

An exploration into nurse managers' experiences of their conflict management skills

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DECLARATION

I declare that this research dissertation titled **An exploration into nurse managers' experiences of their conflict management skills is**, my own work. It has not been submitted before at any university or tertiary institution.

Angela Koesnell

9 January 2017

PREFACE AND ACKNOWLEDGEMENTS

Herewith my sincere gratitude to those who made this journey possible:

- **My Heavenly Father who gave me the ability to fulfil this dream.**
- My late mother who passed on shortly before I finished my study. Thank you for your prayers and faith in me mom. I know you are watching down from heaven and you are smiling at me.
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ABSTRACT

In nursing, a healthy work environment refers to a deliberate context that strives to ensure that patient outcomes are met, organisational goals are achieved and that work and care environments are safe, healing, humane and respectful of the rights, responsibilities, needs and contributions of all people – including patients, their families and nurses (American Association for Critical Care Nurses, 2005:12). Healthy work environments (also known as positive practice environments) support the well-being of healthcare providers in low, middle and high-income countries. It enables a motivated, productive and high performing pool of personnel who deliver high quality care (International Collaborating Partners of the Positive Practice Environments Campaigns, 2008).

Yet, due to globalisation, diversity has infiltrated the workplace, presenting different aspects of culture, gender, age, generations, beliefs, race, historical experiences and qualifications. This makes workplace conflict inevitable (Finance and Accounting Services Sector Education and Training Authority [FASSET], 2013:5). The healthcare industry is not immune against workplace diversity. Nurse managers are central to conflict management and a healthy work environment. This is especially true in South Africa, considering that South Africa is one of the most diverse countries globally.

A literature review was conducted of the most recent national and international literature regarding conflict management and workplace diversity within healthcare and with a specific focus on nurses. The literature review identified a gap on conflict resolution by nurse managers in diverse workplaces in South Africa (a significant publication on conflict management within nursing units was dated as a 1980 publication). Almost four decades later and since the inception of South Africa's new democracy, workplace diversity has been augmented. The aim of this research was to understand nurse managers' experiences of conflict management within a diverse South African workplace (military hospital) in order to foster a healthy work environment. The objectives were to explore and describe workplace diversity within the current South African healthcare organisations and to explore and describe the experiences of conflict management and their conflict management skills within a diverse workplace.

This research followed a qualitative, phenomenological, contextual design. The setting was a national, specialised military healthcare organisation representing a kaleidoscope of diversity. The researcher used purposive sampling (Burns & Grove, 2010:355) by selecting nurse managers based on inclusion criteria, who provided the best information about their real life experiences of conflict and conflict management skills. A mediator recruited participants and explained informed consent. Data were collected by the researcher on the military healthcare organisation's premises by means of unstructured interviews. The data were transcribed and

underwent thematic analysis. Data saturation occurred after 13 in-depth individual interviews (N=13). Six main themes and nine subthemes were formulated. A hierarchical, diverse, organisational culture predisposes conflict and impedes on conflict management. Conflict management is complex where nurse managers present specific conflict management characteristics and skills. Nurse managers are positioned between the organisational management and their nursing teams, they experience intergenerational conflict while noticing a decreased passion, meaning and purpose amongst nurses for the nursing profession. Conflict management skills can be learned and enhanced and require an inside-out process. Recommendations are formulated for nurse managers to embrace diversity, to integrate conflict management into their personal and professional growth and to support younger generation nurses in conflict management.

Key words: Healthy work environment, positive practice environment, workplace diversity, conflict management, nurse manager, military healthcare organisation.

(Abstract word count 548)

Table of Contents

| | |
|--|------|
| DECLARATION | i |
| PREFACE AND ACKNOWLEDGEMENTS | ii |
| ABSTRACT | iii |
| LIST OF TABLES | x |
| LIST OF FIGURES..... | xi |
| ANNEXURES | xii |
| LIST OF ABBREVIATIONS..... | xiii |
| CHAPTER 1: INTRODUCTION TO THE RESEARCH..... | 1 |
| 1.1 INTRODUCTION..... | 1 |
| 1.2 BACKGROUND AND PROBLEM STATEMENT | 1 |
| 1.3 PURPOSE, AIM AND OBJECTIVES | 8 |
| 1.4 PARADIGMATIC PERSPECTIVE | 8 |
| 1.4.1 Meta-theoretical assumptions | 8 |
| 1.4.2 Theoretical assumptions..... | 8 |
| 1.4.2.1 Standards of a healthy work environment..... | 8 |
| 1.4.2.2 Central theoretical statement..... | 9 |
| 1.4.2.3 Definition of concepts | 9 |
| 1.4.3 Methodological assumptions..... | 11 |
| 1.5 METHODOLOGY..... | 11 |
| 1.5.1 Research design | 12 |
| 1.5.2 Research method(s)..... | 12 |

| | | |
|---------|---|-----------|
| 1.5.2.1 | Research setting | 12 |
| 1.5.2.2 | Population, sample, sampling, sample size | 12 |
| 1.5.2.3 | Data collection technique..... | 13 |
| 1.5.3 | Field notes | 14 |
| 1.6 | MEASURES TO ENSURE RIGOUR: TRUSTWORTHINESS | 16 |
| 1.6.1 | Truth value..... | 16 |
| 1.6.2 | Applicability..... | 17 |
| 1.6.3 | Consistency..... | 17 |
| 1.6.4 | Neutrality..... | 17 |
| 1.6.5 | Authenticity | 17 |
| 1.7 | HEALTH RESEARCH ETHICS | 18 |
| 1.7.1 | Levels of clearance, permission and consent..... | 18 |
| 1.7.2 | Respect for persons | 19 |
| 1.7.3 | Relevance and value..... | 19 |
| 1.7.4 | Scientific integrity | 19 |
| 1.7.5 | Risk of harm and likelihood of benefit..... | 19 |
| 1.7.6 | Informed consent | 19 |
| 1.7.7 | Distributive justice | 20 |
| 1.7.8 | Professional competence..... | 20 |
| 1.7.9 | Privacy and confidentiality..... | 20 |
| 1.7.10 | Publication of results..... | 20 |
| 1.7.11 | Storage and archiving | 21 |
| 1.8 | PROPOSED OUTLINE | 21 |

| | | |
|----------|---|----|
| 1.9 | SUMMARY | 21 |
| | BIBLIOGRAPHY | 23 |
| | CHAPTER 2: LITERATURE REVIEW | 28 |
| | AN OVERVIEW OF CONFLICT MANAGEMENT WITHIN DIVERSE HEALTHCARE WORKPLACES | 28 |
| 2.1 | INTRODUCTION | 28 |
| 2.2 | SEARCH STRATEGY FOLLOWED | 28 |
| 2.3 | CONFLICT MANAGEMENT | 28 |
| 2.3.1 | The concepts "conflict" and "conflict management" | 28 |
| 2.3.2 | Models, theories and conceptual frameworks of conflict and conflict resolution | 29 |
| 2.3.2.1 | Dual concerns model by Blake and Mouton (1964) and added leadership styles by Mukthar (2012) | 29 |
| 2.3.2.2 | Thomas and Kilmman model (1974) | 30 |
| 2.3.2.3 | Thomas and Pruitt model (1976 and 1983) and the five conflict management styles | 30 |
| 2.3.2.4 | The five stages framework of conflict by Phillip (1988) | 31 |
| 2.3.2.5 | Process and structural model of conflict management by Thomas (1992) | 32 |
| 2.3.2.6 | Group conflict management by Khun and Poole (2000) | 32 |
| 2.3.2.7 | DeChurch and Marks' conflict management meta-taxonomy (2001) | 33 |
| 2.3.2.8 | Rahim's meta-model of conflict management styles (2002) | 33 |
| 2.3.2.9 | Shetach's model for conflict management (2009) | 34 |
| 2.3.2.10 | Gerardi's relational model for nurses (2015) | 35 |
| 2.3.3 | CONFLICT AS REALITY WITHIN HEALTHCARE | 36 |

| | | |
|---------|---|----|
| 2.3.4 | HEALTHCARE AT A DIVERSE WORKPLACE..... | 38 |
| 2.3.4.1 | Understanding the concept “workplace diversity” | 42 |
| 2.3.4.2 | Models, theories and conceptual frameworks on workplace diversity | 43 |
| 2.3.4.3 | International, African and South African realities of workplace diversity in general | 45 |
| 2.3.4.4 | Workplace diversity as a reality in South African healthcare..... | 48 |
| 2.3.4.5 | The nurse manager within workplace diversity | 49 |
| 2.4 | CONCLUDING REMARKS OF WORKPLACE DIVERSITY IN SOUTH AFRICAN HEALTH CARE | 50 |
| 2.5 | SUMMARY..... | 51 |
| | BIBLIOGRAPHY..... | 52 |
| | CHAPTER 3: RESEARCH ARTICLE | 59 |
| 3.1 | INTRODUCTON..... | 59 |
| 3.2 | AUTHORSHIP | 59 |
| 3.3 | AUTHOR GUIDELINES..... | 59 |
| | TITLE PAGE | 73 |
| | ABSTRACT | 74 |
| | MANUSCRIPT | 75 |
| | BIBLIOGRAPHY..... | 89 |
| | CHAPTER 4: EVALUATION, LIMITATIONS AND RECOMMENDATIONS | 93 |
| 4.1 | INTRODUCTION..... | 93 |
| 4.2 | EVALUATION..... | 93 |
| 4.2.1 | Research methodology | 93 |
| 4.2.2 | Aim and objectives of the research..... | 93 |

| | | |
|-------|---|-----|
| 4.2.3 | Central theoretical statement..... | 94 |
| 4.2.4 | Trustworthiness | 94 |
| 4.2.5 | Health research ethics..... | 95 |
| 4.3 | LIMITATIONS OF THE STUDY..... | 96 |
| 4.4 | RECOMMENDATIONS..... | 96 |
| 4.4.1 | Recommendations for nursing practice | 96 |
| 4.4.2 | Recommendations for nursing education | 97 |
| 4.4.3 | Recommendations for nursing research | 98 |
| 4.5 | SUMMARY..... | 98 |
| | BIBLIOGRAPHY..... | 100 |

List of Tables

Table 1.1: Individual and group-related causes of conflict causes of conflict4

Table 3.1: Demographic profile of participants..... 80

Table 3.2: Themes and sub-themes Error! Bookmark not defined.

List of Figures

Figure 1.1: Graphic depiction of the causes of conflict in healthcare.....3

Figure 1.2: Graphic depiction the steps of the research process applied to this research.....12

Figure 3.1: Graphic depiction of subthemes.....83

| ANNEXURES | Page |
|--|-------------------------------------|
| ADDENDUM A: HREC CERTIFICATE..... | 101 |
| ADDENDUM B: ADVERTISEMENT | 102 |
| ADDENDUM C: INFORMED CONSENT | 103 |
| ADDENDUM D: EXERPT FROM A TRANSCRIBED INTERVIEW | 111 |
| ADDENDUM E: EXAMPLE OF FIELD NOTES | 127 |
| ADDENDUM F: CERTIFICATE OF LANGUAGE EDITING..... | 128 |
| ADDENDUM G: SELF-REFLECTION..... | 129 |
| ADDENDUM H: TURN-IT-IN REPORT | Error! Bookmark not defined. |

LIST OF ABBREVIATIONS

| | |
|--------|---|
| AACN | American Association for Critical-Care Nurses |
| CQ | Cultural intelligence |
| EQ/ EI | Emotional intelligence |
| FASSET | Finance and Accounting Services Sector Education and Training Authority |
| GDM | Gender diversity management |
| GOC | General Officer Commanding |
| RNAO | Registered Nurses' Association of Ontario |
| SANC | South African Nursing Council |
| SQ | Social intelligence |
| UK | United Kingdom |
| USA | United States of America |
| VIP | Very important person |
| WHO | World Health Organisation |

CHAPTER 1: INTRODUCTION TO THE RESEARCH

1.1 INTRODUCTION

Already two decades ago South Africa was listed as a significantly diverse country, while the top twenty most diverse countries globally co-exist on the African continent (Alesina *et al.*, 2003:162). Diversity infiltrates the workplace and aspects of culture, gender, age, generations, beliefs, race, historical experiences and qualifications make workplace conflict inevitable (Finance and Accounting Services Sector Education and Training Authority [FASSET], 2013:5). The healthcare industry is not immune to workplace diversity.

In Chapter 1, the researcher presents the background and problem statement by discussing the realities of conflict management and workplace diversity within South African healthcare organisations. The reader is furthermore accompanied through an introduction to the methodology. Chapter 1 concludes with strategies to enhance trustworthiness and the health research ethics considerations.

1.2 BACKGROUND AND PROBLEM STATEMENT

In nursing, a healthy work environment refers to a deliberate context that strives to ensure that patient outcomes are met, organisational goals are achieved and work and care environments are safe, healing, humane and respectful of the rights, responsibilities, needs and contributions of all people – including patients, their families and nurses (American Association for Critical-Care Nurses [AACN], 2005:12). Healthy work environments (also known as positive practice environments) support the well-being of healthcare providers in low, middle and high-income countries. It enables a motivated, productive and high performing pool of personnel who deliver high quality care (International Collaborating Partners of the Positive Practice Environments Campaigns, 2008). Varieties of a healthy work environment, such as a supportive work environment, are an environment where managers encourage employees to take action based on their best judgement without always seeking approval first (Botes, 2014:51). The guidelines for a healthy work environment according to the AACN (2005:12) are embedded within the following six (6) standards:

- Nurses are proficient in both communication and clinical skills.
- Nurses pursue and foster true collaboration.
- Effective decision-making evident in valued and committed partners in policy, directing and evaluating clinical care and leading organisational operations.

- Appropriate staffing, ensuring an effective match between patient needs and nurse competencies.
- Meaningful recognition of the value that nurses and others bring to the organisation.
- Authentic leadership where nurse leaders fully embrace the imperative of a healthy work environment, authentically live it and engage others in its achievement.

Yet, obtaining and maintaining a healthy work environment is complex when considering the discrepancy between evolved medical technology versus relatively stagnated healthcare organisations (Gerardi, 2004:182). Gerardi (2004:184) describes this discrepancy of advanced technology versus stagnation as a complexity characterised by poor communication, unclear policies, role confusion, turf battles and stressful interpersonal conflicts. Complex healthcare organisations imply that conflict is inevitable in everyday social, organisational and professional nursing life (Meyer *et al.*, 2011:256; Tillet & French, 2012:1). Besides organisational complexities, conflict is inherent in human nature because it is an integral part of personal growth and development (Meyer *et al.*, 2011:256). Each nurse as individual holds different character traits, personalities and life views, and the challenge faced by the manager is how to develop solid working relationships (Booyens, 2011:530; Gerardi, 2004:182). The nurse manager is central to managing a turbulent, ever-changing work environment (Al-Hamdani *et al.*, 2011:573); needs guidance to develop and implement a healthy work environment (Twigg & McCullough, 2014:86) and manage conflict in the organisation.

In order to understand the role of the nurse manager in conflict management, the reader should understand what the concept *conflict* entails. Conflict refers to a situation where two or more parties are aware of needs differences and perceive their values or needs as incompatible (Booyens, 2011:529; Tillet & French, 2012:6; Johansen, 2012:50). Conflict arises when a person knowingly or unknowingly hampers the ideas and/or efforts of another person (Meyer *et al.*, 2011:256). Conflict management refers to a process of i) recognising the conflict, ii) determining the intensity, iii) evaluating the effects of the intensity, iv) determining appropriate intervention methods, and v) observing the results (Çınar & Kaban, 2012:199). The reality of conflict among nurses and the need for conflict management by nurse managers are invigorated by Pavlakis *et al.* (2011:244).

There are various causes of conflict in healthcare as graphically depicted in Figure 1 and discussed in the following paragraphs.

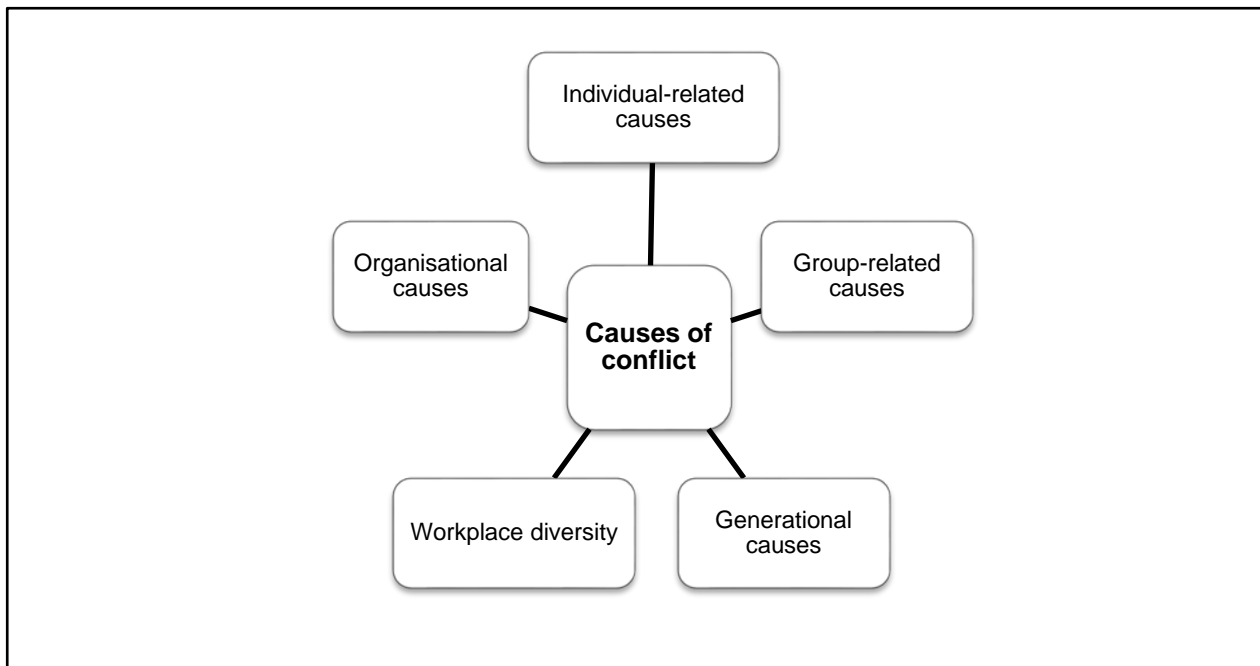


Figure 1.1 Graphic depiction of the causes of conflict in healthcare

In general, the workplace is characterised by differences in employment needs and values, work ethics, attitudes towards authority and professional aspirations (Nelsey & Brownie, 2012:197). When individual team members are brought together to accomplish a task, differences in individual opinions, interests, background and beliefs may give rise to intragroup conflicts (Greer *et al.*, 2012:936). Sources of conflict within a healthcare facility are classified into different groups, such as individual and group-related causes, organisational causes, workplace diversity and cross-generational conflict. Individual and group causes of conflict are listed in Table 1.

Table 1.1: Individual and group-related causes of conflict (Meyer *et al.*, 2011:256)

| Individual causes of conflict | Group-related causes of conflict |
|--|--|
| <ul style="list-style-type: none"> • Role conflict and/or ambiguity. • Over-competitiveness. • Jealousy. • Limited job satisfaction. • Insecurity. • Poor self-esteem. • Too little or too much responsibility. • Lack of managerial support. • Lack of participation in decision-making. • Rapid change. • Pressures such as economic and marital pressures. | <ul style="list-style-type: none"> • Different values, attitudes and personalities. • Poor teamwork. • Poor group cohesiveness. • Ineffective management style. • Rigid policies and/or procedures. • Scarce resources. • Rivalry for rewards or acknowledgement. • Unworkable organisational structure. • Ineffective bureaucratic systems. • Interpersonal conflict. • Power struggles. • Hidden agendas. • Mistrust and misunderstanding. • Dishonest and vague communication. • Unresolved disagreements. • Ineffective problem-solving and decision-making strategies. • 'Us' versus 'them' attitudes. |

In addition to individual and group-related causes of conflict, there are organisational and workplace diversity causes of conflict. The latter causes are listed as:

- personal differences (Higazee, 2015:8; Mokoka, *et al.*, 2010:486; Pavlakis *et al.*, 2011:242) and status differences (Çınar & Kaban, 2012:198);
- lack of clear job descriptions and responsibilities (Higazee, 2015:8; Pavlakis *et al.*, 2011:242);
- role incompatibility (Pavlakis *et al.*, 2011:242) and role uncertainty (Çınar & Kaban, 2012:198, Higazee, 2015:8);
- high stress levels, material and human resource scarcity and job uncertainty (Pavlakis *et al.*, 2011:242, Mokoka *et al.*, 2010:487, Higazee, 2015:8);
- award and incitement systems, the size of the organisation and the differences in the management methods (Çınar & Kaban, 2012:198);
- insufficient communication (Çınar & Kaban, 2012:198; Stimie & Fouche, 2004:4, Higazee, 2015:8);
- strained relations contributing to employee stress, frustration, reduced performance levels and influencing intra-collaboration among personnel (Cohn *et al.*, 2005:53, Higazee, 2015:8);
- ill equipped middle management of employee issues, especially in top-to-bottom decision-making, leaving top management to deal with lower level managerial issues (Stimie & Fouche, 2004:4); and

- unreasonable expectations (Higazee, 2015:8).

Different generations also cause conflict. The current nursing workforce is comprised of three generational cohorts, namely the Baby Boomers, Generation X and the Millennials and presents with challenges in effective communication and workplace harmony (Leiter *et al.*, 2010:971). Enhanced understanding of work life and collegiality across the generations can aid the establishment of healthy work environments and improve retention.

The nurse manager is responsible for managing diverse groups to ensure healthy work relations and effective interpersonal communication. It is also the nurse manager's function to facilitate cooperation despite generational differences (Hahn, 2011:124). Nurse managers should have competencies in conflict management, briefly summarised as:

- Conflict management is a *learned skill* because detecting initial symptoms of conflict and adopting the most effective behaviour to conflict management is essential (Mohamed & Yousef, 2014:164).
- As nursing is an emotionally charged profession, the competence to manage emotion and interpersonal conflict effectively is essential for nurse managers and is captured within *emotional intelligence* (EI) (Heris & Heris, 2011:1621; Mohamed & Yousef, 2014:160; Veshki *et al.*, 2012:154). There are significant relations between EI and subordinates' styles of handling conflict with supervisors. Supervisors with high EI will use an integrating style (both parties find a creative solution to satisfy both parties' concerns) or/and a compromising style (both parties win some and lose some, in an attempt to reach a consensus) (Mohamed & Yousef, 2014:161). Emotional intelligence (EI) refers to the ability to monitor one's own and others' feelings and emotions, to discriminate among them and to use this information to guide one's thinking and actions, also the capacity to perceive emotions, assimilate emotion-related feelings, understand the information of these emotions and manage them (Mohamed & Yousef, 2014:160).
- The ability to develop interpersonal relationships through *collaborative interactions* (Warshwasky *et al.*, 2012:420).
- *Organisational commitment* and *organisational communication* (Chappell & Willis, 2013:401) as nurse managers are required to communicate effectively on multiple levels (Amestoya *et al.*, 2014:81).

Methods of conflict management are important because it will provide the nurse manager with options that will enable her/him to resolve the conflict amicably. Kaitelidou *et al.* (2012:577) suggest conflict management education for healthcare professionals. Another method is to assess how nurses deal with conflict in an effort to develop and implement conflict management

training (Johansen, 2012:50). Furthermore, active undergraduate training in conflict management skills and application to specific team conflict dynamics are critical (Greer *et al.*, 2012:935). More methods of conflict management are avoidance, smoothing, domination or forcing, compromise or bargaining, and problem solving by confrontation and integration (Cremer, 1980:22; Johansen, 2012:50). Cremer¹ (1980:22) identifies the following methods of conflict management in the nursing practice:

- *Avoidance* by taking the line of least resistance. It requires each party to withhold his/her feelings or beliefs. Avoidance does not resolve conflict, but fosters it.
- *Smoothing*, when the differences between conflicting parties are minimised and downplayed and common interests are emphasised. Smoothing is ineffective and short-lived, because the differences almost invariably recur.
- *Domination/forcing* as a superficial method occurring when two parties clash. Their supervisor resolves the conflict and forces them to accept the decision. Although the overt discord may be eliminated, the source is not, and employees may retaliate with poor work outcomes or absenteeism.
- *Compromise/bargaining* is a method requiring each party to give up something. It signifies recognition of each party, whereby one side may gain at the expense of the other. The outcome is seldom satisfactory or lasting.
- *Problem solving by confrontation and integration* is the method requiring considerable thought and insight. The problem or differences must be fully revealed. Both parties should be interviewed and verbal interaction should be clear and easily understood. The manager has to reconstruct the whole from the two (or more) parts in a climate of frankness. The full range of alternatives should be considered and the parties should work towards mutual management of the conflict. This method requires objectivity, honesty and diplomacy.
- *Managers should use a positive approach* to strengthen the self-respect of the persons involved. The interview should continue until a solution is reached that is of mutual satisfaction. If this is not possible, the matter must be referred to higher authority.

