Situational Leadership Theory and Staff Performance: A qualitative cross-sectional study, making use of in-depth interviews, describing the perceptions of Leaders on staff performance within the Durban's Private Hospitals

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DECLARATION:

I hereby declare that the Research Report submitted for The IIE Bachelor of Commerce Honours in Management degree to The Independent Institute of Education is my own work and has not previously been submitted to another University or Higher Education Institution for degree purposes.

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ABSTRACT

The South African Healthcare sector is faced by many Leadership Challenges. Gray, Vawda, Padarath, King, Mackie & Casciola, (2016) identified a lack of efficiency in the South African Healthcare workforce which has a disabling effect on the health of the nation. Additionally, the Future Health Index (2017) analysed 19 countries Healthcare sectors and scored South Africa as the lowest in terms of efficiency.

This cross-sectional qualitative study that was guided by the Paul Hersey and Ken Blanchard's 1972 Situational Leadership theory; and used in-depth interviews to collect data from four of Durban's Private Hospital Managers identified through purposive sampling and then qualitative content analysis was used in order to analyse the data.

The purpose of this interpretivist study was to gain an in-depth understanding of the staff performance as perceived by Hospital Managers in Private Hospitals in Durban. The researcher believes that the study could contribute to further studies aimed at solving Healthcare's efficiency related Leadership Challenges.

The findings of study found that Private Hospital staff showed poor performance, lack of dedication to duty, were resistance to change, and unwilling to learn new skills. Furthermore, themes relating to Leadership strategies were also were identified, these were: that Private Hospital Managers show recognition to deserving staff they provide constructive staff feedback and training, provide encouragement and promoted teamwork. Healthcare's leadership also believed that "enthusiasm" was important trait for employees to have so they learned skills quickly.

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1. INTRODUCTION

This section provided the study's foundation, give contextualisation, relevance and rational to the Private Hospital's Healthcare staff performance Leadership Challenges study in Durban. Additionally, this section formed the basis for the problem and purpose statement, as well as the research questions and objectives identified by the researcher.

1.1. Introduction

The specific problem of this study is that the South African Healthcare sector experienced major Leadership Challenges in staff performance, which led to poor service delivery in Healthcare facilities. The research was aimed at describe how leadership dealt with the challenges and not solve these challenges. Further research would be required to deal with the solve these challenges. The research paradigm was interpretivist, using Situational Leadership theory as the basis, acquiring data form four Private Hospital mangers / leaders through in-depth interviews, and analysed and coded the data using qualitative data analysis. The interviewee responses however clear themes emerged when coding the data which were elaborated on in Presentation and Interpretation of Findings as well as the Conclusion section.

1.2. Contextualisation

The research focused on a very important aspects of the business management profession, namely; leaders', leadership, and Leadership Challenges (Hersey, Blanchard & Johnson, 2013). The study investigated Durban, South Africa's Private Hospital staff performance challenges as related to employees' efficiency, abilities and personalities. The importance of this research study lies in the potential for improvement in the South African Private Hospital performance and image by conducting further studies to mitigate their staff performance related Leadership Challenges.

According to McIntyre & Ataguba (2017) the South African registered death rates are relatively with a rise from 317,727 deaths in 1997 to 614,014 deaths in 2006.There was, though, a decline to 453,360 in 2014; which signified some improvement. The South African Health Department believe that the high death rates could be further improved; through *decisive actions* and *improvement in South African Healthcare facilities* (McIntyre & Ataguba, 2017).

Gray, Vawda, Padarath, King, Mackie & Casciola, (2016) stated that the *ineffectiveness and inefficiency of the South African Healthcare workforce* has a disabling effect on the health of the nation. Substantial numbers of Healthcare workers are either incapable of performing the tasks for which they have been employed or alternatively inadequate assessments have been provided by leadership as they might have been improperly managing their staff. Thus far the South African government has attempted to improve their external management processes; while the Healthcare sector board and the department health believed it was necessary to improve the management of the Healthcare workforce. Gray, *et al,* (2016) suggested that an institutional-level approaches could improve Healthcare staff efficiency, effectiveness.

This study was conducted in order to gain an in-depth understanding of the Leadership Challenges in staff performance within Durban's Private Hospitals. The understanding of these challenges, would be beneficial for further studies focusing on solutions.

This research focused on the Leadership Challenges with staff performance within South African Private Hospitals There are many studies conducted on the incompetence of the South African Healthcare's leadership, and on the conditions of the South African public Healthcare system, however studies on Leadership Challenges with staff performance are limited.

1.3. Rationale and Relevance

The South African private medical industry contributed R55.5 billion (1.3%) of gross domestic product and provided around 248,500 jobs in 2016/2017 financial year (Econex, 2017). However, the private and public Healthcare sectors of South Africa are faced with Leadership Challenges, such as low efficiency, staff shortages and poor leadership in general crippling the Healthcare system (Groenewald, 2017; Cullinan, 2016). Additionally, De Villiers (2006) found that many medical practitioners in the staff were not performing adequately or required further supervision. Researchers suggest that providing relevant information and recommendations regarding proper leadership in the Healthcare system could improve overall efficacy, and reduce unnecessary deaths resulting thereof (McAlearney, 2008; Zanda, 2017).

This study aimed to create an in-depth understanding of the Leadership Challenges affecting staff efficiency and the leadership style utilised in the South African Private

Hospital context. Which is necessary as; De Villiers (2006) stated that providing proper leadership was necessary to improve the overall effectiveness as well as the publics perceptions of the private and public South African medical sector.

1.4. Problem Statement

The private and public Healthcare industry in South Africa showed a decline in certain areas; such as cancer patients care in Kwa-Zulu Natal, and national Healthcare budget cuts (Child, 2017; Teke, 2017). Despite decades of effort to improve the current medical situation in South Africa, much improvement had not materialised (Ruff, 2018). Furthermore, medical facilities are posed by heavy societal scrutiny, and could easily lose their reputation overnight, for example between June and October 2015 Gauteng's department of health decided to terminate their mental patient care agreement with the Life Esidimeni Hospital, moving mentally ill patients to poorly equipped charities where since at least 144 patients have died, with 62 still missing, due to a supposed lack of funding and the deficient amount of public mental health specialists. Additionally, the Life Esidimeni matter is expected to cost the Government (indirectly tax payers) approximately R200 million for arbitration and compensation (Mkize, 2018).

A specific problem is that the South African Healthcare sector experienced major Leadership Challenges in staff performance, which led to poor service delivery in Healthcare facilities. As South Africa is faced by a shortage of Medial professionals (Econex, 2015). Additionally, a study by Delobelle, Rawlinson, Ntuli, Malatsi, Decock & Depoorter, (2010) indicated that most South African state nursing staff, were dissatisfied due to remuneration and working conditions. The dissatisfied and underperforming staff was identified as a major leadership challenge for Durban Healthcare leaders.

This study provided an in-depth understanding of Leadership Challenges, using Situational Leadership theory as a measure, attempting to highlight the challenges for specialists that are interested in reducing or mitigating them. The chosen methodology was from the interpretivist paradigm, interviewing four Private Hospital managers and leaders in Durban, using qualitative content analysis to interpret the interviews. Situational Leadership theory four components identified in the Contextualisation section linked well to leading unskilled, dissatisfied or unmotivated subordinates.

1.5. Purpose Statement

The study's purpose was to gain an in-depth understanding of leadership perceptions on staff performance, within Private Hospitals in Durban. The study utilised the Paul Hersey and Ken Blanchard Situational Leadership theory as the theoretical framework and basis for the study. The research method was qualitative, data collection by means of semi-structured interviews with leaders in Private Hospitals in Durban. The findings were analysed using qualitative content analysis (using thematic coding to categorise information) and was presented in a descriptive format.

1.6. Research Questions

What is the perception of Private Hospital Managers, in Durban, regarding staff performance?

1.7. Research Objectives

- To gain an in-depth understanding of Private Hospital staff poor performance, as perceived by Hospital Managers.
- To gain an in-depth understanding of challenges faced by Private Hospitals due to staff poor performance, as perceived Hospital Managers.
- To gain an in-depth understanding of good performance of Hospital staff, as perceived by Hospital Managers
- To better understand how Managers in Durban Private Hospitals manage staff performance (poor and good).

This section established the importance of understanding the noticeable leadership challenge of low staff performance that are faced by many of South Africa's Healthcare facilities, which motivated the researcher to better understand, the contributing staffing challenges and how leadership currently deal or attempted to deal with these challenges. Additionally, this section established the purpose, research questions and objectives that were later examined.

2. LITERATURE REVIEW

This section encompasses the theoretical foundation, the previous literature, and conceptualisation of key concepts integral to the Situational Leadership theory which forms the basis of the study and the questioning used for the data collection method. The literature review forms the link between literature and the specific research problem.

2.1. Theoretical Foundation

The researcher started with a general theory, statement, or hypothesis and made conclusions based on the evidence. The study was deductive; thus, for theoretical foundation of the study an existing theory was used; namely the study used Situational Leadership theory (Du Plooy-Cilliers, Davis & Bezuidenhout, 2014; Maree, 2016). Situational Leadership theory is a descriptive theory; developed by American professors, Paul Hersey and Ken Blanchard in 1969 and refined by them in 1972 (Hersey, Blanchard & Johnson, 1982). The Paul Hersey and Ken Blanchard Situational Leadership theory and model was an integral foundation of the study; as it determined areas of interest related to leadership styles such as employee enthusiasm, confidence, experience or skill, job requirements, effectiveness and efficiency, (Hersey, Blanchard & Johnson, 2013), and so on. Situational Leadership was thought to be the most applicable as leadership theory for this study as not all health/ medical departments, private-sector and public-sector hospitals, clinics, and individual medical staff are identical. The study's metatheoretical position linked with the individualist paradigm; to creating an in-depth understanding or description of individuals realities, and in order to gain this understanding Situational Leadership theory was utilised to assist the researcher in understanding and evaluating the information/data collected. Additionally, this study was an interpretivist study thus it described and created an in-depth understanding of Durban's Healthcare staff performance related Leadership Challenges (Du Plooy-Cilliers, Davis & Bezuidenhout, 2014).

Situational Leadership theory and model was well researched within the business field of study, and was relevant to this study's undertaking from a business perspective; the theory is able to guide leaders to adapt their leadership style based the employee's skills and work ethic. The model supposed that the leaders could adapt their leadership style to suite their circumstances, not adopting a fixed leadership style and alternating the leadership styles dependent on the employee's task allocation and work readiness; thus, it is believed

to be ideal in order to mitigate staff performance related Leadership Challenges (Hersey, Blanchard & Johnson, 2013).

Furthermore, the world is continually changing, and the requirements of leadership and staff are as well; which lead to the advent of the Situational Leadership theory. The theory and model supposed that the leaders can adapt their leadership style to suite the circumstances, and not adopting a fixed leadership style (Clark & Clark, 1994) thus, the researcher choose the Situational Leadership theory because it was ideal as not all Healthcare facilities leaders could face the same staffing challenges. Chamberlin (2013) noted that the needs of most customers, clients, patients, or students differ, and similarly, staff didn't need identical guidance and mentoring, as their capabilities differed. Differing staff, leadership, mentoring, and guidance, necessitated Situational Leadership (Chamberlin, 2013; Waldman & Bowen, 2016). As Situational Leadership takes into account the subordinates' level of task-readiness due to willingness to do the work, confidence, ability, training, the task allocated as well as the encouragement, and recognition that the subordinates required (Hersey, Blanchard & Johnson, 1982; Norris & Vecchio, 1992; Clark & Clark, 1994).

Clark & Clark (1994) and Chamberlin (2013) noted that Situational Leadership should be approached as a guide for leaders to provide the suitable leadership behaviour and exact amount of assistance an employee needed in a specific situation (Clark & Clark, 1994; Chamberlin, 2013). Elaborating on what the previous authors notions Chatalalsingh & Reeves (2014) stated that Situational Leadership allowed leaders adapt to changes in their local context (Chatalalsingh & Reeves, 2014).

Heckmann and Huneryager (1960 as cited in Chamberlin, 2013) deduced that there were four main 'styles' of management namely; dictatorial, autocratic, democratic and laissez-faire. However, Paul Hersey believed that the two 'predominant leadership styles' were autocratic and democratic, hence these styles were represented by the directing and supporting leadership behaviours or roles of the Situational Leadership theory (Chamberlin, 2013). Notably the Situational Leadership theory was developed the 'Managerial Grid' created Blake and Mouton (1964, as cited in Chamberlin, 2013). The Blake and Mouton 'Managerial Grid' focused on the situational needs of the subordinate at that specific time and entailed guiding the manager or leader to led in the exact and appropriate way depending on the situation (Chatalalsingh & Reeves, 2014).

According to Hersey, Blanchard & Johnson (2013) Situational Leadership initially classified the leadership behaviours into two separate aspects namely: task behaviour and relationship behaviour. Task behaviour mostly consisted of unilateral communication from the leader explaining what each subordinate needed to do, and specified how the tasks should be done. While Relationship behaviour allowed leaders and subordinates to participates in bilateral communication, which provided the support and encouragement based on the subordinate's task. Then Hersey and Blanchard further expanded the task behaviour and relationship behaviour into four specific categories or key leadership styles namely; directing, coaching, supporting, and delegating (Hersey, Blanchard & Johnson, 2013; Chatalalsingh & Reeves, 2014). These specific leadership styles are elaborated on in the conceptualisation section, and for further clarification of the Situational Leadership theory and model, please refer to Appendix A: Situational Leadership Model.

