STAFF NURSE PERCEPTIONS ON THE INFLUENCE OF A FORMAL LEADERSHIP DEVELOPMENT PROGRAM ON THEIR FIRST-LINE NURSE LEADERS

by

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Abstract

Aim: To build on previous British Columbia Nursing Leadership Institute (BC NLI) evaluative research by analyzing the perceptions of staff nurses and identifying whether they have seen any behavior differences in their first-line leaders during the one year period following their leaders' participation in a formal leadership development program.

Background: The healthcare system is absorbed with many demands and complexities that are challenging every aspect of the system. To be able to shift away from the current path, the system requires committed and effective nurse leaders that play a fundamental role in healthcare and its necessary system transformations. To assist nurses to become effective leaders it is essential that organizations recognize the role of structured leadership development education, such as the BC NLI, in shaping nurse leaders who have the potential to impact patient, workplace, staff, and organization outcomes. The BC NLI is a collaborative initiative designed to support first-line nurse leaders by employing an empowerment framework.

Methods: Staff nurses working with first-line nurse leaders who attended the BC NLI between 2008–2009 were included in one of ten focus group sessions that took place one year after their leaders took part in the institute. A qualitative approach of inductive thematic analysis was utilized to conduct a secondary analysis of the staff focus group data and derive code categories and themes.

Results: The BC NLI focus group participants showed support for their first-line leaders. They recognized that leaders face many organizational challenges, possess transformational and transactional qualities, and play a key role in the workplace environment. The importance of organizational support and formal leadership development education were identified as key parts

of the leaders' leadership development. Participants reinforced their support for leadership development education, such as the BC NLI, by attributing their leaders' growth to their participation in the programme. However, some BC NLI focus group participants also expressed their hesitation regarding the possibility of external factors, such as prior experience, having possible influence on leadership development.

Conclusion: This study provides evidence that formal leadership development, such as the BC NLI, is vital for the development of first-line nurse leaders.

Preface

This thesis is part of a larger Canadian Health Services Research Foundation (RC2-1612) funded study of the British Columbia Nursing Leadership Institute with support from the British Columbia Ministry of Health Nursing Directorate, the Chief Nursing Officers of BC, as well as the Vancouver Coastal Health Authority and Fraser Health Authority. Ethics permission was obtained from the University of British Columbia Behavioural Research Ethics Board (approval # H07-01559) as well as the necessary regional ethics review boards from across the province of BC that represented the first-line nurse leaders and staff focus group participants. In conducting this thesis I was responsible for the evaluation of the staff focus group data component of the study.

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CHAPTER 1: Introduction

Background

Ongoing changes in healthcare have resulted in many challenges for nurses and nursing leaders. Widespread health care reforms of the 1990s, the increasing age of nurses, and present healthcare complexities have been recognized as some of the major stressors that have brought about tensions and deteriorating conditions in the healthcare sector (Laschinger & Wong, 2010). This has in turn led to vast nursing staff and nurse leader shortages and put pressure on all aspects of healthcare delivery and nursing practice (Canadian Nursing Advisory Committee [CNAC], 2002; O'Brien-Pallas et al., 2004; Laschinger & Wong, 2010; Villeneuve & MacDonald, 2006).

First-line nurse leaders, in all areas of healthcare, have influence over practice environments and ultimately nurse job satisfaction, organizational commitment, and intent to stay. The main role of the first-line nurse leader is to carry out the vision and mission of the organization while providing an important link between management and the workers. As described by Porter-O'Grady and Malloch (2011), the first-line leader role "defines the location that represents the interface between the structural and process dynamics of the system and the functional and action dynamics of those who do its core work" (p. 124). The first-line nurse leader differs from the second-line leader in that the former manages other workers and the latter manages other managers (Argyle, 1998).

As first-line nurse leaders are situated at a key linking point within the institution they must possess the skills to engage and motivate others while at the same time deal with the

complexities of the job, cultivate peer relationships, and meet the needs of the staff and organization. Investment in creating effective leaders, therefore, is an important organizational retention strategy. Numerous studies, which will be elaborated on in Chapter 2, confirm this vital role of nurse leaders by identifying the impact of effective leadership. At the unit level, Laschinger, Finegan, and Wilk (2009a) have shown that nursing leadership has an important role in creating and sustaining optimal practice environments, which in turn have a positive effect on nurses' organizational commitment. In their systematic review, Wagner et al. (2010) concluded that there is substantial evidence that shows the importance of leaders being able to create an optimal workplace environment for nurses, as such an environment leads to positive attitudes and behaviors and can also contribute to greater staff nurse job satisfaction, organizational commitment, and retention. Further support is provided by Laschinger and Leiter (2006), as they found nursing leadership to be the most essential variable in the relationship between worklife factors and nurse burnout. Their research identified that the leaders' direct influence on the presence of sufficient staffing levels, nurse/physician cooperation and teamwork, and participation in policy development was particularly important with respect to nurse burnout and nurses' perceptions of adverse events or patient quality and safety. Based on this evidence, first-line nurse leaders need to be recognized for their integral role in guiding practice, ensuring the availability of adequate resources, influencing the workplace environment, and shaping staff nurse satisfaction and organizational commitment.

Nurse leaders have great impact on the workplace environment and the well-being of the nursing workforce; however, nursing leadership has also been linked to quality of patient care. Although this association is shown to be present primarily through indirect links, the available studies continue to provide a clear indication of the importance of nursing leadership in having

an impact on quality patient care and patient outcomes. For instance, in a review of factors affecting infection control, Griffiths, Renz, Hughes, and Rafferty (2009) found positive leadership to be a requirement in the process of ensuring effective infection control in hospitals. McKinley et al. (2007) also found a link between effective management/leadership and positive patient outcomes as they identified effective leaders to have great impact on the reduction of patient falls in a hospital setting. A systematic review by Wong and Cummings (2007) further confirms the link between leadership and patient outcomes. Based on the examined studies it was concluded that there is adequate evidence to support the presence of a strong positive relationship between leadership (e.g. leadership qualities, actions, and practices) and patient satisfaction and outcomes. Collectively these studies show the important role of nursing leadership within the healthcare system by outlining the way leaders are linked to the entire system and how they maintain a balance between organizational goals, patient care, and patient and staff outcomes. The well-being of nurses and the quality of patient care are clearly shaped in direct and indirect ways by nurse leaders. This fact reinforces the vital role of nurse leaders and the need for them to have the competencies that will enable them to support nursing staff to provide quality and safe patient care. While the evidence cited above recognizes the significant role of leadership it also implies the need for adequate leadership development training that will prepare nurse leaders for the constantly changing needs of the healthcare environment.

Leadership education has long been recognized by many disciplines as an important component of leaders' development. Leadership education prepares leaders for their role by giving them the knowledge and skills necessary to support their staff and the organization, introducing them to responsibilities of leadership, and offering them an awareness of the impact a leader can have on different aspects within the institution (Brungardt, 1996; Cummings et al.,

2008; Fennimore & Wolf, 2011). In this way, leaders gain training that supports their practice which in turn has a positive impact on staff actions and behaviors (Laschinger & Leiter, 2006; Wagner et al., 2010), the organization, and patient outcomes (Houser, 2003; Wong & Cummings, 2007). Unfortunately, many first-line nurse leaders have limited access to structured leadership education, especially that which is tailored to nurses by offering them an opportunity to develop key leadership competencies and preparing them to meet the many complex system needs and challenges found within the healthcare environment (Eddy et al., 2009; Fennimore & Wolf, 2011; Swearingen, 2009). This limited access leads to many concerns, as insufficient leadership development leaves nurse leaders without the appropriate skills and competencies needed to respond to organizational needs or an understanding of the role they play in maintaining a healthy and effective workforce. As a result, steps need to be taken to ensure nurse leaders are given adequate access to leadership development programs that prepare them to be effective leaders.

As will be further depicted in Chapter 2, in recognition of this education gap, a variety of formal leadership programs have been developed in an attempt to support and meet the needs of first-line nurse leaders (Fennimore & Wolf, 2011; Sportsman, Wieck, Yoder-Wise, Light, & Jordan, 2010; Vogelsmeier, Farrah, Roam, & Ott, 2010). One of these programs is the British Columbia Nursing Leadership Institute (BC NLI) which employed "a theoretical empowerment framework to connect empowerment strategies to practice" (MacPhee, Skelton-Green, Bouthillette, & Suryaprakash, 2011, p. 170). However, like many other leadership programs, the evaluation component of the BC NLI has up to now predominantly involved the perceptions of nursing leaders who have taken part in the leadership program (MacPhee et al., 2011). As part of the BC NLI evaluation, consenting leaders were interviewed by one of the researchers or a

research assistant who asked standardized questions to "evaluate the effectiveness of the NLI and provide evidence of leader empowerment and leader perceptions of staff empowerment" (MacPhee, 2011, p.161). In this way the researchers were able to access the perceptions of the program participants; however, this strategy did not permit them to explore the views of other individuals (e.g. nursing staff) who had come into contact with the leaders before and after their participation in the program. The absence of staff input is of particular concern as it leaves a gap in this area of research and may prevent a complete picture of the effect of leadership development programs. Although self-evaluation strategies provide a great wealth of information, the incorporation of staff input provides researchers an opportunity to not only obtain additional data but also strengthen the validity of the study results by providing access to alternate viewpoints and decreasing the possibility of having inaccurate or incomplete data (Cummings et al., 2008; Dasborough & Ashkanasy, 2002; Kellett, Humphrey, & Sleeth, 2002; Xin & Pelled, 2003). As a result, this thesis will build on previous BC NLI evaluative research by analyzing the perceptions of staff nurses and identifying whether they have seen any differences in their first-line leaders during the one year period following their leaders' participation in a structured leadership program.

The Study

The aim of this study is to determine whether staff perceived changes in their first-line leaders' behaviors after those leaders attended a formal nursing leadership development program, the BC NLI. These behaviors will be defined in broad terms as any actions, attitudes, and affect changes noted by staff nurses in their first-line nurse leaders. For this examination, this study

will recognize relational and management capabilities as essential components within leadership development. It will utilize a theoretical empowerment framework (Laschinger, Finegan, Shamian, & Wilk, 2001), which recognizes structural and psychological empowerment strategies as having an influence on staff nurse outcomes. This theoretical model, which will be further described in Chapter 2, is based on the premise that when leaders are empowered through participation in formal leadership development opportunities, they in turn will empower their staff. Staff, therefore, must perceive changes in their leaders (i.e., empowerment behaviors) in order to be empowered by them. The BC NLI was based on this empowerment framework and evidence-informed leadership and management competencies described in the leadership literatures (MacPhee & Bouthillette, 2008). The intent of the structured leadership program was to increase leader empowerment by influencing leadership behaviors. The theoretical framework that guided all aspects of this program included the empowerment theories (e.g. structural and psychological empowerment) which were utilized to form a connection between empowerment and practice (MacPhee & Bouthillette, 2008; MacPhee et al., 2011).

In Chapter 3, I will provide a comprehensive outline of the methodology of this study, including the research design, the population to be studied, data collection process, and the research instruments/tools used for this analysis. The BC NLI program evaluation was made possible by research funds and in-kind supports received from the Canadian Health Services Research Foundation (CHSRF), BC Chief Nursing Officers, Lower Mainland Healthcare Authorities, and the University of British Columbia (UBC) School of Nursing. This study used staff focus group data from the larger CHSRF-funded study. The study sample is comprised of 10 staff nurse focus groups from the Lower Mainland, British Columbia. To achieve a representation of all healthcare authorities in the Lower Mainland, the sampling process

purposefully included staff nurses from Providence Health, Provincial Health Services Authority, Fraser Health Authority, and Vancouver Coastal Health Authority. Using a qualitative descriptive methodological approach, the staff focus groups were conducted one year after leader participation in the BC NLI, as it was assumed that this period would give the nurse leaders an adequate amount of time to incorporate and make use of their newly acquired leadership competencies and exhibit potential program induced changes/outcomes. During the data collection process, a neutral professional facilitator who did not have any connection to the study or program conducted the focus group sessions using specific, predetermined questions during each session. Digital recordings of each session were made during each focus group. All sessions were professionally transcribed following focus group discussions and were loaded into password protected NVivo 9 software (NVivo 9, 2010) for data analysis in this proposed research.

This qualitative descriptive study used a data-driven inductive thematic analysis approach (Boyatzis, 1998) to identify themes related to perceived leader differences during the year following leader participation in the BC NLI. The particular method of analysis chosen for this study is an approach of thematic analysis that utilizes the step by step process outlined by Braun and Clarke (2006). This approach is a systematic process made up of several actions that include reading and reviewing raw data, data organization, coding, encoding, interpretation, theme recognition, and confirmation of findings that lead to the emergence of common themes directly from the data (Boyatzis, 1998). As described by Graneheim and Lundman (2004), this approach is a method of investigation that can be viewed as an ongoing "communication act" (p. 111) between the researcher and the data during which the researcher focuses on identifying patterns within the existing information.

As with other systems of data analysis, several concerns and limitations exist around this technique. Some of the factors that can affect the analysis process include the projection of the researcher onto the translation process, sampling corruption, loss of non-verbal cues, and the mood/style of the interpreter (Boyatzis, 1998). To reduce the barriers to effective thematic analysis I (i.e. the study investigator) employed several key strategies that included: developing and using clear codes; setting up reliability of decision making; including the opinions and perspectives of several individuals; being open to various theories and ideas; having self-control and recognizing external stressors that may affect the analysis; being transparent regarding the research process through clear description of employed methods and reasoning; and adhering to the raw data without being influenced by personal ideas and values (Boyatzis, 1998). Based on these factors, specific actions were used to ensure that rigor, credibility, dependability, consistency, and transferability were addressed and maintained throughout the analysis process.

Working closely with the thesis committee allowed me to engage them in key aspects of the research process by continually communicating the progress of the analysis. In this way the committee members were informed of steps being taken during the evaluation of the BC NLI staff focus group data and what results were being arrived at throughout the analysis. By taking these steps the committee members had the opportunity to ensure consistency of the examination by making sure the methods being used remained the same throughout the entire analysis process. The committee members' involvement and the provision of regular analysis overview updates enabled them to assist me in adhering to the raw data during the entire analysis process. In this way the committee assisted me to ensure the accuracy of the analysis process, thoroughness of interpretation, and accuracy of results. The committee was utilized during the analytic process when questions arose about interpretation of data to ensure unbiased and well-

balanced results and conclusions (e.g. committee members were consulted about the definitions of codes to ensure precision and consistency of data interpretation). The employment of appropriate tools, such as the NVivo9 software in combination with a non-software method of analysis, were utilized to meet the aim of the investigation and ensure accuracy of interpretation. These steps were further supported throughout the analysis with the use of reflective notes to track the progress of the analysis and to ensure the data analysis process remained consistent and transparent. Rigor was also maintained by following a consistent approach that was maintained throughout the analysis process and by not predetermining codes that could bias the coding process during the analysis.

The study results, which will be outlined in Chapter 4, will be introduced and addressed through a presentation of detailed findings acquired from the thematic analysis of staff nurse focus group data. In Chapter 5, a discussion of the significance of this research for the nursing profession and the healthcare environment will occur along with an examination of study limitations. The study findings will be used to identify further opportunities for research in the area of leadership development education: to advance this area of study and promote further inquiry. The results will also aid to acknowledge the importance of this research as the findings will provide additional information that can be used to explore the assumption that leadership development not only empowers first-line nurse leaders but also consequently leads to the empowerment of their staff. This research may also be used to support the important association between nursing leadership and the well-being of nurses, such as evidence of how leaders enhance nurses' work life and influence their job satisfaction, organizational commitment, and perceptions of quality of patient care.

The themes identified by staff nurses regarding the effect of leadership development programs on first-line nurse leaders will also be used to add to the discussion regarding first-line leader training and development. As recognized by numerous studies, including those cited above and in Chapter 2, leadership education plays an essential role during an individual's transition to a first-line leader. Having insufficient or inadequate opportunities for development leaves leaders without the necessary skills and competencies to fulfill their responsibilities and understand their role in influencing the workplace environment and its workers. Adding the input of staff nurses will hopefully reinforce the important function of nursing leadership education and will facilitate a greater understanding of its role in the development of effective nursing leaders who play an important role in healthcare reform and driving change within organizations.

CHAPTER 2: Literature Review

As I articulated in Chapter 1, the focus of this thesis is staff perceptions of leaders' behaviors after their leaders attended a nursing leadership program in BC, the BC NLI. Analysis of this subject matter is important for nurses and the healthcare field as it offers additional evidence regarding the role of structured leadership education in shaping nurse leaders who have the potential to impact patient, workplace, staff, and organization outcomes. The need to prepare and retain effective nurse leaders is of particular relevance for today's healthcare environment as the Canadian population is becoming more diverse and the healthcare system is being challenged to keep up with a wide variety of system demands (National Expert Commission [NEC], 2012). As described in the NEC (2012) report, healthcare organizations and healthcare professionals alike are finding themselves in the midst of a system that is absorbed with reactive, acute treatment services that are exceedingly inadequate to meet the current and emerging healthcare needs of Canadians. As a result, the healthcare system requires committed and effective nurse leaders that play a fundamental role in healthcare and its necessary system transformations.

Literature Review Process

To conduct a comprehensive literature review the following terms were used to search the professional nursing literature: leadership, development, education, program initiative, first-line leader, front line leader, nurse leader, and nursing. These terms were used individually and in various combinations in order to yield the most thorough overview of the available literature. The databases used were Medline and CINAHL. Inclusion criteria consisted of articles published from 2001 to 2012, available in the English language, and obtainable in full text format. The

search also involved an exploration of relevant reports and guidelines from pertinent healthcare related associations and branches of government, including the Canadian Nurses Association (CNA), the Canadian Nursing Advisory Committee (CNAC), the Canadian Institute for Health Information (CIHI), and Health Canada. In addition to the above search process, the reference list of each eligible article acquired from the database search underwent an examination to determine if there were any studies that were missed through the database search. During this step, all potentially qualifying articles were fully reviewed and included within the review.

Based on the reviewed literature, I will begin this chapter with an overview of the current state of healthcare and leadership development and focus more specifically on one leadership development program and its theoretical foundation. An appreciation of the specific leadership development program is necessary to provide context for staff reports of their leaders' behavior.

Current State of Healthcare in British Columbia

The current state of healthcare is faced with many challenges that influence every aspect of the system. With constant change, staff and leaders have to adjust to factors that are impacting care delivery and practice environments. Despite great progress being made in healthcare advancements and technology, the current and projected population demands are leading to pressures being placed on the system, particularly the requirements of increasingly complex and diverse patients and their families. Some system demands include the rapid growth in the aging population (NEC, 2012; Vogelsmeier et al., 2010; Wolf, Bradle, & Greenhouse, 2006), higher acuity of patients (NEC, 2012), and greater prevalence of chronic illness (Heller et al., 2004; NEC, 2012; Wolf et al., 2006). Institutions are also being expected to keep up with the physical

and emotional needs of patients and families and develop holistic services to address their healthcare needs. This is leading to organizational challenges that include specialist wait times, lack of long-term facility beds, hospitals being over-capacity, and a shift to community care (NEC, 2012; Villeneuve & MacDonald, 2006).

Within this same environment, the nursing profession is faced with its own challenges. As patient and system demands increase, Canada is experiencing a critical nursing shortage (CNAC, 2002; Duffield, 2005; Laschinger & Wong, 2010). This nursing shortage is of great concern on a provincial and national level as large numbers of nurses are ready to retire and new nurse graduates are not exiting programs in great enough numbers to fill current and projected vacancies. The CNA's (2009) report, *Tested Solutions for Eliminating Canada's Registered Nurse Shortage*, highlights the critical state of this issue as it projects that in the next 15 years the nursing shortage will increase by approximately five times and that by the year 2022 Canada will face a shortage of approximately 60,000 nurses.

This health human resource shortage also encompasses nurse leaders who make up approximately 7% of the nursing workforce (Canadian Institute of Health Innovation [CIHI], 2010). This means that based on projected numbers, Canada could face a shortage of approximately 4200 nurse leaders in the next ten years (Laschinger & Wong, 2010). In addition to human resource shortages putting pressure on an adequate supply of nurse leaders, ongoing restructuring has decreased nurse leader numbers through de-layering, or reduction in levels of leadership. Beginning in the 1990s first-line and mid-level leadership positions were eliminated (CNAC, 2002; Cummings & Estabrooks, 2003; Urden & Walston, 2001) and organizations increased leaders' portfolios (Laschinger, Almost, Purdy, & Kim, 2004; Shirey, 2006), which have put additional stress on existing nurse leaders. These increased demands have led to leader

burnout and recruitment problems (Laschinger, Finegan, Shamian, & Wilk, 2003; Laschinger, Leiter, Day, & Gilin, 2009). Collectively these organizational and population changes represent significant challenges for today's Canadian healthcare system, nurses, and nursing leadership. With the changing landscape of the healthcare system, organizations have to strive towards quality patient care while ensuring that staff nurses and nurse leaders have adequate supports that allow them to play a vital role in running the healthcare system and its future direction.

Levels of Leadership in British Columbia

There are typically 3 levels of nursing leadership in British Columbia that consist of executive or upper management leadership, second-line leadership, and first-line leadership. Executive leaders usually hold the positions of presidents, executive directors, and vice-presidents in organizations, may or may not be nurses, and carry out mandates outlined at the government and corporate levels. Second-line leaders, otherwise known as middle managers, are found between upper management and first-line leaders. They report to upper management and are responsible for budget and managing other managers and first-line leaders (Argyle, 1998). The first-line leader, the focus of this thesis, is in direct contact with staff and is responsible for day-to-day operations (Duffield, 1991). In the literature, the term first-line nurse leader is often seen to be interchangeable with head nurse, ward sister, charge nurse, supervisor, ward manager, front-line manager, unit facilitator, and unit manager. In the current hospital setting, the first-line leader role can also hold the title of a clinical nurse leader, program coordinator, clinical nurse coordinator, clinical manager, and many others. Regardless of title, this level of leadership represents the first level of management where the leader is responsible for a unit or ward.

First-line nurse leaders are situated in a critical location within the healthcare system where they influence and guide healthcare delivery (Lee & Cummings, 2008; Stevenson-Dykstra, 2003). The main role of the first-line nurse leader is to carry out the vision and mission of the organization while linking management and the organization's vision and strategic plan with the clinical practice environments and nursing staff. As described by Porter-O'Grady and Malloch (2011), the first-line leader role "defines the location that represents the interface between the structural and process dynamics of the system and the functional and action dynamics of those who do its core work" (p. 124). Their role, which has been expanded as a result of healthcare restructuring, provides them with opportunities to influence the quality of the work environment (Laschinger et al., 2011; Laschinger & Leiter, 2006); nurse outcomes, such as job satisfaction (Laschinger, Finegan, & Wilk, 2009a, 2009b; McNeese-Smith, 1995); and patient outcomes, such as decreased mortality and morbidity (Aiken, Clarke, Sloane, Lake, & Cheney, 2008; Lee & Cummings, 2008).