Effective conflict management impacts positively on organisational outcomes. Managers of organisations with good conflict management practices increase staff efficiency and effectiveness and the organisational behaviour of the nurse manager will contribute to the achievement of organisational goals (Heris & Heris, 2011:1621). There is a positive relationship between organisational culture and business performance (Daft & Marcic, 2014:75).

¹ The Cremer article was published in 1980, yet remains a valuable publication on conflict management in nursing practice to date.

Based on the above methods, it is evident that effective conflict management is a skill that can be learned (Al-Hamdan, 2009:32; Greer *et al.*, 2012:940). Nurse managers can minimise conflict by educating nurses to manage conflict effectively themselves (Johansen, 2012:51). Effective conflict management strategies can minimize the negative impacts of conflict on different parties, which helps to create a healthy work environment (Chan *et al.*, 2014:934). Effective conflict management requires clear communication and a level of understanding of the perceived areas of disagreement (Johansen, 2012:51). Cultivating communication effectiveness can transform the workplace and improve the work environment (Cohn *et al.*, 2005:53). According to Patton (2014:14), the elimination of dysfunctional conflict in healthcare is impossible, but proper management of conflict is feasible. Dysfunctional conflict management refers to avoidance, to ignoring or taking conflict for granted (Meyer *et al.*, 2011:256) and hinders organisational performance (Kreitner & Kinicki, 2010:375). The result of dysfunctional conflict management is mistrust, poor teamwork and poor group cohesion (Meyer *et al.*, 2011:256). There is a negative link between poor conflict management and negative team performance (Greer *et al.*, 2012:936).

The paragraphs expounded above show that conflict is viewed as an inevitable part of human dynamics. This is even more present in complex and dynamic healthcare organisations characterised by diversity. The nurse manager is central to conflict management, although managers don't necessarily have conflict management skills. Nurse managers' active conflict management is central to creating and maintaining a healthy work environment. International literature confirms the role of the nurse manager in conflict management. The gap identified is that limited literature is available on the conflict management skills of nurse managers within the South African healthcare context. Searches from EbscoHost, ScienceDirect, eJournals, Google Scholar presented very limited South African-based literature. In fact, the most appropriate journal article found was dated in 1980 by Cremer. This let the researcher to ask "*what are nurse managers' experiences of conflict management and their conflict management skills within a South African-based, diverse healthcare organisation?*"

The following ensuing research questions were formulated:

- **Central research question:** How do nurse managers within a specific South African Healthcare centre organisation experience the conflict and the management thereof?
- **Probing research question 1:** What is the current workplace diversity within South African healthcare organisations that may cause conflict?
- **Probing research question 2:** What are nurse managers' experiences of conflict management and their conflict management skills within a diverse workplace?

1.3 PURPOSE, AIM AND OBJECTIVES

The purpose of this research was to contribute to the body of knowledge about conflict management skills by nurse managers in a diverse workplace to create a healthy work environment. The research aimed to understand nurse managers' conflict management skills within a diverse workplace in order to formulate recommendations to foster a healthy work environment. The aim was obtained by pursuing the following research objectives:

- **1st research objective:** To explore and describe workplace diversity within the current South African healthcare organisations. This objective was addressed by means of a literature review (presented in Chapter 2).
- **2nd research objective:** To explore and describe nurse managers' experiences of conflict management and their conflict management skills within a workplace with a diverse workforce. This objective was obtained through a qualitative, phenomenological methodology (presented in Chapter 3).

1.4 PARADIGMATIC PERSPECTIVE

A paradigmatic perspective represents the researcher's views about life and its influence on the research (Botma *et al.*, 2010:186). Such a perspective comprises of meta-theoretical, theoretical and methodological assumptions.

1.4.1 Meta-theoretical assumptions

Meta-theoretical assumptions refer to the researcher's beliefs about human beings, the environment they live in, health and interactions of the human beings with the health system / nursing. It refers to the philosophical orientation of the researcher, but it cannot be tested scientifically (Botma *et al.*, 2010:187). Meta-theoretical frameworks are the cohesive set of assumptions about causation and phenomena that guide the generation of pragmatic theoretical models (Hruby *et al.*, 2016:590). The researcher's philosophical orientation is founded on the Christian religion, which states that all humans are equal and should be treated with respect.

1.4.2 Theoretical assumptions

Theoretical assumptions are theoretical knowledge that includes theories, concepts and definitions to support the research (Botma *et al.*, 2010:187).

1.4.2.1 Standards of a healthy work environment

The standards of a healthy work environment (AACN, 2005:13) serve as a theoretical framework in this research, as described hereafter. These standards are supported by an inextricable link

between healthy work environments and optimal outcomes for patients, health care professionals, and health care organisations (AACN, 2016:1).

- **Skilled communication:** This is essential during conflict management. It is crucial for the nurse manager to be equipped with effective communication skills to resolve conflict in the diverse healthcare organisation (AACN, 2016:13).
- **True collaboration:** The nurse manager is at the centre of the multidisciplinary team, and as such must maintain collaboration between the multidisciplinary team and thereby ensure patient care is not compromised due to conflict in the diverse healthcare organisation (AACN, 2016:17).
- **Effective decision-making:** The nurse manager must implement effective decisions in managing conflict and also fulfil her role of ensuring quality patient care is rendered (AACN, 2016:20).
- **Appropriate staffing:** The nurse manager delegates tasks to competent nurse practitioners to render quality healthcare to all patients, therefore creating a safe and therapeutic environment for both patients and healthcare personnel (AACN, 2016:25).
- **Meaningful recognition:** The nurse manager should express how he / she values personnel and extend appreciation for each individual's unique contributions in the healthy work environment (AACN, 2016:29).
- **Authentic leadership:** This implies that nurse leaders must be equipped with the required qualifications and experience to articulate and formulate guidelines that will operationalise a well-functioning positive practice environment in the healthcare organisation (AACN, 2016:33).

1.4.2.2 Central theoretical statement

A better understanding of the diversity within the South African healthcare industry's workplaces in which nurse managers should manage conflict and of nurse managers' current conflict management skills may assist the researcher to formulate recommendations for appropriate conflict management skills within these workplaces. When nurse managers manage conflict within a workplace with a diverse workforce appropriately, conflict and diversity can enrich the facilitation of a healthy work environment.

1.4.2.3 Definition of concepts

In order to ensure consensus on different concepts in the research and to give clarity to the reader, all applicable concepts are defined in the following paragraphs.

Nurse manager

The nurse manager is central to this research, so it is imperative to clarify this concept. The nurse manager functions as a clinical discipline leader who provides the administrative/operational practice on a particular unit, groups of units, product line group, or continuum grouping of units (AACN, 2006:1). The nurse manager is a person who demonstrates professional leadership by taking an active role in the formulation and implementation of policies throughout the health organisation (AACN, 2006:2). For the purpose of this research, it is imperative to understand that the nurse manager is an operational manager and is responsible for leading the unit. As such, he/she should have authority, power and influence to lead followers to their goals, and should implement an effective leadership style in a complex healthcare environment (Meyer *et al.*, 2011:160).

Organisation

An organisation in healthcare is defined as a health service, as all services that deal with the diagnosis and treatment of disease, or the promotion, maintenance and restoration of health (World Health Organisation [WHO], 2015).

Conflict

Conflict is best described as a noun and a verb. As a noun, conflict refers to an active disagreement *between* people with opposing principles or opinions. As a verb, conflict refers to dissimilar and incompatible beliefs, facts, needs (Cambridge University Press, 2016).

Conflict management and conflict management skills

Conflict management is a multidimensional concept, consisting of managing conflict through integration, consideration, domination, avoidance and compromise (Rahim 1983, Ahanchian *et al.*, 2015:141). Conflict management skills are the means through which nurse managers deal with conflict. Therefore conflict management strategies (also referred to as styles) are utilised to resolve conflict in diverse healthcare organisations (Ahanchian *et al.*, 2015:141; Johansen & Cadmus, 2016:212).

Healthy work environment

A healthy work environment is a work and care environment that is safe, healing, humane and respectful of the rights, responsibilities, needs and contributions of all people, including patients, their families and nurses (AACN, 2005:12). A healthy work environment is paramount to the South African healthcare organisation with a diversified workforce where scores of healthcare practitioners are expected to render quality patient care and the nurse manager has a crucial role to play in creating and maintaining a healthy work environment.

Experiences

Experiences are the knowledge and skills gained from doing or performing an act for a period of time (Advanced Oxford Learner’s Dictionary, 2006:513). Experience is also defined as knowledge or practical wisdom gained from what one has observed, encountered or undergone (Mosby’s Online dictionary, 2009).

1.4.3 Methodological assumptions

The research process as stipulated in Botma *et al.* (2010:181-235) directed the methodological assumptions for this research and is graphically presented as follows:

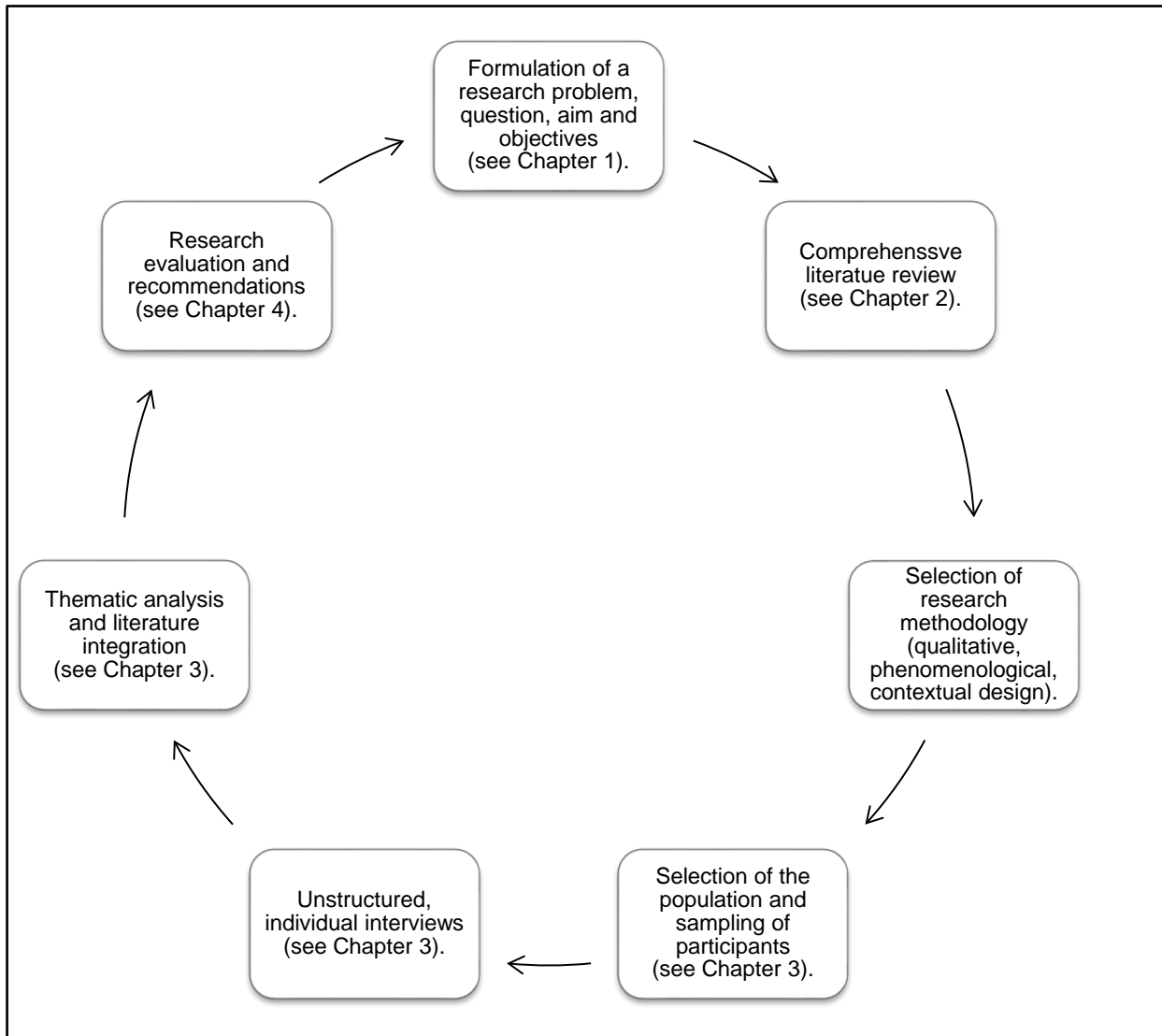


Figure 1.2: Graphic depiction of the steps of the research process applied to this research

1.5 METHODOLOGY

The research methodology can be divided into the research design and method(s).

1.5.1 Research design

The research design was a qualitative, explorative, descriptive, phenomenological, contextual approach because the researcher intended to explore nurse managers' experiences of conflict management and of their conflict management skills within a diverse workplace. The researcher explored and described the conflict management skills of nurse managers based on the real, "lived" experiences (Brink *et al.*, 2012:121). The researcher intended to understand the nurse managers' experiences of conflict management and wanted to collect rich, thick descriptions directly from the nurse managers (Botma *et al.*, 2010:190; Burns & Grove, 2010:54; Brink *et al.*, 2012:121-122).

1.5.2 Research method(s)

The research methods are described as the research setting, the population and sampling, the method of data collection, role of the researcher and data analysis.

1.5.2.1 Research setting

The primary setting where the research was conducted was a military hospital in Gauteng. This was at the participants' place of work, a natural setting that constituted an uncontrolled, real life situation and excluded manipulation in any way (Burns & Grove, 2010:362). Interviews were conducted in a pre-arranged office on the hospital's premises. The office ensured privacy, had a "Do not disturb" notice on the door, and ensured sufficient and comfortable seating and ventilation. A digital voice recorder was used. The office was evaluated according to the level of background noise. It was prepared before interviews started so that it had two comfortable chairs and a suitable space for the digital voice recorder.

1.5.2.2 Population, sample, sampling, sample size

The research population (Burns & Grove, 2010:42) was unit managers in a military hospital in the Gauteng province. The researcher selected the population at this particular institution because the hospital was in Gauteng and employed personnel from all nine provinces of South Africa. It is macrocosm of South Africa at large, a typical diversified workplace.

The researcher used purposive sampling (Burns & Grove, 2010:355) by selecting the nurse managers who were the most likely to provide the best information about their experiences of their conflict management skills. As suggested by Morse and Field (*in* Botma *et al.*, 2010:199), the two guiding principles utilised during sampling were appropriateness (the identification and use of participants - nurse managers - who can best inform the researcher), and adequacy (enough

data are available to develop full and rich descriptions of the phenomenon of conflict management skills). Participants' experiences were explored and described within their natural setting (Botma *et al.*, 2010:200). The following inclusion criteria were applied:

- Participants had to be a professional nurse registered with Nursing Administration at the South African Nursing Council. Nurse managers registered for Nursing Administration complete a formal nursing management programme where conflict management is generally part of the curriculum.
- Participants must have been permanently employed for at least three years preceding the study in a managerial position as this would enable the researcher to provide real lived experiences of conflict within the workplace.
- Participants could represent any culture and gender, but had to be able to use English as mode of communication.
- Participants had to be willing to provide voluntary, written informed consent and to spend at least one hour with the researcher for an in-depth, digitally voice recorded, individual interview.

The process of participant recruitment is discussed under point 10.1. The sample size was 15 and the actual sample was 13.

1.5.2.3 Data collection technique

Unstructured, individual interviews were conducted to obtain rich and in-depth data (Botma *et al.*, 2010:206-207; Brink *et al.*, 2012:157; Burns & Grove, 2010:510) of nurse managers' experiences of their conflict management skills within a diverse workplace. The sample size was established once data saturation occurred (N=13). Data saturation entailed that no new information surfaced. The researcher conducted the interviews herself after receiving training and under close supervision by the study leader. One-day training with the study leader covering the following content regarding unstructured, individual interviews was conducted before starting with data collection. Only after the study leader confirmed that the researcher was able to conduct an effective unstructured, individual interview, data collection was started. The unstructured, individual interviews were conducted as follows:

- The interviewer welcomed the participant and used introductory pleasantries to create rapport and a relaxed atmosphere.
- The interviewer stated purpose of the research, confirmed confidentiality and anonymity and stated the role that the interview plays in the research (Greeff *in* Botma *et al.*, 2010:207).
- When all formalities were done, the interviewer started the interview with a single open question, namely:

As a nurse manager, how do you experience conflict management and your conflict management skills within your workplace?

- The interviewer used non-verbal and verbal communication skills in the exploration of the interview question. The non-verbal communication skills entailed an open posture, active listening and being relaxed. The verbal communication skills refer to minimal verbal responses by only nodding while listening to the participants, paraphrasing, reflecting, probing, summarising, clarifying and acknowledging (Okun *in* Botma *et al.*, 2010:206).
- Once the interviewer summarised the content and the participant had no more information to add, the interviewer ended the interview (Botma *et al.*, 2010:208).

Digitally voice-recorded interviews were transferred from the digital voice recorder to the researcher's password-protected computer. Thereafter recordings were deleted from the voice recorder. Voice recordings were given to the transcriber on an external hard drive. After the transcriber copied the voice recordings to her password-protected computer, the researcher kept the external hard drive and password-protected computer in the lockable office of the study leader on the premises of the Potchefstroom Campus of the North-West University where it will remain for a minimum of five (5) years (2016-2020). When the researcher received the transcriptions, the transcriber permanently deleted all the recordings from her computer.

1.5.3 Field notes

Field notes are a written account of the things the researcher hears, sees, feels, experiences and thinks over the course of the interview. It is much broader, analytical and interpretive than a mere listing of occurrences (Botma *et al.*, 2010:217). It includes both empirical observations and personal interpretations of the researcher. The researcher compiled notes of the discussions, setting where the interview took place, as well as on the thoughts, feelings and observations of the researcher on what methods worked or did not work (Botma *et al.*, 2010:217). Field notes are frequently the record-keeping devices for interviews. It is therefore imperative for the researcher to compile it during the course of the research in order to achieve a detailed account of all the observations of the research (Brink *et al.*, 2012:159). Field notes are either used as part of the data or for verification purposes (Botma *et al.*, 2010:217). It includes demographic notes on the time of the day, the weather and the participants' actions and body language during the interview. Field notes (Creswell *in* Botma *et al.*, 2010:191 & 219) consist of three segments, namely descriptive notes (notes on dialogue, participant actions, immediate surroundings and events), reflective notes (the researcher's own thoughts, feelings and observations about what methods

worked and what did not) and demographic information (notes about the time of day, the weather, the room and participants). See addendum E for a summary of field notes.

The data analysis of the transcribed data was based on the steps of coding by Tesch (1990) as suggested by Creswell *in Botma et al.* (2010:224-225). The steps were as follows:

Step 1: Organising and preparing the data for analysis

All recordings were transcribed in order to organise and prepare the data for data analysis. The researcher typed field notes and ordered the transcriptions with a code according to the sequence of interviews conducted.

Step 2: Developing a general sense of the data

To obtain a general sense of what the information entails, the researcher read through all the transcriptions. During the process of reflection, the researcher wrote notes and general thoughts expressed in the transcriptions.

Step 3: Coding the data

The researcher followed the steps of data coding according to Creswell (*in Botma et al.*, 2010:224). They are as follows:

1. Getting a sense of the whole by reading all the transcripts carefully, and simultaneously jotting down ideas in the margin that might come to mind;
2. Picking the first interview's transcript and asking "what is it about?" to see the underlying meaning of the transcript.
3. Reading through several participants' data with the aim of identifying the underlying meaning and making a list of all the topics that came to mind. These topics are then compiled into columns under major, minor and left over topics.
4. Taking the list of themes and returned to the data, abbreviating the topics as codes and writing the codes next to the appropriate segments of text, identifying whether new categories and codes surfaced during this process.
5. Finding the most descriptive wording for the topics and turning them into categories. Attempting to reduce the list of topics by grouping relevant categories to relate to each other and drawing lines between categories to show interrelationships.
6. Making a final decision on the abbreviations for each category and alphabetise these codes.
7. Assembling the data material belonging to each category in one place and performing a preliminary analysis.

Step 4: Describing and identifying themes

The researcher generated themes and headings that displayed the detailed; multiple perspectives from the participants and their diverse quotations in their own words (see Table 3.2 in Chapter 3).

Step 5: Representing the findings

After identifying themes, the researcher formulated a detailed narrative to convey the findings of the data analysis. The narrative contained several themes with sub-themes, including the use of a table and a figure, multiple perspectives from the individual nurse managers and their direct quotations with specific evidence.

Step 6: Interpreting the data

The interpretation of data implied making meaning, in other words it is the researcher's personal interpretation supported by literature. A second, independent coder conducted data analysis followed by a consensus discussion (Botma *et al.*, 2010:224). The independent co-coder signed a confidentiality agreement before commencing with data analysis. The reporting of the research results was done as a discussion integrated with literature.

1.6 MEASURES TO ENSURE RIGOUR: TRUSTWORTHINESS

Botma *et al.* (2010:232) and Polit and Beck (2012:584) combined strategies from different authors (*with specific reference to* Krefting, 1991; Lincoln & Guba, 1985) to safeguard rigour in qualitative research. It is called trustworthiness. Strategies to enhance trustworthiness are based on risks associated with qualitative research. A discussion of how trustworthiness was applied according to the epistemological standards of trustworthiness as truth value, applicability, consistency, neutrality and authenticity, follows.

1.6.1 Truth value

In pursuit of truth value, the researcher should establish trust that the results from the unstructured, individual interviews with nurse managers within a diverse workplace, were the truth. Truth value was strengthened through credibility. Credibility was obtained through prolonged engagement with literature, which enabled the researcher to fortify an argument as presented in the background and problem statement and prolonged engagement as researcher within the field (Brink *et al.*, 2012:172). Peer review was done through regular follow-up feedback with study supervisors and having one supervisor trained in psychiatric nursing and one supervisor with a master's degree in business administration. The researcher included all information in the findings, attempted to stay neutral despite being emerged in the realities of conflict within diversified workplaces herself because subjectivity leads to criticism in qualitative research.

1.6.2 Applicability

Qualitative research is contextual and within phenomenology the researcher aimed to capture the lived experiences of nurse managers within their diversified workplaces as natural environments. This risked applicability as the findings are representative of the specific military hospital and the specific nurse managers and cannot be generalised to all military healthcare facilities. Therefore, the researcher deployed actions to enhance the transferability of the research. Transferability was improved by means of a rich description of the research methodology to make this research report an audit trail with detailed findings and field notes. Unstructured, individual interviews continued until data saturation was reached.

1.6.3 Consistency

Consistency requires that a repetition of this research will present similar findings. Consistency was strengthened through the following actions to enhance dependability: the literature review explored all available models, theories and frameworks of conflict within the general and the healthcare environment. Chapter 1 provides a detailed description of the proposed and realised methodology. The researcher asked the same open-ended question in every interview. The researcher utilised stepwise replications of each interview and then used a co-coder to confirm the analysis outcomes (Brink *et al.*, 2012: 173).

1.6.4 Neutrality

Neutrality (Sandelowski, 1986) refers to freedom from bias in the research process and results. Neutrality is best maintained through confirmability. Confirmability was strengthened through reflexivity captured within field notes. The prospective participants were recruited by a mediator, not the researcher, and had sufficient opportunity to consider their participation. The researcher declared her position as a lecturer at the nursing college within the military and adhered to ethical considerations. As the researcher's position within the military context was dissimilar to that of nurse managers, there was no coercion. During the interviews, regular summaries of content and clarifications of uncertainties were done.

1.6.5 Authenticity

According to Tobin and Begley (2004:392), authenticity in qualitative research is when dissimilar actualities that arose during the research process, were portrayed with all the related issues, trepidations and underlying beliefs. Authenticity was supported in this research through unstructured, individual and in-depth interviews where the true real lived experiences of nurse managers, with dissimilar demographic characteristics, were explored.

1.7 HEALTH RESEARCH ETHICS

Health research ethics entail the researcher's conscious efforts from the time of conceptualisation and the planning phase, through the implementation phase, to the dissemination phase to ensure adherence to principles of integrity, honesty and truth to protect the research participants (Botma *et al.*, 2010:1; Brink *et al.*, 2012:32; Burns & Grove, 2010:184; Polit & Beck, 2012:150). Health research ethics were essential because it allowed the researcher to generate a sound evidence-based practice for nursing and the research was conducted competently, rigorously and based on scientific methodology. The researcher adhered to the ethical principles that rendered the research findings trustworthy and ethical (Brink *et al.*, 2012:32; Burns & Grove, 2010:184).

1.7.1 Levels of clearance, permission and consent

The levels and processes of ethical clearance, permission to conduct the research, consent to participate and participant recruitment are listed below.