2.2. Literature Review

2.2.1. Introduction of Literature Rreview

Leadership Challenges in the South African Healthcare sector exist. The Future Health Index (2017) is mixed-method research report, analysing 19 countries and 33 000 Healthcare professionals' responses and perceptions; found that South African Healthcare facilities lack efficiency and effectiveness, even though the Healthcare professionals believe that they are treating and aid patients timeously. South Africa scores the lowest of all the participating counties for Healthcare efficiency, which was less than half of the group average. However, the report attributes many of the misgivings of the South African Healthcare sector to the lack of staffing. The Future Health Index report also states that the general South African population perception of Healthcare efficiency is almost half that of the perceptions of the Healthcare professionals. De Villiers (2006) found that medical practitioners in the Western Cape district hospital were underperforming, and that proper leadership in the South African Healthcare sector is necessary to improve the publics perceptions and their overall effectiveness.

Low performance and efficiency within Healthcare facilities is not only wasteful, but could cost patient lives, and loss of life should be avoided particularly for medical facilities, who are often legally liable for any malpractice causing patient harm or death (De Villiers, 2006; Future Health Index, 2017). The Leadership Challenges faced in the South African Healthcare sector is well documented and Situational Leadership is well researched;

however, to the knowledge of the researcher Situational Leadership theory and Leadership Challenges faced in the South African Healthcare sector have not yet been combined. The literature review aids the researcher to acquire knowledge on what is already known about Leadership Challenges, employee performance specifically their efficiency and effectiveness; these notions could further guide the researcher when collecting data from the participants and contribute to the coverall study to identify themes during the data analysis.

As a thematically organised literature review the researcher structured, grouped and discussed sources in terms of the themes, literature commonalities and theoretical concepts. The literature review mainly focuses on sources that are important in order to ultimately describe Leadership Challenges of staff performance in the South African Healthcare industry context. The researcher believes that Situational Leadership theory by Paul Hersey and Ken Blanchard will be pertinent to the study and the literature review. The literature review includes international studies from various industries as an underpinning, although the study is aimed at the South African Healthcare industry.

The literature review consists of the following themes in the review of previous literature: Types of Leadership Challenges; Monitoring and Coaching to Support and Manage staff Efficiency and Resistance to Change; Providing the right Leadership at the “Right time”, and Paradoxes/ Critiques of the Leadership theory; and Teams, Millennials, Alternating Leadership styles, and Achieving both Efficiency and Effectiveness. These themes are clearly be concluded within the body of the literature review.

2.2.2. Types of Leadership Challenges; Monitoring and Coaching to Support and Manage staff Efficiency and Resistance to Change

Gentry, Eckert, Munusamy, Stawiski & Martin (2014) recent mixed method study analysed 763 participants in leadership development programs from seven different countries namely: United States of America, United Kingdom, Egypt, India, Singapore, Spain, and China (including Hong Kong). Their study does not analyse South Africa however their study gave good insight into Leadership Challenges across many industries, including Healthcare, this helps to deduce the most common types of Leadership Challenges applicable to the South African Healthcare industry. Gentry, Eckert, Munusamy, Stawiski & Martin (2014) state that it is important for organisational management to define the complexities of Leadership Challenges; in order to accurately identify them; and that

leaders face Leadership Challenges world-wide, differing in the rate of recurrence and severity. Leadership Challenges are multi-faceted and can be defined and described in three categories to give the widest and most comprehensive definition of Leadership Challenges. Firstly, Leadership Challenges can stem from external challenges that the leader often has no control over. External Leadership Challenges are external or environment factors such as economic, social and political environmental forces that affect the business. Secondly internal challenges infer that leaders are the cause of these challenges. Internal Leadership Challenges such as leaders that are unable to exercise emotional intelligence or applying an appropriate leadership style suited to the situation. These internal Leadership Challenges are noted to be easier to remedy than external Leadership Challenges. Thirdly, Leadership Challenges that stem from the leadership role. These Leadership Challenges are challenges are multifaceted, overwhelming and often cause leaders to burnout, for example leading staff members that are difficult to work with due to laziness or tiredness and dealing with stakeholders that are resistant to change (Gentry, *et al,* 2014). For this study it is important to note that the main focus was Leadership Challenges that stemmed from the leadership role. Additionally, Gentry, *et al*, (2014) discovered that it is a leadership challenge to develop and manage staff efficiently, since leaders found it difficult to identifying if and when mentoring or coaching is appropriate. Chatalalsingh & Reeves (2014) and Waldman & Bowen (2016) agreed with Gentry, *et al*, (2014) that leaders needed use mentoring or coaching techniques at the right time. Gilson & Daire (2014) found that the Healthcare managers and leaders to need to support of their subordinates to successfully implement policies; and to effectively implement peer and other support, require teambuilding for mentoring and coaching. Gilson & Daire (2014) is a recent mixed-method histometric study of the South African public and private Healthcare sector gave great insight into resistance to change and the implementation of policies; however, their focus was mainly on the public-sector Healthcare, while this research was focused more on the private sector.

Kouzes & Posner is the seminal source that originally coining the term Leadership Challenges; although this source is old, the notion of Leadership Challenges has not changed since this source was published. Kouzes & Posner (2007) stated that for a leader to effectively manage, they need to recognise Leadership Challenges and react appropriately adapting or creating preventative strategies. The five practices of exemplary leadership; is a leadership tool used to avert the Leadership Challenges stemming from leading employees. Five practices of exemplary leadership: model the way; inspire a

shared vision; challenge the process; enable others to act and encourage the heart (Kouzes & Posner, 2007). The five practices of exemplary leadership can gage leaders' responsiveness to employee challenges and shares many similarities to the theoretical foundation of the study. Additionally, Hersey, Blanchard & Johnson (2013) stated that resolving Leadership Challenges related to employee efficiency require leaders to adapt, challenge the process, enable others and encourage employees, similarly to exemplary leadership that Kouzes & Posner identified. However, Gilson & Daire (2014) recent study found that the South African Healthcare sector struggled to implement policies due to employee resistance to change, which is creating instead of reducing barriers for access of heartcare patience, decreased Healthcare professionals' motivation and performance, as well as decreasing the quality of care.

2.2.3. Providing the right Leadership at the "Right time", and Paradoxes/ Critiques of the Leadership theory

The business world is changing and understanding the current and future Leadership Challenges is important to the balance priorities and deal with them. Considering the research is focused on Leadership Challenges of staff performance, it is necessary to be aware of the potential Leadership Challenges, balancing of internal and external stakeholder expectations which the implementation of Situational Leadership could pose.

Studies by Zhang, Waldman, Han & Li (2015) mixed-method study was extensive, consisting of 90 supervisors and 607 subordinates od technical or engineering services companies in China; and Waldman & Bowen (2016) qualitative theoretical study identified many leadership paradoxes. Although these studies were not local South African studies they give great insight into the paradoxical world of Leadership Challenges. Zhang, Waldman, Han & Li (2015) identified that business paradoxes are abundant and can be found in every aspect of the modern business world. As organisations evolve, they become more technological, complex, and dynamic in nature, thus paradoxes increase. Paradoxes are interrelated, exist simultaneously, and seem rational in isolation yet are contradictory (Zhang, Waldman, Han & Li, 2015). Waldman & Bowen (2016) hypothesise that leadership paradoxes increase Leadership Challenges. Paradoxical challenges such as the need to deal with present (continuity or the now) organisational concerns, while preparing for future (change or the next) organisational issues; to ensure sustainable organisational effectiveness (Waldman & Bowen, 2016; Zhang, *et al*, 2015). Zhang, *et al*, (2015) believed that the determination of "when" is important; the "now" and "then"

paradoxes is a further leadership challenge, which suggests that the leaders need to choose which current or future task requirements for which or if an employee might need supervision, mentoring or coaching, and when to give it to them (now or then), which essentially concurred with the studies by Chatalalsingh & Reeves, (2014), Waldman & Bowen (2016) and Gentry, *et al*, (2014); determining that leaders needed apply the appropriate leadership techniques at the right time.

Although Graeff (1983) literature, is considered out-of-date in relation to the literature however theoretical concepts have not significantly changed; and it is one of the earliest, widely accepted and respected studies providing as critique of Situational Leadership which believed that further leadership responsibilities or neglecting their responsibilities created further Leadership Challenges. Graeff (1983) asserted that the four categories of Situational Leadership are flawed. While the Situational Leadership style gives premise to the idea that a “motivated person without ability is less mature than an unmotivated person with ability”. Chatalalsingh & Reeves, (2014) added that “taking control while letting go of control”, and the notion that no single best leadership style and depends on the individual employee, creates further stress for the leaders to continuously change their leadership styles. Additionally, Waldman & Bowen (2016) believe that the paradoxical tensions of leadership “centralising and decentralising control” of the subordinate depending on the situation “could be problematic”. Thus, Situational Leadership could be problematic when a leader delegates to a certain employee, however later adapts the leadership style (for example, when task requirement changes). These unexpected or undesired leadership style changes could confuse and disrupt employees, creating further Leadership Challenges (Waldman & Bowen, 2016). Graeff (1983) furthermore stated that “ability and motivation combine interactively and not additively as performance determinants” and therefore, the absence of either would adversely influence performance. Additionally, McCleskey, (2014) recent mixed method study agreed with Graeff, (1983) that in certain cases a difference in opinion between a leader and a subordinate in a given situation, could cause the leader to mistakenly perceive the difference in opinion as lack of skill or experience (Graeff 1983; McCleskey, 2014). It is important to note that differences in opinions are an inherent quality of the medical industry. Graeff (1983) furthermore, believed that “shy or insecure” employees could be overlooked by a leader applying Situational Leadership and diagnosed as unwilling or lacking skills; further complicating leadership responsibilities and decreasing efficiency and effectiveness of the employees. Furthermore, the researchers criticise delegation as defined by Hersey and Blanchard for

fostering inadequately leadership actions, causing dysfunctionality and a leadership void for subordinates that are constantly delegated (Graeff 1983; McCleskey, 2014). Graeff (1983) notes that task-relevant maturity is conceptually ambiguous and exhibits "substantial conceptual contradiction". Ascertaining that no theoretical explanation or justification was given as to how maturity to task and relationship leadership-behaviours links the way Situational Leadership model theorises (Graeff 1983; McCleskey, 2014).

2.2.4. Teams, Millennials, Alternating leadership styles, and achieving both Efficiency and Effectiveness

Kouzes & Posner (2007) emphasised that leaders should enable staff to collaborate in teams, develop mutual trust and respect in order to developed, and supported employees as well as improve their ability to do their allocated critical tasks. Chamberlin (2013) agreed with Kouzes & Posner that teamwork was important in order to develop and support employees. Chamberlin (2013) believed that leadership styles and behaviours need to be based on the development level of the individual or team. Furthermore, that a leader needs to be aware of teams and individual staff competencies and changing needs, thus leaders need to be near their subordinates to be aware of any changing situations. However, leaders overly monitoring staff does alienate staff and is overbearing. Chamberlin (2013) is a published trade-magazine article however he is a trusted source, this qualitative article was well researched and cited as well as collaborated by Chatalalsingh & Reeves (2014) that found that leaders in Healthcare facilitate team practice influence their colleagues to meet patient care-related challenges such as patient safety and quality care. Additionally, Chamberlin (2013) state that it is necessary to gage the assistance an employee requires when learning new processes or when a new millennial team member is integrated into an existing team.

Ramsey (2016) qualitative study from an educational discipline was conducted internationally and provides a fresh perspective of millennials views of leadership and the future of the workplace, as well as the leadership challenge of leading millennials for Healthcare in South Africa. Ramsey, (2016) found that Millennials do not believe that a single leadership style is compatible for everyone. Millennials believe that different Leadership Challenges require alternating leadership styles depend upon the time and circumstances (Ramsey, 2016).

Chatalalsingh & Reeves (2014) qualitative study in the United Kingdom was, consisted of only 30 Healthcare workers namely; physicians, nurses, social workers, pharmacists, dietitians and other Healthcare practitioners including social workers utilised Situational Leadership as the theoretical foundation. Although the geographic location and the aspect of leadership position the study gave great insight into Healthcare Leadership Challenges. Chatalalsingh & Reeves (2014) study found that an immense Healthcare leadership challenge was that staff were obligated to learn new processes and duties often interchange, depending on the situation or the location of the facility. Additional International that were predominantly Asian-continent based studies that not undertaken in the South African context indicate that locational attributes are different depending on the location and that they are often a leadership challenge that needs to be overcome. Luo & Liu, (2014) recent mixed-method study consisted of 182 Chinese supervisor and subordinate dyads on organizational behaviour, that differentiated to western corporations found that multinational companies needed to adapt their leadership styles to fit the Chinese corporate culture and the needs of the individual employees. While Grothaus (2015) mixed-method study consisted of 200 Thai and German employees at German multinationals; concluded that Thai subsidiaries values, relationships, empathy, employee participation, trust, and harmony differed from their German parent companies and thus need to adapt their leadership styles. Additionally, Jamal & Bakar, (2017) study using a mixed-methodology consisted of 1 200 lower and middle managerial staff from various departments in Malaysian public organisations, agreed with Luo & Liu (2014) and Grothaus (2015) although it is a leadership challenge it is important for local companies to adapt their leadership styles to the location's culture and values. The literature set presidency for differing leadership styles depending on the location; evidencing that providing the need for Alternating leadership styles depending on the situation in order to ensure maximum efficiency and effectiveness (Luo & Liu, 2014; Grothaus, 2015; Jamal & Bakar, 2017). Peter Ferdinand Drucker is regarded as the seminal author on management efficiency and effectiveness; Drucker (1967) defined "efficiency as doing things right and effectiveness as doing the right things". Additionally, Drucker (1993) described the balancing and achieving both efficiency and effectiveness concepts in its entirety is a massive leadership challenge. However, Gilson & Daire (2014) suggested that the implementation of new policies or leadership techniques to improve efficiency and effectiveness in the South African Healthcare sector could have the adverse effect of the desired result of improving efficiency and effectiveness.