By working directly with staff on the unit, first-line nurse leaders influence staff and direct patient care (Abdelrazek et al., 2010; Regan & Rodriguez, 2011). These leaders are entrusted with endorsing quality and safe care (Abdelrazek et al., 2010) and ensuring quality practice within the nursing profession (Stevenson-Dykstra, 2003). Due to their direct contact with staff, first-line nurse leaders must possess the ability to influence their staff and engage them in the achievement of the organization's goals. Duffield (1991) describes this role as a balancing act between the self, staff, and the healthcare system. Although there are many challenges facing nurse leaders, leadership is crucial for all aspects of healthcare. Effective nursing leadership is imperative as Weberg (2010) states that "like a rapidly mutating cancer cell, poor leadership within healthcare systems can cause toxic symptoms that adversely impact

organizational work cultures and staff satisfaction and lead to burnout" (p. 246). Investment in fostering effective nurse leaders, therefore, is an important organizational investment and sound strategy for ensuring quality and safe care and healthy workplace environments (Fennimore & Wolf, 2011; Mackoff & Triolo, 2008; McAlearney, 2006).

Leadership Capabilities and Pertinent Theories

Relational and management capabilities are necessary for today's nurse leaders (Yukl, 2006). Relational capabilities focus on the leader relationship building; whereas, management capabilities concentrate on the role of the leader as it pertains to organizational supervision and performance. There are different theories associated with both types of capabilities, and these key theories will be described in the following sections.

Relational capabilities.

Leaders who embrace relational behaviors as part of their leadership style are more "attuned to and in touch with the intricate web of inter- and intra-relationships that influence an organization" (Dyer, 2001, para. 2). In relational leadership, a leader's behavior is a critical element with respect to individual and team performance. The types of leadership behaviors a leader adheres to will not only determine the quality and strength of the relationship that a leader is able to form with teams/employees but also the way teams/employees will act and behave in response (Laschinger, Finegan, et al., 2009a, 2009b; Seibert, Silver, & Randolph, 2004).

Relational behaviors assist leaders to build and sustain truthful, effective, and healthy relationships with relevant stakeholders. As explained by Yukl (2006), "relations-oriented behaviors are used to build commitment to work objectives, mutual trust and cooperation, and identification with the team or organization" (p. 442). Possessing these behaviors also allows leaders to form sound relationships that are necessary for the achievement of the organization's goals. The relational behaviors that are essential for effective leadership consist of: supporting staff, acknowledging achievements or providing positive reinforcement, offering mentoring and education opportunities, involving individuals in decisions, giving staff the opportunity to accomplish tasks in their own way, encouraging and getting involved in team building activities, socializing with staff, providing effective conflict-resolution, and hiring competent staff (Yukl, 2006). Although there have been various perspectives of relational leadership (Uhl-Bien, 2006), one theory that can have great impact in healthcare is the workplace empowerment theory.

Workplace empowerment theory.

Workplace empowerment theory provides a conceptual way to understand leaders' relational influence with regard to individual and team behaviors. Workplace empowerment is vital within the healthcare system as empowered employees appear to be more resilient to the negative effects of stressful workplace environments (Laschinger et al., 2011). Empowerment strategies, such as leader empowering behaviors, help employees gain control over their work, create positive workplace relationships, and achieve healthy practice environments. Several studies link workplace empowerment to staff (e.g. nurse and/or leader) outcomes, such as organizational commitment (Dahinten et al., in press; Laschinger, Leiter, et al., 2009), job

satisfaction (Laschinger, Finegan, Shamian, & Wilk, 2001, 2004; Laschinger, Finegan, et al., 2009a, 2009b; Laschinger, Leiter, et al., 2009), and reduced burnout (Greco, Laschinger, & Wong, 2006; Laschinger et al., 2003; Laschinger, Leiter, et al., 2009).

Workplace empowerment includes structural empowerment (Kanter, 1993) and psychological empowerment (Spreitzer, 1995). Within the theory of workplace empowerment both forms of empowerment play a crucial role towards the achievement of positive outcomes, namely an empowered workforce. As I will explain below, both types of empowerment are associated with specific theoretical roots (Laschinger et al., 2001; Wagner et al., 2010).

Structural empowerment.

Kanter's (1993) structural theory of power in organizations is the foundation behind structural empowerment. Employee behaviors and attitudes are shaped by access to workplace empowerment structures rather than their personal qualities (Greco et al., 2006). According to Kanter (1993), staff members can acquire power and become structurally empowered when their organizations provide them with access to information (e.g. having an understanding of policies and decisions made in the institution), resources (e.g. access to supplies), supports (e.g. receiving constructive evaluation and guidance), and opportunities (e.g. access to continuing education). These organizational empowerment structures can be accessed through formal channels (e.g. the chain of command) or informally (e.g. peer network) (Greco et al., 2006). Effective leaders ensure that staff members have access to organizational empowerment structures. Kanter's structural empowerment perspective identifies the organization and its leadership as important sources of workplace empowerment. (Kanter, 1993; Regan & Rodriguez, 2011).

Psychological empowerment.

Psychological empowerment is described by Conger and Kanungo (1988) as a "motivational" (p. 473) state. As defined by Spreitzer (1995), psychological empowerment can be viewed as the employee's psychological perception of their work. Intrinsic workplace motivation of employees is associated with access to organizational empowerment structures (Laschinger et al., 2001). Psychological empowerment consists of four cognitions: meaning (i.e. a match between person's beliefs and job requirements and values), competence (i.e. a person's view of their own abilities at work), self-determination (i.e. a person's autonomy at work), and impact (i.e. a person's belief that they can influence workplace outcomes) (Spreitzer, 1995). These cognitions have been shown to work collectively to facilitate the achievement of greater work fulfillment and staff satisfaction (Laschinger, Finegan, et al., 2009a; Laschinger, Leiter, et al., 2009; Thomas & Velthouse, 1990; Udod, 2008; Wagner et al., 2010). Together, the four cognitions reveal a person's active rather than passive approach to their work, influencing employee outcomes such as work effectiveness (Spreitzer, 1995). Although the four cognitions are additive and represent an optimal level of psychological empowerment, a deficiency in one area will not completely eliminate its existence (Spreitzer, 1995).

The link between structural and psychological empowerment and outcomes.

Structural and psychological empowerment have been acknowledged in the literature for their combined role in empowering employees and influencing the healthcare environment (Laschinger, Finegan, et al., 2009a; Laschinger, Purdy, & Almost, 2007). The continually evolving empirical evidence regarding workplace empowerment implies that psychological

empowerment mediates the impact of structural empowerment on outcomes. This link has been tested by Laschinger et al. (2001) who found that staff who perceived adequate structural empowerment in their workplace had higher psychological empowerment, which in turn had an impact on reducing job strain and improving job satisfaction. This workplace empowerment process (structural empowerment → psychological empowerment → outcomes) (Laschinger et al., 2003) is further supported by Wagner et al.'s (2010) systematic review, which identified a significant relationship between structural and psychological empowerment with respect to staff nurses. As concluded by Wagner et al., the reviewed "research studies demonstrate that structural empowerment leads to psychological empowerment that culminates in measurable positive workplace outcomes…" (p. 459). In one study, the leader-member exchange (LMX) theory was employed to explore the link between empowerment and organizational commitment (Laschinger, Finegan, et al., 2009a), while also including personal dispositional factors such as personality attributes (e.g. self-efficacy). The researchers found that leaders' relationship with others influenced the workplace empowerment process (i.e. structural and psychological empowerment) and organizational commitment. At the individual level they found that a person's disposition had a direct link to psychological empowerment, which in turn had a direct link to organizational commitment. At the unit level, the LMX quality was found to have a direct effect on structural empowerment which then had a direct effect on psychological empowerment and organizational commitment. The findings also noted that LMX had a direct and indirect link to psychological empowerment and organizational commitment. This research is of particular significance as it underscores the importance of the quality of leader-member relationships. These findings also reinforce the importance of first-line leaders in creating empowered practice

environments and leaders' capacity to influence positive outcomes at the unit, team, and individual levels.

Management capabilities.

Management capabilities need to be possessed by nurse leaders in addition to relational competencies. While relational competencies concentrate on leader relationship-building, management capabilities focus on the technical, conceptual, and cognitive skills of leaders (Swansburg & Swansburg, 2002; Yukl, 2006). As stated by Olum (2004), "management entails the acquisition of managerial competence and effectiveness in the following areas: problem solving, administration, human resource management, and organizational leadership" (p. 2). The right management techniques assist the leaders with coordinating key organizational operations and resources.

Traditionally, management theories were based on transactional leadership theory which recognized management as a process that is necessary for developing and maintaining an environment where goals can be accomplished in an effective and efficient manner (Yukl, 2006). Although this is still true today, the more contemporary theories of management also "tend to account for and help interpret the rapidly changing nature of today's organizational environments" (Olum, 2004, p. 11). Theories that suggest the complex nature of leaders' roles and responsibilities include: complexity theory, innovation/diffusion theory, and change management theories.

Complexity theory.

Complexity theory presents an opportunity to step away from the commonly utilized Newtonian rules and philosophies that view the system or structure and its components as a machine (Carlson, 2003; Plsek & Wilson, 2001). Rather than depicting a healthcare system in a simple, linear manner the complexity theory recognizes that not everything can be predicted or outlined in detail and that simply reducing variation will not lead to better results. Under complexity science the idea of the machine is replaced with the idea of a living system that is "nonlinear and able to adapt to a changing environment" (Carlson, 2003, p. 3). Instead of concentrating on a single aspect or part of the system, the complexity theory urges leaders to pay attention to the interactions or relationships among members/agents of the system (Plsek & Wilson, 2001). In this way, organizational success depends on the quality of relationships among agents or members of the system. Considering healthcare organizations as complex entities is of particular importance for leaders as it allows them to "ask questions based on the flows or patterns among the processes, identify the feed-back loops, explore the interfaces, and ultimately identify an efficient system" (Carlson, 2003, p. 3). Complexity theory gives leaders alternate concepts and tools for responding to the many complex challenges of the current healthcare system and reinforces the significance of relationship-building competencies.

Innovation/diffusion theory.

The healthcare system is highly dependent on evidence-based innovation and diffusion of information. However, it is not uncommon for the current system to lag behind with acquiring, disseminating, and applying new knowledge and advancements which are integral to the

provision of patient care and ensuring healthy practice environments (Yukl, 2006). According to innovation/diffusion theory, diffusion is a multilayered process that is influenced by three clusters which are associated with the way information is spread (Berwick, 2003). The first cluster is the individual's view of the change that is taking place, which notes that the intricacy of the change, compatibility to present values and needs, opportunity to observe others take part in the process, ability to attempt the change in small increments, and belief in the innovation's benefit are all key players in the diffusion of knowledge (Berwick, 2003). The second cluster consists of the attributes of members who are involved in and assume the innovation (Berwick, 2003). It indicates that the rate of spread will be dependent on the mix of individuals (e.g. innovators, early adopters, early majority, etc.) that are involved in the change. The final cluster is noted to fall under background and setting influences, which include leadership aspects (e.g. style of spread) and the support that the innovation and implementation process receives in an institution (Berwick, 2003). Together, all three clusters of influence are vital in making advancements possible and ensuring ongoing innovation within the healthcare environment. As a result, nurse leaders need to value innovation and the implementation and spread of new knowledge.

Change management theories.

Change is often used synonymously with innovation. Innovation is planned, thoughtful change that can be regarded as the antecedent and the outcome of change, whereas change management is how you apply the change. Continuous change in the healthcare environment is a constant challenge. Change management theories describe how change occurs from beginning to

end. One of the first change management theories was Lewin's force-field model which helps to describe the process of change through three stages that consist of "unfreezing, changing, and refreezing" (Yukl, 2006, p. 286). While all three stages are necessary to achieve change, strong leaders are assumed to play an integral role in all aspects of the process. Strong, effective leadership is required to introduce and maintain change by taking steps such as selecting innovation initiatives that are right for the practice environment. Gill (2003) noted that "the leadership of successful change requires vision, strategy, the development of a culture of sustainable shared values that support the vision and strategy for change, and empowering, motivating and inspiring those who are involved or affected" (p. 308). Leaders have to be knowledgeable about how to drive change while also being able to recognize and reduce factors that hinder or block the change process. Leaders need to become successful change enablers by providing clarity, employing appropriate leadership styles (e.g. transformational and transactional leadership), supporting an appropriate culture, and acting as role models of change (MacPhee, 2007).

Importance of Nursing Leadership Development

Leadership is a widely utilized concept that has no single agreed upon definition within the literature. Marquis and Huston (2009) note that leadership can have a number of meanings but there is not one comprehensive definition that incorporates all perspectives of the leadership concept. For the purpose of this thesis, leadership is defined as "an influence relationship among leaders and followers who intend real changes and outcomes that reflect their shared purposes" (Daft, 2008, p. 4).

Leadership education is vital in healthcare as it prepares leaders for their role by giving them the knowledge and skills necessary to support the staff and the organization, introducing them to responsibilities of leadership, and offering them an awareness of the impact a leader can have on different aspects within the institution (Brungardt, 1996; Cummings, 2011). Leadership development education is a strategy with a known positive impact on the personal and professional development of leaders (Dierckx, Willemse, Verschueren, & Milisen, 2008). Through formal leadership development opportunities leaders gain training and competencies that support their practice, which in turn has a positive impact on their own satisfaction and well-being (Laschinger et al., 2004; Lee et al., 2010), staff actions and behaviors, the organization, and patient outcomes. There are many leadership development strategies that have been created to support nurse leaders and guide their leadership growth (Day, Zaccaro, & Halpin, 2004; MacPhee & Bouthillette, 2008; Yukl, 2006). Before discussing leadership development more specifically, the positive outcomes of effective leadership will be summarized.

The influence of nurse leaders.

Strong leadership is necessary in organizations to manage the many complex issues related to patient needs, nursing competencies, and organizational restructuring. Strong, effective leaders help to drive the organization's goals in a way that benefits the entire system. Effective nurse leaders play a role in dealing with workforce issues, influencing the workplace environment, shaping staff nurse satisfaction and organizational commitment, ensuring the availability of adequate resources, and guiding practice. As elaborated by Cathcart, Greenspan, and Quin (2010), nurse leaders hold enormous responsibility around maintaining empowerment,

engagement, “quality, safety, innovation, efficiency, and financial viability” (p. 441). Their leadership is vital for creating a common organizational vision and mission and in assisting to manage resources and relationships. The literature provides clear evidence of how nurse leaders influence the workplace environment, staff nurse outcomes, and patient outcomes.

Workplace environment.

The nursing workplace environment is one area that has been shown to have immense influence on the organization, leader, nursing staff, and patient outcomes (Aiken et al., 2008; Lee et al., 2010; Purdy, Laschinger, Finegan, Kerr, & Olivera, 2010; Van Bogaert, Clarke, Roelant, Meulemans, & Heyning, 2010; Wong & Cummings, 2007). Upenieks (2003a) suggested that optimal workplace environments do not develop on their own. To achieve the most favourable workplace environments it is critical for institutions to possess strong and effective nurse leaders at all levels of the institution, but in particular at the unit level where staff carry out their work and patients receive care (Sherman & Pross, 2010).

The presence of first-line nurse leaders is pivotal in fostering conditions that create a healthy, positive, safe work environment and organizational culture (Baker et al., 2004; Clarke et al., 2012; Duffield, Roche, Blay, & Stasa, 2011; Espinoza, Lopez-Saldana, & Stonestreet, 2009; Germain & Cummings, 2010; Kane-Urrabazo 2006; Laschinger, Finegan, et al., 2009a; Sellgren, Ekvall, & Tomson, 2007; Sherman & Pross, 2010; Shirey, 2009; Squires, Tourangeau, Laschinger, & Doran, 2010; Wagner et al., 2010; Weberg, 2010). As noted by the American Association of Critical-Care Nurses (AACN) (2005), healthy workplace environments are not possible without effective nurse leaders that fully support optimal practice environments. Nurse

leaders are vital in engaging their staff in the improvement and sustainment of environments that support nurses and offer quality patient care.

A number of studies demonstrate the link between leadership and workplace environments (Laschinger, Leiter, et al., 2009; Squires et al., 2010; Wagner et al., 2010). At the unit level, Laschinger, Finegan, and Wilk (2009a) showed that nursing leadership plays an important role in creating and sustaining optimal practice environments, which in turn have a positive effect on nurses' organizational commitment. Cohen, Stunkel, and Nguyen's (2009) exploration of staff nurse's perceptions of their work environment found that nurses who were provided with adequate support from their leader and innovation within their workplace environment were less likely to leave the institution as support obtained from a leader and the presence of innovation were deemed to contribute to the nurse's job satisfaction. In their systematic review of the link between structural and psychological empowerment, Wagner et al. (2010) concluded that there is substantial evidence that shows how leaders contribute to greater staff nurse job satisfaction, organizational commitment, and retention (i.e. ensuring optimal workplace environments). Utilizing Donabedian's Structure-Process-Outcome (SPO) paradigm to examine the process and organizational/leadership factors that play a role in nurse manager support of staff nurses, Kramer et al. (2007) found that supportive nurse manager behaviors gave rise to a productive, healthy workplace environment that enabled nursing staff to better achieve their professional responsibilities. Kramer et al.'s study identified nine specific behaviors and components required by nurse managers to support staff nurses and described how the support process was activated by leaders. The nine supportive leader behaviors consist of: "is available, approachable, safe, and responsive; demonstrates that he/she cares; walks the talk; motivates us to develop our self-confidence, self-reliance, and self-esteem; gives genuine feedback; provides

adequate and competent staffing; watches our backs; promotes groups cohesion and teamwork; and resolves conflicts constructively" (Kramer, 2007, p. 335).

Similarly, a Laschinger, Leiter, et al. (2009) study explored the effect of empowering workplace environments and incivility on the burnout and retention outcomes of nurses and also identified an association between effective nursing leadership and structural and psychological empowerment of nursing staff within specific workplace environments. In this study the researchers showed that when leaders create empowering workplaces there is greater nurse organizational commitment, job satisfaction, and intent to stay. Germain and Cummings' (2010) systematic review further confirms the importance of effective unit-level leadership in creating a healthy workplace environment that motivates nurses to provide quality patient care. They found that nurse leaders shaped the context of nurses' work through the provision of adequate resources and supports, such as autonomy, working relationships, and empowerment. Collectively, these studies show the relationship between nursing leadership and the attainment of optimal workplace environments and illustrate the impact nursing leadership has on nursing staff and patient outcomes.

Staff nurse outcomes.

As suggested by the above studies, nursing leadership can have great impact on the well-being of nursing staff and the quality of patient care by way of supporting healthy workplace environments. This association is further supported by empirical evidence that notes a positive link between the nursing leader's actions, behaviors, and/or leadership style and nursing outcomes, such as organizational commitment (Dahinten et al., in press; Laschinger, Finegan, et

al., 2009a; McNeese-Smith, 1997), job satisfaction (Cummings, MacGregor, et al., 2010; Duffield & O'Brien-Pallas, 2003; Laschinger, Finegan, et al., 2009a, 2009b; McNeese-Smith, 1995, 1997; Perra, 2001; Sellgren et al., 2007; VanOyen Force, 2005; Weberg, 2010), decreased stress and/or burnout (Weberg, 2010), productivity (McNeese-Smith, 1995, 1997; Perra, 2001), and intent to stay/retention of nursing staff (Acree, 2006; Boyle, Bott, Hansen, Woods, & Taunton, 1999; Duffield & O'Brien-Pallas, 2003; Houser, 2003; Kleinman, 2004a; Raup, 2008; VanOyen Force, 2005). For example, Duffield et al. (2011) showed that when effective nursing unit managers are rated highly on numerous leadership behaviors, such as consulting with their nursing staff and providing their staff with positive feedback, nurses are more satisfied with their jobs and the nursing profession in general. In a similar study, Laschinger et al. (2011) found that staff members awareness of greater LMX quality were associated with greater perceptions of structural empowerment on the unit, and greater perceptions of structural empowerment were associated with greater individual job satisfaction. The study also identified that the existing unit-level LMX quality had a direct effect on individual job satisfaction and resulted in lower cynicism, while "higher unit-level structural empowerment was associated with lower emotional exhaustion" (Laschinger et al., 2011, p. 124).

By comparing findings from two similar settings, McNeese-Smith (1995) demonstrated the impact of effective leadership by directly linking the manager's leadership behaviors to improvement in the employee's organizational commitment, satisfaction, and productivity. The author concluded that the use of five leadership behaviors significantly impacted staff outcomes, particularly during restructuring. The five behaviors investigated in this study were: "challenging the process, inspiring a shared vision, enabling others to act, modeling the way, and encouraging the heart" (McNeese-Smith, 1995, p. 22). A systematic review by Cummings, MacGregor, et al.

(2010) concluded that leadership styles have differing effects on staff and the workplace environments. The researchers reported that, in comparison to task-focused leadership styles, relational leadership styles (e.g. transformational, resonant, supportive, and consideration) were associated with better work environment and higher nurse job satisfaction, well-being, organizational commitment, intent to stay/retention, productivity, and empowerment. Laschinger and Leiter (2006) also found that leadership was the most essential variable in the relationship between worklife factors and burnout of nurses. Nursing leadership was noted to have a direct influence on sufficient staffing levels, nurse/doctor cooperation and teamwork, and nursing staff taking part in policy development and an indirect influence on the utilization of a nursing model of care, the three components of burnout, and adverse events. Ultimately, this empirical evidence confirms that the resulting effect that nurse leaders have on staff is irreplaceable in the healthcare system as factors such as staff job satisfaction and retention of nurses have also been shown to be linked to patient satisfaction, morbidity, and mortality outcomes (Aiken et al., 2008; Kane, Shamliyan, Mueller, Duval, & Wilt, 2007; Kutney-Lee et al., 2009).

Patient outcomes and quality of patient care.

The Institute of Medicine's (2004) report on patient safety and nurses' workplace environments identified management practices as one of four central components that have a role in patient safety. This indicates that the practices of first-line nurse leaders are critical within the practice environment and can have a definite effect on patient safety (Herrin & Spears, 2007). This important relationship between nursing leadership and patient outcomes (Anderson, Issel, & McDaniel, 2003; Cummings, Midodzi, Wong, & Estabrooks, 2010; Houser, 2003; McNeese-

Smith, 1997; Pollack & Koch, 2003) and the quality and safety of care (Perra, 2001; Wong & Cummings, 2007) is supported by a number of studies.