- After the research proposal was approved by the postgraduate education and research committee (PERC) of INSINQ focus area of the School of Nursing Science, the researcher applied for ethics clearance from the Health Research Ethics Committee (HREC) of the Faculty of Health Sciences of the North-West University (Potchefstroom Campus).
- Permission was thereafter requested from the Gauteng Department of Health.
- Proof of ethics clearance was submitted for permission from the Chief Executive Officer, known as the General Officer Commanding (GOC), of the identified military hospital.
- The gatekeeper was the central point through which the researcher had access to the population. The researcher submitted a written application to the nursing service manager. The nursing service manager delegated the task to the deputy nursing service manager, who became the gatekeeper who assisted the researcher with easy access to the nurse managers and with appointing a mediator to assist with the recruitment of prospective participants.
- The researcher had an introductory meeting with the mediator to discuss the purpose of the research, the inclusion criteria, the method of data collection, the possible dates and times for interviews, the use of a digital voice recorder and the process of completing the written informed consent.
- The mediator recruited prospective participants, provided at least 24 hours for participants to decide about their participation, and allowed participants to sign the informed consent letter and then scheduled the date and time of interviews.
- Participants could contact the researcher once they declared their willingness to participate if the mediator could not provide sufficient answers.
- The mediator reminded each participant the day before the interviews.

1.7.2 Respect for persons

The mediator was trained regarding her role and responsibilities in the research and completed a confidentiality agreement and consent to act as mediator. The mediator informed the participants of the proposed research and allowed the participants to decide voluntarily whether to participate or not. She therefore respected the dignity and well-being of the participants. The informed consent explained what the purpose of the research was. Participants were informed that they could terminate their participation at any time without discrimination. Anonymity was ensured by giving a code to each participant from transcription. The transcriber signed a confidentiality agreement. Participants were informed that the management of the hospital will not be able to link feedback to a particular participant.

1.7.3 Relevance and value

The research is relevant as South Africa has a diverse workplace. The research can contribute to the body of knowledge and can add value to healthy work environments in diversified South African healthcare organisations. There is a shortage of recent publications on conflict management by nurse managers in a workplace with a diverse workforce.

1.7.4 Scientific integrity

Different types of literature from national and international sources were reviewed during the compilation of this research. The researcher chose the appropriate research methodology and an audit trail was kept of all steps followed in the research process. A phenomenological approach provided rich and in-depth data about nurse managers' experiences. The researcher adhered to academic honesty and prevented plagiarism.

1.7.5 Risk of harm and likelihood of benefit

The research represented a low risk. Participants could perhaps see punitive action as a risk. There was no foreseeable harm. Participants scheduled appointments for interviews when suitable and they were not placed under pressure when they were needed for patient care. There was no direct benefit for participants. If participants experienced any emotional discomfort, the researcher referred the participants to a counsellor from the hospital's employee support programme for support, free of charge. Participants were informed that an interview may last 45-60 minutes.

1.7.6 Informed consent

All prospective participants were informed prior to the research about the purpose of the research and the dissemination of information. The principle of respect was observed by allowing participants to utilise their right to decide voluntarily on their participation in the research without any risk of penalty or prejudicial treatment. Threats to voluntariness were avoided by ensuring

that the participants are not exploited for any reason and that they participated in the research voluntarily. The researcher's behaviour was neutral and professional and she did not coerce the participants in any way. The participants' voluntariness was not infringed upon; therefore the research setting was kept relaxed and therapeutic to foster effective data collection.

All the research participants were able to give personal informed consent. The researcher explained the confidentiality aspects to participants in the consent form they signed prior the commencement of the research.

1.7.7 Distributive justice

Participants were selected fairly and the researcher did not decide on the inclusion or exclusion of participants based on other factors not relevant to the research, e.g. sexual orientation, age, disability, marital status, disability, etc. The researcher made a conscious effort to secure the well-being of the participants, hence the principle of beneficence was observed.

1.7.8 Professional competence

The researcher, study leader and co-coder's narrative curriculum vitae were declared to ensure the correct qualifications. The study leader has supervised more than 15 qualitative research studies with success. The study leader adhered to a prescheduled plan to equip the researcher in both interview skills (one day) and data analysis skills (one day) training. The research theme and research setting was a safe environment and the researcher trained the mediator. The researcher embraced data collection with empathy and compassion towards the participants. The researcher declared her role in the research. The researcher wrote a research report in article format.

1.7.9 Privacy and confidentiality

The researcher ensured autonomy over the personal information obtained from the participants and therefore held in confidence all personal and other information obtained from the participants. The participants' names were not written on the transcriptions, but were replaced with a code. Information was kept under lock and key, the information was not linked to the real identities of the participants. If for some reason the researcher had to involve another person, that person signed a confidentiality agreement explaining that he/she will not divulge any information about the participants or the research.

1.7.10 Publication of results

Not the identity of participants nor of the hospital were identified during the process of publication.

1.7.11 Storage and archiving

The electronic data were stored on a computer in an encrypted file locked with a personal password known by the researcher only. Hard copies were locked in a steel cabinet; no one else except the researcher had access to the keys to the cabinet. Data were controlled only by the researcher and the project head, who had direct access to the data. No person who did not sign a consent form was allowed access to the data. Data will be shredded after five (5) years after completion of the project and permanently removed from external storage equipment.

1.8 PROPOSED OUTLINE

The dissertation was conducted in article format and consists of four chapters, namely:

Chapter 1: Introduction and overview to the research.

Chapter 2: Literature review on workplace diversity in South African healthcare.

Chapter 3: Article for publication in the *Journal for Nursing Management*.

Chapter 4: Evaluation, recommendations and limitations.

1.9 SUMMARY

Conflict management within the nursing profession has not been explored in a sufficient manner, considering a critical publication dated 1980. Chapter 1 proposed that a phenomenological exploration and description of nurse managers' employed within an extremely diverse healthcare facility, experiences of their conflict management skills is necessary. Conflict, as an inherent human reality, can be exacerbated in diversified work environments. Diversity in itself is a growing reality within an age of internationalisation and globalisation and is therefore present within healthcare as well. Within Gauteng, South Africa, a military hospital was selected as a research setting as a representation of diversity related to gender, language, ethnicity, work function, levels of functioning, work experience, etc. This hospital can be presented as a diverse organisation within a rainbow nation.

Conflict experiences are very personal and best explored through phenomenology. This requires interviewing and the relevant data analysis skills. There were also ethics considerations as the researcher accessed a military organisation wired with protocol and hierarchical structure. A phenomenological approach necessitates strategies to enhance trustworthiness. This research is

presented in an article format, with the results reported in a manuscript prepared for the *Journal for nursing management*, an international publication.

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CHAPTER 2: LITERATURE REVIEW

AN OVERVIEW OF CONFLICT MANAGEMENT WITHIN DIVERSE HEALTHCARE WORKPLACES

2.1 INTRODUCTION

Chapter 1 introduced the research problem and methodology. Chapter 2 presents a literature review on conflict management within healthcare as a diverse workplace, in South Africa. The purpose of this literature review was to explore all available literature regarding conflict management and workplace diversity within healthcare. It was undertaken within an existing knowledge base to critique the quality of each study and to synthesise all of the studies to provide evidence of the effectiveness of a particular intervention (Botma *et al.*, 2010:63; Burns & Grove, 2010:90).

2.2 SEARCH STRATEGY FOLLOWED

The following search engines were used: EbscoHost, ScienceDirect, eJournals and Google Scholar. These search engines granted access to various national and international databases. Literature was consulted from May 2015 until October 2016. Primary and secondary research was consulted, including academic articles and peer reviews articles, as well as grey literature. The keywords used were nurse manager, conflict management, conflict resolution, work environment, workplace diversity and generational diversity.

2.3 CONFLICT MANAGEMENT

2.3.1 The concepts "conflict" and "conflict management"

Conflict in nursing is frequently described in terms of the relationship between two occupational groups, such as physicians and nurses, staff nurses and nurse managers, or two different departments (Kaitelidou *et al.*, 2012:574, Okhakhu *et al.*, 2014:117, Higazee, 2015:10). Rahim, (2002:207) defined conflict as an interactive process manifested in incompatibility, disagreement, or dissonance within or between social entities (individual, group, organisation). Kressel *et al.* (2002:367) define conflict as "any general state of tension or opposition between two or more individuals or groups, whether or not that tension is openly expressed." According to Johansen (2012:50), "most definitions agree that conflict is a process involving two or more people, where a person perceives the opposition of the other." *Conflict management* is a process, including the recognition of the conflict, determination of its intensity, evaluation of the effects of this intensity, determination of appropriate intervention methods and observation of results (Çınar & Kaban,

2012:199). Conflict management involves designing effective macro level strategies to minimise the dysfunctions of conflict and enhancing the constructive functions of conflict in order to enhance learning and effectiveness in an organisation (Rahim, 2002:208). Conflict resolution is one part of conflict management. Conflict management skills involve the manner in which nurse managers deal with conflict, therefore the conflict management strategies that are utilised to resolve the conflict in the diverse healthcare organisation (Ahanchian *et al.*, 2015:141; Johansen & Cadmus, 2016:212). To resolve the conflict, the nurse manager has to recognise the conflict, identify the involved parties, establish the causes of the conflict and subsequently implement the relevant conflict management skills to manage the conflict. Both conflict and conflict management can be described as complex concepts. One of the important elements to conflict management is to ensure a workplace where nurses feel free to speak out when difficulties arise. Therefore nurse managers have to be aware of problems and employ timely conflict-resolution plans (Timmins, 2011:34). Different conflict resolution strategies are used in an eclectic manner to form patterns that typically go together (Branje *et al.*, 2009:196). Therefore, the nurse manager must be equipped with various conflict resolution skills to resolve conflict within the South African healthcare organisation.

2.3.2 Models, theories and conceptual frameworks of conflict and conflict resolution

In light of the prevalence of conflict in the diverse workplace and the process of conflict management, it is important for the nurse manager to be familiar with various conflict resolution models and frameworks that are applied in the process of conflict management. It is imperative to understand the various conflict management models and frameworks to have insight on the application of thereof.

2.3.2.1 Dual concerns model by Blake and Mouton (1964) and added leadership styles by Mukthar (2012)

Numerous research studies were conducted to investigate the phenomenon of conflict in general (Tidd & Friedman, 2002:240; Shetach, 2009:86; Mukthar, 2012:45). Blake and Mouton are considered as the pioneers of the conceptual frameworks of conflict management styles. Their work dates as far back as 1964. They developed the managerial grid, known as the dual-concerns model, which describes an individual's conflict management behaviour as a combination of two underlying dimensions. These dimensions are the desire to satisfy one's own concern, and the desire to satisfy the other person's concerns (Tidd & Friedman, 2002:240; Shetach, 2009:86; Mukthar, 2012:45). The dual concerns model state that individuals respond to conflict using behavioural preferences, in other words conflict management styles (Mukthar, 2012:42). Based

on the dual concerns model, Mukthar (2012:42) built further on the Blake and Mouton's model by depicting five different leadership styles utilised especially in the workplace, namely the i) country club leader, ii) impoverished leader, iii) middle team leader, iv) perish leader, and the v) middle of the road style leader (Mukthar, 2012:42). The country club leadership style is employee-centred and focuses on employee's needs. The impoverished leader neither emphasises a concern for people, nor production levels. It is therefore considered an ineffective style. The middle team leader is the best strategy, emphasising both the workforce needs and production while the perish leader sees employees as a source of high productivity and considers their needs as secondary. Finally, the middle of the road style leader is balanced, aiming towards an average performance of the workforce (Mukthar, 2012:42).

2.3.2.2 Thomas and Kilmman model (1974)

In 1974 the Thomas and Kilmman model followed. This model was aligned with Blake and Mouton's dual-concerns model (1964), stating that an individual's preference for applying various conflict management styles arises from a choice between "attempting to satisfy one's own concern" and "attempting to satisfy the other's concerns" (Mukthar, 2012:43). In the event of conflict, the parties will either assertively stand up or advocate in an attempt to satisfy their own interests or collaborate to satisfy the collective needs of all involved (Mukthar, 2012:43). This model identifies the different conflict management styles namely: competition, avoidance, accommodation, collaboration and compromise.

2.3.2.3 Thomas and Pruitt model (1976 and 1983) and the five conflict management styles

Both Thomas (1976) and Pruitt (1983) put forth models based on the concerns of the parties involved in the conflict. The combination of the parties' concern for their own interests (i.e. assertiveness) and their concern for the interests of those across the table (i.e. cooperativeness), yields a particular conflict management style (Mukthar, 2012:43). Five conflict management styles are described, namely: i) competition (the parties are assertive and non-cooperative, they only have one goal, which is to satisfy their own needs) also known as the win-lose approach; ii) avoidance (the parties are non-assertive/avoiding conflict, and non-cooperative, therefore not confronting the conflict), and is useful when we do not need to address the issues causing conflict; iii) accommodation (the parties are non-assertive, they are not standing up to meet their own needs, but they are rather cooperative), thus allowing the other person's need to be met by accommodating the needs of the other parties, iv) collaboration (the parties are assertive by standing up to satisfy their own needs, but the parties are also cooperative in an attempt to meet the needs of the other parties), this method emphasises your own needs being met at any cost,

and v) compromise (there is some extent of assertiveness in standing up for your own needs, but there is also some extent of cooperation to allow the satisfaction of the other parties' needs), which is somewhere between cooperation and compromise (Mukthar, 2012:43).

As part of these conflict management styles, Pruitt describes varying levels of assertiveness (Mukthar, 2012:43 - 44), such as:

- Yielding (low assertiveness/high cooperativeness).
- Problem solving (high assertiveness/high cooperativeness).
- Inaction (low assertiveness/low cooperativeness).
- Contending (high assertiveness/low cooperativeness).

Pruitt argues that problem-solving is the preferred method when seeking mutually beneficial options (win-win) (Mukthar, 2012:44).

2.3.2.4 The five stages framework of conflict by Phillip (1988)

Phillip (1988) developed a framework within which conflict is divided into five stages, running from just surfaced conflict to well-cultivated conflict (Mukthar, 2012:44). The first stage of conflict is that which has just begun. At the onset of conflict it is usually easy to handle. If conflict is not resolved, it goes on to the second stage of dispute, in which the parties consider that the possibility of successful resolution is somewhat diminished, thus it is not easy to resolve the conflict because the parties' ego becomes more of a factor. During the second and dispute stage, there is hope that conflict can be handled so that the losses of parties can be as few as possible. There can be a win-win situation so that all parties can reach a compromise in which parties' losses can be minimised. A third stage of conflict resolution follows in the event that the dispute could not be resolved, namely the contention stage. During the third and contention stage, there is usually a win-lose situation, which is designed to help the person who is right to win and person who is wrong to lose. During this stage parties exchange less information and begin to play dirty tricks on each other, so a third party enters in a scene to select the winners and losers. The fourth stage of conflict progression is called the limited warfare stage, in which the adversary's power and will is diminished and the individual is no longer a threat (Mukthar, 2012:44). The parties' personal security is threatened by this struggle. Subsequently, there are feelings of hurt, anger, distrust, which necessitate the assistance of a third party mediator to resolve the difficulties. The final and fifth stage is all out war, in which power positions have polarized so that the individuals involved feel strongly about the issue and try to limit or completely dominate the opposition, which renders the situation rather challenging and the management of conflict complex. The nurse manager should strive to manage and resolve conflict in its early stages because it is easier and less complicated and to avoid the warfare level (Mukthar, 2012:44).

2.3.2.5 Process and structural model of conflict management by Thomas (1992)

After decades of research on conflict management, Thomas presented two conflict management models, namely the process model and the structural model (Thomas, 1992:269-272). The process model provides an analysis of the mental and interpersonal events that lead to different conflict handling modes and their consequences (Thomas, 1992:267). The process model indicates that the mental and interpersonal processes or cognitive interpretations that are experienced by individuals are a response to what is happening in their surroundings (structures), which can lead to conflict (Thomas, 1992:267). There is a relationship between cognition or reasoning influence and behaviour during conflict (Thomas, 1992:270). Yet reasoning leads to intentions and these intentions are either rational or normative. With rational reasoning, the individual engages in certain behaviour intended to gain the desired outcome (Thomas, 1992:270). With normative reasoning behaviour surfaced reflect an ethical/ moral basis. The following elements are present in conflict management, namely conflict awareness, thoughts and emotions, intentions, behaviour and consequences. According to Thomas (1992:267), the process model describes the cognitive conceptualisations used by parties involved in conflict, which ultimately has an impact on how individuals prefer to manage and resolve conflict. While the process model describes the more personal and individual processes occurring within that individual (such as cognitive reasoning and intention in behaviour), the structural model adds aspects in the individual's external environment that impacts on their behaviour and then leads to conflict. Individuals' personalities and their place of work are two factors that lead to conflict (Thomas, 1992:270).

2.3.2.6 Group conflict management by Khun and Poole (2000)

Khun and Poole (2000) provide two models that originate from the Kozan's confrontational model. The two models are the distributive and integrative models of group conflict management (Mukthar, 2012:45). In the distributive model of group conflict management, the allocations of resources are 'disrupted' irrespective of the outcome of the conflict. A *distributive* style is a confrontive approach that results in one side conceding to the other (Khun and Poole, 2000:560). The integrative model sees conflict as a chance to integrate the needs and concerns of both groups and to make the best outcome possible. According to Khun and Poole (2000:560) integrative conflict management implies an attempt to come to the best (or at least an acceptable) solution for all concerned parties. This model puts a heavier emphasis on compromise than the distributive model. Khun and Poole found that the integrative model resulted in consistently better task-related outcomes than those using the distributive model (Mukthar, 2012:45). Khun and Poole (2000:576) concluded that during group conflict, conflict management style was classified

either as “integrative” or as “nonintegrative,” This study concluded that teams managing conflicts integratively were rated as highly effective (Khun and Poole, 2000:576-577).

2.3.2.7 DeChurch and Marks’ conflict management meta-taxonomy (2001)

DeChurch and Marks (2001) examined the literature available on conflict management at the time and established what they claimed was a "meta-taxonomy" that encompasses all other models (Mukthar, 2012:45). DeChurch and Marx (2001) argued that all other styles have inherent in them into two dimensions - activeness ("*the extent to which conflict behaviours make a responsive and direct rather than inert and indirect impression*") and agreeableness ("*the extent to which conflict behaviours make a pleasant and relaxed rather than unpleasant and impression*") (Mukthar, 2012:46, 47). High activeness is characterised by openly discussing differences of opinion while fully going after their own interest. High agreeableness is characterised by attempting to satisfy all parties involved. In the study they conducted to validate this division, activeness did not have a significant effect on the effectiveness of conflict resolution, but the agreeableness of the conflict management style, whatever it was, did in fact have a positive impact on how groups felt about the way the conflict was managed, regardless of the outcome (Mukthar, 2012:45).

2.3.2.8 Rahim’s meta-model of conflict management styles (2002)

Rahim (2002:218) noted that there is agreement among management scholars that there is no one best approach to how to make decisions, lead or manage conflict. In a similar vein, rather than creating a very specific model of conflict management, Rahim created a meta-model for conflict styles based on two dimensions, concern for self and concern for others (Rahim, 2002:221). Within this framework are five management approaches: integrating, obliging, dominating, avoiding and compromising (Rahim, 2002:221). Integration involves openness, exchanging information, looking for alternatives and examining differences to solve the problem in a manner that is acceptable to both parties (Rahim, 2002:221, Mukthar, 2012:47). The integrative dimension represents a party’s concern for self and others (Rahim, 2002:221). The distributive dimension represents a party’s concern for self or others (Rahim, 2002:221). Obliging is associated with attempting to minimize the differences and highlight the commonalities to satisfy the concern of the other party. When using the dominating style, one party goes all out to win his or her objective and, as a result often ignores the needs and expectations of the other party. When avoiding a party fails to satisfy and own concern, as well as the concern of the other party. Lastly, compromising involves give-and-take whereby both parties give up something to make a mutually acceptable decision (Mukthar, 2012:47).

2.3.2.9 Shetach's model for conflict management (2009)

Based on what has been discussed about conflict, conflict plays a part in every event in which more than one individual is present, whether the individual represents him- or herself, his or her unit or party, his or her organisation, or government (Shetach, 2009:82). According to Shetach (2009:83), conflict is the differences of opinion or contradiction of interests among two or more people, parties or factors (departments, organisations, nations etc.). The model suggests that managers consider four critical tools to increase their ability to control a conflict situation: i) "Northern Star"; ii) "Conflict Evolvement Map"; iii) Awareness of the variety of the available response options; iv) Awareness of one's personal conflict-resolution style (Shetach, 2009:86).

- "Northern Star" denotes "strategy" or "long-term goal", referring to the manager's strategy for the specific conflict constellation in which he/she is (Shetach, 2009:86). It should be considered on two levels: namely, what is the main goal he or she is interested in pursuing regarding the specific communication at hand and what is his or her future objectives regarding the working relationships with the other parties involved (Shetach, 2009:86). Blake and Mouton (1964, 1970) refer to those two dimensions as "task orientation" and "people orientation" (Shetach, 2009:86). The underlying assumption of this notion is that the higher the level of cognitive accessibility of the manager to the strategy and goals before commencing a particular conflict communication process, the higher the probability that the conflict situation will be steered constructively toward the specific goal and, consequently, toward the general strategy (Shetach, 2009:86-87).
- The Conflict Evolvement Map is aimed at helping the user identify his or her level of personal involvement, versus the extent of his or her relevant matter-of-course handling of the conflict at any point in the conflict process. When the image of the "map" is clear enough in one's mind, it can guide a manager in the conflict management process by guiding him or her to detect the first hints of negative emotional reactions within. This redirects the course of the discussion to a matter-of-course level, before emotions become inflamed beyond self-control (Shetach, 2009:89).
- There should be awareness of the variety of the available response options, which is also based on the two-dimensional model of Blake and Mouton of 1964 and 1970. The two dimensions are interpreted in terms of five modes or styles: competition (high assertiveness, low cooperativeness); avoidance (low assertiveness, low cooperativeness); accommodation (low assertiveness, high cooperativeness); collaboration (high assertiveness, high cooperativeness); and compromise (medium assertiveness, medium cooperativeness (Shetach, 2009:91). The manager's familiarity with the five concepts of competition, avoidance, accommodation, collaboration and compromise, increases his or her awareness

of behavioural options beyond his or her own natural, automatic, personality-induced strategies. It increases the probability that he or she will actually and consciously attempt to adapt a strategy to fit the particular situation he or she is in (Shetach, 2009:91).

- Awareness of one's personal conflict-resolution style includes cognitive recognition and understanding of one's personal dominant conflict resolution style and will improve the effectiveness of one's conflict resolution abilities. Each style can be either effective or ineffective, depending on the manager's goals, priorities and the intentions and behaviours of the other party. Each of the five styles can lead to a constructive or a destructive solution to the conflict, depending on the intent of its user, the appropriateness of the style for the conflict situation, and the strategic goals of those involved (Shetach, 2009:92).

2.3.2.10 Gerardi's relational model for nurses (2015)

The relational model address conflict based on recognising the importance of relationships and the patterns they create among healthcare personnel within complex organisations (Gerardi, 2015:56). It stipulates the need for nurse leaders/managers to learn how to work with conflict within the context of the complex organisation and to understand their own personal approach and contribution to conflict. This implies the crucial need for nurse managers to cultivate 'conflict competence' (Gerardi, 2015:56). Cultivating conflict competence involves both an understanding of the dynamic nature of conflict within complex organisations and a deeper understanding of one's own responses to conflict. The nurse manager is responsible for addressing conflict effectively in healthcare organisations and as such must have the ability to understand systemic patterns and group dynamics and how these change over time in the complex health organisation (Gerardi, 2015:56). Addressing conflict effectively also requires the ability to intentionally engage in conflict by using "relational intelligence", which is the ability to notice, reflect on, and shift personal and interpersonal habits and beliefs. This "relational model" blends the skills that enable leaders to observe what's happening within an organisation with the skills that focus on intrapersonal (self) and interpersonal (relationship) abilities (Gerardi, 2015:56).

The managers should analyse conflict in a complex adaptive system. Addressing conflict in complex adaptive systems requires the nurse manager to first have the ability to notice how people interact, and then to be able to work with the patterns that arise from those interactions. Patterns emerge as a result of the self-organising behaviour of people within complex systems (Gerardi, 2015:57). The patterns that emanate from human interactions in the complex organisation, over time, characterise the culture of the unit or group. Conflict is one type of pattern that emerges as a result of on-going interactions among health professionals. Addressing conflict in these systems requires more than good communication skills, particularly in work environments

where tensions are heightened by power dynamics, professional subcultures, productivity pressures and emotionally taxing work (Gerardi, 2015:57).