2.2.5. Conclusion

The first theme clearly concluded that there is a link and similarities between Leadership Challenges, Situational Leadership, and employee performance, efficiency and effectiveness. Finding that leadership is challenged by employees that are resistant to change and by managing staff efficiently, because it difficult to motivate employees and to identify when it is appropriate to be developing employees whether mentoring or coaching. It was established that when dealing with Leadership Challenges trough policy the proper implementation of policies was essential otherwise further Leadership Challenges could materialise. Adversely, the second theme shows critiques indicating that most aspects of Situational Leadership are ambiguous; and that this ambiguity could create further Leadership Challenges as the leaders could misunderstand the theory, mismanage, and cause confusion amongst employees. Furthermore, this theme suggests managing employees with the right leadership style at the right time is necessary. The third theme found that the Leadership Challenge and needs of individuals changes depending on the organisational culture and location. This theme also iterated the importance of staff performance and efficiency. The review of previous literature found that Hospitals worldwide should change their leadership styles according to the leadership challenge or age of employee in order to facilitate successful outcomes.

2.3. Conceptualisation

The four specific leadership behaviour's or styles of Hersey and Blanchard Situational Leadership theory and model were defined in this section. For a graphical illustration please refer to Appendix A: Situational Leadership Model. Directing, Coaching, Supporting, and Delegating leadership styles all had relevance to this study as they are used to manage staff with differing abilities, confidence, and levels of self-motivation; thus, their relevance to the study was creating an in-depth understanding of how how Managers in Durban Private Hospitals manage staff performance, additionally it was used to identify some of these challenges.

Directing leaders closely supervise and give specific guidance. Decisions are made by the leader and communicated to the subordinates (Hersey, Blanchard & Johnson, 1982; Norris & Vecchio, 1992). The Directing style is best suited when leading inexperienced employees who are enthusiastic, yet insecure. Beginners who are enthusiastic rapidly become self-reliant, by learning skills and familiarising themselves with the processes (Hersey, Blanchard & Johnson, 2013; Lynch, 2015; Goldsmith, 2016).

The Coaching style would be best suited when managing employees who are inexperienced and unconfident yet showed improved willingness to do the required task. These beginners are unconfident need to be supervised for longer and take longer to become self-reliant (Hersey, Blanchard & Johnson, 2013; Lynch, 2015; Goldsmith, 2016).

The Supporting style would be best suited for a competent staff that lacked the full commitment or confidence to do certain tasks. These leaders are close to offer support and will not intervene unless asked or the situation was critical (Hersey, Blanchard & Johnson, 2013; Lynch, 2015; Goldsmith, 2016).

Delegating leaders providing minimum guidance to subordinates and take accountability for their subordinates. Additionally, sometimes subordinates may be asked to contribute to the decision-making process (Hersey, Blanchard & Johnson, 1982; Norris & Vecchio, 1992). The Delegating style would be best suited for experienced staff. Furthermore, delegating minimises need for leader supervision as the employees are willing, proficient and confident at the given a task, however they are seldom experts and continue learning while doing (Hersey, Blanchard & Johnson, 2013; Lynch, 2015; Goldsmith, 2016).

In conclusion this section encompassed the theoretical foundation, the previous literature, and conceptualisation of key concepts integral to the Situational Leadership theory which formed the basis of the study and the questions used for the data collection method. The literature review formed the link between literature and the specific research problem and identified themes some of which were used later in the study.

3. RESEARCH DESIGN AND METHODOLOGY

This section encompassed the research paradigm, design, population and sampling method, data collection and analysis method, as well as discussed, the trustworthiness of the findings. Thus, this section illustrates how the researcher conducted the research.

3.1. Research Paradigm

The study's research paradigm was from an interpretivists research tradition as the research undertaken was subjective and qualitative to understand, describe meaningful social actions, common knowledge and experiences of human beings. The experiences and common knowledge of human beings was valuable to the study as the researcher interviewed Private Hospital Leadership in order to collect informative qualitative data (Du Plooy-Cilliers, Davis & Bezuidenhout, 2014).

Ontology is the study of reality. The reality of the Interpretivism approach is subjective (meaning no single truth), which meant people experience and perceive occurrences differently and reality is a social construction, created by individuals or groups (Du Plooy-Cilliers, Davis & Bezuidenhout, 2014). The ontology of the study was to find the reality of the underlying Leadership Challenges that may or may not have existed in the Healthcare industry. The researcher was assisted by Situational Leadership theory which provided the structure and concepts needed intended for searching for the reality of the staff performance related Leadership Challenges in the Durban's Healthcare sector.

The epistemology; is the knowledge or reality that was important and was used in the study, and what the limits of the knowledge was (Du Plooy-Cilliers, *et al*, 2014; Maree, 2016). The interpretivist approach values participants common sense which provided the study with a source of knowledge (Du Plooy-Cilliers, *et al*, 2014). The epistemology of the study focused on the underlying issues, themes, and the meanings of staff performance Leadership Challenges. The knowledge was be gathered by means of interviews with knowledgeable Healthcare professionals' in Leadership positions.

Fundamentally axiology is the study of the nature of value and valuation thus contained the principles of value. The axiology of interpretivism was the researcher's application and interpretation of the research, as well as important ideas that were conveyed (Du Plooy-Cilliers, *et al*, 2014; Maree, 2016). The role of this research was addressed by the identified Leadership Challenges of Durban's Healthcare industry; which with further

research could lead to improvement in the industry. The researcher valued the emotions of the interviewees and was non-judgmental when conducting the research. Additionally, interviewees had varied experiences and subjective views on matters which the study valued.

The methodology would be the methods for gathering and analysis of the data in order to generate knowledge for the study, taking qualitative, quantitative, and mixed methods of research into account (Du Plooy-Cilliers, *et al*, 2014; Maree, 2016). This study was interpretivist so the methodology of the study was subjective and qualitative methods were used to gather and analyse the data (Du Plooy-Cilliers, *et al*, 2014). This study so data gathered was subjective knowledge and the study was qualitative so the researcher used interviews in order to gathering the data.

Metatheory is the theories that were associated with the study, and gave structure to the study (Du Plooy-Cilliers, *et al*, 2014; Maree, 2016). The interpretivist research metatheory attempts to obtain in-depth understanding of peoples' realities, by means of a theory that told a story of their shared experiences or realities (Du Plooy-Cilliers, *et al*, 2014). This study was qualitative, and the metatheoretical position of interpretivism necessitated the narration in the manner in which people conduct themselves namely; how the Hospital managers lead and if Situational Leadership was applied or applicable. The narration of the Hospital Leadership was obtained by means of interviews, and the theory of the study was Situational Leadership theory. The study used a qualitative and interpretivist approach, and thus utilised existing theories, instead of creating a theory. The metatheoretical position of this study was individualism, since Individuals responses were analysed based upon their shared characteristics of leading within a Hospital in Durban.

3.2. Research Design

This study was a qualitative research study. According to Maree (2016) qualitative research relies on words rather than numbers and statistics. The study was subjective in nature due to forming part of the qualitative tradition, as the study found meaning from data gathered from the Healthcare Leadership study participants. The study did not make use of statistics during data analysis and made use of open-ended questions, thus it was not considered a quantitative study. The research design was meant it was an interactive study, as it was a qualitative research design, that made use of interactions with Healthcare leaders in Durban.

The research was qualitative and interactive which meant it linked together with and could utilise descriptive case study design. According to Maree (2016) descriptive case study research, can be used to describe the context of an occurrence and the phenomenon. The study was classified as a descriptive case study, as the study used interviews to gather the data, in order to create an in-depth understanding of staff performance related Leadership Challenges in Durban's Private Hospitals.

Additionally, according to Maree (2016) this study could be described as a descriptive study. The research followed a descriptive design as the researcher aimed to obtain an in-depth understanding of Healthcare staff performance related Leadership Challenges. This design described the responses from Private Hospital leaders which created a deeper understanding of the Leadership Challenges, furthermore descriptive themes found were found during the data analysis, with the assistance of a framework which was the Situational Leadership theory.

Du Plooy-Cilliers, *et al* (2014) stated that a cross sectional study collected data once at a specific point in time and was once-off study that would not being followed by subsequent studies by the same researcher. The researcher collected data once, and remained certain that this study would not be recommenced at another time.

Deductive reasoning would be best suited to describe this study as it used generalised reasoning to create more specific reasoning (Maree *et al*, 2016). Deductive reasoning or theorising is a top down approach; which started with a premise and ended with a conclusion. The study used deductive reasoning as the researcher tested an existent preselected theory (Du Plooy-Cilliers, *et al*, 2014); namely Paul Hersey and Kenneth Blanchard Situational Leadership theory and model.

3.3. Population and Sampling Method

3.3.1. Population

The population is the total number of people or groupings whom could have provided information to add clarification to the study (Du Plooy-Cilliers, *et al*, 2014).
The targeted population parameters of the study, were Private Hospital Management or Leadership professionals, who would have had a formal qualification, as well as unique medical or management skills that were required be in a Healthcare Leadership position,

aged between twenty-five and sixty, within Durban Kwa-Zulu Natal. Note that the population parameter did not specify any specific culture, racial demographic or gender, which added to the diverse perspectives of the sample group.

The accessible population was limited by the researcher's budget, and the willingness of the target population to take part in study. To determine the accessible population the researcher referred to various sources that indicated that there are at least 500 000 individuals employed by the South African private and public Healthcare sector (Econex, 2017; Medical Brief, 2016; South African Nursing Council, 2016); thus, the researcher assumed that there were at least 500 Healthcare workers employed in various Leadership positions in the greater Durban area. However, accessible population to the study would be considerably smaller because of the researcher's limited budget, timeframe and the accessible population's willingness of the target population to take part in study (which was further elaborated in section 5.6. Limitations of the study).

3.3.2. Sampling

Sampling was required in order to select a smaller sample group from the accessible population that represent the population and comply with the population characteristics (Du Plooy-Cilliers, *et al*, 2014). The researcher selected a sampling method that was conducive to the qualitative research approach.

3.3.2.1. Unit of analysis

The unit of analysis obtained from the sample population could be used to represent the entire population. A unit of analysis can be obtained from people or social artefacts that are related to the specific study (Du Plooy-Cilliers, *et al*, 2014). This study's unit of analysis was individuals' perceptions in the form of interview responses, that were fundamental to the study's purpose. The audio copies of these interviews used for transcribing reasons from these participants might also constitute as a (social artefact) unit of analysis.

3.3.2.2. Non-probability sampling

The study utilised non-probability sampling as it was best suited a research qualitative study that was not open to the general public (Du Plooy-Cilliers, *et al*, 2014), only those who hold Leadership positions in a Private Hospital in Durban.

3.3.2.3. Sampling method: Purposive sampling

The purposive sampling method could be used to find a specific set of characteristics in a sample from the entire population. Purposive sampling allowed the researcher to narrow the search further to the extent required to find ideal sampling sizes, participants, and could narrow the search to specific areas of interest (Du Plooy-Cilliers, *et al*, 2014).
The researcher searched thoroughly in order to find the interviewees that matched the population parameter defined in the study. The researcher categorically searched for the sample: Firstly, individuals that worked in a Private Hospital. Secondly, individuals that worked these facilities in the greater Durban area. Thirdly, the individual's that were part of the Private Hospitals Leadership or Management.

3.3.2.4. Sample size

It was important to properly identify the size, considering that a small sample can often accurately, describe what a larger sample could. Qualitative research usually consists of smaller sample sizes, compared to a quantitative study (Du Plooy-Cilliers, *et al*, 2014).
This qualitative study planned and did only interview four Private Hospital managers/leaders; as the researcher was unable to facilitate a larger sample due to time and labour constraints, which were exacerbated by financial constrains (which was further elaborated in section 5.6. Limitations of the study).

3.4. Data Collection Methods

The data collection method was qualitative as the researcher searched for personal and subjective views from the sample population to capture their experiences of encounters of a single sphere of influence (Du Plooy-Cilliers, *et al*, 2014). Additionally, this study collected stories, phrases, words and made observations to create a deeper understanding Leadership Challenges in the South African Healthcare industry.

In-depth interviews were costly manner however it was beneficial to the study; these interviews were semi-structured (questions were created in advance), which linked well to the research method and improved the accuracy of the data as researcher could ask for further clarification from the interviewees (Du Plooy-Cilliers, *et al*, 2014). The researcher and the interviewees' met at locations that were mutually agreed in advance, and two recording devices were used to record the interviewee and collect the data (for an example of an agreement to be interviewed and recorded refer to appendix C, D, and E).

Pre-testing was an important part of research; pre-testing is used to tested the effectiveness of the data collection the researcher wished to use (Du Plooy-Cilliers, *et al*, 2014). Before the interviewees were interviewed, the researcher pre-tested the interview questions that formed part of the semi-structured interviews. The researcher only embarked on a single pre-tested interview due to time constraints; thereafter the researcher made minimal changes to the questions. Note that the participant that participated in the pre-test did not contribute to the research, analysis or findings of the study.

