- I hereby confirm that I have been informed by the researcher, Theresa Anne Manson, about the nature, conduct, benefits and risks of this study - Research Ethics Clearance Number: REC 23/17,
- I have also received, read and understood the above written information (Participant Letter of Information) regarding the study.
- I am aware that the results of the study, including personal details regarding my sex, age, date of birth, initials and diagnosis will be anonymously processed into a study report.
- In view of the requirements of research, I agree that the data collected during this study can be processed in a computerised system by the researcher.
- I may, at any stage, without prejudice, withdraw my consent and participation in the study.
- I have had sufficient opportunity to ask questions and (of my own free will) declare myself prepared to participate in the study.
- I understand that significant new findings developed during the course of this research which may relate to my participation will be made available to me.

_____	_____	_____	_____
Full Name of Participant	**Date**	**Time**	**Signature / Right Thumbprint**

I, _____ (name of researcher) herewith confirm that the above participant has been fully informed about the nature, conduct and risks of the above study.

_____	_____	_____
Full Name of Researcher	**Date**	**Signature**
_____	_____	_____
Full Name of Witness (If applicable)	**Date**	**Signature**
_____	_____	_____
Full Name of Legal Guardian (If applicable)	**Date**	**Signature**

Appendix 6: Strengths survey

	Very Much Like Me	Like Me	Neutral	Unlike Me	Very Much Unlike Me
Being able to come up with new and different ideas is one of my strong points.					
I have taken frequent stands in the face of strong opposition.					
I never quit a task before it is done.					
I always keep my promises.					
I have no trouble eating healthy foods.					
I always look on the bright side.					
I am a spiritual person.					
I know how to handle myself in different social situations.					
I always finish what I start.					

	Very Much Like Me	Like Me	Neutral	Unlike Me	Very Much Unlike Me
I really enjoy doing small favors for friends.					
There are people in my life who care as much about my feelings and well-being as they do about their own.					
As a leader, I treat everyone equally well regardless of his or her experience.					
Even when candy or cookies are under my nose, I never overeat.					
I practice my religion.					
I rarely hold a grudge.					
I am always busy with something interesting.					
I am thrilled when I learn something new.					
I like to think of new ways to do things.					

Appendix 6: Strengths survey (continued)

	Very Much Like Me	Like Me	Neutral	Unlike Me	Very Much Unlike Me
No matter what the situation, I am able to fit in.	○	○	○	○	○
I never hesitate to publicly express an unpopular opinion.	○	○	○	○	○
I believe honesty is the basis for trust.	○	○	○	○	○
I go out of my way to cheer up people who appear down.	○	○	○	○	○
I treat all people equally regardless of who they might be.	○	○	○	○	○
One of my strengths is helping a group of people work well together even when they have their differences.	○	○	○	○	○
I am a highly disciplined person.	○	○	○	○	○
I always think before I speak.	○	○	○	○	○
I experience deep emotions when I see beautiful things.	○	○	○	○	○

	Very Much Like Me	Like Me	Neutral	Unlike Me	Very Much Unlike Me
At least once a day, I stop and count my blessings.	○	○	○	○	○
Despite challenges, I always remain hopeful about the future.	○	○	○	○	○
My faith never deserts me during hard times.	○	○	○	○	○
I do not act as if I am a special person.	○	○	○	○	○
I welcome the opportunity to brighten someone else's day with laughter.	○	○	○	○	○
I never seek vengeance.	○	○	○	○	○
I value my ability to think critically.	○	○	○	○	○
I have the ability to make other people feel interesting.	○	○	○	○	○
I must stand up for what I believe even if there are negative results.	○	○	○	○	○

Appendix 6: Strengths survey (continued)

	Very Much Like Me	Like Me	Neutral	Unlike Me	Very Much Unlike Me
I have often been left speechless by the beauty depicted in a movie.					
I am an extremely grateful person.					
I try to add some humor to whatever I do.					
I look forward to each new day.					
I believe it is best to forgive and forget.					
I have many interests.					
When the topic calls for it, I can be a highly rational thinker.					
My friends say that I have lots of new and different ideas.					
I am always able to look at things and see the big picture.					