Addressing conflict effectively also involves the mechanistic view, which implies fixing or addressing the broken parts (or processes) in a system that will lead to an improved overall performance. However, the mechanistic approach ignores the dynamic interrelationships between the parts of the system, the interactions between healthcare personnel — it does not account for the influence of human interactions (Gerardi, 2015:58). Effectively addressing conflict in complex systems requires an understanding of how systems function and ultimately a shift in thinking toward a systems view of organisations. This implies an understanding that the organisation is composed of interrelated parts. A heightened understanding will increase the personnel's response to conflict (Gerardi, 2015:58). System thinking is described as “a general conceptual orientation concerned with the interrelationships between parts and their relationships to a functioning whole, often understood within the context of an even greater whole. It provides a method for incorporating the dynamic, interconnected nature of clinical work into the approaches for managing how the work gets done” (Gerardi, 2015:59). To address conflict in a complex system, a conflict specialist would take the following steps in the complex health organisation: (i) ask questions about group dynamics and patterns; (ii) identify themes embedded in the conflict narratives; (iii) and sort these themes into one of four categories in order to design a comprehensive conflict intervention (Gerardi, 2015:59). Following these steps enables the nurse leader/manager to investigate conflict in the complex organisation with the aim of effectively addressing the conflict.

2.3.3 CONFLICT AS REALITY WITHIN HEALTHCARE

Conflict is a reality that affects all healthcare organisations due to daily human interactions and communication among diverse healthcare personnel. Several studies (Cohn *et al.*, 2005; Adebamowo, 2006; Moore *et al.*, 2013) discovered that healthcare personnel world-wide experience conflict as a common occurrence in everyday personal and professional nursing life. According to Pavlakis *et al.* (2011:246) and Kaitelidou *et al.* (2012:575), conflict is inherent in hospitals as in all complex organisations, and health professionals seem to deal with internal and external conflicts on a daily basis. Conflict in nursing is frequently described in terms of the relationship between two occupational groups, such as physicians and nurses, staff nurses and nurse managers, or two different departments (Kaitelidou *et al.*, 2012:574, Okhakhu *et al.*, 2014:117, Higazee, 2015:10). Physicians and nurses receive training and education from different curricula and schools of thought about conflict. Yet, physicians and nurses continue to display little understanding of different health professionals' roles and norms, creating an “us versus

them” mentality, also known as identity conflicts (Gardner, 2010:265). There is an inability to appreciate different perspectives in a reasonable and coherent manner and to appreciate that the views of those with whom they disagree, can be reasonable and coherent (Tuller *et al.*, 2015:18).

As a result of the prevalence of conflict within diverse healthcare organisations, nurse managers are central to conflict management. Nurse managers and health professionals in general have to deal with internal and external conflicts on a daily basis (Pavlakis *et al.*, 2011:245). Internal conflict is within the person, when the person experiences an internal struggle to clarify contradictory values or wants (Marquis & Houston, 2012:471). External conflict occurs as a result of interpersonal relationships among nurses and other healthcare providers with different values, beliefs and goals in the workplace (Ahanchian *et al.*, 2015:141; Marquis & Houston, 2012:471). In addition to internal and external conflict, Bao *et al.* (2016:542) refer to interpersonal conflict. This is the most common type of conflict and interpersonal conflict is an interaction of interdependent people who sense disagreement and opposing interests, incompatibility and the possibility of interference, and negative emotion from others (Bao *et al.*, 2016:542), misunderstandings and poor communication skills (Pavlakis *et al.*, 2014:246; Timmins, 2011:34) and conflict between health professionals and patients (Kressel *et al.*, 2002:371). Common conflict topics in healthcare are about scheduling, carrying out daily work assignments, discipline, handling difficult behaviours and interdepartmental conflict, educational differences, and dissatisfaction with rewards and remuneration (Brinkert, 2011:85; Kaitelidou *et al.*, 2012:575). In response, the nurse managers are responsible for empowering nurses with conflict management training (Johansen, 2012:50).

Pavlakis *et al.* (2011:244) reported that 60% of the healthcare professionals experience conflict with colleagues one to five times per week, devoting 90 minutes of work time during their shift to conflict resolution in their own wards. Approximately 64% of healthcare professionals have never been informed about conflict management strategies, with physicians being the least informed (Pavlakis *et al.*, 2011:244). A study by Çinar and Kaban (2012:204), found that in organisations where there are too many conflicts, problems such as deviations from organisational aims and objectives arise. Hence, as leadership, the nurse manager should manage the conflicts in line with the organisational benefits to avoid the manifestation of negative effects of conflict in the healthcare organisation (Çinar & Kaban, 2012:204). Brinkert (2011:83) found that nurse managers readily acknowledge that they deal with conflict and that it is common for conflicts to arise with patients and their families, nurses, other professionals and staff.

2.3.4 HEALTHCARE AT A DIVERSE WORKPLACE

The reality of conflict among nurses and the need for conflict resolution by the nurse manager is fortified by Pavlakis *et al.* (2011:244). As healthcare organisations are complex, the nurse manager is responsible for managing diverse groups within the healthcare organisation (Hahn, 2011:124). Managing diverse groups within the workplace requires of the nurse manager to facilitate and ensure healthy work relations and effective interpersonal communication (Hahn, 2011:124). The diverse workplace is characterised by differences in employment needs and values, work ethic, attitudes towards authority and professional aspirations that contribute to cross-generational problems (Nelsey & Brownie, 2012:197). The diverse workplace is a macrocosm of society due to different cultures, age groups, genders, religions and sexual orientations.

One prominent factor within diversity highlighted in this literature review is the uniqueness of the different generations. A generation is defined as an “*identifiable group that shares birth years, age location and important life events at critical developmental stages*” (Sherman, 2006:2). Members of a cohort will therefore be born, attend educational institutions, start work, engage in marriage and retire from the workforce during roughly the same period of time, whilst members of a generational cohort are exposed to historical happenings and certain phenomena on cultural and social terrains (Hoole & Bonemma, 2015:683). The unique set of cultural experiences is a learned set of shared interpretations that affects the behaviour of generational groups and that should therefore be considered, because the different behaviour patterns have the potential to cause conflict (Hendricks & Cope, 2013:718). The healthcare workforce constitutes healthcare practitioners of different age groups, gender, sexual orientation, different cultures and religions, and therefore the richness and dynamic nature of the diverse healthcare organisation. The current nursing workforce is comprised of three generational cohorts, namely the Baby Boomers (1946-1964), Generation X (1965-1980) and the Millennials (1980-2000). These diverse age groups present with challenges in effective communication and workplace harmony (Leiter, Price & Laschinger, 2010:971). The key is for employers and organisations to strive to create meaningful and healthy work places that maximize worker potential, programs that focus on diversity, culture, team work and common values. Such programs promote the full realisation of each team member’s potential as the most fundamental underpinning of a healthy and vibrant work environment Registered Nurses Association of Ontario (RNAO, 2007:17). The organisation’s culture is a learned set of shared interpretations which affect the behaviour of generational groups and therefore needs consideration (Hendricks & Cope, 2012:718). Therefore, the organisation will have to develop and implement good diversity and anti-discriminatory practices that are congruent with the organisation’s culture (Hunt, 2007:2255). The implication is that

educationalists, trainers, managers and employers should recognise the presence and power of cultural differences that can be a brick wall and therefore affect learning negatively. By creating awareness on all hierarchical levels in the organisation, it can enable the different stakeholders to assist each other to steer their way through these cultural difficulties. In other words, education and training of healthcare personnel is also about achieving a greater sensitivity to, and acceptance of, racial and cultural differences, which will sensitise healthcare personnel on how to manage workplace differences to minimise conflict (Hunt, 2007:2255). In light of the fact that the nurse manager is central to the management of the diverse healthcare organisation, he/she is confronted with the challenge of working with different generational groups and to educate the healthcare personnel on cultural diversity and how to utilise such differences to the benefit of the healthcare organisation. Furthermore, with the predicted shortages in the nursing workforce coupled with the change of its make-up, it is timely for nurse managers to focus on providing an environment which reflects the needs of the current workforce whilst also focusing on the sustainability of the nursing profession by making it lucrative for younger nurses to enter and for older nurses to stay (Hendricks & Cope, 2012:718). There are specific factors that will enable the nurse managers to take on the challenging task of managing the diverse healthcare organisation, namely: i) the formal education and training of nurses at an undergraduate level to engender greater integration of the political, economic, social and cultural dimensions that result in a heightened, increasing understanding of diversity (Cioffi, 2013:252); ii) the crucial role of the nurse manager is to effect a positive work environment which attracts and retains staff, implying the nurse manager should use the strengths of each cohort as a guidepost to establish management strategies (Hendricks & Cope, 2012: 720). It is therefore apparent that diversity is beneficial to the health organisation, because it fosters a collaboration of different personalities that will complement each other to eventually achieve organisational goals and objectives. The nurse manager must possess specific attributes that will enable him/her to manage conflict effectively in the diverse workplace. Thus, by highlighting mutual team goals and keeping patient care as the focal point will promote effective work (Hendricks & Cope, 2012:720). In order to understand generational diversity, one must take cognisance and be aware of the diverse characteristics of the workforce. Therefore, the nurse manager has a clear-cut function to facilitate cooperation among the cohorts, despite generational differences in the complex healthcare organisation (Hahn, 2011:124). It is therefore imperative for the nurse manager to understand and comprehend the dynamics of the different cultures and generational cohorts in the workplace (Holt & DeVore, 2005:186).

Furthermore, the nurse manager is expected to accommodate employee differences between the Veterans and Baby Boomers (older) generation and Generation X (the younger generation) of nurses in the workplace (Hahn, 2011:124). The nurse manager must display respect, competence

and initiative to diffuse the conflict between the generations, because by displaying respect for both generations, the nurse manager will resolve conflict amicably (Hahn, 2011:125). In addition to the attributes necessary for diversity management, the nurse manager must be consistent in displaying understanding and respect for all her subordinates, no matter their age groups, in order to diffuse and resolve conflict. Furthermore, a subsequent study concluded that it is important for the nurse manager to develop strategies that display an awareness of cross-generational differences and how to use these differences toward achieving positive organisational goals and outcomes and to create a positive and harmonious work environment (Maragh, 2011:40). Furthermore, the nurse manager is supposed to recognise his/her staff nurses' behavioural patterns, particularly their conflict management styles, because recognising the staff nurses' behaviour will provide the nurse manager with insight into how to assign tasks to the various staff nurses in order to minimise conflict (Ahanchian *et al.*, 2015:144). In terms of the cohorts' diverse age groups, age diversity is positively related to developing team cooperation among the various generations in an environment in which the older generation of nurses can impart knowledge and skills to the younger generation of nurses (Liang *et al.*, 2015:55). The different generational cohorts are beneficial for the complex healthcare organisation in relation to the exchange of knowledge and skills between the older nurse practitioners and the younger nurse practitioners. The outcome of mutual understanding and respect will help to facilitate intergenerational cooperation, resulting in the retention of the older nurses, mentoring and sharing from expert to novice nurse, and a decrease in workplace stress and tension (Hahn, 2011:120).

Healthcare as a diverse workplace also implies gender differences and different ethnicities, which influence the way in which males and females resolve conflict in the diverse workplace. A study in which gender and culture were investigated and analysed together concluded that the compromising style of conflict management was used more frequently by females (Holt & DeVore, 2005:183). Furthermore, it was concluded that males applied the technique of forcing more frequently when resolving conflict and to serve their own needs (Holt & DeVore, 2005:184). However, another study revealed that males were more often involved in conflicts than their female colleagues and that the male nurses' preferred method of conflict resolution is dominance (Kaitelidou *et al.*, 2012:575). Furthermore, in a more recent study, it was concluded that male nurses applied the compromising and competing styles of conflict resolution more than their female colleagues did (Ahanchian *et al.*, 2015:143). The above conclusions signify that the nurse manager has to utilise different conflict management skills for males and females in the diverse workplace to manage and resolve conflict effectively. The diverse workplace also includes different ethnicities having to work together to achieve patient outcomes. Wilson (2007:148) conducted an investigation on the experiences of African American registered nurses, and the conclusion was that these registered nurses were constantly struggling and proving themselves

against multiple and simultaneously occurring oppressions of i) racism, ii) classism, iii) sexism, and iv) power relations that occurred in the diverse healthcare setting. According to Mwebi (2012:53), East African professional nurses who immigrated to Canada experienced major problems with the transfer of their qualifications and or existing accreditations with the Canadian statutory body and these registered nurses also experienced major problems with gaining recognition for previous work experience and a professional license for practice in Canada (Mwebi, 2012:53). Another study conducted in Australia investigated the experiences of African migrant nurses in the Australian workplace. The study investigated the daily experiences of black, skilled migrant nurses who were recruited from Africa to overcome shortages of nurses in the workplace. The conclusion was that racism is played out in the seemingly “normal” functioning of everyday interactions in a white dominated workplace that privileges the ideals of a “non-racist” profession while systematically avoiding confronting racism when it occurs (Mapedzahama *et al.*, 2012:161).

In light of the multitude of diverse characteristics in the workplace, culture is central because culture determines behaviour displayed by healthcare personnel. The nurse manager should therefore develop a deeper understanding of cultural differences because it will put all the healthcare personnel in a position to have a better understanding of each other’s behaviour in the workplace, which in turn will lead to greater respect amongst healthcare personnel and a more cohesive work environment (Holt & DeVore, 2005:186). Understanding cultural background and how this affects preferences regarding conflict management styles may create a greater understanding and less conflict in the workplace. Furthermore, the nurse manager should not only focus on efforts to understand the different cultures and how it influences workplace behaviour, but should strive to make conscious efforts to explore different cultures in an attempt to unravel existing power structures and managerial practices in the organisation (Hunt, 2007:2256). Understanding the different cultures will assist the nurse manager to reduce discriminatory practices and to place a strong emphasis on promoting equality and diversity in health service employment. It is therefore imperative that all hierarchical levels of the diverse workplace should be informed and aware of the diverse cultures in the workplace because this will translate in the delivery of culturally relevant care to the diverse community that receives healthcare (Hunt, 2007:2256).

The diverse workforce is representative of the society it originates from, hence the amalgamation of different cultures in the diverse healthcare organisation. Furthermore, Moore *et al.* (2013:173) conclude that the nurse manager fulfils an important role in establishing a respectful and positive practice in addition to having the organisational structures and policies in place that also contribute to the development of respectful workplaces in which favourable nurse relations thrive.

It has become clear that the healthcare organisation should strive to foster an environment in which all personnel members' cultures are respected, because by so doing healthcare personnel will experience a sense of belonging. Furthermore, the nurse leader can be influential in developing an appreciation for the ways generation's value work and the balance of work in their lives, this will help to create a space where individuals, as representatives of a cohort, feel valued and builds strategies for retaining staff and promoting satisfaction in the workplace, all of which contribute to a positive practice environment (Hendricks & Cope, 2012:721).

Effective conflict management strategies can minimize the negative effects of conflict on different parties. This helps to create a trusting environment and healthy workplace to improve interpersonal relationships, job satisfaction and staff retention (Chan *et al.*, 2014:934). Ultimately, this is what the nurse manager wants to achieve in the healthcare organisation, to manage conflict effectively and to create a positive practice environment that will improve patient outcomes.

2.3.4.1 Understanding the concept “workplace diversity”

As healthcare organisations are complex and diverse, it is important to explain the meaning of the concept of workplace diversity. A diverse workplace comprises a multitude of beliefs, understandings, values, ways of viewing the world and unique information (Shen *et al.*, 2009:235). This implies that workforce diversity expresses the multi-faceted, all-encompassing, complex nature of the work environment. Workforce diversity refers to the composition of work units (work group, organisation, occupation, establishment or firm) in terms of the cultural or demographic characteristics that are salient and symbolically meaningful in the relationships among group members in the diverse workplace (DiTomaso *et al.*, 2007:474). However, diversity in itself is a simple concept to understand. It refers to nothing more than variance or difference (Gwele, 2009:5). Aligned with workplace diversity is diversity management. The latter is a holistic and strategic intervention that administers all variables in gender, race, culture, sexual orientation, and it is aimed at maximising every individual personnel member's potential to contribute towards the achievement and realisation of the organisation's goals by capitalising on individual talents and differences within a diverse workforce environment and ultimately improving organisational outcomes (Chartered Institute of Personnel and Development, 2005 *cited in* Gwele, 2009:4; Uys, 2003:33; Podsiadlowski *et al.*, 2013:161). Diversity management encompasses all forms of difference based on race, ethnicity, disability, linguistic difference, socio-economic background and gender (Blackmore, 2006:185).

2.3.4.2 Models, theories and conceptual frameworks on workplace diversity

2.3.4.2.1 Resource dependence theory by Pfeffer and Salancik (1978) added on by Ortlieb and Sieben 2013

This theory posits that organisations strive to control critical resources to survive. In line with Fields, Goodman and Blum (2005), organisations employ ethnic minorities to obtain critical resources (Ortlieb & Sieben, 2013:481). These resources are particular knowledge, skills and abilities, for instance foreign language skills, cultural knowledge and skills. This basic argument allows us to define different organisational diversity strategies according to the kind of critical resources to be obtained (Ortlieb & Sieben, 2013:481).

According to Pfeffer and Salancik (1978), the quest to accrue critical resources drives organisational strategies. Resources are critical if they are essential, rare, and their accrual uncertain. Examples include money, know-how and technology, as well as individual behaviours, capabilities and social networks (Ortlieb & Sieben, 2013:482-48). Organisations are dependent on the actors who control critical resources, that is, who either have access to resources or possess critical resources themselves. Consequently, organisational strategies aim at managing such resource dependencies and reducing them. Decision makers such as top human resource managers and CEOs base their strategic staffing decisions on assessments of which critical resources will be gained through the employment of particular individuals. A central assumption of Pfeffer and Salancik (1978) is that behaviour of individuals and groups is constrained, for instance, by cognitive capacities or social influences. Managers' subjective perceptions and interpretations therefore also influence organisational strategies, perhaps more than the "objective" criticality of resources (Ortlieb & Sieben, 2013:482-483). It facilitates the identification of different resources that ethnic minorities control and that may be critical for organisational success (Ortlieb & Sieben, 2013:483). Dependence arises from difficulties in attracting and retaining employees, a growth in the number of employees that a firm needs, and a high fraction of professional and technical jobs within the firm (Ortlieb & Sieben, 2013:483).

2.3.4.2.2 Signalling theory by Spence (1973)

This theory's perspective details how organisations or individuals communicate information to others with the hope of receiving investments of some kind (Olsen *et al.*, 2016:272). It explains how diverse organisations implement diversity management as part of its organisational strategies to effectively manage the diverse workforce (Olsen *et al.*, 2016:272). Organisations utilise this theory when recruiting diverse employees by signalling information about the organisations in a very convincing manner and describing the employee benefits to prospective employees applying for vacancies. Many organisations and developed countries are utilising the

signalling theory to describe organisational attractiveness during the recruitment of employees from developing or under-developed countries to apply for vacancies, thus recruiting a diverse workforce that will assist the organisation with achieving its organisational goals (Olsen *et al.*, 2016:273, 280). Recruiting a diverse workforce also includes focusing on gender diversity management (GDM), which includes programmes such as affirmative action prescribed by government legislature aimed at the inclusion and advancement of women in the workplace (Olsen *et al.*, 2016:272). Extensive gender diversity management programmes (GDM) are likely to signal greater opportunities for women to advance within an organisation, which is communicated to prospective employees by the signalling theory (Olsen *et al.*, 2016:272, 280). Olsen *et al.* (2016:282) conclude that women's interpretation of the signal in terms of what it suggests about the potential for advancement in organisations influences the evaluation of the organisation's attractiveness, though this evaluation will also be moderated by the national context.

2.3.4.2.3 Framework of individual level of cultural intelligence (CQ) conceptualisation by Earley and Ang (2003)

Early and Ang's framework conceptualises an individual's Cultural Intelligence (CQ) in the diverse workplace (Early & Ang, 2003:6). CQ refers to an individual's capability to function and manage effectively in culturally diverse environments (Earley & Ang, 2003:6) (Moon, 2010:457). Individual CQ is based on the domain of intelligence, an attribute that is necessary for conceptualising organisational CQ (Moon, 2010:457). At an organisational level, CQ is a part of organisational capabilities, also termed cultural capability. Organisational CQ is another complementary form of organisational capability (Moon, 2010:457). Organizational CQ (cultural capability), is defined as an organisation's capacity to reconfigure its capability to function and manage effectively in culturally diverse settings (Moon, 2010:460).

At the individual level, CQ functions as a causal factor or facilitator of outcomes such as cultural adjustment and effective performance of individuals in cross-cultural environments in which diverse employees function by utilising their cognitive functions in performing their activities. The larger domain of individual differences in diverse employees consists of personality, capability and interest. CQ is conceptually differentiated from general capabilities, such as general cognitive ability (IQ), emotional intelligence (EQ) and social intelligence (SQ) because it concentrates on culturally relevant capabilities (Early & Ang, 2003:4, 7, 8, Moon, 2010:457). CQ at the individual level is consistent with Schmidt and Hunter's (2000) definition of general intelligence as the capability to read and understand concepts accurately and engage in problem solving, which originated from Sternberg and Detterman's (1986) framework of the multiple foci of intelligence (Early & Ang, 2003:9, Moon, 2010:457). Both concepts, individual CQ and organizational CQ, are

defined as an individual or an organisation's capability to function and manage effectively in culturally diverse environments and it may help firms or organisations to adjust effectively in different cultural settings and to gain and sustain their competitive advantages (Moon, 2010:458). In the light of Early and Ang's framework, an organisation's success is linked to the collaboration between the organisation's CQ and the CQ of the diverse workforce.

Cognitive CQ refers to declarative knowledge about culture and reflects the specific knowledge of content and mental maps concerning a target culture that is gained through metacognitive mechanisms (Moon, 2010:462). Metacognitive and cognitive facets of CQ deal with information processing aspects of intelligence that are closely linked to individual learning processes in culturally diverse situations (Moon, 2010:462). Motivational CQ involves the inherent preference for interacting with people from different cultures, having confidence in culturally diverse interactions and the management of stress from adjusting to unfamiliar settings (Moon, 2010:463). Finally, behavioural CQ refers to individual capability to display adequate verbal and nonverbal actions in cross-cultural context (Moon, 2010:463). Employees in the diverse workforce possess the respective facets of cognitive cultural intelligence that enable them to function effectively in the diverse workplace.

2.3.4.3 International, African and South African realities of workplace diversity in general

From what has been discussed thus far regarding workplace diversity, it becomes clear that workplace diversity is managed by applying theories and models that enable the organisation to integrate all the diversity factors in the workplace. Health services should understand the diverse nursing workforce and examine how a diverse nursing workforce influences the achievement of a country's health outcomes within healthcare organisations (Gilliss *et al.*, 2010:299). In response to this analysis, Cioffi (2013:249) concludes that nurses are in a position to positively influence health-related outcomes by actively addressing the diversities that patients and clients bring to their healthcare experiences in this diverse workplace. Workplace diversity's manifold aspects were investigated among African American nurses, and the research indicated that despite possessing similar or greater credentials than colleagues, these nurses felt that they still had to prove themselves (Wilson, 2007:146). In addition, the diverse nursing work also includes marginalised groups such as individuals with different sexual orientation (such as homosexual and bisexual), requiring organisational support to gay, lesbian and bisexual workers (Huffman *et al.*, 2008:246).

Workplace diversity is also a reality within South African healthcare, making it essential for Human Resource (HR) management to provide and implement proper HR approaches and techniques

that can successfully manage these organisational diversities (Tshikwatamba, 2003:37). One example of such an HR approach is collectivism. Collectivism entails acknowledging various diversity-based conflicts in the workplace and is aimed at understanding different opinions to enhance continuous engagement between management and the personnel. Continuous engagement can be achieved by utilising the different opinions raised by the employees when verbalising their challenges and their proposals on how management can resolve the conflicts so that all parties find an amicable solution in pursuit of a healthy relationship with employees (Tshikwatamba, 2003:37). The nurse manager enables collectivism by engaging with personnel and by providing a safe environment to manage conflict effectively (Tshikwatamba, 2003:37).

Enabling a safe environment for conflict management is viewed as inevitable in diverse workplaces in general. For example, Zulu and Parumasur (2009:5, 7) conclude that employees perceive that organisations in general do not make concerted efforts in addressing the real, relevant issues pertaining to employee needs and cultural differences of workplace transformation that can facilitate the successful integration and coexistence of diverse employees in the workplace. In addition, Tshikwatamba (2003:38) concludes that it is imperative that management truly understand and acknowledge the cultural diversity in the workplace without attaching negative judgement to it. By so doing, the organisation will function more efficiently through regular engagement with the diverse workforce and address challenges successfully. This means that diverse employees are acknowledged. This leads to a better understanding among members of management, which enables management to be equipped with knowledge that will enrich management (Tshikwatamba, 2003:37). The implication is that the nurse manager will have to acquire knowledge on workplace diversity characteristics to gain an understanding of workplace diversities in order to match these diversities to the appropriate conflict management skills.

