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Clinical leadership of Registered Nurses working in an Emergency Department

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**A research portfolio submitted in partial fulfilment of the
requirements for a degree of Master of Nursing**

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ABSTRACT

Clinical leadership of Registered Nurses working in an Emergency Department

Aim To examine clinical leadership of registered nurses (RN) in an Adult Emergency Department (AED), based on the evidence that it is important for nurses to feel psychologically and structurally empowered in order to be able to act as clinical leaders (Laschinger, Gilbert, Smith & Leslie, 2010).

Background Every registered nurse is a clinical leader (Patrick, Laschinger, Wong & Finegan, 2011). Clinical leadership is defined as staff nurse behaviours that provide direction and support to patients and the healthcare team in the delivery of patient care (Patrick et al., 2011). Clinical leadership is important for patient safety and improves patient outcomes (DeVivo, Quinn Griffin, Donahue & Fitzpatrick, 2013). The Emergency Department (ED) is an ever-changing critical-care environment that requires every nurse directly caring for patients to be empowered to act as a leader (Raup, 2008). However, research on leadership in nursing mostly focuses on delegated leader roles, with some focus on all nurses as leaders, but little on clinical leadership by nurses in ED.

Methods A non-experimental survey design was used to examine the psychological empowerment, structural empowerment and clinical leadership of RN's working in an AED in a large tertiary hospital in Auckland City. Qualitative questions relating to factors that support and inhibit their clinical leadership abilities were also included.

Results The response rate was low at 33%. However the ED nurses that responded felt as though they showed clinical leadership behaviours most of the time, even though their sense of being psychologically empowered was only moderate, with improvements possible in structural empowerment.

Conclusion This research portfolio highlights the need for further research on the phenomenon of clinical leadership at the point of care (Patrick, 2010). The overall results, albeit not statistically significant, showed that staff nurses feel they

perform clinical leadership behaviours, but that structural and psychological empowerment have an impact on their ability to act as clinical leaders.

Implications for Nursing Management Ways in which management within the hospital can support clinical leadership behaviours by nurses in ED have been identified in this research. The results support the literature that states management must create empowering environments for nurses to be able to provide clinical leadership to their patients and colleagues. Other research identifies that providing an empowering environment will improve patient outcomes and quality of care (Patrick, 2010).

Keywords: clinical leadership, psychological empowerment, structural empowerment.

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I have learnt that the journey of study not only teaches you many things about your subject, it teaches you many things about yourself.

‘If your actions inspire others to dream more, learn more, do more and become more, you are a leader’

John Quincy Adams

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Chapter One: Introduction

The purpose of this study is to examine the clinical leadership of registered staff nurses in the Adult Emergency Department (AED) and to explore the concept that nurses need to be psychologically and structurally empowered to perform clinical leadership behaviours. In this study clinical leadership relates to nursing behaviours embedded in the practice of staff nurses providing direct patient care at the bedside. This differs from the more familiar view of clinical leadership behaviours in more formal leadership positions (Patrick, 2010). A clinical leader is defined as a registered nurse who is a clinician involved in providing direct patient care, who influences and coordinates patients, families and health care teams for the aim of achieving positive patient outcomes (Patrick, 2010).

Structural empowerment is based on the definition of power by Kanter (1977), which is “the ability to mobilise resources and get things done” (p.166). Kanter (1977) describes six structural organisational conditions conducive to workplace empowerment: access to information, support, resources, learning opportunities, formal power and informal power. Kanter (1977) went on to theorise that these workplace characteristics are more influential to employees’ attitudes and behaviours than personal characteristics (Faulkner & Laschinger, 2008).

Psychological empowerment is based on Spreitzer’s (1995) theory that an employee’s perception of their work environment shapes feelings of empowerment and that structurally empowering conditions cannot be fully realised unless the individual is psychologically receptive (Faulkner & Laschinger, 2008). Psychological empowerment consists of four subconstructs: autonomy, competence, meaning and impact (Spreitzer, 1995). Clinical leadership behaviours are defined as staff nurse behaviours that provide direction and support to patients and the healthcare team in the delivery of patient care (Patrick et al., 2011).

The purpose of this study based on these theories is to improve the provision of quality patient care and patient safety in an emergency department setting. Nurses are essential to clinical leadership as they represent a large proportion of the

healthcare work force and provide continuous care for patients from the time of admission to the time of discharge (Tornabeni & Miller, 2008). The role of nurses as effective communicators and coordinators of care is essential, particularly in the ED, given the degree of complexity of the clinical setting which is characterised by high patient acuity and multiple care providers (Patrick, 2010). These circumstances increase the risk for miscommunication, lack of care coordination and in increase in potential for adverse patient events (Baker et al., 2004).

Improving patient safety is a priority for healthcare organisations (Institute of Medicine, 2004) and nursing has been identified as a key role in keeping patients safe (American Association of College of Nurses, 2003). There is a focus on leadership at the clinical level, and recognition of nursing leadership at all levels in order to create safer healthcare organisations (Laschinger & Armstrong, 2006). The Emergency Department is an environment in which examining and seeking to improve clinical leadership by all staff nurses is vital, as it is an ever-changing environment with many clinical challenges faced on a daily basis. Emergency nurses must be able to adeptly deal with increasing patient acuity and volume while collaborating with other departments to expedite the administration of safe and effective patient care (Braun, Howerton Child & Saborio, 2014). Although the AED is highly regulated, nurses appear to work in an autonomous manner, needing to problem solve and make clinical judgements. Such departments rely on nursing expertise built up over time to care for complex critically ill patients (Young-Ritchie, Laschinger & Wong, 2009); therefore, it is imperative to enhance retention and recruitment by improving working conditions for those nurses currently in the system, and well as attracting new nurses to the department.

It is essential that all nurses working in the AED work together to create an environment that can produce outcomes of decreased staff turnover, thereby enhancing nurse retention and potentially positively impacting patient satisfaction. The concepts of structural and psychological empowerment provide an approach to understanding what is needed for the creation *and* maintenance of an

empowering environment in which staff nurse clinical leadership behaviours are encouraged and fostered.

The motivation for this study stemmed from an observation by the researcher of the way AED nurses operated post the introduction of the New Zealand Ministry of Health (NZ MOH) (2009) target for shorter stays in ED. This target stipulates that ninety five percent of patients will be admitted, discharged or transferred from an ED within six hours (NZ MOH, 2009). This target was aimed at improving the quality of emergency department care and whole hospital performance (Jones et al., 2012). The researcher undertook a post-graduate course titled: “Leadership and management for quality health care”. With the newly found concept (to the researcher) that every nurse is a leader, the introduction of the six hour target raised the question of what requirement meant to the ability of nurses to act as clinical leaders. From this basis, this study was designed to explore the clinical leadership behaviours of AED nurses, using the concepts of structural and psychological empowerment.

Chapter Two: Literature Review

2.1 Introduction

The concept of clinical leadership at the point of care is an area of increasing interest in health care organisations (Patrick et al., 2011). In this chapter, literature leading to and supporting the concept of clinical leadership as a process of leadership behaviours that need to be demonstrated by all staff nurses in providing direct patient care is reviewed. A definition of clinical leadership is presented and discussed. The concept of management is then contrasted with leadership. Magnet Hospital literature is used to support this. The key theories of clinical leadership are examined and attributes of clinical leaders and discussion of the more historical theories of leadership in nursing reviewed.

Nursing leadership is a large and complex concept, and the key themes from the literature that relate to this specific area are discussed. This includes exploration of literature summarising psychological empowerment and structural empowerment.

The context of the Emergency Department is presented as this is the setting in which the study was undertaken.

Finally, literature will be reviewed to provide rationale for the use of the leadership measurement tools used in this study.

2.2 Search Methods

A literature search was undertaken using the major databases Cumulative Index to Nursing and Allied Health Literature (CINAHL) and Medline. Google Scholar was also utilised. In addition the Auckland City Hospital web site, the New Zealand Ministry of Health and the New Zealand Nursing Council sites were searched. Hand searching from articles already read proved very helpful in sourcing useful relevant data. Expert author searches were extremely helpful.

Heather K.S. Laschinger is a major expert in the field of clinical nurse leadership and empowerment so all available literature from her was accessed

The keywords for the literature search were:

Emergency department (emergency unit, emergency service/hospital/trauma centre, accident and emergency)

Nurse (nurse/nurses/nursing)

Leader (leader/leaders/leadership); the term clinical leadership produced few results

Empower (empower/empowers/empowerment).

The only limitation applied was that all articles were in English. The year published was not applied as a limitation.

2.3 Background and Significance

Improving patient safety and positive patient outcomes are a priority for healthcare organisations internationally (Armstrong & Laschinger, 2006). The New Zealand Health and Disability Commissioner has highlighted the need for progress on improving patient safety and service quality (Ministry of Health, 2009). Models of care have remained largely unchanged while the challenges facing health services have changed significantly over recent years, with an increasing number of patients living longer with more complex co-morbidities and needs while having expectations of care and cure (Cornwall & Davey, 2004). Resource constraint, poor management practices, negative working conditions and a fragmented healthcare system have been identified as major threats to patient safety (Institute of Medicine, 2004). Within this scenario, nurses have been identified as essential for ensuring effective communication across healthcare teams and providing the continuity of patient centred care (Patrick, Laschinger, Wong & Finegan, 2011). Nurses have been cited as the professionals most likely to identify and respond to those issues that threaten patient safety (Patrick et al., 2011).

The increasing complexities of current healthcare systems demand new and improved ways of working to provide safe and excellent quality patient care, under ever increasing budget constraints (Honour, 2013). This has necessitated the need to think differently about how nurses are positioned to lead the profession into the future, by delivering competent, credible and visionary nurses to maintain nursing excellence (Honour, 2013) and protect patient safety (DeVivo, Quinn Griffin, Donahue & Fitzpatrick, 2013).

Nursing leadership is unique in that nurses have the main responsibility for patient care and safety, plus the monitoring of service and individual outcomes (Davidson, Elliot & Daly, 2006). Effective nurse leaders must ensure that sufficient nursing resource are assigned to achieve this safe care and optimal patient outcomes (Wong, Cummings & Ducharme, 2013). At the organisational level, senior nurse directors contribute to strategic decisions to achieve this (Huston, 2008). At departmental levels, nurse leaders are involved in daily operational decisions such as patient flow and staffing resource, quality improvement and risk monitoring to maintain safe care delivery (Thompson et al., 2011). At the frontline level, nurses lead patients, their families and multi-disciplinary teams on a daily basis through the patient journey to achieve good patient outcomes (Pate, 2013). Leadership is required at every level of the nursing hierarchy.

This study focuses on Emergency Department (ED) nursing leadership. Emergency Departments are a unique working environment, as patients can present with a variety of health needs at any degree of urgency, with unpredictable rates of presentation. Emergency nurses practice in a seemingly hectic and stressful environment (DeVivo et al., 2013). Raup (2008) reports that statistics are variable, but some findings suggest higher nurse turnover rates, higher nurse vacancy rates and lower patient satisfaction rates in an ED compared to other units in the hospital. The literature on EDs is generally focussed on such issues as nursing shortage, nurses' burnout, overcrowding, government targets for waiting times, financial and personnel constraints. These are all issues that reflect the complexity organisations face when attempting to meet and balance the needs of

Chapter2: Literature Review
patients, staff and funding requirements. This is the just the type of acute environment which requires a strong nursing leadership presence by all nurses because it has been identified that nurses are the glue that holds it together (Shirey, 2006). However, there is limited literature to support this.

2.4 Review of the Literature

Leadership exists on many levels of the nursing hierarchy (Patrick, 2010). However, the concept this study builds on is that all nurses are leaders. Some nurses may not see themselves as leaders. Some nurses may identify more with the traditional view that individuals must be in a formal leadership position to be seen as a leader (Patrick et al., 2011). However there has been a shift in the nursing leadership paradigm to recognise that every nurse is a leader (Honour, 2013; Pate, 2013; Patrick et al., 2011).

Across the globe, the role of clinicians as leaders and managers of health is increasingly viewed as a very important one (Swanwick & McKimm, 2011). Clinical leadership is not a new concept, but the need to optimise leadership potential across healthcare professions, and the critical importance of this to the delivery of excellence and improved patient outcomes, is now increasingly echoed by clinicians, managers and politicians within the UK and internationally (NHS Leadership Academy, 2011).

2.5 Clinical Leadership

Patrick et al. (2011) define clinical leadership as “staff nurse behaviours that provide direction and support to patients and the healthcare team in the delivery of patient care” (p.450). Clinical nurse leadership has also been defined as “a nurse directly involved in providing clinical care that continuously improves care through influencing others” (Cook, 2001b, p.39). A clinical leader has been described as “one who possesses clinical expertise in a specialty practice area and who uses interpersonal skills to enable nurses and other healthcare providers to deliver quality patient care” (Harper, 1995, p.81). Rocchiccioli & Tilbury (1998) also site excellence in clinical practice as an element of clinical leadership, where the environment allows empowerment and a vision for the future. Clinical leadership also requires skills such as team building, confidence and respect of

others, as well as vision and empowerment (Cook & Holt, 2000). The common elements in these definitions identify that a clinical nurse leader has excellent clinical skills using them as a basis from which to engage the patient and families and the rest of the healthcare team to find solutions to patient care. This fits with the concept that a leader is a person who seeks to find a solution to a challenge and engages with other people to find that solution (Pedler, 2010).

The 'leader' term is also used to describe managers who work in the clinical setting. Firth (2002) explored the balance of clinical and managerial roles of ward leaders, concluding that ward managers experience conflict between the managerial and clinical aspects of their role (Stanley, 2006b). There is evidence that the functions of leadership and management in the same post can lead to confusion, conflict and diminished clinical and managerial effectiveness (Stanley, 2006a).

In reality, the term clinical leadership is used interchangeably and inappropriately alongside the terms nursing leadership and nursing management. However, it can be argued that these terms actually refer to very different functions (Lett, 2002; Stanley, 2008). If nurses are to understand and apply clinical leadership principles, clinical nurse leadership needs to be framed so that nurses engaged in clinical practice can recognise clinical leadership in themselves and in their colleagues, and therefore work toward developing their clinical leadership skills (Stanley & Sherratt, 2010).

The definition of clinical leadership in this study posits that every nurse must function as a leader, not just the nurses in management or senior positions. The capacity to be a leader exists at many levels. Cook's (2001b) definition of a clinical leader as a nurse directly involved in providing clinical care that continuously improves care through influencing others implies that clinical leaders do not need to be in a management or senior position. The concept of all nurses as leaders has been around for some time even though some may still see it as a new way of thinking about nursing and leadership (Stanley, 2006a).