Although the association between nursing leadership and patient outcomes is shown to be present primarily through indirect links (e.g. staffing adequacy, collaboration, etc.), the available empirical evidence provides an indication of the important role of nursing leadership in this relationship. Kooker and Kamikawa (2011) noted that nurse leaders in management positions can impact outcomes of both patients and staff by ensuring that the workplace environment has adequate resources, engaged staff, organizational support, and accessible information on the attainment of quality measures. By taking steps that contribute to a healthy work environment culture, the researchers were able to show that a large medical center can achieve greater staff retention and a reduction in nosocomial decubitus ulcer rates. In a review of factors affecting infection control, Griffiths et al. (2009) found positive leadership to be a requirement in the process of ensuring effective infection control in hospitals.

Similarly, McKinley et al. (2007) study examining falls in a hospital found a link between effective management/leadership and positive patient outcomes, such as the reduction of patient falls in a hospital setting. In their multiple-centre cohort study, Pollack and Koch (2003) noted how managerial practices and organizational processes in a neonatal intensive care setting had an effect on acute, chronic, and critical morbidities (e.g. mortality, bronchopulmonary dysplasia, periventricular/intraventricular hemorrhage or periventicular leukomalacia, etc.) of very low birth weight premature infants. This study noted a significant inverse relationship between the overall values of leadership and periventricular/intraventricular hemorrhage or periventicular leukomalacia. In a study examining complex adaptive systems, Anderson et al. (2003) found that management processes, actions, and skills (e.g. effective communication,

involvement in decision making, etc.) that promote self-organization were associated with the achievement of better patient outcomes. In Anderson et al.'s study, a significant relationship was found between positive management practices and a reduction in the use of restraints as well as a decrease in the prevalence of adverse events, such as fractures and complications of immobility.

In a systematic review by Wong and Cummings (2007), the link between leadership and patient outcomes was further confirmed. They concluded that there is adequate evidence to support the presence of a strong positive relationship between nursing leadership (e.g. leadership qualities, actions, and practices) and patient satisfaction and outcomes. The previously mentioned work of Laschinger and Leiter (2006) also highlighted the key role of strong nursing leadership through their nursing worklife model. Leaders' influence on particular workplace environment conditions, such as nurse/doctor teamwork and cooperation, staffing levels, nursing staff taking part in policy development, and backing of the nursing model of care were associated with staff perceptions of prevalence of adverse events (Laschinger & Leiter, 2006). Collectively, these studies demonstrate the role of nursing leadership in influencing quality patient care and patient outcomes and reinforce how critical it is for organizations to ensure leadership development is incorporated within the organization's strategic plan.

While the evidence cited above recognizes the significant role of nurse leaders and their leadership style, the research also brings to the forefront the vital position of nurse leaders and the need for adequate leadership development training and education that will help leaders to transition into their role and prepare them for the constantly changing needs of the complex healthcare environment. Nurse leaders need to be given access to structured leadership development opportunities that will help them grow into leaders who can articulate the organization's vision, enact and adapt to change, empower and engage employees, and create a

healthy workplace environment that is conducive to staff, organization, and patient outcomes. This education needs to be available to all levels of leadership, but in particular to first-line nurse leaders who are transitioning into formal leadership roles.

Effectiveness and Challenges of Leadership Development Programs

Leadership development programs are a vital component of the healthcare system as they provide essential knowledge, tools, mentorship, and awareness to nurse leaders. Recent research highlights the importance of leadership development as a number of studies have shown that positive outcomes (e.g. improved staff and leader retention, effectiveness of staff at work, better workplace environments, etc.) result from nurse leaders participating in evidence-based leadership development programs (Dahinten et al., in press; Lee & Cummings, 2008; Lee et al., 2010; Shirey, 2006; Tourangeau, 2003). For instance, in the evaluation of the Dorothy M. Wylie Nursing Leadership Institute, staff nurses noted that leaders who took part in the leadership development program exhibited improvements in their leadership behaviors in all of the identified leadership practices (Tourangeau, 2003). Similarly, the latest evaluation of the BC NLI has shown that the leadership program was directly associated with leaders' perceptions of using more empowering behaviors (MacPhee et al., in press) and that nurse leaders' participation in the program directly increased staff reports of greater organizational commitment (Dahinten et al., in press). The latter finding is of particular importance as organizational commitment of staff nurses has been linked by other studies to turnover or retention of staff (Hayes et al., 2006; Laschinger, Finegan, et al., 2009a; Laschinger, Leiter, et al., 2009). Due to this evidence, organizations need to make better use of leadership development opportunities (Cummings, MacGregor, et al.,

2010) as leadership development is clearly a key strategy that can drive and shape the future of nursing leadership within healthcare organizations. Unfortunately, the current reality is that leadership development for nurse leaders is often unavailable or poorly structured and does not allow nurses to develop effective leadership competencies that are necessary to deal with the challenges of the current healthcare system (Conley, Branowicki, & Hanley, 2007; Fennimore & Wolf, 2011).

A number of studies have identified that nurses are asked to take on leadership roles with little preparation or that nurse leaders themselves often feel that they are not provided with adequate support, tools, resources, or formal leadership education before and during their transition into a leadership role (AACN, 2005; Harkins, Butz, & Taheri, 2006; Ingersoll, 1998; Kleinman, 2003; Moran et al., 2002; Paliadelis, 2005; Sherman, Bishop, Eggenberger, & Karden, 2007; Swearingen, 2009; Willmot, 1998). Wolf et al. (2006) explained that nurse leaders frequently feel frustrated and unprepared to meet the demands and challenges of their roles as they are frequently brought into their new position with the hope that their prior experience is adequate to meet the demands of their new job. However, for many, the lack of education and leadership competencies is disastrous on a personal as well as professional and practice level. Harkins et al. (2006) supported this claim by stating that most nurses are thrown into formal leadership roles without being provided with adequate business and management training or sufficient time to carry out leadership responsibilities. Moran et al. (2002) also identified that leadership development remains fragmented and that for the most part new nurse leaders learn their new skills and competencies by chance and by using informal strategies. They found that instead of acquiring leadership skills before taking on a role many nurse managers learned in a "reactive rather than proactive fashion" (Moran, 2002, p. 19) that mirrors an ineffective trial and

error method. Similarly, Paliadelis (2005) noted that nursing unit managers felt that they received lack of support and training/education for the administrative and managerial responsibilities that come with their role. The study determined that most managers taking on a formal leadership position did not have any managerial/leadership education or training when they came into their role. The participating managers stated that they were greatly dependent on other unit managers for their development or had to go out on their own to seek out their own opportunities as there were very few, if any, development possibilities offered by the organization. This documented lack of organizational investment in the development of current and future nurse leaders (Sherman et al., 2007) is concerning with respect to nurse leaders' roles in promoting healthy work environments and impacting a variety of staff and patient outcomes.

Gap in leadership development.

The present circumstances leave many first-line nurse leaders with limited access to formal leadership education, especially leadership development opportunities that are tailored to first-line nurse leader competencies. (CNAC, 2002; Eddy et al., 2009; Fennimore & Wolf, 2011; Sherman et al., 2007; Swearingen, 2009). These limited leadership development opportunities only add to the continued deterioration of the workplace environment which can lead to detrimental effects on leader, staff, and patient outcomes (O'Neil, Morjikian, Cherner, Hirschkorn, & West, 2008). As described by Conley, Branowicki, and Hanley (2007), organizations need to realize that nurses in leadership positions are "gatekeepers of an organization's culture" (p. 491) who align staff to meet the vision and mission of the organization. As a result, steps need to be taken to close the gap between leadership education

and the complex needs of the healthcare environment which currently prevents nurse leaders from effectively transitioning into their position, functioning in their role, and carrying out their responsibilities. Healthcare organizations need to step up and invest in the development of nurse leaders and start acknowledging the importance of having formal leadership development education as part of the organizational strategy (Day et al., 2004; McAlearney, 2005).

As noted above, a number of formal leadership programs have already been developed in an attempt to support and meet the needs of first-line nurse leaders (Fennimore & Wolf, 2011; Sportsman et al., 2010). Greater commitment is needed from the government and the healthcare system in order to have better availability and access to leadership development for nurses transitioning into leadership roles. At the same time, leadership development programs need to undergo more thorough evaluation processes that consider multiple perspectives and offer further evidence of the important role of leadership development education. The program evaluation needs to go beyond the predominantly utilized nurse leader perspectives and incorporate the input of the leaders' staff that can provide a more comprehensive picture of the effect of leadership development programs.

Gap in leadership development evaluation.

Although some empirical studies have incorporated peer perceptions or observer-reports within their evaluation of a leadership development program, (George et al., 2002; Krugman & Smith, 2003; Tourangeau, Lemonde, Luba, Dakers, & Alksnis, 2003) the majority of the evaluation studies have been based on leader self-reporting which provides only the participants' perspective of their experience and outcomes stemming from their participation in a leadership

development initiative (Cleary, Freeman, & Sharrock, 2005; Fennimore & Wolf, 2011; Krejci & Malin, 1997; Sportsman et al., 2010; Vogelsmeier et al., 2010; Werrett, Griffiths, & Clifford, 2002; Wolf, 1996). By utilizing participant self-reporting and self-evaluation strategies these studies provide a great wealth of data on nurse leadership needs, the experiences of leaders, and the impact and effectiveness of leadership development programs (Lee et al. 2010). This information is vital as it can help to support future leaders, develop more effective leadership development programs, and establish the importance of incorporating leadership development within the structure and culture of healthcare organizations. However, participant self-reporting can also be biased and provide inaccurate or one sided conclusions (Cummings et al., 2008). According to Cummings et al. (2008), incorporating observer/peer appraisal strengthens the validity of studies evaluating leadership development initiatives as "leadership measures by followers are free of social desirability response bias often associated with leaders' self-report measures" (p. 245). In the next section of this chapter I will describe the BC NLI and provide details regarding the way this study will try to address this gap in leadership development program evaluation research by examining the rarely utilized perceptions of staff nurses.

Leadership Development Program in British Columbia: BC NLI

The establishment of the BC NLI program was initiated as a result of the CNAC (2002) report that expressed the need for greater presence of nursing leadership for the creation of professional practice environments that would attract, support, and retain sufficient and dedicated staff within organizations. In collaboration with the Nursing Directorate of the BC Ministry of Health, the BC Chief Nursing Officers, and the UBC School of Nursing, the BC NLI

program was developed, implemented, and evaluated over a 4-year funding period. This program was based on leadership development literature and a provincial nurse leader needs assessment of essential leadership and management competencies (MacPhee & Bouthillette, 2008). Research funds provided by the CHSRF were used to conduct a mixed methods study of leader and staff outcomes between 2007 - 2010.

The aim of the BC NLI was to develop relational and management competencies of first-line leaders and improve leader and staff job satisfaction and organizational commitment. The central theoretical assumption was that "participation in a specially designed formal leadership development programme would empower leaders who in turn would empower their staff" (MacPhee et al., 2011, p. 161). During the program's operation almost 1,000 novice nurse leaders participated in the BC NLI. Each leadership session consisted of about 35 to 40 participants that came from various healthcare sectors and represented all regions within the province. Although the program was designed for novice first-line nurse leaders with less than 3 years of experience the BC NLI participants also included novice mid-level leaders (MacPhee et al., 2011). The reason for this modification was due to the overwhelming demand for nursing leadership training within the province. To achieve the program's aim, the BC NLI offered its participants a yearlong structured program that comprised of four elements:

1. A four day retreat workshop: This component was offered at the beginning of the one year period and provided the nurse leaders with an opportunity to network with their peers, explore their leadership abilities, and gain knowledge about leadership development and ways to support staff and the practice environment. The workshop consisted of a combination of key speakers, lectures, participant interaction, and leadership development activities.

2. Mentor support from a senior nurse leader: Each nurse leader participant was paired with a senior nurse leader within their organization, who acted as mentor. The participants and their mentors had an opportunity to connect and get to know each other outside of the workplace environment during the last two days of the retreat workshop. During this time the mentors and novice nurse leaders were also given a chance to begin planning the project component of the BC NLI program.
3. Virtual networking: Networking after the four day workshop between the participants was made possible by way of an online web-based system that enabled the nurse leaders to virtually connect with each other and request assistance or information related to their leadership needs.
4. A healthcare related project: All participating nurse leaders were expected to implement a leadership project in their practice area with the support of their mentor and organization. This project was used to consolidate participant knowledge and provide practical learning opportunities.

The BC NLI used a workplace empowerment framework based on the many decades of empowerment research conducted by Laschinger and colleagues (Laschinger, n.d.). This framework acknowledges the importance of the workplace empowerment process where leader empowering behaviors act as a stimulus or catalyst for the process (Leader Empowering Behaviors→Structural Empowerment→Psychological Empowerment→Positive Outcomes). As explained by MacPhee et al. (in press) the "curriculum focused specifically on training and applications for leader empowering behaviors" (Leadership Development section, para. 2). This empowerment framework facilitated the development of curriculum intended to inspire and positively influence/empower new first-line nurse leaders -- their behaviors, attitudes, and values

(MacPhee et al., 2011). The program also provided opportunities for leaders to hone key relational and management capabilities, particularly by conducting project work under the mentorship of experienced nurse leaders within their respective organizations.

BC NLI evaluation.

As I have explained in Chapter 1, this thesis builds on previous BC NLI evaluative research by analyzing the perceptions of staff nurses and identifying whether they detected any behavior differences in their first-line leaders during the one year period following their leaders' participation in a structured leadership program. For the purpose of this study these behaviors will be defined in broad terms as any actions, attitudes, and affect changes noted by staff nurses in their first-line nurse leaders. This study addresses the knowledge gap with respect to the impact of leadership development programs on outcomes, particularly staff perceptions in local, Canadian context. The results derived from staff nurse perspectives will contribute additional data regarding the effectiveness of a formal nursing leadership development program.

CHAPTER 3: Methodology of the Study

Aim

The aim of the study was to build on previous BC NLI evaluative research by analyzing the perceptions of staff nurses and identifying whether they have seen any behavior differences (i.e. changes in actions, attitude or affect) in their first-line leaders during the one year period following their leaders' participation in a formal leadership development program.

Design

This study used a qualitative descriptive study approach. The purpose of this approach was to explore relatively un-researched areas of an empowerment-based leadership development program and its impact on first-line leader behaviors.

Ethical Consideration

Ethics permission for the evaluation of the BC NLI program was obtained from the University of British Columbia ethics review board and the necessary regional ethics review boards from across the province of BC that represented the first-line nurse leaders and staff focus group participants. Participants were given at least 24 hours to look over the study cover sheet and consent form. Advertisement of staff nurse focus groups and the relevant study information were distributed at least a week before the commencement of each session. At the time of each focus group session, participants were again provided with a description of the study in the form

of a study cover letter and a focus group consent form to sign. All participants were also given an opportunity to ask questions regarding the study and were able to withdraw at any time during the process.

Participant Recruitment

Nurse leaders who participated in the BC NLI were invited to participate in several components of a larger study designed to evaluate the BC NLI. The nurse leaders who consented to participate in the staff focus group component of the program's evaluation were asked to post and distribute recruitment brochures to their staff. To decrease the possibility of coercion, nurse leaders were not directly involved in staff focus group recruitment. Instead, the brochures instructed any interested staff to contact the study's research project manager. Leaders, therefore, were not aware of those staff participating in focus groups.

Participants were invited to take part in the focus group sessions by way of a hard copy advertisement being posted by the nurse leader in lounges and in staff nurse/unit mailboxes. Accompanied with the advertisement were copies of the study cover letter and consent form. Staff nurses were asked to contact the research director if they were interested and willing to take part in a focus group session.

Sample and Setting

The sample for this study was a convenience sample of staff nurses whose nurse leaders attended the BC NLI between 2008 and 2009. Nurse leaders who attended the BC NLI during

this time period represented all the regional health authorities in BC; however, for this part of the study the participants included only staff nurses from the BC Lower Mainland health authorities so that focus group arrangements could be managed by the study project director. The staff nurses who participated in the study had to have direct pre and/or post experience of their leader's leadership and be available for focus group sessions that were held in a private location within their organization.

Data Collection

Focus group sessions were conducted by a neutral, professional facilitator who was not affiliated with the evaluation process of the BC NLI. The facilitator asked specific, predetermined questions (see Appendix A for focus group questions) during each session. Open-ended questions were designed to elicit focus group participants' perceptions of any leader behaviour changes noted after their leaders' BC NLI participation. The BC NLI leaders completed their program one year after attending a five day residential workshop and completed year-long projects within their organizations. The staff focus groups were conducted one year from the leaders' workshop attendance and at the end of their BC NLI project completion. The focus group sessions usually lasted 30 minutes and were never longer than an hour. Each session was digitally recorded among consenting, volunteer staff nurses. The recordings of each focus group were professionally transcribed and names were deleted to ensure confidentiality. Most staff focus groups were conducted during meal/rest breaks in a private space that was reserved for these sessions to minimize interruptions and to ensure confidentiality of participants. Beverages and snacks were provided to focus group participants. Each transcribed digital

recording from the focus group sessions was loaded into password protected QSR International's NVivo 9 software (NVivo 9, 2010) which was used to assist in the analysis process.

Method of Analysis

I used the qualitative approach of inductive thematic analysis (Boyatzis, 1998) to conduct a secondary analysis of staff focus group data. I used the step by step analytic process outlined by Braun and Clarke (2006) that is described in Table 3.1 – Phases of thematic analysis.

Table 3.1 Phases of thematic analysis.

Phase	Description of the process
1. Familiarizing yourself with your data:	Transcribing data (if necessary), reading and re-reading the data, noting down initial ideas.
2. Generating initial codes:	Coding interesting features of the data in a systematic fashion across the entire data set, collating data relevant to each code.
3. Searching for themes:	Collating codes into potential themes, gathering all data relevant to each potential theme.
4. Reviewing themes:	Checking if the themes work in relation to the coded extracts (Level 1) and the entire data set (Level 2), generating a thematic 'map' of the analysis.
5. Defining and naming themes:	Ongoing analysis to refine the specifics of each theme, and the overall story the analysis tells, generating clear definitions and names for each theme.
6. Producing the report:	The final opportunity for analysis. Selection of vivid, compelling extract examples, final analysis of selected extracts, relating back of the analysis to the research question and literature, producing a scholarly report of the analysis.

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The thematic analysis approach is a method of analysis that can be viewed as an ongoing communication act between the researcher and the data during which the researcher focuses on identifying patterns within the existing information (Graneheim & Lundman, 2004). Thematic

analysis is not attached to a particular theoretical framework or requires specific technological knowledge that is commonly found with similar approaches, such as grounded theory (Braun & Clarke, 2006). As noted by Fereday and Muir-Cochrane (2006), thematic analysis involves a "form of pattern recognition within the data, where emerging themes become the categories for analysis" (p. 4). Boyatzis (1998) adds to this description by comparing the process of thematic analysis to a "translator" (p. 145) of qualitative information, which assists to decode information and ultimately aids researchers in their search for insight.

The qualitative technique of thematic analysis can be used with a wide variety of qualitative information that ranges from interviews to video recordings to memos or personal letters. In a distinctive way, thematic analysis offers researchers a flexible and useful tool that can "provide rich and detailed, yet complex account of data" (Braun & Clarke, 2006, p. 78). It uses a non-linear, systematic process made up of several actions that include: getting acquainted with the raw data (i.e. data organization, reading, and re-reading), identification of codes (i.e. coding and encoding), theme recognition, assessment of themes, outlining themes, and drawing conclusions (i.e. interpretation and confirmation of findings) (Boyatzis, 1998; Braun & Clarke, 2006). Although thematic analysis examines only data derived from qualitative studies the technique does offer researchers an opportunity to apply statistical analyses to frequency counts of themes or codes.

In the course of thematic analysis, coding includes the identification of important events that are then encoded to organize and prepare data for theme development and interpretation. The resulting themes in this case represent a pattern in the collected data that have the ability to describe the content or even decipher the meaning of the event (Boyatzis, 1998). The identified themes can vary in their depth and level of deduction in that they can either be manifest/semantic

or latent. With manifest/semantic themes, the analysis considers only content that is present in the actual data; whereas, with latent themes one goes a step further by analyzing the underlying meaning of the same content (Boyatzis, 1998; Braun & Clarke, 2006; Graneheim & Lundman, 2004). For the purpose of this study, thematic analysis at the manifest/semantic level was utilized for the examination of collected data.

The NVivo 9 software was employed in addition to manual, non-software methods of data assessment to ensure that a comprehensive examination and detailed acquisition of results were obtained from the collected data. Following the step-by step method of Braun and Clarke (2006), I independently reviewed and re-reviewed the transcripts to extensively familiarize myself with the content of the staff focus group data. This allowed me to begin the identification of codes based on words and phrases used by participants during each focus group session and eventually code the data for each session in a systematic manner. This coding process was initially carried out manually and then repeated through the use of the NVivo 9 software to ensure that potential coding opportunities were not missed. The manual and software versions of coding were then compared and any discrepancies were addressed by assessing each discrepancy, referring back to code definitions, and consulting with the team when discrepancies could not be resolved. The use of the NVivo 9 software during this coding process was deemed to be of particular assistance in the process of analyzing the large amount of data by keeping track of coded passages and collating them into relevant categories. Although the NVivo 9 software automatically organizes coded data, the manual method of keeping track of codes was maintained by assigning each identified code to the constructed excel code tables and coded categories which were supported by direct quotes from the focus group sessions. The coded categories within this analysis were developed with input from the thesis committee members

and after the development of clear definitions for each code. Code definitions were developed based on codes identified directly from focus group data and based on common definitions that corresponded with the subject matter delivered by focus group participants. From the constructed code tables, themes were then identified based on one or more of the detected code categories and conclusions were drawn from the results obtained from the combined manual and NVivo 9 software analysis process. Throughout this process, all reviews of transcripts were supported by the supervising researcher and two assisting committee members in order to ensure the rigor and validity of the study.

Validity and Rigour

As with other systems of analysis, several concerns and limitations of this technique can be identified. Boyatzis (1998) explains that since thematic analysis is a way of "seeing" (p. 4) it may result in every individual identifying something different when interpreting the same information or event. Insight into every event may also be shaped by each individual's experiences, beliefs, and perceptions which can lead to differences in the interpretation of qualitative information. Along with projection of the researcher into the translation process, sampling corruption and mood/style of the data interpreter are also recognized as barriers that can impede or even manipulate effective analysis (Boyatzis, 1998). Analyzing transcripts or any written text may also be of concern in thematic analysis as this form of information lacks the non-verbal cues found in verbal communication (Graneheim & Lundman, 2004). This is a matter that needs to be recognized as the loss of non-verbal cues can lead to loss of meaning and ultimately affect the study results and conclusions. However, there are several steps that each

researcher can take to try to reduce these obstacles and ensure that rigor, credibility, dependability, consistency, and transferability are addressed and maintained throughout the analysis process.

