THE NURSE MANAGER'S PERSPECTIVE
IN MAINTAINING A QUALITY PRACTICE ENVIRONMENT
by
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ABSTRACT

The quality of the working environment is currently an important and rising issue in a number of disciplines, including nursing. To practice effectively, nurses today need an environment that supports quality professional practice. This qualitative research study used an interpretive description methodology to examine the nurse manager's perspective on creating and maintaining a quality practice environment. Four nurse managers were recruited from an acute care setting to be interviewed for this study. The deductive data analysis of participant narrative revealed three major and broad themes. These themes are: establishing a trust relationship; leadership philosophy and style; and organizational and staff support. The process, as the participants' stories reveal, is a cyclic, responsive, and interactive one, in which managers bring to bear an array of interdependent strategies on the complex problem of creating a quality practice environment. The results of this study shed light on the processes and challenges nurse manager's face in the current and ever changing health care system and provide a foundational background to the leadership traits needed to create and maintain a quality practice environment that promotes nurses' satisfaction and good patient outcomes. The findings of this research offer insights to inform nursing researchers, institutions, and policy makers in their efforts to understand and improve nursing practice, provide appropriate levels of support, improve educational programs, and develop better guidelines for creating and maintaining a quality practice environment.
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The Researcher
CHAPTER ONE: INTRODUCTION

The quality of the working environment is currently an important and rising issue in a number of health care disciplines, including nursing. For nursing in particular there is a growing body of literature and research that shows a direct correlation between the quality of the practice environment and factors such as job satisfaction, productivity, recruiting and retaining of employees, and most important, quality patient care and health care outcomes (Winslow, 2001).

While trying to maintain a quality practice environment, Canadian nurse managers face the ongoing challenge of health care reform. These changes not only alter the practice environment drastically, but also affect the quality of patient outcomes and care. Although at this time there exist outlines for policies and guidelines that seek to create and maintain quality practice environment in which nurses can practice, these guidelines are based on the (valid, but particular) perspectives of staff nurses. Throughout the literature, studies both assume and conclude that nurse managers or leaders are very important in creating working conditions that maintain quality employee and patient outcomes; surprisingly few, though, address the particular concerns and points of view of nurse managers during the course of their investigations. Unfortunately, therefore, we have not yet heard fully and clearly from nurse managers and leaders on this issue, despite their important role in creating and maintaining a quality practice environment that promotes satisfaction, productivity, and positive outcomes for nurses and patients.

If we are to understand how nurse managers and leaders engage with the problems of the workplace, we will need more research directed specifically at exploring this phenomenon. I have undertaken this study, therefore, with a view to acquiring a better understanding of this important but neglected aspect of our ongoing pursuit of a quality nursing practice environment.
In this study, an interpretive descriptive method is used to investigate the perspective of nurse managers on their efforts to create and maintain a quality practice environment. The discussion and analysis herein focuses on nurse managers' diverse stories and interprets both the variations and the similarities in these narratives. This study thereby explores the rich possibilities inherent in the many strategies nurse managers employ in their efforts to create and maintain a quality practice environment.

Fewer nurse managers volunteered to participate in the study than I anticipated at the outset of this research project. It is unclear why this is so, although this participation level may reflect the current rarity of "quality practice environments" and the extraordinary workload and responsibility of nurse managers today. Nevertheless, the four participating nurse managers and leaders offered insightful and wide-ranging perspectives on their experiences and efforts such that the knowledge gained from this study will contribute directly to the knowledge of current and future nurse managers and leaders. This knowledge is based on the realities of the practice world, and explicates many of the ways in which managers in acute care settings seek to create and maintain a quality practice environment.

This study consists of an introduction and five chapters. In this introductory chapter, I provide the background to the problem, set out the problem statement, describe the research purpose of the study, outline the research question, and explain the significance of the study. In the final two sections of this chapter, I provide a definition of important terms as they pertain to this research area, and outline the assumptions upon which the study is based.

Chapter Two contains a comprehensive review and analysis of the current research as it pertains to the quality practice environment for nurses. I have divided the review into three sections. In the first section, I describe the studies that analyze and categorize the attributes of a quality practice environment. The treatment in the literature of leadership models and the role of nurse managers is the subject of the subsequent section. This chapter concludes with a
description of the small body of literature that investigates the specific perspectives of nurse managers.

In Chapter Three I describe in the detail the interpretive descriptive design and qualitative method of this study. I have divided the chapter into sections in which I describe the methodology, selection criteria, recruitment process, participants, data collection and analysis, rigor, ethical considerations, and limitations of the study. Within the three main themes that emerged during the data analysis: trust, leadership, and organizational issues, the presentation of results in Chapter Four articulates the various strategies nurse managers employ in the context of the experience and vision each brings to her practice.

I present in Chapter Five the interpretive product of the data analysis, and explain both the ways in which these findings confirm some of our current understandings of the quality practice environment, as well as the ways in which these findings seem to depart from received wisdom and offer insight into new understandings. Finally, Chapter Six contains my assessment of the implications of the findings of this study for nursing practice. Based on these findings, I make recommendations for further research and for the refinement of guidelines that accommodate and account for the specific perspective of nurse managers.

Background to the Problem

Since the 1990s, the Canadian health care system has been undergoing continual changes and reforms: reductions in nurse staffing, reductions in funding to the health care system, internal cost-cutting, and hospital downsizing and closure. The result has been significant increases in workloads for nurses. Increased patient acuity related to aging of the population (Mackay & Risk, 2001; McGirr & Bakker, 2000; Shamian, Kerr, Laschinger & Thomson, 2002; Zboril-Benson, 2002) is a further complicating factor in attempts to manage health care. These changes have had dramatic effects on the quality of nurses' practice environment and on the quality of outcomes for nurses and patients. The restructuring has also
affected the roles of nursing leadership and management (Clarke, Laschinger, Giovannetti, Shamian, Thomson & Tourangeau, 2001).

In the 1980s, as McGirr and Bakker (2000) note, the Canadian Nurses Association (CNA) emphasized the importance of nurse managers and administrators providing a practice environment that allows for quality patient care and maintains staff well-being. The role of the nurse manager in today’s health care system remains a crucial one, given the cumulative and ongoing effects of changes in the system. The quality of the practice environment for nurses has deteriorated such that it can be very difficult to meet the goals of nursing and the needs of nurses within the present framework. Nevertheless, the expectation remains in place today that nurse managers can and indeed must find ways to fulfill all these needs.

The proliferation of current research that investigates the practice environment reflects our concern with this area of nursing. Numerous nursing researchers have approached the subject by attempting to evaluate the work environment and identify the attributes of a quality practice environment. For example, Villeneuve and colleagues (1995, cited in Mackay & Risk, 2001) define a quality practice environment for nursing as one in which the needs of both patients and nurses are met and the staff and patient outcomes are achieved within the cost and work frame mandated by the organization in which care is being delivered (p.19).

Other studies have taken the approach of evaluating the effects of health care reform that have increased workloads and adversely affected working conditions for nurses. Based on these evaluative studies, various professional regulatory bodies and institutions have created policies and guidelines aimed at creating and maintaining a quality practice environment for nurses. There are numerous examples of this type of guideline. The Registered Nurses Association of British Columbia (RNABC) established in 2001 a policy statement entitled “Nursing Practice Environment for Safe and Appropriate Care”. The RNABC subsequently published its quality practice environment guidelines (RNABC, 2002). The first document
indicates that government, employers, unions, and schools of nursing, are all responsible for creating an environment that is appropriate and necessary for safe practice and care (Winslow, 2001); the second document provides specific guiding principles for nurses to create and maintain a practice environment that promotes quality care and positive outcomes. A year later, the Canadian Nurses Association (CNA) came out with its guidelines for quality professional practice environments for registered nurses (CNA, 2003). According to both provincial and national nursing associations, nursing leadership is an important factor in promoting and maintaining a quality practice environment (CNA). As Winslow notes, the RNABC (2001) policy statement recommends the presence of effective leadership that is supportive, visible, and understanding as part of the effort to create and maintain quality practice environments. Such policy statements have been based on broad consultations and interviews with nurses across the country and on an extensive review of literature describing the qualities and characteristics needed in the practice environment (Winslow). These guidelines provide indicators for nurses, nurse managers, and employers to follow in an effort to create, maintain, and improve the quality of practice environment. However, only some – most certainly not all – of these indicators are characteristics of a quality environment over which nurse managers may be able to exert some control. That is, nurse managers have little or no control over total workloads, institutional and union policies, health care costs, and patient acuity, but do have some control over aspects of educational programs and opportunities, flexible scheduling and workload distribution, safe work environment, opportunities for professional and personal growth and development, autonomy, and empowerment in decision-making regarding patient care. Because the areas over which nurse managers have little control nonetheless affect the quality of the practice environment, it is essential to ascertain and understand the particular perspective of nurse managers who necessarily mediate between on the one hand, organizational vision and
exigencies, and on the other hand, those of staff nurses whom nurse managers supervise. This perspective is an area of study which remains under-explored.

To improve our understanding of the challenges nurse managers currently face, it will be important to expand our research horizons beyond the areas that dominate the extant research. There have been two predominant approaches to research that is relevant to the role of nurse managers in maintaining a quality practice environment. First, most of the existing studies have investigated the perceptions of staff nurses and their need for a quality practice environment (McGirr & Bakker, 2000; Shamian et al., 2002). Most of these studies are quantitative and examine attributes of the practice environment that could affect the quality of patient care and outcomes (Estabrooks et al., 2002; Shamian, Kerr, Laschinger & Thomson, 2002). Although most studies acknowledge the issue of leadership as an important factor in creating and maintaining a quality practice environment, few have consulted nurse managers themselves. Second, nursing researchers have developed their leadership models and their recommendations for nurse managers or leaders from the business and management literature. These two approaches in the current literature underpin the processes whereby Canadian nursing associations have created their guidelines for nurses. For the most part, policy makers have directed their attention to, and based their guidelines on, these available studies. This means that researchers and policy makers reach their conclusions about the role of nurse managers without benefit of the specific perspective of the very leaders whose roles they purport to understand, and whose behavior they seek to influence and guide.

There are a few existing studies that are qualitative, but these explore only the perceptions of staff nurses, not nurse managers, about how changes in the practice environment affect their abilities to implement quality professional practice (Tillman, Salyer, Corley, & Mark, 1997). Even those studies that purport to focus on the influence of nurse managers on nurses’ job satisfaction and productivity rely primarily on data collected from
registered staff nurses (Havens & Vasey, 2003; Ma, Samuels & Alexander, 2003; McNeese-Smith, 1997). As McGillis, Hall and Donner (1997) note, although creating and maintaining quality practice environment is a shared responsibility, the leadership of nurse managers is thought to be key to a quality practice environment, quality nursing care and good outcomes. Yet, guidelines and recommendations for maintaining and providing quality practice environments are based of necessity in the existing research, and therefore in response primarily to the (valid, but nevertheless limited) perspectives of employees rather than managers.

The findings of most practice-environment studies suggest the need for supportive leadership to maintain healthy employees and a quality environment. It is unfortunate, therefore, that despite our broad understanding of the importance of leadership, the body of nursing research that has examined this concept has tended to neglect the crucial perspective of nurse managers themselves. This gap in the literature exists even as research concludes that much of the burden of responsibility for a quality practice environment rests within this group of nurse leaders.

Managers face not only the day-to-day reality of a working environment whose quality is seriously affected by changes in the health care system, but also the responsibility for ensuring that these changes affect neither the nurses they supervise nor the patients in their care. It is striking, then, that the decisions of policy makers and governmental regulatory bodies, with respect to the institutional environment in which nurses practice rely heavily on business administration principles (Attridge & Callahan, 1990). Mackay and Risk (2001) have pointed out that when models for nursing originate in a discipline other than nursing, there is a real risk that the guidelines and recommendations may fit neither with the realities of the health care system nor with nursing practice. Business models are not designed with health care priorities in mind; efforts to fit these administrative models to the health care system must
therefore rely heavily on the individual nurse manager's ability to apply these administrative strategies in ways that do not impinge upon quality patient outcomes.

In addition to their responsibility to patients, the leadership behavior of nurse managers, as Loke (2001) notes, also has a great impact on employee outcomes, and the nurse manager is an important factor in maintaining and providing a quality practice environment by inspiring collaboration, empowerment, and commitment to achieve organizational goals. Thus, in this time of continuous change in the health care system, we would do well to offer nurse managers and leaders the opportunity to articulate their perceptions and concerns, and to incorporate into our practice models this essential perspective.

**Problem Statement and Purpose of the Study**

In recent years, as health care reform has accelerated and its effects have reverberated in nursing practice, nursing researchers have made considerable efforts to understand and categorize the attributes of a quality practice environment (Attridge & Callahan, 1990; Mackay & Risk, 2001; O'Brien-Pallas & Baumann, 1992). These efforts have focused primarily on the perceptions of the largest group affected by these changes, staff nurses. At the same time, nursing theorists and researchers have also been developing models for nursing management and leadership. These nursing management studies have tended to be aligned with the main theoretical and methodological approaches to healthcare reform, which looked to the business administration literature and regulatory body principles as sources. Since the research investigating both the practice environment and the role of nurse managers has largely neglected the voice of the nurse manager, little is known about the many facets of management and leadership from the perspective of these important – indeed crucial – individuals.

This qualitative study addresses this dearth of knowledge concerning the individual nurse manager's perspective on creating and maintaining a quality practice environment. The study's purpose is to improve our understanding of the conditions in which nurse managers
practice, and the challenges they face, in their efforts to promote quality staff and patient outcomes. To accomplish this aim, this study addresses the factors that nurse managers believe affect their practice environments. It also examines the barriers and facilitating factors that managers find are present in, and influence the quality of, current practice settings. Of particular importance to this research are the strategies nurse managers use to create and maintain a quality practice environment.

Significance of the Study

Because so few studies consider the viewpoint of nurse managers, this descriptive study will increase our knowledge about the efforts of nurse managers and leaders to create and maintain a quality practice environment in an acute care setting. The role of the nurse manager in these settings is among the most challenging in the health care system today. Since there is evidence that the existence of such quality practice environments is limited, it is important to hear the nurse manager's voice to understand and support their efforts in providing environments where nurses can provide quality and safe care.

The value of qualitative studies such as this is the rich insights offered into the experience of individuals; the results can then be available to inform research and policy. Qualitative research that acknowledges the perspectives of nurse managers will lead to better representation, in both the research literature and in health care policy, of the hitherto neglected voice of this group of leaders.