For example, Lett (2002) described the notion of clinical leadership as staff nurses leading their patients. The followers of clinical leaders are colleagues, students, patients and their families. The staff nurses lead their followers to better health and healthcare (Patrick, 2011). Staff nurses use leadership behaviours to support patients in achieving their health related goals and to influence other members of the healthcare team in providing quality patient care, even though they themselves may not perceive themselves as leaders (Lett, 2002).

Cook (2001b) proposed that the most influential people, in terms of improving care provision, are those that directly deliver nursing care. He researched the leadership attributes of those nurses who deliver patient care, identifying them as highlighting, respecting, influencing, creativity and supporting:

- Highlighting - having the ability to see potential for change, asking questions and finding a new way of doing things. Also having the ability to challenge the status quo and use the new knowledge to generate meaningful change with others
- Respecting - showing alertness for signals from individuals and the wider organisation, and the ability to act upon these signals
- Influencing - the ability to assist others to see and understand situations from various perspectives
- Creativity - finding a new way of doing things through using creativity from within themselves and releasing creativity in others
- Supporting - helping others through the change process (Cook, 2001a).

Stanley (2006a) also conducted research on the attributes of clinical nurse leaders. He identified that clinical nurse leaders desire to role model high quality care, are passionate about hands on patient care and interaction, are visible, and demonstrate credibility because of their clinical experience. He found that the following attributes are strongly associated with clinical leadership: clinical competence, clinical knowledge, effective communication, being a decision maker, empowerment/motivating, openness/approachability, being a role model and visible:

Chapter2: Literature Review

- Clinical competence - others are able to recognise ongoing credibility through demonstration of clinical experience and confidence
- Clinical knowledge - able to demonstrate knowledge of nursing, of specialty knowledge and knowing about teamwork and interpersonal relationships
- Effective communication - a central attribute, including showing listening ability
- Decision maker – being an effective decision maker is another critical attribute, along with the ability to delegate and problem solve
- Empowerment/motivator - showing enthusiasm, empowering colleagues and making them feel confident, supported and encouraged
- Openness/approachable - showing an ability to be understanding, open and caring
- Role model - demonstrating a high standard of care, being able to effectively care for patients, being inspirational to colleagues
- Visible - being available and present, engaged and involved in clinical activity (Stanley, 2006a).

Kouzes and Posner (1995) carried out research to establish the practices and qualities of leaders. They developed a model of leadership based on five fundamental leadership practices that allow ordinary leaders to achieve extraordinary things in organisations. The five fundamental practices are: challenging the process, inspiring a shared vision, enabling others to act, modelling the way and encouraging the heart. From these findings they then developed the Leadership Practices Inventory (LPI) as a tool for measuring the extent to which these practices are being followed (Kouzes and Posner, 1995).

Patrick et al. (2011) argued that the leadership practices identified by Kouzes and Posner are applicable to staff nurse practice behaviours at the bedside. They described the practices as follows:

- Challenging the process - seeking out opportunities for change, challenging the status quo, taking risks to improve the process and thinking creatively
- Inspiring a shared vision - positive communication, interpersonal competence and sharing a common purpose
- Modelling the way - setting an example, clarifying values, sustaining commitment and making a plan
- Enabling others to act - collaboration, building trusting relationships, sharing information and resources
- Encouraging the heart - recognising contributions, providing feedback and celebrating accomplishments (Kouzes & Posner, 1995).

Patrick et al. (2011) built on the clinical leadership attributes in Kouzes and Posner's model when developing their concept of clinical leadership. They hypothesized that staff nurse performance of clinical leadership behaviours on a daily basis would be positively related to their managers' use of the five leadership practices (as described by Kouzes & Posner, 1995) and the degree of structural empowerment within their work environments. Based on the conceptual analysis, they then developed a measure to operationalise this concept. They categorised the themes from a review of the literature on nursing and leadership into five defining attributes or characteristics of clinical leadership:

- Clinical expertise
- Effective communication
- Collaboration
- Coordination
- Interpersonal understanding (Patrick, 2010).

From a New Zealand perspective, these attributes correlate with the New Zealand Nurses Organisation (NZNO) and New Zealand Nursing Council's domains of the Professional Development and Recognition Programmes (PDRP) framework. This framework is utilised by most District Health Boards in New Zealand to enable

nurses practice to be recognised and rewarded. The four domains of nursing competencies are:

- Professional responsibility
- Management of nursing care
- Interpersonal relationships
- Interprofessional health care and quality improvement (NZNO, 2013).

Although the word leadership is not mentioned, these competencies all contain the elements of the clinical leadership behaviours described above. In particular interpersonal relationships relates to the core behaviours of Kouzes & Posner's (1995) leadership practices related to interpersonal competence, clarification of values and establishing trusting relationships (Patrick, 2010).

The Auckland District Health Board (ADHB) PDRP for senior nurses states that the competency requirements for interprofessional health care and quality improvement include the provision of clinical leadership to both the nursing and wider team, ensuring care is coordinated, and promoting and taking leadership for ensuring the team model of care functions to ensure patient care is safe and effective (ADHB, 2015). This shows that ADHB recognises and supports the concept that nurses are expected to be leaders and perform clinical leadership behaviours. This provides support for leadership training and development to be instigated in the under-graduate stages of nurse education and preparation and through ongoing nursing education. Health care systems that expect that effective nursing leadership will lead to improved patient care should look at funding for education and research into this important area (Patrick, 2010). Clinical leadership at the point of care can be developed with opportunities for professional and personal mentoring (Davidson, Elliott & Daly, 2006). Magnet recognition programmes acknowledge the benefit of formal leadership training of nurses. Positive links have been made to improved patient safety and outcomes as evidence of this (Armstrong & Laschinger, 2006).

2.6 Leadership vs. Management

Management can be defined as the organisation and planning of services, whereas leadership can be defined as the activities of an individual that are visionary and critical in directing and shaping clinical practice (Davidson, Elliott & Daffurn, 2003). Given that the most influential people, in terms of improving direct care provision, are those that directly deliver nursing care (Cook, 2001). The assumption that managers are the only leaders must be challenged. Nurses who provide direct patient care must also perform leadership functions (Raelin, 2011). The key themes that have emerged from the literature on what makes a leader as opposed to a manager are:

- Experts in the field
- Use knowledge and expertise to drive reform and change
- Effective communication and interpersonal skills
- Empowerment, respect for others
- Provide quality care
- Vision (Cook, 2001a; Davidson et al., 2003; Firth, 2002; Lett, 2002).

The American Nurses Association established the Magnet Recognition Program in the 1990's to acknowledge excellence in nursing services (Armstrong & Laschinger, 2006). Employees working within the magnet hospital frame that supports unit-based decision making, has a powerful nursing structure and promotes professional nurse practice have been shown to be likely to provide higher quality care (Aiken, Havens & Sloane, 2000). There are also positive effects of magnet hospital characteristics in inpatient mortality and patient satisfaction (Scott, Sochalski & Aiken, 1999). The five aspects of the nursing work environment that define Magnet hospital environments are: nurse participation in hospital affairs; nursing foundations for quality of care; nurse manager ability, leadership, and support of nurses; staffing and resource adequacy; and collegial nurse –doctor relationships (Lake 2002). Laschinger, Shamian & Thomson (2001) linked staff nurse empowerment to Magnet hospital characteristics in three independent studies in a variety of settings.

One of the key characteristics of magnet hospital work environments associated with superior patient care, reflected in better patient outcomes, has been effective leadership by nurse managers (Armstrong, Laschinger & Wong, 2009). This has highlighted the importance of nurse managers supporting the creation of empowering work environments, with the creation of these environments being an outcome of effective leadership (Upenieks, 2003).

Upenieks (2003) identified that magnet hospital nurse leaders attributed their success in creating empowered work environments to their level of support for nurses, and the fact that the nurse leaders had sufficient power and status within the organisation to enable them to do provide this support. This relates to Kanter's (1993) model of structural empowerment, in which the work environment is shown to support the empowerment of the workforce to the extent to which it provides access to information, opportunity, support, resources, and formal and informal power (Patrick, 2011). The provision of access to these empowering structures is an important leadership responsibility.

2.7 Leadership Styles

While there are many leadership styles (Jackson, 2008), four in particular are acknowledged in the leadership literature as having a useful contribution to make to discussion about nursing leadership. These are transactional, transformational, authentic and congruent leadership.

2.7.1 Transactional and Transformational Leadership

Thyer (2003) describes nurse leadership behaviours as transformational, particularly in their role as change agents, visionaries and advocates for their patients and their profession. Lett (2002) believes these behaviours align with the attributes of clinical leadership.

Burns (1978) first identified the concepts of transactional and transformational leadership. From the transactional view, leadership is based on an exchange (or transaction) where the follower expects rewards and support from the leader in return for effort and contribution. While the outcomes of the relationship can be good, the follower only contributes what is expected of them. From a

transformational view, leaders engage the full attention of the follower with a shared vision of the future and can move followers to exceed beyond expectations (Patrick, 2010). While transactional leadership can be effective, transformational leadership can elevate followers to perform beyond expectations (Bass & Riggio, 2006). Followers can then, in turn, be transformed into effective leaders, creating an empowering environment and inspiring others to achieve common goals (Bass & Avolio, 1990).

In his seminal work, Bass (1985) applied the concepts of transformational and transactional leadership to organisational behaviour. This theory formed the basis of the Multifactor Leadership Questionnaire (MLQ) that measures three leadership styles: Laissez- Faire, Transactional and Translational (Bass & Avolio 1995). The Laissez- Faire style is where the leader avoids making decisions and taking responsibility (Lievens & Vlerick, 2013).

Transactional leaders engage in transactions or exchanges with their employees by giving their subordinates rewards, such as a promotion, that are congruent with their performance (Avolio, Bass & Jung, 1999). Transformational leaders create a culture of leadership for all team members, nurturing empowerment, promoting individualism, open communication and inclusive decision-making (Davidson et al., 2006).

The features of the transformational leader are that they:

- Align people
- Are motivational and inspirational
- Establish direction and produce change
- An effective communicator, as well as being creative and innovative (Stanley, 2006b).

These features are congruent with clinical leadership behaviours and may explain how staff nurses can be effective leaders, who improve care, by enacting transformational leadership practices (Cook, 2001). A meta-analysis of leadership styles in nursing demonstrated that transformational leadership is positively related to productivity and effectiveness (Cummings et al., 2010). Bass &

Avolio's (1990) concepts of transactional and transformational leadership also link well with the leadership practices in Kouzes and Posner (1995) leadership model (consisting of challenging the process, inspiring a shared vision, modelling the way, enabling others to act and encouraging the heart).

2.7.2 Authentic leadership

“Leaders who are more authentic draw on their life experiences and psychological capacities, a sound moral perspective and a supporting organisational climate to produce greater self-awareness and self-regulated positive behaviours” (Wong & Laschinger, 2012, p. 948).

This then translates to their own and their followers' authenticity and development, resulting in genuine sustained performance. The authentic leader builds trust and healthier work environments through four key components:

- Balance processing - requesting input, both positive and negative, from followers before making important decisions
- Relational transparency - showing a level of openness and truthfulness that allows others to be forthcoming with their ideas
- Internalised moral perspective - sets and role models a high standard of ethical and moral conduct
- Self-awareness - by understanding their own strengths and limitations, and how these affect others (Wong & Laschinger 2012).
-

By performing these behaviours of authentic leadership, authentic leaders facilitate better quality relationships leading to active engagement of employees in workplace activities, which results in greater job satisfaction and higher productivity and performance (Avolio, Gardner, Walumbwa, Luthans & May, 2004).

2.7.3 Congruent Leadership

Stanley (2006b) identified that existing leadership theory did not explain why clinical leaders were identified or followed. He proposed the concept of congruent leadership. Congruent leadership is described as “where the values and beliefs match the leader's actions, deeds and involvement in care” (p.110). The concept

of being a congruent leader fits well with the attributes identified previously in this literature review if a nurse is to be a clinical leader who will be followed because their values and beliefs are matched by (congruent with) their actions.

The features of congruent leaders are as follows:

- Motivational and inspirational
- Approachable and open
- Actions based on and match values and beliefs, upheld principles
- Effective communicator
- Visible
- Empowered (Stanley, 2006b).

Indeed the clinician identified by their patients and colleagues as performing leadership functions may not in an organisational leadership role. Congruent leadership theory therefore sits well alongside the notion that all nurses must act as leaders. If nurses are seen to uphold nursing care principles at the point of care, by doing so they will be seen as leaders (Stanley, 2006b).

2.7.4 Emotional Intelligence (EI)

Emotional intelligence, discussed in nursing literature as a key attribute of exceptional leaders, is defined as how people handle themselves and their relationships (Goleman, Boyatziz & McKee 2002). EI consists of two sets of competencies: personal competence and social competence. In total there are 18 specific competencies that Goleman et al. (2002) describe in their model of EI. Thee competencies that reflect emotionally intelligent behaviour are as follows: Self awareness (emotional self-awareness, accurate self-assessment, self-confidence), self-management (emotional self-control, transparency, adaptability, achievement, initiative, optimism), social awareness (empathy, organisational awareness, service orientation) and relationship management (developing others, inspirational leadership, catalyst for change, influence, conflict management, teamwork and collaborations) (Goleman et al., 2002).

These competencies are congruent with clinical leadership behaviours. Brown & Moshavi (2005) have made links between EI behaviour and transformational

leadership practices, reporting that leaders with high EI report greater use of transformational leadership practices (as described by Kouzes and Posner, 2002). The result of these practices is the creation of more empowering work environments by EI leaders (Young Ritchie, Laschinger & Wong, 2009).

Leadership consists of opposing strengths, and most leaders have a natural tendency to over develop one at the expense of its counterpart (Kaplan, 2003). Taking one leadership approach to the extreme while giving its complement less attention leads to imbalance and ineffectiveness. The versatile, and therefore effective, leader can draw upon the virtuous aspects of each approach to suit the circumstances at hand. Below is a partial list of the virtues and vices associated with each of leadership's dominant dualities - forceful/enabling and strategic/operational (Kaplan, 2003). The advantage of this theory is that the clinical nurse leader can utilise different aspects of versatile leadership during interactions, and this can affect the outcome for the clinical leadership behaviour and the outcome for the patient.