Steps taken to ensure validity and rigour.

To prevent or reduce the barriers to effective thematic analysis I used key strategies during all stages of the study. As originally outlined in the study's introduction, the steps taken included the development and use of clear codes, having a clear pre-set decision making process, including the opinions and perspectives of several individuals, being open to various theories and ideas, having self-control and recognizing external stressors that may affect the analysis, being transparent regarding the research process through clear description of employed methods and reasoning, following a consistent approach throughout the analysis process, avoiding predetermining codes that could bias the coding process, and adhering to the raw data without being influenced by personal ideas and values (Boyatzis, 1998). It also involved following Braun and Clark's (2006) standards to good thematic analysis which the authors identified as necessary components for generating transparent, authentic, and rigorous analysis (see Table 3.2 – A 15-point checklist of criteria for good thematic analysis).

Table 3.2 A 15-point checklist of criteria for good thematic analysis

Process	No.	Criteria
Transcription	1	The data have been transcribed to an appropriate level of detail, and the transcripts have been checked against the tapes for 'accuracy'.
Coding	2	Each data item has been given equal attention in the coding process.
	3	Themes have not been generated from a few vivid examples (an anecdotal approach), but instead the coding process has been thorough, inclusive and comprehensive.
	4	All relevant extracts for all each theme have been collated.
	5	Themes have been checked against each other and back to the original data set.
	6	Themes are internally coherent, consistent, and distinctive.
Analysis	7	Data have been analysed – interpreted, made sense of – rather than just paraphrased or described.
	8	Analysis and data match each other – the extracts illustrate the analytic claims.
	9	Analysis tells a convincing and well-organized story about the data and topic.
	10	A good balance between analytic narrative and illustrative extracts is provided.
Overall	11	Enough time has been allocated to complete all phases of the analysis adequately, without rushing a phase or giving it a once-over-lightly.
Written report	12	The assumptions about, and specific approach to, thematic analysis are clearly explicated.
	13	There is a good fit between what you claim you do, and what you show you have done – ie, described method and reported analysis are consistent.
	14	The language and concepts used in the report are consistent with the epistemological position of the analysis.
	15	The researcher is positioned as *active* in the research process; themes do not just 'emerge'.

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These steps were further supported throughout the analysis by three particular approaches. One of the approaches included regular contact with the committee for the purpose of sharing progress and findings, engaging them in the research process, and keeping them informed of steps being taken during the analysis. Close contact with committee members helped me remain consistent throughout the analytic process, and ensured that I was not deviating from codes and themes evident from the raw data. The regular contact also offered me regular opportunities to obtain assistance when questions arose around any aspect of the study. All of the contact with the thesis committee consisted of a combination of face-to-face meetings and electronic communication via email.

A second approach included the use of reflective notes to keep a detailed history of my research process, providing an overview and timeline of how I analyzed focus group data over a one year-long period. These notes helped me ensure consistency and transparency with the analytic process. My notes also included documentation of questions, concerns, and problems I had during the process and how I addressed them.

The third approach involved the employment of the NVivo 9 program. As I have indicated above, the use of the Nvivo 9 software was used in conjunction with a non-software method of analysis to enhance consistency of data analysis and interpretation. The program allowed me to quickly track and search for key words and compare my coding scheme and definitions with my manually coded version. Frequent comparisons and cross-checks between the two coding approaches helped me ensure coding consistency.

CHAPTER 4: Findings

In Chapter 3, I provided a detailed description of methods used to code BC NLI staff focus group data. The definitions of the various concepts used in my thematic analysis were based on explanations provided by Graneheim and Lundman (2004). The authors describe a meaning unit as a "constellation of words or statements that relate to the same central meaning…" (Graneheim & Lundman, 2004, p. 106). The labels used for the identified meaning units are denoted as codes. Codes allow for "the data to be thought about in new and different ways" (Graneheim & Lundman, 2004, p. 107). Developed codes are grouped into sub-categories and/or category. Sub-categories can be viewed as subsections of a category that differ from each other but have some similar component between them that allows them to be brought together into a category. A category is a "group of content that shares a commonality" (Graneheim & Lundman, 2004, p. 107). When the researcher has a number of categories he or she can formulate themes. Graneheim and Lundman (2004) explain that a theme is a "thread of an underlying meaning" (p. 107) that enables the researcher to link the fundamental meanings of the categories. In what follows I will provide an overview of participant demographics and the key study findings, which were arrived at using Graneheim and Lundman's (2004) definitions in conjunction with Braun and Clarke's (2006) step by step approach to thematic analysis.

Results

Focus group participant demographics.

Ten nursing staff focus groups were part of the larger CHSRF-funded study described in Chapter 2. Two groups were affiliated with nurse leaders who attended the BC NLI program in 2008 and the remaining eight groups were affiliated with nurse leaders who attended in 2009. The ten focus groups were held in British Columbia, Lower Mainland. The convenience sample of staff resulted in the participation of four healthcare authorities in the Lower Mainland, which included Providence Health, the Provincial Health Services Authority, the Fraser Health Authority, and the Vancouver Coastal Health Authority. The sample process gave rise to a cross-section of nurses from acute to residential care.

Thematic analysis findings.

A summary of the number of themes, categories, and sub-categories associated with the study questions are outlined in Table 4.1. In the remainder of this chapter, I will define and describe the themes associated with specific study questions and provide illustrative quotes. Brackets in quotations (i.e. […]) depict my insertions where actual words were dropped or unclear in the audio recording. Appendix A contains all the themes, categories, sub-categories, codes, and sample quotes relevant to this analysis.

Table 4.1 Analysis summary

Question(s)	Themes	Category	Sub-Category	Code
Question 1 and 2: 1. How would you describe your nurse leader's leadership style? 2. What do you think is positive or successful about your leader's style?	2	5	6	57
Question 3: 1. Give an example of how your nurse leader has helped to create a more positive work environment for you.	1	4	0	6
Question 4 and 5: 1. What are some challenges or difficulties you've had in your work environment? 2. How has your leader helped you deal with these work environment challenges?	4	6	8	60
Question 6 and 7: 1. If you could change anything about your leader's style, what would you want to change? Why? 2. Your nurse leader attended a nursing leadership workshop. Since their attendance, have you noticed any differences in their leadership behavior? If you have noticed differences, please describe them.	2	5	0	36
Question 8: 1. From your perspective, would you recommend this type of leadership training for other nurse leaders? Why or why not?	3	4	6	16

Focus group questions 1 and 2: Leader/leadership characteristics and skills.

Focus group questions 1 and 2 were: How would you describe your nurse leader's leadership style? and What do you think is positive or successful about your leader's style?

Participants in each focus group identified positive and negative aspects of their first-line nurse leaders' leadership style with predominant focus being placed on positive aspects. When participants were asked to describe their nurse leader's leadership style, two key themes were

identified to be most prevalent amongst the ten groups. The two themes were distinguished from one another in that characteristics were seen as personal attributes of an individual, whereas skills were viewed as the capabilities that the participants acquired from aspects such as training or education. The two themes identified were: *characteristics possessed by first-line leaders* and *skills possessed by first-line leaders*.

Characteristics possessed by first-line leaders.

The theme "characteristics possessed by first-line leaders" was defined by focus group participants as positive and negative personal traits or qualities of a first-line nurse leader that distinguish him/her from others. Under this theme, some of the positive aspects mentioned by the participants included: approachable, caring, confident, committed, focused, non-judgemental, and motivated (see Table 4.2 Leader Characteristics). Participants provided a description of a number of positive characteristics possessed by their leaders when they stated:

> Positive Attributes – approachable & non-judgmental: "Well she's very approachable, she's easy to talk to, she's non-judgmental, she never makes you feel like you're wasting her time."

> Positive Attributes – approachable: "She's very approachable ... I'm not hesitant to walk into her office and to ask questions or come with my problems there. I know she will listen to me, I might not always [get] the answer I want which is understandable too right but, yeah."

Positive Attributes – caring: “I think she’s also very caring about staff as well, she’s the one of all our leaders that will go around and ask you ‘are you alright, are you doing okay?’”

Positive Attributes – openness: “Well I find that she’s very open and very, um, what’s the word I’m looking for? Um, she will actually sit down and listen if there is something that you are concerned about? She’s around a lot more than anybody we’ve ever [had] before. It’s nice to have, I find that [it’s] nice to have her in and out on the floor because it seems to me that she has a better grip of what’s really, really going on rather than the hearsay third person type of thing.”

The less commonly mentioned negative characteristics of first-line nurse leaders were identified by participants when they perceived their leaders as unapproachable, intense/upfront, distracted, or unfocused. The participants provided examples of negative characteristics of their leaders by identifying the following:

Negative Attributes – intense: “...I’m not scared of her or whatever but some people … [are] and it’s just, she’s very intense and you’re almost afraid that she’s going to think you don’t know what you’re doing. Sometimes you get that sense so it’s not as comfortable to go to her, you know, something might not be going right or whatever so I think she could benefit from, you know… learning to not be so intense ...”

Negative Attributes – intense & blunt: "Yes, she can be intense sometimes and blunt which I kind of put under the umbrella of assertive but … to certain people that may not be as assertive … she'd be scary especially if you don't know her."

Negative Attributes – distracted: "It depends on the situation I mean she can be quite an effective communicator … when it's manageable when there's not a lot of other people coming down on her. I find that when there's a lot of people ... from the other places coming down on her then her leadership kind of gets more … distracted."

Table 4.2 Leader characteristics

THEMES	CATEGORY	FREQUENCY COUNT	CODES
Characteristics possessed by first-line leaders	Positive attributes	22	approachable
		17	caring
		15	openness
		9	confident
		9	effective
		7	assertive
		6	committed
		5	enthusiastic
		4	focused
		4	jokes or humor
		4	trust
		3	fair
		2	non-judgemental
		1	genuine
		1	honest
		1	motivated
		1	relaxed
		1	transparent
	Negative attributes	5	unapproachable
		4	intense or upfront
		2	distracted
		1	blunt
		1	unfocused

Skills possessed by a first-line leader.

The theme "skills possessed by first-line leaders" was defined as any leadership abilities that could be acquired from training, education, practice, etc. When participants brought up information about their first-line nurse leader's skills, they mentioned factors that can be categorized as *personal* (i.e. related to leader abilities), *organizational* (i.e. related to running/operation of institution), or *workplace* (i.e. related to staff and/or environment) related (see Table 4.3 Leader or Leadership Skills). Within this part of the focus groups' conversations, the participants had similar perceptions to when they discussed their leaders' characteristics in that they primarily expressed positive thoughts about their leaders' skills. When it came to personal leader factors, participants recognized communication, decision making, reaction during stressful period, leader visibility, and delegation as some of the key skills possessed by their leaders. For instance, the participants expressed their thoughts about some of the skills by stating:

> Personal Leader Factors - communication: "…she's got … lots of things on her mind but … she always communicates with us like, 'Okay, we're going to get this patient, this is the report' and then you …know, she's fully focused on … [what] we are getting. So communication is a strong one when you initiate it…"

> Personal Leader Factors - decision making: "I find XXX, she listens but she, she's not afraid to make the decision. So she listens to people … [and then] she'll make the decision whereas some leaders…, they listen but they don't make the decision and some people don't listen at all they're just 'that's it'."

Personal Leader Factors - delegation: “Like she’s learnt now to delegate and not just take everything on herself.”

Personal Leader Factors - reaction during stressful period: “Another thing that I really like about XXX is the fact that … when you are put in a situation that’s extremely stressful she doesn’t really like take that all on her own and then trickle it down to the rest of the team. Like I find that she can stay calm in whatever situation or [she] lets you know that she’s going to get through it, and the team together we’re going to get through it.”

Personal Leader Factors - leader visibility: “She’s around a lot more than anybody we’ve ever [had]…before. …I find that [it’s] nice to have her in and out on the floor because it seems to me that she has a better grip of what’s really, really going on rather than the hearsay third person type of thing.”

Table 4.3 Leader or leadership skills

THEMES	CATEGORY	SUB-CATEGORY	FREQUENCY COUNT	CODES
Skills possessed by first-line leader	Personal leader factors *(related to leader abilities)*	Positive	220	communication
			19	decision making
			14	organization skills
			12	delegation
			12	reaction during stressful period
			11	deals with issues head on
			10	leader visibility
			7	listening skills
			6	leadership skills
			6	ability to cope
			3	knowledgeable
			2	consistent
		Negative	7	communication
			6	decision making
			5	reaction during stressful period
			4	leader visibility
			3	ability to cope
			1	listening skills
	Organizational factors *(related to running/operation of institution)*	Positive	174	leader involvement
			123	access to resources
			25	availability
			10	accessible
		Negative	13	leader involvement
			7	access to resources
			4	availability
			1	accessible
	Workplace factors *(staff and/or environment related)*	Positive	84	support of staff
			28	teamwork
			23	positive reinforcement
			6	advocates for nurses
			2	acknowledges staff
		Negative	10	support of staff
			3	teamwork
			2	positive reinforcement

Under organizational factors, participants recognized *leader involvement*, *access to resources*, *availability*, and *accessibility* as skills possessed by their first-line nurse leader. The participants provided the following as examples:

Organizational factors - leader involvement: “If you have a difficult patient she will go and speak with them. She’s always, she will go and address the issue that you have with the person so that’s very helpful for us. … [At times] they won’t listen to us but she is willing to go and address the issue, she’s supportive of us.”

Organizational factors - access to resources: “... she’ll give you additional resources, you know, if you need to follow up a situation where in which a patient needed to have a specific intervention. And she actually went on the computer and downloaded it and … [presented] it so I was like whoa, wait a minute here this is great, I really appreciated that.”

Organizational factors - availability: “Participant 1: I haven’t been here very long but … for the short time I was here…I find the manager is very approachable as XXX said. And she’ll talk with you if there’s a problem, anything. And if you make a call to her I find that she returns your call, you know, in a timely manner. And I think she really works for the good of the whole unit.

Participant 2: She’s stalking us. [Laughter] I think it’s the right thing like she’s always available and I never had that before.”

Organizational factors - accessible: “She’s accessible without judgment, which is nice.”

Under workplace factors, participants recognized *support of staff*, *teamwork*, *positive reinforcement*, *advocating for nurses*, and *acknowledgment of staff* as important skills possessed by their first-line nurse leader. Examples of these factors were provided by the participants when they noted:

> Workplace factors - support of staff: "I had a situation in which I really felt that I needed to do something -- it was an aggressive doctor. And I expressed my frustration to XXX, you know, I like to use her as a sounding board [laughter], so anyway I expressed my frustration and I felt supported to the point that I was very confident in dealing with the doctor on my own. I didn't necessarily need her to step in, however, she was in the background and I appreciated that but I felt confident enough to go on my own but as I said I felt free that I could express how I was feeling, you know, prior to stepping out, you know, and I really felt supported there."

> Workplace factors - teamwork: "It's a nice place to work and you are supported and it's not just with the leadership it's the, it's the whole team. And I think,… that we have a very good leadership team for the majority of the time."

> Workplace factors - positive reinforcement: "She makes a point to come to the ward and say 'I know it's overwhelming changes but you guys are amazing, I love the work you do'. She sent us flowers that time [we had difficulties] and a card that said keep up the good work or whatever…"

Workplace factors - advocating for nurses: "...I think standing up for us, like really being … proactive at defending and advocating for us as a unit, like as a staff. I mean … [she also advocates for] the patients…that's always been her part especially coming from being a floor nurse. But as staff, you know, seeing her, she really advocates for us."

Workplace factors - acknowledgement of staff: "But she really acknowledges the staff, you know, when she goes onto the floor she actually will acknowledge the staff saying 'hi' to them and that's huge because then you feel like you do have somebody that perhaps is willing to be supportive."

Less commonly mentioned were negative comments about the leader and/or leadership skills. Interestingly, negative comments were identified in many of the same skill areas as positive comments (see Table 4.3 Leader or Leadership Skills). Some observations were related to areas where participants identified skills that their first-line nurse leaders were lacking; however, the majority of remarks identified negative leader and/or leadership skills that were attributed to an external influencing factor (e.g. organizational or workplace related) that was outside of the leaders' control. An example of a negative leadership skill that was attributed directly to the leader centred around the leader's decision making abilities. As remarked by a focus group participant:

Personal leader factors - decision making: "...she's very like go…by the book, you know, 'this, this, this'. And there's really no other way around it like it's not as pleasant to

> work with a … [charge nurse] when it's super busy and everybody is stressed … to get that kind of response."

The more frequently mentioned examples identified external influencing factors playing a role in how their leaders utilized and applied skills in the practice setting. Such examples involved areas such as communication, decision making, leader visibility, and accessibility. This was illustrated, for example, when participants offered the following around their leader's accessibility and communication:

> Organizational factors - accessible: "She's not here. I mean she's not physically [near us] . . . I mean her office is nowhere near us right? It's way the hell over in the … [other] building. It takes her about ten minutes to get here from her office. So to ask her to be here to give that kind of immediate support is a bit unreasonable really."

> Personal leader factors - communication: "Participant 1: I find that when there's a lot of people coming down from the other places, coming down on her, then her leadership kind of gets more … distracted".

> "Participant 2: Yeah, distracted just a little, it's not as focused, whereas usually…when it's a calm environment she's [a] very effective communicator and tries very hard to discuss, a very almost democratic process, discussing what the best options are for the team, for the unit, for all of us together."

Focus group question 3: Workplace environment.

Focus group question 3 was: Give an example of how your nurse leader has helped to create a more positive work environment for you?

When asked for input regarding the practice setting, all staff focus group participants recognized that first-line nurse "leaders play a major role in the workplace environment". During the course of this dialogue, participants pointed out the far reaching effect of first-line nurse leaders and how their position within the system affects aspects of the unit and of the organization.

Leaders play a major role in the workplace environment.

The extensive discussion of this subject matter by focus group participants aided in defining the theme. Overall, this definition included any direct or indirect function, position, or responsibility of a first-line nurse leader in the workplace environment that has an impact on staff, the practice setting, and the healthcare institution. The particular workplace areas where leaders were identified to have had impact included: *workload* (e.g. patient load or workload); *practice environment/workplace* (e.g. positive workplace, unit culture, and unit changes); experience (e.g. prior experience); and *staff* (e.g. staff turnover) (see Table 4.4 Workplace environment). In what follows, I have elaborated on these categories by providing quotes from participants that indicate their leader's impact within these areas of the workplace environment:

Workload – patient load or workload: "Especially for us on the front team we do a lot, …we have such a high turnover, we have a lot of transferring and stuff so we're doing a

lot of the admissions and stuff and XXX really does try to balance that out for us with, you know, if she can find transfers or just stuff that will help our workload for the day."

Practice environment/workplace – unit culture and positive workplace: "It's a nice place to work and you are supported and it's not just with the leadership…it's the whole team. And I think, and, yeah, I think that we have a very good leadership team for the majority of the time."

Experience – prior experience: "She's been a staff nurse, she knows what the realities of a staff nurse are. So if the nurses say …'we need an extra person, we need workload, this is the reason why'. She says, 'yeah, fine', because she gets it right? She understands what it means to work as a front line nurse..."

Staff – staff turnover: "Well because we've had so many managers and she's actually been willing to stay and she's put a lot of effort into it and I think from what I've seen and heard I thoroughly enjoy working with her. And for her being the manager on my floor is one of the reasons I'm staying."

Table 4.4 Workplace environment

THEMES	CATEGORY	FREQUENCY COUNT	CODES
Leaders play a major role in the workplace environment	Workload	16	patient load or workload
	Practice Environment/ Workplace	22	constant unit changes
		11	positive workplace
		5	unit culture
	Experience	6	prior experience
	Staff	2	staff turnover

Focus group questions 4 and 5: Workplace challenges.

Focus group questions 4 and 5 were: What are some challenges or difficulties you've had in your work environment? and How has your leader helped you deal with these work environment challenges?

When asked about workplace challenges, the focus group participants showed support for their leaders and for what they do. However, within the same discussion the participants also made it clear that first-line nurse leaders face many barriers, constraints, and restrictions in the workplace environment that affect them personally, their leadership, and the individuals who come into direct and indirect contact with them. The same conversation also led some participants to express their belief that the workplace challenges are not exclusively experienced by leaders as there is also a lack of organizational support provided to nursing staff. Four key themes were identified with the workplace challenges questions: *leader support in the workplace*, *organizational restrictions*, *negative impact of organizational restrictions*, and *lack of organizational support for staff*.

Leader support in the workplace.

Focus group participants made it clear during the sessions that staff nurses usually back their leaders and view them in a positive manner regardless of the challenges within the workplace environment. Based on the presented evidence, "leader support in the workplace" theme (see Table 4.5 Workplace Challenges – leader support in the workplace) was defined as participants having positive perceptions of a leader and an understanding of the importance organizational support plays in assisting leaders to grow and provide effective leadership. This theme was identified and reinforced by several participants, some of whom expressed the following positive views of their first-line nurse leader:

> Staff support for leaders - the leader does a good or great job: "I mean I think she's doing great, I think she's really good at it. She's got a really nice manner about her, she's got a really nice manner about her and, yeah, she's easy to deal with."

> Staff support for leaders – enjoy working with her: "It's just starting a day that stresses me that I would say that I don't get stressed when I have to work in …[this unit] because she's there … you know, your manager is going to be with you so it doesn't stress me."

Table 4.5 Workplace challenges - leader support in the workplace

THEMES	CATEGORY	SUB-CATEGORY	FREQUENCY COUNT	CODES
Leader support in the workplace	Staff support for leaders	Positive views of leaders	8	the leader does a good or great job
			5	leader makes a difference for staff
			4	leader is good or great
			2	enjoy working with her
			1	has become a stronger leader
			1	makes it look simple
			1	she is the best manager we have had
		The importance of staff support	2	staff identify that they also need to support their leader
			2	leadership support is good and necessary
	Staff awareness of external factors	Staff recognition of leader limitations	2	staff is understanding of leader limitations
			1	impact of management or leadership style

Organizational restrictions.

While great support was expressed for first-line nurse leaders, the staff focus group participants also recognized the existence of organizational challenges that affect not only leaders but the individuals who are directly and indirectly connected to them. From this discussion and the many comments made by the focus group participants, the analysis led to the identification of the theme of "organizational restrictions" (see Table 4.6 Workplace challenges – organizational restrictions). This theme was defined as the identification of constraints, limits, or challenges stemming from or found within the workplace environment which impact the first-line nurse leader and his/her leadership abilities. When describing the many organizational challenges faced by first-line nurse leaders the focus group participants identified factors that can be categorized under *practice environment* (e.g. institutional/environmental factors leading to constraints), *power* (e.g. power/hierarchy limitations), and *workload* (e.g. leader workload

constraints) categories. Some of these constraints were described by focus group participants in the following ways:

Practice Environment - administrative constraints or organizational rules/expectations: "Well it's really hard for her, I think, to try and give us an alternative when that's the new protocol and it's handed down and you've got to do it. It then falls on the nurse educator's hands to then find a different way so it's out of her hands as the PCC (Patient Care Coordinator) in a sense when she's got so many other things on her plate. So I can understand her frustration as well, it's like, okay, yes, I understand you have to do this, there's only so many things she can say to try and make it warm and fuzzy but … You have to do it."