Based on the fact that workplace diversity is a global reality, it is clear that organisations have to formulate and implement realistic policy measures in dealing with workplace diversity. However, very few measures have been put in place to fast-track transformation programmes in organisations (Zulu & Parumasur, 2009:6). The delay in implementing transformation programmes has led to a number of challenges, including a lack of understanding among the various stakeholders in the diverse organisations on how to manage workplace diversities; little or no commitment from top management in addressing issues of workplace transformation and a lack of resources in organisations to implement programmes aimed at addressing the management of cultural issues (Zulu & Parumasur, 2009:6). Gwele (2009:7) notes that diversity management must be approached as part of the organisation's strategic direction so that it is prioritised and implemented by all levels of management in the organisation. This implies that diversity management must be elevated to the level of strategic direction, for all to implement and

translate within policies. This is viewed as an essential way to achieve organisational outcomes in terms of managing diversity in the workplace (Gwele, 2009:7).

Workplace diversity is universal, including South African organisations. In general, South African employees are dissatisfied about the rate at which South African organisations are implementing workplace transformation policies to provide an enabling environment for diverse cultures to coexist (Zulu & Parumasur, 2009:5). If diverse cultures can coexist, it will ultimately modify the corporate culture, which will propel organisations to address and manage all aspects around cultural diversity so that it can allow the necessary changes and manage workplace diversity in a collective (Zulu & Parumasur, 2009:5).

In South Africa, marginalised groups result when workers immigrate from rural to urban areas (Ng, 2008:72). Changed demographics urge organisations to take responsibility for employment equity (Ng, 2008:72). An international study conducted in London concluded that the national Department of Health took a strong stance on promoting equality and diversity in the health service employment, implying that the organisation upheld their responsibility to address workplace diversity (Owen & Khalil, 2007:475).

Diverse workplaces constitute diverse cultures and languages for both patients and healthcare personnel, which render the diverse workplace a very enriching and educational environment (Wyrley-Birch, 2006:81). This implies a multitude of languages spoken by patients and healthcare personnel, where students are exposed to the diverse workplace and all its dynamics (Wyrley-Birch, 2006:81). This enrichment is in addition to the bridging of language barriers for effective communication between patients and members of the multi-disciplinary team (Wyrley-Birch, 2006:81). Again the nurse manager is placed central to ensure that conflict and grievances and its relevant resolution processes are culturally and linguistically sensitive to all and capable of identifying, preventing and resolving cross-cultural conflicts or complaints by employees or consumers of health (Williamson, 2007:335). Another positive initiative is healthcare organisations proactive in providing a healthy work environment for the diverse workforce. As Durham *et al.* (2015:11) conclude, healthcare considers both public and private healthcare service providers, with communication and interaction between public and private services, having professional gatherings where different sectors can outline strengths and advantages of the diverse workforce and how to utilise the positive attributes of the diverse healthcare personnel to improve healthcare outcomes. The complexities already captured in health systems were confirmed by Aries (2004:172-180). Within the USA, senior managers, line managers, patients and frontline workers in six hospitals expressed that although cultural competence was viewed as critical for patient care, understanding its meaning was determined by the individual's role within healthcare. This makes workplace diversity both collective and very personal. Furthermore,

Aries (2004:172-180) describes that senior managers were satisfied that hospitals took cultural competence seriously when culturally diverse staff was employed to render healthcare to diverse patients.

2.3.4.4 Workplace diversity as a reality in South African healthcare

In South Africa (as also aligned with emerging economies globally), workplace diversity within healthcare is presented by diverse patients, diversity in employees and services rendered to diverse community needs. Another diversifying factor in South Africa's current nursing workforce is the collaboration between four generations, namely: i) the silent generation, ii) baby boomers, iii) generation X and iv) generation Y, or millennials (Mokoka *et al.*, 2010:485). This is congruent with the workplace diversity encompassing culture, gender and race. Yet, Mokoka *et al.* (2010:491) identify the current South African nursing workforce according to different generational cohorts, adding another dimension to an already complex work environment. The different generational cohorts present different viewpoints and behaviours in the workplace. The Baby Boomers are the more experienced, veteran nurses and they require more monetary reimbursement for all their hard work over many decades in the nursing profession. Generation X and Y nurses and the Millennials prefer more time off duty because of their different lifestyles. Generational diversity should be considered by nurse managers to increase productivity and to have a greater sense of team work while minimising conflict (Mokoka *et al.*, 2010:487).

Therefore it can be concluded that healthcare professionals face a diverse hospital population (patients and staff) whose way of life is markedly different from the dominant Western healthcare model (Gwele, 2009:6). Again, the nurse manager is placed in a central role to manage workplace diversity. As Gwele (2009:4) concludes, nurse managers have to value individual differences and talent more among the different generations, instead of focusing on the collective viewpoints of healthcare personnel as a group when managing diversity. Pretorius and Klopper (2012:69) confirm that nurses feel that unit managers should be more accessible to and supportive of personnel working in intensive care units in South Africa. Furthermore, nurse managers experience that too little is being done to recognise or even develop their leadership roles to manage workplace diversities successfully (Mokoka *et al.*, 2010:489).

Workplace diversity is also closely linked with job satisfaction. Bangdiwala *et al.* (2010:297) confirm that workforce retention remains a challenge in current healthcare. Women leaders in general, have a need to project masculinity into their leadership roles to be more effective. In turn, employees in general display resistance to female leadership. They project a sense of inadequacy onto the women leaders and use aggression to dominate and de-authorise them (Motsoaledi & Cilliers, 2012:6). According to Motsoaledi and Cilliers (2012:7), executives in charge of healthcare

organisations trigger unconscious conflicts in subordinates when they make decisions that are not in the interest of nurse practitioners. Furthermore, Motsoaledi and Cilliers (2012:6) conclude that splits among different race groups make pairing across races difficult and challenge the role of the nurse manager in facilitating an environment in which different race groups can debate and address their unique challenges.

2.3.4.5 The nurse manager within workplace diversity

The nurse manager is a key role player for healthcare services to function within the realities of diverse workplaces. How the nurse manager supports subordinates strongly relates to the levels of job satisfaction experienced by employees (Huffman *et al.*, 2008:245). The nurse manager's management of diversity stretches beyond managing different individuals. It involves recognising the value of differences, combating and eliminating discrimination, promoting inclusiveness (Green *et al.*, 2002:2) and exert influence (Tappen *et al.*, 2004:5).

The literature that follows describes how the nurse manager can manage workplace diversity, namely to:

- Recognise and value diversity (Williamson, 2007:329).
- Create and facilitate a healthy work environment (Ganz *et al.*, 2015:43).
- Strengthen nurses' autonomy (Charalambous *et al.*, 2010:503).
- Present an intrinsic sense of motivation to develop the cultural and cultural competence (Hunt, 2007:2255).
- Accept personnel as a primary responsibility (Ganz *et al.*, 2015:47).
- Manage generational conflict (Shacklock & Brunetto, 2012).
- Manage the conditions that can lead to potential conflict to decrease adverse effects on patient outcomes (Hendricks & Cope, 2013:721).
- Use appropriate communication strategies, undertake commitment building activities and implement compensation relevant to the personal needs of nurses (Hendricks & Cope, 2013:721).
- Develop a sense of appreciation and understanding for the ways in which the different generations value and perceive their work and the how they balance their work lives (Hendricks & Cope, 2013:721).
- Consciously explore (Hendricks & Cope, 2013:723) the nature of generational differences and their mental perception and models.
- Apply a collectivistic culture orientation (Holt & DeVore, 2005:182).
- Ensure that standards of healthcare are maintained in the diverse workplace and to ensure that the personnel is skilled in communication (Timmins, 2011:31).

- Utilise effective conflict management strategies to minimise the negative impacts of conflict on different parties that will contribute to the creation of a trusting environment and healthy workplace to improve interpersonal relationship, job satisfaction and staff retention (Chan, Sit & Lau, 2014:934).

Should the nurse manager disregard conflict, it may lead to an increased staff turnover as a result of dissatisfaction among personnel and a working environment that does not meet the needs of individual nurses (Hendricks & Cope, 2013:721). Yet, by investing diversity, the nurse manager will foster positive work environments in which highly experienced staff function optimally and this will encourage nurses to remain in the diverse workforce (Hendricks & Cope, 2013:721). When nurses receive support from managers, they experience and achieve high levels of performance at work and they can ultimately achieve personal goals (Huffman *et al.*, 2008:246).

As nurse managers are central to manage workplace diversity, they have to be equipped to apply different workplace diversities management skills. Workplace diversity management does not necessarily require capacity building, including a personal repertoire of skills to manage the wide range of generational diversity in the workplace with regard to communication, commitment and compensation (Hendricks & Cope, 2013:720). The skills needed can be listed as:

- Being knowledgeable of the generational staff mix (Mokoka *et al.*, 2010:486).
- Understanding the support needs of each generation (Hendricks & Cope, 2012:720; Mokoka *et al.*, 2010:489).
- Knowing when and how reward systems should be used for different generations of nurses (Hendricks & Cope, 2013:722).
- Being skilled in the 3-C approach as communication, commitment and compensation (Hendricks & Cope, 2013:723).
- Exhibiting communication skills (Timmins, 2011:32).

2.4 CONCLUDING REMARKS OF WORKPLACE DIVERSITY IN SOUTH AFRICAN HEALTH CARE

Expounded from the literature review presented, the following concluding remarks are highlighted:

- There is congruence nationally and internationally on the meaning of conflict and conflict resolution and conflict management.
- Conflict management is an evolving reality. As society develops, so does research about conflict management. Therefore, conflict management cannot be viewed as a stagnated and once-off event.

- Research on conflict management presents predominantly within the international arena. Models, theories and frameworks developed over time. Yet, there is a similar pattern of concepts and relational statements amongst these theories, models and frameworks. What differs is the depth of the research. As conflict management research developed since the 1960's, an in-depth and rich depiction of the contributing, attributing factors, processes and consequences of conflict management are presented.
- Conflict is a harsh reality within international and national healthcare. It is an organic occurrence that one can expect in diverse and complex work environments.
- Workplace diversity is a natural habitat for conflict and requires therefore deliberate conflict management.
- Although workplace diversity within healthcare is a global and South African reality, one cannot underestimate the debilitating impact of insufficient resources within South African healthcare to manage workplace diversity and associated conflict.
- Within diverse healthcare workplaces, the nurse manager functions centrally to conflict and diversity management. It is therefore essential for nurse managers to be fully equipped and supported in conflict management.
- In general, conflict management and workplace diversity in South Africa builds on international literature. The realities of a South African paradigm of a rainbow nation cannot necessarily be adopted in international literature.

2.5 SUMMARY

Chapter 2 discussed the main concept of this research, namely conflict management within diverse healthcare workplaces, from the international and national perspectives. Conflict management's theoretical origin stretches over decades, presenting a cascade of strategies and styles. Workplace diversity describes the inevitable differences between people that exceeds culture and ethnicity. The nurse manager is presented as a pivotal role player in the activation and maintenance of a healthy work environment. This implies that the nurse manager is central to conflict management. Chapter 3 follows with the results of the research presented in a manuscript format.

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CHAPTER 3: RESEARCH ARTICLE

3.1 INTRODUCTON

Chapter 2 presented a literature review regarding conflict management in healthcare as a diverse workplace within South Africa. The literature review included workplace diversity and nurse managers' experiences during conflict management on a national and an international level. In this chapter the research results are presented in the form of a manuscript. The manuscript, *Conflict pressure cooker: Nurse managers' conflict management experiences in a diverse, South African workplace*, was prepared for the *Journal of nursing management*. The Harvard reference style was maintained within this manuscript.

3.2 AUTHORSHIP

Authorship to this manuscript adhered to the International Committee of Medical Journal Editors' (ICMJE) four criteria, as confirmed hereafter.

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TITLE PAGE

Manuscript title: Conflict pressure cooker: nurse managers' conflict management experiences in a diverse, South African workplace

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ABSTRACT

Aim(s) - To understand nurse managers' experiences of conflict management within a diverse South African workplace (military hospital) in order to foster a healthy work environment.

Background - Nurse managers are central to conflict management and a healthy work environment. South Africa is one of the most diverse countries globally and workplace diversity is a reality in healthcare organisations. A gap was identified in literature on conflict resolution by nurse managers in diverse workplaces in South Africa.

Methods – Thirteen (N 13) in-depth, unstructured, individual interviews from a phenomenological design followed by content analysis. Six main themes are declared.

Results – Five themes and nine subthemes are formulated. Hierarchical, diverse organisational culture impedes conflict management; conflict management is complex where nurse managers present specific conflict management characteristics and skills. Nurse managers experience nursing as profession pressurised by present challenges. Conflict management skills can be taught, improved and requires an inside-out process.

Conclusion – A military healthcare organisation presents an organisational culture and combined with diversity, is predisposed to conflict that endangers the work environment. Yet, both conflict and workplace diversity can, when managed correctly, enrich a healthcare organisation. Nurses and nurse managers will benefit from reflective conflict management training as an inside-out process.

Implications for nursing management - It is vital to reconsider the impact of organisational culture and workplace diversity on nursing and conflict. Support groups are necessary to give perspective to nurse managers to identify causes of conflict proactively; to support nurse managers exposed to conflict daily and to reflect on their more and less effective conflict management skills.

Keywords - Healthy work environment, positive practice environment, workplace diversity, conflict management, nurse manager, military healthcare organisation

(word count: 275)

MANUSCRIPT

Background and problem statement

Workplace diversity can either be enriching or detrimental to the organisation (Guillaume *et al.*, 2015). The diverse healthcare organisation includes healthcare personnel from different cultures, religions, social standing and different ethnicities and represents a microcosm of society. The current nursing workforce reflects this diverse complexity as it is comprised of three generational cohorts, the Baby Boomers (born between 1946 and 1964), Generation X (born between 1965 and 1980) and the Millennials (born between 1981 and 1999), and presents with challenges in effective communication and workplace harmony (Leiter *et al.*, 2010:971; Hoole & Bonnema, 2015:6). When considering that Africa is one of the most diverse continents and South Africa has eleven official languages, one can imagine the predisposed realities of workplace diversity within typical work environments in South Africa. Workplace diversity in South Africa is evident also in the health sector.

It is imperative for the nurse manager to acquire an understanding of work life and collegiality across the generations to aid the establishment of healthy work environments. The nurse manager is responsible for facilitating cooperation despite generational differences (Hahn, 2011:124) and plays a pivotal role in creating and facilitating a healthy work environment (Ganz *et al.*, 2015:43). Healthy work environments (positive practice environments) support the well-being of healthcare providers across the globe; and it enables a motivated, high performing pool of personnel who deliver high quality care (International Collaborating Partners of the Positive Practice Environments Campaigns, 2008). Healthy work environments strive to ensure that patient outcomes are met, organisational goals are achieved and a work and care environment is created that is safe, healing, humane and respectful of the rights, responsibilities, needs and contributions of all people – including patients, their families and nurses (American Association for Critical Care Nurses [AACN], 2016:9). There are six standards of a healthy work environment according to the guidelines of the AACN (2016:10), namely nurses who are proficient in both communication and clinical skills; team members that pursue and foster true collaboration; effective decision-making evident in valued and committed partners in policy, directing and evaluating clinical care and leading organisational operations; appropriate staffing to ensure an effective equal between patient needs and nurse competencies; meaningful recognition of the value that nurses and others bring to the organisation; and authentic leadership where nurse leaders fully embrace the imperative of a healthy work environment, authentically live it and engage others in its achievement. Healthy work environments may exist within very complex, diverse workplaces and exist amid conflict.

Complex healthcare organisations [such as a military hospital in this research] imply that conflict is inevitable in everyday social, organisational and professional nursing life (Meyer *et al.*, 2011:256; Tillet & French, 2012:1). Conflict refers to a situation where two or more parties are aware of need differences and perceive their values or needs as incompatible (Booyens, 2011:529; Tillet & French, 2012:6; Johansen, 2012:51). The nurse manager is central to managing a turbulent, ever-changing work environment (Al-Hamdan *et al.*, 2011:573); extending their responsibility to develop and implement a healthy work environment (Twigg & McCullough, 2014:86) and managing conflict in the organisation. Conflict management refers to a process of recognising the conflict, determining the intensity, evaluating the effects of the intensity, determining appropriate intervention methods, and observing the results (Çınar & Kaban, 2012:199). Sources of conflict within a healthcare facility include individual and group-related causes, organisational causes, workplace diversity and cross-generational conflict. The nurse manager should be equipped with competencies that will enable the manager to detect the initial symptoms of conflict and to adopt the most effective behaviour to conflict management (Mohamed & Yousef, 2014:164). Nursing is an emotionally charged profession, the competence to manage emotion and interpersonal conflict effectively is essential for nurse managers and is captured within emotional intelligence (EI) (Heris & Heris, 2011:1621; Mohamed & Yousef, 2014:160; Veshki *et al.*, 2012:154). Emotional intelligence (EI) refers to the ability to monitor one's own and others' feelings and emotions, to discriminate among them and to use this information to guide one's thinking and actions, as well as the capacity to perceive emotions, assimilate emotion-related feelings, understand the information of these emotions and manage them (Mohamed & Yousef, 2014:160). Supervisors with high EI will use an integrating style (both parties find a creative solution to satisfy both parties' concerns) or/and a compromising style (both parties win some and lose some to reach consensus) (Mohamed & Yousef, 2014:161). Cremer (1980:22) identifies the following methods of conflict management in the nursing practice: avoidance, smoothing, domination/forcing, compromise/bargaining, problem-solving by confrontation and integration as a positive approach to strengthening the self-respect of the persons involved.

International literature confirms the role of the nurse manager in conflict management. The identified gap lies in the limited literature on the conflict management skills of nurse managers within diverse South African healthcare organisations. Searches from EbscoHost, ScienceDirect, eJournals and Google Scholar presented very limited South African-based literature. In fact, the most appropriate journal article found was dated 1980 by Cremer. This led the researcher to ask "*what are nurse managers' experiences of conflict management and their conflict management skills within South African-based healthcare organisations?*"

Method

The research setting was a highly diverse, level three, military healthcare organisation representative of all the different cultures, ethnicities, languages, qualification levels, foreign and 'Very Important People' (VIP), civilian, private and force-enrolled employees, patients and service providers. This military healthcare organisation of 556 beds is situated in Gauteng, rendering specialised healthcare across the borders of nine provinces. Data collection was activated once ethical clearance was obtained from the Health Research Ethics Committee of the North-West University (NWU-000196-15-S1), followed by consent from the Ethics Committee of the participating organisation and consent by hospital management, including the nursing service manager. Due to possible power struggles within this military healthcare organisation, the researcher utilised an independent person as mediator to identify and recruit prospective participants, which proved to be a daunting task. After completing voluntary informed consent, data collection started. Purposive sampling with strict inclusion criteria led to the participation of thirteen (N=13) nurse managers. From a qualitative phenomenological design followed unstructured, individual interviews (Botma *et al.*, 2010:206-207; Brink *et al.*, 2012:157; Burns & Grove, 2010:510) by the researcher, building on one open interview question "*as a nurse manager, tell me how you experience conflict management and your conflict management skills within your workplace....*" Digitally voice-recorded interviews were transcribed by an independent transcriber and data analysis conducted according to the six steps by Tesch (1990) and Creswell (2009), in Botma *et al.* (2010:224-225). Consensus with a co-coder led to the formulation of five themes and 12 sub-themes. The four strategies to increase rigour by Lincoln and Guba (1985) were applied based on the epistemological standards of trustworthiness as truth value, applicability, consistency, neutrality and an additional standard of authenticity (Botma *et al.*, 2010:232).

Results

Table 3.1: Demographic profile of participants (N=13)

| | N | % |
|-------------------------------------|----|----|
| Male | 3 | 23 |
| Female | 10 | 77 |
| 35-44 (years age) | 2 | 15 |
| 45-54 (years age) | 10 | 77 |
| 55-64 (years age) | 1 | 1 |
| Bachelor's degree | 7 | 54 |
| Honours degree | 1 | 1 |
| Setswana (Language) | 4 | 31 |
| Sesotho (Language) | 2 | 15 |
| Zulu (Language) | 1 | 1 |
| Pedi (Language) | 1 | 1 |
| Afrikaans (Language) | 1 | 1 |
| Venda (Language) | 3 | 23 |
| Ndebele (Language) | 1 | 1 |
| Black (Nationality) | 12 | 92 |
| White (Nationality) | 1 | 1 |
| 0-5 years (management experience) | 6 | 46 |
| 6-10 years (management experience) | 4 | 31 |
| 11-15 years (management experience) | 3 | 23 |
| 6-10 years (at hospital) | 3 | 23 |
| 11-15 years (at hospital) | 4 | 31 |
| 16-20 years (at hospital) | 3 | 23 |
| 21-25 years (at hospital) | 3 | 23 |
| General (Unit) | 3 | 23 |
| Paediatric (Unit) | 1 | 1 |
| Intensive care (Unit) | 4 | 31 |
| ER (Unit) | 1 | 1 |
| Primary healthcare (Unit) | 2 | 15 |
| Theatre (Unit) | 1 | 1 |
| Mental health (Unit) | 1 | 1 |

The demographic profile of the thirteen participants (N=13) is presented in Table 3.1. Of the 13 participants, 10 were female and 3 male as aligned with the nursing profession in South Africa with a female-dominant representation (South African Nursing Council [SANC], 2014b). Most held a Bachelor's degree as dominant qualification. The majority participants were aged 45 to 54 years (SANC, 2014b), representing seven cultures in sequence of representation. The combination of these cultures presents a diverse workplace when considering the diverse ethnic groups who practice different beliefs and values. The participating nurse managers spoke with reasonable experience as the average time of employment at this particular hospital was fifteen years, employed as a manager for ten years and being within the nursing profession for twenty years.

Table 3.2: Themes and sub-themes

| Theme | Sub-theme |
|---|--|
| 1. Hierarchical, diverse and fixed organisational culture impedes and complicates conflict management | 1.1 Organisational culture is complex, problematic and increase conflict. 1.2 Presents with interpersonal conflict. 1.3 Ranking structures overrule policy and procedures. 1.4 Organisational distrust in performance management. |
| 2. Nurse managers have different experiences of conflict management. | 2.1 Conflict management as a here-and-know process. 2.2 Conflict management as a personal reality, requiring the nurse manager's presence. 2.3 When the nurse manager is in sync with team dynamics, conflict management becomes relative. |
| 3. Characteristics of nurse managers in conflict management | 3.1 Nurse managers should be experienced, mature and open to diversity. 3.2 Nurse managers should cope with being central to workplace conflict. 3.3 Nurse managers are integral to a harmonious workplace. |
| 4. Nurse managers utilise specific conflict management skills during conflict resolution. | 4.1 Aim to balance the conflict between patient demands and nurses feeling unappreciated. 4.2 Conflict management is first an intrapersonal/inside-out process, needing practical skill and exceeding theory. 4.3 Conflict management training to all managerial levels. |
| 5. Nursing managers experience conflict management amidst a nursing profession in peril. | 5.1 Nurse managers experience a gradual decline in younger generation nurses' meaning and purpose in and passion for nursing. 5.2 Nurse managers experience themselves as a link between polarities of the nursing team and the organisation. |

From the analysed data, five main themes and 15 sub-themes were categorised as graphically depicted in Figure 3.1.