The knowledge gained from this study will provide information on the perspective of nurse managers for researchers and policy makers. This knowledge may offer insights and inform nursing researchers, institutions, and policy makers in their efforts to understand and improve nursing practice, provide appropriate levels of support, improve educational programs, and develop better guidelines for creating and maintaining a quality practice environment. The intent of this study then is to generate information that will contribute to the development of a
broader foundation upon which to base guidelines for future nurse managers and leaders to better understand their practice environment, and to help them develop effective leadership strategies. Thus, these leaders will be better equipped to maintain a quality practice environment for nurses, an environment that could stand in the face of present and continuous changes in the health care system. As well, because the work environment in which nurses practice influences the outcomes of health care consumers, nurse managers and leaders can use this research-generated knowledge about the practice environment to enhance both nursing care delivery and patients' health outcomes.

**Research Question**

I designed this study to answer the question "How do nurse managers create and maintain a quality practice environment?" This question assisted me in exploring the topic of interest.

**Definition of Terms**

For the purpose of this study, I follow the recommendation of Sleutel (2000), who indicates that "practice environment" is the preferred term in the nursing discipline. Thus, I use herein the term "quality practice environment" as synonymous with "quality work environment".

A Quality Practice Environment: is a setting in which "the needs and goals of individual nurses are met at the same time as the patient or client is assisted to meet his or her individual health goals and where both outcomes are realized within the costs and quality framework mandated by the organization where the care is being provided" (O'Brien Pallas, Baumann & Villeneuve, 1994, p.14).

A Nurse Manager: is (1) a registered nurse who is accountable and responsible for a unit or services and able to demonstrate leadership behavior that is necessary in facilitating quality
patient care and ensuring a quality work environment for staff nurses (McGillis Hall & Donner, 1997); also, (2) a person who acts as a link between the organization and her staff and ensures a collaborative relationship between her staff and the interdisciplinary team to enhance patient outcomes and staff well-being (Eubanks, 1992). For the purpose of this study both definitions are useful.

Assumptions

For the purposes of this research, I make some assumptions that are acceptable as being true and logical:

1. Nurse managers are important key elements in creating and ensuring the existence of a quality work environment in which staff nurses can practice.

2. The practice environment is a key determinant of staff professional and personal satisfaction and patient outcomes.

3. Nurse managers will be able and willing to articulate their perspective on a quality practice environment and their role in promoting these environments.

Summary

The quality of the working environment is an increasingly important issue, especially in the nursing discipline. For most nurses, the workplace accounts for most of their working hours, and the practice environment has a great influence on their satisfaction, productivity, and patient care outcomes. Today the nursing profession faces serious challenges such as nursing shortages, decreased funding to the healthcare system, and increased patient age and acuity; therefore, the practice environment in which nurse’s work has been greatly affected. There is a general acknowledgement of the importance of the role of nurse managers in today’s health care system as crucial one in this time of continuous change. We need to research the strategies nurse managers are using in their attempts to create and maintain a quality practice
environment, and allow these leaders the opportunity to articulate their perspectives on this process.
CHAPTER TWO: LITERATURE REVIEW

Numerous researchers have examined the effects of changes and reforms in the healthcare system due to cost-cutting, closure and downsizing of hospitals wards, increased patient acuity, the aging population, the shortage of nurses, and increases in workloads (Mackay & Risk, 2001; McGirr & Bakker, 2000; Shamian, Kerr, Laschinger & Thomson, 2002). Early in the process of health care restructuring, nurses became dissatisfied with the quality of the work environment they had to practice in, particularly in acute care settings. As Attridge and Callahan (1990) indicate, this dissatisfaction is an issue of concern to the government, employers, professional associations, unions and schools of nursing, and to nurses themselves. A number of the dissatisfactions nurses expressed were related to the consequences of restructuring as they affected aspects of their organizational systems: lack of opportunity for professional growth, development and education; lack of promotion and rewards; inflexibility in scheduling; lack of organizational support and collaborative decision-making; work overload; strained interpersonal relationships; and unsatisfactory resources and financial supports (Attridge & Callahan, 1990; Clarke et al., 2001; O’Brien-Pallas & Baumann, 1992; Tillman, Sayler, Corley & Mark, 1997). Despite the abundance of research that purports to address exactly these workplace challenges for nurses, this list of dissatisfactions has not diminished.

In the context of the ongoing efforts to reform Canada’s health care system, the outcry among nurses continues over many of these effects (Clarke et al.; Tillman et al.) This indicates that researchers and policy makers may have neglected to account for certain crucial aspects of the issue of the practice environment. In the following review, I summarize the current state of the research that pertains to the practice environment, and also identify significant gaps in the literature. These neglected aspects of the problem may, upon further investigation, yield important insights into the problem of the quality of the current nursing environment.
The Quality Practice Environment in Nursing

The literature contains a range of definitions of the work or practice environment and work culture. In an effort to categorize and identify the various definitions of work environment, culture and climate, and the difference between these terms in the nursing setting, Sleutel (2000) conducted an extensive literature review. It is important to note that health care-related research into the subject of organizational setting derives primarily from theoretical models and studies conducted in the business and management disciplines. Sleutel and Flarey (1993) indicate that most of these studies use the term "work climate" to refer to the organizational setting or work environment, but researchers in some disciplines use both "work environment" and "work climate" to describe the practices and procedures that characterize the entire organization. "Environment" or "climate" may also refer to subunits within the organizational components of the settings that have a particular meaning or value to the setting and employee such as rewards, support, risk and conflict management, and resolution. These terms also apply to features in the organization that have an influence on the employees' attitudes, beliefs and behaviors that lead to certain out comes (Sleutel). For the purposes of this study, it is important to distinguish the terms "work culture" and "work environment" as they are used in the business-oriented literature from terms and usages that appear in the context of nursing research and practice.

As Schein (1986 as cited in Sleutel, 2000) and Flarey (1993) define it, "work culture" is a set of beliefs, values, rituals, and assumptions that the members of a particular work culture share. Some times, a group of people within an organization may create or develop a culture of their own that could differ from the organizational culture. This general term may refer to the overall organizational setting in which nursing takes place, but "practice environment", as Sleutel indicates, is the preferred term in the nursing discipline to describe the specific setting for and attributes of nursing practice. This "practice environment", according to Sleutel, has a
distinct set of attributes and characteristics in the nursing workplace such as employee job
satisfaction, autonomy, and promotion and professional growth opportunities. These attributes
act as factors within the organization that influence and impact employee performance and thus
organizational outcomes.

The Attributes and Characteristics of a Quality Practice Environment

Attridge and Callahan (1990) claim that nurses themselves must identify and address the
attributes and characteristics of the environment in which they practice, and the elements that
motivate and satisfy them in this environment. This notion is based on the Quality of Working
Life (QWL) concept, which Attridge and Callahan note emerged in the 1970s in business and
management literature. The QWL concept focuses on the relationship between individual
workers and their total work environment with a view to redesigning work environments.
According to its proponents, QWL-based redesign of the work environment would
acknowledge and develop the multiple capabilities of the individuals, and would represent a
wide array of concerns ranging from the provision of a safe and healthy workplace to the
creation of a new form of organization; Attridge and Callahan apply the concept to the nursing
practice environment. These scholars refer to Walton’s (1975, as cited in Attridge & Callahan)
previous application of business-based research in a framework that represents the
characteristics of the quality work situation based on male and business perspectives.
According to Walton, characteristics of the quality work environment include “adequate and
fair compensation, safe and healthy working conditions, opportunities for continued growth and
education, safety and security, development of human capacities, social integration in to the
workplace, the social relevance of work, and the balance between work and the rest of one’s
life” (cited in Attridge & Callahan, p.19). The QWL research in the business and management
literature also claims that one of the critical elements in achieving these features of a quality
work environment is the participation and collaboration of both workers and management, with management playing a major role in providing and maintaining these qualities.

Guided by Walton's framework, nursing researchers Attridge and Callahan (1990) conducted a study with the intent of identifying and prioritizing the characteristics of quality work environments as defined by nurses for nurses. In other words, the study adapted a business-based, male-oriented model, to reflect nurses' perspectives about quality work environments in a health care setting in which females predominate in both managerial and general staff positions. Using a qualitative method, the researchers interviewed sixty-four nurses from different areas in British Columbia, and compiled characteristics that nurses identified as significant and important for their work environment. Some of these nursing-specific characteristics differ from those noted in the QWL literature. They include: adequate staffing; positive work relationships; more human resources and benefits; effective communication of organizational values and goals; control over nursing work; recognition by professional colleagues; opportunities for personal, career and professional growth and development; comfortable and efficient environment; and, participative management that allows for autonomy and staff participation in decision-making. Attridge and Callahan claim that nurses have identified this last attribute, the role of participative management in their environment, as a critical element in maintaining and providing some of the highly ranked characteristics of the quality work environment: positive employee relationships; the ability to trust; flexibility in scheduling of work hours, sick time, vacations, and overtime; and empowerment.

In 1992, O'Brien-Pallas and Baumann formulated a model that focuses on and examines factors influencing nursing work life, also based on the QWL literature. In this study of the issues and complexity of the work environment, these two scholars claimed that although the quality of nurse's work life or environment had been an issue of concern in numerous prior
studies, there had not yet been any attempt to develop a framework to evaluate the quality of the work environment issues for nurses. Therefore, O'Brien-Pallas and Baumann developed their framework in an attempt to establish links between nurses’ experience, the context of their working organization, and features of the health care system. The resulting model identifies two categories of factors that have an influence on nurses’ worklife issues. In the internal dimension, factors such as individual, social, environmental, contextual, operational, and administrative factors have an effect on nurses and the environment in which they work. In the external dimension, client demands on the system, health care policy, and the labour market are the factors affecting nurses and their environment. All these factors, both internal and external, have an effect on outcomes for nurses and patients (O'Brien-Pallas & Baumann). Because the issue of nurse worklife is important, O'Brien-Pallas and Baumann suggest that many of the influential factors in creating a quality work or practice environment are within the control of the nurse manager, and that therefore we need more specific studies to understand how management philosophy and the environment affect nurses and their activities.

The concept of “magnet hospitals” has reinforced the notion that it is useful to attempt to maintain a quality practice environment. As Havens and Aiken (1999) indicate, the concept of magnet hospitals emerged in the 1980s during a major nursing shortage. The magnet designation was applied to certain hospitals that were able to attract nurses and be successful in retaining them. Magnet hospitals also had nurses who reported high levels of job satisfaction, low job turnover and vacancies, and lower levels of emotional exhaustion. Such hospitals have demonstrated organizational attributes that enable nurses to fully use their knowledge and experience to provide quality patient care and thus maintain their professional and personal satisfaction. These institutions provided opportunities for personal and professional growth and development, offered higher salaries, empowered nurses to use their professional knowledge and skills in patient care, allowed nurse autonomy, had flat organizational structures, maintained
effective communication between nurses and other healthcare professionals, and attracted nurses to work within an environment that provided support and enhanced productivity. Because of these attributes, "magnet" studies claim, some hospitals had the ability to retain nurses, and thus had better outcomes for patients and nurses (Coile, 2001; Havens & Aiken). Havens and Aiken indicate that, in studies that compared magnet hospitals with non-magnet hospitals, nurses in magnet hospitals reported that it was important to them that the hospital and nursing management and administration supported them and valued their practice. These reports indicate that the role of nursing management is important in maintaining and providing a quality environment in which nurses may practice, to ensure high quality patient care.

However, magnet hospital studies have tended to examine the phenomenon from a QWL-style perspective of the employee, and neglect the point of view of nurse managers.

As researchers became aware of the importance of the work environment in which nurses practice, they attempted to develop nursing-specific tools. One such tool was the Nurses Work Index (NWI), was first developed in the 1980s by Kramer and Hafner (as cited in Estabrooks et al., 2002) to measure hospital nurses' job satisfaction. Kramer and Hafner used magnet hospital characteristics to develop a tool that was designed to measures four variables: "(a) work value related to job satisfaction, (b) work values related to perceived productivity, (c) staff nurses' job satisfaction, and (d) staff nurses' perception of an environment conducive to quality nursing care" (p.257). More recently, several researchers have revised this tool. For example, Yoder (1995, as cited in Estabrooks et al., 2002) and Aiken and associates (1997, as cited in Estabrooks et al., 2002) developed new subscales to help make this tool more useful in measuring aspects of hospital environments in which nurses practice. The tool was re-labeled the NWI-R when Aiken and Sloane (1997, as cited in Estabrooks et al., 2002) revised it in their study of the impact of specialized AIDS patient care units on both patients and nurses outcomes. This revised tool has three subscales that were used to measure the professional
environment: (1) nurse autonomy, (2) control over the practice, and (3) nurse-physician relationship (Shamian et al., 2002).

Numerous studies have used the NWI-R tool to measure the attributes of the nursing practice environment. For example, Estabrooks and colleagues (2002) studied staff nurses and their practice environment to measure the relationship between these and hospital outcomes. Based on the results of their study, these researchers proposed a simplified, single factor solution to the NWI-R, which they called the practice environment index (PEI). This index captured the practice environment as "a unitary concept" (p.263). This tool is the first to be developed based on Canadian hospital data, and it was anticipated that it would be helpful in assessing the impact of the hospital and work environment on outcomes for Canadian nurses and patients (Estabrooks et al., 2002). Also using the PEI, Clarke et al. (2001) and Shamian et al. (2002) conducted further studies to explore outcomes for nurses and patients with respect to the impact of the workplace environment. In both studies, the quality of the practice environment was found to be a critical issue in retaining and recruiting nurses and improvement of patient care. According to the viewpoint of nurses participating in both of these studies, certain practice environment characteristics are the most important factors in the practice environment. These factors support and retain nurses, and ensure their well-being, job satisfaction, control over one's work environment, sufficient resources, effective and supportive leadership, and collaborative nurse-physician relationships.

A recent study also used the NWI-R tool examined the relationship between nurse perception of workplace empowerment and the characteristics of magnet hospitals. Laschinger, Almost, and Tuer-Hodes (2003) measured nurse autonomy, nurse control over practice, and nurse relationships with physicians. Their results support the findings of the magnet hospital research, which suggest that when the work environment provides support to nurses, this leads to quality patient care outcomes and staff satisfaction. Hospitals can ensure
such support, the study indicates, by providing access to information, supply, supportive resources, and opportunities for career development and learning. In addition, the organization may support professional practice through flexibility in scheduling by enhancing positive relationships with other healthcare teams. Laschinger, Almost, and Tuer-Hodes strongly assert the importance of the role of nurse managers and leaders. Their study results suggest that managers' and leaders' efforts to create an empowering practice environment can influence nurses to practice in a professional manner that will ensure excellent patient care quality and positive organizational outcomes.