Power – limited power: "I think sometimes with the staff meetings our concerns are addressed but again XXX can only go, do so much with what she has as far as her powers go right? She's told from above what she's supposed to be doing and she has to follow those so we know that, understand that."

Workload – big workload: "I think she makes it look really simple like she has like a lot of workload but like when she's not on and when someone else is like taking over you can really see the difference when she's on because of the way she does things. And I guess you don't notice it until someone else does it and you realize what a big workload she has."

Table 4.6 Workplace challenges - organizational restrictions

THEMES	CATEGORY	FREQUENCY COUNT	CODES
Organizational restrictions	PRACTICE ENVIRONMENT *(Institutional/ environmental factors leading to constraints)*	5	administrative constraints or organizational rules/expectations
		2	organizational initiatives leading to restrictions
		1	need a better workplace environment
	POWER *(Power/ hierarchy limitations)*	4	handed down or comes from above
		4	organizational pressures or demands or leader requirements
		3	stuck between management and staff
		2	limited power
		1	coming from many different avenues
	WORKLOAD *(Leader workload constraints/ workload of a leader)*	3	huge portfolio
		3	swarmed with meetings
		2	a lot coming down on her
		2	has many other responsibilities
		1	big workload
		1	demands of position
		1	has a lot of balls in the air...
		1	has her own work that she has to do
		1	has too much on her head
		1	increase in administrative duties
		1	it's out of her hands
		1	more and more being pushed on leaders
		1	pulled in many directions
		1	responsible for many tasks or staff or patients

Negative impact of organizational restrictions.

Many focus group participants recognized that various organizational challenges and barriers play a major role in the practice environment. However, the participants also acknowledged the negative effects of these workplace challenges. The information provided by the focus groups resulted in the identification of a theme that was titled “negative impact of organizational restrictions” (see Table 4.7 Workplace Challenges – negative impact of

organizational restrictions). The theme was defined as the recognition of the outcomes of organizational barriers and/or constraints that are identified to have a negative effect on leaders, their staff, patients, and/or the practice setting. The many negative effects listed by participants were categorized as either *impact on leader* or *impact on staff, patients, and the workplace environment*. The perceived repercussions of the various organizational influences were extensively described by participants. Some of the comments regarding the impact on first-line nurse leaders included:

> Impact on Leader - unable to do what needs to be done: "Yeah, I agree. I think her situation is absolutely horrendously difficult because I think in her heart she has what she wants to do but practically it's impossible."

> Impact on Leader - emotionally tied to decisions that are out of her control: "…she's able to do the hard line when she has to but she's also got a good combination of she does care and she does, her decisions do affect her. She is emotionally tied to a lot of the decisions that she makes whether she agrees with them or not because of different constraints from administration."

When it came to identifying and describing the negative impact of workplace challenges the focus group participants shared their frustrations and concerns of how the organizational restrictions also have the potential to lead to detrimental effects on staff, the work that staff members carry out, patients, and the practice setting. These concerns can be illustrated by the following excerpts from comments made by two of the focus group participants:

Impact on staff, patients and the workplace environment - increased risk to patients: "[It would help] if they followed … [the project] through the leadership and … [put] everything in place rather than just throwing residents back [from hospital to an extended care bed] without everything being in place and putting everyone at risk."

Impact on staff, patients and the workplace environment - inadequate access to resources: "She's here but she has…her work to do for the floor where it's a little difficult…at times to, to provide [staff] with…information [they need] right at the time…".

Table 4.7 Workplace challenges - negative impact of organizational restrictions

THEMES	CATEGORY	FREQUENCY COUNT	CODES
Negative impact of organizational restrictions *(Outcomes of organizational restrictions)*	Impact on leader	4	unable to do what needs to be done
		1	cannot focus
		1	emotionally tied to decisions that are out of her control
		1	has to get things done on her own time
		1	increased workload
		1	job becomes diluted
		1	leader is limited
		1	leadership becomes distracted
		1	limited time for positive reinforcement
		1	taking frustration out on leader
		1	things fall apart
	Impact on staff, patients and the workplace environment	5	inadequate leader involvement
		4	inadequate access to resources
		1	creating a division between leaders and staff
		1	inadequate staff support
		1	inadequate staffing
		1	increased risk to patients
		1	lack of visibility of upper management
		1	nursing component is getting compressed
		1	rushed communication
		1	rushing through with decisions

Lack of organizational support for staff.

The recognition of challenges in the workplace environment and their impact was accompanied with the identification of a "lack of organizational support for staff" (see Table 4.8 Workplace challenges – staff). This theme was defined as staff perceiving that nurses do not receive adequate backing or assistance from the organization. The organization in this case was viewed to consist of administration, higher level management, and/or healthcare authority. The comments around this theme did not pertain to any support provided by first-line nurse leaders. The focus group participants identified that their frustration was with the organization rather than the leaders themselves. Participants shared numerous examples that can be related to *lack of resources* or *lack of support/backing from the organization*:

> Lack of resources - don't feel like they are being heard: "...So I mean I don't feel like we're being heard. And I think more than anything else if we could have some understanding … from the organization I think it would be a little bit more [positive] because we're willing to give, that's not the issue. And we want to know that we're being heard and, you know, that we can be able to have some feeling and as you said there's just more and more [work and changes] coming but nobody seems to hear."

> Lack of backing/support - lack of support from organization/administration: "Participant 1: You know, I don't feel like we're cared for in that, from our organizational point of view.

> Participant 2: Yeah ...

Participant 3: [All we see is] cuts of staff, … [more] paperwork, added duties…

Participant 4: With less people."

Table 4.8 Workplace challenges - staff

THEMES	CATEGORY	FREQUENCY COUNT	CODES
Lack of Organizational Support for Staff *(Staff nurses do not feel support from organization)*	Lack of resources	2	don't feel like they are being heard
	Lack of backing/support	3	lack of support from organization/administration
		1	lack of educational support
		1	lack of recognition or positive reinforcement from organization
		1	lack of understanding from organization
		1	staff feeling upset with organization

Focus group questions 6 and 7: Leader growth.

Focus group questions 6 and 7 were: If you could change anything about your leader's style, what would you want to change? Why? and Your nurse leader attended a nursing leadership workshop. Since their attendance, have you noticed any differences in their leadership behavior? If you have noticed differences, please describe them.

Discussion around leader improvements provided a wealth of ideas from focus group participants. The dialogue involved identifying areas where staff felt their first-line nurse leaders still needed to evolve, recognizing the improvements that participants have noted since their leaders took part in the BC NLI, and pinpointing factors that affect the transition process of the

first-line nurse leaders. The analysis of the focus group discussion data for these questions led to the detection of two themes: the *need for leader improvement* and *notable changes*.

Need for leader improvement.

The "need for leader improvement" theme was defined as the identification of any factors that were recognized as requiring growth or development by the first-line nurse leader. The variety of improvements that the participants felt their leader could still work on can be classified under relational (i.e. personal aspects/characteristics) and task (i.e. skills/strategies) categories (see Table 4.9 Leader growth – need for improvement). A sample of *relational* and *task related* improvements mentioned by focus group participants included:

> Relational - takes things personally: "I think she needs to learn how not to take every single thing so personally, she needs to distance herself a little bit more…"

> Relational – intense: "Sometimes you get that sense so it's not as comfortable to go to her, you know, something might not be going right or whatever so I think she could benefit from, you know not being so like learning to not be so intense…"

> Task – out of touch: "Participant 1: Yeah, but sometimes you [as a leader] get… out of touch and then you often [think] … this can't be right like you must be out of touch…

Participant 2: And their angle on that is that they haven't had the information from a previous shift about [what is happening on the unit]…

Participant 3: That's true and they need to seek that out, like when I'm in charge I say 'She's got an infusion do you think your assignment is too heavy for days?' Like you have to seek out the information, people aren't necessarily going to offer that and I think that, that's part of being a leader."

Task – micromanaging: "I don't think it's ever been an issue of no confidence, its more what [the leader is] able to do because, you know, like I've, I've experienced her as, you know, allowing other people to do their things, but as … [the other focus group participant] said, … because she's micromanaging it's overwhelming for her, she's trying to be all to … [everyone]."

Table 4.9 Leader growth - need for improvement

THEMES	CATEGORY	FREQUENCY COUNT	CODES
Need for leader improvement *(Staff identified areas where some leaders still need to improve)*	RELATIONAL *(Personal aspects/ characteristics)*	1	intense
		1	unapproachable
		1	takes things personally
	TASKS *(Skills/ Strategies)*	2	lack of leader involvement
		1	micromanaging
		1	needs to take on all aspects of project
		1	not good at allocation
		1	out of touch

Notable changes.

The BC NLI was focused on fostering the first-line nurse leaders' leadership and management abilities, performance and job satisfaction along with heightening nursing staff perceptions and satisfaction with their leaders (Bouthillette & MacPhee, n.d.). Based on the integrated aim of the BC NLI, the focus group participants had an opportunity to examine their perceptions of how their nurse leaders have grown and changed a year following the leaders' attendance at the institute. In conjunction with recognizing that their first-line nurse leaders have areas where they need to improve the participants also recognized "notable changes" in their leaders and/or their leadership following participation in the BC NLI (see Table 4.10 Leader growth – post BC NLI). The theme "notable changes" was defined as any leader growth or development a staff member was able to identify after the leader's participation in the BC NLI leadership program. Differences in a particular aspect of their leader or his/her leadership were noted by all ten focus groups. The identified changes can be grouped under *relational* (i.e. personal leader improvements) and *task* (i.e. improved leader skills/strategies) based categories. The changes can be illustrated by the following sample of comments that participants have seen in their leaders during the year following the BC NLI:

> Relational - improvement in focus and coping: "...she's managed to focus so much better on her position and coping with, with all the things that are coming at her from so many different directions. And the difference from being how I worked with her as a floor nurse to PCC to …now, in the last two years and the growth of … her leadership skills … [have] improved vastly and I think leadership includes her coping of how you manage things coming at you from different directions."

Relational - more relaxed: "...Yeah, no I find her more relaxed when she … [comes] in, in the morning, and, you know, just that whole atmosphere is more relaxed, more confident, that you feel, okay, great, we can go with the flow of the day and, you know, connect with her in whatever way we see fit. But I've really seen a change there."

Task – improved communication: "… she's really able to stand up for us and I think more so in a positive manner. I've seen [this more] in the last year than before … [whereas before] she'd just get frustrated or angry or emotional, [and now] she's really got that more in check and is able to, you know, communicate [the unit issues better]… she's putting her foot down she's standing up for us. And having seen that interaction with other nurses and other charges coming from other floors they kind of come on the fly at her and she's able to, you know, communicate … [the issues] better to them. Why she's, you know, taking that stand … whereas before it would be, there would be a lot more emotion, a lot more of an emotional response from her."

Task – increase in leader involvement: "I think more so, you know, more and more she's, you know, she'll roll up her sleeves and get in there to help us. I mean I know like for me she can't help with the monitor, my tele monitor and stuff but, you know, she's rolling up her sleeves and going to help us make the [patient] moves and stuff, you know, more and more we see that."

Table 4.10 Leader growth - post BC NLI

THEMES	CATEGORY	FREQUENCY COUNT	CODES
Notable changes (Changes noted in first-line leaders following participation in the BC NLI)	difference in leader noted post BC NLI	3	saw any or general difference in leader
	RELATIONAL *(Personal leader improvements)*	6	more confidence
		4	improvement in coping
		3	more knowledgeable
		2	less chaotic or calmer
		2	less emotional
		2	more comfortable
		2	more focused
		2	more relaxed
		1	broader shoulders
		1	improved natural abilities
		1	more assured
		1	more competent
	TASK *(Improved leader strategies/ skills)*	4	noted a change in leadership style
		3	improved communication
		3	increase in leader involvement
		2	improvement in leadership skills
		2	moved away from micromanaging
		2	stronger as a leader
		1	able to stand up for us
		1	better at delegating
		1	better handling of situation(s)
		1	better in managing the unit
		1	growth in how she leads
		1	improved organizational skills
		1	more efficient
		1	sharing of resources
		1	strong leadership role

Focus group question 8: BC NLI program support.

Focus group question 8 was: From your perspective, would you recommend this type of leadership training for other nurse leaders? Why or why not?

When focus group participants were given an opportunity to discuss the BC NLI and its role in leadership development they exhibited a positive view of leadership education. Recognizing the importance of leadership education and its key components was accompanied by participants sharing their perceptions of how the BC NLI influenced their first-line nurse leaders, as can be seen in some of the quotes above. Although support was shown for the BC NLI, numerous participants also brought up the possibility of factors outside of the program having the potential to influence their leaders' growth and development. It led some participants to speculate that leadership education, such as the BC NLI, may not be the only aspect involved in leadership development. The three themes emerging from this question were: *formal leadership development opportunities*, *program influence on leadership* and *external factors influencing leadership development.*

Program influence on leadership.

When taking into consideration the BC NLI specifically, the focus group participants recognized that this particular "program influences leaders" (see Table 4.11 BC NLI program support). This theme was defined as participants expressing their belief that the BC NLI had an effect on the nurse leaders that participated in the program. The positive view of the BC NLI was shared by several staff focus group participants who attributed positive general and/or specific changes in their nurse leader to the program and its education. The role of the BC NLI in helping first-line nurse leaders grow, develop, and transition into their role is supported by comments describing participants' perceptions of the changes that they have attributed following their attendance in the program:

General change identified as a result of BC NLI – this program…makes a difference: "Well this program for what it's worth it makes a difference I've seen it."

Specific change identified as a result of BC NLI – helped her transition: "...I have seen many changes on the basis of your education…"

Table 4.11 BC NLI program support

THEMES	CATEGORY	FREQUENCY COUNT	CODES
Program influences leaders *(NLI support/ changes attributed to NLI program)*	Specific change identified as a result of BC NLI	1	Helped her transition
	General change identified as a result of BC NLI	1	Many changes on the basis of BC NLI
		1	This program…makes a difference

Formal leadership development opportunities.

The focus group data identified that structured leadership training and continued development are key elements for nurse leaders and their leadership growth. The theme "formal leadership development opportunities" (see Table 4.12 BC NLI support – impact on leader growth) was defined as the recognition of diverse education programs or initiatives as playing an integral role in how leaders develop and refine their leadership abilities and mature as leaders. Participants not only identified components that are beneficial for leadership development but

recognized that making adequate leadership development education available to first-line nurse leaders is important. This was exhibited by several participants who touched on this subject:

> Important components – leadership is a dynamic process: "...I think that, you know, even courses just up, you know, updating and stuff, good workshops … [continuing] to work on it I think that that's always beneficial in a leadership program, you know."

> Recognized importance of formal training – leader will benefit from leadership training: "More training can always help eh, more training can always help."

Table 4.12 BC NLI support - impact on leader growth

THEMES	CATEGORY	SUB-CATEGORY	FREQUENCY COUNT	CODES
Formal leadership development opportunities	Important components	Description of leadership training	1	Leadership is a dynamic process
		Components of leadership training	2	Leadership support is good and necessary
			1	Components beneficial for leadership development
	Recognized importance of formal training	Benefits of leadership training	1	Sharing of acquired skills/information
		Leadership training is essential	6	Leader will benefit from leadership training
			1	You can always work on leadership

External factors influencing leadership development.

As I have indicated above, although participants clearly attributed leader changes or growth to the BC NLI and recognized its benefits, several participants also noted that external factors could have played a role in the leadership development of first-line nurse leaders. The "external factors influencing leadership development" theme (see Table 4.13 BC NLI Program Support – External Factors Affecting Leader Growth) was defined as any aspects outside of the BC NLI that could be viewed as having or having the potential to impact how a leader grows and develops at all stages of his/her leadership (i.e. the transition period into a leader and at any time of while he/she is a leader). The possible external elements mentioned by participants can be categorized under *personal factors* (e.g. personal growth, getting used to the job, and growing in her position) or *organizational factors* (e.g. role of experience, being in the job, different training you go through, or role of support). The focus group participants shared their thoughts and hesitations regarding what factors actually play a role in leader and leadership development by stating:

> Personal factors – growing in herself: "Yeah I've noticed and since she's gotten a new job I've noticed definitely a change. Now I don't know if it's to do with the program that she took or if it's just because she's growing in her, her own self right?"

> Personal factors – growing in her position: "… I definitely notice a difference [after the BC NLI] but it could be like she's getting more, you know, like more comfortable and more confident in herself so I can't say that it's to do with this conference that she went

to or she's just grown in the position but I definitely noticed, you know, a difference with her just by speaking with her."

Organizational factors – being in the job: "I'm not sure what helped her, if it was the Institute or just the fact of being in the job and just doing it and being… And just getting… Better at it, yeah."

Organizational factors – role of experience: "…because she was a ward nurse here and then she had a hard role to step into, being a leader to leading the people she used to work with, so I think it's [the BC NLI that]helped her transition in that role."

Organizational factors – role of support: "It's got to be nice to have some kind of support in your transitioning through a new role like that. I mean it's probably a great program for them, the managers for sure."

Table 4.13 BC NLI support - external factors affecting leader growth

THEMES	CATEGORY	FREQUENCY COUNT	CODES
External factors influencing leadership development *(Changes attributed to other factors, outside of BC NLI)*	PERSONAL FACTORS (KANTER) (Personal growth)	3	Growing in her self
		1	Getting used to it (the job)
		1	Growing in her position
	ORGANIZATIONAL FACTORS (CSE) *(External influences)*	7	role of experience
		1	Being in the job
		1	Different training you go through
		1	role of support

Chapter Summary

The thematic analysis of staff focus group data yielded 12 themes and numerous categories and subcategories. The BC NLI focus group data showed that participants recognized the importance of leadership education by providing a wealth of evidence of its impact on first-line nurse leaders and the workplace environment. The results derived from this study helps to reinforce previous leadership development research, including earlier studies of the BC NLI. In the next chapter, I will provide a discussion of the results obtained from this study along with an exploration of the leadership development evidence available in the literature.

CHAPTER 5: Discussion

Study Limitations

This study included a convenience sample of staff nurses from workplace environments of first-line nurse leaders who attended the BC NLI. The sample did not provide an opportunity for formal exploration of the same participants' perceptions pre and post leader attendance at the institute due to staffing changes and logistic restrictions (e.g. staff turnover, structural changes in institution, etc.) that naturally occur over time within a workplace setting. The use of formal pre-BC NLI staff nurse data could have been utilized to compare responses to post-BC NLI focus group data and possibly provide further support to the focus group participants' statements on the numerous subject matters explored during the sessions. Future studies should attempt to use a study design that will allow for data collection from the same individuals at multiple points during the study period (i.e. pre and post intervention), which can then be compared and utilized to show more support for the statements provided by staff nurses.

Nurse leaders attending the BC NLI represented all regional healthcare authorities in BC. However, the staff focus group component of the study included only staff nurses from the BC Lower Mainland health authorities to enable the study project director (who was located in the Lower Mainland) to arrange and manage the focus groups. The use of staff nurses from regions outside of the Lower Mainland of BC would possibly provide additional insights from focus group participants that are unique to their regions. Further research is needed to identify if there are any differences in perceptions between nurses in the largely urbanized Lower Mainland versus those that are located in the more rural communities of BC.

The use of thematic analysis posed its own limitations on this study due to the concerns around consistency of data interpretation that exist with this method. Although specific steps were taken to reduce the possibility of inconsistencies and to ensure rigor and validity of all stages of the analysis process (see Chapter 3, Methods) there are still limitations that are present with this method. Future studies should consider taking the qualitative method a step further by exploring the opportunity that is offered through the statistical analyses of frequency counts of themes or codes (Boyatzis, 1998).

Discussion

Questions 1 & 2 - characteristics and skills.

BC NLI focus group participants recognized the importance of their first-line nurse leader's leadership style by describing positive and negative qualities (e.g. characteristics and skills) possessed by their leaders. They acknowledged that certain leader characteristics and skills were more positive and successful when it came to their leader's leadership style and how the leader is able to function and interact within the workplace environment. The most commonly mentioned positive leader characteristics noted were: approachable, caring, open, confident, effective, assertive, committed, and enthusiastic. When it came to skills, the positive leader skills most frequently identified by BC NLI focus group participants were communication, decision-making, organizational skill, leader involvement, access to resources, availability, support of staff, teamwork, and positive reinforcement. The qualities that were identified by the focus group participants are similar to the descriptions of effective leader

qualities recognized by studies in the literature. For example, Feltner, Mitchell, Norris, and Wolfle (2008) identified "communication skills, fairness, job knowledge, role model, dependable, participative partnership, confidence, positive attitude, motivating, delegation, flexibility, compassionate, employee loyal, and sets objectives" (p. 366) as the qualities possessed by an effective leader. Feltner et al.'s list contains some of the same examples mentioned by the focus group participants and indicates that the nurse leaders that took part in the BC NLI possess skills and characteristics that are essential for effective leadership. For example, communication was identified most frequently during the BC NLI focus group sessions. Communication between first-line leaders and staff is essential for their relationships and for ensuring the development and sustainment of a healthy workplace environment. As stated by Mathena (2002), the communication that is exhibited by leaders, along with their leadership, is instrumental in helping to keep open lines of communication between leaders and staff, ensuring staff members are provided with ongoing and truthful information, and leading to more concrete leader-staff relations. Chase (1994) reinforced the vital role of effective communication in a descriptive study examining nurse manager competencies. The study identified effective communication and decision making as the most highly rated skills of nurse leaders, which highlights the importance of communication in the practice environment.

When listing positive leader attributes, the BC NLI focus group participants identified qualities of first-line nurse leaders commonly found in transformational and transactional leadership styles. This finding is consistent with research that shows that both leadership styles are necessary in today's healthcare system as they are distinctive concepts that are not mutually exclusive of each other (Bass, 1985; Firth-Cozens & Mowbray, 2001; Yukl, 2006). Transformational leadership, which also falls under relationally focused leadership, "looks for

ways to motivate followers with a view to engaging them more intimately in the process of work" (Firth-Cozens & Mowbray, 2001, p. 5). In contrast, transactional leadership, which also falls under task-based leadership, stems from the more traditional view of a leader having power over others and is more "concerned with the day-to-day operations" (Marquis & Huston, 2009, p.41). Although transformational leadership qualities have been recognized to have greater impact on areas such as satisfaction, motivation, performance, and retention (Cummings et al., 2008; Kleinman, 2004b; Laschinger, Wong, McMahon, & Kaufmann, 1999) it is essential for a leader to combine both abilities in order to be an effective leader (Bass & Avolio, 2000; Kleinman, 2004b; Marquis & Hudson, 2009). The identification of both transformational and transactional leadership qualities by the BC NLI staff focus group participants indicates that first-line nurse leaders who attended the institute possess many of the qualities necessary for effective leadership.