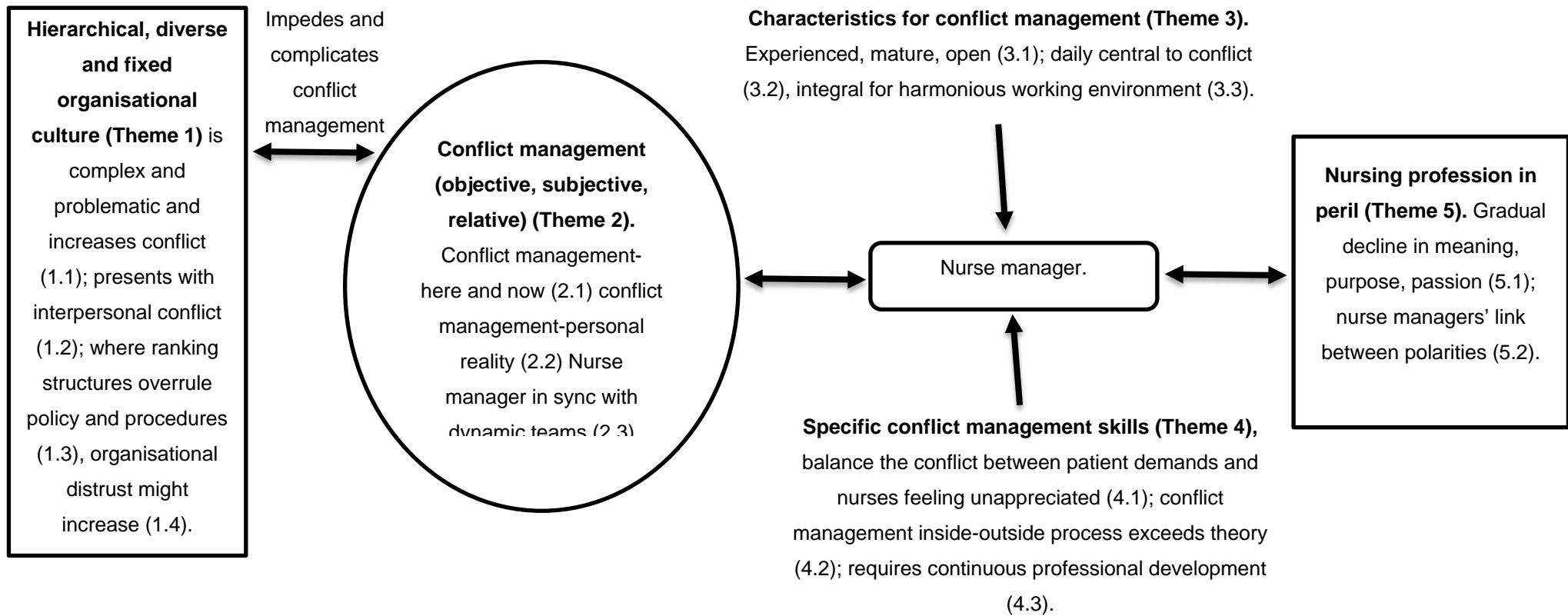


Figure 3.1 Graphic depiction of the research themes and sub-themes

Theme 1: Hierarchical, diverse and fixed organisational culture impedes and complicates conflict management

The organisational culture is characterised by nurse managers as hierarchical and diverse, presenting a perfect conflict storm that impedes on conflict management (Theme 1). *“We learn about conflict management skills, but in the military environment when you have to apply it, the rank is the issue”*; *“Once you have to deal with it (conflict) on a higher level that is where I have experienced a lot of hiccups”*. Within this rigid, yet diverse workplace, conflict presents as a daily reality, as two participants voiced *“Conflict management is what is happening I think on a daily basis”* and *“Conflict is there, we live with it on a daily basis”*. For example, the medical military context is more complex and diverse than the public health sector, and even more problematic when hierarchy requires immediate gratification against organisational limitations (sub-theme 1.1) as a nurse manager motivated: *“In my experience here, it’s quite different from the public sector....”* Furthermore, nurse managers reasoned that conflict within the medical military context increases when resource shortages cause stressful working conditions; remuneration and promotions are perceived as unfair; there are miscommunication as poor heard-and-tell among people and failing information communication technologies; when working with ‘outsiders’ such as civilians, private service-providers and non-military members. For example, two participants stated: *“The shortage of staff as well causes a lot of conflict in my unit”* and *“Shortage of human resources is a main problem with other resources, shortage is the problem”*.

In addition, this organisational culture presents with interpersonal conflict (sub-theme 1.2) between colleagues and within the multidisciplinary team. These conflicts are especially directed to unfair promotions and jealousy, as best captured in the following participants words: *“If you are promoted amongst your colleagues because you have the qualifications”*; *“From top management to the last subordinate, there’s a lot of tensions between the interpersonal relationships”*; *“In nursing there’s a lot of conflict between different categories of nurses, between nurses and doctors... the jealousy thing might come up”*. Interpersonal conflict presents also as projected conflict in the absence of effective communication; employee mediocrity and negative working attitudes; generational differences when Baby Boomers experience younger generations as unteachable and disrespectful, while students’ high absenteeism over holiday seasons leads to conflict and increased work-pressures on experienced staff. These generational differences are captured in the following statements: *“Our nurses of this generation they don’t want to be told”*; *“Junior registered nurses, nobody wants to take responsibility”*; *“We expect them to be responsible and take charge, but some of them compare themselves being young and trendy and they expect to be recognised better than the older, experienced trained personnel”*.

Within this hierarchical organisation, ranking structures can influence and/or overrule policies and procedures (sub-theme 1.3). Nursing managers experience that the military healthcare organisation functions as a general operations system against a superior ranking system that nurses sometimes experience as unfair, a licence to belittle reasonable effort (*'There's a lot of times I've experienced members are being belittled'*) while higher ranked colleagues don't necessarily have more effective conflict management skills. When conflict remains unresolved due to inefficient conflict management, it increases nurses' intention to leave. Within this hierarchical and fixed organisational culture, some nurse managers voiced an increased distrust (sub-theme 1.4), especially in performance management. A participant voiced: *"It has really affected me so much, I wanted to resign"* when speaking about the distrust and conflict surrounding staff promotions and when an outsider enters the military healthcare organisation into a higher position than employees who have been loyal to the force.

Theme 2: Nurse managers have different experiences of conflict management.

Nurse managers experience conflict and conflict management as objective (process-focused), subjective (relational) or relative (theme 2). *"As I say conflicts differ, and how we manage them will differ"; "People are different and they manage differently"*. Conflict management is to some nurse managers a specific, here-and-now, step-by-step process and they discount the very human dynamics involved in the conflict (sub-theme 2.1). These nurse managers view conflict management as an objective process, where *"You call one of them to hear the part of the story, then you call the other party to hear his/ her part of the story, thereafter you call them together to resolve the conflict"*. Nurse managers also differentiate between 'process/organisational' and 'personal' causes for conflict. As one participant said: *"I have stopped a number of times conflict issues where I felt that members started to get personal, because I don't like any personal issues"* and *"I try not to be personal with the conflict management"*. Yet, some nurse managers experienced conflict management as a subjective process, being present during conflict management and spending sufficient time to resolve conflict on a personal level (sub-theme 2.2). Then to some nurse managers conflict management is relative (sub-theme 2.3). When these nurse managers are in sync with team dynamics, they are less eager to respond to first line complaints, but are comfortable to first scope the working dynamics and then decide on a response.

Theme 3: Characteristics for conflict management

The respondents listed the characteristics of nurse managers in conflict management within a diverse workplace (Theme 3). First, nurse managers have to be experienced, mature and open to diversity (sub-theme 3.1). This implies that the nurse manager first seeks to understand cultural differences and team members' perspectives and take the necessary time to understand the

actual events because when cultural awareness lacks, conflict management is complicated. As two participants described: *“I was the only white member, a few times I had to stop a session to go and get more information to be able to assist”* and *“I constantly have to keep in mind the cultural differences when dealing with conflict”*. Second, nurse managers are central to conflict and have to cope with conflict daily (sub-theme 3.2). *“It’s not an easy thing if you have been put in a position; the difficult part in the ward is conflict management”*. Third, nurse managers are integral to facilitating a harmonious workplace by displaying interest in and enabling the continuous development of their personnel through facilitative teamwork and deliberate team cohesion (sub-theme 3.3). Two participants stated: *“So it was the matter of developing rapport between you and the workers and then team work”*; *“As an operational manager you try to have some means of creating a harmonious environment in the department and be visibly hands-on and it’s less conflicts. Even if maybe I’m being subjective, but the way I see it, it does work in creating a harmonious environment”*.

Theme 4: Specific conflict management skills

Nurse managers described the specific conflict management skills they require within this conflict-prone organisational culture (Theme 4): *“As registered nurses we need to understand what our role is”* and *“The thing that works for me is to bring them together, talk to them and listen to them”* and *“When you approach a conflict, you have to be kind and not manage it with emotions”*. The first skill is to balance the conflict that arises from patient demands against nurses feeling unappreciated (sub-theme 4.1). For example: *“.... the patient’s family will come to visit during unit routine, so it causes conflict that you have to manage.....”* and *“.....you find if the family don’t agree they just go down to the matrons’ office..”* and *“Military patients’ families submit big letters of complaints if you don’t accommodate their requests”*. As military patients are much more coached to voice their complaints and demands, they are not necessarily informed on the rules and regulations governing nursing practice. The nurse manager strives to maintain a balance between patients’ complaints against nurses feeling unappreciated and disrespected and giving both parties a voice. In addition, the nurse manager understands that military patients may display a sense of entitlement, requesting special and immediate attention that may be incongruent with the current workplace challenges such as staff shortages. The second skill is to engage with conflict management as not only theoretical knowledge, but as an inside-out process of knowing oneself, gaining experience and having the opportunity to grow (sub-theme 4.2). One participant voiced: *“I think that’s important growing from our experiences and learning from them in a human way”*. Nurse managers motivate nurses to participate in self-growth, establishing an environment where nurses can apply and then reflect on their conflict management skills during teaching-learning, within the multi-disciplinary team and before nurses become managers. *“As an operational manager we were supposed to be exposed or taken for a conflict management*

course, but it did not happen". Conflict management in action is time consuming and requires emotional labour, as one participant acknowledged, "Sometimes I feel so overwhelmed". Third, conflict management is also a skill that can be mastered and that requires conflict management training (sub-theme 4.3) presented to lower, middle and top-level management.

Theme 5: Nursing profession in peril

As the fifth theme, nurse managers experience conflict management as part of a nursing profession in peril, being firmly aware of the pressures on the nursing profession and the pressures on the organisation. Nurse managers experience a gradual decline in younger nurses' meaning, purpose and passion for nursing (sub-theme 5.1) on the one hand, and they receive insufficient support from their supervisors on the other hand. Two managers stated: "If we were working like a team from top management to unit managers' level, it would be easier to manage conflict more effectively" and "I have experienced lack of support from our top managers". Furthermore, nurse managers voiced the perceived lack of integrity and ownership displayed by younger generation nurses as "Some of the younger generation nurses are behaving like junior or 3rd year students, they are not yet acting like professionals"; "The junior sisters run away from the responsibility of handling scheduled medication"; "...junior sisters lack a sense of responsibility because nobody wants to take the blame for mistakes.....". As nurse managers observe this declining passion for nursing, they experienced themselves as a link between polarities within this diverse workplace (sub-theme 5.2). There is an incompatible polarity between nurse managers who know that their personnel are overworked, struggle with work-life balance and absenteeism, and the global shortage of nurses. Quality care despite a shortage of resources is an incompatible polarity for nurse managers that they have to manage within a diverse workplace. Two nurse managers stated: "You are expected to do the nurse thing.....expected to rinse the patient's cup....fetch stock, at the end of the day it end up being the duty of the manager" and "Everything that goes wrong a nurse manager has to answer. I'm unhappy about how top level nursing management treats area managers".

Discussion

Various international texts echo the organisational culture as an enabling impetus for conflict. The military culture is hierarchical and fixed, impacting negatively on conflict management. The medical military context is more complex and diverse than the public health sector. An Italian study on public employees and managers (Di Pietro & Di Virgilio, 2013:918) confirmed that the organisational culture in general impacts on conflict frequency. A Finland-based study on nurse managers in specialised healthcare organisations and primary healthcare (Aitaama *et al.*, 2015:7) confirmed the disregard for existing problems within the organisational culture indicating wrongs, with an associated inaction to correct these problems. The nurse managers experience a lack of

top management support and lack of teamwork between top and unit managers, which is a conflict enabler (Aitaama *et al.*, 2015:7). Rovithis *et al.* (2016:4) concluded that nurses in the Island of Greece's four public hospitals and health care centres experienced the organisational culture as aggressive/defensive, encouraged competitiveness, adopting superior attitude even when they lacked necessary knowledge, skills, abilities and experience. Nurse managers in general experience more conflict daily (Di Pietro & Di Virgilio, 2013:917) when line manager communication channels and complain procedures are not followed. Aitaama *et al.* (2015:6) acknowledge that nurse managers are expected to act according to the organisation's values because of their management role, although these nurse managers' own values are based on their nursing and professional values.

The literature provided contradicting findings regarding nurses' experiences with working amidst resource limitation. On the one hand nurses may experience a devaluing of nursing staff when there are insufficient resources for nursing in specialised healthcare organisations and primary healthcare in Finland (Aitaama *et al.*, 2015:7). There is inconclusive evidence on the prevalence of resource conflict and status conflict in public administrations and organisations in Italy (Di Pietro & Di Virgilio, 2013:917). However, the participants in this study experienced that a lack of resources contributes positively to the existence of conflict. The participants expressed a prevalence of conflict among the multi-disciplinary team members, especially between nurses and doctors. This finding also prevails in a study conducted in Nigerian hospitals where the relationships between the multidisciplinary team may increase conflict considering that nurses accuse physicians of having a domineering approach in practicing medicine and patient care Okhakhu *et al.*, 2014:3) and reports of unsatisfactory and non-accommodating multidisciplinary teamwork (Aitaama *et al.*, 2015:7). The latter may be evident in nurses' experiences of *argumentum ad expertiteto* by physicians, leading to verbal coercion and undermining nurses' concerns (Okhakhu *et al.*, 2014:3).

Nurses' and nurse managers' conflict management skills present in contradicting literature not categorised into objective, subjective and relative. In Nigerian hospitals, 60% of nurses reported avoidance as their coping mechanism (Okhakhu *et al.*, 2014:3). Humour was positively related to conflict management strategies, except forcing in a study conducted on Anglo-Americans (Wanda *et al.*, 2000:617-618), with females reporting high utilisation of humour, smoothing and compromising more than males, who reported high utilisation of humour, but more confrontational than females. Okhakhu *et al.* (2014:3) reported an unwillingness among nurses to compromise or to use dialogue or negotiation with the doctor to reach an agreement in Nigerian hospitals. However, in Cairo nurses preferred accommodation followed by collaboration with the least adoption of competition (Abudahi *et al.*, 2012:32). In contradiction to these results, a study

conducted on nurse managers in critical care units in a hospital in Iran revealed that the dominant conflict management style was compromising, followed by collaborating (Ahachian *et al.*, 2015:143). During conflict resolution, nurse managers drew on personal and institutional resources and maintained increased objective views when dealing with issues and conflicts (Kim & Windsor, 2015:25). Nurse managers in specialised and primary healthcare organisations in Finland experienced that negative behaviour, bullying, scapegoating and an inability to solve problems in a constructive manner (Aitaama. *et al.*, 2015:6) do occur during conflict resolution and nurse managers cannot always indicate a clear “who’s right and who’s wrong” conclusion. This result is congruent with this study, because participants of this study perceived that senior management do not necessarily assist them to manage conflict and they feel bullied when senior management overrules their decisions. Contrary to this finding, Charalambous *et al.* (2010:503) concluded that nurses perceived that they used a problem-solving approach to handle disagreements and conflicts and had well-functioning teamwork. Considering conflict activation through patient and family demands, Aitaama *et al.* (2015:6) linked patient care-related demands to conflict between patients and staff, between nurses and physicians, between patients and their relatives. Nurse managers face dissatisfied patients and their relatives, who have unrealistic demands and special requests from the nurses. Nigerian nurses prefer not to confront demanding patients and family directly (Okhakhu *et al.*, 2014:4), although nurses experienced resentment when they had to comply with doctors’ orders, which led to interpersonal and professional conflicts-in-care (Okhakhu *et al.*, 2014:3). However, in different types of hospitals in Finland (acute, district and general hospitals) nurses perceived relationships with physicians as good and communication as satisfactory between the multi-disciplinary team members (Charalambous *et al.*, 2010:503). The need to teach nurses and nurse managers practical conflict management skills cognisant of cultural ways was confirmed in Nigerian hospitals (Okhakhu *et al.*, 2014:4). Nurse managers’ experience that the nursing profession is in peril was confirmed in literature and presented as nurse managers experiencing the lack of valuing the nursing profession and a negative public image of the organisation (Aitaama *et al.*, 2015:7) as well as the lack of independent decision making and associated authority related to nursing issues. This impacts negatively on nursing care outcomes (Kieft *et al.*, 2014:6). The attitudes of nurse managers towards senior management tended to “rub off” on their subordinates. A study in British national health services concluded that the nurse managers’ role was considered highly significant in developing trust, in the immediate work environment and in the wider organisational context (McCabe & Sambrook, 2014:821).

Conclusions

Workplace diversity is a reality in South Africa and in global healthcare organisations, predisposing them to conflict. It becomes the responsibility of the nurse manager to work towards a healthy work environment. Nurse managers should be equipped to embrace workplace diversity and to be actively involved within nursing teams towards a harmonious working environment. Workplace diversity and a predisposition to conflict are exacerbated in a complex, hierarchal and fixed organisational culture, especially within military healthcare organisations. Within such an organisational culture the nurse manager conducts conflict management daily. In addition, the nurse manager might experience that the complex, hierarchical, diverse and fixed organisational structure presents a barrier to conflict management. The nurse manager is positioned centrally to conflict management and should therefore have specific conflict management characteristics and skills. Humour and avoidance are the most preferred conflict management skills. The manager should know him/herself, understand when conflict is objective, subjective or relative and be self-aware when personal and professional values clash with organisational values. As nurse managers experience workplace conflict and workplace diversity, they experience a change in the nursing profession towards gradual decreased meaning, purpose and passion first-hand.

Implications for nursing management

In a complex, hierarchal and military healthcare organisation, the organisational culture predisposes the organisation to conflict and distrust. Nursing management should deploy conflict management strategies to enhance the standards of a healthy work environment. Nurse managers should embrace diversity responsibly as an enriching factor, but remain aware that diversity can increase conflict in the absence of strong team cohesion. Being a manager doesn't automatically imply being efficient with conflict management and coping better with conflict on a daily basis. Conflict management requires skill and experience best explored and improved through practice in a non-threatening environment and best learned through reflection. Continuing conflict management training as an inside-out process can be presented to all nurses so that they are prepared for conflict when entering management. Mentoring young managers in conflict management will support the intra- and interpersonal stress and growth presented by managers exposed to conflict every day. Organisations should activate strategies, proactively, to bridge generational gaps.

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CHAPTER 4: EVALUATION, LIMITATIONS AND RECOMMENDATIONS

4.1 INTRODUCTION

Chapter 4 concludes the research. This chapter offers an evaluation of the research and presents the limitations experienced. This is followed by recommendations. Special attention is granted to recommendations for nurse managers functioning within a complex, diverse work environment.

4.2 EVALUATION

In the final section, I conducted a self-evaluation of specific aspects of the conducted research as stipulated below.

4.2.1 Research methodology

A qualitative, phenomenological, contextual approach (Brink *et al.*, 2012:121) was suitable for this research. An explorative, descriptive approach was followed because the researcher obtained rich data about nurse managers' experiences of conflict management and of their conflict management skills within a diverse workplace. Data saturation was reached during the unstructured individual interviews with a total of thirteen (N=13) of a total of 15 prospective participants. These interviews lasted 45 minutes to one hour, granting the researcher the opportunity to explore every comment made by the participants.

The context was a diverse healthcare organisation. The military criterion added to this complex and hierarchical organisation. It is macrocosm of South Africa at large, a prototype of a diverse workplace. As is evident from the participants' demographic data, the nurse managers presented a variety of South African cultures.

4.2.2 Aim and objectives of the research

The research aimed to understand nurse managers' conflict management skills within a diverse workplace in order to foster a healthy work environment. This research aim was reached. The nurse managers' experiences of conflict and their conflict management were explored and described. Recommendations are formulated below for nurse managers, researchers and the institution to enhance nurse managers' conflict management skills. Both the research objectives as indicated on page eight were reached. Therefore, the research did explore and describe workplace diversity within the current South African healthcare organisations. The research also

explored and described nurse managers' experiences of conflict management and their conflict management skills within a workplace with a diverse workforce.

The research results exceeded the researcher's expectations. The results depicted the reality of the rigid, complex environment, which has an impact on the experiences and conflict management skills that nurse managers need and the challenges of this diverse work environment. Managers expressed a need for conflict management training.

4.2.3 Central theoretical statement

This research results match the central theoretical argument, as declared in Chapter 1, namely: A better understanding of the South African workplace diversity in which nurse managers should manage conflict and nurse managers' current conflict management skills can assist the researcher in formulating recommendations for appropriate conflict management skills. When nurse managers manage conflict within a diverse workplace appropriately, it might imply that conflict can be positive towards the facilitation of a healthy work environment.

Through an extensive literature review, the researcher gained a better understanding of workplace diversity and conflict management. Through the proposed phenomenological approach, the researcher obtained an in-depth understanding of nurse managers' conflict management experiences and conflict management skills. Using the standards of a healthy work environment as theoretical framework, the researcher was able to formulate recommendations to facilitate conflict amidst workplace diversity (American Association for Critical-Care Nurses [AACN], 2016:10).

4.2.4 Trustworthiness

The research complies with the following five epistemological standards for trustworthiness (as outlined by Botma *et al.*, 2010:233):

Truth value: The researcher engaged with relevant literature over a period of three years. Peer review was done by the research supervisor and co-supervisor to facilitate accuracy. The truth value was obtained by discovering the experiences from the participants in their natural context. Unstructured individual interviews were appropriate to reflect participants' experiences. The researcher declared all the negative information in the findings. The researcher aimed to remain neutral during the data collection process by using a mediator to recruit participants and not coercing participants to participate. The analysed data was co-coded for congruence. The co-supervisor has an MBA with in-depth experience of organisational behaviour.

Applicability: The findings of this research are only applicable to the selected military healthcare organisation in Gauteng. Yet, the research context was described in detail to increase the transferability of the research methods and results.

Consistency: The research report can serve as an audit trail to repeat this methodology. The researcher declared the participants' demographic characteristics.

Neutrality: Freedom from bias was assured by the researcher by making use of an independent co-coder. The researcher reflected the participants' views by confirming statements made by participants.

Authenticity: The researcher provided a range of different realities. National and international literature was consulted to identify the broad reality. The participants' different experiences were described with consideration of their different backgrounds and underlying values.

4.2.5 Health research ethics

All the health research ethical principles declared in Chapter 1 were applied. The researcher obtained written consent from Organisation A (pseudonym), the NWU's HREC and informed consent from participants. Participants received consent documents at least 24 hours before the research to discuss with friends and families to make an informed decision. Their privacy and confidentiality were maintained as stipulated in the informed consent document. The participants experienced no harm or any emotional trauma and they were treated fairly. The participants were not identifiable and all documentation, voice recordings, and transcripts will be stored for seven years after the completion of the research at the study leader's office at the NWU.

Autonomy: The participants' right to self-determination was assured. Participants were recruited by a mediator who had easier access to the population. The researcher conducted the unstructured interviews. Written informed consent was signed by participants after they were informed regarding the research process and that they may withdraw from the research at any stage without negative consequences. Participants' identities were protected by limiting access to their information. The interviewer, mediator, transcriber, study leader and researcher signed confidentiality agreements.

Non-Maleficence: No harm was done to any participant. The research was non-invasive. Participants shared their experiences with the researcher. The interviews were digitally voice-recorded and explained to participants. All the data will be stored on the premises of the NWU for at least seven years after the completion of the research under lock and key, and on a password-

protected computer. Thereafter all the data will be destroyed. The transcriber deleted audio recordings after completion of the transcriptions.

Beneficence: The benefits are indirect, but were explained to the participants in the informed consent document. However, without this having been intended, the participants experienced the interviews as an emotional venting session in a safe environment. The findings of the research will be published to make recommendations to the research community, authorities and nurse managers regarding the barriers, complexities and challenges experienced by nurse managers. The participants did not receive any incentives. The researcher communicated easily and ensured the participants' emotional and physical comfort. The mediator was present to oversee the process. Feedback will be available to participants on completion of the research.

4.3 LIMITATIONS OF THE STUDY

The researcher identified the following limitations:

- Due to time constraints and the participants' responsibilities in the hospital, the researcher had to reschedule some interviews on the spur of the moment due to the hectic nature of the participants' workload.
- The venue was average and the researcher had to alter the venue as per the hospital's needs to utilise the room. The researcher had to conduct some interviews in the nurse managers' units.
- The population was restricted to the military healthcare organisation. An inclusive population from hospitals of the Department of Health would give more insight into the experiences of nurse managers' on conflict and their conflict management skills. Comparative studies could point out differences in regions, towns and student groups.

4.4 RECOMMENDATIONS

The following recommendations are formulated for nursing practice, education and research.

4.4.1 Recommendations for nursing practice

Nursing practice should consider the following actions:

- Reconsider the impact of organisational culture and workplace diversity on nursing and conflict. This requires from the nurse manager to broaden her scope from the typical healthy work environment directed to the nursing unit, towards organisational thinking.
- Provide support groups with nurse managers to understand organisational complexity and its effect on conflict. Support groups are necessary to give perspective to nurse managers to

identify causes of conflict proactively; to support nurse managers exposed to conflict daily and to reflect on their more and less effective conflict management skills.