3.5. Data analysis methods

Qualitative content analysis was the researchers preferred method of data analysis. According to Maree (2016) qualitative content analysis would be used to press many words into categories and subcategories based on the rules of coding, while facilitating systematic, agile and time efficient data analysis. Content analysis assisted the researcher to report and categorise the relevant content that was useful to the study in an efficient manner. Maree (2016) asserted that content analysis could be assisted by an existing theory as a foundation or allowed the researcher to create a theory. The research utilised an existing theory; Paul Hersey and Ken Blanchard's Situational Leadership theory.

Qualitative content analysis or textual analysis was used to discover and display patterns that emerge from the data in text form, and not statistical occurrences. The research approaches can be "deductive or inductive" (Du Plooy-Cilliers, Davis, & Bezuidenhout, 2014, p 234-235). This was a deductive study approach that structured the data in terms of theories and concepts that were identified as important to the study. The deductive approach was used to find applicable theories and creates a general framework and later a specific the framework to examine the data to place the information in categories and subcategories (Du Plooy-Cilliers, *et al*, 2014).

3.5.1.1. Coding

Coding meant that data was categorised into groups to make analysis convenient, for all texts, focus groups notes, observations, interviews, visual images and any tangible interpretable artefacts. Coding reduced the data, by making data important to the discipline and study understandable. Coding was an important technique to group and understanding the data (Du Plooy-Cilliers, *et al*, 2014). To code the study made use of an eight-step qualitative content analysis technique. The researcher used these eight steps to

apply it to the coding for this Situational Leadership Theory and Staff Performance: A qualitative cross-sectional study, making use of in-depth interviews, describing the perceptions of Leaders on staff performance within the Durban's Private Hospitals. The eight steps that were used are explained below:

3.5.1.1.1. Preparing the Data

The data was transcribed in order to start the analysis process. The researcher was guided by the research goal and question, in order to decide chose which of the transcribed data was useful to use towards the study and which to exclude (Du Plooy-Cilliers, *et al*, 2014).

3.5.1.1.2. Define the Coding Unit to be Analysed

To define the coding unit that was analysed meant identifying the text the study used (Du Plooy-Cilliers, *et al*, 2014). The units of coding or texts the researcher used were specified; such as single words, phrases, sentences, or paragraphs, that made the content analysis process manageable by grouping important aspects and unnecessary elements were excluded. Additionally, the data was organised at the researcher's discretion using a filing and referral system to group and easily revisit the data during the study.

3.5.1.1.3. Develop Categories and a Coding Scheme or Conceptual Framework

The researcher grouped coded units to form categories, and developed a framework which was assisted by the literature review in order to support in coding the data collected. Categories were labelled as terms and key information that reoccurred that were vital to the study (Du Plooy-Cilliers, *et al*, 2014). These categories contained the exhaustive, mutually exclusive or Specific characteristics. Exhaustive meant that practical or fictional categories that were used to sort and categorise the data the better. The researcher looked for inspiration in the data collected to find categories needed. Mutually exclusive was used to avoid uncertainty when grouping information, each category was distinct, though similar meaning themes were found in the responses however these themes were necessary. Specific meant that the themes and categories were relevant, easily understood, distinct, detailed and explicit (Du Plooy-Cilliers, *et al*, 2014).

3.5.1.1.4. Test Coding Scheme on a Sample of Text

Du Plooy-Cilliers, *et al*, (2014, p 240) stated that "this step tests the researcher tests the clarity and consistency of the category definitions on a sample (small part) of the data".

Changes to the coding definitions and rules were established, and all problems identified with the codes were resolved in this step to ensure consistency.

3.5.1.1.5. Code All the Text

Coding could include line-by-line coding, open or substantive coding, axial coding, selective coding, and thematic coding (Du Plooy-Cilliers, *et al*, 2014). The researcher made use of thematic coding for this cross-sectional, qualitative study analysing Leadership Challenges related to staff performance in Durban's Private Hospitals. The researcher searched and highlighting the data for anticipated themes many of which were found in the literature review. Coding the data meant extracting and organising all applicable segments in the transcribed data (Du Plooy-Cilliers, *et al*, 2014).

3.5.1.1.6. Assess the Coding Consistency

In order to assess the coding consistency, the researcher re-examine the consistency of all the coded data (Du Plooy-Cilliers, *et al*, 2014). The researcher was very careful during this stage as the researcher did not have any assistance in testing the coding process.

3.5.1.1.7. Draw Conclusions from the Coded Data

The bigger picture of the findings was looked at during this step, the researcher connected the dots to find connections and answered the research question and objectives during this phase. The researcher interpreted the categories or themes identified, the interpretation of an existing theory and studies was necessary, requiring repetition. The researcher looked at what information was important as well as the circumstances around the text identified. This example would cause unethical results; a text that a researcher wanted to use stated that patients receiving care in Somalian Hospitals death toll was particularly high during the 1980's and 1990's; and thus, concluded that it was due to inapt medical staff or hygienical practices however failed to analyse the text in context (for example, there were famines and wars during these years), creating a false interpretation (Du Plooy-Cilliers, *et al*, 2014).

3.5.1.1.8. Report the Methods and Findings

The qualitative data analysis and coding was helpful to understand the research topic or issue better. The researcher pledged that the coding, analysing, interpreting, recording and reporting of the information, remained undertaken in a truthful, ethical, honest and accurate as possible manner. The researcher used qualitative content analysis to find

themes or categories, and searched for “words or phrases” that were applicable to merge and create new themes which were repeated by the interviewees (Du Plooy-Cilliers, Davis, & Bezuidenhout, 2014, p 243). The findings can be found in the Presentation and Interpretation of Findings as well as Conclusion section.

3.6. Trustworthiness of the Findings

The trustworthiness of the research was assessed as per the criterion required for a qualitative study. All research including qualitative research is reliant on the trustworthiness to ensure accuracy; thus, there were many components of trustworthiness that were required to ensure and demonstrate the credibility and trustworthiness of the study to all whom are interested in this new body of knowledge (Du Plooy-Cilliers, Davis, & Bezuidenhout, 2014; Maree, 2016), for the most part the IIE higher learning institution Varsity Collage Campus Westville. The researcher ensured the trustworthiness of the literature review, by using well researched, credible, seminal and recent sources. The researcher has not been biased in any way and pledges that the research was conducted in an unbiased manner.

The researcher endeavoured to research the issues and viewpoints related of the research title (Situational Leadership Theory and Staff Performance: A qualitative cross-sectional study, making use of in-depth interviews, describing the perceptions of Leaders on staff performance within the Durban’s Private Hospitals) to the best of the researcher’s ability to ensure ethical and moral standards were uphold throughout the development of the research. To ensure accurate and trustworthy findings the during the interview process the researcher asked questions that could clearly be related to the Hospital leaders, Leadership Challenges regarding staff efficiency. Lincoln and Guba (1985) determined that there were four main criteria when shaping the trustworthiness of research; these four criteria for trustworthiness of research elaborated on below are credibility, transferability, dependability and confirmability.

3.6.1. Credibility

Lincoln & Guba (1985) identified credibility as a criterion that dealt with extent to which the wider public believed that the study’s findings; through aspects such as well-defined sampling, and detailed data-collection (Lincoln & Guba, 1985). Credibility was ensured by the researcher’s accuracy interpreting the data collected from in-depth interviews which increased the clarity of the data by the long period spent a of time that the researcher

spent on the interview and transcription process. The credibility of the research was further ensured by the researcher avoidance of unclear interview questions and the ability to ask follow-up questions for further elaboration and clarity (Du Plooy-Cilliers, *et al*, 2014). Please note that participation of this research was open to any level of Leadership in a Durban Private Hospital that was willing and able to participate in the study; which increased the representation of diverse experiences and views which increases accuracy (credibility) of the information collected while simultaneously reducing the specificity (credibility) of the data.

3.6.2. Transferability

As per Lincoln & Guba (1985) transferability did not allow the researcher to make generalised claims about how leaders' actions related to staff performance or how leaders had to fulfil subordinates' various needs. Transferability signifies that a study's findings are able to be used for a comparable conditions or situation; thus, the results and analysis can be used beyond the specific study (Du Plooy-Cilliers, Davis, & Bezuidenhout, 2014). This research's findings would be useful to many researchers that are able find applicable information and knowledge within it. The study was intended for and able to be applied to the commerce or business field studies. The transferability of the study was diverse as the study could contribute psychology (motivation), Healthcare, teaching/training other fields of study. Additionally, study could add to the body of knowledge or research regarding Situational Leadership theory.

3.6.3. Dependability

Lincoln and Guba (1985) stated that the connection between credibility and dependability was strong; as credibility to an extent ensured dependability. Dependability referred to the excellence of the method and procedure of integration "that took place between the data collection method, data analysis and the theory generated from the data" (Du Plooy-Cilliers, Davis, & Bezuidenhout, 2014, p 258-259).

The researcher kept track of any changes that were made to the data collection or data analysis methodology as well as the reasons why. Data in the forms of interviews, were recorded in the form transcriptions, and analysed in the interpretations of findings section in detailed to the best of the researcher's ability. The dependability of the research was ensured as the researcher seamlessly integrated the data collection method and data

analysis, as well as used Situational Leadership theory as the foundation to reach an unbiased conclusion.

3.6.4. Confirmability

Lincoln & Guba (1985) defined confirmability as the extent to which the research was unbiased. According to Du Plooy-Cilliers, Davis, & Bezuidenhout (2014) confirmability refers to the importance of data collected that supported the interpretation and findings of the research. The findings are validated by the data. The researcher needed to describe the research process fully in order to assist others that scrutinised the research design and anyone would need to reach similar conclusions as the study did (Du Plooy-Cilliers, Davis, & Bezuidenhout, 2014).

The to ensure the confirmability of the research the researcher obtained the data in an orderly and ethical manner, scrutinised the data and ensured consensus on a matter instead of accepting and interpreting the statement of an isolated participant difference of opinion as fact. In order to scrutinised the data, the researcher relied on the research process, data capturing and design to find consensus on stances or ideas from various sources. The researcher was ethical and unbiased in the reporting process thus the same conclusion would have been reached by other researchers with the same data. The researcher removed bias and can evidence that bias is absent by making the audio recordings available to the institution of study as evidence of unbiased research, was absent of manipulation by researcher. It must be noted that the researcher asked the supervisor for advice when the data was interpreted in order to increase the confirmability. It must be noted that the researcher revealed all the data collection and interpretation processes which increased the dependability and ensured transparency of the findings (as per this research report refer to the above section of the research design and methodology).

In conclusion, this section illustrated how the researcher conducted the research; as this section fully encompassed and discussed the research paradigm, design, population and sampling method, data collection and analysis method, as well as the trustworthiness of the findings.

4. PRESENTATION AND INTERPRETATION OF FINDINGS

The aim of qualitative content analysis results, should be to a balance presenting the description and interpretation in a manner; additionally, organise the information throughout the presentation of findings into themes and categories used in the analysis and interpretation of the data (du Plooy-Cilliers, *et al*, 2014, p. 249). This section presented the data gathered from Healthcare Leadership using interviews in a table format and interpreted them in terms of themes. The themes that found had relevance to the central theory (Situational Leadership theory), or the objectives that were identified in the main research introduction.

4.1. Poor Staff Performance and Lack of Dedication

One of the objectives of this study was to gain an in-depth understanding of Private Hospital staff poor performance, as perceived by Hospital Managers. The interview participants responses suggest that there might be certain staff that are poor performance or lack of dedication to duty.

Table 1: Question 1.

Question 1 "In terms of staff performance what are your challenges?"	
Participant A:	"I have people that need to pay attention to detail"
Participant B:	"Sometimes they didn't do their part or it is like a personal lack of performance"
Participant C:	"Having to deal with people's acceptance of responsibilities, that they signed up for and not doing it" … and "you get a list of things they supposed to be doing, that they are not doing at all" "So, I think laziness definitely plays a big part of it"
Participant D:	"Staff evaluations are done twice a year, and sometimes staff fail these evaluations"

Participant A's response suggested that staff don't always pay attention to detail which is a skill needed in the medical field. While Participant B clearly stated that the challenge he/she sometimes faces is a lack of staff performance. Participant C furthermore suggested that laziness "plays a big part" in the Leadership challenge he/she identified of staff not doing what they supposed to do resulting from a lack of "acceptance of

responsibilities". While, Participant D a middle or senior manager admitted that staff don't always pass their evaluations, which suggested a lack of performance or skills required.

4.2. Resistance to change, and learning new skills

The only other Leadership challenge relating to staff performance that collaborated by participant B, C, and D is that a proportion resistance to change, unwilling to learning new skills, and showed unwillingness to do more than they did previously. This suggests a lack of motivation amongst some of their staff. This suggests Situational Leadership theory could be a relevant Leadership tool to assist Durban's Healthcare industry to improve staff willingness to learn and change as makes provisions for employee willingness to do the work (Hersey, Blanchard & Johnson, 2013).

Table 2: Participant B[1]

Question 8 "Do you notice a difference in the time it takes for inexperienced staff who lack confidence the at become self-reliant?" (Compared to inexperienced confident staff).	
Participant B:	"Once they start becoming experienced, because of that lack of confidence, they will still only be confident in the small piece that they know"

Participant B suggested that certain staff who lacked confidence were reluctant to learn new skills and could be resistant to the change.