	Very Much Like Me	Like Me	Neutral	Unlike Me	Very Much Unlike Me
I always stand up for my beliefs.					
I do not give up.					
I am true to my own values.					
I always feel the presence of love in my life.					
I can always stay on a diet.					
I think through the consequences every time before I act.					
I am always aware of the natural beauty in the environment.					
My faith makes me who I am.					
I have lots of energy.					

Appendix 6: Strengths survey (continued)

	Very Much Like Me	Like Me	Neutral	Unlike Me	Very Much Unlike Me
I finish things despite obstacles in the way.	○	○	○	○	○
I love to make other people happy.	○	○	○	○	○
I am the most important person in someone else's life.	○	○	○	○	○
I work at my very best when I am a group member.	○	○	○	○	○
Everyone's rights are equally important to me.	○	○	○	○	○
I see beauty that other people pass by without noticing.	○	○	○	○	○
I have a clear picture in my mind about what I want to happen in the future.	○	○	○	○	○
I never brag about my accomplishments.	○	○	○	○	○
I try to have fun in all kinds of situations.	○	○	○	○	○

	Very Much Like Me	Like Me	Neutral	Unlike Me	Very Much Unlike Me
I love what I do.	○	○	○	○	○
I am excited by many different activities.	○	○	○	○	○
I am a true life-long learner.	○	○	○	○	○
I am always coming up with new ways to do things.	○	○	○	○	○
People describe me as "wise beyond my years."	○	○	○	○	○
My promises can be trusted.	○	○	○	○	○
I give everyone a chance.	○	○	○	○	○
To be an effective leader, I treat everyone the same.	○	○	○	○	○
I never want things that are bad for me in the long run, even if they make me feel good in the short run.	○	○	○	○	○

Appendix 6: Strengths survey (continued)

	Very Much Like Me	Like Me	Neutral	Unlike Me	Very Much Unlike Me
I can find something of interest in any situation.	○	○	○	○	○
I read all of the time.	○	○	○	○	○
Thinking things through is part of who I am.	○	○	○	○	○
I am an original thinker.	○	○	○	○	○
I am good at sensing what other people are feeling.	○	○	○	○	○
I have a mature view on life.	○	○	○	○	○
I am as excited about the good fortune of others as I am about my own.	○	○	○	○	○
I can express love to someone else.	○	○	○	○	○
Without exception, I support my teammates or fellow group members.	○	○	○	○	○

	Very Much Like Me	Like Me	Neutral	Unlike Me	Very Much Unlike Me
My friends always tell me I am a strong but fair leader.	○	○	○	○	○
I always keep straight right from wrong.	○	○	○	○	○
I feel thankful for what I have received in life.	○	○	○	○	○
I know that I will succeed with the goals I set for myself.	○	○	○	○	○
I rarely call attention to myself.	○	○	○	○	○
I have a great sense of humor.	○	○	○	○	○
I rarely try to get even.	○	○	○	○	○
I always weigh the pro's and con's.	○	○	○	○	○
I stick with whatever I decide to do.	○	○	○	○	○

Appendix 6: Strengths survey (continued)

	Very Much Like Me	Like Me	Neutral	Unlike Me	Very Much Unlike Me
I enjoy being kind to others.					
I can accept love from others.					
Even if I disagree with them, I always respect the leaders of my group.					
Even if I do not like someone, I treat him or her fairly.					
As a leader, I try to make all group members happy.					
I am a very careful person.					
I am in awe of simple things in life that others might take for granted					
When I look at my life, I find many things to be grateful for.					
I have been told that modesty is one of my most notable characteristics.					