- Nurse managers should explore strategies to voice their experiences where ranking systems overrule the values of nursing, as this may cause intrapersonal discomfort within nurses.
- Activate a conflict management committee within the management structures of the diverse workplace. This committee's responsibilities should be to advise executive management on organisational causes for conflict (tangible and intangible); to organise conflict management in-service training; workplace diversity workshops; profile repetitive interpersonal conflict and to provide human capital support.
- Because nurse managers experience conflict management subjectively, it is recommended that complex and diverse and especially military healthcare organisations revisit policies and procedures related to conflict management. Standard operating procedures on conflict resolution can assist nurse managers with more congruence in applying theoretical knowledge to real-life experiences.
- Revisit the culture on consumerism within healthcare organisations. When nurses and nurse managers experience an unreasonable acknowledgement of healthcare users' demands when top management silences nurses' voices, it impacts negatively on nurses.
- Activate a management succession plan with younger nurses that includes a mentoring system where intergenerational differences can be overcome with an experience of "we as nurses" and not "they as the younger ones against us, the older nurses". The succession plan and associated mentoring process should aim to facilitate nurses' professional development and their personal experiences and dealing with conflict as an inside-out process.
- Reconsider the organisation's values to adopt workplace diversity and efficient conflict management as two mechanisms that can enrich the organisation through tolerance and respect.

4.4.2 Recommendations for nursing education

- It is recommended that health service management curricula adopt a stronger acknowledgement of the role of the nurse manager within the realities of a diverse workplace. It will be beneficial to add the following to curricula as well:
 - Map potential conflicts that are specific to diversity in healthcare organisations and formulate a proactive action plan.
 - Focus more on organisational culture, on the non-written ground rules that direct organisational behaviour and enable nurse managers to identify indicators faster.
 - Principles and good practices in performance appraisal, especially within healthcare organisations with a fixed and exclusive culture.

- Dare to enrich current curricula and training on conflict management to exceed repetitive theoretical knowledge towards an enriched personal reflection and personal growth experience.
- Acknowledge conflict management literature from abroad, but start to develop South African and contextual conflict management literature applicable to the South African cultures. Adopting literature from the United States of America (USA), United Kingdom (UK) and European countries (North and South) can be beneficial to understand workplace diversity and conflict management from an international perspective, but it requires an additional process to truly contextualise this information for South Africa.
- Practica within professional nursing syllabi, healthcare dynamics syllabi and health service management should include conflict management under close supervision of a mentor with an inside-out approach. Present syllabi to student nurses to engage their cognitive skills, practical competence and their personal development.
- Present practical examples of intergenerational conflict within nursing typical to South Africa and mechanisms to manage these conflict.

4.4.3 Recommendations for nursing research

The following themes for future research were identified during the completion of this research process and report:

- The views, experiences, passion, meaning and purpose that younger generation nurses have for the nursing profession.
- Consumerism of patients as healthcare users against patient rights and responsibilities.
- Nurse manager presence within the dynamics of nursing teams.

4.5 SUMMARY

In Chapter 4 the reader walked with the researcher through the process of evaluating the research and the limitations. Recommendations were formulated for nursing practice, nursing education and nursing research with a strong focus on the experiences and skills of nurse managers' conflict management in the diverse healthcare organisation. The recommendations were also contextualised as the researcher acknowledges the realities of the complex military health environment and the rigid nature of the environment that impacts negatively on nurse managers' experiences and their conflict management skills.

The research results have been formulated as a manuscript that is at present submitted for peer review. The manuscript has been prepared for the *International Journal of Nursing Management*.

This chapter concludes the research report on the study titled *An exploration into nurse managers' experiences of their conflict management skills*. The researcher also committed herself to share this research report with the applicable healthcare organisation, learning centre and the national nursing education institution of Company A.

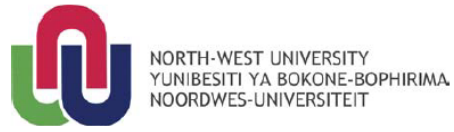
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ADDENDUM A: HREC CERTIFICATE



NORTH-WEST UNIVERSITY
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Institutional Research Ethics Regulatory Committee

Tel +27 18 299 4849
Email Ethics@nwu.ac.za

ETHICS APPROVAL CERTIFICATE OF PROJECT

Based on approval by **Health Research Ethics Committee (HREC)**, the North-West University Institutional Research Ethics Regulatory Committee (NWU-IRERC) hereby approves your project as indicated below. This implies that the NWU-IRERC grants its permission that, provided the special conditions specified below are met and pending any other authorisation that may be necessary, the project may be initiated, using the ethics number below.

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|--|---|-------------|----------------|---|---|---|---|---|------|---|---|--------|---|---|---|---|-------------|--|--|----------------|--|--|--|--|--|------|--|--|--------|--|--|
| Project title: An exploration into nurse managers' experiences of their conflict management skills. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Project Leader/Supervisor: | Prof P Bester | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Student: | AM Koesnell | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Ethics number: | <table border="1"><tr><td>N</td><td>W</td><td>U</td><td>-</td><td>0</td><td>0</td><td>1</td><td>9</td><td>6</td><td>-</td><td>1</td><td>5</td><td>-</td><td>A</td><td>1</td></tr><tr><td colspan="3">Institution</td><td colspan="6">Project Number</td><td colspan="3">Year</td><td colspan="3">Status</td></tr></table> <small>Status: S = Submission; R = Re-Submission; P = Provisional Authorisation; A = Authorisation</small> | N | W | U | - | 0 | 0 | 1 | 9 | 6 | - | 1 | 5 | - | A | 1 | Institution | | | Project Number | | | | | | Year | | | Status | | |
| N | W | U | - | 0 | 0 | 1 | 9 | 6 | - | 1 | 5 | - | A | 1 | | | | | | | | | | | | | | | | | |
| Institution | | | Project Number | | | | | | Year | | | Status | | | | | | | | | | | | | | | | | | | |
| Approval date: 2016-02-26 | Expiry date: 2017-02-25 | Risk | Minimal | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

Special conditions of the approval (if any):

- Translation of the informed consent document to the languages applicable to the study participants should be submitted to the HREC (if applicable).
- Any research at governmental or private institutions, permission must still be obtained from relevant authorities and provided to the HREC. Ethics approval is required BEFORE approval can be obtained from these authorities.
- Any further information and any report templates is obtainable from Carolien van Zyl at Carolien.VanZyl@nwu.ac.za.

General conditions:

While this ethics approval is subject to all declarations, undertakings and agreements incorporated and signed in the application form, please note the following:

- The project leader (principle investigator) must report in the prescribed format to the NWU-IRERC and HREC:
 - annually (or as otherwise requested) on the progress of the project, and upon completion of the project
 - without any delay in case of any adverse event (or any matter that interrupts sound ethical principles) during the course of the project.
 - Annually a number of projects may be randomly selected for an external audit.
- The approval applies strictly to the protocol as stipulated in the application form. Would any changes to the protocol be deemed necessary during the course of the project, the project leader must apply for approval of these changes at the HREC and NWU-IRERC. Would there be deviated from the project protocol without the necessary approval of such changes, the ethics approval is immediately and automatically forfeited.
- The date of approval indicates the first date that the project may be started. Would the project have to continue after the expiry date, a new application must be made to the NWU-IRERC and new approval received before or on the expiry date.
- In the interest of ethical responsibility the NWU-IRERC and HREC retains the right to:
 - request access to any information or data at any time during the course or after completion of the project;
 - to ask further questions, seek additional information, require further modification or monitor the conduct of your research or the informed consent process.
 - withdraw or postpone approval if:
 - any unethical principles or practices of the project are revealed or suspected,
 - it becomes apparent that any relevant information was withheld from the NWU-IRERC or that information has been false or misrepresented,
 - the required annual report and reporting of adverse events was not done timely and accurately,
 - new institutional rules, national legislation or international conventions deem it necessary.

The IRERC would like to remain at your service as scientist and researcher, and wishes you well with your project. Please do not hesitate to contact the IRERC for any further enquiries or requests for assistance.

Yours sincerely

Prof LA
Du Plessis

Digitally signed by Prof LA Du Plessis
DN: cn=Prof LA Du Plessis, o=North-West University, ou=Campus Rector, email=Linda.DuPlessis@nwu.ac.za, cn=ZA
Date: 2016.02.29 16:10:45 +02'00'

Prof Linda du Plessis

Chair NWU Institutional Research Ethics Regulatory Committee (IRERC)

ADDENDUM B: ADVERTISEMENT



INVITATION TO PARTICIPATE IN RESEARCH

An exploration into nurse managers' experiences of their conflict management skills



DATA COLLECTION

Nurse managers can participate.

Participants should be registered with SANC as a professional nurse with nurse administration and have management experience for at least three years at this Hospital.

Individual interviews conducted by the researcher on the Hospital's premises. Interviews will last 45-60 minutes and will be voice recorded. Participants will have to give written, informed consent.



DATES

Interviews will be conducted during March 2016. The venue at the hospital will be confirmed when appointments are scheduled.

ETHICS AND CONSENT

Ethics clearance was granted by the Health Research Ethics Committee of the North-West University and consent granted by the CEO of the Hospital.

CONTACT PERSONS

Lt Col Seemola: 072 479 3035.

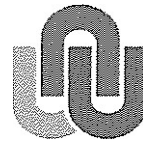


'For good ideas and true innovation, you need human interaction, conflict, debate.'

Margret Heffernan



ADDENDUM C: INFORMED CONSENT



NORTH-WEST
UNIVERSITY
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NOORDWES-UNIVERSITEIT
POTCHEFSTROOM CAMPUS

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| Health Research Ethics Committee Faculty of Health Sciences NORTH-WEST University (Potchefstroom Campus) 2016 -02- 2 6 HREC Stamp |
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PARTICIPANT INFORMATION LEAFLET AND CONSENT FORM FOR NURSE MANAGERS TO PARTICIPATE IN UNSTRUCTURED INTERVIEWS

TITLE OF THE RESEARCH PROJECT: An exploration into nurse managers' experiences
of their conflict management skills

REFERENCE NUMBERS: NWU-00196-15,,S1

PRINCIPAL INVESTIGATOR: Angela M. Koesnell

ADDRESS: 12 Ashwood Gardens, Ashwood Drive, Clubview, Pretoria

CONTACT NUMBER: 073 785 6070

You are being invited to take part in a research project that forms part of my. Magister
Curationis in Nursing Science (Health Service Management). Please take some time to read

the information presented here, which will explain the details of this project. Please ask the researcher any questions about any part of this project that you do not fully understand. It is very important that you are fully satisfied that you clearly understand what this research entails and how you could be involved. Also, your participation is entirely voluntary and you are free to decline to participate. If you say no, this will not affect you negatively in any way whatsoever. You are also free to withdraw from the study at any point, even if you do agree to take part. This study has been approved by the Health Research Ethics Committee of the Faculty of Health

Sciences of the North-West University (NWU-000196-15-S1) and will be conducted according to the

You are being invited to take part in a research project that forms part of my *Magister Curationis* in Nursing Science (Health Service Management). Please take some time to read the information presented here, which will explain the details of this project. Please ask the researcher any questions about any part of this project that you do not fully understand. It is very important that you are fully satisfied that you clearly understand what this research entails and how you could be involved. Also, your participation is **entirely voluntary** and you are free to decline to participate. If you say no, this will not affect you negatively in any way whatsoever. You are also free to withdraw from the study at any point, even if you do agree to take part.

This study has been approved by the Health Research Ethics Committee of the Faculty of Health Sciences of the North-West University (NWU-000196-15-S1) and will be conducted according to the ethical guidelines and principles of the international Declaration of Helsinki and the ethical guidelines of the National Health Research Ethics Council. It might be necessary for the research ethics committee members or relevant authorities to inspect the research records.

What is this research study all about?

The objectives of this research are:

- To explore and describe workplace diversity within the current South African healthcare organisations.
- To explore and describe nurse managers' experiences of conflict management and their conflict management skills within a diverse workplace.

Why have you been invited to participate?

You have been invited to participate because you are:

- a nurse manager, permanently employed for at least three years in a Military hospital in Gauteng.

- sufficiently trained by being registered for Nursing Administration with the South African Nursing Council.
- comfortable to use English when talking to the researcher.
- willing to give voluntary, written informed consent and also willing to spend at least one hour with the researcher for an interview that will be recorded on a digital voice recorder.

What will your responsibilities be?

You will be responsible to spend approximately 45 minutes to one hour of your time with the researcher in an individual interview. During the interview the researcher will ask you to talk about your experiences of conflict management and your conflict management skills. It will be your responsibility to give your honest feedback to the researcher. It will also be your responsibility to first sign this informed consent, voluntary. Please ask all the questions you wish to ask before onset of the interview. If you consent to participate and you cannot adhere to a scheduled interview, it will be your responsibility to inform the mediator that you will not be able to participate. Please state if you wish to stop with an interview or don't want to continue with the research as you can withdraw from the research at any time without discrimination.

Will you benefit from taking part in this research?

- *There are no direct benefits for your participation in this study.*
- *The indirect benefit will be the scientific significance to improve the understanding of how conflict manifests within a diverse South African health organisation as workplace. The practical implication of the study is to foster and maintain a healthy work environment, to improve patient outcomes, to prevent poor interpersonal relationships among colleagues, enhance communication, build morale, and improve discipline and ethical conduct.*

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

There are minimal risks involved in taking part in this research and although you might be afraid that punitive action might follow if you provide honest feedback, this will not occur. Should you experience any discomfort, especially emotional discomfort, you can be referred for counseling, free of charge. Your name will under no circumstances be linked back to your work unit. Please note that your name will be replaced with a code and your response will by no means be linked to you. The researcher will give the final research report to the hospital management. Your unit might be very busy with a high patient turnover and it might be stressful for you to participate in research whilst your colleagues have to work without your support. In this event, always remember that the safety of patients and employees remain the first consideration. You can therefore terminate your participation at any stage without discrimination.

What will happen in the unlikely event of some form of discomfort occurring as a direct result of your taking part in this research study?

Should you have the need for further discussions after feeling emotional about your experiences; you can be referred to the hospital's employee assistance programme for counseling, free of charge.

Who will have access to the data?

- Anonymity will be applied as participants will not write their names on the interview schedules or in the transcriptions. Anonymity will be complete because no person other than the researcher will have access to your data and your particulars.
- Confidentiality will be ensured by reporting of findings in an anonymous manner. The researcher will ensure autonomy over the personal information obtained from the participants, meaning the researcher will keep in confidence all personal and other information obtained from the participants.
- The researcher will not allow anybody else to have access to the personal information obtained from the participants. Information will be kept under lock and key, the information will not be linked to the real identities of the participants.
- Only the researchers and the data analysis expert, who will sign a confidentiality agreement, will have access to the data. Data will be kept safe and secure by locking hard copies in locked cupboards in the researcher's office and electronic data will be password protected. As soon as data has been transcribed it will be deleted from the digital voice recorder. Data will be stored for seven (7) years on a password protected computer in a lockable office on the premises of the North-West University's Potchefstroom Campus.

What will happen with the data?

This is a once-off collection and data will be analysed in this study only.

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

No, you will not be paid to take part in the study. Although it is planned to conduct interviews at the Hospital, travel expenses will be paid for those participants who have to travel to the site only if applicable. There will thus be no costs involved for you, if you do take part.

Is there anything else that you should know or do?

- You can contact the researcher, Ms Angela Koesnell at 073 785 6070 if you have any further queries or encounter any problems.
- You can contact the Health Research Ethics Committee via Mrs Carolien van Zyl at 018 299 2089; carolien.vanzyl@nwu.ac.za if you have any concerns or complaints that have not been adequately addressed by the researcher.
- You will receive a copy of this information and consent form for your own records.

How will you know about the findings?

The research findings will be reported back to the hospital CEO. The researcher will also declare her availability to present the results to the hospital's management, and if requested, participants will be invited to the presentation.

DECLARATION BY PARTICIPANT

By signing below, I agree to take part in the research titled: **An exploration into nurse managers' experiences of their conflict management skills**

I declare that:

- I have read this information and consent form and it is written in a language with which I am fluent and comfortable.
- I have had a chance to ask questions to both the person obtaining consent, as well as the researcher and all my questions have been adequately answered.
- I understand that taking part in this study is **voluntary** and I have not been pressurised to take part.
- I may choose to leave the study at any time and will not be penalised or prejudiced in any way.
- I may be asked to leave the study before it has finished, if the researcher feels it is in my best interests, or if I do not follow the study plan, as agreed to.

Signed at (*place*) on (*date*) 20....

.....

Signature of participant

.....

Signature of witness

DECLARATION BY PERSON OBTAINING CONSENT

I (*name*)declare that:

- I explained the information in this document to
- I encouraged him/her to ask questions and took adequate time to answer them.
- I am satisfied that he/she adequately understands all aspects of the research, as discussed above
- I did/did not use an interpreter.

Signed at (*place*) on (*date*) 20....

.....

Signature of person obtaining consent

.....

Signature of witness

DECLARATION BY RESEARCHER

I declares that:

- The mediator did explain the information in this document to after I explained the research in detail to the mediator.
- The participant was encouraged to ask questions to the mediator and myself and adequate time was taken to answer him/her.
- The participant understands all aspects of the research as discussed above, adequately.
- I did/did not use an interpreter.

Signed at (*place*) on (*date*) 20....

.....

Signature of researcher

.....

Signature of witness

ADDENDUM D: EXERPT FROM A TRANSCRIBED INTERVIEW

Date: 15/06/2016

Venue: Military Hospital in Pretoria

Participant's Name & Surname: XXXXXXXX

R: Good morning Miss Mogoka (spelling). I hope you don't mind me calling you Miss Mogoka (spelling). Is it OK?

P: No problem.

R: Or should I call you on your first name?

P: It doesn't matter.

R: So thank you very much for honouring this appointment with me this morning. I really appreciate it. I can't begin to express my appreciation for your willingness really. I really appreciate it. I said it but I'm saying it again and it's on record.

P: You're welcome.

R: Miss Magopa (spelling), the purpose of the research as I said to you is I'm exploring nurse managers experiences of the conflict management skills and their experiences of conflict and how they handled it in the unit. Right, I just have to confirm with you. This is totally confidential; nobody else outside the research will have access to the data, nobody. I will not use any names. I will not attach any information to any names right. That is totally against the rules and best out of confidentiality and what we say here will stay here. So be free and be open to share all the experiences you want to share. I believe it's also going to be helpful to you, to perhaps just get it off your chest if you want to and ja. The interview is just so that I can gather in depth information on your experiences as a unit manager on conflict management. Is that OK? It's only me and the supervisor and the transcriber who will have access to the data and we've all signed confidentiality agreements. So there's total confidentiality, you are safe. Physically and psychologically.

P: Supervisor from the University?

R: From the University, not anybody here. Not even the mediator. That would be against the rules ja. So Miss Magopa(spelling) are you comfortable?

P: Alright, OK. I'm very much comfortable ma'am.

R: I apologise for the chairs you know Miss Magopa(spelling) we at the hospital.

P: Don't worry, it is not your home this one.

R: Yes, yes, ja. So you've been a nurse manager in this diverse health care organisation for more than three years I believe.

P: Yes.

R: So as a unit manager, can you tell me about your experiences of conflict management. Your experiences of conflict management and then after that you'll tell me about your experiences of your own conflict management skills that you applied in unit.

P: You know conflict management in this hospital specifically. I can say the way it's managed is not according to the book. A book is there as a guideline but it's the opposite of what is happening. It is the opposite of what is expected from the book. As a result, it causes a tension amongst the colleagues and the staff members. From top management to the last subordinate, there's a lot of tensions between the interpersonal relationships, it's compromised. As a result, it also affects the savers delivery of an organisation. Why I'm saying this is because of I can say why is there a lack of resources. To start personnel resources and other logistical things, equipment and other things but the main concern is the personnel resources that is the problem but can be the cause of this conflict management resources problem. In my own ward how I manage it, I'm using what you call the old system where we used to say a rotor system. Let me be specific, in this hospital we are running short of senior personnel's. As a result, it's mostly the junior ones. The senior is most who qualified I think 2010 in my ward now 2014. Those I call them seniors who qualified. You can imagine professional nurses and ward nurses who qualified from 2014. As a result I make a rotor system work by I can't mix the seniors in the same shift. I can't mix the juniors in the same shift but somewhere, somehow it will lead where by being there will be only seniors and juniors because there is no personnel and this is what is happening in all this infertility. If we had had maybe enough personnel, I don't think the conflict would be that much. We will be resolving some of the things that we are...because we will be sharing ideas but now it's all about change. If we...people are resistant to change. If one is bringing changes in the department, it will end up as being a chaos because you won't have support, that's the problem.

R: All right, so am I right when I say that you saying the lack of human resources.

P: The lack of human resources is a main problem with other resources because that will also help to improve the savers delivery but at the moment, the conflict, the most important ones are the lack of resources.

R: All right, you also said earlier on that there's tension from top management to the most junior category of nurses in the hospital.

P: Yes, yes.

R: All right, do you think I should say earlier on the lack of resources is the main cause of the tension of the tension between the different categories?

P: The personnel resources, yes it is because when managers sitting down and discuss the personnel distribution. It becomes...it won't be fairly distributed amongst the units, all the units of all the wards. Hence there are some other wards that will be suffering. There will be some other wards that will be having at least mostly senior personnel. That's what I'm saying, it starts up there. If they were about to discuss, in their discussion of the change list, they will include the unit managers or the operational managers in the ward that will be less tension or less conflict because operational managers we are there, people on the ground. We could move the subordinates. They are discussing it without including us and we know the problematic amongst us on the floor on the ground. So we suggested that they can in their discussion include the operational managers. It's only the area manager and the top management mainly may choose and in their discussions one will suffer and one will not. Meaning the distribution is unfairly done yes.

R: OK, can you tell me more about the fact that you said you know the problematic members in your unit. In that regard can you tell me more about the conflict that's occurring in your unit and how you've experienced that as a unit manager?

P: Specifically in my unit I'm not specifically talking about now because currently now I'm three months old in that unit. I'm from you know, from deployment but in my experience the priority of the members. There's a record of them, there's a profile that we make for them. I normally call the member, one to one have a face to face. What you call, sessions with the member. For instance I will take out your profile, we call it individual absenteeism. This is your individual absenteeism for the year. For the period of say maybe three months, this is your absenteeism. Either sick leave, I felt like any kind of leave this is what...or from there I develop a development health plan for a member. If when it comes to what you call, PMDS Performance Management System, this member I will use it with the profile together with the job description. With the... it will be the job description and the developmental plan and the profile so that we can improve the member in what I think the member lacks. That will also improve the member by so doing developing the member. That we also, it helped me to reduce the conflict in the ward that I'm working because the conflict it might not be with me and the individual. It's the interpersonal relationship amongst nurse to nurse, nurse to patient because this member who's a problematic will end up being a burden to other members or to other colleagues. So by so doing, I'm trying to improve this poor little kid or how about either improving you. I'm going to help you with two things,

to better yourself or else to exist because you are not fit to be in this profession. Meaning to better yourself, you must have that passion of nursing care. So that the savers deliverance, deliver at the end of the day to be rendered. This is my own management system, in my unit where I'm working with my own members in my ward.

R: OK, tell me more about you said that interpersonal conflicts among the nurses right? In your unit, whether it's this unit or where you previously worked in the other units. Can you tell me more about that? How did you experience the interpersonal conflict among nurses?

P: I can say it's bad. It's not worse, it's bad because as I'm saying this ward would be a better to the others. At the end of the day, it affects their social relationship to such an extent. They would prefer not to work with this one and work with this one. When it comes to social event, they don't want to sit with this one, they will sit with this one. As a manager, I'm expected to be a mediator and then I'm not going to be a mediator or a middle man. I'm going to make them sit together so that let's solve this problem. If I saw the member by calling the member and having a plan for the member, I'm expecting a member to respond. This will not escalate to work but it affects their social life even after hours even after work. So at some stage I can't say it's not worse, it's bad. If one can be able to handle it with individuals, have a one to one talk with the member. I think it also helps me a lot but I didn't want to discuss this other member and the other member says no. We discuss at the end of the day your story will be heard all over. I'm avoiding that as a manager because I know that can make a situation become worse. And I don't want it to be worse.

R: All right, you said just now that it affects interpersonal contact; it affects their social interaction as well. So in your experience as a unit manager, do you think there are other causes besides interpersonal conflict in the unit that can occur? That can cause conflict in your ward?

P: Ja, mostly in the unit it will be work related issues. Meaning the absenteeism of the member in a team. This is Team A and Team B, they are working opposite each other and forever this member in his team, is forever sick or is forever absent. That will also cause the conflict amongst the members because the end of the day you have to report this member to me. Even in my absinthial where by example if the member they are in a permanent night for that month and then only to find that in five nights the member is only working two nights and then they will keep a record for themselves until I come up and they will say, captain this is what is happening. It's up to you to talk to a member and approach the members and say look this is your colleagues what have been saying. This is what they have observed so I'm expecting you to improve on 1, 2, 3.

R: OK, all right you said in the unit its mostly work related? Can you perhaps identify specific incidences? If you can remember that you have experienced as a unit manager where conflict irrputed in the unit.

P: It's a, what you call this duty scheduling.

R: Duty scheduling yes.