Table 3: Participant C[1]

Question 1 "In terms of staff performance what are your challenges?"	
Participant C:	"When you give them a task they seem like they seemed surprised" "So, it is enthusiasm there is none, it completely lacks" "They set in their ways; things had been done a certain way, so they were very resistant to change"
Question 2 "How do you usually deal with these challenges?"	
Participant C:	"They make their suggestions, but then they don't follow their own suggestions; so, it is that constant battle of what is it what you actually want to do versus what you are prepared to do"
Question 6 "Do you notice a difference in the time that it takes for inexperienced staff who are enthusiastic to learn skills?" (Compared to unenthusiastic inexperienced staff)	
Participant C:	"Those who are unenthusiastic will sit back and do absolutely nothing about it; Ugh I don't know, and then you get those who I don't know for two, three, four, five years"

While, Participant B's responses suggested to the researcher that amongst certain of his/her subordinates there is a lack of enthusiasm, resistance to change, unwillingness to learn or do certain tasks.

Table 4: Participant D[1]

Question 3 "Do you ascribe to any specific leadership style?"	
Participant D:	"Some people don't want too … and are quite resistant to change"
Question 11 "How would you as a supervisor support staff whom are competent, yet unconfident?"	
Participant D:	"Sometimes they are not familiar with the software"

Furthermore, Participant D's responses showed that certain staff are "resistant to change" and that sometimes his/her unconfident subordinates were slow or unwilling to learn new skills needed, such as familiarity "with the software".

4.3. Alternating Leadership styles

This theme evidences that, Healthcare Leadership often utilise more than a single Leadership style, sometimes even without having realising. This theme relates to Situational Leadership theory as the name suggests that the Leadership style changes depending on the situation (Hersey, Blanchard & Johnson, 2013). The leaders adapted their Leadership style dependant on the situation or simultaneously utilised more than one Leadership.

Table 5: Participant A[1]

Question 3 "Do you ascribe to any specific leadership style?"	
Participant A:	"Charismatic and quite democratic"
Question 4 "What values or characteristics do you believe makes a good leader?"	
Participant A:	"Lead by example; how people see you should be how they must want to be"

Participant A's responses suggested he/she made use of more than one Leadership style, such as charismatic, democratic and leading by example.

Table 6: Participant B[2]

Question 3 "Do you ascribe to any specific leadership style?"	
Participant B:	"I like to lead by example. I would say I am a little bit of a combination between Charismatic and Democratic leadership style"
Question 4 "What values or characteristics do you believe makes a good leader?"	
Participant B:	"Leading by example"

In addition, Participant B's responses correlated with Participant A suggesting that he/she made use of more than one Leadership style, such as charismatic, democratic and exemplary Leadership.

Table 7: Participant C[2]

Question 3 "Do you ascribe to any specific leadership style?"	
Participant C:	"Democratically I do involve them in making decisions, because I want them to have that sense of responsibility" "if you get their input then it makes it a unanimous decision and then they take ownership of that" "But then depending on the challenges you have daily, then I go between democratic and then obviously Transactional, you know then it is a give and take, like all the time, most of the time they don't give (laughs), it's take, take, take" "And then every other day I think that it is the *Laisser-faire* leadership"

Participant C's response suggested he/she made use of more than one Leadership style depending on the situation presented, namely democratic, transactional, and *laisser-faire* Leadership style.

Table 8: Participant D[2]

Question 3 "Do you ascribe to any specific leadership style?"	
Participant D:	"Transformational leadership … I have worked very closely with a lot of directors over the last thirty years … they have empowered me, and they have imparted their knowledge and their experience … and that is the same sort of philosophy that I have". "I feel that it is important to empower the people"
Question 12 "How comfortable do you feel when delegating responsibilities to most of your staff?" – Unscripted follow-up question: "So you would say it is kind of like *Laisser-faire* leadership style, sit back and only intervene if you see it is going to fail?"	
Participant D:	"Yes, like that"

Participant D's responses suggested he/she made use of more than one Leadership style, namely transformational Leadership as a catalyst for change empower subordinates, and agreed with the researcher that he/she utilised *laisser-faire* Leadership.

4.4. Practice and repetition

The main research question was; how do leaders in Durban's Healthcare facilities manage Leadership challenge related to staff performance? This theme identified that practice and repetition was encouraged by (interview participants A, B, and C) the majority of Healthcare Leadership interviewed and was seen as essential to improve the Leadership challenge of improving the abilities and skills of employees learning new tasks. Additionally, the Directing Leadership style involved repetition to familiarise employees with the processes (Hersey, Blanchard & Johnson, 2013; Lynch, 2015; Goldsmith, 2016).

Table 9: Participant A[2]

Question 5 "How do you handle inexperienced employees who are enthusiastic, yet insecure?"	
Participant A:	"Telling them it is actually a process and continue to do the same thing; the longer you in it the better you get at it"
Question 8 "Do you notice a difference in the time it takes for inexperienced staff who lack confidence the at become self-reliant?" (Compared to inexperienced confident staff).	
Participant A:	"Sometimes they think that I can be intimidating; by asking them questions all the time, but that is just so that they can get to build that confidence; by actually knowing and getting the knowledge, and by being repetitive"

Participant A responses stated that learning is a process that requires practice and that repetition is important.

Table 10: Participant B[3]

Question 7 "How do you manage inexperienced staff, who are lacking confidence, but show willingness to do the task at hand?"	
Participant B:	"Practice makes perfect and the confidence comes with experience, … have patience, and let them just practice, practice, until they get that confidence"
Question 11 "How would you as a supervisor support staff whom are competent, yet unconfident?"	
Participant B:	"Practice makes perfect, they will get that confidence as soon as they start seeing they are getting the results that are needed"

Participant B agreed with participant A, stating that "practice makes perfect" and that over time employees will learn skills and acquire confidence.

Table 11: Participant C[3]

Question 5 "How do you handle inexperienced employees who are enthusiastic, yet insecure?"	
Participant C:	"It is repetition so, we do the same thing every day" "do it by doing repetition"
Question 7 "How do you manage inexperienced staff, who are lacking confidence, but show willingness to do the task at hand?"	
Participant C:	"Give that person all the time that is necessary"

Furthermore, Participant C agreed with participant A and B, that repetition was important and that management should be patient giving all the time needed to build confidence.

4.5. Building mutual respect is important.

Motivating staff and building mutual respect; making them feel at ease through recognition, constructive feedback, encouragement and guidance was an important part of this theme. This theme relates to being supportive which was a concept that appeared in the literature review section of the research. It has been established that these leaders are in a challenging environment that requires staff to overcome critical tasks. According Kouzes & Posner (2007) providing the support, and encouragement to staff need to overcome critical

tasks. Kouzes & Posner (2007) suggested that Situational Leadership at all stages allowed leaders to placed emphasise on the encouragement of employees, as well as developing mutual trust and respect.

Table 12: Participant A[3]

Question 2 "How do you usually deal with these challenges?"	
Participant A:	"I build my employees up with motivating them, and making them believe in themselves, teaching them how to cope with pressure, persevere and persist, and not to take things personally"
Question 7 "How do you manage inexperienced staff, who are lacking confidence, but show willingness to do the task at hand?"	
Participant A:	"I reassure them, encourage them, compliment them, and tell them that they are doing a good job"
Question 8 "Do you notice a difference in the time it takes for inexperienced staff who lack confidence the at become self-reliant?" (Compared to inexperienced confident staff).	
Participant A:	"So basically, it would be to compliment and reassure"
Question 10 "Do you (often) come across staff in who are competent, yet unconfident when doing work, they know how to do?	
Participant A:	"I do, and as I say it is about building peoples' self-esteem and making them believe in themselves"
Question 11 "How would you as a supervisor support staff whom are competent, yet unconfident?"	
Participant A:	"I once again motivate, encourage, compliment and build them up"

Participant A's responses suggested that he/she preferred to build-up employees, or empowering them with self-belief; complimenting, encouraging, and motivating his/her staff while guiding them through a process, this suggested that staff needed to have a level of feedback in the form of complements to encourage and encourage self-reliance.

Table 13: Participant B[4]

Question 1 "In terms of staff performance what are your challenges?"	
Participant B:	"It is usually to keep everyone motivated and positive"
Question 2 "How do you usually deal with these challenges?"	
Participant B:	"When we do meet the expectations, it is important to recognise that"
Question 4 "What values or characteristics do you believe makes a good leader?"	
Participant B:	"Recognition is very important; so that people stay motivated and positive"
Question 5 "How do you handle inexperienced employees who are enthusiastic, yet insecure?"	
Participant B:	"It is important to make them feel at ease" "just to make them feel at ease"

Additionally, Participant B's responses showed that it was important to keep employees "motivated and positive", "recognition was very important" thus he/she recognised staff accomplishments, and made sure to make insecure staff "feel at ease".

Table 14: Participant C[4]

Question 5 "How do you handle inexperienced employees who are enthusiastic, yet insecure?"	
Participant C:	"If they uncomfortable remove them from the setting" "encouragement; if they need you to be there to watch them or go through it with them"
Question 7 "How do you manage inexperienced staff, who are lacking confidence, but show willingness to do the task at hand?"	
Participant C:	"Sometimes you just need a moral support … to build your confidence"
Question 8 "Do you notice a difference in the time it takes for inexperienced staff who lack confidence the at become self-reliant?" (Compared to inexperienced confident staff).	
Participant C:	"If someone is constantly encouraging you and showing you the right way, you build that confidence very quickly"

While, Participant C's responses suggested "moral support" was necessary to build confidence, thus sometimes close morally supportive guidance was necessary.

Additionally, Participant C stated that encouraged and guided staff build confidence, very quickly and thus become self-reliant. Furthermore, Participant C suggested that removing medical staff (such as trainee's or nurses perhaps) from uncomfortable setting's was justified in order to make them feel comfortable.

Table 15: Participant D[3]

Question 6 "Do you notice a difference in the time that it takes for inexperienced staff who are enthusiastic to learn skills?" (Compared to unenthusiastic inexperienced staff)	
Participant D:	"We encourage them"

Participant D specified "we encourage them" this was supported by Participant's A, B and C's responses, which further supported the proposal that encouragement was important to help unenthusiastic employees learn skills quicker.

4.6. Teamwork Works

It was established that these leaders are in a challenging environment that requires staff to overcome critical tasks. This theme relates to teamwork which was mentioned in the literature review section of the research. The theme suggested that collaborative team work or team spirit is vital to the Healthcare sector; according Kouzes & Posner (2007) staff need to overcome critical tasks. Kouzes & Posner (2007) suggested that Situational Leadership can allow leaders to placed emphasise on team building, that results in developing mutual trust and respect.

Table 16: Participant A&B

Question 13 "How comfortable do you feel giving subordinates the opportunity to contribute to decision-making processes?"	
Participant A:	"As a team, each person like a body contributes to making us a great team, not just an ordinary team"
Participant B:	"Because I believe we are a team, and can all learn from each other"

Participant A believed that making a decision as a team was important as each member would be vital to the team, the team work or team comradery made their group great. Participant B added to participant A's point by stating that they could "all learn from each

other". Thus, Participant A&B agreed that team work and contributions to processes or decision making was important.

Table 17: Participant C[5]

Question 8 "Do you notice a difference in the time it takes for inexperienced staff who lack confidence the at become self-reliant?" (Compared to inexperienced confident staff).	
Participant C:	"If you have a strong team behind you it doesn't take that long, to build your confidence" "I think definitely team work plays a big part in that"

While Participant C believed that a strong team behind a subordinate that lacked confidence, could help build confidence and help them become self-reliant quicker.

Table 18: Participant D[4]

Question 7 "How do you manage inexperienced staff, who are lacking confidence, but show willingness to do the task at hand?"	
Participant D:	"She was excellent working with the ### at ###, but she could not work in an environment where there is sixty people working in there, that you need to report to other people and you have got to come in on time, that you need to live the ### values, greet and say thank you, and so forth and give feedback, and she couldn't adjust to that, and we had to let her go"

Participant D's example showed that it is vital for employees to be able to work in teams, groups and departments, and hierarchical structures, reporting to supervisors in the facility. Furthermore, team works importance is exemplified by the account given by Participant D suggesting that a lack of team work and cross-hierarchical skills could eventually lead to an employee's dismissal.

4.7. Effective training is essential

This theme suggested that the Healthcare Leadership interviewed (specifically participants B, C, and D) are always willing to send the employees for further training, guide, and closely supervise and give specific guidance. Directing leaders closely supervise and give specific guidance (Hersey, Blanchard & Johnson, 1982; Norris & Vecchio, 1992).

Table 19: Participant B[5]

Question 5 "How do you handle inexperienced employees who are enthusiastic, yet insecure?"	
Participant B:	"We are not here to bite of their heads; to just ask and we are there as a team to assist them, with everything they need"
Question 7 "How do you manage inexperienced staff, who are lacking confidence, but show willingness to do the task at hand?"	
Participant B:	"So, you just need to guide them"
Question 11 "How would you as a supervisor support staff whom are competent, yet unconfident?"	
Participant B:	"You need to guide them"

Participant B's responses suggested that assistance and guidance whether from him/her or the team was important to assist employees who are insecure or lacked confidence.