	Very Much Like Me	Like Me	Neutral	Unlike Me	Very Much Unlike Me
I am usually willing to give someone another chance.					
I think my life is extremely interesting.					
I read a huge variety of books.					
I try to have good reasons for my important decisions.					
I always know what to say to make people feel good.					
I may not say it to others, but I consider myself to be a wise person.					
It is important to me to respect decisions made by my group.					
I always make careful choices.					
I feel a profound sense of appreciation every day.					

Appendix 6: Strengths survey (continued)

	Very Much Like Me	Like Me	Neutral	Unlike Me	Very Much Unlike Me
If I feel down, I always think about what is good in my life.	○	○	○	○	○
My beliefs make my life important.	○	○	○	○	○
I awaken with a sense of excitement about the day's possibilities.	○	○	○	○	○
I love to read nonfiction books for fun.	○	○	○	○	○
Others consider me to be a wise person.	○	○	○	○	○
I am a brave person.	○	○	○	○	○
Others trust me to keep their secrets.	○	○	○	○	○
I gladly sacrifice my self-interest for the benefit of the group I am in.	○	○	○	○	○
I believe that it is worth listening to everyone's opinions.	○	○	○	○	○

	Very Much Like Me	Like Me	Neutral	Unlike Me	Very Much Unlike Me
People are drawn to me because I am humble.	○	○	○	○	○
I am known for my good sense of humor.	○	○	○	○	○
People describe me as full of zest.	○	○	○	○	○

Appendix 7: Leadership survey

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	Section 3: The Leader Within					
I.	**PERSONAL AND PROFESSIONAL ACCOUNTABILITY**	**1 (Novice)**	**2 (Advanced beginner)**	**3 (Competent)**	**4 (Proficient)**	**5 (Expert)**
1.	**Personal growth and development:** Manage through education advancement, continuing education, career planning and annual self-assessment and action plans					
2.	**Practice ethical behaviour**: Including practice that supports nursing standards and scopes of practice					
3.	**Involvement in professional associations: I**ncluding membership and involvement in an appropriate professional association that facilitates networking and professional development					
4.	**Achieve certification in an appropriate field/specialty**					
II.	**CAREER PLANNING**	**1 (Novice)**	**2 (Advanced beginner)**	**3 (Competent)**	**4 (Proficient)**	**5 (Expert)**
1.	**Know your role:** understand current job description / requirements and compare those to current level of practice					
2.	**Know you future**: Plan a career path					
3.	**Position yourself:** Develop a career path/plan that provides direction while offering flexibility and capacity to adapt to future scenarios.					
III.	**PERSONAL JOURNEY DISCIPLINES**	**1 (Novice)**	**2 (Advanced beginner)**	**3 (Competent)**	**4 (Proficient)**	**5 (Expert)**
1.	**Apply Action learning:** Apply techniques of 'action learning' to problem solve and personally reflect on decisions					
2.	**Engage in Reflective practice:** Includes knowledge of and active practice of reflection as a leadership behaviour					

KEY:

Novice: Demonstration of behaviour is absent
Advanced Beginner: Minimal demonstration of behaviour
Competent: Solid demonstration of behaviour at a basic level
Proficient: Significant demonstration of behaviour
Expert: Demonstrates role model behaviour

Appendix 8: Interview guide

Interview questions guide

	QUESTION	NOTES
1	Can you tell me your current beliefs about leaders and leadership?	
2	Do you believe nurses can lead at the bedside? Explain.	
3	Do you think you have leadership ability? Explain.	
4	What is the practice environment like for you and your colleagues? Explain.	
5	Do you think leadership influences nursing practice, the practice environment and patient outcomes? Explain.	
6	Give examples of activities you have been exposed to that have developed your leadership skills in nursing.	
7	What would you hope to gain from leadership education? You can use your leadership survey to identify skills you need.	
8	Can you describe your leadership vision for 2020?	
9	Is there anything else that you would like to share?	

Appendix 9: Interview orientation and transcript sample

INTERVIEW ORIENTATION

Before we begin the interview, I would like to read through this orientation.