Clarke et al. (2001) also indicated that it is important to have nursing leadership that is supportive, visible, and fosters employee growth and development, and that such leadership means that nurses will experience lower turnover, less burnout and exhaustion, and higher a rate of retention. However, Shamian et al. (2002) found that full-time employment is a strong predictor of illness and increased health risk. Nurses who were working as full-time employees reported more sickness, burnout, and job dissatisfaction than part-time nurses did. Shamian also noted that positive practice environment characteristics could be overshadowed when the workload is too heavy, and that this will lead to poor outcomes for both nurses and patients (Shamian et al).

Other studies have evaluated and examined the practice environment and its impact on nurses and patient outcomes from different perspectives. Grindel, Peterson, Kinneman, and Turner (1996) conducted a study to evaluate the practice environment characteristics that will help to provide quality patient care. They developed a practice environment project (PEP) to act as a foundation framework for the evaluation of planned change and an ongoing evaluation of practice environment in their acute care setting. Through the assessment of patient satisfaction, physician satisfaction with patient care, and the satisfaction of nurses with their jobs, autonomy, and collaboration with physicians, Grindel and associates indicated that the
PEP was helpful in evaluating the current state of the practice environment and developing a process to manage the factors that affected the provision of patient care. They reported that the PEP achieved positive results through implementing mechanisms and recommendations that could help nurses and administrators to maintain a quality practice environment and ensure quality patient care and outcomes. For example, they reported improved communication within the nursing department; staff was empowered and able to manage problems that could affect the provision of quality nursing care, and an increased level of job satisfaction among the nurses (Grindel et al.).

Another approach to the problem of the quality practice environment is from the regulatory body perspective. For example, College of Nurses of Ontario (CNO) recently developed the Quality Practice Setting Attribute Model, which Mackay and Risk (2001), describe in a recent article. The CNO model emerged from extensive literature reviews and focus group interviews that included more than 300 nurses from 16 sites across Ontario. The aim of the CNO was to develop an attribute model that would help employers, nurses, and regulatory bodies to work collaboratively to create a workplace that promotes and supports quality professional practice (Mackay & Risk). The model was the foundation for the practice setting consultation program that is a component of a quality assurance program. This attribute model specifies seven key attributes as essential elements in supporting quality professional practice: care delivery processes, communication systems, facilities and equipment, leadership, organizational support, professional development systems, and response systems to external demands (Mackay & Risk). These attributes are dynamic and synergistic, Mackay and Risk claim, and their presence in any healthcare organization will help to create a quality practice environment. The attributes are linked together as complementary pieces of the model. Of these, the CNO model identifies the leadership attribute as one of the important elements in
this model in providing and maintaining quality practice environment, because leadership occurs in all levels of the organization and contributes to the success of the organization.

A recent telephone survey with 61 nurses at the executive, director, and management level confirmed the importance of the leadership role. McManis and Monsalve Associates (2003) conducted their survey to identify how hospitals were successful at recruiting and retaining nurses and in determining the work improvement initiatives they used to promote a quality practice environment for their nurses. Survey participants specifically identified six critical factors for achieving work environment excellence: leadership development and effectiveness; empowered collaborative decision making; work design and service delivery innovation; values-driven organizational culture; recognition and reward system; and lastly, professional accountability. The leadership factor, these participants noted, is the one on which all other factors depend. They recommended that hospitals invest in nursing leadership capacity from the top, from senior managers down to the unit level managers, by promoting career and training programs. Such programs would develop accessible, supportive leaders who would become trusted coaches and advisors for their staff nurses. This survey by McManis and Monsalve Associates points to nurse managers and leaders as a valuable source of insight into possible strategies for maintaining a quality practice environment.

**The Question of Leadership and the Role of Nurse Managers**

Snow (2002b) claims that health care organizations currently demand productivity, performance, innovation, and flexibility from their employees, especially nurses. In turn, those employees demand a good working environment, opportunities for professional and personal growth and development. Organizations also look for leaders who will value and appreciate their contributions, provide them with clear and honest direction, and reward them. Snow claims that if these needs are not met, nurses will suffer from absenteeism, poor morale, and resistance to change, or, they may quit their jobs, and the organization will suffer from high recruitment
costs, patient dissatisfaction, and maybe long term damages. Thus, Snow contends, it is critical at this time to create a working environment that has a positive influence on the employee as the practice environment accounts for 25% of the variance in performance measures among different organizations. McClelland (1990, as cited in Snow) claims that leadership style and behavior had a 28% to 40% effect on the performance of the employees in the organization and a 70% to 80% effect on the work climate. Thus, Snow suggests nursing leaders must create a climate in the practice environment that fosters creativity and motivates staff to produce quality care.

In addition to Snow's (2002b) work, numerous other studies have concluded that leadership style is an important factor in retaining nurses, promoting group cohesion, and creating a warm environment that is good for professional practice (Gillies, Franklin, & Child, 1990; Leveck & Jones, 1996, Snow, 2001a). Recent research confirms that the role of nurse managers continues to be a crucial one, particularly given the ongoing changes and reforms in the health care system. Laschinger et al. (1999) and Goddard and Laschinger (1997) note that nurse managers and leaders are faced with the difficult challenges of developing and maintaining professional practice environments that promote quality patient care while dealing with the fiscal and human shortages in the health care system. McGillis Hall and Donner (1997) indicate that nurse managers are key both in facilitating quality patient care and in ensuring the quality work life of staff nurses. Also according to Coulson & Cragg (1995) and Perra (2000), the role of nurse managers is pivotal to the effectiveness of the health care system and essential to the success of nursing services because of their impact and influence on nurses and health care settings.

A number of studies have considered the importance of the role of the nurse manager or leader from different perspectives. For example, Laschinger, Wong, McMabon, and Kaufmann (1999) consulted staff nurses in their examination of the importance of the leader's behavior
and role in creating a working environment that facilitates effectiveness by empowering staff nurses. These researchers found that staff nurses perceive themselves to be empowered when their leaders do the following: provide support, meaning, and purpose for their work; help them to understand the importance of their roles in the organization; encourage their participation in decision making; enhance their skills; provide resources; show confidence in their abilities to perform tasks at a professional level; and promote an autonomous working environment. The relationship between leadership behavior and an empowerment scale as perceived by staff nurses were strongly correlated in this study ($r = 0.61$). This strong correlation between leadership empowering and staff nurses' perception of empowerment is an indicator that the leaders and managers can create conditions for work effectiveness and are able to encourage their staff nurses to participate in accomplishing individual and organizational goals. That this occurs within the current turbulent work environment attests to the importance of the nurse manager's role in creating a practice environment that benefits both clients and nurses and results in better outcomes (Laschinger et al.). Laschinger and Shamian reported similar results in a 1994 study, in which staff nurses related their perception of work empowerment to their immediate manager's ability to empower them ($r = 0.77$, $p = 0.001$), noting that, in organizations where powerful managers exist, they empower their staff by association. These results suggest that the actions of such managers can contribute to a quality practice environment. Powerful managers, for example, may increase their staff's professional growth and development, increase their access to the resources and information, provide opportunities for decision making, and share opinions. Laschinger and Shamian's results suggest that these actions lead to increased feelings of empowerment among staff nurses, and thus lead to more productivity and job satisfaction. These factors are important in maintaining successful teamwork and a positive practice environment.
In another study, Upenieks (2003) suggested that certain leadership attributes among nurse leaders and managers are necessary to produce an empowered environment. These attributes include: "credibility, passion and value of the nursing profession as well as self confidence" (p.140). Other leadership attributes identified were the "ability to be visible and accessible, influential, credible, honest, articulate, knowledgeable, and supportive of advancement and educational opportunities" (p.146). Upenieks's study results suggest that a supportive work climate is related to leadership, nurse retention, and that loyal management and executive teams are those who value nursing and act as nursing advocates.

Dixon (1999) suggests that for managers and leaders to be able to find a balance between their leadership and management requirements, they needed also to find a balance in their personal lives, attend to their intellectual, physical, and spiritual needs, and engage in continuous education to enhance growth and change. Dixon also suggests that managers, in this time of instability and turbulence in the health care system, need to stay focused and clear in their values and beliefs because clarity and consistency are major elements that sustain leaders in uncertain times.

Kerfoot (2001) discusses the ability to motivate staff as a desirable leadership quality. She contends that there is an important difference between motivation and inspiration. Kerfoot claims that managers motivate, on the one hand, by directing, delegating, and controlling others to achieve organizational goals through fear of punishment or external rewards. On the other hand, leaders inspire by believing in people's abilities and enabling them to explore their potentials and talents: inspiration “unleashes creativity, enthusiasm and passion” (p.338). Inspired people, Kerfoot claims, will always have the “passion that drives them independently and intrinsically to achieve the right things” (p.338). Views such as Kerfoot (2001) expresses, in her study examining leadership attributes, are common in the business-derived management literature. One potential problem with this view in the nursing context is that it may lead to
notion that the inspirational leadership of a nurse manager may address or solve problems in the workplace such as employee dissatisfaction, stress, overwork, and demotivation, or difficulties with recruitment and retention. While it may be true that inspirational leadership could have a positive effect on the practice environment, to look to nurse managers as “inspired leaders” to ameliorate such major workplace problems as now exist in the nursing practice environment, displaces the responsibility for matters which are organizational in nature onto a middle manager whose workload is extremely heavy and whose power to effect change is limited.

Perra (2000) suggests the use in nursing of the integrated leadership practice model (ILPM), which has its origins in the business administration literature. The ILPM defines nine fundamental qualities of leadership have been associated with desirable staff and organizational outcomes: “self knowledge, respect, trust, integrity, shared vision, learning, participation, communication, and change facilitator” (p.57). By using this model, Perra contends, “nurse executives” will be able to develop high-efficiency teams whose practice is competently and professionally based: “the environment which nurse administrators create and the way they relate to their work force are pivotal to organizational viability” (p. 56). Perra also associates this result with outcomes of quality patient care and staff job satisfaction. Thus, Perra’s business-derived model of nursing administration concurs with the prevailing view in nursing research that because of the challenges inherent in the current health care system, the behavior of nurse managers and leaders is very important, as it falls to them to create and maintain a practice environment that will ensure desirable and successful employee and patient outcomes.

Evans (1994) explored another aspect of the role of nurse managers, that of creating an environment for collaborative practice in which the collaboration of nurses and other health care providers is the expected norm and outcome. Evans claims that the nurse manager’s role in creating a collaborative environment assumes two dimensions. First, the practice
environment must be free from barriers that could affect collaboration and facilitate the success of this relationship. Second, the manager facilitates professional growth, development, and maturity of the employee. In addition, the nurse manager's role is important in achieving desirable organizational outcomes, Evans suggests. For example, the manager ensures the existence of other favorable practice environment variables such as coordination, collegiality, communication, promotion of high personal self esteem, and belief in one's abilities and potentials.

The manager's need to communicate well is a recurring theme in the literature. In a recent article exploring a new technique of communication based on David Whyte’s “Crossing the Unknown See,” (cited in O'Connor, 2001, p.403), O'Connor suggests that managers can achieve these attributes by clearly communicating or conversing with their staff members so as to convey their own and the organization’s vision and goals. Based on Whyte's analysis, O'Connor suggests changing the mode of communication to a conversation, with four levels of communication or conversation: conversation about the indefinite future on the personal and professional level; conversation with the employing organization; conversation with our colleagues; and lastly, conversation with our selves.

McNeese-Smith (1997) explored staff nurses' perceptions of the ways in which managers increase their job satisfaction, productivity, and commitment to the organization. Staff nurses reported the importance of their managers in maintaining their job satisfaction. For example, they provided recognition, prizes and rewards, met the professional and personal needs of staff by being flexible in scheduling, and helped and guided them. Managers also used leadership skills to empower others, supply vision, use open communication skills, and act as role models for staff nurses. In general, the nurses felt that the actions of their managers created a positive work environment that promoted quality outcomes (Hoffman & Martin, 1994; McNeese-Smith).
As the above discussion suggests, numerous studies offer evidence of the importance of the nurse manager's role in influencing staff nurses' job satisfaction and productivity (Coulson & Cragg, 1995; Hoffman & Martin, 1994; Loke, 2001; Ma et al, 2003; McNeese-Smith, 1997). However, in the course of this literature review, I found few studies that included the perspective of nurse managers. A single study focused on the contribution of nurses at various organizational levels – and therefore included nurse managers and directors of nursing as well as staff nurses, – in maintaining the quality of the practice environment (McGirr & Bakker, 2000). McGirr and Bakker studied these nurses' perceptions of their individual contributions to the work environment and examined several work-life issues in a work environment identified as positive. In their study, the researchers used a framework that took into account the quality work environment characteristics that Attridge and Callahan (1990) identified and the workplace factors of O'Brien-Pallas and Baumann (1992). They found that quality work environment characteristics do exist in the units involved in the study, according to the perceptions of the nurses working there. One study finding was that the actions of nurse managers increased self-esteem among employees, which in turn led to greater job satisfaction and better job performance (McGirr & Bakker). However, a comparison of the views of the different levels of staff and management sampled points to important differences in perception. On the one hand, staff nurses and directors of nursing in this study felt that nurse managers contributed to a quality work or practice environment by promoting effective functioning, maintaining collaborative relationships among employees, ensuring staff participation in decision making, and allowing autonomy. On the other hand, nurse managers themselves believed that they contributed to the quality work environment by initiating change, increasing staff morale, and promoting their staff's professional growth and development. This study therefore offers some intriguing insights into the different perceptions of the various participants in a quality practice environment. This finding suggests that further research to
explore these differences will be necessary to develop a more complete picture of nurse managers' efforts to maintain a quality practice environment than findings from the extant research has so far been able to supply.

The missing voice of the nurse manager is also apparent in the job satisfaction research. Although the literature is rich in studies that address job satisfaction in nurses (Sengin, 2003), and many studies contain discussions of the ways in which nurse managers can make improvements that will increase job satisfaction for the nurses they supervise, there is a dearth of research specifically addressing job satisfaction for nurse managers themselves. For example, I found only a single study that described the factors that contribute to successful retention of nurse managers in the health care system. This qualitative study was conducted by Parsons and Stonestreet in 2003 as the first of a series that will provide the foundation for developing the nursing organization as a "health promoting organization" (p.120). The researchers in this study interviewed 28 nurse managers from five hospitals. Their responses indicated three factors that were the most important contributors to nurse manager retention, quality of patient care, and positive work environment. These factors were: the quality of the relationship between executives and nurse managers, the quality of the administrative system, and the quality of work/life balance.