Possessing the right balance of leadership styles is of particular importance in healthcare, as studies have shown that effective leadership plays an important role in establishing an empowering workplace for nursing staff (Laschinger et al., 1999; Lucas, Laschinger, & Wong, 2008; Greco et al., 2006; Upenieks, 2003a. 2003c) and has an effect on patient (Cummings, Midodzi, et al., 2010; Wong & Cummings, 2007; Upenieks, 2003a), staff (Cullen, 1999; Cummings, Hayduk, & Estabrooks, 2005; Cummings, MacGregor, et al., 2010; Kleinman, 2004b; Upenieks, 2002a, 2003b), and organization outcomes (Cummings, MacGregor, et al., 2010). According to numerous studies, positive staff outcomes and empowerment have been linked to transformational leadership (Laschinger et al., 1999; Lucas et al., 2008; VanOyen Force, 2005). This is supported by Weberg's (2010) review of the literature examining the impact of transformational leadership on staff satisfaction and burnout. Weberg's study

identified that there is a clear link between transformational leadership and staff members' experiences of greater satisfaction and well-being as well as staff members' decrease in stress and burnout. While administrative and practical support is available for transformational leadership, and studies have shown that transactional leadership lacks influence on empowerment, there is still great value in transactional leadership as it has been shown to have a direct positive effect on areas such as job satisfaction (Morrison, Jones, & Fuller, 1997). Morrison et al.'s (1997) finding further supports the importance of leaders possessing a combination of transformational and transactional qualities as the ability to utilize both styles seems to offer the most optimal and well-rounded leadership within the practice setting. The BC NLI staff focus group participants' identification of transformational and transactional qualities in their leaders and the support provided by available literature clearly indicate that both transformational and transactional qualities need to be possessed by first-line nurse leaders who require these qualities to deliver effective leadership.

Question 3 – workplace environment.

BC NLI staff focus group participants expressed their belief that first-line nurse leaders play a key role in the workplace environment, as they hold a distinct position in the organization. They outlined what they believe to be the function of first-line nurse leaders and their leadership when it comes to staff, the unit, and the organization. Participants deemed first-line nurse leader's actions around workload and their role in creating a positive workplace, motivating unit culture, and managing unit change and organizational initiative as areas through which leaders influence the practice setting. Throughout the BC NLI staff focus group discussions, teamwork

and the working relationship between first-line nurse leaders and their staff were regularly alluded to as key components of meeting staff needs and shaping the workplace environment. Statements provided by the BC NLI focus group participants are consistent with previous research showing the role and effect of leaders and their leadership on aspects within the workplace. Laschinger et al.'s (1999) examination of the role of leader empowering behaviors and their impact on staff members highlights the important role that nurse leaders play in the healthcare system. Their study concluded that leader behaviors influence empowerment structures (e.g. information, resources, supports, and opportunities) in the workplace environment, which considerably affect staff perceptions of power, promote staff empowerment and lead to a decrease in job tension and greater productivity.

Similarly, Greco et al.'s (2006) exploration of the link between "nurse leaders' empowerment behaviors, perceptions of staff empowerment, areas of work life and work engagement" (p. 41) concluded that leaders influence the person-job fit and structural empowerment of staff, which eventually leads to decreased staff burnout. In a study employing the LMX theory, Laschinger, Finegan, and Wilk (2009a) explored the link between organizational commitment of staff and empowerment. The researchers identified that nurse leaders impact the workplace empowerment process and organizational commitment of employees in that environment by influencing the relationship the nurse leaders have with others (e.g. their staff members). Furthermore, Laschinger and Leiter (2006) study investigated the mediating role of burnout between conditions in the practice environment and patient outcomes and found that strong leadership holds a key position in the relationship between worklife factors (i.e. staff taking part in policy development, nurse/doctor cooperation and teamwork, sufficient staffing levels, and backing of the nursing model of care), burnout of nurses, and adverse events.

Overall, the available empirical evidence from numerous studies and the BC NLI focus group participants reinforces the importance of the quality of the leader-member relationship and the leaders' influence on numerous aspects in the workplace environment. In summary, first-line nurse leaders are key individuals in the healthcare setting as they play a role in creating a quality practice environment and effective leader-member relationships that directly and/or indirectly influence a wide range of outcomes in the organization.

Questions 4 & 5 – workplace challenges.

Workplace challenges were described with respect to first-line nurse leaders and their staff. BC NLI staff focus group participants showed support for their nurse leaders and their leadership, but they also recognized that leaders face many organizational challenges in the form of barriers, constraints, and limitations. The organizational challenges that were identified by BC NLI focus group participants consisted of factors that can be categorized under practice environment, power, or workload. Practice environment associated challenges involved administrative or organizational constraints. Power related challenges consisted of factors that described leaders as having tasks and responsibilities handed down to them from above, being stuck between staff and management, and having to face organizational pressures. When it came to workload the BC NLI participants identified challenges as leaders having huge portfolios, being pulled in many directions, and having too many responsibilities.

The presence of various workplace challenges in nurse leader roles is well documented in the literature. Bellack et al. (2001) reinforced the presence of workplace challenges by stating that:

> Trends such as higher penetration of managed care, consolidation of health care providers and health systems, the shift in focus to population-based health management, advances in information technology, and the influence of economic and political forces on health organization and financing are placing new demands on as well as creating new opportunities for the [nursing] profession (p. 24).

Similarly, O'Neil et al.'s (2008) more recent exploration of leadership challenges and what constitutes effective leadership education provides examples of what nurse leaders identified as the main barriers or limitations that they face in their organizations. The study found that mid-level and front-line nurse leaders deemed the top five leadership challenges as: "funding and budgeting, workforce challenges, leadership development, patient safety and quality improvement, and time management and handling workload" (O'Neil et al., 2008, p. 180). In a study examining the roles, demands and challenges of Swedish ward managers Persson and Thylefors (1999) also noted that continued presence of nurse leaders in the workplace environment is vital yet difficult as they are forced to cope with different personal/co-worker demands, insufficient time, shortage of various resources, too much administrative work, diminished ability to interact with staff, strained relationships within upper management, role conflict, pressures from bellow and above within the organization, and lack of opportunity for growth.

Many of the identified challenges require nurse leaders to continue adapting to the constantly changing complexity of the system and to continually develop their competencies. Workplace-based restrictions placed on nurse leaders by the policies, guidelines, organizational mandates, and structural changes can prevent them from carrying out their professional duties, strip them of required authority, and lead to power and support inconsistencies. When it comes to

the power present in an organization, one has to look at both the formal and informal forms of power, as I mentioned in Chapter 2. Formal power has been described by Kanter (1993) to derive from "jobs that provide recognition and are relevant to key organizational goals" (Upenieks, 2002b, p. 623); whereas informal power is identified as being "derived from relationships, political processes, and alliances with people in the organization, or 'whom one knows'" (Upenieks, 2003a, p. 141). Informal power is also recognized as a key facilitator of formal power (Kanter, 1993; Upenieks, 2002b, 2003a).

The lack of formal and informal power that is given to first-line nurse leaders has been recognized by BC NLI focus group participants and other studies as a key challenge for the leaders themselves. Goddard and Laschinger (1997) found first-line leaders to have the lowest scores on all eleven characteristics of personal power. This absence of power is of great concern when it comes to first-line nurse leaders. According to Kanter, power is a required component of the practice environment as both formal and informal power have been identified to play a key role in the development of employee empowerment and in helping individuals to access empowerment structures (Kanter, 1993; Upenieks, 2002b, 2003a). When power is absent or lacking it prevents individuals from becoming effective leaders and making changes or decisions that are needed to ensure the development and sustainment of an optimal workplace environment. The concern with the presence of any of the workplace challenges described above is that they can have an effect on first-line nurse leaders and their leadership which ultimately influences the workplace environment and the individuals who are in direct and indirect contact with leaders.

While discussing the presence of workplace challenges the BC NLI participants also brought up the consequences stemming from these challenges. The participants noted their

impact on the nurse leader (e.g. resulting in the leader being unable to do what needs to be done, unable to focus, the job becoming diluted, etc.) and the staff, patients, and workplace environment (e.g. leading to inadequate leader involvement, inadequate access to resources, creating a division between leaders and staff, increased risk to patients, etc.). The negative consequences of challenges found within the healthcare system have been recognized by several researchers. In a study exploring new roles of first-line nurse managers, Thorpe and Loo (2003) recognized that "additional expectations and demands coming from supervisors and staff nurses, result in role overload and role conflict being added to role ambiguity" (p.323). O'Connor (2002) highlighted the consequences of changes and growing pressure in the healthcare system by identifying the resulting job stress leaders experience from workplace induced problems (e.g. workplace challenges ranging from larger span of control to interpersonal conflict). By examining the changes in the healthcare system, O'Connor notes the significance of job stress by outlining the detrimental effects that stress can have on physical, emotional, and behavioral aspects of the individual experiencing the stress. The presence of workplace challenges in various areas of the healthcare environment is clearly inevitable in the present healthcare system and organizations need to take the necessary steps to provide leaders with adequate leadership education to be able to cope, handle, and manage the challenges and their consequences.

During the focus group sessions, the BC NLI focus group participants also made it clear that these challenges and their consequences are not exclusive to their first-line nurse leaders. Workplace challenges were also acknowledged to impact staff nurses and were recognized to have consequences that trickle down the system by affecting the workplace environment and influencing work experiences of staff members as well as the quality of patient care. Most commonly, the BC NLI focus group participants noted a lack of resources and support as key

areas that were deficits within the organization. The interesting aspect of their concerns was that they did not attribute the challenges to lack of leadership from their first-line nurse leaders but rather to the organization, which was defined as the administration, upper management, and/or the healthcare authority.

When it comes to staff nurses receiving inadequate organizational support (e.g. lack of resources, inadequate reinforcement, etc.), the BC NLI staff focus group participants as well as previous studies recognized it as an area of great concern as lack of support can affect staff and patient outcomes. Organizational support for staff nurses has been recognized as a component of a healthy workplace environment (Parsons, Cornett, & Golightly-Jenkins, 2006). It has been shown to be a factor in the retention/organizational commitment of nurses (Bowles & Candela, 2005; Laschinger, Leiter, et al., 2009), increased nurse satisfaction (Laschinger et al., 2001; Laschinger, Finegan, et al., 2009a; Laschinger, Leiter, et al., 2009, McNeese-Smith, 1995), decreases in nurse burnout (Greco et al., 2006; Laschinger et al., 2003; Laschinger, Leiter, et al., 2009), and optimal workplace outcomes. The perception of having a lack of organizational support has been previously identified by Tyson, Pongruengphant, and Aggarwal (2002), who investigated nurse workplace stressors and their ways of coping and the causes of their stress. Although the study participants did not define whether first-line nurse leaders were included under the term 'organization' they did note that insufficient backing and participation by the organization was deemed to be the main source of stress for them. The BC NLI study reinforces the critical role of organizational support and involvement in an industry that is undergoing constant changes and where nursing staff are being asked to take on more responsibilities and are required to adapt to the growing patient population requirements. Based on the available evidence, having adequate organizational support is important to staff nurses and needs to be

seen as a more critical component of healthy workplace environments by healthcare organizations.

Questions 6, 7 & 8 – leader growth and BC NLI support.

The BC NLI staff focus group data provides evidence that formally structured leadership development education is viewed by staff as an asset and a positive resource for nurse leaders. Focus group participants recognized the importance of leadership education as part of the leader's growth and leadership development by expressing their views concerning the significance of leadership programs, the importance of continued education, and the role leadership education plays in influencing leader qualities.

While participants commented on their leaders' growth in the year since their first-line nurse leaders took part in the BC NLI, the same participants also identified areas where their leaders still needed to improve. Participants recognized that leaders can always improve in their leadership qualities and grow as a leader. However, greatest attention was paid by BC NLI staff focus group participants to the areas where leader growth and leadership development were noted to have occurred. This is consistent with experiences of Jennings, Scalzi, Rogers, and Keane (2007) who noted that their study participants portrayed competencies in a positive way while paying less attention to the negative or "shadow side of attributes" (p. 172). The literature suggests that when a leader exhibits positive progression/development the employees assign greater attention to benefits rather than to any of the flaws that a leader may still possess.

The BC NLI focus group participants reinforced their support for leadership development education by attributing their first-line nurse leaders' growth to their participation in the BC NLI.

The participants made clear statements indicating that the BC NLI made a difference for leaders and their development. They also offered numerous examples of areas where they perceived that their nurse leaders have exhibited improvements one year after they attended the BC NLI. The areas where first-line nurse leaders were identified to have shown growth included relational qualities such as confidence and coping, together with task-based areas, such as communication, leader involvement, and staff support.

Similar changes in leader qualities following attendance at a leadership development program have been previously recognized in the literature. In a study examining the effectiveness of a leadership institute, Tourangeau (2003) found that peers perceived positive changes in their leaders' leadership behaviors following the leaders' participation in the institute in all of Kouzes and Posner's leadership practices that contribute to exemplary leadership. The five leadership practices included in their framework were: "challenging the process, inspiring a shared vision, enabling others to act, modeling the way, and encouraging the heart" (Torangeau, 2003, p. 625). Although peer reviews of nurse leader behavior changes post attendance at a leadership development program are limited, this current BC NLI study also reinforces studies that examined the opinions of actual leaders that attended formal leadership development programs. Vogelsmeier et al. (2010) is just one study that identified that a structured leadership development program for nursing home RN leaders appears to improve leadership behaviors after the leaders participated in an education program over an extended period of time. The positive effects gained from leadership development education is further confirmed in a systematic review by Cummings et al. (2008), who concluded that "educational activities (e.g. leadership development programs) were … [identified as] the most significant factor contributing to increased leadership practices" (p. 244).

The BC NLI staff focus group participants' attribution of leader behavior changes also provides a level of support to the initial studies of the BC NLI that explored the opinions of nurse leaders that attended the leadership institute. This study supports the results of MacPhee et al. (2011), which evaluated the nurse leaders' perspectives of their own growth post attendance at the BC NLI. Within their research, MacPhee et al. (2011) showed that taking part in a leadership development program that incorporates "theoretical empowerment framework and strategies can empower nurse leaders" (p. 159). This current BC NLI analysis further supports these findings as it reinforces the growth or changes that were identified by the leaders themselves. For example, MacPhee et al. (2011) found that nurse leaders reported an increase in their own level of confidence. This is supported by this BC NLI study as growth in the leaders' confidence was mentioned most frequently when staff focus group participants discussed notable behavior changes in their first-line nurse leaders after they attended the BC NLI. Leader confidence is one of several attributes that has been linked to what Spreitzer (1995) identified as psychological empowerment. This suggests that the leaders' participation in the BC NLI may have led them to become psychologically empowered, which has in turn been proposed to lead to empowerment of staff and improved unit and individual level outcomes (Laschinger et al., 2011).

The examples of leader improvements provide evidence that after the first-line nurse leaders participated in the BC NLI they exhibited improvement in qualities that can be categorized as relational or task-based. Such improvement in relational qualities assists leaders to create positive relationships within the organization by supporting, developing, recognising, consulting, and team-building (Yukl, 2006). Growth in task-based qualities is of equal importance as task-based qualities assist the leader in the accomplishment of duties and

responsibilities (Yukl, 2006). Enhancement in both relational and task competencies have been shown to occur through attendance at leadership development programs, such as the BC NLI.

The current BC NLI study and previous research examining numerous leadership programs confirm this finding. A study that provides support to this claim is a study by Fennimore and Wolf (2011), who conducted an evaluation of the University of Pittsburgh Medical Center Leadership Development Program for nurse middle managers. The researchers found that providing nurse leaders with the appropriate leadership education resulted in "an average raw score improvement of 0.68 for all competency areas 6 months following the completion of the course" (Fennimore & Wolf, 2011, p. 207). The competencies that were included within this study involved both relational and task-based qualities that were arranged in three groups titled: " the science of managing the business (e.g. financial management, human resource management, performance improvement, foundational thinking skills, technology, strategic management, and appropriate clinical practice knowledge), the art of leading people (e.g. human resource leadership skills, relationship management and influencing behaviours, diversity, and shared decision making), and creating the leader in yourself (e.g. personal and professional accountability, career planning, personal journey disciplines, and reflective practice)" (Fennimore and Wolf, 2011, p. 205). Further support is provided by prior research of the BC NLI where leaders identified their participation in a leadership program to have helped them achieve their role and responsibilities (MacPhee et al., 2011; MacPhee et al., in press). MacPhee et al. (2011) identified that the participating nurse leaders noted improvements in both relational and task-based areas as they identified gaining or achieving changes in areas such as "confidence, project management competencies, validation/affirmation of themselves as a leader, and resources and tools" (p.164). In a study examining effects of a leadership development

program on leader outcomes, MacPhee et al. (in press) also identified that leader attendance in a program, such as the BC NLI, had a positive effect on self-identified use of relational competencies, such as leader empowering behaviors.

While some BC NLI staff focus group participants clearly attributed changes in their nurse leaders to the BC NLI, there were also many participants expressing hesitation regarding the possibility of external factors influencing the changes that their leaders were noted to exhibit following their participation in the institute. Several participants stated that they were not sure about the actual cause of their leaders' growth as many aspects can play a role in shaping a leader and his/her leadership. The idea that factors outside of formal leadership education can shape a leader and his/her leadership is not new to this study. The literature provides a wealth of possible influences outside of leadership education that can have an effect on how a leader grows and develops. For example, in a study examining the factors that influence the development of leadership characteristics, skills, and expertise in nursing, Allen (1998) provided a list of five predominant factors that nurse leaders identified as having a role in influencing their development. These factors include "self-confidence, innate leader qualities/tendencies, progression of experiences and successes, influence of significant people, and personal life factors" (para. 7). The role of external factors in leadership development is also confirmed by a systematic review of factors contributing to nursing leadership conducted by Cummings et al. (2008). The authors of this review concluded that leadership development is not only influenced by nurse leaders taking part in educational activities but also by their "behaviors and practices, traits and characteristics, and context and practice setting" (Cummings et al., 2008, p. 240).

The presence of a range of influencing factors indicates that leadership development education is just one part of the development process. Thus, organizations need to recognize the

critical role of formal leadership development education while keeping in mind that they also need to take into consideration a variety of other factors (e.g., practice environment, leader attributes, etc.) in order to be able to help nurse leaders grow and become effective leaders.

Two areas that were specifically mentioned by BC NLI focus group participants to have potential impact on all stages of the leader's development (i.e. including the transition process into a new leadership role and their continued development) involved the role of support and prior clinical experience. Organizational support was defined as instances when first-line nurse leaders received backing or assistance from administration, staff, and/or co-workers. Prior clinical experience was described as any personal on the job experience a first-line nurse leader acquired within the organization, department, or unit before taking on the formal first-line leader position. Both components have been shown to play a role in how well a leader is able to transition into a new position and function as an effective leader.

Having prior clinical experience assists nurse leaders to take on leadership positions as they have personal knowledge of the way things run in the organization which staff appreciate and view as helping the leader to be more understanding and effective in their role. This was reinforced by Swearingen (2009) who noted that it is more common for nurses to move from staff nurses positions into leadership roles within their organizations, bringing with them a wealth of knowledge and experience that needs to be recognized and valued. Experience at the clinical, managerial, professional, and leadership levels were also noted to be of great importance by Scoble and Russell (2003). In their examination of the types of leadership skills required by future nurse leaders, respondents identified clinical experience and practice as the "experiences that nurse managers must bring to their leadership positions" (Scoble & Russell, 2003, p. 327).

The possession of clinical experience was described as the most crucial type of experience but managerial, professional, and leadership experiences were also noted as assets.

Along with prior experience, the BC NLI staff focus group participants identified the role of organizational support in helping first-line nurse leaders to transition into their roles and provide effective leadership to staff members in the organization. Receiving support from the organization during and after a transition into a first-line leader role is crucial as it allows nurse leaders to adjust to their position, gain the required knowledge, and develop necessary relationships. The role of organizational support is reinforced in the literature as a key component of the transition process and leadership in general. Goodyear and Golden (2008) identified support as one of the key features of effective transitions that are marked by favourable outcomes. They state that "successful leadership transition requires support for new leaders and their follower, along with a focus on trustworthy communication and clear decision-making process" (Goodyear & Golden, 2008, p. 52). The role of support during the transition stage is further reinforced by Mitchell (2007) who notes that the presence or absence of support in the transition process can either assist or hinder the success a leader can achieve in his/her role. However, the lack of leader support in general is a critical issue, as together with inadequate education and lack of resources it makes the workplace environment even more challenging for all nurse leaders who are being asked to take on more responsibilities and adjust to the constantly changing complexities of the healthcare system (Mathena, 2002). As stated by Jackson and Daly (2010) "leaders [at all stages of their leadership development] need support and resources to be able to enact their roles in the complex, turbulent healthcare environments, and may feel they have limited support from both followers and others higher up in their organizations to either effect or persist with essential change processes" (p. 83). Adequate leader support also needs to

be taken more seriously as it has been shown to be essential to the satisfaction (Laschinger, Purdy, Cho, & Almost, 2006; Parsons & Stonestreet, 2003; Rhoades & Eisenberger, 2002; Tansky & Cohen, 2001) and recruitment and retention of leaders in the organization (Laschinger, Purdy, et al., 2006; Patrick & Laschinger, 2006; Parsons & Stonestreet, 2003).

This implication is supported by Laschinger, Purdy, et al. (2006) who examined the Theory of Perceived Organizational Support amongst first-line nurse managers in a practice setting. Their study found that organizational support is an important predictor of managers' work attitudes and behaviors. Patrick and Laschinger's (2006) examination of the relationship between structural empowerment and organizational support further reinforces the need for leaders to have adequate support. The researchers concluded that receiving adequate organizational support in combination with access to empowerment structures (e.g. opportunity, information, support, and resources) impacts the satisfaction of nurse leaders. Based on previous studies and the comments of BC NLI staff focus group participants it is clear that external factors, such as prior clinical experience and organizational support, are viewed as key factors in helping a leader transition into a leadership role while also being crucial for leaders at all levels of leadership development.