The four leadership styles of transactional, transformational, authentic and congruent leadership are the most significant theories explored in research literature related to clinical nurse leadership. No single one of these theories on its own appears to be sufficient however Stanley (2006,b) questions the appropriateness of transformational leadership as a theory to support an understanding of clinical leadership. Transformational leaders are described as being able to set a direction and establish a vision, although visionary leadership was not identified as a characteristic sought after or identified in clinical leaders (Stanley, 2006b).

Kouzes and Posner's (1995) leadership model integrates both transformational and transactional leadership concepts within the five leadership practices (Patrick, 2010). Leaders tend to use the composite of all or most of Kouzes and Posner's five leadership practices rather than implement one practice at a time (Patrick, 2010). Authentic leadership theory purports to explain the underlying processes by which authentic leaders and followers influence work outcomes and

organisational performance, and has been linked with creating healthy work environments that support clinical leadership behaviours and staff retention (Shirey, 2006). Congruent leadership is a theory best suited for understanding clinical leadership because it defines leadership in terms of a match (congruence) between activities and actions of the leader and the leader's values, principles and beliefs (Stanley, 2005).

2.8 Empowerment

“Empowerment is an abstract concept that is fundamentally positive, referring to solutions rather than problems” (Kuokkanen & Leino-Kilpi, 2000, p.236). In the process of empowerment, individuals and organisations pursue maximal impact on their own life and eventual choices (Gibson, 1991; Kieffer 1984). Empowerment is associated with growth and development at all levels but ultimately is about people uniting to achieve common goals (Rodwell, 1996). Empowerment is an important concept in nursing for both nurses and their patients (Laschinger, Gilbert, Smith & Leslie, 2010). The core of this concept is that individuals have the power to accomplish their work in a meaningful way (Laschinger et al., 2010). This power is derived from working environments that enable employees to exercise personal agency to achieve work goals (Laschinger et al., 2010). In health care and promotion, empowerment refers to ensuring individuals have the resources necessary for maintaining their health and well being (Faulkner, 2001). Laschinger et al. (2010) suggest that it is an inherent part of the nurse manager's job to provide and maintain an environment that allows nurses to have the resources to be empowered. Similarly it can be said that a goal of nursing practice is to empower patients for optimal functioning and improved health outcomes. Laschinger et al. (2010) argue that nurses can promote patients' health by ensuring patient access to empowering conditions described by Kanter (1993) in the nurse/patient environment. Patient empowerment is thus conceptualised as “patient perceptions of access to information, support, resources and opportunities to learn and grow that enable them to optimise their health and gain a sense of meaningfulness, self-determination, competency and impact on their lives” (pg.5). What this means in practice, empowerment of nurses is

necessary if we are to create a health system in which patients are increasingly self-managing (NZ Ministry of Health, 2009)

2.9 Power

In healthcare, the concept of power may have negative connotations as health provision is often within a hierarchical system in which ‘management’ is seen to have all of the power. From a critical social theory perspective, however, power is not just a matter of coercion and domination, it is a dynamic concept; power is taken over and given away, power is shared (Kuokkanen & Leino-Kilpi, 2000). Kanter (1979) states that instead of being framed as coercion and domination, power can be seen as a means to efficacy and goal-orientation. In a nurse-patient relationship of shared power rather than imposed power, working in a partnership model with patients to achieve shared health goals means that power is used to enable rather than dominate. The key components that create this empowering environment are the creation of opportunities, effective information and support at all levels of the organisation. Power and the exercise of power merge within empowerment, however empowerment is not purely an outcome of power. There is a reciprocal character of a power relationship; employees have their own personal qualities, which tend to drive them to seek knowledge and power, and then to act in a meaningful way (Kuokkanen & Leino-Kilpi, 2000). The ability to create this sort of empowering environment is part of the competencies aligned with the concept of nurses who demonstrate clinical leadership behaviours.

2.10 Structural Empowerment

Kanter’s theory of organisational empowerment is the basis of the definition of structural empowerment. Rosabeth Kanter is a professor of business at the Harvard Business School. She wrote the seminal book ‘Men and women of the corporation’ (1977) which is regarded as a classic in management studies. There is substantial support for the theory of structural empowerment, which was first raised in this book, in nursing literature. Several nursing studies have made links between Kanter’s structural empowerment theory and positive nursing outcomes such as job autonomy (Sabiston & Laschinger, 1995), job satisfaction (Laschinger, 2001) and lower levels of burnout (Hatcher & Laschinger, 1996). Kanter identifies six structural organisational conditions conducive to workplace

empowerment (Faulkner & Laschinger, 2008). These are more significant to employees' attitudes and behaviours than the individuals' characteristics.

1. Access to information
2. Access to support
3. Access to resources
4. Learning opportunities
5. Formal power
6. Informal power (Kanter 1977).

“Employees who have access to these empowerment structures are more likely to be motivated and committed to the organisation” (Faulkner & Laschinger, 2008, p. 215). Employees who are less supported by these structures have lower ambitions and are less committed (Laschinger, 2004; Laschinger & Finegan, 2005).

Kanter's empowerment theory has been used to develop a theory of nurse/patient empowerment. Laschinger et al. (2010) proposed that empowering working conditions for nurses can lead to empowered patients and therefore better health outcomes. Empowering working conditions can increase feelings of psychological empowerment in nurses, resulting in greater use of patient empowerment strategies by nurses, and therefore greater patient empowerment (Laschinger et al., 2010).

There are strong similarities between the nurse behaviours when they feel structurally empowered and clinical leadership behaviours. Nurse's perception of the degree of empowerment they feel within their work environments influences their use of clinical leadership behaviours (Manojlovich, 2005).

2.11 Psychological Empowerment

Psychological empowerment is defined as the psychological state that employees must experience for empowerment interventions to be successful (Spreitzer, 1995). Conger and Kanungo (1988) defined psychological empowerment as the motivational concept of self-efficacy (one's belief in one's own ability to

achieve). However, Thomas and Velthouse (1990) theorised that empowerment is more complex and defined it more broadly as “increased intrinsic task motivation manifested in a set of four conditions reflecting an individual’s orientation to his or her work role; meaning, competence, self-determination and impact”. Spreitzer built on these prior theories to develop the PES, (Spreitzer, 1995, p. 1443). Laschinger et al. (2004) building on Spreitzer’s work identified the key components of psychological empowerment as being:

- Meaning: A congruence between an employee’s beliefs, values and behaviours, and job requirements
- Competence: Confidence in one’s job performance abilities
- Self-determination/Autonomy: feelings of control over one’s work
- Impact: A sense of being able to influence important outcomes within the organisation.

When people feel empowered at work, positive individual outcomes are likely to occur (Spreitzer, 2008). Researchers have linked psychological empowerment to a variety of outcomes including: organisational commitment, job satisfaction and less job strain (Laschinger et al., 2000; Laschinger, Finegan & Shamian, 2001).

There is a relationship between structural and psychological empowerment. Structural empowerment and psychological empowerment may seem quite similar, but they can be differentiated as psychological empowerment represents a reaction of employees to the structural empowerment conditions (Laschinger et al., 2004). This is important because psychological empowerment of the nurse can be effected by many factors including their culture and previous experiences. Organisations working to create an empowering environment must therefore acknowledge these elements and support nurses to feel personally able to engage and become empowered (Armstrong & Laschinger 2006). Management need to adapt structural empowerment approaches to match the psychological empowerment characteristics of the nursing staff (Armstrong & Laschinger, 2006).

2.12 Emergency Departments

In 2009, the New Zealand Government announced a new policy named the ‘Shorter Stays in ED’ target (Jones et al., 2012). This target required 95% of patients to be admitted, discharged or transferred from an ED within six hours (NZ MOH, 2009). The policy was aimed at improving the performance of the ED and of the hospital by initiating quality improvements across the whole hospital system.

While the introduction of the target has changed the way ED nurses need to work in an ever-changing health care system, a UK study exploring emergency nurses’ views on ED waiting time targets (the target time is four hours in the UK) found ED nurses felt the negative aspects of the target were surpassed by the perceived benefits of meeting the target (Mortimore & Cooper, 2007). The introduction of the target is an example of how system changes can mean nurses need new skills to support them into the future, as it is filled with increasing complexities (Pate, 2013).

There has been a study done on perceptions of empowerment among ED nurses. The study by DeVivo et al. (2013) was conducted across six EDs in the United States, focussed on RNs only (not nurse managers/educators) and utilised the Conditions of Work Effectiveness Questionnaire (CWEQ-II) (Laschinger et al., 2004). The study reported that it was the first to explore the structural empowerment of ED nurses, with participants reporting moderate levels of empowerment. DeVivo et al. (2013) found that this result was consistent with levels of empowerment reported in similar studies of staff nurses. They attributed this result to the many opportunities for staff nurse involvement in the hospitals within the reported health care system. However, they found that there is a need for further research among specialty nurses.

2.13 Rationale For Use Of Leadership Measurement Tools

The concept of clinical leadership as behaviours demonstrated by clinical nurses directly involved in patient care differs somewhat from the more traditional view of leadership as only the realm of nurses in formal leadership positions (Patrick, 2010). However, this new definition of nursing leadership forms the basis for

ongoing research aimed at identifying how clinical leadership practices by frontline nurses can be encouraged and supported by various levels of the hierarchy within a health organisation.

In order to do this research, it is necessary to find ways to measure these behaviours, as being able to accurately and consistently measure the concepts of interest is the basis of research (Schneider, Whitehead & Elliot, 2007). A nomological framework was developed by Patrick et al. (2011) to test the relationship between psychological empowerment, structural empowerment and clinical leadership behaviours of nurses.



Figure 1: The relationship between psychological empowerment, structural empowerment and clinical leadership behaviours

The previous review of psychological and structural empowerment showed there is an essential difference between them. Structural empowerment is the perception of the presence or absence of empowering conditions in the workplace; Psychological empowerment is an employee's psychological interpretation or reaction to these conditions (Laschinger et al., 2004). If the nurse is both structurally and psychologically empowered, one could hypothesize that the nurse is therefore empowered to demonstrate clinical leadership behaviours at the point of care. This may then translate into patient empowerment, thus positively effecting patient outcomes. A purpose of meaningful nursing practice is to empower patients for optimal functioning and better health (Laschinger, Gilbert, Smith & Leslie, 2010). Patient empowerment is conceptualised as "patient perceptions of access to information, support, resources and opportunities to learn and grow that enable them to optimise their health and gain a sense of meaningfulness, self-determination, competency and impact on their lives" (Laschinger et al., 2010, p.5).

This literature review has identified that a nurse needs to be psychologically empowered and structurally empowered to be able to perform clinical leadership behaviours. Gaps in the literature exist around nurses working in specialty areas such as Emergency Departments. There is also very little literature or research from New Zealand, the majority being from Canada, United States and United Kingdom.

The study will explore the gap, asking the question of whether staff nurses in AED perform clinical leadership behaviours, and whether they feel psychologically and structurally empowered to do so.

Chapter Three: Methodology

3.1 Overview

This chapter explains the study design. This includes an explanation of the clinical setting and the sample used. The methods of data collection are explained. Study measures such as the definition of leadership being used and the questionnaires will be defined.

3.2 Study Design

This research utilised a non-experimental descriptive design to measure the clinical leadership of Registered Nurses who provide direct patient care at Auckland City Hospital's (ACH) Adult Emergency Department (AED). An online questionnaire was used to survey the participants, comprising of three previously validated surveys on clinical leadership, psychological empowerment and structural empowerment. This was followed by free text questions relating to the factors that affect their clinical leadership behaviours.

The study is comprised of a mixed method approach. Quantitative research is the foundation of the research with qualitative methods used to provide complementary information (Schneider, Whitehead & Elliot, 2007). These methods were used concurrently. Qualitative open-ended questions followed the quantitative questionnaires in the online survey. The purpose of this was to provide methodological triangulation. Triangulation has the potential to offer wider scope and present more complete and comprehensive research (Schneider et al., 2007). In this research, qualitative data is used to enhance and explain the meaning of the quantitative results.

The survey questionnaire was used to obtain data from a large population. Analysis of that data can provide useful information, though may leave unanswered questions about context and a range of issues that could be further explored through words (Moule & Goodman, 2009). The researcher has the opportunity to gain wider and deeper understanding of the topic by adding the qualitative section.

The research used a cross-sectional design as the surveys measured data at one point in time.

Participants were formally invited by way of an email with information given through the participant information sheet (PIS). A suitable period was provided for participants to complete the survey; data collection was completed within a five week survey period. The aim of non-experimental design is to identify variables and then to explore relationships between these variables (Schneider et al., 2007).

The descriptive method involved an online questionnaire. The questionnaire was distributed to all Registered Nurses in the AED at ACH. The survey questions explored participant's knowledge, beliefs and attitudes towards clinical leadership by nurses. Three questionnaires were used to gather this information. These were the Clinical Leadership Inventory (CLI) (Patrick, 2010), Psychological Empowerment Scale (PES) (Spreitzer, 1995) and Conditions of Work Effectiveness Questionnaire-II (CWEQ-II) (Laschinger, Finegan, Shamian & Wilk, 2001). These questionnaires have been previously utilised in similar studies conducted in Canada. However, these surveys have not been widely used and/or published in the New Zealand setting. Therefore this research is experimental.

This leads into analysis of the three psychometric tools to be used to test the relationship between the variables of clinical leadership.

3.2.1 Conditions for Work Effectiveness Questionnaire-II (CWEQ-II)

This is a modification of the original Conditions of Work Effectiveness Questionnaire (Chandler, 1986), this tool has 19 items, 3 for each of Kanter's empowerment structures of; access to information, support, resources, learning opportunities, formal power and informal power (Kanter, 1977). These are rated on a 5-point likert scale.

Validation of the factor structure was shown by Laschinger, Finegan, Shamian & Wilk (2001), and this tool was found to have strong internal reliabilities and construct validity.

3.2.2 Psychological Empowerment Scale

Spreitzer (1995) developed the Psychological Empowerment Scale. Empowerment is expressed as increased intrinsic task motivation manifested in a set of four cognitions reflecting an individuals' orientation to his/her work role: meaning, competence/self-efficacy, self-determination and impact. Three questions are asked for each of the four items of empowerment.

3.2.3 Clinical Leadership Inventory

The Clinical Leadership Inventory (CLI) was developed by Patrick (2011) for her PhD study to measure the use of leadership practices of staff nurses providing direct patient care in an acute setting. This was adapted from Kouzes & Posner's (1995) management leadership practices to reflect clinical leadership practices of staff nurses. The CLI consists of 15 items to measure the 5 leadership practices, using a 5-point likert scale. A nomological conceptual framework model hypothesizes that nurse managers' leadership practices have a direct positive effect on staff nurses' clinical leadership behaviours as well as an indirect positive effect through workplace (structural) empowerment.