There are a number of examples of studies that implicate nurse managers in discussions of factors that can affect job satisfaction and performance, without consulting nurse managers themselves. For example, Kennedy, Camden, and Timmerman (1990), and Leppa (1996), examined the interpersonal relationship and communication between the employee and the employer. These scholars found that a high staff turnover rate stems from dissatisfaction with either the relationship with supervisors and other employees or working conditions, or both (Kennedy et al.). On the other hand, higher satisfaction and better patient outcomes patient are related to good interpersonal relationships among employees and within the organization.
Kennedy and colleagues noted that staff nurses demonstrated more job satisfaction and positive morale when their managers used a "feminine" communication style (that is, a style that is open) and were willing to meet their needs, answer questions, ask for input from others, and attend to the general emotional climate of the group and work (Kennedy et al. p.43). Yet, these researchers contend that in many management situations, a strong, male style of communication behavior is required to accomplish the necessary organizational tasks. Attempts to categorize communication and management style link these nursing leadership studies with the business-based origin of management and leadership studies, and also feed into a tendency in health care for gendered hierarchies to persist in institutional cultures. Moreover, more nuanced analytical processes and interpretive possibilities than the gendering of styles are available to the researcher who wishes to understand how managers manage and leaders lead.

The Perceptions of Nurse Managers

As I noted at the outset, and as is apparent from the foregoing discussion, few nursing research studies that have examined the quality practice environment have articulated the perspectives of nurse managers themselves. Among the few that have examined this important point of view are studies by Coulson and Cragg (1995) and Loke (2001) that explore nurse managers' perceptions of the effect of their roles on employee outcomes, and reveal some results that indicate some intriguing directions for further research. These studies found that although nurse managers share some similarities, they differ in their individual leadership styles and the ways they empower their staff nurses. Coulson & Cragg speculate that this diversity of styles may be due to differences in the experience, background, workloads, and staffing responsibilities of nurse managers. Based on data collected from nurse managers themselves, Loke suggests the practice environment would benefit from training managers to incorporate their leadership behavior with management skills to induce greater productivity, lead to better
outcomes, promote advanced organizational performance and a higher level of organizational commitment, and improve job satisfaction for nurses.

Most of the extant research consists of quantitative studies that measure employee satisfaction with their practice environment; this is not surprising in light of the ongoing shortage of nurses related to difficulties with retention and recruitment. These studies typically confirm the acknowledged role and importance of nurse managers in maintaining the quality of the practice environment. This picture is clearly incomplete, and, it is interesting to note, the problem of the nursing shortage remains unsolved. This suggests that despite concerted efforts to address the problem, important aspects of the situation remain un- or under-explored. As this survey of the literature reveals, there is insufficient research that qualitatively investigates the perspective of nurse managers themselves. Those few studies that have done so suggest that there may be considerable variety as well as recognizable themes or patterns in the strategies nurse managers employ. This points to the need for further qualitative research to elucidate our understanding of nurse managers’ experience.

**Summary**

My review of the literature review reveals that the methodological underpinnings of quality practice environment research lie in the business administration literature. Several interesting issues arise from this approach. One issue is that the nursing research strategy has apparently tended to follow that of business-based methodologies, that is, to consult employees as the primary informants in the quest for information about quality practice environments. The result has been that very few researchers have consulted nurse managers to solicit their perspectives on the very matter for which they are almost unanimously held responsible. Another issue is the role of the nurse manager, and the importance of this role, both of which are clearly set out in the literature – but researchers have failed to examine the unique context in which nursing managers must now practice when they describe this role. Specifically, the
primary consideration of nurse managers must always be to ensure positive patient outcomes while balancing the needs of the nurses and other healthcare professionals they supervise, but always within the confines of institutional economics. Moreover, nurse managers are the main (or even the sole) liaison between senior administrators and bedside nurses, and must continuously balance the exigencies of the institution with the needs of front-line staff. There is abundant research that supports the notion that nurse managers can, and do, accomplish such a delicate balancing act; there are very few studies, however, that examine under what circumstances – and exactly how – they achieve their results. Thus, these gaps in the literature suggest a useful direction for my own research: to use a nursing-based methodology to explore and hear from nurse managers in an attempt to understand their efforts to create and maintain a quality practice environment in the realities of the current health care system.
CHAPTER THREE: RESEARCH METHOD AND PLAN

Research Methodology

For this study, I have used an interpretive descriptive qualitative design to develop a practice-based knowledge that explains nurse managers' attempts to maintain a quality practice environment. Thorne, Kirkham, and MacDonald-Emes (1997) developed the interpretive description method to explore issues and inquiries related to individual experiences of health and illnesses for the purpose of advancing and developing practice knowledge for nursing. This method is based on a "solid ground" of the analytic framework that infers its general principals of data analysis, sample selection, data source, and rigor from the existing knowledge of other traditional qualitative methodologies. According to Thorne and colleagues, "human health and illness experiences are comprised of complex interactions between psychosocial and biological phenomena" (p.172). Moreover, these experiences consist of "common patterns" that act as a central focus of nursing practice. Thus by exploring and reflecting on these lived experiences of health and illnesses, nurses will be able to understand these patterns and use the knowledge derived from it in the context of caring for other individual persons (Thorne et al.).

The interpretive descriptive method is "grounded in an interpretive orientation that acknowledges the constructed and contextual nature of much of the health and illness experience, yet also allows for shared realities" (Thorne, Kirkham, & MacDonald-Emes, 1997, p.172). Thus, for this study, I have applied this method not to investigate individual health and illnesses experience but rather to explore and interpret the patterns in nurse managers' experiences and attempts to create and maintain a quality practice environment. Although researchers have not typically used this method to explore psychosocial processes other than illness, it is my contention that interpretive description lends itself to this study for several reasons. First, the method has arisen as a means to conduct a "...qualitative investigation of a
clinical phenomenon of interest to the discipline for the purpose of capturing themes and patterns within subjective perceptions and generating an interpretive description capable of informing clinical understanding” (Thorne, Kirkham, & O'Flynn-Magee, 2004). Thus, although the method has evolved as a means to investigate clinical phenomena, there is nothing in interpretive descriptive design itself that precludes its application to human, but non-clinical, phenomena related to nursing. That is, the logic of the study design is consistent with an investigation of all aspects of the psychosocial phenomenon under study herein. Next, the design is consistent with the aims of the investigation – to organize the data into a framework or pattern of themes that illuminates the phenomenon and offers previously unrevealed insights. In addition, interpretive description is intended fulfill the need for qualitative investigation into phenomena of interest to nursing researchers, who perceived the need to “articulate distinct methodological approaches designed to fit the kinds of complex experiential questions that they and other applied health researchers might be inclined to ask (Thorne et al., 2004, p. 2). Interpretive description is by nature a method that is evolving at the methodological boundaries of the discipline of nursing while enabling research that is coherent and rigorous as well as relevant. Finally, theoretical considerations aside, I have found that, in practice, interpretive description has been applicable and appropriate throughout the research process. Through listening to nurse managers’ and leaders’ stories and exploring the realities of their work life in the health care system and acute care settings, it has indeed been possible to create a sound interpretive description of the nurse managers’ experiences in creating and maintaining a quality practice environment.

**Sampling, Sample Characteristics, and Setting**

Thorne and colleagues (1997) recommend the use of theoretical sampling for the interpretive description method. Thus, for this study a theoretical, purposive sampling technique was used. In theoretical sampling, the researcher starts collecting the data from the
initial participants and once some theoretical ideas and interesting themes start to emerge, the researcher determines which data to collect next. Ideally, the researcher would then also decide which additional participants to search for that would contribute more to explaining the data, help in the conceptual development, and who can best provide sufficiently rich information (Dey, 1999). In this case, I found that it was not possible to recruit such additional participants, given that it was extremely difficult to recruit any volunteers for this study. The reasons for this are speculative; however, in the context of current nursing practice, quality practice environments are, it would seem, a rarity. The economic realities of the health care system are also perhaps implicated: nurse managers handle increasingly heavy supervisory roles, so fewer managers are managing more staff. In addition, the heavy workload of nurse managers may also have made it difficult for some nurse managers to consider taking on an extra burden such as volunteering to be a research participant.

A further recommendation for this type of study is to select for conceptual variation from the themes that emerge from the initial analysis. This means to select cases or participants with wide range of variation and with diverse and different views and perceptions (Dey, 1999; Polit & Hungler, 1999; Thorne et al., 1997). Variation will provide more understanding of the phenomena under study and will help in the interpretation of the social process under investigation (Thorne et al.). The original research design included the use of snowballing technique for this study. However, the lower than predicted response to solicitations for participants meant that I was unsuccessful in securing referrals from the initial participants to others who could be of benefit to the study and who might hold different points of view that could enhance the knowledge development in this study. Nevertheless, the study participants did provide a considerable diversity of values, views, and perceptions.

The research participants for this study are nurse managers who are working in an acute care setting. Although the study consists of four participants only, these four were able to
inform the research, provide adequate information to enrich the research, and help in
developing a full description of the phenomenon under study (Morse & Field, 1995). For this
study, I deemed it more important to capture the diversity and depth of information provided
by the research participants than to sample a pre-determined number of participants. Therefore,
I chose purposive sampling to gather data. As data analysis proceeded, I conducted two second
interviews that lasted for more than half an hour each, to ensure the accuracy and clarity of the
information and to enrich the research. The number of interviews depended on achieving data
saturation, when no new themes emerged in the interviews and in the responses from
participants during those second interviews.

Selection Criteria for the Participants

Selection criteria required that each participant: a) be a registered nurse manager or
leader with a full accountability for one or more units in an acute care setting; b) be currently
employed as a full time manager in one of the acute care hospitals in the Greater Vancouver
area; c) have a minimum one year of experience as a manager or leader; d) be willing to
participate and complete the research study; and e) be able to articulate and communicate ideas
clearly. The reason for choosing participants with at least one year experience as a manager is
that these individuals are able to provide more information and data about their experience to
maintain a quality practice environment than newly appointed managers with limited
experience. Such managers have also have been through at least some of the changes that have
occurred in the health care system.

Recruitment Process

I recruited participants for this study from one acute care hospital in the Greater
Vancouver area of British Columbia, and sought approval to conduct the study in this setting
from the hospital's ethics committee. An information letter explaining the study and its purpose
(see Appendix B) was sent to hospital administration staff and nursing directors to request help in recruiting participants for the study. Once I obtained permission to conduct the study, I sent sealed envelopes that contained participants’ information letters to the directors, who were asked to hand these to all nurse managers and leaders under their employment (see Appendix C). The participant information letters had information explaining the study purpose, significance, ethical considerations, and participants’ rights, to ensure full awareness.

Description of Participants

Four female nurse leaders participated in this study. They all held a patient service manager position. All were registered nurses; three had a master’s degree and one had only a bachelor’s degree in nursing. All these managers had other qualifications in addition to their degrees and had completed other post-basic specialization in different specialties. The age range was between 42 and 53 years. Their clinical experience also varied from 18 to 34 years in nursing practice with a mean of 25 years. The mean number of years in a patient service manager position was seven years, with a maximum of 15 years management experience and a minimum of one year. All participants managed more than one unit and more than two health care programs. In addition to managing nursing staff, they also managed other services such as physiotherapy and occupational therapy.

Data Collection

For this study, I was the primary research instrument for data collection and participants’ responses constituted the data collected (Polit & Hungler, 1999). The data was collected through in-depth face-to-face interviews and follow-up telephone interviews with the participants. Morse and Field (1995) indicate that the interview is the basic and major mode for data collection. To ensure richness of the data obtained, interviews are to be focused, deep,
and should explore the subject in detail. This interview procedure helped me to gain a thorough understanding of the phenomenon under study.

To start the interview, I asked broad, open-ended question related to the topic of interest, such as, “Could you tell me what you know about a quality practice environment?” Subsequent questions were based on and guided by participant responses. I used open-ended trigger questions and probes that helped to capture the important points and to stimulate the discussion (see Appendix A). Interviews were conducted at a time and place acceptable and convenient to the participant. The interview process was conducted over one session of one to one and a half hours each. Tape recording was used to collect data. Following each interview, I recorded field notes expressing my observations and reflections regarding the interview, as well as a brief description of the setting and any additional observations that could benefit the research. Field notes and memos are helpful in the process of data collection, and also assist analysis. These notes record any emerging ideas and questions that can shed more light on the phenomenon under study. I collected the initial data based on emerging themes, and sought further data on the subject of interest in the second interviews until data saturation was achieved or redundancy of information had occurred.

Data analysis

As in any qualitative study, data analysis began once I obtained the first piece of data. Analysis continued during data collection, and was subject to ongoing analysis. Analysis is the most critical and exhaustive step in the research process. In approaching data analysis, the researcher needs to be creative, conceptually sensitive, and insightful (Morse & Field, 1995). Particularly for the interpretive description approach, Thorne and colleagues (1997) recommend that the data analysis technique supports inductive rather than deductive thinking. I have followed this recommendation and used inductive data analysis, which, according to Lincoln and Guba (1985) is “a process for making sense of field data” (p.202); that is, a way of
uncovering the embedded information and essences from the data and making it explicit and clear. Data are constructions that stem from an interaction between the researcher and the source. In analyzing these data, I have reconstructed them into meaningful themes and sub-themes. As Thorne et al (2004) explain:

Interpretive description cannot yield “facts” but rather “constructed truths.” The degree to which those constructions are viable and defensible for their intended purpose (that of offering the practice disciplines an extended or alternative understanding) will depend on the researcher’s capacity to present them in a manner that transforms raw data into a structure that makes aspects of the phenomenon meaningful in some new and useful way” (p.4).

Thus, the data analysis process in this study has been informed by the analytic technique of Lincoln and Guba and the recommendations made by Thorne and colleagues. Specifically, the analysis involved the process of unitizing and categorizing the raw data in order to present reconstructed data that represent the reality and meanings.