Conclusion

The current healthcare system presents many challenges and complexities in the practice environment for nurses and nurse leaders at various levels within the organization. Nurse leaders play a vital role in the healthcare setting as their leadership is critical for the achievement of quality and safe patient care, for the creation and maintenance of healthy workplace

environments, and in the retention, recruitment, and satisfaction of nursing staff. To achieve and support effective leadership it is imperative that institutions and the healthcare system commit to optimal leadership development education that is recognized and acknowledged for its value and effectiveness.

This study supports the need for nurse leaders to have adequate access to formal leadership development education in the healthcare setting. The BC NLI staff focus group participants' description of specific leader behaviour changes, and their direct attribution of these changes to the Leadership Institute, support prior evidence that not only leaders but also their followers deem a formal leadership development program (such as the BC NLI) vital for the development of first-line leaders. Having access to leadership development education assists leaders to transition into their new roles and continue growing as leaders by way of acquiring and modifying qualities and behaviors necessary for them to be effective leaders who can support healthy workplace environments. Leadership education, such as the BC NLI, needs to be recognized and supported for promoting leadership practices, knowledge, and skills of nurse leaders which influence nursing staff and the quality of patient care provided in health care organizations.

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Appendices

A. BC NLI Focus Group Questions

Nursing Staff Leadership Focus Group Questions

1. How would you describe your nurse leader's leadership style?
2. What do you think is positive or successful about your leader's style?
3. Give an example of how your nurse leader has helped to create a more positive work environment for you.
4. What are some challenges or difficulties you've had in your work environment?
5. How has your leader helped you deal with these work environment challenges?
6. If you could change anything about your leader's style, what would you want to change? Why?

For NLI Leaders' Staff:

1. Your nurse leader attended a nursing leadership workshop. Since their attendance, have you noticed any differences in their leadership behavior? If you have noticed differences, please describe them.
2. From your perspective, would you recommend this type of leadership training for other nurse leaders? Why or why not?

B. Summary of Thematic Analysis

QUESTION:

1. How would you describe your nurse leader's leadership style?
2. What do you think is positive or successful about your leader's style?

Leader Characteristics

THEMES	CATEGORY	SUB-CATEGORY	CODES	Source Count	Frequency Count	MEANING UNITS	DIRECT QUOTES (examples)
Characteristics possessed by first-line leaders	Positive attributes		approachable	8	22		P: She's very approachable ... I'm not hesitant to walk into her office and to ask questions or come with my problems there. I know she will listen to me, I might not always [get] the answer I want which is understandable too right but, yeah.
			caring	6	17		P: I think she's also very caring about staff as well, she's the [only] one of all our leaders that will go around and ask you 'are you alright, are you doing okay?'
			openness	8	15		P: Well I find that she's very open and very, um, what's the word I'm looking for? Um, she will actually sit down and listen if there is something that you are concerned about? She's around a lot more than anybody we've ever [had] before. It's nice to have, I find that [it's] nice to have her in and out on the floor because it seems to me that she has a better grip of what's really, really going on rather than the hearsay third person type of thing.
			confident	4	9		P: ...Yeah, no I find her more relaxed when she come in in the morning and, you know, just that whole atmosphere is more relaxed, more confident, that you feel, okay, great, we can go with the flow of the day and, you know, connect with her in whatever way we see fit.

THEMES	CATEGORY	SUB-CATEGORY	CODES	Source Count	Frequency Count	MEANING UNITS	DIRECT QUOTES (examples)
			effective	6	9		P: Yeah, everything is very clear, things are laid out very [well], we know exactly where we stand.
			assertive	2	7		Participant 1: Well she's very assertive. Participant 2: I was going to say that too. Participant 3: I think that's good just because it's effective. ... it's a positive thing for a leader to be assertive because if they're passive then things don't get done, communication isn't clear and that kind of thing so it works very well.
			committed	3	6		P: Yeah and she's committed to staying, she said 'I'm not going anywhere', she's reassured us of that.
			enthusiastic	2	5		P: ...And her enthusiasm, motivation, I mean she's, she's like a little whirlpool of energy I would say when she's here. Yeah which is nice, it's just nice to have around.
			focused	2	4		P: ...I think that the job itself lends itself to being diluted because it ... gets pulled in so many directions... but... she's managed to focus so much better on her position and coping with ... all the things that are coming at her from so many different directions...
			jokes or humor	2	4		P: I think XXX tries to always inject a little bit of humor like when she's giving announcements in the morning or something like that just to make, you know, things a little bit lighter, appropriate humor but she can also be serious when she needs to be serious if it's, you know, an announcement that is of a serious nature, she will be serious as well.
			trust	3	4		P: Um, I'd say speaking for me personally she leaves me, you know, she trusts what I do …

THEMES	CATEGORY	SUB-CATEGORY	CODES	Source Count	Frequency Count	MEANING UNITS	DIRECT QUOTES (examples)
			fair	2	3		Participant 1: She's very fair . . . Participant 2: ... she'll try her best for everyone in terms of, you know, granting LOA's or vacation or that sort of thing.
			non-judgemental	2	2		P: Well she's very approachable, she's easy to talk to, she's non-judgmental, she never makes you feel like you're wasting her time.
			genuine	1	1		P: I would say she's quite genuine in her interactions and personal experiences, like she's really approachable and I think she does ... what she can, she tries to go the extra [mile] but I understand that there are restrictions that are placed on her that are not her fault.
			honest	1	1		P: ...I mean she's a very open, honest person, she doesn't hold anything back, she's very good at communicating…
			motivated	1	1		P: I think the biggest thing that comes to my mind about XXX like you said [is] her sense of humor ... her enthusiasm, motivation, I mean she's ... like a little whirlpool of energy I would say when she's here. Yeah which is nice, it's just nice to have around.
			relaxed	1	1		P: ...I find her more relaxed when she comes ... in the morning and, you know, just that whole atmosphere is more relaxed, more confident, [so much so] that you feel, okay, great, we can go with the flow of the day and, you know, connect with her in whatever way we see fit.
			transparent	1	1		P: …I think she's quite transparent, so if there is an issue about something ... she gives you enough information that you understand why that [is occurring], [she gives you] the rationale of why something is happening and that's nice, you know.

THEMES	CATEGORY	SUB-CATEGORY	CODES	Source Count	Frequency Count	MEANING UNITS	DIRECT QUOTES (examples)
	Negative attributes		unapproachable	3	5		P: ...I think XXX is the least approachable ..., I'm not scared of her or whatever but some people do [find her scary] and it's just, she's very intense and you're almost afraid that she's going to think you don't know what you're doing. Sometimes you get that sense so it's not as comfortable to go to her, you know, [when] something might not be going right or whatever so I think she could benefit from, you know not being so like learning to not be so intense . . .
			intense or upfront	1	4		P: ...I'm not scared of her or whatever but some people … [are] and it's just, she's very intense and you're almost afraid that she's going to think you don't know what you're doing. Sometimes you get that sense so it's not as comfortable to go to her, you know, something might not be going right or whatever so I think she could benefit from, you know… learning to not be so intense ...
			distracted	1	2		P: It depends on the situation I mean she can be quite an effective communicator … when it's manageable when there's not a lot of other people coming down on her. I find that when there's a lot of people ... from the other places coming down on her then her leadership kind of gets more … distracted.
			blunt	1	1		P: Yes, she can be intense sometimes and blunt which I kind of put under the umbrella of assertive but … to certain people that may not be as assertive … she'd be scary especially if you don't know her.
			unfocused	1	1		P: So you see it is basically because she doesn't really have [time], she's got so much on her head that she really can't focus . . .

Leader or Leadership Skills

THEMES	CATEGORY	SUB-CATEGORY	CODES	Source Count	Frequency Count	MEANING UNITS	DIRECT QUOTES (examples)
Skills possessed by first-line leaders	Personal leader factors *(related to leader abilities)*	Positive	communication	10	220		P: …she's got … lots of things on her mind but … she always communicates with us like, 'Okay, we're going to get this patient, this is the report' and then you …know, she's fully focused on … [what] we are getting. So communication is a strong one when you initiate it…
			decision making	8	19		P: I find XXX, she listens but ... she's not afraid to make the decision. So she listens to people … [and then] she'll make the decision whereas some leaders…, they listen but they don't make the decision and some people don't listen at all, they're just 'that's it'.
			organization skills	6	14		P: She's pretty on top of things ... if there's anything that needs [to be] done around patients, anything that's going on she's always there to tell me what, what still needs to be done.
			delegation	5	12		P: Like she's learnt now to delegate and not just take everything on herself.
			reaction during stressful period	4	12		P: Another thing that I really like about XXX is the fact that … when you are put in a situation that's extremely stressful she doesn't really like take that all on her own and then trickle it down to the rest of the team. Like I find that she can stay calm in whatever situation or [she] lets you know that she's going to get through it, and [together as a] team ... we're going to get through it.
			deals with issues head on	6	11		P: …you can come across [to her] with any problem you have like I mean we can just throw it out in the open and then she'll answer to it and like I say again she'll try to do to the best of her abilities…

THEMES	CATEGORY	SUB-CATEGORY	CODES	Source Count	Frequency Count	MEANING UNITS	DIRECT QUOTES (examples)
			leader visibility	6	10		P: She's around a lot more than anybody we've ever [had] … before. …I find that [it's] nice to have her in and out on the floor because it seems to me that she has a better grip of what's really, really going on rather than the hearsay third person type of thing.
			listening skills	4	7		P: ...I know she will listen to me, I might not always [get] the answer I want which is understandable too right but, yeah.
			leadership skills	3	6		P: ...her leadership skills … [have] improved vastly and I think leadership includes her coping of how you manage things coming at you from different directions.
			ability to cope	2	6		P: Her coping style, I'd say a huge piece of … [her growth] is her coping style with the pressure...she's managed to focus so much better on her position and coping with ... all the things that are coming at her from so many different directions.
			knowledgeable	2	3		Participant 1: And she's become more knowledgeable. Participant 2: Yeah. Participant 1: Probably ... about the job and what's expected of her and just, yeah, you know, like the sort of manager hierarchy there is within a hospital or within a health region.
			consistent	2	2		P: I don't know [how long she has been in her position now] ... but she's definitely consistent [with the things she does].

THEMES	CATEGORY	SUB-CATEGORY	CODES	Source Count	Frequency Count	MEANING UNITS	DIRECT QUOTES (examples)
		Negative	communication	4	7		Participant 1: I find that when there's a lot of people coming down ... on her, then her leadership kind of gets more … distracted. Participant 2: Yeah, distracted just a little, it's not as focused, whereas usually … when it's a calm environment she's [a] very effective communicator and tries very hard to discuss [things in] a very almost democratic process, discussing what the best options are for the team, for the unit, for all of us together.
			reaction during stressful period	3	6		P: The thing I've noticed with XXX is when ... the unit is crazy busy which it always is but when it's like out of control she's definitely like I said intense, ... she's very like go, go, go by the book, you know, this, this, this. And there's really no other way around it ... it's not as pleasant to work with a ... [charge nurse] when it's super busy and everybody is stressed ... to get that kind of response.
			decision making	1	5		P: ...she's very like go…by the book, you know, 'this, this, this'. And there's really no other way around it like it's not as pleasant to work with a … [charge nurse] when it's super busy and everybody is stressed … to get that kind of response.
			leader visibility	4	4		P: I find I don't see her that much during the shift like especially if I'm on the side where I am today.
			ability to cope	1	3		P: I think she needs to learn how not to take every single thing so personally, she needs to distance herself a little bit more…
			listening skills	1	1		P: Sometimes she's not as good of a listener [as she could be]…

THEMES	CATEGORY	SUB-CATEGORY	CODES	Source Count	Frequency Count	MEANING UNITS	DIRECT QUOTES (examples)
	Organizational factors *(related to running/ operation of institution)*	Positive	leader involvement	10	174		P: If you have a difficult patient she will go and speak with them ... she will go and address the issue that you have with the person so that's very helpful for us. … [At times] they won't listen to us but she is willing to go and address the issue, she's supportive of us.
			access to resources	10	123		P: ... she'll give you additional resources, you know, if you need to follow up a situation where in which a patient needed to have a specific intervention. And she actually went on the computer and downloaded it and … [presented] it so I was like whoa, wait a minute here this is great, I really appreciated that.
			availability	10	25		Participant 1: I haven't been here very long but … for the short time I was here…I find the manager is very approachable as XXX said. And she'll talk with you if there's a problem, anything. And if you make a call to her I find that she returns your call, you know, in a timely manner. And I think she really works for the good of the whole unit. Participant 2: She's stalking us. [Laughter] I think it's the right thing like she's always available and I never had that before.
			accessible	8	10		P: She's accessible without judgment, which is nice.
		Negative	leader involvement	4	13		P: ...she's at the desk kind of person so, you know, if you have a question she will answer it but she's not out there [asking] ... 'how are you doing' ... [or] in the [patient] rooms. Whereas certain ... leaders actually sit in the room when you're talking to parents or getting [work done]. Rather than saying 'you do this for me' she'll actually do it, you know.

THEMES	CATEGORY	SUB-CATEGORY	CODES	Source Count	Frequency Count	MEANING UNITS	DIRECT QUOTES (examples)
			availability	3	7		P: ...sometimes she does seem too busy for you to ask her small questions. So you will bypass her like you won't bother her.
			access to resources	3	4		P: [Information is] not shared much, it's not shared much actually.
			accessible	1	1		P: She's not here. I mean she's not physically [near us] . . . I mean her office is nowhere near us right? It's way the hell over in the … [other] building. It takes her about ten minutes to get here from her office. So to ask her to be here to give that kind of immediate support is a bit unreasonable really.
	Workplace factors	Positive	support of staff	10	84		P: I had a situation in which I really felt that I needed to do something -- it was an aggressive doctor. And I expressed my frustration to XXX, you know, I like to use her as a sounding board [laughter], so anyway I expressed my frustration and I felt supported to the point that I was very confident in dealing with the doctor on my own. I didn't necessarily need her to step in, however, she was in the background and I appreciated that but I felt confident enough to go on my own but as I said I felt free that I could express how I was feeling, you know, prior to stepping out, you know, and I really felt supported there.
	(staff and/or environment related)		teamwork	9	28		P: It's a nice place to work and you are supported and it's not just with the leadership it's the, it's the whole team. And I think … that we have a very good leadership team for the majority of the time.

THEMES	CATEGORY	SUB-CATEGORY	CODES	Source Count	Frequency Count	MEANING UNITS	DIRECT QUOTES (examples)
			positive reinforcement	8	23		P: She makes a point to come to the ward and say 'I know it's overwhelming changes but you guys are amazing, I love the work you do'. She sent us flowers that time [we had difficulties] and a card that said keep up the good work or whatever…
			advocates for nurses	3	6		P: ...I think [she's] standing up for us, like really being … proactive at defending and advocating for us as a unit, like as a staff. I mean … [she also advocates for] the patients … that's always been her part especially coming from being a floor nurse. But as staff, you know, seeing her, she really advocates for us.
			acknowledges staff	2	2		P: But she really acknowledges the staff, you know, when she goes onto the floor she actually will acknowledge the staff saying 'hi' to them and that's huge because then you feel like you do have somebody that perhaps is willing to be supportive.
		Negative	support of staff	4	10		P: ...but specifically XXX in terms of supporting like we said before, for instance when she's in the office it's kind of hard to judge that because she's not really with us anyway but when she's charge, um, yeah, she's at the desk kind of person so, you know, if you have a question she will answer it but she's not out there [helping staff] ...
			positive reinforcement	1	3		P: I don't think she's given me so much back about my work, she's supported me personally through some health issues, she's been very good there. But I don't think she's said much about my work either way whether it's good or bad.

THEMES	CATEGORY	SUB-CATEGORY	CODES	Source Count	Frequency Count	MEANING UNITS	DIRECT QUOTES (examples)
			teamwork	2	2		P: You know she relies on a lot of us more senior nurses to help her make decisions and so it's, you know, we're all involved in the [decision making] processes so we feel part of it, yeah, [but when] there's a lot ... coming down on her then that kind of falls apart.

QUESTION:
1. Give an example of how your nurse leader has helped to create a more positive work environment for you.

Workplace Environment

THEMES	CATEGORY	SUB-CATEGORY	CODES	Source Count	Frequency Count	MEANING UNITS	DIRECT QUOTES (examples)
Leaders play a major role in the workplace environment	Workload		patient load or workload	8	16	Discussion of workload and leader assisting with workload issues	P: Especially for us on the front team we do a lot, …we have such a high turnover, we have a lot of transferring and stuff so we're doing a lot of the admissions and stuff and XXX really does try to balance that out for us with, you know, if she can find transfers or just stuff that will help our workload for the day.
	Practice Environment/ Workplace		constant unit changes	8	22	Projects taking place on the unit	P: ...I do think there's been a lot of changes, sometimes too many, but there's been a lot of changes overall in terms of the running of the unit which I think XXX has been a part of ... in terms of getting the unit running a bit more smoothly...
			positive workplace	5	11	Leaders play a great role in shaping/ creating a positive workplace environment	P: It's a nice place to work and you are supported and it's not just with the leadership … it's the whole team. And I think, and, yeah, I think that we have a very good leadership team for the majority of the time.

THEMES	CATEGORY	SUB-CATEGORY	CODES	Source Count	Frequency Count	MEANING UNITS	DIRECT QUOTES (examples)
			unit culture	4	5	Impact of unit culture on staff satisfaction and retention	P: It's a nice place to work and you are supported and it's not just with the leadership … it's the whole team. And I think, and, yeah, I think that we have a very good leadership team for the majority of the time.
	Experience		prior experience	3	6	understanding of nursing workplace and job	P: She's been a staff nurse, she knows what the realities of a staff nurse are. So if the nurses say …'we need an extra person, we need workload, this is the reason why'. She says, 'yeah, fine', because she gets it right? She understands what it means to work as a front line nurse...
	Staff		staff turnover	2	2	Staff turnover has decreased	P: Well because we've had so many managers and she's actually been willing to stay and she's put a lot of effort into it and I think from what I've seen and heard I thoroughly enjoy working with her. And for her being the manager on my floor is one of the reasons I'm staying.

QUESTION:

1. What are some challenges or difficulties you've had in your work environment?
2. How has your leader helped you deal with these work environment challenges?

WORKPLACE CHALLENGES – leader support in the workplace

THEMES	CATEGORY	SUB-CATEGORY	CODES	Source Count	Frequency Count	MEANING UNITS	DIRECT QUOTES (examples)
Leader support in the workplace	Staff support for leaders	Positive views of leaders	the leader does a good or great job	5	8		P: I mean I think she's doing great, I think she's really good at it. She's got a really nice manner about her, she's got a really nice manner about her and, yeah, she's easy to deal with.

THEMES	CATEGORY	SUB-CATEGORY	CODES	Source Count	Frequency Count	MEANING UNITS	DIRECT QUOTES (examples)
			leader makes a difference for staff	4	5		P: ... she kind of lets the floor know like this is what's coming up, this is what we're dealing with and its nicer because I mean it's out of her hands too the stuff that's coming down her side but we want to be well informed as well and not just sort of told that [this is what we have to do], I find that she's really good at that.
			leader is good or great	3	4		P: ...I think she's really good at [her job]. She's got a really nice manner about her ... and ... she's easy to deal with.
			enjoy working with her	2	2		P: It's just starting a day that stresses me that I would say that I don't get stressed when I have to work …[on this unit] because she's there … you know, your manager is going to be with you so it doesn't stress me.
			has become a stronger leader	1	1		P: And I guess that ... she's improved in the last year, don't you think she's becoming a stronger leader…
			makes it look simple	1	1		P: I think she makes ... [her job] look really simple…
			she is the best manager we have had	1	1		P: She's by far the best, I've been here for fifteen years and I think she's one of the best managers we've had.
		The importance of staff support	staff identify that they also need to support their leader	2	2		P: [We have to] work together and make it work because if there's no money to pay overtime that's out of her hands really, the money isn't there so we have to band together and do what we can to support her as well.
			leadership support is good and necessary	2	2		P: I think leadership support is good for anybody, as … [much] as we need the support I think she as a leader needs it too right, anything helps, yeah.

THEMES	CATEGORY	SUB-CATEGORY	CODES	Source Count	Frequency Count	MEANING UNITS	DIRECT QUOTES (examples)
	Staff awareness of external factors	Staff recognize their leader's limitations	staff is understanding of leader limitations	2	2		P: ...She's told from above what she's supposed to be doing and she has to follow those [instructions] so we know that, understand that [there is only so much she can do]…
			impact of management or leadership style	1	1		P: ... I've worked in other units where [the leader had a] very different management style ... and it's very difficult to actually give up a position because of that difficulty.

WORKPLACE CHALLENGES – organizational restrictions

THEMES	CATEGORY	SUB-CATEGORY	CODES	Source Count	Frequency Count	MEANING UNITS	DIRECT QUOTES (examples)
Organizational restrictions	PRACTICE ENVIRONMENT		administrative constraints or organizational rules/ expectations	3	5		P: Well it's really hard for her, I think, to try and give us an alternative when that's the new protocol and it's handed down and you've got to do it. It then falls on the nurse educator's hands to then find a different way so it's out of her hands as the PCC (Patient Care Coordinator) in a sense when she's got so many other things on her plate. So I can understand her frustration as well, it's like, okay, yes, I understand you have to do this, there's only so many things she can say to try and make it warm and fuzzy but . . . You have to do it.

THEMES	CATEGORY	SUB-CATEGORY	CODES	Source Count	Frequency Count	MEANING UNITS	DIRECT QUOTES (examples)
	(Institutional/ environmental factors leading to constraints)		organizational initiatives leading to restrictions	1	2		P: Well the most recent challenge I guess would be the overtime ban for nursing where she's expected to wear her pager 24/7 when she's not on duty and that's a huge challenge. She's got a family and so I mean she certainly had her memo out this is the way it is now and this is the way we're going to work through it so we kind of knew where we stood, it wasn't a big [thing] .... We actually had it on paper this is the way it's going to work, call me or call bed manager, this is the way it's going to be...
			need a better workplace environment	1	1		P: [In order to] have a better work environment … [she has to] advocate for us.
	POWER *(Power/ hierarchy limitations)*		handed down or comes from above	4	4		P: Well it's really hard for her I think to try and give us an alternative when that's the new protocol and it's handed down and you've got to do it…
			organizational pressures or demands or leader requirements	3	4		P: I would say she's quite genuine in her interactions and personal experience like she's really approachable and I think she does when she can, she tries to go the extra [mile] but I understand that there are restrictions that are placed on her that are not her fault.
			stuck between management and staff	3	3		P: … [when you are in the leader's position] you're kind of stuck in-between [management and staff] because you have some other people above you [that] you have to listen to plus you're listening to your colleagues who you used to work with…

THEMES	CATEGORY	SUB-CATEGORY	CODES	Source Count	Frequency Count	MEANING UNITS	DIRECT QUOTES (examples)
			limited power	2	2		P: I think sometimes with the staff meetings our concerns are addressed but again XXX can only go, do so much with what she has as far as her powers go, right? She's told from above what she's supposed to be doing and she has to follow those [instructions] so we know that, understand that...
			coming from many different avenues	1	1		P: Frustrated, yes, but I mean that's so much beyond ... frustration. It's, you know, … [there is] a lot … that's just coming from so many different avenues and ... It's not a leadership aspect it's just … more an administrative aspect.
	WORKLOAD *(Leader workload constraints/ workload of a leader)*		huge portfolio	1	3		P: ...she stepped up to the plate to take on that role as well as ….[taking on] a huge portfolio…
			swarmed with meetings	1	3		P: Most of the time ... [the information] will be there but if she is swarmed with a lot of meetings that comes with the leadership role then it's sometimes hard [to provide it]. Like I mean that's why I say she is approachable but if she is swamped with all her meetings then it can be overwhelming like I mean and that can sometimes put a little downside on her leadership.
			a lot coming down on her	1	2		Participant 1: It depends on the situation I mean she can be quite an effective communicator ... when it's manageable when there's not a lot of other people coming down on her. I find that when there's a lot of people coming ... down on her then her leadership kind of gets more . . . Participant 1: Distracted.