Table 20: Participant C[6]

Question 5 "How do you handle inexperienced employees who are enthusiastic, yet insecure?"	
Participant C:	"Come to me and make yourself available for questions for teaching sessions" "it is education" "give them the necessary training"
Question 7 "How do you manage inexperienced staff, who are lacking confidence, but show willingness to do the task at hand?"	
Participant C:	"Go through every section of that task to make sure they understand what they are doing, how it needs to be done and how to troubleshoot that task" "knowledge is power"
Question 10 "Do you (often) come across staff in who are competent, yet unconfident when doing work, they know how to do?	
Participant C:	"We will have a on the spot teaching session or a discussion"

Participant C's responses showed that guidance in the form of 'on the spot teaching sessions', 'discussions' or "necessary training" were important to educate, and empower staff with the knowledge needed to even be able to "troubleshoot a task".

Table 21: Participant D[5]

Question 2 "How do you usually deal with these challenges?"	
Participant D:	"The nurses needed to go every two year they needed to go for basic life support; so, they will go to our ### training academy, receive a three-day course" "in a case where staff are non-compliant or below expectations, … staff have 6 months in which to that i.e. management will provide the time, tools, resources and education"
Question 5 "How do you handle inexperienced employees who are enthusiastic, yet insecure?"	
Participant D:	"Okay well look we spend a lot of time, on orientation and induction, we send them on a 3-day course" "I provide proficient training, sufficient support" "strong people are able to guide … shadow someone else"
Question 6 "Do you notice a difference in the time that it takes for inexperienced staff who are enthusiastic to learn skills?" (Compared to unenthusiastic inexperienced staff)	
Participant D:	"We spend a lot of time in the afternoons between 5 and 6 when it's quiet, the staff come through and say look I've done this; is there a better way of dealing with it?" "And we say no let's take you to staff who has done this before, … we get them to shadow another staff; a mature staff will show them this is what I've done"
Question 11 "How would you as a supervisor support staff whom are competent, yet unconfident?"	
Participant D:	"I think I am going to repeat this but a lot of training, we do have one-on-one discussions"
Question 13 "How comfortable do you feel giving subordinates the opportunity to contribute to decision-making processes?"	
Participant D:	"We have regular workshops"

While participant D's responses showed that specific offsite and onsite training, courses and "regular workshops" as well as "one-on-one discussions" were believed to be important to overcome the many diverse staff related Leadership Challenges he/she is faced with.

4.8. Enthusiasm is key

This theme showed that employee enthusiasm is important factor contributing to employees rapidly becoming self-reliant and learning skills as these staff ask the right questions and are willing to learn. Which supports the Directing Leadership style as it is best suited for enthusiastic trainees as they become self-reliant quickly, learning skills and become accustomed to processes rapidly, as opposed to unenthusiastic trainees (Hersey, Blanchard & Johnson, 2013; Lynch, 2015; Goldsmith, 2016).

Table 22: Question 6

Question 6 "Do you notice a difference in the time that it takes for inexperienced staff who are enthusiastic to learn skills?" (Compared to unenthusiastic inexperienced staff)	
Participant A:	"Absolutely. It is far easier to train someone who is enthusiastic, they are like a sponge and want to soak it all up, and learn new things"
Participant B:	"Oh, definitely" "it makes it so much easier for the other staff to approach them" "they are enthusiastic and ask the right questions, and they willing to learn" "those are the ones who will excel, and who will get to know everything"
Participant C:	"Yes, absolutely there is definitely a big difference" "They want to learn" "They take on the tasks" "They will come to you and say yes, yes can I do this can I, can I" "You as a leader want to send them on more courses and you will want to advance that person"
Participant D:	"Yes, most definitely" "have the will power and drive, you know enthusiastic, they are willing to learn, they learn from their mistakes, they are not shy to ask other people"

Participant A's response suggested that enthusiastic employees will learn skills quicker as they want to learn thus, they will soak up information like a sponge soaks up liquid. Participant B responded similarly to A, recognising that enthusiastic employees learn quicker as they are "willing to learn", ask appropriate questions, and will excel within the Healthcare facility. Participant C believed that enthusiasm made a "dig difference" in reducing the time needed to learn Healthcare related new skills, and supported Participant B's claim that they will excel within the business and advance within the company. Participant D concurred with Participant A, B, and C that enthusiastic employees have the willingness or "drive" learn skills quicker, whilst suggesting that enthusiastic employees

learn from their mistakes and are “not shy to ask other people” questions (which linked to B that suggested they asked the right questions).

4.9. Staff lacking confidence take longer to perform

This theme suggests that staff lacking confidence take longer to become self-reliant and use up a lot of the leader’s time for supervision; which could mean that the time spent supervising staff who lack confidence takes away from other Leadership duties. The theme supports has shown that inexperienced staff lacking confidence take longer to master skills, require more supervision and for a longer period of time. Supported by the Coaching style which is best suited when leading employees who are inexperienced and unconfident which suggests if they are unconfident they will take longer to becoming self-reliant and need supervision for longer periods of time (Hersey, Blanchard & Johnson, 2013; Lynch, 2015; Goldsmith, 2016).

Table 23: Question 8

Question 8 “Do you notice a difference in the time it takes for inexperienced staff who lack confidence the at become self-reliant?” (Compared to inexperienced confident staff).	
Participant A:	“It does, however when they confident and start take notes they actually learn to become self-reliant”
Participant B:	“Definitely, because they might only do the things they know and not try to do more things and to grow in the business”
Participant C:	“They might take a little longer; but it depends on the team that you are working with”
Participant D:	“Yes, sometimes they take very long”

Participant A’s response stated that “it does” take longer for staff who lack confidence to become self-reliant. Participant B concurred with Participant A; stating that it would “definitely” take longer for staff lacking confidence to become self-reliant, as they would “not try to do more” or new tasks. Participant C suggested that subordinates that lacked confidence may “take a little longer”, however believed that this can be offset by working with a capable team. While Participant D agreed with the other participants, stating they sometimes take much longer to become self-reliant.

Table 24: Question 9

Question 9 Do you notice a difference in the amount of time spent on supervising inexperienced staff who lack confidence?	
Participant A:	"Yes, I do. It takes a lot longer and it can be quite exhausting, but you need to persevere; because each person learns differently and sometimes it takes a longer time, but once they get it and grasp it, they will be a lot better"
Participant B:	"Yes, definitely because they might not have the confidence to ask the questions" "I definitely think that there will be more supervising needed"
Participant C:	"Definitely, those who are confident take flight very quickly, and need a lot less supervision"
Participant D:	"I've had a staff member for years that literally spent the entire day asking me or other staff members if she did certain tasks correctly, even though she has done them for years"

Additionally, Participant A believed he/she spent more time supervising staff who lacked confidence. While Participant B agreed with Participant A, because the staff members might not have the confidence to ask questions so more supervision would be needed. Whereas, Participant C agreed with Participant A&B; and elaborated that confident staff "take flight quickly and need a lot less supervision". While, Participant D elaborated stating that he/she had staff that for years repeatedly asked for confirmation that certain of the tasks were done correctly even though she had done them correctly many times before.

4.10. There is sufficient employee support from Managers

This theme suggested that the Healthcare leaders (particularly participant B, C, and D) are often close offering support to certain of their subordinates who need it and do not intervene unless asked or until the situation is critical and are willing to compromise until then, as long as it does not negatively affect the business. The Supporting Leadership style requires that the leaders are close offering support to their employees and only intervene when asked or the situation is critical (Hersey, Blanchard & Johnson, 2013; Lynch, 2015; Goldsmith, 2016).

Table 25: Participant B[6]

Question 4 "What values or characteristics do you believe makes a good leader?"	
Participant B:	"Don't stress about the small things" "doing it slightly different than you want it done, is not always wrong" "there needs to be a bit of give and take; as long as it doesn't affect business"
Question 5 "How do you handle inexperienced employees who are enthusiastic, yet insecure?"	
Participant B:	"Tell them that everyone makes mistakes, but to rather ask before they do anything"
Question 9 Do you notice a difference in the amount of time spent on supervising inexperienced staff who lack confidence?	
Participant B:	"You are not going to know when they are actually making mistakes or not; so, you are constantly going to have to keep an eye on them, just to make sure and … they are just going to do their own thing"
Question 12 "How comfortable do you feel when delegating responsibilities to most of your staff?"	
Participant B:	"They got the ability, and I do check-up"

Participant B's responses suggest that he/she is not pedantic about the exact details when staff are doing their job, and wont intervene as long as it does not "affect the business" or will certainly lead to failure; he/she would prefer that staff rather ask for help than being unwillingly assisted or making mistakes that could have been avoided; and he/she does "check-up" to see if staff and intervene if they are going to make a serious mistake, even if they have "got the ability".

Table 26: Participant C[7]

Question 3 "Do you ascribe to any specific leadership style?"	
Participant C:	"They do as they please and then I take corrective actions from there; you know so you sit back and watch"
Question 4 "What values or characteristics do you believe makes a good leader?"	
Participant C:	"I think compromise" "I think your relationships with your colleagues or employees or employers is definitely compromise" "it is a constant compromise"
Question 10 "Do you (often) come across staff in who are competent, yet unconfident when doing work, they know how to do?	
Participant C:	"Yes, I do find that and then what happens is we deal with people, because of the confidence that they lack you just often need to take over"

Participant C similarly to Participant B, compromises on how certain tasks are done, as long as they are not critical; whilst keeping his/her distance, takes corrective action when necessary, and should a staff member need the assistance he/she would complete the required tasks for them.

Table 27: Participant D[6]

Question 7 "How do you manage inexperienced staff, who are lacking confidence, but show willingness to do the task at hand?"	
Participant D:	"Whether it is the nursing station or in the theatre, if they are working with our patients, and if they are not coping we try and put them in our other environments that are, you know work environments that they don't need to work with patients"
Question 12 "How comfortable do you feel when delegating responsibilities to most of your staff?"	
Participant D:	"I stand back and say okay fine is there anything I can help you with?" … "And it must never come as though I didn't like what you did and I want you to do it this way" "Only intervene if you see it is going to fail"

Additionally, Participant D if the task is vital such as working with patients he/she would intervene, moving the staff to a different workstation not requiring patient interactions; and

is close by offering support to staff and would not intervene unless asked or the staff member is sure to fail.

4.11. Leaders had the confidence to delegate

This theme suggests that the participants were comfortable delegating due to the confidence they have in most of their subordinates' abilities. Delegating Leadership minimises the supervision needed as leaders trust their subordinates are confident and proficient at the given the task; although the subordinates are seldom experts and can continue learning while doing (Hersey, Blanchard & Johnson, 2013; Lynch, 2015; Goldsmith, 2016).

Table 28: Question 12

Question 12 "How comfortable do you feel when delegating responsibilities to most of your staff?"	
Participant A:	"I feel very comfortable, because you learn to trust someone and when they learn to trust you it is better than being loved"
Participant B:	"Yes, again I won't tell them to do something unless I know they are able to do it" "I am confident that they have the proper training" "You need to delegate and get everything done, and that also comes from your own confidence, because it is not as easy in the beginning to just tell people do this, do that"
Participant C:	"Delegating duties I don't have an issue with" "actually, I am comfortable"
Participant D:	"I like to be in the trenches with the staff, as I delegate, and try and engage with them and get their ideas and share my ideas to make them part of the solution"

Participant A was comfortable delegating to his/her subordinates, as he/she trusted them. Whilst, Participant B was confident enough in his/her staffs training in order to delegate, and cited that the work load is too much to not be delegating. Additionally, Participant C was comfortable with delegating and did not have "an issue with" delegating duties. However, Participant D did delegate, in a more participative by engaging with employees whilst delegating and making "them part of the solution" and had more hands-on approach to delegating by preferring to be in the "trenches with staff".

4.12. Subordinates contribute to decision-making process

This theme suggested that on occasion the Healthcare Leadership have the faith in their staff's better judgments to make the right decisions and contribute to decision-making processes. Supported by Situational Leadership theory's Delegating Leadership approach which is more willing to ask subordinates to contribute to decision-making processes (Hersey, Blanchard & Johnson, 1982; Norris & Vecchio, 1992). The reasons given for the opportunity to contribute to the decision making were linked to gain staff interest in projects, achieve greater buy-in, and the Leadership were encouraged by the company to make staff part of the decision-making process.

Table 29: Participant C[8]

Question 2 "How do you usually deal with these challenges?"	
Participant C:	"I ask them to give me feedback on how we can improve things"

Participant C early in the interview process showed a tendency involve his/her staff in finding solutions to problems.

Table 30: Question 13

Question 13 "How comfortable do you feel giving subordinates the opportunity to contribute to decision-making processes?"	
Participant A:	"I'm very comfortable with that as well because we work together"
Participant B:	"No, that I am also comfortable with, … and it is actually encouraged in our business setup as well, that the staff show interest in the business and come up with ideas" "involving them more then they show more of an interest, and understand things better as well"
Participant C:	"If there is anything like any new programs; I am very comfortable with them being part of the decision making" "they don't like a boss, they don't want to be told what to do, they like to be part of it"
Participant D:	"I must tell you that it is not only my personal work ethic, but it is also what ### and ### *(mother company and subsidiary names)* encourages" … "I am extremely and always comfortable, and extremely encouraged to give my subordinates the opportunity to contribute to making a decision; because to me that is critical because then I get their buy-in"

Participant A was "very comfortable" allowing subordinates to contribute to the decision-making process. Participant B also felt comfortable and "encouraged" in his/her business set-up to allow staff that "show interest" to "come up with ideas". Participant C added that he/she was comfortable with allowing staff to contribute to the decision making because he/she felt that staff liked to be part or to be involved of the discussion or decision-making process. Participant D's comfort level was definitively high as personally he/she was inclined to ask subordinates to contribute to the decision-making process in order to get employee "buy-in", additionally he/she encouraged by the company (possibly through policy or directives) to allow subordinates to contribute to the decision-making processes.