Following each interview, a transcriptionist listened to and transcribed audiotapes. I then reviewed the transcription with the tape recording to ensure accuracy. Next, I read and re-read the transcripts in an effort to discover and identify themes and concepts of interest, in a process known as “unitizing”. This is a process of coding that transform data into units that can stand by themselves, are interpretable in the absence of any additional information, and serve as a basis for the categories (Lincoln& Guba, 1985). Coding requires that important incidents, events, and information relevant to the phenomenon under study are given conceptual labels. In this way, conceptually similar events are grouped together to form categories or subcategories (Corbin & Strauss, 1990). Categories include data that have been previously unitized, and I developed these through comparing one incident or event with another and then comparing new events to the emergent categories. Through linking and constant comparison of categories and events, I discovered similarities and differences, which start to form a foundation from to develop a practice-based knowledge that is derived from the realities of nurse managers’ work lives (Dey, 1999; Lincoln & Guba).
Rigor

To assess the quality of data and findings in this study, I have used recommended methods that help to establish the trustworthiness of the qualitative data on hand. One such method is triangulation. This refers to inclusion of multiple data sources and referents to draw conclusions about the data that could make sense and represent the truth (Polit & Hungler, 1999). Specifically, to help me analyze and interpret the data, I have used a method of investigator triangulation. As Polit and Hungler note, this method involves “the use of two or more trained researchers to analyze and interpret a set of data” (p.428). Throughout the analysis process, I have consulted the principal investigator in this research study (a member of the faculty of School of Nursing at the University of British Columbia) to read the findings and offer opinions. This consultative process reduced the possibility of bias during interpretation and provided another expert and divergent perspective in the analysis of the data.

In addition, I have used the member validation (or member checking) technique with the research participants throughout the study and after the data was collected and fully analyzed. This technique confirmed the credibility of the data and established validity of the researchers’ interpretations of the data collected from participants (Sandelowski, 1993). I validated the findings with the participants by contacting them for the second interview to help revise and further evaluate the findings, and to check the accuracy and adequacy of my analysis and synthesis of the data.

However, the credibility of a qualitative study such as this one occurs “when complexities are made visible through the analytic process and are articulated with an openness or “criterion of uncertainty” (Emden & Sandelowski, 1999, cited in Thorne et al., 2004). Thus, as the researcher, I have endeavored to maintain an awareness of the subjectivity and constructedness of “knowledge”, and have been alert to the necessity of ensuring transparency throughout this project.
Ethical Considerations

Before starting the interviews, I obtained University ethical approval for this study from the University of British Columbia Behavioural Research Ethics Board, and also obtained an approval from the acute care setting ethics committee before conducting the interviews. Participants received an information letter that explains the study so they would have adequate information regarding the research purpose and significance and freedom of choice either to accept or decline participation in the study. Study participants signed a consent form (see appendix D) that explained the confidentiality and voluntary nature of the study. I ensured that participants had the opportunity to review the consent form and ask any questions regarding the study or request clarification, before signing the consent and undergoing the interview process. Participants in this study had the freedom to refuse to participate or withdraw from this study at any time without any obligation to me, or any jeopardy to their employment. They also had the freedom to refuse to answer any question with which they were not comfortable.

Through anonymity and confidentiality procedures, I maintained and assured the privacy of participants. Each was assigned an identification number (ID) that ensured anonymity. I did not record the names of participants in typed transcripts or field notes; only ID numbers were used. I have given assurance to participants that upon reporting or publishing results from this study, I will not report information in a manner that might identify them, nor will I share the information with any person who might identify them. Audiotapes, field notes, and transcripts will remain in a locked file cabinet to which only I have access. All research materials including data, audiotapes, transcripts, and field notes will be stored for five years according to UBC policy of storing research materials. At the end of the storage period, audiotapes will be demagnetized and paper copies of the data and field notes will be shredded.
Limitations of the Study

Morse (1995) suggests that the most articulate members of a given group may be those who are most prepared to step forward as participants in a study such as this one. One of the limitations of the study may be, then, that those nurses who were prepared to participate in the study were motivated to share their views and articulate; this may be associated with particular styles of leadership. If so, this may limit the applicability of this study to the experiences of less articulate persons with perhaps different leadership styles and qualities. It might not be possible to generalize the findings in this study to those who did not participate, but only reflect the perspectives of the nurse managers who are able to articulate and discuss their insights and perceptions.

Another limitation of the study is that the sample size was very small. Only four participants volunteered from the acute care facility chosen for this study. Also, all four of the participants are female. It is not possible, then, to generalize the findings of this study as representing all nurse managers.

A further limitation of the study is associated with member checking. Sandelowski (1993) has noted reservations about this process because both the researcher and the participants are stakeholders with respect to certain events, persons, or claims contained in the data. Although in certain instances member checking might therefore be a threat to validity rather than a safeguard of it, it is still the preferred technique and the best method available to the researcher. In the member checking process, I have remained aware of Sandelowski’s warning and have attempted to be appropriately cautious in choosing the synthesis of data to present to the participants. To minimize potential conflict, I have made every effort to present the material from as neutral viewpoint as possible, to appeal to different audiences or participants, as Sandelowski recommends.
Summary

It is somewhat unusual to combine an interpretive-descriptive, qualitative study with an issue not related to health or illness; however, it my contention that it is particularly well suited to research projects of this type; moreover, in a recent paper discussing the interpretive descriptive method, Thorne, Reimer Kirkham, and O'Flynn-Magee (2004) suggest that this methodology “offers the qualitative health researcher an opportunity to work outside of the disciplinary confines of the more traditional methodological approaches” and “As long as clinical researchers feel the need to document and understand human phenomena, we are sure to seek new methodological alternatives (p. 18). I have taken particular care to ensure that this methodology is appropriate to this exploration of the area of interest, and have ensured rigor in my data sampling, collection, and analysis. I have used inductive rather than deductive data analysis technique to interpret the phenomenon and uncover the embedded essence to make it explicit and clear. The patterns that have emerged in the course of my analysis reveal much about nurse managers’ and leaders’ experiences as they attempt to create and maintain a quality practice environment. I believe that this method is an appropriate one that has served to answer the research question and has enabled me to explore and understand the participating nurses managers’ and leaders’ experiences in the realities of their work life.
CHAPTER FOUR: FINDINGS

The nurse managers involved in this study have described a variety of skills, strategies, characteristics, and values that they have brought to bear on the challenge of creating or maintaining a quality practice environment. These are organized here according to three broad themes: establishing a trust relationship; leadership philosophy and style; and organizational and staff support. These themes are further broken down into sub themes, within which categories are the participants’ descriptions of their experiences and understandings of nursing management.

Theme One: Establishing a Trust Relationship

Trust is defined as the belief, reliance on, or confidence in the integrity, reliability, ability, and strength of a person or a thing (College Dictionary, 1980). All four participants affirmed their belief that trust is the foundation of any relationship between employees and their employer, trust, or a lack of it, has a great impact on the work environment. Throughout the interviews I conducted with the four nurse managers, trust appeared to be the most important feature for each participant. Each of the participants described the importance of establishing a trust relationship. As the participants explained, this means gaining the trust of employees and showing them that they can rely on the manager’s strength and integrity.

Part of the trust relationship with employees, because of the current change and uncertainties that nurses face within the healthcare system, involved using techniques and methods to support the application of change and also to support and protect their staff members during these adjustments. Thus, managers and their staff members establish and reinforce mutual trust through a sequence of actions and interactions. Under the umbrella of the trust theme fall a number of interrelated and interwoven sub-themes that together constitute the processes through which nurse managers establish trust relationships with their employees. Sub-themes that help to explain the theme of manager-staff trust are: open and
honest communication; role identification and self knowledge; strategies for dealing with personal issues; and, fairness in dealing with employees. Throughout the following discussion, these sub-themes are related in an interactive cycle. For example, managers explained that their self-knowledge helped them to present information in an open and honest way; combined with proper communication techniques, nurse leaders and managers were able to share valuable information with their employees that could have a direct impact on them and on their practice environment. Due to their awareness of their own and others’ roles, the managers and leaders in this research project were able to clarify and support individual capacities and competencies, and were also able to set goals and expectations for their staff members and make decisions based on these expectations. Each of these actions and interactions promotes trust, and conversely, the trust relationship allows the actions and interactions to occur in a healthy and positive practice environment.

Openness and Honesty

Nurse leader participants emphasized the value of openness and honesty, which they all felt helped to reduce their staff members’ stress, especially during change periods. For example, they updated their employees regularly, notifying them of changes that might be applied in the future. They also encouraged staff members to express their concerns about workload, changes in staff rotations, the introduction of licensed practical nurse (LPN) programs, and the change in the RN and LPN ratio. Such factors could affect staff members’ ability to produce quality care and might affect patient outcomes, so careful management of these situations was needed, according to participants. For example, one leader said:

Well, everybody knew it was coming so it had to happen with rotation, is that you have to go on a rotation. I was very honest from the very beginning about the number of nurses we would have on each shift. So people can do the math very quickly and see that we have three RNs instead of four and I’m the fourth RN and I have the least amount of seniority. So it was really no surprise to anybody and this is the process we take. The other thing I did before I started I met with every nurse in the unit and told them why we were doing this and then really the biggest issue, of course, is financial. But all secured, because nurse and LPNs are in the full scope. There is work here that
definitely the LPNs can do. You see…you have to look at it sometimes that maybe it needs a nurse to do it.

This leader’s testimony suggests that when starting a new job or taking over a new service, managers will find it helpful to be open and honest from the beginning to establish that important trust relationship.

Another strategy managers used was to share their vision, goals, and expectations as an initiative to start the trust relationship. Participants were aware that their staff might not trust them from the beginning; their concerns with this issue meant that from the outset they worked on establishing and building that trust relationship with their staff. Participants pointed out that managers need to recognize that employees tend to perceive or even erect barriers between themselves and their manager. The manager’s job is simultaneously to reduce the anxiety that tends to precipitate such barriers, and to recognize legitimate boundaries. This is a delicate balancing act. For example, staff members may feel insecure with a new manager, fearing perhaps that she will support organizational initiatives rather than support her nurses. Thus, when an initiative comes down from above, the nurse manager must demonstrate her concern for her staff throughout the change process. Alternatively, nurses may worry that an incoming manager will not be capable of providing the quality of practice environment they need and want to work in. In response to such concerns, nurse managers worked hard to show their staff members that they could be trusted to work on their behalf. As part of this process, managers shared their vision and expectations with nurses, and informed and updated them about changes their practice environment. They also endeavored to let their staff get to know their personalities, including their sensitivities as well as their strengths. These actions were helpful in establishing trust. One manager described this process of developing trust through some initial, difficult stages:

I just said, “You know what? We’re all we have is each other so we need to work together and what matters is the patients; if you’re not happy with my performance or I’m not happy with yours we just need to talk about it and be honest about it and I told them how bad it made me feel…the behaviors that went on behind my back or in that
sense that it just doesn’t improve practice. I said, ‘I know it doesn’t make you feel any better. And it certainly doesn’t make me feel any better and you know if you go over my head they’re just going to come to me and talk to me anyway...first. And if you do have performance issues with me, talk to me first. If I don’t fix them or resolve things with you, then go over my head that’s okay. But that’s the process.’ And I said, ‘No one else is going to accept you doing anything different anyway.’ So... I feel it took a number of months and then one ... (time) we had... a party, they actually gave me a present and told me they’ve never done that for a manager before.

Part of this manager’s strategy was to clearly define appropriate and inappropriate processes for registering complaints, and to be both persistent and consistent in reinforcing the need to use the accepted process. In other words, this manager taught her staff a new and effective communication style.

Another participant explained her approach to open communication as follows:

I had a meeting and then I explained to them that...if I had a meeting actually I told what was going to happen, it was not official but wanted you guys to know what is happening and what is being discussed and mostly likely change will happen in January...so I called them and told that...what is beyond our control and what is under our control. So this restructuring, losing... beds is totally beyond our control because that has to do with the cost saving. I mean money talks, right? So I told them many times before, so they knew...nothing was a surprise.

This manager prepared her staff for the change by supplying them with all the information she had at her disposal. Part of this interaction with her staff is trust-building based on her reliability in providing them with information.

The “open door policy” for employees was a recurring concept during the interviews; most managers found it difficult to accomplish given workloads and geographic issues, but necessary nonetheless. Managers explained that they needed to reassure nurses that they were there to listen to their concerns and issues. Being available for employees increased trust in their managers. As they described it, the employee feels supported by the manager who is available when needed, and has good listening skills. One manager offered the following:

...for some I might be a coach and some I might be just an ‘ear’ to hear their problems but you have to know people in order to do that as far as I’m concerned, so I do try to have an “open door” policy whenever I can, which is not always easy.
In other cases, the employee needs to listen to the manager. Participants handled such situations in a straightforward, honest way, as one manager described:

But, really I think that nurses should be able to talk about that and then select the best option rather than try to hide and this is the reason I think collaborative leadership or having that close relationship with the staff works. So they could discuss their problems with me... [When there's an issue] I usually tell them, “Well, I have life experience. This works better than that.”

This same manager gave an example of a situation in which she felt the employee might have a problem by observing that the staff member had suddenly made dramatic changes to her appearance:

... and I called her in and said, ‘your appearance seems to be really, really different from before. What is happening?’ So, hopefully if that’s the case people share their problem and I usually say, ‘It’s not only your problem, it is my problem as well, too. We have to put our heads together to find the right solution.’

The manager also offered her insight into the role of mutual testing as part of the process of developing trust:

...we went through a lot of changes so each time when change is happening so of course people go through a difficult time but I always feel that every cloud has a silver lining so what...that means difficulties present opportunities as well, too. So we went through a lot of changes together therefore we also had many opportunities to test each other to see whether we could trust each other. Trust is actually a big thing in management.

Other managers also described testing behaviors as a common occurrence, particularly when the manager-employee relationship was new. One manager commented “There’s always the distance between us... the moment you have a management position it’s a bit ‘us and them,’ and so you do the best you can, but people will not totally trust you”. Partly because of the decisions managers must make that often have negative effects on employees, this distance may be inevitable. If the manager does not maintain the trust relationship, however, the nurses might worry whether she would support them when they need her.

Role Identification and Self Knowledge

In the previous example, the manager demonstrated her self knowledge and used it to good advantage. In this case she explained that since she knows she shows her feelings easily,
she does not try to hide them, but relies on effective communication to ensure that her employees understand her and see the correlation between what she appears to be thinking or feeling and the feelings she expresses. The result is increased trust, and as she noted, the outcomes are better than those based in less honest interactions.