THEMES	CATEGORY	SUB-CATEGORY	CODES	Source Count	Frequency Count	MEANING UNITS	DIRECT QUOTES (examples)
			has many other responsibilities	2	2		P: How many [responsibilities] does she have, how many, she's just got too much responsibility so I think she does the best she can.
			big workload	1	1		P: I think she makes it look really simple like she has like a lot of workload but like when she's not on and when someone else is like taking over you can really see the difference when she's on because of the way she does things. And I guess you don't notice it until someone else does it and you realize what a big workload she has.
			demands of position	1	1		P: I think there's good communication although often it can be rushed but I don't think it's ... personal, ... it's just the nature of her position and the demands that are probably [put] on her but then at the same time it does trickle down to us…
			has a lot of balls in the air...	1	1		P: ... she's also gotten to know more of us in … a different scope too but I think a lot of it is just, you know, coping with … [responsibilities and having] a lot of balls in the air and she's got to keep them all up.
			has her own work that she has to do	1	1		P: She's here but she has her … [own] work to do for the floor where it's a little difficult ... at times to ... provide [staff] with that information right at the time.
			has too much on her head	1	1		R: ...she's got so much on her head that she really can't focus . . .
			increase in administrative duties	1	1		P: ...Of course a person who was leading four years ago they didn't have as many administrative duties [so they] could roll up their sleeves a lot more…

THEMES	CATEGORY	SUB-CATEGORY	CODES	Source Count	Frequency Count	MEANING UNITS	DIRECT QUOTES (examples)
			it's out of her hands	1	1		P: ...she kind of lets the floor know like this is what's coming up, this is what we're dealing with and its nicer because I mean it's out of her hands too the stuff that's coming down her side…
			more and more being pushed on leaders	1	1		P: …[new projects and initiatives] keep getting more and more ... pushed on us and we as leaders don't really know what we're supposed to be doing next…
			pulled in many directions	1	1		P: ...I think that the job itself lends itself to being diluted because it ... gets pulled in so many directions…
			responsible for many tasks or staff or patients	1	1		P: ...from above they keep getting more and more and more pushed on us and we as leaders don't really know what we're supposed to be doing next. Because we get one memo that says this is for managers and we're supposed to do that. And then we get somebody sick on the unit and we're supposed to do that. Then we've got somebody on hypodermic [needles] so they've got you doing that...

WORKPLACE CHALLENGES – negative impact of organizational restrictions

THEMES	CATEGORY	SUB-CATEGORY	CODES	Source Count	Frequency Count	MEANING UNITS	DIRECT QUOTES (examples)
Negative impact of organizational restrictions	Impact on leader		unable to do what needs to be done	2	4		P: Yeah, I agree. I think her situation is absolutely horrendously difficult because I think in her heart she has what she wants to do but practically it's impossible.

THEMES	CATEGORY	SUB-CATEGORY	CODES	Source Count	Frequency Count	MEANING UNITS	DIRECT QUOTES (examples)
			cannot focus	1	1		R: ...she's got so much on her head that she really can't focus
			emotionally tied to decisions that are out of her control	1	1		P: …she's able to do the hard line when she has to but … her decisions do affect her. She is emotionally tied to a lot of the decisions that she makes whether she agrees with them or not because of different constraints from administration.
			has to get things done on her own time	1	1		P: ...But most of … [the project] is getting done on her own time … [as she] can't get this done as well [as her leadership responsibilities] …
			increased workload	1	1		P: I think she makes it look really simple ... she has ... a lot of workload but ... when she's not on and when someone else is like taking over you can really see the difference when she's on because of the way she does things. And I guess you don't notice it until someone else does it and you realize what a big workload she has.
			job becomes diluted	1	1		P: ...I think that the job itself lends itself to being diluted because it ... gets pulled in so many directions…
			leader is limited	1	1		Participant 1: ... [the leaders are] limited yeah. Participant 2: They're so limited ... [in what they can do]. . . Participant 1: They [are] very limited.
			leadership becomes distracted	1	1		Participant 1: ...I find that when there's a lot of people coming down ,,, on her then her leadership kind of gets more... Participant 2: Distracted.
			limited time for positive reinforcement	1	1		P: ...because of her [huge] portfolio, how can she be there encouraging every single one of us?

THEMES	CATEGORY	SUB-CATEGORY	CODES	Source Count	Frequency Count	MEANING UNITS	DIRECT QUOTES (examples)
			taking frustration out on leader	1	1		P: ...it's just, you know, frustrations not really with her although sometimes she takes the brunt of it because she's right there…
			things fall apart	1	1		P: You know she relies on a lot of us more senior nurses to help her make decisions and so it's, you know, we're all involved in the [decision making] processes so we feel part of it, yeah, [but when] there's a lot ... coming down on her then that kind of falls apart.
	Impact on staff, patients and workplace environment		inadequate leader involvement	4	5		P: [The leaders don't help out] unless they're called out so I'm not sure if that's what the management team wants her as a leader [to do] and that's what she does … [but] I prefer the other's way of doing it.
			inadequate access to resources	4	4		P: She's here but she has … her work to do for the floor where it's a little difficult…at times to, to provide [staff] with… information [they need] right at the time…
			creating a division between leaders and staff/pushing us apart	1	1		P: …[they tell us] 'Okay, no, it's okay you can have one more [patient], you can have two more'. So that's kind of pushing us apart…
			inadequate staff support	1	1		P: I think she supports us in our work ... the best that she can, however I think that there's powers beyond her that can, you know [restrict what she can do] …

THEMES	CATEGORY	SUB-CATEGORY	CODES	Source Count	Frequency Count	MEANING UNITS	DIRECT QUOTES (examples)
			inadequate staffing	1	1		P: ...[they tell us] 'Okay, no, it's okay you can have one more [patient], you can have two more'. So that's kind of pushing us apart ..., on the ... regular units where there is no... RN assigned to that unit, the RN is floating around ... [and the] staff has to [take on more] ... everybody is saying it's a good thing to do but how?
			increased risk to patients	1	1		P: [It would help] if they followed … [the project] through the leadership and … [put] everything in place rather than just throwing residents back [from hospital to an extended care bed] without everything being in place and putting everyone at risk.
			lack of visibility of upper management	1	1		P: …So whereas like with management who are higher [within the administration structure] we don't even know half of them exist right?
			nursing component is getting compressed	1	1		P: ... [the management component] just keeps getting to be bigger and bigger. And the nursing component gets more compressed and more compressed and more compressed.
			rushed communication	1	1		P: I think there's good communication although often it can be rushed but I don't think it's ... personal, ... it's just the nature of her position and the demands that are probably on her but then at the same time it does trickle down to us.
			rushing through with decisions	1	1		P: [It would help] if they followed … [the project] through the leadership and … [put] everything in place rather than just throwing residents back [from hospital to an extended care bed] without everything being in place and putting everyone at risk.

WORKPLACE CHALLENGES – staff

THEMES	CATEGORY	SUB-CATEGORY	CODES	Source Count	Frequency Count	MEANING UNITS	DIRECT QUOTES (examples)
Lack of Organizational Support for Staff	Lack of resources		don't feel like they are being heard	1	2		P: ...So I mean I don't feel like we're being heard. And I think more than anything else if we could have some understanding … from the organization I think it would be a little bit more [positive] because we're willing to give, that's not the issue. And we want to know that we're being heard and, you know, that we can ... have some feeling and as you said there's just more and more [work and changes] coming but nobody seems to hear.
(Staff nurses do not feel support from organization)	Lack of backing/ support		lack of support from organization/administration	2	3		Participant 1: You know, I don't feel like we're cared for in that, from our organizational point of view. Participant 2: Yeah ... Participant 3: [All we see is] cuts of staff, … [more] paperwork, added duties… Participant 4: With less people.
			lack of educational support	1	1		P: [the organization and its leaders need to] provide more educational opportunities for the staff. Time for education, workshops, seminars that would be supportive for doing our job…
			lack of recognition or positive reinforcement from organization	1	1		P: But you don't hear ... [any reinforcement], we don't hear it from upper management right? And, you know, ... it's been frustrating. And like I say even though we get well paid it would be nice to get some actual recognition once in a while, a reward.
			lack of understanding from organization	1	1		P: ...And I think more than anything else if we could have some understanding ... from the organization I think it would be a little bit … [better] because we're willing to give [to the organization] that's not the issue…

THEMES	CATEGORY	SUB-CATEGORY	CODES	Source Count	Frequency Count	MEANING UNITS	DIRECT QUOTES (examples)
			staff feeling upset with organization	1	1		P: ... [we are] upset with the organization as opposed to XXX. She's done a wonderful job for us [the nurses]...

QUESTION:

1. If you could change anything about your leader's style, what would you want to change? Why?
2. Your nurse leader attended a nursing leadership workshop. Since their attendance, have you noticed any differences in their leadership behavior? If you have noticed differences, please describe them.

Leader Growth – need for improvement

THEMES	CATEGORY	SUB-CATEGORY	CODES	Source Count	Frequency Count	MEANING UNITS	DIRECT QUOTES (examples)
Need for leader improvement *(Staff identified areas where some leaders still need to improve)*	RELATIONAL *(Personal aspects/ characteristics)*		intense	1	1		P: Sometimes you get that sense so it's not as comfortable to go to her, you know, something might not be going right or whatever so I think she could benefit from, you know not being so like learning to not be so intense…
			unapproachable	1	1		P: ...I'm not scared of her or whatever but some people ... [are as] she's very intense and you're almost afraid that she's going to think you don't know what you're doing. Sometimes you get that sense so it's not as comfortable to go to her...
			takes things personally	1	1		P: I think she needs to learn how not to take every single thing so personally, she needs to distance herself a little bit more [from her job]…

THEMES	CATEGORY	SUB-CATEGORY	CODES	Source Count	Frequency Count	MEANING UNITS	DIRECT QUOTES (examples)
	TASKS (Skills/ Strategies)		lack of leader involvement	2	2		P: ...I don't know if that's just the charge nurse role but I think she could be teaching ... I mean I don't expect her to be an educator but ... there's opportunities for her to go to ... [teach] patients and [be involved]…
			micromanaging	1	1		P: I don't think it's ever been an issue of no confidence, its more what [the leader is] able to do because, you know, like ... I've experienced her as, you know, allowing other people to do their things, but as … [the other focus group participant] said, … because she's micromanaging it's overwhelming for her, she's trying to be all to … [everyone].
			needs to take on all aspects of project	1	1		P: ...it's kind of like pulling teeth to get her to do the, the writing part of … [the project] on the computer but the presentations have gone really well…
			not good at allocation	1	1		Participant 1: I'm thinking that sometimes she's not so good at allocation ... Participant 1: In terms of patients . . . Participant 1: In terms of [allocating] the patients to the nurses... Participant 2: ...[she assigns] too big of loads.

THEMES	CATEGORY	SUB-CATEGORY	CODES	Source Count	Frequency Count	MEANING UNITS	DIRECT QUOTES (examples)
			out of touch	1	1		Participant 1: Yeah, but sometimes you get… out of touch and then you often [think] … this can't be right like you must be out of touch… Participant 2: And their angle on that is that they haven't had the information from a previous shift about [what is happening on the unit]… Participant 3: That's true and they need to seek that out, like when I'm in charge I say 'She's got an infusion do you think your assignment is too heavy for days?' Like you have to seek out the information, people aren't necessarily going to offer that and I think that, that's part of being a leader.

LEADER GROWTH – post BC NLI

THEMES	CATEGORY	SUB-CATEGORY	CODES	Source Count	Frequency Count	MEANING UNITS	DIRECT QUOTES (examples)
Notable changes	difference in leader noted post BC NLI		saw any or general difference in leader	3	3		P: Yeah I've noticed [a change] ... since she's gotten a new [leadership] job I've noticed definitely a change.
(Changes noted in first-line leaders following participation in the BC NLI)	RELATIONAL		more confidence	2	6		P: ...if anything we noticed her being just a little bit more confident in her role because she knows where she stands now…

THEMES	CATEGORY	SUB-CATEGORY	CODES	Source Count	Frequency Count	MEANING UNITS	DIRECT QUOTES (examples)
	(Personal leader improvements)		improvement in coping	1	4		P: ...she's managed to focus so much better on her position and coping with, with all the things that are coming at her from so many different directions. And the difference from being how I worked with her as a floor nurse to PCC to, …now, in the last two years and the growth of … her leadership skills has improved vastly and I think leadership includes her coping of how you manage things coming at you from different directions.
			more knowledgeable	1	3		Participant 1: And she's become more knowledgeable. Participant 2: Yeah. Participant 1: Probably ... about the job and what's expected of her and just, yeah, you know, like the sort of manager hierarchy there is within a hospital or within a health region.
			less chaotic or calmer	1	2		P: Yeah ... it's chaotic actually when you come on. And I think that has lessened more as time has gone by.
			less emotional	1	2		P: ...she's got a lot broader shoulders [now] ... she brushes it off with us and, you know, we're able to talk about … [the issues] instead of it just being kind of an emotional thing.
			more comfortable	2	2		P: Well ... I definitely notice a difference but it could be like she's getting more, you know, like more comfortable and more confident in herself so I can't say that its to do with this conference that she went to or she's just grown in the position but I definitely noticed, you know, a difference with her just by speaking with her.
			more focused	2	2		P: ...she's managed to focus so much better on her position…

THEMES	CATEGORY	SUB-CATEGORY	CODES	Source Count	Frequency Count	MEANING UNITS	DIRECT QUOTES (examples)
			more relaxed	1	2		P: ...Yeah, no I find her more relaxed when she … [comes] in the morning, and, you know, just that whole atmosphere is more relaxed, more confident, that you feel, okay, great, we can go with the flow of the day and, you know, connect with her in whatever way we see fit. But I've really seen a change there.
			broader shoulders	1	1		P: ...although sometimes she takes the brunt of it because she's right there ... she's good at that now too. I mean she's got a lot broader shoulders [now] ... she brushes it off with us and, you know, we're able to talk about ... [the issues] instead of it just being kind of an emotional thing.
			improved natural abilities	1	1		P: Yeah I just see that she's just kind of built on all her natural abilities…
			more assured	1	1		P: …[she's] more assured of ... her abilities ... over the last year…
			more competent	1	1		P: ...My first couple of meetings we found XXX a little nervous but, you know, she's doing a great job, very competent and experienced…
	TASK		noted a change in leadership style	3	4		P: ...in the last couple of years it is a night and day difference in her leadership style…

THEMES	CATEGORY	SUB-CATEGORY	CODES	Source Count	Frequency Count	MEANING UNITS	DIRECT QUOTES (examples)
	(Improved leader strategies/ skills)		improved communication	3	3		P: … she's really able to stand up for us and I think more so in a positive manner. I've seen [this more] in the last year than before … [because before] she'd just get frustrated or angry or emotional, [and now] she's really got that more in check and is able to, you know, communicate [the unit issues better] … she's putting her foot down she's standing up for us. And having seen that interaction with other nurses and other charges coming from other floors they kind of come on the fly at her and she's able to, you know, communicate … [the issues] better to them. Why she's, you know, taking that stand … whereas before ... there would be a lot more emotion, a lot more of an emotional response from her.
			increase in leader involvement	3	3		P: I think more so, you know, more and more she's, you know, she'll roll up her sleeves and get in there to help us. I mean I know like for me she can't help with the monitor, my tele monitor and stuff but, you know, she's rolling up her sleeves and going to help us make the [patient] moves and stuff, you know, more and more we see that.
			improvement in leadership skills	2	2		P: …in the last two years ... her leadership skills … [have] improved vastly and I think leadership includes her coping of how you manage things coming at you from different directions.
			moved away from micromanaging	1	2		P: ...she used to try and micro manage every little thing. But now she's stepped away and like she's let the people that are supposed to micromanage micro-manage. And so looking at the more global bigger picture now. It's a different focus.

THEMES	CATEGORY	SUB-CATEGORY	CODES	Source Count	Frequency Count	MEANING UNITS	DIRECT QUOTES (examples)
			stronger as a leader	2	2		P: ...her leadership strengths are [that] she's a lot stronger as a leader than she was…
			able to stand up for us	1	1		P: … she's really able to stand up for us and I think more so in a positive manner. I've seen [this more] in the last year than before … [whereas before] she'd just get frustrated or angry or emotional, [and now] she's really got that more in check and is able to, you know, communicate [the unit issues better] … she's putting her foot down she's standing up for us...
			better at delegating	1	1		P: ...she's learnt now to delegate and not just take everything on herself…
			better handling of situation(s)	1	1		P: ...I have seen a lot of changes in XXX's, the way she is handling the situation, the way she is managing the unit…
			better in managing the unit	1	1		P: ...I have seen a lot of changes in XXX's, the way she is handling the situation, the way she is managing the unit…
			growth in how she leads	1	1		P: ...I've seen a difference over the last I guess it's been two years [that she's been] in this position, so especially over the last year there's been quite a growth in how she leads…
			improved organizational skills	1	1		P: ...And I think one thing is that I think over the year her organization skills have improved…
			more efficient	1	1		P: ...I think just having different situations thrown at her out of the blue she's able to resource the necessary things more quickly, more efficiently…

THEMES	CATEGORY	SUB-CATEGORY	CODES	Source Count	Frequency Count	MEANING UNITS	DIRECT QUOTES (examples)
			sharing of resources	1	1		P: ...some of that stuff she would bring to the staff meetings as well some of the skills that you're talking about that they could learn, she brings that to the staff meetings too, the communication and that kind of stuff.
			strong leadership role	1	1		P: ...prior to having her as our manager [we] knew what some of her strong points were and certainly over the past year [we are] just seeing her grow with that to a strong leadership role.

QUESTION:
1. From your perspective, would you recommend this type of leadership training for other nurse leaders? Why or why not?

BC NLI Program Support

THEMES	CATEGORY	SUB-CATEGORY	CODES	Source Count	Frequency Count	MEANING UNITS	DIRECT QUOTES (examples)
Program influences leaders	Specific change identified as a result of BC NLI		Helped her transition	1	1		P: ...it's helped her transition in that role.
(NLI support/ changes attributed to NLI program)	General change identified as a result of BC NLI		Many changes on the basis of BC NLI	1	1		P: ...I have seen many changes on the basis of your education…
			This program…makes a difference	1	1		P: Well this program for what it's worth it makes a difference I've seen it.

BC NLI SUPPORT – impact on leader growth

THEMES	CATEGORY	SUB-CATEGORY	CODES	Source Count	Frequency Count	MEANING UNITS	DIRECT QUOTES (examples)
Formal leadership development opportunities	Important components	Description of leadership training	Leadership is a dynamic process	1	1		P: I think leadership is an ongoing [process of development], I think it's a dynamic process, I think that ... you can always work on leadership.
		Components of leadership training/ development	Leadership support is good and necessary	2	2		P: I think leadership support is good for anybody, as … [much] as we need the support I think she as a leader needs it too right, anything helps, yeah.
			Components beneficial for leadership development	1	1		P: ...I think that, you know, even courses just ... updating and stuff, good workshops … [continuing] to work on it I think that that's always beneficial in a leadership program, you know.
	Recognized importance of formal training	Benefits of leadership training	Sharing of acquired skills/ information	1	1		P: ...some of that stuff she would bring to the staff meetings as well some of the skills that you're talking about that they could learn, she brings that to the staff meetings too, the communication and that kind of stuff.
		Leadership training is essential	Leader will benefit from leadership training	5	6		P: More training can always help eh, more training can always help.
			You can always work on leadership	1	1		P: I think leadership is an ongoing [process of development], I think it's a dynamic process, I think that ... you can always work on leadership.

BC NLI SUPPORT – external factors affecting leader growth

THEMES	CATEGORY	SUB-CATEGORY	CODES	Source Count	Frequency Count	MEANING UNITS	DIRECT QUOTES (examples)
External factors influencing leadership development *(Changes attributed to other factors/unsure if change was the result of leadership training or experience)*	PERSONAL FACTORS (KANTER) (Personal growth)		Growing in her self	2	3		P: ... since she's gotten a new job I've noticed definitely a change. Now I don't know if it's to do with the program that she took or if it's just because she's growing in her, her own self right?
			Getting used to it (the job)	1	1		R: Getting used to … [the job plays a role in the development]? Participant 1: And just getting [used to it]... Participant 2: All the wonderful staff she has.
			Growing in her position	1	1		P: … I definitely notice a difference [after the BC NLI] but it could be like she's getting more, you know, like more comfortable and more confident in herself so I can't say that it's to do with this conference that she went to or she's just grown in the position but I definitely noticed, you know, a difference with her just by speaking with her.
	ORGANIZA-TIONAL FACTORS (CSE) *(External influences)*		role of experience	5	7		P: …because she was a ward nurse here and then she had a hard role to step into, being a leader to leading the people she used to work with, so I think it's [the BC NLI that]helped her transition in that role.
			Being in the job	1	1		P: I'm not sure what helped her, if it was the Institute or just the fact of being in the job and just doing it and being… And just getting… Better at it, yeah.
			Different training you go through	1	1		P: I think it's a combination, I think she's an organized person to begin with but I think with all the different training you go through ..., you know, inter personal skills and leadership and all that kind of stuff it just reinforces [the qualities] I think.

THEMES	CATEGORY	SUB-CATEGORY	CODES	Source Count	Frequency Count	MEANING UNITS	DIRECT QUOTES (examples)
			role of support	1	1		P: It's got to be nice to have some kind of support in your transitioning through a new role like that. I mean it's probably a great program for them, the managers for sure.