In conclusion the trustworthiness of the data that contributed to the Presentation and Interpretation of Findings was ensured by the fact that four Healthcare facility leaders that are trusted professionals in their respective roles, gave full and lengthy answers to each question and many of their responses linked up well when the thematic analysis was concluded although not always for the same questions. This contributed to better understanding the staff related Leadership Challenges faced by Healthcare facilities in

Durban. Additionally, Situational Leadership theory, which formed the basis for most of the research questions appeared to be utilised by the Leadership and applicable to the Healthcare facilities in Durban. Furthermore, the Presentation and Interpretation of Findings covered and responded to the research questions and objectives that will be further applied in the next section.

5. CONCLUSION

The research was concluded in this section; the research question and objectives that were formulated at the onset of the study were answered and covered. Additionally, the research problem was addressed, the implications of findings were discussed, the heuristic value was identified and elaborated on, whilst the ethical considerations and steps taken to ensure the ethicality of the study along with the limitations of the study was reviewed hereunder.

5.1. Research Objectives and Questions Analysed

This section of the research properly demonstrated how the research question and objectives were analysed. To achieve the research goal the researcher the critically evaluated whether the research objectives and questions were answered. The research questions and objectives were formed in a way to best understand Hospital Leadership Challenges in Durban.

Research question one: “What is the perception of Private Hospital Managers, in Durban, regarding staff performance?” The perceptions of Private Hospital Managers were obtained from the in-depth interviews. Situational Leadership theory formed the basis of many of the interview questions. Research question one was fully resolved in the Presentation and Interpretation section. The first research objective was: “To gain an in-depth understanding of Private Hospital staff poor performance, as perceived by Hospital Managers”. The Presentation and Interpretation section suggested that there were certain staff that lacked poor staff performance and some respondents indicated a lack of dedication which could be a contributing factor. The second research objective was: “To gain an in-depth understanding of challenges faced by Private Hospitals due to staff poor performance, as perceived Hospital Managers” Resistance to change, and learning new skills were one of the major Leadership challenges. The third research objective was: “To gain an in-depth understanding of good performance of Hospital staff, as perceived by Hospital Managers”. The interviews indicated that good or enthusiastic staff learned skills quicker and did not need as much supervising thus leadership monitored and closely supervised confident enthusiastic employees less frequently. The third research objective was: “To better understand how Managers in Durban Private Hospitals manage staff performance (poor and good)”. The Hospital Managers suggested they delegate instead of supervise performing staff and allow them to contribute to the decision-making process to gain their “buy-in” and support while underperforming staff were closely supervised.

5.2. Research Problem Addressed

The wider research problem was that the private and public Healthcare industry in South Africa showed a decline in quality (Child, 2017; Teke, 2017). Healthcare's reputational loss a symptom of the wider problem was externalised by Mkize's (2018) news article on the Life Esidimeni matter that was costly financially and in terms of loss of human life (Mkize, 2018). This study was a descriptive thus the researcher searched for Healthcare's staff performance related Leadership Challenges, in order to find some of the issues that contributed to the wider research problem which was dealt with in the first research question and objective.

The specific problem was demonstrated by Life Esidimeni a symptom that demonstrated Leadership Challenges. Currently there is a shortage of Healthcare professionals in South Africa, worsened by the fact that many of the remaining Healthcare professionals are unhappy due to their current employment challenges (Delobelle, Rawlinson, Ntuli, Malatsi, Decock & Depoorter, 2010; Econex, 2015). The specific problem that was identified was that the South African Healthcare sector experienced major Leadership Challenges in staff performance, which continues worsens the service delivery. The study provided an in-depth understanding of Leadership Challenges, highlighted and described the key challenges for future studies to be undertaken by specialists that are interested in mitigating them. Additionally, the researcher identified how Healthcare Leadership dealt with these challenges.

5.3. Implications of Findings

This research found that certain Healthcare staff might lack performance or dedication to duty, were resistance to change, and were unwilling to learn new skills. Staff unwillingness to complete tasks which was expanded on by Situational Leadership theory being a technique of improving staff willingness to learn or at least makes provisions for willing of employee (Hersey, Blanchard & Johnson, 2013).

The research suggested that Healthcare leaders alternate their Leadership styles sometimes without even realising depending on the situation. Which further linked to Situational Leadership theory as the name suggested the Leadership style changes depending on the situation (Hersey, Blanchard & Johnson, 2013).

The interviews suggested constantly motivating staff making them feel at ease through recognition, constructive feedback, encouragement and guidance as well as teamwork, and the ability to work in teams was important. Which Kouzes & Posner (2007) suggested that Situational Leadership at all stages allowed leaders to placed emphasise on the encouragement of employees, build strong team spirits, as well as develop mutual trust and respect. Additionally, practice and repetition were encouraged by the interviewees and they believed it was essential to improve to improve the ability and skill of employees at learning new tasks.

The research determined that the Healthcare leaders were always willing to send the employees for further training, closely supervise and provide specific guidance in order to offset Leadership Challenges related to staff performance. Which was supported by the directing Leadership style which provided close supervision and specific guidance (Hersey, Blanchard & Johnson, 1982; Norris & Vecchio, 1992).

The research suggested that Healthcare Leadership believed that “enthusiasm” as a trait for employees’ was important in order to learn skills quickly and the unenthusiastic staff required more supervision resulting less time for other Leadership duties; suggesting that enthusiasm was an important component when hiring staff. Which was supported by the directing Leadership style which suggested that enthusiastic trainees become self-reliant quicker, learning skills and become accustomed to processes rapidly, as opposed to unenthusiastic trainees (Hersey, Blanchard & Johnson, 2013; Lynch, 2015; Goldsmith, 2016). Further supported by the Coaching Leadership style which was best suited for leading employees who are inexperienced and unconfident which suggested that unconfident staff will take longer to becoming self-reliant and need’s supervision for longer periods of time (Hersey, Blanchard & Johnson, 2013; Lynch, 2015; Goldsmith, 2016).

The study showed that Healthcare leaders are often close offering support to certain of their subordinates who need it and will not intervene unless asked or until the situation is critical and are willing to compromise as long as it does not negatively affect the business. This was supported by the Supporting Leadership style which required that leaders are close offering support to their employees and would only intervene when asked or the situation is critical (Hersey, Blanchard & Johnson, 2013; Lynch, 2015; Goldsmith, 2016).

The Healthcare leaders were comfortable delegating due to the confidence they had in most of their subordinates' abilities. Supported by the Delegating Leadership style which minimises the supervision needed as leaders trust their subordinates are confident and proficient at the given the task (Hersey, Blanchard & Johnson, 2013; Lynch, 2015; Goldsmith, 2016). Additionally, the Healthcare Leadership had faith in their staff's better judgments to make the right decisions and contribute to decision-making processes. Which was supported by Situational Leadership theory's Delegating Leadership approach; as leaders are more willing to ask subordinates to contribute to decision-making processes (Hersey, Blanchard & Johnson, 1982; Norris & Vecchio, 1992).

5.4. Heuristic Value

This qualitative study analysed Healthcare leaders and Leadership Challenges related to employee efficiency; focusing on aspects such as employee work readiness, training, and work requirements.

The researcher believes that the business management, specifically Healthcare sector is expected gain knowledge generated from the study regarding Private Hospital Leadership Challenges, in regards to Situational Leadership theory as a basis. Although the research was not undertaken under the ideal circumstances (described later in 5.6 Limitations of the study) the research findings suggested that South Africa's Healthcare sector should if possible hire competent staff, who are confident, willing to do the work expected, in order to reduce required training and supervision as they will learn quicker; and thus, result in improved performance, efficiency and effectiveness.

The study could form the basis for further well-funded qualitative or mixed method studies to investigate the South African Healthcare Leadership Challenges, using a larger sample group (more than 4 participants) and geographical area (entire provinces or South Africa), which could be a catalyst for the change needed to improve the effectiveness and efficiency of South African Healthcare sector.

5.5. Ethical Considerations

The researcher's personal reputation was at risk; thus, attempted to ensure an ethical study. The participants needed to have trust in the researcher not to exploit them, so the study conforms to the highest ethical standards desired by the broader population being studied (Du Plooy-Cilliers, *et al*, 2014; The IIE 2018) and the Independent Institute of

Education Varsity College Westville campus. Please refer to the IIE ethics clearance letter contained in the research as appendix F.

The researcher avoided unethical/ inappropriate research methods. The interview participants were consenting adults' that were not in any way interrogated or scientifically tested to gauge their responses. If the participants felt uncomfortable they would have been permitted to leave anytime during the interview and decline to continue the research process. Please refer to appendixes C, D & E for the various consent forms complying with ethical standards of the IIE, such as the consent form agreeing to consented legal voice recordings; that will be given to participants of the research to peruse and sign (The IIE 2018: 18-19).

The IIE (2018: 18-19) posits that high-risk research should be avoided, thus the researcher avoided vulnerable groups of society or groups, such as mentally impaired and HIV/AIDS patients; that can be easily manipulated as well as physically or mentally harmed by participating in unconventional research studies. Rather low risk research was conducted with professional members of society, mainly nurses, doctors and managers that hold Leadership positions in Private Hospitals.

Du Plooy-Cilliers, *et al* (2014) iterated the importance of making the participant feel comfortable to achieve the best possible results, thus participants were given the option to change the interview location to where they preferred. The researcher attempted to ensure that none of the questions were unreasonable or overly sensitive, and pre-tested the set semi-structured interview questions. Additionally, the researcher allowed participants to decline to answer any questions they were not comfortable answering.

Gatekeeper access was not necessary as the study did not be name any specific Healthcare facilities or Hospitals that employed the participants; only the geographic location of the research conducted. Untruthful representation or deception of participants regarding the purpose of the study was avoided as participants were informed of the purpose of the study, before consent was given. All participants' voluntary contributed to the research; and as per the IIE (2018: 18-19) participants were required to give consent, and signed a consent form assuring their confidentiality, and collaborated that the interviews were not commenced under duress and that the participants were fully informed to the purpose of the research.

Please note that at end of each interview the researcher provided a small non-bribe token of gratitude (an 80-gram Cadbury slab of chocolate), which was purely to thank the participants; these did not affect the answers provided or the research outcome, considering the purposefully nominal nature of the token and the positions held by the participants.

The participants were given alphabetical aliases in the research paper to ensure their anonymity. As per the IIE (2018: 18-19) the information provided by the participants will remain privileged; and only known to researcher and if necessary the data will be obtainable by the IIE institution should they require it however further steps can be taken to ensure their anonymity such as non-disclosure agreements between the researcher and the IIE officials.

The researcher took every reasonable precaution to avoid distorting results, whether intentional or unintentional. The researcher promises that study was done to the highest ethical and moral standards possible; the researcher counteracted biased reporting by avoiding the use of any information out of context, and information whether undesired or convenient was not underemphasised or overemphasised. The researcher did not falsify any information at any stage; for example, to biasedly report, to please any external entities or conserve time and effort. The avoidance of these biases was ensured through the researcher's own moral standards, conformity to the data analysis rules and steps, as well as the detailed records of the evidence that was collected in support of the research claims and deductions.

5.6. Limitations of the Study

The researcher's main limitation was due to a lack of time as the research was a cross-sectional study in within in 2018, which allotted approximately 3-6 months. The time constraint added to the sample size limitation the researcher would have liked to have interviewed a larger sample to create to increase the accuracy and credibility of the study that is disadvantaged by the small sample size was only 4 Healthcare leaders. While the sample size (of 4) was purposefully chosen to ensure that there was enough to complete the interviews, transcribe the data, and complete the final research report within the relevant time frame. Additionally, the researcher admits that some of the sources used were older than five years thus they could be outdated, however some of these sources

were seminal. According to Du Plooy-Cilliers, *et al* (2014, p 275-276), the research is limited by the budget, accessibility to the population, and shifts in conditions.

5.6.1. Budget Limitations

The budget is a significant limitation to the extent of the research that can be undertaken (Du Plooy-Cilliers, *et al* 2014). The study was conducted in the Durban area thus the geographical undertaking was minimised which allowed the researcher to lower the travel costs for example compared to the costs of traveling throughout South Africa, however this regional analysis might not reflect the situation across South Africa. The researcher was self-fund; and to reduce traveling costs the researcher's own vehicle used.

5.6.2. Accessibility

Accessibility of the target population could be hampered by the target populations unwillingness to participate in the study (Du Plooy-Cilliers, *et al* 2014); and their availability due to work or personal schedules. The researcher conveyed the aim of the research to participants in order to gain their approval to being interviewed. The researcher did not plan to but twice needed to enter Private Healthcare facilities in Durban as per the interviewees' instructions due to working schedules, the interviewees permitted access and so access was not denied. A permission gatekeeper access was not needed as the researcher only named the geographic location and not the Healthcare facilities.

5.6.3. Shift in Conditions

Shift in conditions are large occurrences or instances where an issue is publicised or politicised, which could taint studies results (Du Plooy-Cilliers, *et al* 2014). For example, the interview participants perceptions could easily have change during this qualitive study due to publicised matters such as the Life Esidimeni matter that discussed earlier in this proposal. Luckily to the researcher's knowledge there were no publicised controversial occurrences in the South African Healthcare system it could have discourage participants from taking part in the study even though the researcher had already gained approval from participants to participate in the study.

In conclusion this section; the research questions' and objectives were answered, the research problem was addressed, the implications of findings, the heuristic value, the ethical considerations and limitations of the study were concluded upon.