1. This interview is voluntary; you may stop at any time
2. The aim of the interview is to get in-depth information that you perceive about leadership at the bedside
3. The information you provide will be used to develop a leadership framework for bedside nurses.
4. The results of this interview will appear in my thesis
5. Confidentiality: Nobody other than me will hear the tapes
6. Your name will not appear anywhere in the notes or the thesis- a code will be used to match your leadership survey and your interview records
7. I will ask you 9 questions, one at a time, and allow you to respond (you can read through them now)
8. Take your time as you answer the questions, and you can go back to a previous question if you like
9. I will write notes while you are speaking
10. Your answers will not be judged by me
11. There is a pen and paper should you wish to write something down
12. Please help yourself to water on the table
13. Please feel free to ask for a break if you need one
14. Is the temperature of the room comfortable for you?
15. The session will be audio-taped
16. Are you ready to begin?

INTERVIEW TRANSCRIPT

PARTICIPANT: 009 (26min)

Q1: CAN YOU TELL ME ABOUT YOUR CURRENT BELIEFS ABOUT LEADERS AND LEADERSHIP.

A: What I believe about leaders, so leaders are those that empower people and doesn't impose, but rather transform them into something, so I believe in the type of leadership transformational leadership. Because I know that leadership doesn't dictate but it changes people. And we all know the different types of leadership ma'am, the liaises faire leadership as well as dictatorship but then I chose to be a good leader because I believe people should be given choices not to be dictate.

Q2: DO YOU BELIEVE NURSES CAN LEAD AT THE BEDSIDE? In other words do you believe that you don't have to be in a position, you can still be a leader at the bedside? Do you believe that?

A: Yes. Actually we are now exercising being a team leader in the position in our departments so being a team leader you will be the one to coordinate. You should be the one to be able to oversee all of the functions and the responsibilities of the staff but by doing so you are not in the bedside, you are not actually engaging the physical activities that some of the staffs are in but you are doing an ocular inspection, assessing each of the staffs will able to perform at their best and within their scope of practice. So I believe being a leader, I mean nurses would be able to be leaders in their specific fields and that's why we have a nursing team leader.

Q: And do you believe that a nurse who is not in a team leader position, just somebody who is providing primary care to a patient, do you think that they ever need to be leaders?

A: Being a team leader is on their own because being a nurse you should be accountable in all of your actions because with each action you will have consequences so what I mean is not the type of consequences that other professions would have because these types of consequences involves lives of our patients. So each of them should be a leader because we all know that

good leaders are good followers. So each of us have different stages. They are all already leaders but we have stages of leadership.

Q3: DO YOU THINK YOU HAVE LEADERSHIP ABILITY?

A: Yes of course, I think I also have leadership ability we all have different styles of leadership. There are times that we go into the dictatorship, we go into the liaises faire but that's an experience so that when we realise that we should be the transformational type of leadership because we as leaders I admit that we also have made mistakes as we know and those mistakes will make us realise what is the true leadership that we are seeking. And that would be able to show everyone also be enlighten everyone that the actions that you let them see would be able to enlighten them you would be the type of role model that we will want to be.

Q: Right, do you think you're a role model?

A: We have a role model ma'am in a sense that there are different types of role models depending on the perception of the person so I also have different talents capabilities ma'am I mean I can use nursing in IT but then it depends on the perception of the person so I think I should strive hard in order for me to let them see the role model that is within me so that is a peculiar one that is a unique one that nobody will be able to compare because leadership should not be compared it should be exercised. But I think I'm a leader in my own way.

Q4: WHAT IS THE PRACTICE ENVIRONMENT LIKE FOR YOU AND YOUR COLLEAGUES? Where you work.

A: In the Emergency Department ma'am?

Q: In the department where you are working.

A: Actually the emergency department is a high pressured environment so the atmosphere is very what would I term….chaotic in a sense that if there is an influx of patients ma'am sometimes you will be confused or perplexed in what you are doing but then I have learned times to focus on the things that matter and the things that don't; to prioritise things. When you are put under pressure

they say that you should be graceful, you should exercise grace over pressure and that's the thing that I want most, especially in the emergency department.