Kouzes and Posner (1995) designed the leadership practices inventory to measure what leaders do. They describe five fundamental leadership practices that enable leaders to be effective in organisations (Patrick, Laschinger, Wong & Finegan, 2011). The five behaviours identified were challenging the process, inspiring a shared vision, enabling others to act, modeling the way and encouraging the heart. Each practice is associated with observable behaviours that effective leaders use. These behaviours align with and reflect leadership behaviours of clinical nurses at the point of care.

These three tools will be the most effective in measuring clinical leadership at the point of care, and fit the nomological network. However, in nursing literature, it appears that the combination of these three tools has not been used before. There are a multitude of psychometric testing tools used in the nursing leadership literature to date, and these appear to be used in various arrangements to fit what the researcher is looking to measure. Most published results recommend

replication studies utilising the same or similar tools in the same or similar settings, to provide evidence for valuable contribution to nursing practice.

Demographic information was also gathered through a questionnaire. This individual data has been collected to enable exploration of any correlations between variables and the demographics of participants. Demographic information was also gathered in order to establish whether the survey population was representative of the New Zealand general RN nursing population.

The qualitative section of the survey asked participants to explain the answers they had given to the Likert questions. In particular, participants were asked to identify factors that support or inhibit their clinical leadership behaviours. They were also asked to identify clinical leadership behaviours they feel they demonstrate and behaviours they find difficult. This qualitative method has been used to enable understanding of the personal experiences, interpretations and constructs from the perspective of the research participants (Schneider et al., 2007).

3.2 Setting and Sample

The setting is an Adult Emergency Department in a large tertiary teaching hospital in central Auckland City. The AED sees and treats an average of 140 patients per day (ADHB, 2014). ADHB services a culturally diverse population with heart disease and cancer being the biggest health problems for the population (ADHB, 2014). ACH AED is also a major trauma centre. The nurses employed have a mix of skill and level of experience, from RN level 2 to senior RN level 4. A clinical charge nurse (CCN) coordinates every shift. There is a 1:6 nurse to patient ratio in the acute admission area, with an increase of 1:2 in the cardiac monitoring and resuscitation areas. While there are formal leadership positions such as the CCN, nurse specialists, nurse practitioner, nurse consultant, nurse educator and nurse manager, the area of interest for this research was the RN's who provide leadership at the point of care/bedside.

For this study, a convenience sample of 112 Registered Nurses (RN) who provide direct patient care in ACHs ED were invited to participate. This number represents the total number of RN employees in ACH AED. They might work any hours ranging from fulltime employment (FTE) to casually employed nurses. The Nurse Consultant provided this information about the number of staff, their hours of employment, as well as a list of email addresses for the survey to be sent too.

A convenience sample was utilised, as it was a way to invite the most readily accessible participants, who all work in the same department. As this research is focussed on one area of nursing, it was hoped that the respondents would be representative of the total invited population. A disadvantage of convenience sampling is self-selection, in that the respondents who chose to return their completed surveys were motivated to do so and the others were not. Some of the non-respondents may have been nurses on leave. Whatever the reason for non-response, the quality of data will not be as high as it would have been if non-participants had also responded (Schneider et al., 2007).

Demographic data was collected to identify the extent to which the respondent population matched the sample population.

3.4 Inclusion/Exclusion Criteria

All RNs who are employed by ACH AED were invited to participate in the study. By completing the survey, they indicated their willingness to be included. There were no other criteria.

3.5 Sample Size

All of the nurses who matched the sample criteria were invited to participate. The total number was 112 RN's. A response rate of at least fifty percent was hoped for as a fifty percent response rate is required to ensure representativeness of the sample (Moule & Goodman, 2009).

3.6 Sample Response Rate

A total of 37 completed surveys were returned out of 112, a response rate of 33 per cent. This is less than the suggested fifty per cent (Moule & Goodman, 2009).

The original sample was already a relatively small number, so this will negatively affect the generalisability of the sample. This is a limitation of the study.

3.7 Methods of Data Collection

The AED Nurse Consultant (NC) provided a list of RN email addresses. The NC then emailed a pre-written (submitted to ethics) email (Appendix B) to invite the nurses to participate, with the link to the Buzz survey. Participant Information Sheets were attached to the email (Appendix A). Buzz Channel is a modern online research company. The client is able to utilise tools to design and deliver user-friendly online surveys. The Nurse Consultant facilitated time for the nurses to complete their surveys before, after or during (as allowed) work time, as agreed by nursing management in the AED.

The Internet based surveys were accessed through hospital email accounts and the results were sent through the 'Buzz' survey link. Once the questionnaires were completed, the participant clicked on a submit button which delivers the responses to the 'Buzz' channel survey website. Buzz survey coded each returned survey with a response ID number, so that the identity of the respondent remains anonymous. Only the researcher, through a secure network, was able to access the 'Buzz' survey results.

3.8 Measures

The survey was comprised of three questionnaires. The CWEQ-II was used to measure structural empowerment, PES to measure psychological empowerment and the CLI to measure staff nurse clinical leadership (Appendices F, G, and H). The definition of leadership used in this study is "clinical leadership is registered nurse behaviours that provide direction and support to patients and the health care team in the delivery of patient care" (Patrick, Laschinger, Wong & Finegan, 2011, p. 450).

3.8.1 Condition for Work Effectiveness Questionnaire-II (CWEQ-II)

Structural empowerment of the work environment was measured using the CWEQ-II. This consists of 19 items, with items rated on a five point likert scale. Laschinger, Finegan, Shamian & Wilk (2001) validated the factor structure of these empowerment measures and a total empowerment score was created by

summing the six subscales of the CWEQ-II (Patrick, 2011). Cronbach alpha reliabilities from previous studies ranged from 0.72 to 0.82 (Patrick, 2011).

3.8.2 Psychological Empowerment

Spreitzer's (1995) 12-item Psychological Empowerment Scale was used to measure the four components of psychological empowerment construct: meaningful work, competence, autonomy, and impact. Each component is measured by three questions rated on a 5-point likert scale. The reliabilities of these subscales are high (between 0.85 and 0.91) (Laschinger et al., 2004). Spreitzer (1995) found evidence of convergent and divergent validity for these subscales in a study of managers and non-management personnel. Laschinger et al. (2000) further validated the proposed factor structure in a confirmatory factor analysis.

3.8.3 Clinical Leadership Inventory

The CLI was developed by Patrick (2011) to measure the use of leadership practices of staff nurses providing direct patient care in an acute setting.

Participants are asked to reflect on a range of leadership behaviours that they may use in their practice. There are 15 questions to be rated on a five-point likert scale. The Cronbach alpha reliability coefficient for CLI is 0.86.

A two-item global clinical leadership scale was added to serve as a reliability check. Respondents rated the extent to which they saw themselves as clinical leaders in their practice.

3.8.4 Qualitative questions

The qualitative questions were about the factors that the participants thought supported or inhibited their clinical leadership behaviours. The participants were also asked about clinical leadership behaviours that they felt they demonstrated and ones they found difficult. This qualitative section was the only part of the survey that involved open ended, free text answer options and the option to skip the answers. Open-ended questions enable participants to respond in their own words, and can be helpful when the researcher does not know all of the possible alternative responses (Schneider et al., 2007). Having unstructured response formats therefore allow a greater range of responses to be collected (Schneider et

al., 2007). During the design phase of the online survey, then qualitative section was intentionally designed so the participants could skip these questions if they wanted. This was due to the researchers' desire to want as many completed surveys as possible and the extra time and thought required to complete open ended questions was thought of as a potential deterrent. Questionnaires are most useful when there is a finite set of questions, and there is assurance of clarity and specificity of the items (Schneider et al., 2007). If questions are too long or complicated, respondents are less likely to complete them, this relates to 'respondent burden'

The factors relating to the lack of complete answers could be the time involved in formulating an answer, as extra thought can be required compared to ticking a box. Also respondents may not have understood the questions, as no further information was supplied other than the questions as shown. However there were no respondents that emailed or verbally asked for verification of the questions.

This was followed by a demographic questionnaire. This also gained data about previous leadership training and preceptorship experience.

3.9 Data Analysis

Data collected from the surveys was internally analysed by the 'Buzz' survey site. The results were formatted and exported into MS excel. From excel, the data was imported and further analysed using Statistical Package for the Social Sciences Programme (SPSS, version 22).

Demographic data was analysed using the 'Buzz' survey result charts and descriptive analysis statistics such as the mean, standard deviation and frequencies where appropriate.

The total scores for each of the three surveys were analysed using Pearson's correlation. Correlations are used to answer questions such as to what extent these variables are related to each other (Schneider et al., 2007). To prove or disprove the researchers' hypothesis, correlation coefficients were calculated. A zero coefficient means there is no relationship, a perfect positive correlation is +1 and a

perfect negative correlation is -1 (Schneider et al., 2007). Sig. (2-tailed) value is also used in the analysis. This value informs the researcher if there is a statistically significant correlation between the variables, that is when the value is less than or equal to .05 (Moule & Goodman, 2009). However, it is necessary to be cautious of the significance of the above statistical coefficients in smaller sample populations (Moule & Goodman, 2009).

Qualitative data was analysed by the researcher using ‘free form’ thematic analysis. Free form analysis can be described as coding data without following any specific instructions (Schneider et al., 2007). The line by line coding occurs by examining words to assess for their relevance to the overall research question, the codes are then put into logical groupings or categories. The final step is finding relationships through placing (gluing) the groupings into hierarchies, known as conceptual ordering (Schneider et al., 2007).

3.10 Ethical Considerations

Applications for ethical approval were submitted and UAHPEC ethics approval (011911) was obtained for this research (Appendix L), as well as approval from the ADHB research group and the AED research group (Appendices M and N).

The participants were asked to comment on work conditions. However responses were anonymous so that respondent confidentiality has be maintained. No responses are traceable to specific individuals. The buzz survey site only gives each completed survey a response ID number.

Chapter Four: Results

The aim of this chapter is to present the results of the surveys and report the statistical analyses of these results. The demographic data of the population of participants is presented, followed by the correlation coefficient analysis of the survey results. The results of the three surveys are presented and then comparing and combined. The qualitative results are then presented, with themes identified as well as the frequency of those themes.

4.1 Demographics of the Participants

The survey was sent to all 112 RNs employed in the AED. There were a total of 37 respondents to the survey. This is a 33% response rate. The results show the age range of respondents was between 20 – 60 years of age. The largest group of respondents were in the 40-45 year age group (29.7 %). The majority of respondents were female (95%). The majority of respondents identified as New Zealand European ethnicity (73%).

Table 1: Age of respondents

Options	N	% of Respondents
20-25	2	5.4 %
25-30	4	10.8 %
30-35	8	21.6 %
35-40	5	13.5 %
40-45	11	29.7 %
45-50	2	5.4 %
50-55	3	8.1 %
55-60	2	5.4 %
60+	0	0 %

In comparison, the average age of RNs in New Zealand in 2011 was 45 years (New Zealand Nursing Council, 2011) and in 2013 was 46.3 years of age (New Zealand Nursing Council, 2013).

Table 2: Gender of respondents

Options	N	% of Respondents
Male	2	5.4 %
Female	35	94.6 %

The gender of respondents was identified as 5% male with 95% female. New Zealand Nursing Council statistics show that, in 2011, 92% of all RNs were female, compared with 2013 where 94% were female.

Table 3: Ethnicity of respondents

Options	N	% of Respondents
NZ European	27	73 %
Maori	1	2.7 %
Pacific Peoples	2	5.4 %
Asian	2	5.4 %
Indian	1	2.7 %
Other	4	10.8 %

The majority of respondents identified as NZ European (73%). In both 2011 and 2013, 67% of all NZ RNs identified as NZ European (New Zealand Nursing Council, 2011; 2013). Respondents of Maori ethnicity made up only 3%. Pacific Peoples were represented at 5.4%. New Zealand Nursing Council statistics reveal that 7% of RNs in both 2011 and 2013 identified as Maori and 3-4% respectively identified as Pacific Peoples Ethnicity.

Table 4: What is your current employment status with regard to hours worked?

Options	N	% of Respondents
Full-time	23	62.2 %
Part-time	11	29.7 %
Casual	3	8.1 %

Almost two thirds (62%) of respondents work full time (1.0 FTE) (fulltime equivalent). The average amount of hours worked for RNs in acute DHB settings is 0.8 FTE (New Zealand Nursing Council, 2013).

Table 5: Part time hours

Options	N	% of Respondents
0.8 Fte- 0.9 Fte	1	9.1 %
0.5 Fte- 0.7 Fte	5	45.5 %
Less than 0.5Fte	5	45.5 %

Almost half of the respondents who work part time work less than 0.5Fte, which equates to 40 hours per fortnight, an average of 20 hours per week. 0.7Fte is 56 hours per fortnight, 0.8Fte is 64 hours per fortnight and 0.9Fte equates to 72 hours per fortnight. Half of the respondents, who work part time, work between 40-56 hours per fortnight.

Table 6: Length of time working in an Adult Emergency Department

Options	N	% of Respondents
0-1 years	1	2.7 %
1-2 years	2	5.4 %
2-3 years	6	16.2 %
3-4 years	8	21.6 %
4-5 years	6	16.2 %
5-10 years	6	16.2 %
10-15 years	3	8.1 %
15+ years	5	13.5 %

Over 20% of respondents have worked in the AED for 3-4 years. The least amount of respondents have worked there for less than 2 years. 13.5% have worked in the AED for over 15 years.

Table 7: Length of time working at ADHB

Options	N	% of Respondents
0-1 years	1	2.7 %
1-2 years	1	2.7 %
2-3 years	2	5.4 %
3-4 years	4	10.8 %
4-5 years	3	8.1 %
5-10 years	11	29.7 %
10-15 years	6	16.2 %
15+ years	9	24.3 %

The largest group (29.7%) of respondents have worked at ADHB for 5-10 years. This is followed by 24% having worked at ADHB for over 15 years.

Table 8: Level (according to the PDRP) RN working as

Options	N	% of Respondents
New Graduate	0	0 %
Level 1 RN	0	0 %
Level 2 RN	5	13.5 %
Level 3 RN	22	59.5 %
Level 4 RN	5	13.5 %
Clinical Charge Nurse	4	10.8 %
Nurse Specialist	1	2.7 %
Nurse Practitioner	0	0 %

Most (59.5%) respondents are level 3 RNs. There were even numbers of respondents are level 2 and level 4, both reported at 13.5%. Four charge nurses are represented in the survey (10%).