Participants alluded to their need for and reliance on self knowledge in a number of instances. For example, the nurse managers worked on identifying their roles and capabilities to their workers, but also made certain that, to the best of their abilities, they represented themselves honestly to their staff. By being honest about what they could do (and not do) for them during necessary changes, the nurses saw that they were reliable. When they had to make difficult decisions for their practice environment, the nurses recognized that their managers honestly represented themselves. As part of the trust relationship, then, managers must relay exactly what their roles are so that their employees know exactly where they stand in relation to one another. In addition, though, the participants commented frequently that they tried not only to listen to their employees but also to know them personally. They used negotiation techniques and collaboration with their employees when changes were occurring. Often, however, both quantity and quality of personal interaction is not always possible. When the nature and volume of the work prevents a manager from being present as frequently as she would like, it may be possible to try creative solutions, or to protect certain essential interactions and preserve at least their quality. As one leader said:

I don’t even have time to go out onto the floor so what I’ve done is that I’ve started to put calls on the practice council and I have nursing representatives from LPNs and RNs, in all of the programs, and we meet once a month for two hours and in that we bring forward what the practice issues are so recently we had a lot of issues around how our code blues were handled...we had a [situation] that really went very badly and we lost the patient. Now we might have lost [the patient] anyway but [if our handling of the situation] had gone better, maybe that wouldn’t have happened. So we had to look at the whole policy. So that practice council should do that. Then ... educators [make] recommendations about that, that actual nurses at the bedside were saying no, it doesn’t work and these are the reasons why. So I made a decision to support the practice council and say, ‘Well, when things happen do this, we maintain to do it all the time,’ so I think that in those ways, that’s how I support practice from my position.
In the situation this manager describes, it was necessary for her to have a well-developed sense of the roles and capabilities of each member of the entire team, and to balance and integrate these to ensure the decision she made would be consistent with positive patient outcomes and a quality practice environment.

Sometimes managers are “parachuted” into a new situation and staff resent the arrival of an unwanted supervisor. One manager described the way she and her employees worked through this scenario by making certain they knew both the manager’s role and their own, and ensuring they established and respected boundaries. The result was, eventually, a foundation of mutual respect and trust:

You have to know...and that was part of my problem when I took over places like [name of the center] ...these are free standing clinics that have become very adept at managing their own affairs because they’ve not had the “hands-on” approach in the past so I was kind of torn between them thinking I was ‘just another manager who didn’t do their job; didn’t do anything’ or someone who came in and suddenly thought that they needed to micro-manage everything. So I was just very honest with them and I just sat down and had a meeting with each group and just said, ‘What is it that you see as my role and what is it that you see as your role?’ And I was honest...I said, ‘I don’t want to step on your toes, I don’t want to start doing things that you’ve done perfectly well by yourself...thank you very much...all along, however if there are things that you do that you feel are not your job or that are my job, I want you to be honest about that and let me know because I’m quite happy to take it on. That’s what I do...all those things that I do I think are really important.

As this manager notes, it helps everyone to have clearly delineated roles and boundaries.

Participants also made certain that their employees understood that these roles and boundaries need not be synonymous with traditional hierarchies:

...although I have title “Manager” and the people think that I have most important position, and that’s not true ...so, in my opinion, front line staff really make the difference because they’re the ones dealing with the public... and if front line staff provide quality care, patients will receive quality care. My role as a manager is to provide a quality practice environment. So, therefore, I feel this topic is very relevant. So what I think is that quality practice environment doesn’t come from managers’ wish but has to have plans and goals and then, in order to meet that goal, they need to implement your strategy and then evaluate, and then just like a nursing process, you go through the cycle ...so I think the first thing, as a manager, and there are many ways you improve quality practice environment, but the first thing you have to do is make sure that these employees that you hire – their education or preparation and their philosophy,
let's say, nursing philosophy, match with your philosophy or the philosophy of the unit or mission of the hospital. That's how I feel.

The approach describes here is respectful and democratic, although at the same time she recognizes the different roles each member of the unit plays.

One of the ways nurse managers maintain their equanimity is to avoid taking personally the criticism they receive from their staff. All participants were clear about their own boundaries. They tended to take the staff’s criticism and passive aggression in their stride, and to recognize it as an artifact of the traditional hierarchy of managers and staff, which promoted alienation of managers from their employees. In addition, managers showed maturity and wisdom in being able to understand that nurses are stressed due to the changes in the health care system and that had affected their lives and attitude. As this manager said:

At the beginning... They were tough. They would do things like going over my head and talking to my superior, if they didn’t get what they wanted. Sometimes they wouldn’t even ask me first...I was tested in very many ways. They were rude... and disrespectful in some cases and just that testing...testing behavior. And always with that, ‘Oh, well everybody says that’s going to get fixed and it never does. And we had eight managers and you are just one more.’ And ...Yes. I’ve heard it all! (Laughter) But I chose not to get angry about that stuff because I really didn’t feel that it was me, personally. I felt that it was the situation.

When the staff chose to issue challenges, the leader realized that the way she reacted would set the tone for future interactions with staff. One leader said, “many people would say, ‘Isn’t it too difficult to discipline your staff, if you have that relationship! But for me if people know that I’m here for them but they also have to meet certain expectations”.

Overall, the managers delineated their boundaries clearly, and knew how to maintain these across all kinds of interactions, from disciplinary matters to social events.

Finally, managers knew their own limits and modeled healthy behaviour for staff. One of the managers said:

I do take care of myself. I’m very physically fit and I do a lot of walking, I work out, I try to keep my hours down...I try not to do more than 8 or 9 hours a day although sometimes if it’s going to be longer, as long as it’s my choice and I am not being forced, then I am usually walking the way out. You have got to do what you have got to do to stay healthy. But as long as I feel I can make a difference then I’ll be here. If the day
comes where I'm dreading coming to work then I'm just going to have to leave. If I don't feel that...because you are not much help to anybody if you're burned out.

With the pressures and challenges they face in the health care system, leaders and managers noted that they had to remain aware of what they needed to do for themselves to maintain a balance between their own life and work.

**Personal Issues**

Nurse managers noted that personal deficiencies tend to have a detrimental effect on the practice environment because unprofessional or unethical behaviour in dealing with other staff members or with patients undermines or even destroys trust. One manager described a scenario that is probably not isolated or even rare, given the Canadian multicultural mix:

...I had two employees who did not work well together...did not! And they ended up in some horrendous, very unprofessional fights and so they all got disciplined. They all got disciplinary letters but you know it took me months to find out what was going on. But the fact of the matter was, was one was [from one country] and one was [from another country]. And ... one treated the ... [other] like a servant because in her country that's what they were. And [she] took exception! As she rightly should have. And that's what it all boiled down to. Amazing! But, boy it took a lot to get to that point. I sent them both to Human Rights and...because it just blew up into such a big thing.

When prejudices such as this, or personal issues, come to work with employees, it affects the way they deal with each other or with patients. Another manager commented:

...with one nurse there were a number of patient complaints so...the way that the patients were treated, from a particular nurse, so you know, she had some very good qualities too, she’s excellent... yeah so in that case where there was harm to the patient I brought her in and I really talked about these complaint cause she had excellent clinical skills but her manner with the patients was very abrupt and I just talked about that and how that needed to change and it didn’t really stop, so I brought her in again and talked about it again and it really was...I think in her case it was maybe a little bit cultural, maybe a little bit her personality and she actually said that to me, ‘In my culture this is the way we act’ and I said, ‘Well, I can appreciate that but it’s being not perceived that way. It’s being perceived ... that you are rude’.

The other factor in the personal issues theme was patient cultural biases and preference of nurses. Nurse managers noted that although their main goal is good patient outcomes and wellness, this is not to be achieved at the expense of the nurses. When a patient refuses to have a specific nurse from a specific ethnic group, managers tried to work
with the patient, explaining that such requests are not acceptable. Acceding to such requests could foster cultural bias and could lead to more problems, as this manager noted:

We have a situation where a patient did not want a particular nurse. She was of a different ethnic origin and that brought up the whole situation. It happened on a weekend and what happened was the nurses had changed the nurse. I didn’t particular agree with that because I could see down the road that if we did that for every person, to me that would foster cultural bias and not support being fair and how do you learn about each other if you never have any contact with one another. So what I did is I went to the Professional Practice Leader and we struck a committee and we developed a protocol for it if this happens. So that was part of it. We have a huge number of different ethnic groups in this city and years and years ago, when I first came here, it was more because it was a port city but now with the huge immigration influx we see more and more [different culture] people...you know, of all those different groups. I did take a class at university on cross-cultural nursing. I developed a binder for the unit with all the information in it as well as using the textbook so that we could look at different groups of people and see what their issues are and they do come up all the time, surprisingly...or not surprisingly.

In addition to cultural factors, the managers identified the presence of some psychological problems and problems of addiction; these have a direct effect on the quality of practice environment. For example:

You know nursing represents a small section of society so like any other profession we have large members, we have people whose health is not good or who don’t have that integrity....so as a nurse leader, if you’re going to be a nurse leader, you will see not only the small segment of your society but a small segment of all kinds of cultures. You will see nurses from (different) countries, you’ll see from all that and they have same kind of problems as anyone in society. I have equal portions of nurses with mental illness, equal number of or rate of nurses with alcohol and drug problem, a similar range of nurses, compared to society, going through divorce and separation...that’s actually...it’s like a ripple effect...like if you drop a spoon in the water, you get ripples, even if it happens at home...It comes here. It does. And then people will become moody and all that. We are not machines; we cannot just shut out everything. It seeps out. When people are so stressed out, it seeps out.
Dealing with personal issues that create problems in the workplace is of course the responsibility of managers; the issue here is that the stress of the current health care work environment exacerbates both the issues (such as substance abuse) for the affected individuals and the stressful effects of their problems on co-workers. This, as this participant describes, creates an additional issue for nurse managers.

The ability of the nurse managers to identify the presence of underlying problems that had an impact on the practice environment came from their experience and knowledge about their own biases and their ability to work on it so it would not affect their relationships with their employees and patients. As this manager said:

Well, I always think it's a matter of knowledge. You know a lot of bias sort of, it seems to me, comes from lack of knowledge; of fear and not understanding each other, so I'm pretty honest and up-front about that stuff. I have a unit meeting and we talk about those things. If you're different and you come from different cultures, there's still a basis of respect of each other as a human being and we don't treat each other that way here...and part of it, too, is educating people and the way things are in Canada...hopefully we're setting a good example. I know there's prejudice and I know there's bias and even in the health care system there are nurses who are biases against obese people; there's nurses who hate drug addicts or alcoholics because of their own past history and you really need to be sensitive to that fact...and like I told you before, know your own biases and be able to deal with them because you don't want them out there...on the front line.

The managers' zero-tolerance approach to cultural or racial bias and their comprehensive and consistent actions in the face of actions that seemed based in prejudice, helped staff and patients alike to understand the guidelines for acceptable behavior. Insight and intuition also played a part for these managers in perceiving underlying problems and dealing with them appropriately.

Fairness

There are few aspects of human interactions that affect trust more than the perception of unfairness. One of the techniques nurse managers therefore used to promote and maintain trust, improve the practice environment, and maintain patient safety was the use of documented evidence as a basis for decision-making. Participants indicated that they
established from the outset of their tenure that gossip would always be unacceptable, although they would have their doors open to listen to staff concerns. In keeping with the no-gossip policy, managers insisted on staff having documentation to back up the concerns raised. Without documentation, the managers would not act on a complaint. This point is an essential one to ensure trust. As one manager said:

There’s a complete process and what normally happens with a problem employee is that people have a hard time documenting so you finally get them to document; you address the issue with the employee, you make expectations up, there’s the whole thing that you go through and then you wait to see if they improve. Well, everyone out there gets tired of documenting so you don’t hear anything so you think everything’s better cause you’re not out there 24/7. And then it all dies down and then all of a sudden it flares up again and everyone will say, ‘Well, that person has never done any better, they’re just awful and they have done this, this, and this, and you say, ‘Well, why didn’t you document?’ ‘Well, you know, I documented before and it never did any good.’ And I said, ‘Well, you know, it’s a process’. They will come and talk to me; it’s harder to get them to document. They always want to talk! And then they want me to fix it, but that’s not the way I do things so it’s not...I mean I would get slaughtered by the union anyway. You can not just go on gossip.

Educating staff to follow procedures can be a long process, as this manager explains. In the end, employees will learn that this manager can be trusted because she will not act on hearsay or gossip, but only on evidence. Sometimes managers have to collect such evidence themselves, however:

In this case of this particular nurse I now have her off work. I have said that she can’t come back to work until [she has taken the necessary steps so she can be cleared] to return to work.... Because otherwise it’s so disruptive for the rest of the unit and so stressful for everybody else working with her and there were situations with certain patients that you can’t allow to continue so you have to step in and I think when you do, actually the nurses really do see you, when it comes to this matter, we’re actually supporting them because nobody wants to come to work...and they weren’t. They were calling in sick when she worked because nobody wanted to work with her...And so...and also too...you can’t keep supporting the environment, you have to look at why they are calling in sick. You have to look at what’s going on”.

Having collected this documentation of the disruptive behaviour of one staff member, the manager was able to act to improve the situation by making it clear to the employee that she was expected to work towards taking responsibility for her problem, and taking the needed steps towards recovery and a return to work. Thus the staff learned that the manager was likely
to show compassion and understanding rather than react in anger when problem behaviour arises.

One of the typical problems that occurs in the nursing workplace today, as noted above, is excessive sick leave. This is an issue that requires the manager to keep careful records. An alert manager in such a case perceives that often there is an underlying problem as well as the obvious one:

If I ... have one nurse who’s coming to work sick and five of them have to look after 36 patients, I might as well have five nurses rather than six nurses. So, although I had a very good relationship with [the nurse] I called her in [...] on the calendar I marked how many days she was sick and then told her that...I mean I really do like her but according the statistics, she is not able to hold down a full-time job. It’s because she’s sick this many times and she’s coming to work this many times and it cause undue hardship to her co-workers because when she’s unwell, her co-workers feel like they have to look after this nurse’s patients as well too. So she and I negotiated and of course the union was involved. [...] she actually ended up quitting this job and she actually went into [another profession]. She was very qualified person but her health was not good enough to do shift work. So, that I feel that kind of example is the initiative a manager needs to do in order to provide a quality working environment”.

Sometimes when a manager identifies a problem that an employee has been ignoring or denying, the resulting discussion may lead to a workable solution. In the case above, it might have been possible for the nurse to continue in part-time work and for her health to improve. Although this looked like a solution in this case at first, in the end, the manager’s decision to change the employee to part-time led to her realization that bedside nursing was clearly unsuitable for her. In any case, the manager’s decision was taken in response to evidence, with careful thought, and in a fair and neutral way, without malice.