Q: And do you find that atmosphere there, that environment; do you have good leadership there?

A: Yes. Actually I have good leadership there. What you all know, as a new hospital I am a little bit confused with the policies, what do you call- it the Administration policies and procedures and the Departmental policies and procedures because they are continually changing. It is confusing.

Q5: DO YOU THINK LEADERSHIP INFLUENCES NURSING PRACTICE, THE PRACTICE ENVIRONMENT AND PATIENT OUTCOMES?

A: Yes ma'am, because as a leader you are influencing people and affect each other in the same way for example if I'm a negative kind of leader, negative thinking, it will show in my actions as well as in my facial expressions so those people that will see me….. so that will pave a way to experience negative emotions and a negative atmosphere. So negative emotions, negative atmosphere negative actions will lead to habits and those habits will lead to the change in the character of the persons. So eventually they will be negative persons. So as a leader it is very important to have an attitude that fosters positiveness because the way people see you influences their job, influences how they act and how they implement those tasks as well as the outcomes of the patient because the patient will be able to see how those nurses will perform. For example if a leader gives a negative atmosphere those nurse that will be affected we have a domino effect so those nurses who are affected, their performance in accomplishing those patient tasks especially will also be affected. So in a negative way the patient also will be able to see that "what is this nurse doing?" so I don't want to see this nurse doing something like this again so I will report, I will go to the patient services and report.

Q: So do you think that the leadership then, the positivity will get a better outcome?

A: Yes.

Q: And it's up to the leader to make that happen?

A: Yes, it's up to the leader.

Q6: GIVE EXAMPLES OF ACTIVITIES YOU HAVE BEEN EXPOSED TO THAT HAVE DEVELOPED YOU LEADERSHIP SKILLS IN NURSING. Why do you think you have leadership- maybe you're born with it; what activities?

A: Yes ma'am, one of the most challenging tasks that I have is to be a chairman of the task formation order of the nursing informatics because although I am already good at IT if I'm not that good, I'm not the best at the IT, but I was really challenged by the nursing informatics because I was able to see a different kind of view in nursing, the nursing informatics, that's why I also enrolled in the university I was gelled by that. Actually in establishing this hospital I inspected all of the data ports as well as the sockets and not only that I also did the setup of the computers as well as I also created the data base, the one that you are using staff data base so with that, that is really challenging for me, especially when those people, the members of our team also from different departments have also been tasked. So I usually need to make sure that each of us would be able to meet every now and then and discuss and contribute for the betterment of the hospital. So it is a challenge for me because it is a new field and I need to maintain the competencies (?) as well the participation of my members.

Q: So that taught you about handling teams?

A: Yes ma'am.

Q: Were there any other activities other than that committee? For leadership, you know anything that we have exposed you to?

A: Being a team leader because as of now I need to oversee the team to make sure that what they are doing is within their scope of practice and I need to balance the policies and the actual activity that they are doing. I also need to maintain the positivity in the team because we are not just doing tasks in the area, we are not just delivering care to the patients we also have UBC's, we also have different lectures so sometimes it's very tiring for the staff to

multi-task because we all now ma'am that being able to be a productive person means that you should focus on one task at a time so sometimes those tasks screwing up certain tasks that you are doing so sometimes it's important to be positive, it's important to know what is important first before doing other things.

Q: And any other activities that we do up here like the huddle and any activities that you think might have developed leadership as well? What kind of things have you been exposed to that you think has developed you?

A: Also in the huddles because it develops us. I'm a shy type of person but through huddles I was able to express myself because if those leaders would be able to mould you as a person. I have only been standing in front of those persons who are of my age. There are those that are younger than me so I was able to stand up for myself because I don't know actually ma'am in this hospital if really development of those skills because I don't know how to speak in front of those people like DON's/Executive directors and directors of nursing like you ma'am, because I have this fear of speaking and expressing myself.

Q: And that really helped you because you were put into that position and you had to do it and you grew from that.