Table 9: Highest level of education qualification

Options	N	% of Respondents
Nursing Certificate	6	16.2 %
Bachelor Degree	10	27 %
Post-Graduate Certificate	9	24.3 %
Post-Graduate Diploma	8	21.6 %
Masters Degree in Nursing	2	5.4 %
Masters Degree in Other	2	5.4 %
PhD Nursing	0	0 %
Other (Please specify):	0	0 %

A third (27%) of the respondents report a Bachelor degree as their highest qualification. A further 24% of respondents report having also gained a Post-Graduate Certificate. A further 22% have also gained a Post-Graduate Diploma.

Table 10: Ways in which continue learning

Options	N	% of Respondents
Moodle (ADHB online learning)	35	94.6 %
Hospital in-service teaching sessions	33	89.2 %
Certificate Courses	12	32.4 %
University Study	9	24.3 %
Conferences	25	67.6 %
Workshops	16	43.2 %
Journal Subscriptions	6	16.2 %
Other (Please specify):	3	8.1 %

Respondents reported utilising multiple ways of furthering their learning. Almost all (95%) use ADHB online learning and in-service teaching sessions (90%). 67% of respondents attend conferences.

Table 11: Numbers who have been a preceptor to new RNs or student nurses

Options	N	% of Respondents
Yes	34	91.9 %
No	3	8.1 %

Almost all (92%) of respondents have been a preceptor.

Table 12: Numbers who have participated in a leadership training programme

Options	N	% of Respondents
Yes	10	27%
No	27	73 %

Over two-thirds (73%) of respondents have not participated in a leadership training programme.

4.2 Results of the three Survey Instruments

The respondents were asked to answer three survey instruments. These consisted of questions to be answered on a Likert scale. The following results table shows the mean and standard deviation of the three surveys.

Table 13: Results of the Psychological Empowerment Scale (PES), Conditions of Work Effectiveness Questionnaire-II (CWEQ) and Clinical Leadership Inventory (CLI)

Surveys	Mean	SD standard deviation
PES meaning	4.12	0.56
PES competence	4.29	0.52
PES self-determination	3.72	0.57
PES impact	3.55	0.53
PES total	15.68	1.33
PES total mean	3.92	0.33
CWEQ opportunity	3.92	0.66
CWEQ information	2.77	0.87
CWEQ support	2.61	0.85
CWEQ resources	2.41	0.65
CWEQ formal power	2.35	0.71
CWEQ informal power	3.21	0.53
CWEQ total	13.36	2.38
CWEQ total mean	2.23	0.40
Global empowerment mean	3.18	1.05
CLI challenging	12.22	1.75
CLI enabling	12.57	1.82
CLI inspiring	12.14	1.83
CLI modelling	12.95	1.84
CLI encouraging	10.97	2.40
CLI total	60.84	7.18
CLI total mean	12.17	1.44

The results of the surveys are presented below in a more descriptive manner, listed from the highest to lowest element of each survey, based on the mean value.

Table 14: Survey results

PES- Spreitzer	
1 Competence or self-efficacy	An individual's belief in his/her capability to perform activities with skill
2 Meaning	Value of a work goal or purpose, judged in relation to an individual's own ideals and standards
3 Self-determination	An individual's sense of having choice in initiating and regulating actions
4 Impact	Degree to which an individual can influence strategic, administrative, or operating outcomes at work
CWEQ-II- Laschinger	
1 Opportunity	Challenging work, gain new skills, tasks using own skills
2 Informal power.	Collaboration with doctors and the multi-disciplinary team.
3 Information	Current state of the hospital, values and goals of top management
4 Support	Feedback on things you do well, things you could improve and problem solving help
5 Resources	Time available for paperwork, time to accomplish job and gaining temporary help
6 Formal power	Rewards for innovation, flexibility and visibility
CLI- Patrick	
1 Modelling the way	Work to achieve goals, follow through on promises, commit to patient centred care
2 Enabling others to act	Develop cooperative relationships, establish therapeutic relationships, actively listen
3 Challenging the process	Engage in reflective practice, take risks, use evidence-based rationale
4 Inspiring a shared vision	Engaged communication, meaningful conversations, negotiate and support
5 Encouraging the heart	Celebrate colleagues achievements, acknowledge colleagues values, provide positive feedback

4.4 Global Clinical Leadership Scale

A two-item global clinical leadership scale was added to serve as a validity check. Respondents rated the extent to which they perceived themselves as leaders in clinical practice. Respondents scored above average on the global clinical leadership scale

Table 15: Overall I consider myself a clinical leader in my practice

Almost never	3
Occasionally	9
Some of the time	11
Most of the time	11
Almost always	3

Thirty percent of respondents consider themselves a clinical leader in practice some of the time and 30% most of the time.

Table 16: I demonstrate leader behaviours in my practice

Almost never	3
Occasionally	5
Some of the time	10
Most of the time	16
Almost always	3

Forty three percent of respondents reported they demonstrate leader behaviours in their practice most of the time. A total of over three quarters (78%) of respondents reported that they demonstrate leader behaviours some to all of the time.

The following table analyses the sums of the three surveys using correlation coefficient analysis.

Table 17: Correlation Coefficient Analysis

		PES total	CWEQ total	CLI total
PES total	Pearson Correlation	1	.131	.129
	Sig. (2-tailed)		.438	.445
	N	37	37	37
CWEQ total	Pearson Correlation	.131	1	.077
	Sig. (2-tailed)	.438		.653
	N	37	37	37
CLI total	Pearson Correlation	.129	.077	1
	Sig. (2-tailed)	.445	.653	
	N	37	37	37

PES- Psychological Empowerment Scale

CWEQ- Conditions of work effectiveness Questionnaire-II

CLI- Clinical Leadership Inventory

This table shows the correlation coefficient analysis of the sums of the three surveys, in order to show a relationship between them. As discussed earlier in methods, the Pearson correlation (r) can range from -1 to +1 (these values both showing a perfect negative and a perfect positive relationship). A Pearson r -value that is equal to zero shows no relationship.

The PES, CWEQ and CLI have similar Pearson r -values which are close to zero, indicating there is no statistical correlation: PES and CWEQ = 0.131; PES and CLI = 0.129; CWEQ and CLI = 0.077

The CWEQ and CLI have the closest relationship statistically, but this relationship is statistically insignificant.

4.5 Results of comparing and combining the surveys

The following analysis is testing the hypothesis that nurses need to be structurally empowered and psychologically empowered to demonstrate clinical leadership behaviours.

- 1) Respondents needed to score highly on the CWEQ-II to score highly on the CLI
- 2) Respondents needed to score highly on the PES to score highly on the CLI

Table 18: CWEQ-II vs. CLI

Group 1= those respondents with below median CLI total scores
Group 2 = those respondents with average median CLI scores

Group	N	Mean	CI	F	P
1	18	12.92	11.61 14.22	– 1.24	0.27
2	19	13.79	12.51 15.06	–	

The hypothesis is that Group 2 should have had a higher mean (CWE-II score) than Group 1; however the analysis shows that both the groups had a similar mean, which although marginally higher in Group 2 is not statistically significantly higher.

Table 19: PES vs. CLI

Group	N	Mean	CI	F	P
1	18	3.84	3.66 – 4.04	1.90	0.18
2	19	3.99	3.80 – 4.18		

The hypothesis is that Group 2 should have had a higher mean (PES score) than Group 1; however the analysis shows that both the groups had a similar mean. The above analysis demonstrates that the proposed hypothesis for the comparison of survey results is rejected. In fact, the null hypothesis, that is there is no relationship between psychological empowerment, structural empowerment and clinical leadership behaviour, is supported.

4.6 Qualitative Results

The four qualitative questions of the survey are shown below. The tables show the main themes identified from the data. These were then grouped using thematic analysis and the frequency of identified answers collated.

Table 20 Question7: What factors support your clinical leadership behaviours?

Themes identified	Frequency of themes
Team work, collaboration, communication	9
Coordinator role, orientating new staff, being a mentor	8
Supportive team	7
Confidence	6
Opportunity to lead, autonomy	4
Trust	4
Resources	3
Senior colleagues, more experienced staff	3
Respect	2
Multidisciplinary team approach	2

The main factors identified as supporting AED nurses to be clinical leaders are teamwork, collaboration and communication.

Table 21 Question 8: What factors inhibit your clinical leadership behaviours?

Themes identified	Frequency
Being too busy, time poor	11
Lack of teamwork	8
More experienced staff better suited to lead	7
Lack of knowledge	4
Lack of support	4
Low skill mix of staff	4

The main factors identified as inhibiting AED nurse's leadership behaviours are being too busy and time poor. This is followed by a lack of teamwork.

Table 22: Question 9: Which clinical leadership behaviours do you demonstrate?

Themes identified	Frequency
Communication skills	9
Support, being a mentor	6
Fair, Approachable	5
Time management, organisation	5
Assertiveness, Confidence	5
Knowledge	4
Awareness	4
Teamwork, collaboration	3
Role model	3

The leadership behaviour that AED nurses report they demonstrate the most are good communication skills, followed by being a good support and providing mentorship.

Table 23: Question10: Which clinical leadership behaviours do you find difficult?

Themes identified	Frequency of themes
Challenging others' practice	5
Lack of teamwork	4
Conflict	3
Lack of knowledge, skills	2
Difficulties with patients	2
Being patient	1
Lack of support	1

The clinical leadership behaviour that AED nurses find most difficult is to challenge others' practice.

Table 24: Response rate

Q7	25/37	68%
Q8	30/37	81%
Q9	25/37	68%
Q10	24/37	65%

The mean response rate was 70%.

The most answered (81%) qualitative question by respondents was Question 8: "What factors inhibit your clinical leadership behaviours?"

Chapter Five: Discussion

5.1 Overview

This chapter will present an integrated summary and discussion of the results. Study limitations along with recommendations for implications of the findings for nursing practice and nursing management will be summarised. The chapter will conclude with recommendations for future research.

5.2 Demographic Data

The sample population is representative of the New Zealand registered nursing population. The registered nurse (RN) workforce gender of New Zealand is overwhelmingly female (92%), with only 8% of nurses being male (Nursing Council of NZ, 2013). The workforce is also an ageing one, with 44% of nurses aged 50 years or older (Nursing Council of NZ, 2013). The average age of the nursing workforce is 46.3 years, with the average age of male nurses being 44.1 years and the average age of female nurses being 46.5 years (Nursing Council of NZ, 2013).

The population that was sampled in AED is reflective of the New Zealand nursing population. The majority (30%) of respondents were aged 40- 45 years (N=11). Ninety five percent of respondents were female (N=35), which is slightly more than the overall population. Five percent of respondents were male nurses, which is slightly lower than the overall average.

The largest single ethnic group in the New Zealand RN workforce is New Zealand European, with 67% of nurses identifying with this ethnic group (Nursing Council of NZ, 2013). Overall, 7% of nurses working in New Zealand identified as NZ Maori, and 4% with Pacific ethnic groups (Nursing Council of NZ, 2013). Seventy three percent of respondents identified as New Zealand European ethnicity (N=27), with 3% Maori and 5.4% Pacific Peoples represented. This is a higher representation of NZ European nurses than the NZ average. A lower percentage of Maori nurses were represented than the overall NZ nurse population.

An explanation of why Maori nurses may have been under-represented in this study is that only 6.5% of the total NZ Maori registered nurse population work in Emergency and Trauma, compared with 11% working in primary health care and 11% in community mental health (Nursing Council of NZ, 2013).

The participants consisted of a higher proportion of fulltime FTE nurses compared to the general population of nurses. Sixty two percent of AED nurses (N=23) work fulltime 1.0 FTE (80 hours per fortnight). This was 13% higher than the forty nine percent of the NZ RN population that work fulltime. The average number of hours worked by NZ RNs is 64 hours per fortnight (0.8 FTE) (Nursing Council of NZ, 2013).

Nationally, emergency and trauma practice areas show an average of 0.8 FTE employed nurses. One rationale for the higher response rate of full time nurses may be that they had more opportunity to complete the survey because they are at work more often. No research exploring why nurses in particular are more or less inclined to answer self-report survey questionnaires has been found. This is a potential area for future study.

There was good representation in this study of different levels (according to PDRP) of RNs. The majority of respondents are level 3 (60%) with even amounts of level 2 and level 4 RNs represented (13.5 % each). This meant that the theory underpinning this study, that every nurse is a leader and leadership behaviours can be demonstrated at all levels of practice, was able to be tested. This theory proposes that while leadership skills may be clearly necessary for those whose position gives them direct leadership responsibilities, even the most recently qualified nurses need the confidence and skills to be able to offer leadership to their patients, student nurses and other colleagues such as healthcare assistants (Middleton, 2011). In this study, a comparison of leadership activity was undertaken by looking at level of practice and answers to the overall global leadership scale (Laschinger, Finegan, Shamian & Wilk (2001).

The results of the three survey questionnaires will now be discussed and integrated with the literature.

5.3 Psychological Empowerment Scale (PES)- (Spreitzer 1995)

The highest scoring factor within the PES was identification of a belief by participants in the competence of their own practice. The factor participants showed the lowest confidence in was that their work had a positive impact on patient outcomes. In this section, participant reaction to each factor will be explored and the significance of this for practice will be discussed.

The following quote highlights and summarises the essential components that comprise psychologically empowerment: a sense of meaning, competence, self-determination, and impact.

'Having an underlying commitment to quality. Having an inner drive to do the very best I can do under sometimes difficult circumstances'

Participants scored highest in competence. Competence (or self-efficacy) is an individual's belief in his/her capability to perform activities with skill (Spreitzer, 1995). This result shows that AED nurses believe in their ability to do their job. They report self-assurance in their capabilities to perform their daily work activities and in having mastered the skills necessary for their job. These are extremely important beliefs to have in an acute environment such as the ED, as rapidly changing patient conditions and clinical situations require nurses to feel confident and proficient in their competence to perform their required skills and duties. Unlike other areas of the hospital, patients present to the ED with a wide range of diagnoses, illness severities and ages (Perry, 2013), therefore ED nurses need to be equipped with a wide knowledge and skill base which they are required to rapidly draw upon as new patients and situations arise.

Meaning was scored second highest. Meaning is the value of a work goal or purpose, judged in relation to an individual's own ideals and standards and moral judgement. By scoring this factor highly, AED nurses have expressed that the

work they do is important to them and that they find their job activities are personally meaningful.