There are other circumstances in which managers must produce evidence, or at the very least, adequate explanations. For example, in the current, financially-driven era in health care, participants sometimes had to find a way to ensure a quality practice environment for their staff while applying changes that were in the interest of the organization. One manager gave an example of this situation:

The other thing that had to change because of the financial reasons is with the old rotations...the way they were made up. There would be...like you know you have to
have a certain number of staffing; like you have to have four RNs and three LPNs. Sometimes the way rotations were made up you would go for a whole week where you did not have that kind of combination and so they were relying on casual staff a lot to kind of fill that. Well, with the rotations we made up I just thought that with the financial constraints it did not make any sense because you are always going to be deficient in the casual staff and you can't bring casual staff in and then you get into overtime so we make sure that the rotations meet the needs...that there were no gaps and by doing that we are able to work on the budget”.

In such a case, perhaps the only solution is the one this manager describes: to be honest with staff and present the situation as it is, and to explain the extent to which one's hands are tied given budgetary considerations. There may not be evidence available to support the institutional decision, but in the absence of such evidence, employees will at least appreciate the effort the manager makes to bring them information, and trust the manager to do her best for them.

Fairness in the work place, as one manager pointed out, does not mean absolute equality regardless of particular issues and circumstances:

The definition of fair, exactly, and that's a huge issue in the unionized culture because their definition of “fair” is everybody gets the same thing. My definition of “fair” is for example: If you're 60, why should you have to work as many nights as a 20-year old? Is that fair? If you've already nursed for 30 years? So I think to myself, you know, when you get older, perhaps it would be nice if there was a bit of a career ladder and it was something that you had worked for that would make your life a bit easier. That's fair to me. So, like I said, it's a fine line that you walk, trying to be a fair person. Is it fair that the staff here went without a nurse for a day? Well, maybe not, but it's more fair than if somebody went without a nurse at all, so you're always going through that in your mind and trying to remember what the definition is for everyone and then coming up with a solution that sounds reasonable. My staff, I think, are all well aware that whatever I do they get a fair amount of explanation for it and if they don't like it, then it's okay to talk to me about it. It doesn't mean you're going to get your wish, but we talk about things and I think it's come a long way towards making people understand. If I interview five people for a job and one person gets it, then I'll tell the other four why they didn't get it. I'll meet with them if they have a problem. I interviewed four clerks last month and one got it and the other two didn't. I actually met with one of the clerks and went through the whole interview with her because she interviewed very poorly and I wanted to help her to discover how to improve and you know when you do things like that, you don't have as much trouble within your staff because they feel like they are being treated fairly. So...that's what that means to me.

Fairness may often be relative. This manager's managed the dilemma when she did not have enough staff to provide adequate coverage by decided which of two unfair alternatives would
be more unfair. When not everyone can receive treatment that seems “fair” they at least have
an opportunity to air their grievances with the manager and learn her reasons for doing things as
she did. Thus, her consistent fairness in communicating fully and openly with her staff helped
to mitigate situations that were inherently, but unavoidably, unfair.

Theme Two: Leadership Philosophy and Style

The leadership philosophies and styles of the nurse managers who participated in this
study represent another important and dominant theme. A diverse group with respect to their
personalities, abilities, experience and interests, they nevertheless all share an interest in
improving and enhancing the quality of patient care and the practice setting for their nurses.
Although there were differences in leadership styles, the participants, overall, preferred a
participative style of leadership, believed in fostering a supportive and respectful relationship
with staff, acted as coaches, mentors, and advocates for their nurses, and avoided personalizing
criticism.

Participative Leadership

Participants tended to viewed themselves as participative leaders. They felt an
obligation to their nurses and wanted to make a difference by meeting their needs. One
manager described the participative style as follows:

I always think of myself as the bottom of a triangle so that I’m not at the top, I’m at the
bottom, trying to support my staff and the people that need me. And try to provide the
things that they need in order to do the job well.

The participants also preferred a collaborative approach to management. Their employees were
encouraged to participate in decisions that could affect their practice environment. As this
manager noted:

... at staff meeting sometimes you make decisions and only the staff that are working
make that decision that will affect everybody else so sometimes I find that a little
difficult too, because I should have a bigger quorum for decision-making but I don’t
expect them to come on their days off so if they’ve just worked nights, they might not
come, so we just do it that way and we decide on things; I minute the meeting and hopefully that gets spread and we change practice that way.

At times, though, these managers had to take decisions based on staff representations only, or on organizational requirements. In such cases, employees may have been less satisfied with the decision, but then they were welcome to come and negotiate or give feedback on the decision made on their behalf.

Participants also empowered their employees to make decisions regarding their environment and their personal and professional growth and development; the aim of such autonomy is to increase job satisfaction. However, one of the managers claimed that although it is the nurse's responsibility to seek professional development opportunities, nursing culture tends towards an avoidance of more education. She insisted that even those who are reluctant must attend professional development programs for their own good and that of the unit; in the face of resistance, the manager must take the decision for those who will not take responsibility. As this manager noted:

You know its learning again. People...some people don't want to go on to school. Others love going to school...Well, I drag in one or two a year. So, a couple of years ago I had two staff members come so that was good. And last year they kind of missed the boat, they didn't register early enough so they didn't get the grant. This year I'm hoping to drag three.

More successful was one manager's empowerment of her employees to make their own schedules:

So what I did was I said to staff that we need to have six RNs on day and five RNs on night and we need to do the rotation and this is what you need to have. You cannot work any more than 44 hours in a stretch and that you need to have two weekends off every four weekends. And so people submitted their rotations. So we posted and majority of the rotation won, so after that I calculated everything, I wrote a letter and sent that to the union and HABC. HABC is the hospital boss - like a hospital association. So it is their rotation, as long as it's meeting the criteria, it saves my time, I don't have to spend a weekend doing the rotation and if I do it, they will say, "Oh, I don't like this rotation" but everyone who wanted...I think we have a five rotation or something, so posted. The downside of that is process is very intensive that it usually takes time but you know what? You would rather spend that time to have everyone's input because I truly believe in this change process.
This manager’s comments underscore her commitment to a participative style of management, despite the time pressures of her job. Because nurse leaders are now typically managing more than two units and clinical programs, it was often a challenge for participants to enact the kinds of processes they believed were important. As this manager said, she wishes she could return to a time when she had the time she needed to be available to her staff:

I would go back to being a leader that was here all the time. I think that’s the most frustrating thing to me is that I can’t just be everywhere and it’s hard to be visible when you’re not present... I meet with every group monthly and then whenever I need to in-between but we have monthly team meetings because I just can’t manage any more meetings than that, you know, with all the other stuff and other committee work that you’re expected to do cooperate and now with all these sustainable workforce that we’re doing is mind-boggling.

This manager is typical of the study participants. She, like her colleagues, has to try to find ways to enact the processes she knows are essential to support her leadership philosophy, despite the extreme time constraints of her job and her heavy workload.

Ability to Cope with Practice and Change Issues

Due to the many changes in the health care system, nurse managers now look with dismay at their large work portfolios. They notice the challenges they face every day in their practice environment because of the increased workload. They no longer manage one unit, but more than two units, and more than two clinical programs. One manager said:

First of all I do have to say that I think right now in health care, our span of control is too large. I mean it’s very hard to be a leader for ten separate groups of people that are scattered a number of blocks apart because I think part of being a good leader and providing a quality practice environment involves being present. It’s very hard to be present at ten places at once. So I need to say that because I have worked where I was the manager of one unit and then my portfolio gradually got larger so your strategies have to change because of that.

There are numerous challenges that go along with these ever-expanding portfolios. As one manager commented, it becomes a problem even to know that problems exist because of the difficulty of managing so many units, programs, and employees:

Well, it’s so challenging because the portfolios...like you asked, “how big is your portfolio,” your portfolios are huge that you’re really challenged to even know when you
have problems within that environment or how to support those environments unless the people reporting to you recognize there are problems too and let you know.

This manager relies on the open communication channels she has established to ensure she hears about problems from her staff. In many cases, changes in the practice environment can put the well-being of patients at risk unless management and staff remain alert. It is important to remember that not only is the practice environment of staff nurses and other health care workers the responsibility of these increasingly overburdened nurse managers, but so is patient safety. Accordingly, nurse managers had to identify the deficiencies in their staff members and specify the qualities needed to ensure good patient care. They insisted on having highly qualified nurses with good educational backgrounds and motivation to help patients. One manager described not only the science but also the art of nursing:

So what I do for quality work environment is actually selecting their team members with qualifications and then also a similar approach to patient care. So it is really difficult to find all that within 40 minutes of interview of course but then after they are hired they have a three-month probationary period so during that time and I usually make sure that they get feedback at least monthly.... I always think that nursing is a combination of science and art. Nursing...you cannot have just the nurse from the street because nursing has to have specialized body of knowledge so we get that from people going through school and passing the RNABC exam. So, we get that special body of knowledge but the art part – you could actually nurture the nurse to develop that art part. And I think that you need culture and a manner...philosophy has a lot to do with how you mold a nurse to be the nurse you’d like to have if you were a patient”.

Another manager also discussed her perception of the unique art of nursing and the therapeutic use of self to provide care that has that a human touch:

Nursing...it’s important to have the theory and it’s important to have the knowledge but that isn’t what nursing is about to me...nursing is about the therapeutic use of self and in order to use yourself as a therapeutic tool you have to be aware of who you are and what you consist of, and what you have to give someone else. And when you know those things, I believe it is magic. You can create such changes, such fundamental progress in a person...in a person’s health and in their care of themselves. But I don’t think...to me this is a tool you can’t measure...nursing has never been able to articulate that. And it’s so...obvious and it’s so apparent when you see an interaction between a nurse and a patient that has therapeutic value to it and it isn’t just about “I know how to do the dressing and tell you how to do it yourself at home.” It’s about being able to convey the depth of your caring that you want that person to get well and be independent and on their own, and if you can get that across to them whether it’s verbal or non-verbal you have accomplished something really important. And no doctor can do that.
Participants were convinced that the art of nursing was an important component of high quality practice, and that the stress of the practice environment was not always conducive to this unique quality of nursing.

Experience, along with coaching and mentorship, is how nurses develop this art. Although participants insisted on hiring the best qualified nurses they could, they noted that increasing numbers of junior staff with less than five years of experience was a growing problem. With this increase in junior staff percentages, the senior employees have begun to experience burnout because of the increased demand this ratio places on them. The work overload during times of crisis, orientation, teaching and coaching is daunting. One manager described the situation very well:

At the moment, I think we're struggling. About 70 percent of our staff are junior staff so five years and under which means that we need to mentor them a lot and so while the senior nursing staff are slowly leaving, we are not cultivating ... new nurses who can take on that role. So we are kind of burning the ones who are here by being bodies when the new staff comes on board and so we find that we can't teach them everything, so everyday there are lots of things that clinical nurse specialists and nurse educators, the senior occupational therapist and the senior PT would inform me about.

Additional practice issues identified by nurse managers were the increased acuity of patients together with fast patient turnover because the health care system is overloaded with patients. Compounding this is the unavailability of vacancies in community care for discharged patients. All of this has the potential to affect patient care outcomes, as this leader comments:

I think the quality of patient care can be subtle...medications may be given incorrectly or...I think it can be much more of how people treated the client. On [one] floor [...] most of the clients, in fact all of the clients' activity is impaired, they are challenging to work with, they won't remember things, they can act inappropriate at times [...] so it requires a certain skill among the nurses and you see she is under stress...they're going to be less able to deal with it in the way that I could deal with it. I won't necessarily hear about it, like a nurse hit a patient, or yelled at a patient, but they might not be as kind or as patient or as caring as they normally are. So you worry about it because you need to make sure that the environment is conducive to providing good care.

This example also describes the ongoing dilemma of trying to promote good care for patients in a system in which the pressure is increasing:
While we are experiencing the forces, to have people come into our program, we can't... you know, it's like a funnel, right. Like there's like a little bottleneck here, if you can't send them out, you can't really receive. And what we are doing is sometimes we are receiving and receiving and receiving but the bottleneck is not being fixed. So I say fix the bottom end as well and not just the top end. Not just the "in" but the "out" as well. Like that whole continuum and that's a big thing. So, because of that pressure, the team members feel frustrated. They feel that they are spinning their wheels; they are feeling that we are discharging patients when they are not quite ready to be discharged; sometimes we are compromising their care because... they are acutely ill and not ready [to be transferred]...

With the ongoing effects of health care reform, it is difficult to imagine how nurse managers will be able to continue to maintain a quality practice environment and ensure positive outcomes for patients. A participant offered another similar comment that illustrates the pressures in the system:

The acuity, complexity and dependencies, not only are they sick and complex, they are dependent upon nurses because [of their injuries]... so other people might see that “well, they’re not acute anymore so why spend that much time.” Well, it's because they can't [yet function]... we have to do it all for them. So every time I speak about the program I have to make sure that I talk about the acuity, complexity and the dependability... the dependency factor on the staff which makes for a very, very busy program which is why we need a lot more staff than maybe other programs...

Although it is possible to generalize about issues of patient acuity, overcrowding, lack of beds, and other aspects of the so-called “healthcare crisis,” this last comment highlights the fact that each nursing unit has its own particular attributes and problems. But what the nurse manager is trying to do in this time of healthcare turmoil is at least try to provide safe and appropriate care for the patient while at the same time provide support for their staff members. As this manager said:

When it gets overwhelming I just put my head down and remember what the basics are. Take care of the patients; take care of the staff. I do my best in doing that, because to me that's my line of safety and if they ask me to step over it, budget-wise or any otherwise, I won't do it. You have to have your own line and you have to be true to yourself and you have to have integrity as far as I'm concerned.

On the other hand, one of the issues that nurse managers identified, and that has a direct effect on the quality of the practice environment, is the change fatigue factor. Nurse managers suggested that change fatigue is implicated in the problem of increased sick time among their
nursing staff. Constant change is sweeping the health care system: staff reductions, decreases in budget, increased workloads and rising levels of patient acuity all have had a direct effect on the health of nurses. As nurses become enormously stressed, they begin to use more sick time, perhaps because of illness, perhaps to escape the stress of uncertainty in their work environment and the worries of losing one’s job. An enormous source of stress that affected the practice environment were the cuts in staffing levels. There are numerous ramifications. As one manager said:

...although on one unit where we have really high sick leaves, because like I was telling you, they were very stressed because of all the changes on that unit so there’s a lot of sick time right now. 70% of the RNs on that unit are calling sick....Well, we’re trying to bring them in...some of them have been back injured but you may have an idea that back injuries is usually because of stress and back injury so we have brought in somebody from musculoskeletal team to work with nurses, we are running a relaxation class, we have classes in the morning, we are trying to get those nurses to get better...