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7. APPENDICES

7.1. Appendix A: Situational Leadership Model

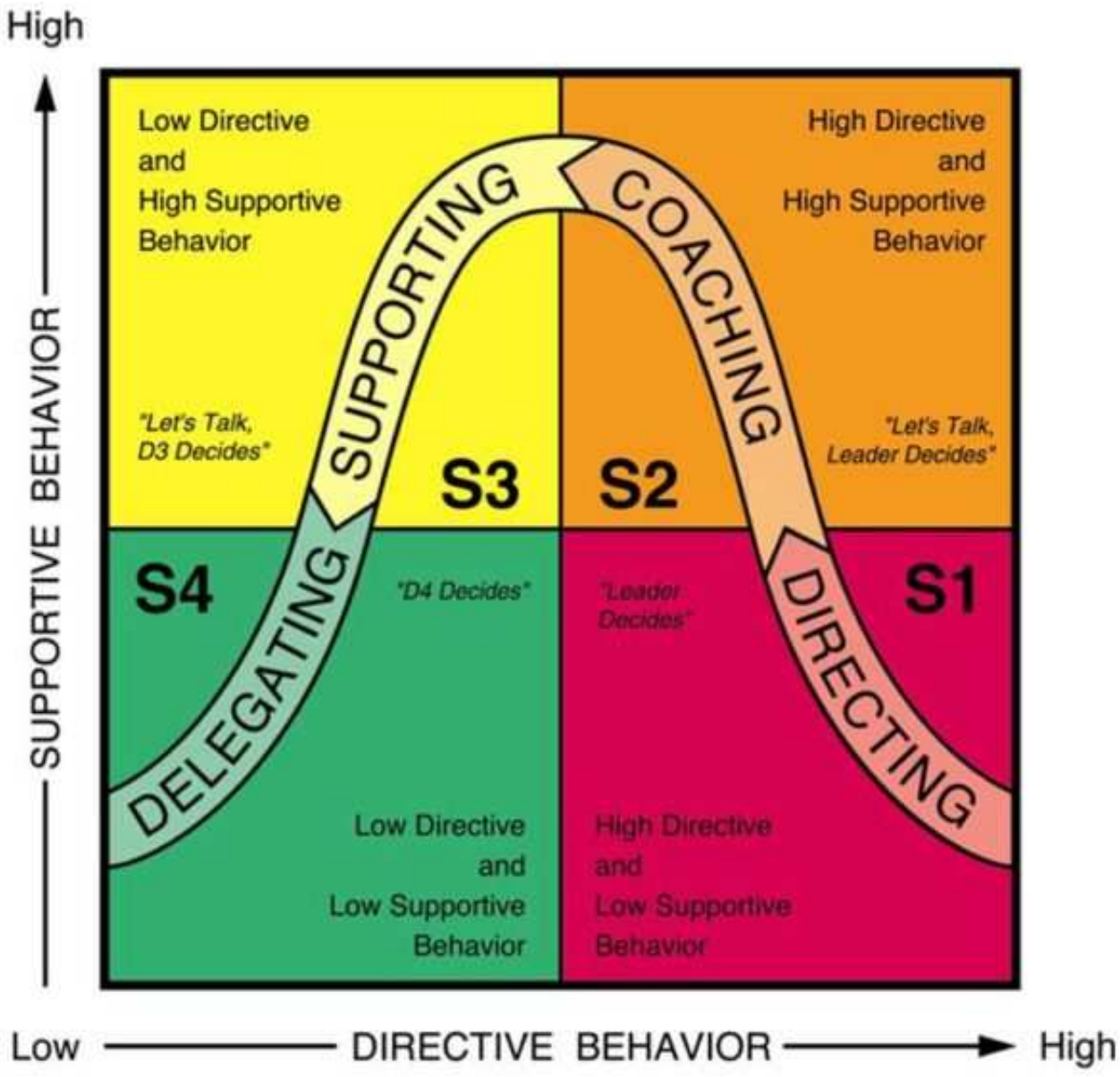

Figure 1: Situational Leadership Model. (https://goitalk.com, 2017).

7.2. Appendix B: Final Research Report Summary Document Table

Title: Situational Leadership Theory and Staff Performance: A qualitative cross-sectional study, making use of in-depth interviews, describing the perceptions of Leaders on staff performance within the Durban's Private Hospitals

Research Purpose	**Primary Research Question**	**Research Rationale**	**Seminal Authors/ Sources**	**Literature Review – Conceptual Framework**	**Paradigm**	**Approach**	**Data Collection Method(s)**	**Ethics**	**Key Findings**	**Recommend-ations**
The study's purpose was to gain an in-depth understanding of leadership perceptions on staff performance, within Private Hospitals in Durban. The study utilised the Paul Hersey and Ken Blanchard Situational Leadership theory as the theoretical framework and basis for the study.	What is the perception of Private Hospital Managers, in Durban, regarding staff performance?	This study aimed to create an in-depth understanding of the Leadership Challenges affecting staff efficiency and the leadership style utilised in the South African Private Hospital context. As De Villiers (2006) stated that providing proper leadership was necessary to improve the overall effectiveness as well as the publics perceptions of the private and public South African medical sector.	Seminal Authors: Paul Hersey & Ken Blanchard. As well as James Kouzes & Barry Source Example: Hersey, PH, Blanchard, KH & Johnson, DE. 2013. Management of Organizational Behaviour: Leading Human Resources. 10th edition. London: Pearson Corporation	Theme 1: Types of Leadership Challenges; Monitoring and Coaching to Support and Manage staff Efficiency and Resistance to Change. Theme 2: Providing the right Leadership at the "Right time", and Paradoxes/ Critiques of the Leadership theory. Theme 3: Teams, Millennials, Alternating Leadership styles, and Achieving both Efficiency and Effectiveness.	**Interpretivism Paradigm** Epistemology: focused on the underlying issues, themes, and the meanings of staff performance Leadership Challenges. Gathered by means of interviews. Ontology: was to find the reality of the underlying Leadership Challenges that may or may not have existed in the Healthcare industry. Axiology: The role of this research was addressed by the identified Leadership Challenges of Durban's Healthcare industry; which with further research could lead to improvement in the industry.	Qualitative approach.	The researcher used semi-structured In-depth interviews to collect data from various hospital leaders / managers in Durban. Pre-testing was also an important part of research/	The study conforms to ethical standards of by the IIE Varsity College Westville campus. The researcher avoided unethical/ inappropriate research methods. Took every reasonable precaution to avoid distorting results; intentional or unintentional. The interviewees anonymity was ensured. Please refer to consent forms appendixes C, D & E. High-risk research was avoided.	Certain Healthcare staff might lack performance or dedication to duty, were resistance to change, and were unwilling to learn new skills. Leaders provided Motivation, recognition, constructive feedback, encouragement and guidance.	Hiring enthusiastic staff is important as they learn skills quickly. Healthcare could implement more Teamwork activities; as the ability to work in teams was important in order to overcome teaching and performance difficulties. Hospital Leaders indicated that leaders need to alternate their Leadership styles sometimes without even realising depending on the situation. Additionally, allowing staff to form part of the decision-making process is important to get buy-in.
Research Problem	**Objectives**	**Key Concepts**	**Key Theory**			**Population**	**Data Analysis Method(s)**	**Limitations**	**Key Contribution**	
South African Healthcare has major Leadership Challenges. Under-performing staff was identified as a major leadership challenge for Durban Healthcare leaders.	To gain an in-depth understanding of challenges faced by Private Hospitals due to staff poor performance, as perceived Hospital Managers. To gain an in-depth understanding of good performance of Hospital staff, as perceived by Hospital Managers To better understand how Managers in Durban Private Hospitals manage staff performance.	Delegating leaders; Participating leaders; Selling leaders; and Telling leaders.	Paul Hersey and Ken Blanchard (1969 and refined in 1972) Situational Leadership theory and model.			The targeted population parameters were Hospital management or Leadership professionals, with a qualification, as well as unique medical or management skills required in Healthcare Leadership position, aged between 25 and 60, within Durban. **Sampling** The study used non-probability sampling. Using the Purposive sampling method. The sample size: Consisted of four Hospital leaders / managers in Durban.	Unit of analysis was interviewee perceptions in the form of responses, that were fundamental to the study's purpose. Deductive approach structured data in terms of important concepts. Qualitative content analysis was used to analyse the collected data.	The researcher was limited by time constraints, budget, and limited accessibility to the target population.	Based off of the research further well-funded studies could investigate the South African Healthcare Leadership Challenges, using a larger sample group which could be a catalyst for the change needed to improve staff performance in the South African Healthcare sector.	

7.3. Appendix C: Example of explanatory information sheet for participants

To whom it may concern,

My name is Walter George van der Hoven and I am a student at the Independent Institute of Education's; Varsity College Westville campus. I am currently conducting research under the supervision of Siva Moodley about the Leadership Challenges in Healthcare related to staff efficiency, including but not limited to staff experience, staff need of Leadership and staff ambition. I hope that this research will enhance our understanding of Healthcare Leadership Challenges related to staff efficiency and effectiveness.

I would like to invite you to participate in my study. In order to explain to you what your participation in my study will involve, I have formulated questions that I will try to fully answer so that you can make an informed decision about whether or not to participate. If you have any additional questions that you feel are not addressed or explained in this information sheet, please do not hesitate to ask me for more information. Once you have read and understood all the information contained in this sheet and are willing to participate, please complete and sign the consent form below.

What will I be doing if I participate in your study?
I would like to invite you to participate in this research because you are in a position of Leadership within a South African Healthcare facility, with the knowledge to help my research. If you decide to participate in this research, I would like to conduct a single interview with you, for approximately thirty minutes to an hour. These interviews will be commenced at a time and place that is convenient for both of us. The questions asked will be related to your experience dealing with or noticing factors relating to staff efficiency and how situations differ between employees and Leadership provided.

You can decide whether or not to participate in this research. If you decide to participate, you can choose to withdraw at any time or to decide not to answer particular interview questions.

Are there any risks/ or discomforts involved in participating in this study?

Whether or not you decide to participate in this research, there will be no negative impact on you. There are no direct risks or benefits to you if you participate in this study. You might, however, indirectly find that it is helpful to talk about your views on the Leadership Challenges related to managing individuals with diverse Leadership needs and the suitable management styles for ensuring that they are working at their ultimate efficiency and effectiveness levels. If you find at any stage that you are not comfortable with the line of questioning, you may withdraw or refrain from participating.

Do I have to participate in the study?

- Your inclusion in this study is completely voluntary;
- If you do not wish to participate in this study, you have every right not to do so;
- Even if you agree to participate in this study, you may withdraw at any time without having to provide an explanation for your decision.

Will my identity be protected?

I promise to protect your identity. I will not use your name in any research summaries to come out of this research and I will also make sure that any other details are disguised so that nobody will be able to identify you. I would like to ask your permission to record the interviews, but only my supervisor, I and possibly a professional transcriber (who will sign a confidentiality agreement) will have access to these recordings. Nobody else, including anybody at Varsity College Westville Campus, will have access to your interview information. I would like to use quotes when I discuss the findings of the research, but I will not use any recognisable information in these quotes that can be linked to you.

What will happen to the information that participants provide?

Once I have finished all interviews, I will write summaries to be included in my research report, which is a requirement to complete my qualification; Honours in Business Management. You may ask me to send you a summary of the research if you are interested in the final outcome of the study.

What happens if I have more questions about the study?

Please feel free to contact me or my supervisor should you have any questions or concerns about this research, or if there is anything you need to know before you decide whether or not to participate.

You should not agree to participate unless you are completely comfortable with the procedures followed.

My contact details are as follows:

Walter van der Hoven

[redacted]

[redacted]

The contact details of my supervisor are as follows:

Siva Moodley

[redacted]

[redacted]

7.4. Appendix D: Example of consent form for participants

I, _____ , agree to participate in the research conducted by Walter van der Hoven about a cross sectional, qualitative study, making use of in-depth interviews to describe hospital Leadership Challenges in staff performance in Durban, KZN; based upon Situational Leadership theory. The Healthcare Leadership Challenges will for the most part be concerning the staff efficiency and effectiveness.

This research has been explained to me and I understand what participation in this research will involve. I understand that:

1. I agree to be interviewed for this research.
2. My confidentiality will be ensured. My name and personal details will be kept private.
3. My participation in this research is voluntary and I have the right to withdraw from the research at any time. There will be no repercussions should I choose to withdraw from the research.
4. I may choose not to answer any of the questions that are asked during the research interview.
5. I may be quoted directly when the research is published, but my identity will be protected.

_____ _____

Signature Date

7.5. Appendix E: Example of consent form for audio-recording/ video recording

I, _____ , agree to allow Walter van der Hoven to audio record my interviews as part of the research about a cross sectional, qualitative study, making use of in-depth interviews to describe hospital Leadership Challenges in staff performance in Durban, KZN; based upon Situational Leadership theory. The Healthcare Leadership Challenges will for the most part be concerning the staff efficiency and effectiveness.

This research has been explained to me and I understand what participation in this research will involve. I understand that:

1. My confidentiality will be ensured. My name and personal details will be kept private.
2. The recordings will be stored in a password protected file on the researcher's computer.
3. Only the researcher, the researcher's supervisor and possibly a transcriber (who will sign a confidentiality agreement) will have access to these recordings.

_____ _____

Signature Date

7.6. Appendix F: Ethics clearance letter

7.7. Appendix G: Originality report