Quotes from nurses when asked what clinical leadership skills she/he demonstrates revealed examples of psychological empowerment meaning:

'Self critique when things don't go as well as you had hoped and the ability to accept feedback when it's not necessarily positive. Flexibility around ever changing situations and the desire to bring about any change that will benefit the patient journey and provide a patient focused approach'

'Acknowledgement of a job well done gives you hope you are doing a good job'

These examples express a desire to do a good job and to implement the value and purpose of the nurses' ideals and standards of nursing care to benefit the patient. The nurses are alluding to finding their work personally meaningful by being able to positively influence their patients' journey and doing so adds value to their work.

Self-determination was scored third of the four factors. Self-determination is defined as 'an individual's sense of having choice in initiating and regulating actions. It reflects autonomy in the initiation and continuation of work behaviours and processes; examples are making decisions about work methods, pace, and effort' (Spreitzer, 1995, p.1443). The elements that make up this factor include nurses feeling that: they have significant autonomy in determining how they do their work; they can decide on their own how to go about doing their work, and; they have considerable opportunity for independence and freedom in how to do their job. In nursing, there is structure around how to do one's work. While policy and procedure manuals dictate a lot of the nursing tasks, the autonomy of how to go about these is an important factor in psychological empowerment. The fact that the AED nurses scored averagely on this factor may mean that there is limited

ability to initiate and regulate nursing activities in the ED, possibly because of the acute response nature of the environment. The following quotes reflect nurses' desire to have significant autonomy in determining how to do their work:

'Being given the opportunity to 'act up''

'The degree of autonomy accorded by the clinical charge nurse'

'A micro manager stifles all leadership potential, whereas other leaders trust in the ability of their nursing staff and allow them to step up into a leadership role, and develop this professionally'

The quotes show that the charge nurse, or the 'one in charge', can operate in a way which either supports or is contradictory to the concept that every nurse is a leader. These comments support the contention that a manager must allow staff nurses to feel psychologically empowered if they are to be able to demonstrate clinical leadership behaviours (Armstrong & Laschinger, 2006).

The lowest score on the Psychological Empowerment Scale was for impact. Impact is the degree to which an individual can influence strategic, administrative or operating outcomes at work. The elements that make up impact include having a great deal of control over what happens in the department and having a large impact and significant influence over what happens in the department. The fact that this was scored lowest could mean that the AED nurses feel that as staff nurses they have less impact on the overall operational running of the department than on their own direct clinical input.

In response to the question: 'What factors inhibit your clinical leadership behaviours?' one nurse said:

'Being a staff nurse, decisions are sometimes overridden by the clinical charge nurse'

Another said:

'I am only a level two. When others are more senior than me, I am less likely to try to lead'

While it is not certain that these statements mean that the people making them feel disempowered, Aiken, Havens & Sloane (2000) showed through Magnet hospital research that hospitals that support unit-based decision making are more likely to provide superior patient care. The quality of patient care is directly affected by the degree to which hospital nurses are active and empowered participants in making decisions about their patients' plan of care and by the degree to which they have an active voice and presence in organisational decision making (Armstrong & Laschinger, 2006). Perhaps AED nurses feel they have low impact in their department is due to the sheer size of the AED, and its' position within the larger organisation. Large institutions do lend themselves to the creation of an environment in which teams work in isolation. Silos, departmental turf issues and professional territoriality in health care systems must be removed to enhance patient safety and create organisational cultures in which staff are empowered (Armstrong & Laschinger, 2006). By ensuring all members of the health care team are empowered and respected advocates for patient safety, a culture of patient centered care and patient safety can flourish.

5.4 Conditions of Work Effectiveness Questionnaire-II- Laschinger, Finegan, Shamian & Wilk (2001)

The CWEQ-II, based on Kanter's (1977, 1993) structural theory of organisational empowerment, explores the extent to which structures within the work environment allow employees to achieve their work goals.

A structurally empowering environment is one that allows access to information, provides organisational support, opportunity to learn and grow, and access to the resources needed to do the job. Formal power comes from a job's visibility within the organisation and its overall importance to the organisation's goals. Informal power comes from the development of relationships within the organisation

(Patrick, 2011). Kanter (1977) suggests that employees who have a high degree of formal and informal power have better access to organisational structures of information, support, resources and opportunities.

This study found that nurses in AED report feeling they have high levels of informal power. They also rated highly their access to opportunity. This is congruent with Kanter's (1993) theory. Conversely, the AED nurses identified formal power as the lowest rating factor of structural empowerment. AED nurses may feel a greater sense of informal power within their department due to close working relationships with nursing colleagues, doctors and the multi-disciplinary teams. But in the overall hospital, feel they have very little formal power, meaning they feel disempowered on a wider scale within their organisation.

Too often, the position (formal) power of nurses is understood as being beneath that of healthcare organisations and doctors. Although nurses are often perceived as not having significant amounts of formal power, they are able to use their personal (informal) power to implement patient care (Paynton, 2009). Ironically, within healthcare organisations, formal power is often proportional to time spent separated from patients. Nurses spend considerable time assessing and caring for patients and therefore have a great deal of power relating to health outcomes for patients because they spend the greatest amount of time in direct contact with them.

Participants scored highest to lowest in the following elements:

- 1st -Opportunity – challenging work, gain new skills, tasks using own skills
- 2nd - Informal power- collaboration with doctors and the multi-disciplinary team, peers seek advice from one another.
- 3rd - Information- current state of the hospital, values and goals of top management
- 4th - Support- feedback on things you do well, things you could improve and problem solving help
- 5th - Resources- Time available for paperwork, time to accomplish job and gaining temporary help
- 6th - Formal power- rewards for innovation, flexibility and visibility

The AED nurses scored highest in opportunity, which indicates that their workplace provides challenging work but also the opportunity to learn and master new skills. This positive result ties in with the demographic data collected on ways AED nurses continue their education and learning. Ninety five percent of nurses surveyed said they participated in hospital wide online ‘Moodle’ learning modules, 89% participated in hospital in-service teaching sessions, while 67% of AED nurses attended conferences, that might be within or outside of the hospital. Allowances are made for paid study leave to attend these. These results show the nurses use a wide variety of modalities to continue their learning and education and this is congruent with the structural empowerment provision of opportunity.

The opportunity element of empowerment suits ED nurses, which is a skill related and challenging area by nature. Nurses responded to the question of what factors support your clinical leadership behaviours with the following quotes;

‘My experience, knowledge and confidence’

‘Working closely with the multi-disciplinary team, having trust and respect from colleagues and knowing my own skills and limitations’

‘Good skill and knowledge base, as well as a great supportive work team’

These quotes can be interpreted as AED nurses identifying that knowledge and good skills base are important factors, but that they also need to work with a supportive team. This means that although they are psychologically empowered (confident in their own ability), they must also gain structural empowerment through gaining informal power through team work. The qualitative data supports this theoretical hypothesis, although the quantitative data does not statistically support it. Further research with greater numbers of nurses will be recommended in the recommendation of future research section.

Access to informal power was rated highly by AED nurse respondents, showing they place importance in their work life on collaborating with the

multidisciplinary team (MDT). One nurse, when asked what factor supports their clinical leadership behaviour, said:

'Working with excellent communicators, workplace culture of collaboration, and acceptance of multi-disciplinary discussion of clinical challenges'

Informal power refers to the ability to develop effective relationships within the organisation. This is important because staff nurses report that effective relationships with patients and colleagues facilitate their ability to practice at higher levels of expertise (Roche, Morsi & Chandler, 2009) and clinical expertise is an essential attribute of clinical leadership behaviour (Davidson, Elliott & Daly, 2006).

The next four elements of the structural empowerment (CWEQ-II) scale were scored below average. Comments from the nurses support the contention that these areas need improvement for nurses to feel further empowered and better able to perform clinical leadership behaviours.

While information was ranked third highest, the comments highlighted AED nurses' feelings of disempowerment over lack of information;

'Unknown information relating to the wider hospital –that is relating to capacity planning, escalation plans- they contribute to disempowering local decisions made to assist in managing the clinical floor within AED'

'Lack of support from management'

'Lack of time to attend teaching to gain information'

These messages show nurses' desire for information and sufficient time to receive information. Management will need to act to improve these aspects if they are to acknowledge and implement a nurse empowerment strategy. Structural

Chapter5: Discussion
empowerment in terms of access to time, resources, information and support has been consistently associated with positive nurse outcomes such as satisfaction, productivity and autonomous clinical leadership behaviours (Patrick, 2010). In times of financial constraint in healthcare, organisations need to be aware of the need to protect this time to allow employees to be informed (Patrick, 2010).

Support was rated the second lowest factor. Comments such as the next quotes identified that this low rating had negative implications:

‘Lack of appreciation from management of how busy the department is’

‘Lack of support from management’;

‘Lack of opportunity from a micro-manager’

When management supports the empowerment of employees, the organisation benefits in terms of improved employee attitudes and increased organisational effectiveness (Kanter, 1993). In Upenieks’ (2003) qualitative study, the importance of a supportive organisational culture where the administration supports nursing’s role in the provision of patient care is shown.

AED nurses rated the resources element of structural empowerment as low. The most common theme in the qualitative data was the nurses were too busy to do much more than the basic level of care required by their patients and that this related to the lack of resources (staffing and other resource) provided by management:

‘No time, too busy, just try to get on with it and get the work done’

‘Time restrictions- just keeping head above water due to high acuity and throughput reduces ability to mentor’

'Too busy in department, colleagues not interested in anyone else's opinion'

'Insufficient time and necessary task-focussed nursing, causing some 'silo' behaviours'

These are summarised by:

'When there is not enough staff to help me achieve my goals for proper patient care'

The implications for management are serious when nurses feel they do not have adequate resource to properly care for their patients. Nurses report this inhibits their clinical leadership behaviours in the department. This is particularly important because efficient allocation of resources for nursing care has been linked with improved quality of care (Harrison & Coppola, 2007).

Formal power was rated the lowest scored factor of structural empowerment. Formal power can be obtained from jobs that allow for flexibility, creativity, and visibility in the organisation. Formal power is also derived from jobs that are considered important and relevant to accomplishing the goals of the organisation. (Kanter, 1977; 1993). Nurses represent the majority of healthcare workers and are in a unique position to demonstrate their clinical leadership behaviours in providing quality care for patients in their daily practice (Patrick, 2010). Therefore the work of nurses should be well aligned to higher levels of formal power. This is clearly not always the case. Kanter's (1977) contention that employees with higher positions within the organizational hierarchy have a perception of greater power and access to opportunity structures, supports the importance of nurse managers use of empowering work environments to promote staff nurse empowerment (Patrick, 2010). Staff nurses who perceived their nurse managers as strong leaders, also perceive their environments as empowering and as a result believe in their own ability to demonstrate clinical leadership behaviours (Manojlovich, 2005).

5.5 Clinical Leadership Index- Patrick (2010)

This scale, based on Kouzes and Posner's (1995) five leadership practices, revealed AED nurses rated modelling the way as the highest practice they valued, followed closely by enabling others to act. Challenging the process and inspiring a shared vision were rated similarly. Encouraging the heart was rated the lowest of the clinical leadership inventory scale practices.

1st – Modelling the way: work to achieve goals, follow through on promises, and commit to patient centered care

2nd- Enabling others to act: develop cooperative relationships, establish therapeutic relationships, and actively listen

3rd- Challenging the process: engage in reflective practice, take risks, and use evidence-based rationale

4th- Inspiring a shared vision: engaged communication, meaningful conversations, negotiate and support

5th- Encouraging the heart: celebrate colleague's achievements, acknowledge colleagues values, and provide positive feedback

Modelling the way is a visible leadership practice reflecting the core behaviours of setting an example, clarifying values, sustaining commitment and making a plan (Kouzes & Posner, 1995). Nurses who model the way aim to create shared values and achieve small wins. The clinical leadership attributes aligned to this are interpersonal understanding, collaboration and coordination. When staff nurses take the time to understand others' spoken and unspoken concerns and are able to perceive a situation from the patients' view they serve as role models for both patients and other healthcare team members (Cook & Leathard, 2004).

AED nurses showed they are committed to patient centred care as they try to work toward achievable goals, and attempt to follow through on promises and commitment to their patients (Patrick, 2010):

'Workplace culture of collaboration'

'Knowledge, collaboration and team work'

'Good role model, approachable and non-judgemental'

'Awareness of others'

Enabling others to act is a leadership practice that reflects the core behaviours of collaboration, building trusting relationships, sharing information and resources (Kouzes & Posner, 1995). Collaboration, effective communication and interpersonal understanding are clinical attributes consistent with the core behaviours of enabling others to act (Patrick et al., 2011). All dimensions of structural empowerment are positively related to enabling others to act clinical leadership practice (Patrick, 2011). This is consistent with research that suggests access to empowering work structures supports professional clinical practice (Laschinger, 2008), which includes interprofessional collaboration and participation in decisions, both of which are important staff nurse clinical leadership behaviours (Patrick et al., 2011):

'I try to be fair, approachable and have integrity'

'Collegial relationships'

'Trust and respect from colleagues'

While the above quotes are examples of factors that support clinical leadership behaviours and behaviours AED report to perform well, there were some quotes that identified factors that inhibit clinical leadership behaviours, examples of where nurses are not 'enabling others to act', and not working in a collaborative manner. The examples given all coincide with when the department is too busy:

'Team members not pulling their weight'

'A lack of cooperation'

These were common themes in the qualitative data.

Challenging the process is a leadership practice reflected by the core behaviours of seeking out opportunities for change, questioning the status quo, taking risks to improve the process and thinking creatively (Kouzes & Posner, 1995). Clinical expertise and interpersonal understanding are clinical attributes consistent with core behaviours of challenging the process (Patrick et al., 2011). Nurses who use this leadership behaviour would use their knowledge and expertise to critically reflect on outcomes. The result of this is perception by other members of the healthcare team that nurses are knowledgeable clinicians who demonstrate leadership in providing high quality patient care (Patrick et al., 2011). This is further demonstrated by staff nurses who engage in reflective practice so they gain an understanding of what went well and what did not go well; who take risks when concerned about patients' well being; and who provide evidence-based rationale for their clinical decisions (Patrick, 2010). Comments from AED staff nurse practice show these behaviours:

'Modelling interest in education and evidence based practice, modelling professional development',

'Self critique when things don't go as well as you had hoped and the ability to accept feedback when it's not necessarily positive'

'I am open to others, can guide less experienced nurses and can rationalise decisions with evidence based practice'

These are very positive affirmative comments that show AED nurses feel that they have autonomy and control over their practice, which allows them to challenge the process. Staff nurses who have freedom to make independent clinical decisions based on their knowledge and judgment may exceed standard nursing practice to achieve the best outcomes for patients (Kramer & Schmalenberg, 2004). A final comment that supports this is:

‘Considering rationale and questioning orders when appropriate, making decisions within my scope of practice’

Inspiring a shared vision is a leadership practice reflected in the core behaviours of positive communication, interpersonal competence and sharing a common purpose (Kouzes & Posner, 1995). Effective communication and collaboration are clinical leadership behaviours attributes consistent with inspiring a shared vision. When nurses communicate their assessment of a patient’s condition, convey this to the medical team and advocate for the patient, they may inspire a more comprehensive approach to patient care (Patrick et al., 2011). By rephrasing and clarifying information to patients and their families, nurses promote a greater understanding of their illness and the treatment options available which may inspire patients to aspire to better health through greater involvement in their own care (Patrick et al., 2011).