A: Because I didn't have a choice that's why I'm very thankful.

Q7: WHAT WOULD YOU HOPE TO GAIN FROM LEADERSHIP EDUCATION? YOU CAN USE YOUR LEADERSHIP SURVEY TO IDENTIFY SKILLS YOU NEED. So if I was to say there was going to be a leadership program or framework that was being developed, what would you expect to gain from that? What would you like to see in that program that you would gain from it? You can look at the leadership survey to get any ideas.

A: before we have a leadership program ma'am, what I want is, because as of this moment, i play each as I have been established, I really don't know if I have reached the peak of my leadership skills but I know there is more to me that I should learn so I would love to have a leadership program that inspire us to be leaders so not force us but makes us see who we are, makes us find

the uniqueness in us, and transform ourselves so that we can transform other people. So I want to see that leadership program to be able to inspire me to work hard in this institution and to contribute their uniqueness in this institution in this Saudisation. Because each of us has different gifts although we are nurses we have specific fields that we work on but that we can use our talents, our gifts in other aspects. So we can enhance the nursing profession.

Q: That's great, so I'm interested that you said about "seeing who you are" so on this form it has a section here, well it's about the leader within so do you believe that is a good starting point, to start off learning about yourself in leadership? If you can lead yourself, then you can lead other people?

A: Yes ma'am, because we know the quote ma'am "the greatest thing we need to learn first is about yourself". Confucius said "Know thyself first". Because if you don't know about yourself, how can you share your uniqueness in others, how can others see you if you can't see yourself.

Q: Is there any way or things that could be included I this program that could be interesting for somebody from your generation?

A: Actually I this program I think as I told earlier, they need to know their capabilities as well as their unique talents so I think if there is certain, for example in the Philippines ma'am, interview as well as written exam before you will proceed with a course that you like I life, you will take that kind of exam.

Q: Like a pre-test?

A: Yes, and what is your score and if each of those items eg 150 each of those 20 items will cost 1,2 of science for example, in each will be like that and for those specific works eg it depends on the scoring eg nurse you will be a medical profession like that. So I think if we can conduct an examination as well as an interview for each staff who will be able to know the extent of their talents you will be able to identify what the uniqueness. And if you were able to identify that you would be able to know where to place them in this

institution eg in nursing we have a team leader so we would be able to know if they are capable of handling those tasks as well as eg if they e = want to be in the nursing informatics you would be able to go there if you are interested.

Q8: CAN YOU DESCRIBE YOUR LEADERSHIP VISION FOR 2020?

A: My leadership vision ma'am, for myself or for the institution?

Q: For you and then we can talk about the institution.

A: Actually I have a big dream for of the organisation that is why I am studying informatics and I am also planning to study diploma computer science because I want to use technology with nursing so I know that there are certain software as well as hardware that will really be able to help nursing. I want to contribute something wherein as part of 2 0r 3 years, 2017. 2020 I will be able to graduate from computer science and I want to create a software that will be able to help nursing. Actually, I don't know what is that software but deep inside me I want to really create something unique. Because we are not stuck in diverse because the nursing field is really developing because life is in our hands so we need technology enhancement and innovation. The number one innovation that I like more is TrakCare as well as Severno. I really like the way, actually I don't like TrakCare now, but I know that in time it will be better ad will really help us because it's not fully functional yet the TrakCare, and I understand but if that technology will be fully developed, that will really help nursing.

Q: So that's your leadership vision, is to lead an IT group in the nursing field.

A: Yes.

Q: And any vision of leadership for our hospital? Or is it all the same thing?