P: One of the incident that happened was when the member, the members requested the same work here. Only to find that either me or other colleague that have dedicated to make the duty scheduling for the month. They have some challenges where they are in the same shift, they are in the same team and then they are more than three that requested the same off days. How is this one going to give who to whom? That also causes a conflict where by either you give one or you don't give all of them. Or you make what you call according to the guideline. A request is not a must, it's a privilege. It also causes a problem because they will now tend to hate you or at the end either you don't give all of them because you are trying to avoid favouritism but coming that day, they will all be upset. So the very same team they will suffer on that day. So you must be very sceptical. Either you call them together and show them or they will all give you their own reasons remember but according to the guideline professional practices say no. Request is a privilege, it's not a must. How about, I cannot weigh their requests according to their needs. Everybody requested according to their own plans isn't it? But then this is the problem, let's sit down and discuss how are you and I normally give them an example. If you are a person that's going to make duties for that month or if you are a manager, how would you be able to solve this problem? Three people, same shift and then the same team that are requesting the same days off. How are you going to give the others the off duties in that team, what are you going to do? It means now you must shift people from their team and swap them around so that the ward should be covered or the unit should be covered. Then if you call them it's a problem and they will start blaming you. This I think in my experience, the duty scheduling is the most problem problematic act that can cause conflict amongst the staff members. Where by people fail to understand that it's not a must, it's a privilege. Yet we have to accommodate each other yes but then who must be the first be the first priority? The unit because we are...our core business is patient care. We are all together because of one thing. Our main goal is patient care but people they put their needs first. Of which if subordinates, we have to advise them. It's not all know about the professional practice or the guidelines or how to do the duties scheduling. Even our junior sisters, when you teach them how to do the duties scheduling. You refer them to some guidelines that these guidelines will be able to help you. There are some twelve principles that you must follow when you are or must consider when you are doing the duty scheduling that we also help you to reduce or minimise the tension of the conflict that you are having in the ward. So it's like it's a problem, either one will take it or not at the end they will need to. The duty scheduling is not everybody will be satisfied with them. I don't know if I answered.

R: No, I hear you. You are answering me in a very interesting way. I hear you saying that duty scheduling is the most prominent factor that leads to conflict. Not only between subordinates, but also between new unit managers and the subordinates. Am I right?

P: True, that's very true.

R: OK, so how do you think you have handled that conflict if it's now between you and the subordinates?

P: If it's me and subordinates, I normally believe in one to one confrontation, face to face. I sit down with the subordinates. Listen, this what I experience, this is what is going to do and this is what I'm expecting from you. You support me, I support you so that we can solve this problem because at the end of the day this is our own unit. The environment has to be conducive for us and if you and I we don't agree, then we can move it to a higher level. Of which means now I have to intervene major work or my senior have to intervene so that as a matron we can solve this problem. I normally talk to the members first or the member maybe if you not aware. This is what I experienced; this is what I picked up from your side. What are you saying?

R: So in your experience, that method that you have applied, that you are applying.

P: It helped me a lot. It helped me and some of them after some they been rotated some other units. They would normally come back to me and say captain you are very strict and then somewhere somehow but this helped me a lot because maybe some people they are doing things that are not aware. You'll continuously do the wrong things because there's no person that can guide you in whatever you are doing or there is no person who can rectify the mistake. So continuously doing the wrong things, you'll able to end up doing for the sake of, what can I do? At the end of the day, when you have to choose whatever you want or the passion where you want to work, you become a problem. So some of them come back and say but thanks you being harsh but hey it helped me a lot.

R: OK and how does it make you feel Miss Magopa (spelling) when they come back and give you that positive feedback about the fact that you helped them a lot?

P: It helped me feel so good because now it means somewhere somehow change is there and I'm one person that really wants to bring change in a department where I'm working. I don't want to continue watering this flower that somebody was watering even if I can see the flower is dead. There's no root in that flower. So I normally want to bring in my own changes because you know in management, we are not using the same style. Each and every person has his or her own way of managing. So I think my way of managing the unit, it helped me. It improved the service in the ward of the unit and it also improved a lot of members in my unit. Some of them they developed

now and I'm one person that I want to see changes in each member. Either way but I want to see changes. Development is the key to my members. When we do a yearly plan, I sit down with them who have studied either nursing related courses or not courses but whoever is studying, I want to know the members. Then I want to know the members who are military orientated. Who are interested in following the military career? So that you know functional and military are two different things.

R: Yes.

P: But now this one's interested in this makes me have a plan with them so that I know for this one will be following this dream, this one will be following this dream.

R: OK, I wanted to take you back on what you said on, allow me to please. You said earlier on that conflict in the hospital is bad. All right, what do you mean when you say that?

P: Personnel, shortage of personnel. Let me put it in a simple way. Shortage of personnel or human resources, shortage is the problem. Hence it will be unfairly distributed. That causes...that makes it bad because in one unit it will be same for instance four senior or five senior personnel. What is the other unit? It's only the unit manager and most juniors. That makes it bad because when you go to the meeting, in my absence they either leave or anything or cause. My ward is suffering. Nobody is taking care of them because they are all juniors especially if they are in the same peer group, they qualified same year. When I came back, the very same managers would be hearing me. Why didn't I hand over? Whom am I handing over to? The juniors. Yes I handed over but the juniors didn't carry the orders as expected. So hence I'm saying the unfairly distribution of personnel causes the tension in this hospital.

R: All right, so you saying?

P: The shortage of personnel is all over but with the little that we are having, it should be fairly distributed to everyone. The little staff that we have there.

R: In your experience do you think in your unit you have sufficient human resources to fulfil patient needs?

P: I have sufficient yes but they are juniors.

R: So there is a lack of experience?

P: I am the only captain with the CO's ordinal ranking people. They don't have ranks anymore, they are still and then without even the rank. When you check when they qualified is from 2013. I've got one 2013 and the rest is 2014. I don't even talk about who qualified last year. So in my

opinion it's a challenge because these people, they need to be groomed, they need to be mentored in the management skills with the leadership skills. They're still learning, they' in a learning process. Some of them are behaving like concepts or most junior students or third years because they are not yet there in like acting like professionals. They don't take responsibility as a serious thing today.

R: That poses as a challenge to you.

P: A lot, a lot of incidents that are happening. I can't just mention it to you but it's a lot in my unit specifically because of the most junior that are placing in one department.

R: No, I want you to mention the incidents were conflict erupted due to this lack of experience because I think that's so important.

P: It's a lot my dear. It's a lot. I can tell you.

R: You can just...

P: A simple thing, handling of scheduled medication. One would run away from that responsibility. That's what I'm saying, they need to be mentored. Handling of scheduled medication, I don't know if they are taught and I know definitely let me put it, they are taught from their third level giving on their fourth stage how to handle scheduled 5/6 medication. Registering of the drug is a mess. Whereby, the entering of the patients in the register. Either one will write the name without the first number of the patient because it's a mat number. It's not everybody who's got the first number, they've got this mat number we call it M.E especially the veterans. One will not enter the veterans as a mat number in the registered book or they will enter, the Doctor without entering the signature. It will be Doctor Magopa (spelling) but how many Magopa's (spelling) do we have? We have a lot of Magopa's (spelling) but which one is this one? With the initials it's very much important and I normally emphasise with them. Rather write the initials than any other thing but initials and surnames that base that is provided is enough to write both initials and surname. The next thing the signature is reachable. When you ask, we have got what you call signature record on the front page. Whereby when you compare the signature, you can't even read it, it's illegible that signature. Then when you ask the member, you call them. We normally have monthly board meeting when you sit down and discuss such things with this registered book. It will be, I don't know. Nobody wants to take the responsibility. Nobody wants to be accountable for that. Hence as a manager, group manager of the ward. At the end I am accountable for that. So it's like now, it means every day we have to do in service training or induction training on the same thing, record keeping. One of this is illegal document drug book. Registered nurses are one of your main responsibilities. Please, the counting is a mess, the sequence of the numbering in chronologically

they don't follow each other. The counting is with red pen and then when you are issuing to the patient, you issue, you write in black pen but you find that the member you are counting out of in stock. You counted say for instance twenty. Then when you are going to give to patient Magopa (spelling) or whatever drug, you are going to give that number you found in stock isn't it? Number twenty but the person will write nineteen. At the end of the day, when you are doing the quarterly counting of the drugs, they are running short. Either they are short or there are extra. Meaning one patient was not entered. So this is what I've encountered with my junior nurses that I'm working with. But I'm trying by so means, before they leave my ward before they can be rotated with the other nurses. This thing should be read through their mind, they should be well equipped with that.

R: I hear you say this is also a prominent cause of conflict, the lack of sense of responsibility of your junior professional nurses.

P: It's true.

R: Lack of sense of responsibility that leads to conflict also.

P: Lack of sense of responsibility because nobody wants to take the blame and then if the formal sister come, the matrons come and do the counting, weekly counting or the monthly counting. Nobody wants to take the blame. Even that signature that people would contact and sign, then nobody want to take the blame. You write with your own signature because it's you that made a mistake. Then you just decide it's not me I don't know because I don't know it means we are not all on duty at the same day.

R: Yes, yes.

P: Because we will be saying it will be those who are off. Who will be doing competence here? Are the culprits not want to be corrected?

R: So they also not accountable?

P: It's a problem and I think they need to be mentored. They need to be groomed so that they can be in a real professional, not really. They are professionals yes but to take the full responsibility of their own professions.

R: Yes, yes.

P: So that even if they are taken to court, they will be able to answer for themselves. Now it will be, I don't know. The next things are, I'm sorry captain it won't happen again. Why you saying sorry but if it's not you, you understand? If it's not you it's fine. You are saying sorry on behalf of

everybody but now who is this culprit because we need to correct this now. It's a problem. At the end they fight amongst each other. Ja, but I told you this that, especially the professional nurses and the NCO's. Remember the NCO's sometimes they are the call checkers.

R: Are the enrolled nurses, right the NCO's?

P: Yes, enrolled nurses they are the call checkers, the second checking because the drugs are supposed to be opened by two people. So if I'm a professional nurse and I call them, the draw nurse to check with me, the tension when a mistake being encountered, it will be now I told you, you mustn't do this, I told you you should not do this. At the end of the day they will fight amongst each other. But I'm happy at the end of the day. They able to solve it themselves because I think they are mostly peer group, they in the same group.

R: The evolved ones is under professional nurses, the newly qualified professional nurses.

P: Yes, the newly qualified professional nurses.

R: So I hear you say there's also now conflict between different categories of nurses?

P: Ja, that's true. Enrolled nurses and professional nurses.

R: OK, right you said earlier there's a lack of human resources that's the main problem and also the duties scheduling. Can you perhaps identify in your experience other causes of conflict? Are there perhaps conflict involving different members of the team? Different multi professional team member's conflict?

P: The conflict amongst the other multidisciplinary or multi professional team is very minimal. It will be the nurse and the Doctor but with our professionals it's not that much because we refer when it's necessary according to the patients' needs to those discipline but the daily ones is with the Doctors. Hence I'm saying, the conflict will be the patient will be admitted and the patient will be until discharged. The Doctors without giving us the results of that patient and hence the nurses the next day, if the nurses had to find out the problem of that patient, really it's a problem. They don't want to do the rounds anymore with the specific Doctors because the specific Doctors they've got this thing, I don't know why they don't communicate. There's a poor communication among the nurses and the Doctors about what the patient. It means we are fighting against one patient care but the Doctors are there to prescribe, the Doctors are there to update, in order to see the patient's progress but the Doctors they fail the nurses with what? With the privileged information. For instance with a patient, the very contagious patient with the...

R: MDR?

P: MDR, PTB's, Military TB you name them. All those contagious diseases. It will be query, tests will be done. Then after that, they don't come back to us and say people this is very resistant to this. This patient is very resistant to that but will take precautional measures, they don't. Until we decided, I made on the presentation I take them as high protocol. I conveyed the message to open my members like, listen if it happens that the patient will be admitted with the peri-infection diseases, anything. Isolate that patient until proven but that patient if you isolate, it will be isolation until discharged. Meaning the very same Doctors, the treating Doctors they don't come back twice. No, don't cancel or stop the isolation or discontinue the isolate because of the results say negative or whatever. It will be upon myself again. So the conflict between the nurse and the Doctor, it's a conflict of everyday. I can't say it's bad, I can't say it's worse but it's a conflict of everyday.

R: It's consistent of everyday.

P: It's consistent fighting every day amongst each other for one thing.

R: So what would you say is the cause of that?

P: It's poor communication.

R: Poor communication?

P: Yes.

R: Or no communication?

P: There is communication but there's poor communication because why I'm saying poor, they know the results. They failed to communicate to us. Hence they said we must admit the patient.

R: Yes, yes. Lack of transparency from the Doctors?

P: Oh yes, that one is the worst thing. That one is very serious and we spoke about it, we talked about it with the head of department of the Doctors. She explained clearly to them, she expected them to improve but still it's still going like that. Especially, especially when it comes to, if the admitting Doctor was an intern. The intern will not communicate the information or conveyed message to the nurses but only to the head of department of that specific firm sort off, you know. So instead of tomorrow morning when they doing the rounds, the head of department of that firm. Remember we've got different firms. Conveyed the message to the nurses, they fail. They don't even explain to the very same patient that they are treating. So at the end of the day, we are stuck with patient and also that it prolongs the stay of the patient. At the end of the day it causes the conflict between the nurse and the patient. It's a lot of things my dear. It causes a tension between

a nurse and a patient because the patient will demand information. I've done the sonar yesterday, what are the results? The nurses are unable to interpret the sonar results. It's the responsibility of the Doctors and they got the results. The patient want then they give the results they give it to the nurses to file in the file. So that the nurse, the Doctor first thing tomorrow must be able to read and interpret and explain to the very same patient, but they don't. At the end of the day, when the rounds are done they just check in the script, that's it. Then they left, the patient will ask the nurse again what is the result? What are the results?

R: So am I right when I say, there's almost a sense of lack of commitment from the Doctors side?

P: It's not commitment. It's poor communication.

R: Poor communication?

P: If they can improve, I think we'll have a better way of working. It will improve, we'll improve from our side also and then we'll have a good relationship in working.

R: Do you think, you said in a sense a lack of respect from the Doctors for the nurses perhaps?

P: Not respect per say, but how can I elaborate?

R: Recognition maybe, lack of recognition?

P: Recognition maybe, not respect because some of them, yes there is an element or respect. Yes, they respect us but they don't recognise us because they don't want to be corrected. The minute you correct them, they feel offended. They will tell you, you are not a Doctor you are a nurse. So you must work according to your scope, you must know your limit; you must know where to draw the line. At the end of the day, what is that? It's a conflict because tomorrow you going to do the rounds with the same Doctor or look for another team Doctors. At the end of the day it comes a problem, it's a challenge to a unit manager. Whereby to have peace amongst the Doctor and the nurse, you will delegate the very same nurse again to do the rounds with the same Doctors that they had until they resolve their thing. Remember we are not here for business pleasure. We are not here for pleasure, social purposes. We are here for patient care. So if I separate them for good, it means there won't be service. There will be some stage where the very same Doctor is the Doctor on call for the shift and the very same nurse is the shift leader for a shift and they'll be absent but it's going to happen because the very same nurse will now delegate the others. What if he or she is alone? So for a unit manager you have to meet them together so that we must reach a common goal.

R: Very interesting what you are saying. I'm going to come back to now the meeting together. I'm hearing you mentioning multitude of factors causing conflict in the unit in your experience right? I see you the nurse manager being in the centre of this conflict. Am I right?

P: Because you have to act as a mediator.

R: Ja, ja.

P: A middle man.

R: Yes. It means to me it says, the unit manager must be equipped right with the various conflict management skills?

P: It's true. You must be very well equipped. You must have the qualities of a leader. You must have qualities meaning you must also able to solve problems. Problem solving is one of the skills that we are expecting from the unit manager. So if you don't know how to solve problems, you don't have the qualities then we have a problem. Everything will be a challenge to you and at the end of the day it means everything will be referring to the matron. Instead as they trust and they put you in that position because they trusted you. You must take your own initiative in your own unit.

R: All right. It's important that the unit manager must be skilled, right? With conflict management skills?

P: Very skilled yes.

R: Now in your experience Miss Mogopa (spelling), in your experience do you think you have the necessary required conflict management skills to be able to allow you, unit manager to function effectively in managing conflict unlike ably?

P: Conflict management, I think it will be easier managed or well managed if you have supporting elements like enough resources. If your logistical issues are sorted by then, I know specific people who are able to or are trained to do those specific things. Then enough personnel, I don't think it will be. We'll have a conflict. We'll be maybe having harmonious working environment but at the moment it's a problem because of a shortage of staff.

R: All right.

P: And the shortage of staff with the limited source, you have to plan for the courses. Absenteeism also you know there's so many things.

R: And it makes it even more challenging for the unit manager?

P: It makes it worse. It makes it worse if we have twenty personnel and then five are going on leave and then five are going on courses. How many are left to cover both shifts? Day and night and the opposite shift of each other, it's a problem. It means, somewhere, somehow you have to reduce the number of personnel going on leave. You have to reduce the number of personnel who are on courses or whatever. Then it's this hospital training that's also some days that's scheduled. It's part of development, they have to go but then you concentrate more on the patient care. Patient care is going to be compromised if you let everybody go on courses with the little that we are having as a staff.

R: OK, well earlier on you said you believe in calling the member yourself and sit the member down. Am I correct?

P: Yes.

R: Right and you also said at some stage you would call two people together.

P: Can I have something to drink? Is it mine?

R: Yes please. Yes that's why it's here. It's yours that's why it's here, no problem.

P: Thank you my dear.

R: So you have also applied this collaborative style where you call the members together and whereby you are in the present and you allow each party now to voice his or her opinion and that's how you solving the conflict?

P: And it worked and it's working for me. It worked previously and it's working for me first. If you as a manager you don't sit down, one to one with your member. Number one, you will never know your members very well. I'm not working in all shifts. I'm not working day, I'm not working night. You'll never know your members well. Two, you'll have a challenge when it comes to priorities yes, when you have to motivate your subordinates because you don't know them well. So what you going to write when you don't know them? So sit down with them either with positive things or any negative things but one to one it helped me a lot.

R: OK, do you think you know of any other method or methods on how you can solve the conflict?

P: Ja, let me think.

R: Or do you mainly prefer to use the one to one or calling them together?

P: At the moment, I prefer to use one to one as it works for me and it solves the...it helps to solve the rumour thing of who said this who said this and I think it gives you an opportunity. It gives one

the opportunity to validate their own. Some of them it's a social issue from home. You need to be supportive and their frustrations from home, they will take it to work. Whereby it will also affect now everybody in the unit. So I think for me one to one works perfectly for me.

R: All right, I want to ask you this one last question.

P: But there are some other methods of course where one will prefer to use.

R: Ja, ja and they situational, right?

P: Ja.

R: Do you think the management is supporting you in terms of conflict management?

P: In my opinion, not enough. They supporting yes but not enough because I think the shortage of personnel is not only affecting me. It starts with them. I think even for them, if they had enough personnel they will provide. So ja, they supportive but it's not enough. There's nothing now that they can do because I believe supporting, it means you allow a member to work when they want to work. So that the member can be productive in the unit and there will be peace and harmony. It will also reduce the absenteeism of the member but in this case, they don't listen to a member where you want to work or where you have a passion. They will rather rotate the members where there's a need of personnel. At the end of the day you rotate me to a unit that I don't like. That obviously will affect my productivity that will increase my absenteeism because I will be forever sick. I'll request the ablate leave. I have all this funny FRL's until, until because simply saying I'm not happy to work in this unit. So they are supporting but they are not doing enough. If they could listen to the members or if they can't listen. The main thing, if they can add the unit managers in their discussion that would also help to reduce this whole problems or this so called conflict. But now I can't say they supporting enough because they are not willing to listen to the operational managers and hence they are choosing people for the departments without even listening to people, where do you want to work. We might have the same profession but I have a passion of a specific. That's why we've got specialities.

R: Yes, true, WOW. Very interesting what you are saying. WOW.

P: That's why you need profession somewhere along the line. The curriculum will change. We'll have people that are going to do general and follow their own strengths/specialities. Hence it started there somewhere it was seen from them because people are now working in general supposedly at the end of the day. I think by so doing that, trying to reduce the rate of absenteeism in these disciplines or in the unit and I think it will work.

R: OK, ja, WOW. Miss Magopa(spelling) thank you very much. I had a very interesting interview with you. I got a lot of information from you and I'm grateful for that and I'm sure this will add a lot of value when we ultimately analyse the nurse managers experiences on conflict management. I thank you very much.

R: Thank you so much Miss Koesnell. OK.

P: All right, let's stop.

ADDENDUM E: EXAMPLE OF FIELD NOTES

Descriptive notes: notes on dialogue, participant actions, immediate surroundings, events.

It is the 20/06/2016, time 14h00. The room is quiet; the hospital intercom is playing soft music in the background. I would have appreciated more comfortable chairs, but it's a hospital. I can hear footsteps and voices in the background. This particular participant is open, appears professional and answers questions fluently. Is spontaneous in sharing experiences.

Reflective notes: researcher's own thoughts, feelings and observations about what methods worked and what did not.

My first interview for the day, I could not schedule participants for earlier in the day, because it's Monday and the unit managers are usually busy Monday mornings. I feel I should have tried harder to get a participant for an interview after 12Pm, but I must make it work, feeling a bit drained after a busy Monday morning. I should not have exerted myself this morning in my office. Not to repeat it next time. I am rather impressed with the experiences of this nurse manager, it is very vast, and she is sharing rich experiences. I probed a lot in order to clarify the various contexts of the different conflict she experienced as a manager. The probing is really helpful; she shared lot of her experiences. I also had to probe on the different conflict management skills the manager utilised.

Demographic notes: notes about the time of day, weather, room and participants:

It is 14h00, a sunny winter's afternoon. At least the weather is playing along today. The room is cool, but comfortable. Participant is transparent about her conflict management experiences. A very insightful interview indeed. I nailed this interview. Thank God.

ADDENDUM F: CERTIFICATE OF LANGUAGE EDITING



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DECLARATION OF LANGUAGE EDITING

I, Christina Maria Etrechia Terblanche, hereby declare that I edited the following research study:

An exploration into nurse managers' experiences of their conflict management skills

for **A.M. Koesnell** for the purpose of submission as a dissertation for examination. Changes were suggested in track changes and implementation was left up to the author.

Regards,

CME Terblanche

Cum Laude Language Practitioners (CC)

SATI accreditation nr: 1001066

Registered with PEG

ADDENDUM G: SELF-REFLECTION

A narrative of my experience on conflict in the workplace and how the nurse manager resolves it.

I have been a professional nurse for 19 years and I have witnessed conflict in many different situations. Conflict is an interesting phenomenon and it occurs everywhere and anytime. It requires a conscious effort from the nurse manager to resolve conflict amicably and effectively. The workplace is a mirror reflection of society at large, because it constitutes of individuals hailing from different cultures, sexual orientations, religions, nationalities, class and so forth. In essence, it is those very differences that set the tone for misunderstandings, a difference of opinions and conflict. The nurse manager is therefore confronted with a challenging task in terms of managing his/her personnel and subordinates and to resolve the conflict that will definitely occur in the work environment at various time intervals.

Conflict has various causes and it manifests in different ways and it certainly can be a daunting task to resolve the conflict among personnel. The nurse manager has to be equipped with the skills that will enable him/her to resolve conflict amicably and effectively. I have come to believe that not all nurse managers are equipped to resolve conflict so that what may seem to be an insignificant misunderstanding among subordinates, can escalate into conflict that can have devastating effects on the work environment in general.

Conflict does not always warrant lengthy, difficult interventions to resolve it. However, this can only be true once the nurse manager is able and equipped to resolve the conflict among her personnel. Conflict can and only will be resolved if the nurse manager remains objective, impartial and professional in any given situation. My experience has taught me that the nurse manager is not necessarily aware of how to resolve the conflict, therefore conflict can easily escalate into an unbearable situation for all personnel. Nurse managers cannot fulfil his/her role in terms of maintaining harmony in his/her department so as facilitate an environment that can foster positive patient outcomes. A nurse manager's inability can cost the health organisation more than just fiscal rands and cents, it also negatively affects the quality of care rendered to patients and clients. The latter is the most unwanted outcome that any nurse manager wants to witness. Hence, the nurse manager has a clear-cut function to that ensure he/she resolves conflict amicably. The question that arises is if nurse managers are equipped with the skills to resolve conflict. It has also become increasingly clear that nurse managers must be aware of the phenomenon of conflict in order to understand it in its essence.

The nurse manager has a responsibility to ensure that a safe, healthy environment prevails in order to render quality patient care, so this should be a point of departure when attempting to resolve conflict. If conflict is left unattended or is avoided, it will have untoward effects in the workplace. The best medicine is therefore to ensure that nurse managers are skilled and able to resolve conflict amicably.