AED nurses, when asked what clinical leadership behaviours they demonstrate that support inspiring a shared vision, stated:

‘Good strong communication, able to take on new challenges and succeed at them, supporting my peers, as well as advocating for my patients and their families’,

‘Support and knowledge with the ability to remain calm’

‘Knowledge, collaboration, team work and able to direct (patients and other team members)’

Some AED nurses also reflected on clinical leadership behaviours they found difficult and the factors that inhibited their ability to perform the desired behaviours:

‘When you have difficult patients or ones that have no interest in their own care, it's hard to sometimes get plans and care in place for them’.

Lastly, encouraging the heart is a leadership practice that reflects the core behaviours of recognising contributions, providing feedback and celebrating accomplishments (Kouzes & Posner, 1995). Clinical leadership attributes consistent with the core behaviours of encouraging the heart practice are demonstrated by staff nurses who create supportive relationships using interpersonal understanding and collaboration with both patients and colleagues. Clear communication of positive feedback and recognising contributions reflect leadership at the clinical level (Patrick et al., 2011).

Encouraging the heart leadership practice has been identified as having the strongest relationship with staff nurse perception of structural empowerment (Patrick et al. 2011). This is consistent with Upeniek’s (2003) study of Magnet hospital nurse leaders attributing their success in creating empowered work environments to their level of support for nurses. However, this is the behaviour AED nurses scored lowest in. It is possible they are identifying that the management practices they experience they feel are insufficiently encouraging of the heart.

Patrick et al. (2011) found that encouraging the heart leadership practice had the strongest relationship with staff nurse perceptions of support in their work environment, consistent with other studies where Magnet nurse leaders attribute their success in creating empowered work environments to their level of support provided to their nursing staff (Armstrong & Laschinger, 2006).

The fact that AED nurses rated this the lowest practice in their experience may reflect feelings that there is little to no celebration of colleagues’ achievements, little acknowledgment of colleagues’ values and little to no provision of positive feedback. If this is the case, this is valuable feedback for management. Demonstrating ‘encouraging the heart’ to the nursing staff appears to be a relatively straightforward matter of staff encouragement and acknowledgement when due. Management may argue that they do give positive feedback and

acknowledge staff values and achievements by such means as local 'hero' awards, nurse of the year awards or a mention in the hospital bulletin, but this study shows that there is opportunity to improve in this important area. Staff nurses feel that more feedback and time with their nurse managers to discuss issues contributed to their perception on support, professional growth and improved practice (Rosengren, Athlin & Segesten, 2007).

Consistent and constructive structured feedback is important for nurses. Magnet hospital research supports the acknowledgment of nurses' values. Nurse managers must take steps to ensure they are effective communicators and acknowledge the concerns and needs of nurses and consistently demonstrate support for them (Armstrong & Laschinger, 2006).

5.6 Global Clinical Leadership Scale - Laschinger, Finegan, Shamian & Wilk (2001)

Over two thirds (68%) of AED nurses consider themselves a clinical leader in their practice some, most and all of the time. Respondents showed 30% practiced as a clinical leader some of the time, 30% most of the time and 8% all of the time. Over three quarters (78%) of AED nurses report demonstrating leadership behaviours in their practice some, most and all of the time. Respondents showed 27% showed these behaviours some of the time, 43% most of the time and 8% all of the time. Patrick (2010) found in their study that staff nurses reported that they use clinical leadership behaviours in their practice most of the time also.

This is an important finding because empowering work environments support staff nurses as clinical leaders, and when recognised nurses may have control over their work and provide the autonomy they need to practice beyond expectations (Laschinger, Finegan & Shamian, 2001). This suggests that staff nurses have integrated clinical leadership into their practice and are beginning to perceive their role as clinical leaders at the bedside (Patrick, 2010). The perception of one's professional self as a clinical leader is important for the professional practice of nurses at the bedside because nurses who view themselves as professionals with the ability to influence decisions that affect patient care are more effective (McGoldrick, Menschner & Pollock, 2001).

A staff nurse performing clinical leadership behaviours one hundred percent of the time does not mean, according to the definition being used in this study, that in practice they are always the visible leader. When a nurse is simply listening to their patient, they may actually be engaged in active listening and in doing so establishing therapeutic relationships with patients. In providing direct clinical care to a patient, the nurse may believe she/he is simply following orders from the charge nurse or from the procedure manual, however their analysis and synthesis of that knowledge means they are always making judgement calls on the validity of the patient of the practices they are performing and deciding whether or not to 'challenge the process'. This can be demonstrated by nurses who take risks when concerned about a patient's well being and can provide evidence-based rationale for their clinical decisions. It is important to acknowledge these behaviours as clinical leadership, as staff nurses have already integrated these practices into their daily work, and by doing so are providing continuous clinical leadership which ensures quality and safe care for patients (Patrick, 2010).

The majority of nurses surveyed said that they are leaders in their practice. Despite this, they reported low levels of organisational structures, such as support, resources and formal power, which empower nurses:

'Lack of teamwork'

'Low skill mix'

'Too busy'

'Lack of support from management'

'Non supportive peers'

'Lack of appreciation from management of how busy the department is'

'Lack of information regarding the wider hospital, this contributes toward disempowering local decisions'

A majority of AED nurses also reported that they demonstrate clinical leadership behaviours. They also revealed the clinical leadership behaviours that they found difficult, including:

'Directing others and challenging practice in colleagues that is less than a standard I would expect, especially those more senior than me'

'Dealing with conflict- with patients and with colleagues'

'Not being able to please everyone, and giving negative feedback'

5.7 Comparison to study by Patrick (2010)

The purpose of Patrick's (2010) study was to develop and test a model of staff nurse clinical leadership in order to increase understanding of how nurse managers' use of leadership practices create empowering work environments which enable clinical leadership behaviours of staff nurses (Patrick, 2010). This differs from this study in that nurse manager practices were not part of this research. However two of the three survey tools utilised by Patrick (2010) in surveying staff nurses were also used in this study as they focused on staff nurse need to be psychologically and structurally empowered to perform clinical leadership behaviours.

Patrick's (2010) study showed that staff nurses reported that they use clinical leader behaviours in their practice most of the time. In this study, staff nurses also reported that they demonstrate leader behaviours in practice most to all of the time (51%). This result may be indicative of a work force that inherently see themselves as competent leaders and provide competent care. This mirrors Magnet principles, in which organisations in which nurses are empowered to practice their profession optimally (with leadership behaviours) are organisations that optimise the provision of safe patient care conditions.

In the staff nurse empowerment scale (CWEQ-11), participants of both surveys scored in almost the same order. Opportunity was scored highest in both. This was followed by informal power then information in both studies. The only difference was in Patrick's (2010) study resources were scored fourth followed by support, whereas in this study participants scored support above resources. Formal power was scored lowest in both studies.

In the staff nurse clinical leadership behaviour (CLI) scale the results were also comparable. Both survey respondent groups scored modelling the way highest, followed by enabling others to act. Patrick's (2010) survey respondents then scored challenging the process and encouraging the heart equally, followed lastly by inspiring a shared vision. The AED nurse participants scored challenging the process, inspiring a shared vision then encouraging the heart in that order.

The results of Patrick's (2010) study were consistent with other research linking leader-empowering behaviours to staff nurses' workplace empowerment and provide evidence of the critical role of nursing leadership in positively influencing work environments (Greco, Laschinger & Wong, 2006). Patrick's (2010) study also provides initial support for the notion that structural empowerment could be one mechanism through which nurse managers' leadership practices have an impact on staff nurses' clinical leadership behaviours. The study is one of the first published pieces of literature to establish the link between empowering nurse work environments and staff nurse clinical leadership behaviours. Patrick's (2010) study has increased the understanding of the use of clinical leader behaviours by staff nurses and how these relate to workplace empowerment and nurse manager leadership practices, which has important implications for nursing administration and education. This study has added the element of psychological empowerment, and has shown similar outcomes, yet highlights the need for further examination of clinical leadership as it operates at clinical practice at the bedside.

5.8 Discussion of correlation coefficient analysis

Statistical analysis of the three surveys showed no strong relationship between them. This may be due to the low sample size. The CWEQ and CLI have the closest relationship statistically, from which a conclusion could be drawn that nurses who are structurally empowered in the AED are more likely to perform clinical leadership behaviours.

This was shown again in Table 17, where the survey results were analysed to look at their relationships. The CWEQ-II and the CLI had the most similar relationship.

5.9 Study Limitations

This was a cross-sectional study, which limits understanding of causality. The study variables of psychological and structural empowerment are complex constructs and it is uncertain as to whether testing these at one point in time will provide a firm view of the strength or direction of their relationship.

Method bias may also be a limitation in this study. Self survey and social desirability were minimised by ensuring the confidentiality of the survey respondents.

The computer based element of this survey may have been a limitation. Participants needed to have time to access a computer and needed to have a hospital email account. This is given to each nurse when they are employed and it is a general means of everyday communication for all staff. Participants needed to know how to access their email accounts in order to follow the survey link. A suggestion of the researcher was to do a test email to ensure all participants did in fact use and check their work email accounts.

Although the demographic results showed the population was representative of the registered nurse population of New Zealand, a 33% response rate may limit the generalisability of the findings.

Time may have also been a limitation. The approximate time needed to complete the survey was 15 minutes. This could have taken less or more time depending on several factors, but including how easily the participant understood the questions. The participants were given the opportunity to email the Nurse Consultant with any queries and questions they may have had. However, no participants did this (according to the NC). The workload of the department at the time the participants' completed their survey can be viewed as a limitation, and may have had a large impact on the response rate.

Mood and/or most recent experiences may affect participants' response to survey questions and lead to bias. Participants had five weeks to complete the survey, which may have reduced the above effect. However, the length of time the survey

was available to complete could also have been a bias, as too short or too long time period could have meant less urgency for completion and some nurses may have simply forgotten to complete it.

The use of these three survey tools in combination has not been widely undertaken; therefore the experimental use of these instruments may have been a limitation of the study.

5.10 Implications for Nursing Management

The study findings are important for nursing management within AED as they identify an ongoing need to ensure work environments for staff nurses that are empowering and supportive. Although not statistically proven in this study, the qualitative data shows that empowering work environments positively influence staff nurses' ability to perform clinical leadership behaviours while providing direct patient care (Patrick, 2010). This is consistent with research that shows that environments perceived as supporting professional practice were also considered empowering and that nurses who had access to empowering work structures were more likely to practice in an autonomous and collaborative manner (Faulkner & Laschinger, 2008; Manojlovich, 2005).

The study also provides encouragement for nursing management to recognise and promote clinical leadership at staff nurse level. Research has shown that staff nurses display many of the attributes of highly effective leaders, suggesting that that capacity to undertake leadership exists at many levels (Cook, 2001b). Nursing management need to be encouraged to recognise that leadership qualities exist at all levels as supporting this would further enhance patient care improvements (Cook, 2001b).

Given the evidence regarding the positive impact of empowerment on both patient outcomes and staff retention, nursing management would sensibly work to improve access to empowering structures. Kanter (1977; 1993) has shown that when organisations are structured to support the empowerment of employees, the organisation benefits in terms of improved employee attitudes and overall

organisational effectiveness. There is literature that links structural empowerment with relevant nursing outcomes such as autonomy, control over practice, positive multidisciplinary relationships, job satisfaction, trust in management and therefore a desire to stay with an organisation (Laschinger et al., 2001).

The provision of adequate resources is imperative for nurses to feel structurally empowered. Management must empower nurses through the provision of access to information, support, resources and opportunity to learn and grow in their work (Kanter, 1977). Access to resources refers to the necessary time and materials to get the job done effectively and efficiently (Faulkner & Laschinger, 2008). Management may address such practical issues as time allocated for nurses to complete necessary paperwork, time to accomplish job requirements and the ability to acquire temporary help when needed (DeVivo et al., 2013). This may be achieved through the utilisation of assist nurses during busy periods, allocation of fair workload, monitoring of skill mix, technological improvements for documentation, and adequate physical resource such as observation equipment to allow nurses to work efficiently. In a time of economic and budgetary constraint, healthcare organisations must protect and maintain these empowering work structures (Patrick, 2010).

5.11 Implications for Nursing Education

There are post-graduate courses that describe aspects of leadership theories and attributes, however clinical leadership behaviours are not generally assumed in the curriculum in under-graduate study programmes (Patrick, 2010). Leadership skills are integral to the nursing role and should similarly be embedded throughout pre-registration nurse education, rather than confined to a single dedicated programme of study (Watts & Gordon, 2012). This education and recognition would prepare newly graduated nurses to meet the challenges of clinical leadership in practice to ensure positive patient outcomes (Patrick, 2010). While the creation and implementation of post-graduate advanced roles such as nurse specialist and nurse practitioner have been associated with improved patient safety outcomes (American Association of College of Nurses, 2004), the development of these programmes promotes the notion that clinical leadership can only be demonstrated

Chapter5: Discussion
in advanced practice roles (Patrick, 2010). It makes more sense fiscally and functionally to support the clinical leadership of all staff nurses providing direct patient care, at all levels of practice, and across all shifts, to improve outcomes for all patients (Patrick, 2010).

5.12 Recommendations for further research

This study has provided an examination of the clinical leadership behaviours of staff nurses working in an adult Emergency Department in New Zealand. It has also provided a contribution toward the study of nurses' feelings about structural and psychological empowerment from the point of view of nurses working in an AED in New Zealand. The survey tools could usefully be administered to nurses working in different areas such as long-term care or critical care environments.

An under-studied area of nursing leadership literature identified in this study is exploration of the ethnicity and country of training of nurses to assess whether these factors makes them less likely to feel empowered. Nurses from particular countries, cultural beliefs and religions may react/act differently to structural and psychological behaviours and may be more or less likely to perform clinical leadership behaviours (Suliman, 2009).