A: The leadership also in the hospital besides the one I envisioned, yes for myself as well as for the hospital because I would also like to create a software for the hospital. I don't know when I will achieve it but I will be and for the hospital for the leadership for 202 I would like to see the hospital is already working fully functional, as well as having the right equipment for the right reason as well as having staff that are in maximum performance using

their uniqueness, in….having…working together as a team. So I want to see the staff performing simulations as of now ma'am, I want to see them performing series of simulations, because if we will not do some series of simulations, we will get stuck. Because we are not always engaged in patient here especially we are a new hospital so we need to perform series of simulations activities and we need to know our weaknesses so eg IV cannulations, I think in other departments having difficulties with IV cannulations so I think we should conduct a review on what is the source of that; it might be the cannula because the cannula doesn't have a wig and the cannula is opaque so we cannot see the blood and it pains the patient ma'am. And when we try to insert the cannula in the vein of the patient and if it's already in and we advance the cannula it comes out, I don't know why, it might be that it penetrates the vein it will pierce a few millimetres and then it will not come into the vein, it will just pass through. That's why I want to not fully eliminate, but at least not aggravate the circumstances, develop fully by a series of trainings and I'm also sad about the payment of ACLS. Sadly we are I think we are, since we are a training hospital…..that is should be paid. So that is also one of the rewards that nurses should have because they are struggling and they won't be able to learn.

Q9: IS THERE ANYTHING ELSE THAT YOU WOULD LIKE TO SHARE?

That was our last question. Is there anything else that you want to add about leadership or do you think we have covered everything?

A: Lastly ma'am I just want to emphasise transformational leadership, because that is what I really want. I really believe in that. I like to see a person transform, no because of me but because they like to be transformed, they like to change for the good, and that is true leadership. The might of leadership is not being able to say that because of him I was transformed, the true might of leadership is that the person is able to say to you that "I changed because I like it and because I really changed myself".

Appendix 10: Letter from the statistician

Gill Hendry B.Sc. (Hons), M.Sc. (Wits), PhD (UKZN)
Mathematical and Statistical Services

Cell: 083 300 9896
email : hendryfam@telkomsa.net

12 August 2016

To whom it may concern

Please be advised that I will be assisting Mrs Theresa Anne Manson (student number 21242581) who is presently studying for a PhD in Health Sciences: Nursing with the statistical aspects of her study.

Yours sincerely

Gill Hendry (Dr)

Appendix 11: Non-disclosure agreement

Appendix 6: Non-disclosure agreement

05 June 2017

Ms. R.K. Cassimjee
The Manager
Student Development Unit

Dear Ms. Cassimjee,

RE: NON-DISCLOSURE AGREEMENT

I am registered for a Ph.D at Durban University of Technology (DUT). I will be collecting data from Staff Nurses working at during June and July 2017. As per my Proposal to DUT, you are required to assist me by recruiting consenting participants for data collection.

I have all necessary permission to collect data as follows:

- Full Ethics clearance from DUT (REF 23/17)
- Approval from the Institutional Review Board (REF 17-0099)
- Permission from the Executive Director of Nursing.

I am required to ask you to please sign this letter as assurance that you will not divulge the identification of the participants to anyone.

Regards,

Theresa Manson

Signed as agreement to non-disclosure of identification of participants in the study.

Rabia Cassimjee — Name

Signature

6 June 2017 — Date

Appendix 12: Letter from the professional editor

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EDITING CERTIFICATE

Re: **Theresa Anne Manson**
Master's dissertation: **THE LEADERSHIP POTENTIAL OF GENERATION Y PRACTITIONER NURSES: BASIS FOR A DEVELOPMENTAL FRAMEWORK**

I confirm that I have edited this thesis and the references for clarity, language and layout. I did not check the references for accuracy. I am a freelance editor specialising in proofreading and editing academic documents. I returned the document to the author with track changes so correct implementation of the changes in the text and references is the responsibility of the author. My original tertiary degree which I obtained at the University of Cape Town was a B.A. with English as a major and I went on to complete an H.D.E. (P.G.) Sec. with English as my teaching subject. I obtained a distinction for my M.Tech. dissertation in the Department of Homeopathy at Technikon Natal in 1999 (now the Durban University of Technology). During my 13 years as a part-time lecturer in the Department of Homoeopathy at the Durban University of Technology I supervised numerous Master's degree dissertations.

Dr Richard Steele
21 November 2018
per email