The area of psychometric testing and why nurses are more or less likely to answer self-report surveys and the reasons for this is also a gap in the literature that this study has identified. Larger scale research on ED nurse participants could be implemented to add statistically meaningful data to further support the qualitative findings from this study.

5.13 Conclusion

This research portfolio highlights the need for further research on the phenomenon of clinical leadership at the point of care (Patrick, 2010). The overall results, albeit not statistically meaningful, showed that staff nurses feel they perform clinical leadership behaviours, and that structural and psychological empowerment have an impact on their ability to act as clinical leaders.

Appendix A: Participant Information Sheet

THE PROJECT TITLE:

Clinical Leadership of Registered Nurses at the point of care in the Emergency Department

You are invited to take part in a study on clinical leadership. Your participation is voluntary.

This Participant Information Sheet will help you decide if you would like to take part. It explains why we are doing the study, what your participation would involve, what the benefits and risks to you might be, and what will happen after the study ends. The study will be carried out over a period in June-July 2014. We expect the questionnaires will take approximately fifteen minutes to complete.

Principal Investigator: Megan Connolly, enrolled in the Master's Degree in Nursing programme through the School of Nursing, University of Auckland. Megan is currently employed as a Clinical Charge Nurse, Admission Planning Unit, Auckland City Hospital, Auckland District Health Board (ADHB).

If you have any questions feel free to contact Megan on 09 3074949 ext. 24210 or her supervisors Dr Stephen Jacobs on 09 9233975 and Karyn Scott on 09 9234206.

Explanation of the research study

The purpose of this study is to look at Clinical Leadership behaviours of registered nurses working in Auckland City Hospital (ACH) Adult Emergency Department (AED).

You have been invited to participate in this study because you are a registered nurse who is employed by ADHB AED, working full-time, part-time or on a casual basis.

Participation in this research study is entirely voluntary (your choice). You do not have to take part in this study. There will be no negative impact on your employment, or your relationship with management, regardless of whether you decide to participate in this study or not. Your consent is assumed if you complete the survey and click the send button. As the survey is an online survey, your anonymity will be protected, as the researcher will not be able to identify who has agreed to participate in the study and who has declined the invitation.

As a participant in this research study you will be asked to complete a confidential demographic questionnaire and answer the three questionnaires. This will take approximately fifteen minutes. Consent is assumed by participants completing questionnaire and pressing the send button. Participants have the right to withdraw by not submitting the questionnaire.

Your name will not appear in any reports or subsequent publications, and your responses will not be identifiable. There is no financial cost associated with participation.

There are no anticipated physical or psychological risks involved in this. However, the Employee Assistance Programme (EAP) is available at ADHB if you wish to seek independent assistance (0800 327 6699).

This study will provide nursing management with valuable information that will assist them to look at solutions to better support nurses and strengthen the workplace environment.

As a participant you will likely benefit by enhancing your critical thinking of clinical leadership behaviours. It is expected that the study will improve the care provided to patients by providing information to management that will assist them to better empower nurses. Your participation in this study will have a direct effect on this.

Data storage and destruction

All printed data related to the study will be locked up in a filing cabinet at the University of Auckland for a period of six years. After this time they will be destroyed in a secure manner. No material that could personally identify you will be used in any reports on this study. Study data will be kept on a password protected computer at the University of Auckland. Electronic information that could identify you will be destroyed after six years.

At end of the study, the findings will be disseminated to all staff in AED.

Funding

No funding has been sought at the present time for this research project.

Contact Details

The contact information for my research supervisor is:

Dr Stephen Jacobs - 09-923 3975, or email s.jacobs@auckland.ac.nz

The contact information for Judy Kilpatrick, the Head of the School of Nursing at the University of Auckland, is: 09-373 7599 ext. 82897, or email: j.kilpatrick@auckland.ac.nz

For any queries regarding ethical concerns you may contact the Chair, The University of Auckland Human Participants Ethics Committee, The University of Auckland, Office of the Vice Chancellor, Private Bag 92019, Auckland 1142. Telephone 09 373-7599 ext. 83711.”

Appendix B: Nurses' invitation letter



Dear Nurses

This is an email to invite you to participate in a study on clinical leadership.

This study is being conducted by Megan Connolly, Clinical Charge Nurse, Admission Planning Unit as part of her Masters Degree fulfilment.

Please take the time to read the attached Participant Information Sheet.

The survey is online and will take approximately fifteen minutes to complete

Simply click on the below link

<http://tiny.cc/aednursing>

Thank you in advance for your time

Kind Regards
Karen Schimanski
Nurse Consultant
Adult Emergency Department
Auckland City Hospital

Appendix C: Approval to use the Work Empowerment Scale



NURSING WORK EMPOWERMENT SCALE

I request permission to copy the Nursing Work Empowerment Scale as developed by Dr. G. Chandler and Dr. Heather K. Spence Laschinger. Upon completion of the research, I will provide Dr. Laschinger with a brief summary of the results, including information related to the use of the Nursing Work Empowerment Scale used in my study.

Questionnaires Requested:

Conditions of Work Effectiveness-I (includes JAS and ORS):

Conditions of Work Effectiveness-II (includes JAS-II and ORS-II): Yes

Job Activity Scale (JAS) only:

Organizational Relationship Scale (ORS) only:

Organizational Development Opinionnaire or Manager Activity Scale:

Other Instruments:

Please complete the following information:

Date: 26 FEBRUARY 2014

Name: Megan Connolly

Title: CLINICAL LEADERSHIP BY REGISTERED NURSES AT THE POINT OF CARE IN THE EMERGENCY DEPARTMENT

University/Organization: University of Auckland

School of Nursing

Address: The School of Nursing

Faculty of Medical and Health Sciences

The University of Auckland

Private Bag 92019, Auckland Mail Centre 1142, New Zealand

Phone: 0064 21 377211

E-mail: megancon@xtra.co.nz

Appendix D: Approval from Gretchen Spreitzer

From: Gretchen Spreitzer <spreitze@umich.edu>
To: Megan Connolly <megancon@xtra.co.nz>
Sent: Wednesday, 26 February 2014 2:13 AM
Subject: Re: Permission to use Psychological Empowerment Scale

Hello Megan, what interesting work you are doing! Yes, you have my permission to use the instrument in your research. Please share your findings so that I can learn from you. Best wishes!

Appendix E: Approval from Allison Patrick

February 24, 2014

Megan Connolly
Clinical Charge Nurse, Acute Admissions Unit,
Auckland City Hospital,
Auckland, New Zealand
megancon@xtra.co.nz

Dear Megan,

Thank you for your interest to use the Clinical Leadership Survey (CLI) in your proposal. I am giving you permission to reproduce the instrument as outlined in your request.

I would like to request you share your thesis electronically with me when you have completed your studies.

Best wishes for your success.

Allison Patrick, RN, PhD
apatrick@cnomail.org

Appendix F: Psychological Empowerment Scale (PES)

Listed below are a number of self-orientations that people may have with regard to their work role. Using the scale please indicate the extent to which you agree or disagree that each one describes your self-orientation.

Strongly disagree

Disagree

Neutral

Agree

Strongly agree

1. I am confident about my ability to do my job.
2. The work that I do is important to me.
3. I have significant autonomy in determining how I do my job.
4. My impact on what happens in my team is large.
5. My job activities are personally meaningful to me.
6. I have a great deal of control over what happens in my team
7. I can decide on my own how to go about doing my own work.
8. I have considerable opportunity for independence and freedom in how I do my job.
9. I have mastered the skills necessary for my job.
10. The work I do is meaningful to me.
11. I have significant influence over what happens in my team.
12. I am self-assured about my capabilities to perform my work activities.

Appendix G: Conditions of Work Effectiveness Questionnaire-II

These general questions help us understand more about you and your organization. To what extent is each of the following present in your current job? Indicate your choice by choosing one of the options in the scale below each question.

Almost never

Occasionally

Sometimes

Most of the time

Almost always

1. Opportunity for challenging work.
2. The chance to gain new skills and knowledge on the job.
3. Tasks that use all of your own skills and knowledge.
4. Information about the current state of the hospital.
5. Information regarding the values of top management.
6. Information regarding the goals of top management.
7. Specific information about things you do well.
8. Specific comments about things you could improve.
9. Helpful hints or problem solving advice.
10. Time available to do necessary paperwork.
11. Time available to accomplish job requirements.
12. Acquiring temporary help when needed.
13. Rewards for innovation on the job.
14. Amount of flexibility in my job.

15. Amount of visibility of my work related activities within the hospital.
16. Collaborating on patient care with physicians.
17. Being sought out by peers for help with problems.
18. Being sought out by managers for help with problems.
19. Collaborating with other health care professionals such as Physiotherapists, Occupational Therapists, Dieticians.

Appendix H: Clinical Leadership Inventory

In your role as a staff nurse providing direct patient care, you are being asked to reflect on a wide range of leadership behaviours that you may use in your practice. Look at the rating scale and decide how frequently you engage in the behaviour described.

Almost never

Occasionally

Some of the time

Most of the time

Almost Always

1. When I am concerned about the patient's wellbeing, I take risks by questioning orders and/or treatments.
2. I am able to provide evidence-based rationale for my clinical decisions.
3. I engage in reflective practice and try to understand what went well and what did not go well.
4. I negotiate with and support members of the inter-professional healthcare team to help patients achieve their goals.
5. I am enthusiastic and engaged when communicating with patients to achieve patient-centered goals.
6. I engage in meaningful conversations with colleagues to foster our ability to provide patient-centered care.
7. I actively listen to colleagues' diverse points of view.
8. I establish therapeutic relationships with patients and their families that are based on trust.
9. I develop co-operative relationships with my peers and colleagues.
10. I do my best to follow through on the promises and commitments that I make to patients.
11. I try to ensure we work towards achievable goals, make concrete plans and establish measureable objectives in achieving clinical patient outcomes.

12. I am committed to patient centered care.
13. I publicly acknowledge my colleagues who exemplify commitment to professional values.
14. I provide positive feedback to colleagues when their actions contribute to the wellbeing of patients and families.
15. I find ways to celebrate colleagues' accomplishments.

Appendix I: Global Clinical Leadership Scale

Please rate the extent to which you agree or disagree with the two statements

Almost never

Occasionally

Some of the time

Most of the time

Almost always

1. Overall, I consider myself a clinical leader in my practice
2. I demonstrate leader behaviours in my practice

Appendix J: Qualitative Questionnaire

Please explain your answers above:

(free text)

What factors support your clinical leadership behaviours?

What factors inhibit your clinical leadership behaviours?

Which clinical leadership behaviours do you demonstrate?

Which clinical leadership behaviours do you find difficult?

Appendix K: Participant Demographic Questionnaire

The information requested about you is to help describe who the participants are in the study and is for research purposes only. The information collected will not be used to identify you, and will be presented as a summary of the participants involved in the study.

Give options

1. Age in years – age brackets of 5 year increments 20-25, 25-30, 35-40, 40-45, 45-50, 50-55, 55-60, 60+
2. Gender
3. Ethnicity
4. Highest level of education qualification
 - Nursing Certificate
 - Bachelor Degree
 - Post-Graduate Certificate
 - Post-Graduate Diploma
 - Masters Degree in Nursing
 - Masters Degree in other
 - PhD Nursing
 - Other
5. How long have you been working as a Registered Nurse- increments 0-5 years, 5-10 years, 10-15, 15-20, 20-25, 25+
6. How long have you been working in the Adult Emergency Department- increments 0-1 years, 1-2 , 2-3, 3-4, 4-5, 5-10, 10-15, 15+
7. How long have you worked at the ADHB- same increments as above
8. What is your current employment status with regard to hours worked
 - Full time
 - Part time
 - Casual
9. What level (according to the PDRP) RN are you working as
 - New Graduate
 - Level 1 RN
 - Level 2 RN
 - Level 3 RN
 - Level 4 RN
 - Clinical Charge Nurse/Nurse Specialist/Nurse Practitioner
10. Have you been a preceptor to new RNs or student nurses
 - Yes
 - No
11. How do you continue your learning
 - Moodle (ADHB online teaching)
 - Hospital in-service teaching sessions
 - Certificate Courses
 - University Study
 - Conferences

Workshops
Journal subscriptions
Other- please specify

12. Have you ever participated in a leadership training programme

Yes
No

Appendix L: Ethics Approval

Office of the Vice-Chancellor

Finance, Ethics and Compliance

UNIVERSITY OF AUCKLAND HUMAN PARTICIPANTS ETHICS COMMITTEE (UAHPEC)

14-May-2014

MEMORANDUM TO:

Dr Stephen Jacobs Nursing

Re: Application for Ethics Approval (Our Ref. 011911): Approved with comment The Committee considered your application for ethics approval for your project entitled **Clinical**

Leadership by Registered Nurses at the point of care in the Emergency Department. Ethics approval was given for a period of three years with the following comment(s): 1. Please provide a signed support letter from the ADHB when available. The expiry date for this approval is 14-May-2017.

If the project changes significantly you are required to resubmit a new application to UAHPEC for further consideration.

In order that an up-to-date record can be maintained, you are requested to notify UAHPEC once your project is completed.

The Chair and the members of UAHPEC would be happy to discuss general matters relating to ethics approvals if you wish to do so. Contact should be made through the UAHPEC Ethics Administrators at ro- ethics@auckland.ac.nz in the first instance.

All communication with the UAHPEC regarding this application should include this reference number: **011911**.

(This is a computer generated letter. No signature required.)

Secretary University of Auckland Human Participants Ethics Committee

c.c. Head of Department / School, Nursing Ms Megan Connolly Ms Karyn Scott

Woodnorth Manager, Research ADHB

c.c. Karyn Scott, Anil Nair, Jo Mack

Appendix N: AED Approval



Adult Emergency Department

Phone: (09) 307 4949

Phone Internal: 24293

Address: Level 2 Main Building
Auckland City Hospital

Postal Address: Private Bag 92-024
Auckland

Email: PeterJ@adhb.govt.nz

7th April 2014

Dear Megan

**Re: Clinical Leadership by Registered Nurses in the Adult
Emergency Department**

The Auckland Emergency Research Group (AERG) would like to thank you for the opportunity to review your study in Clinical Leadership. We would like to inform you that we have given approval for your research project to be conducted within the Auckland Adult Emergency Department (AED) subject to approval from the following 2 committees:

- Auckland DHB Research Review Committee
- UAHPEC

We look forward to supporting you with your research

Yours sincerely

Dr Peter Jones
Chairperson
Auckland Emergency Research Group.

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