Cuts to management also have had detrimental effects on practice. Because the patient coordinators were eliminated, the management structure changed on one unit. The change itself was very stressful for the already stressed staff:

...so the nurses have had to do a huge shift, and it’s difficult because it’s gone from reporting to someone who is very, very kind and very caring and very supportive but not too...not too rigorous...to someone who may not be quite so caring and a lot more rigorous. So it’s pretty extreme. So it’s very stressful to the staff because it’s a real change.

This manager’s implication is that when managerial changes are made, and positions are deleted, it can have a devastating effect on the nurses. Nurse managers correlate such stress in the workplace with high levels of illness and absenteeism:

Because of the unrest right down within the hospital the deletions, the changes, deletions of positions, the outsourcing, all the privatization, everyone’s stressed and worried about it. And I think that always makes, you get a break in your sick time. Plus, it fluctuates too, according to busy times that we have here where we are pretty overwhelmed ....

...and the workload is very heavy and we end up using a lot of overtime...

We had moved from an old unit to a brand new unit up here and you’d think that would make everyone happy. Nope! It made everyone sick! (Laughter) So...we had to work our way through some of those issues but I think that it’s a high stress area. I mean (this
unit) is not an easy place to work. It's extremely emotionally exhausting and very labor intensive so you have both the physical workload and the mental anguish that go with...hand-in-hand... they don't ever get away from it.

Finally, the introduction of new health team members such as LPNs to some of the health programs is a practice issue. One of the managers described this situation:

One of the most recent ones that we are working on is we have introduced LPNs to our Program. It used to be all RNs... But what happened was that the LPNs don't know their scope of practice, the RNs don't know the LPNs scope of practice; they are suppose to be working on their own but we are finding that they can't because their level of critical thinking and problem-solving and just their scope of their practice, what they can and cannot do, does not seem to be appropriate for our population... we welcome that model where we pair the LPN and RN because my fear was...LPNs are now full scope. Well, they have always been but we have never looked at them that way and so our expectations became more. But the reality is maybe the LPNs themselves, are not at that stage where they feel confident about their workload.

This shift in RN-LPN ratios, as this manager reported, causes frustration and work overload for the RNs, and uncertainty and stress for LPNs.

Use of Effective Communication Styles

Participants noted that to be open and honest, while helpful in building a trusting relationship, was only one aspect of a manager's overall communication strategy. Participants needed specific, effective communication techniques for use in all their interactions with staff, but perhaps in particular when negotiating goals and expectations or when problem solving. In general, the managers' communication styles exhibited a number of features of the relationship-building interaction (RBI) model (Moore, 2004). For example, the managers worked on knowing each employee well, addressing the problem with the employees, listening to concerns, and collecting information regarding the issue at hand. If necessary, the manager and employee together developed a plan to solve the problem or address the issue by gathering suggestions and ideas, and agreed on a plan or action to be taken by the employee to improve or correct the issue. Lastly, the manager gained a commitment in the form of an agreement from the employee to change or correct the issue of concern. Describing such a process, one manager said:
"I just bring them in and I just show it to them. And first I would say, 'you know, you had 12 sick days in the last month or two, you know I'm concerned about you...are you okay?' So I always start with that because maybe there's something I don't know about their health and then I'll say, 'Well, I don't think you look sick to me, is there a problem. I'm worried about that.' ...and a lot of times that's all you need to say and never have to visit it again. For other people it continued to, so you have to visit it again. I'm pretty up front with people like for instance I would bring her in and I would say, 'Are you aware...do you know that this is happening, what do you think...why do you think that is happening? What can I do to help you so we can change this environment because it can't continue to go on.' And then it just depends on how that nurse responds. If the nurse responds and says there's not a problem, well I have to push it and say, 'yes, there is...and we have to work on that.' If she responds in a genuinely quite shocked way, then I can really help her around some strategies that she might use to help her in that matter".

Another manager also watched for problems by keeping very careful track of staff behaviour, and documenting employee sick leave:

First of all before we started I met with each staff member in the unit and then I started keeping statistics. I did it every six months...if people were under a certain...if they had no sick time, I gave them a congratulatory letter; if there sick time was starting to creep up I would give them a letter saying, 'This has been your sick time and I'm concerned about it and I'm going to watch it but if it continues this way, then we're going to have to sit down and try and figure something to do', and if it continued I would meet with them. Anyone who got a letter that said anything...like my letter #2, 3, or 4...I would meet with them personally and actually talk to them about it because I had worked very hard not to make them think it was punitive. And I got a visit from the union every single time I put the letters out...But, as I said, to maybe someone who's 25 and they'd been off for four sets throughout the year, with a cold... like 'Why is that? Have you investigated it? Have you been to a doctor? Doesn't that concern you?' Because it's not really normal for a young healthy person to pick up every...and in several instances I would say that...we were able to figure out what the problem was...just by talking and working our way through it and then there would be an improvement. So...how I define my success in that area is that the culture has completely changed on this unit.

Although this manager's intention was to watch for problems and then to deal in a positive way with the employee, she noted that an initial lack of trust on the part of staff nurses meant that they asked for union representation to help them deal with the manager. Eventually the manager seems to have been able to convince the employees that she was not being vindictive or punitive, but was genuinely interested in the well-being of both the staff and in what she terms the unit culture. As a side benefit of her perseverance, the manager made friends with the formerly antagonistic shop steward. She explains further:
We talk about the issues and we talk about what they are here for and what their professional obligations are and usually I can work my way around to them becoming more aware of their own feelings and their own issues and dealing with it. That's what I prefer.

This manager, to judge from this comment, felt that her success owed something to her ability to encourage opportunities for personal growth and insight as part of her interactions with staff. Not all managers act in such an overtly therapeutic role, however. Another manager arrived at a similar result by first perceiving the existence of a problem, and attempting to problem-solve. Failing that, she then encouraged nurses to make use of appropriate institutional resources:

I usually find out a kind of pattern and when I present that kind of information they are usually very surprised, “Oh, I didn’t know that I was calling in sick that much; I didn’t know that I was calling in every last shift” or something. There was actually a wonderful nurse who was calling in sick on her first shift usually and I said, “What do you do on your days off? Are you doing too much? It’s none of my business what you do on your own time but it looks like you must be overdoing something on your days off that first day of your return you quite often call in sick.” And they usually don’t think there is any association but I usually let them think and let them track because we’re dealing with professionals so just to let them know that that’s what it is. And then go through a few more months to see if there is an improvement. If there isn’t an improvement then I ask them to come up with a solution and if they don’t come up with a solution then I usually suggest how do you think, since you could work 50% of your whole shift, do you think a part-time is the answer. Or go and see a counselor. We have EFAP – Employee Family Assistance Program so if there’s any issue at home then go and talk to counselors. And I try to actually involve the union as well too.

In this case, the ends the manager achieves are similar to those of the previous manager, but she uses somewhat different means to arrive at a solution. Probably because of the stress, workloads, and constant change in the nursing practice environment, this issue of excessive sick leave is a recurring one for managers. One noted that the approach she found best was to approach the matter directly and frankly.

I would say, ‘I noticed that your sick time is quite high. Is there any medical reason?’ So I explore it with them and then most of the time, it’s actually good conversation...I’m pretty direct. I’m pretty transparent. I don’t hide anything so...and I’ve learned that when you’re more honest with them, actually the outcome is a lot better.

In general, the managers appeared to be cautious in their approaches to employees about problem issues, so as not to be perceived as harassing them. Moreover, they seemed careful
about their boundaries, and made it clear they were addressing problems that affected the workplace, as opposed to prying into the personal lives of her employees. They expressed their desire to establish a trust relationship and to be available to provide support and help.

Managers also adopted or developed techniques to communicate with staff members such as journals or email newsletters. Often the idea to use such strategies arose in response to the pressures inherent in the nurse manager’s position given today’s heavy workloads. As one manager said:

...one of the things I’d decided to do and I’ve started, is an e-mail newsletter that I just do because all of my staff is on e-mail and because I can’t be there and get there and especially now when things are so uncertain and they’re just upset...all the time because they don’t know what’s going on. Even if I don’t say anything in particular, just contacting them and being in touch with everybody ... makes me feel better and I think it makes them feel better too. So, I’ve just started trying to do that. I’m going to try and do it regularly.

In this case, the experiments the manager had been conducting with email communications, to help maintain a sense of connection when she could not be present, seemed to have had positive results, and she clearly planned to add this technique to her arsenal.

Respectful and Supportive Relationship and Feedback

The managers were caring and humanistic in dealing with their staff; they had empathy for the nurses and their problems. They provided support when employees were sick or in crisis, and in most cases frequently offered appreciation and thanks. One manager said:

I do send them cards; I do try to touch base with people on the phone, although you have to be careful of that...the Union doesn’t think you are “harassing” people but most of my staff will phone in and talk to me if they are ill. So, it’s not...I mean if their sick time continues, then I will refer them to employment health.

Sometimes a manager’s support for her staff is accomplished with such a light and subtle touch that her nurses suddenly become aware that a positive change has occurred, without having any idea exactly what had happened or how it had come about. One manager described such a scenario:

[We had]...patients with large wounds. Like...I mean...large wounds! That needed free flaps or needed massive surgeries......we used to get them here off and on, over the
years, and they were always difficult patients...always patients who are not complying to, who gave everyone a hard time, who were bitter and miserable...a lot of them. They weren’t happy people for the most part. So when we started the program there was a very large prejudice on the staff towards looking after these patients so we met every week for six months with a couple of people to help us...to talk through our issues and we talked about every patient that we had on the unit on a daily basis with the nurses until...it was funny because after about six months, the staff started saying, ‘You know, the patients we’re getting in now are much better than they used to be before’ but it was really them who had changed their attitudes. So, it worked...but it takes a lot of work...

This manager not only supported her team, but demonstrated her respect for them by allowing them to register the changes in their own way, without feeling the need to point out how she had orchestrated the changes in the nurses rather than the patients.

Sometimes the entire team pulls together for support, such as on one occasion a manager described, when her nurses were devastated by the tragic death of one of their colleagues. The whole unit came together to support each other, and the manager felt she too needed to be there to provide her support and keep the work going. As this manager reported:

...And it was very tragic and the nurses were devastated because it’s a small hospital...everybody knows everybody here well so I just felt I had to come in to work so I kept coming in every night and talked to the nurses because they had to keep working even though their co-worker is dead. And there is a very tight community...they’re very close...they’re like family to each other....So in that case too I really encouraged them to access EFAP (employee family assistance program). We tried to bring in casuals as much as we could...But the other part of that was that it brought all the nurses together...like grief always does. There was a good side and a bad side. So...but creating an environment to support nurses in these instances is crucial, because I could have just not come in. I could have left the things go, but I felt sad for them....So that would be a thing, you have to let them know that you care for them.

Although the participants varied somewhat in the way they related to their employees, they agreed that caring for their staff was part of their jobs. One manager said:

I have always felt that the human touch is what matters the most. When it comes down to the bottom line, people are happier, I think, and produce for you and are happier in the care that they give if they are happy themselves. And part of that is feeling comfortable at work and feeling that you are supported and that you are understood.

According to this participant, managers should consider what can be done for their employees to ensure they feel valued:
It's not getting everything that you want of course, because we can't do that but it's trying...at least if they feel you're trying and that you hear them, it makes a difference...

I try to celebrate all the multi-disciplinary staff because they’re all under us...it's not just about nursing...its about patient services managing and I spend...I have spent and put quite a lot of time and effort into trying to create an equal environment so we celebrate Nurses’ Week, we celebrate Social Work week, we celebrate Dieticians’ Week...all of those things on our particular unit. My clinician and I have been, for as long as I can remember, have done specific things, particularly during Nurses’ Week but there are all the other ones as well. We always do something special for them in the Nurses’ Week. I have a little bit of difficulty with the fact that a lot of people, during Nurses’ Week, think it’s the nurses to do more. I kind of think it’s nice to celebrate nurses and say “thank you” to them for all they have done. So every Nurses’ Week almost everywhere you go, everybody’s saying, “Oh, are you going to put up a booth, are you going to do people’s blood pressure, are you going to do...some kind of presentation” and to me it’s just asking more. And I think that’s fine as far as it goes but I personally like to celebrate each of my staff members when the time comes so we try and do that here.

Participants did realize that if they concentrated all their attention on supporting or dealing with staff who have (or cause) problems, they might end up neglecting their “stars”, whose development was necessary for the long-term quality of the team and the practice environment. As one manager explained, some of your time and effort must be spent on showing them that you appreciate their work and that you support them:

...there's always a performance issue wherever you are, you've always got people you're dealing with. I try very hard to focus a little more time on people that are doing well and a little less time on...a little less of my emotional time on the people who aren't doing well because, you know, they say 5% of your staff take up 80% of your time and it's true and I just feel very strongly that your “stars” that you have, that are going to grow and become and be the backbone and be the people that succeed us need to have some time and attention devoted to them. You can't spend all your time dealing with the people who are not willing to help themselves. In the past I've invested so much time and energy in those people, trying to fix them. I think I'm improving...at knowing when...where my boundaries are and that I've done all I can do and it's no longer up to me...it's up to them. They have to make a decision regarding their own life....

Nurse managers generally felt responsible for maintaining general workplace morale by providing the necessary support, particularly when the workload increases:

It is not only because of the workload but also morale goes down if someone comes to work sick all the time or calling in sick all the time because if you don't look after issues such as that, people who are always doing their job well, like people who go to bed early and makes sure they keep themselves healthy...like you go to gym, eat healthy, so they
maintain their health and come to work every time they're supposed to come to work, they don't feel rewarded so that is an indirect way to control quality work environment.

Another way to boost morale in the workplace was through socialization. For example, one manager noted:

I think nurses always have close relationship among themselves because they spend so much time together and they go through difficulties together, like if there's a Code Blue or something. You're dealing with life and death together. I mean, emotionally you become so intimate, right. So, using that kind of emotional condition I like to extend that to outside of work so we have a lot of social functions like I had a big Christmas party at my house, rather than having it at a restaurant. Like had everyone at home so it's like 'let your hair down and relax' kind of thing. And also we had a baby shower for someone about a month ago so we all bring food and having potluck so I think, for me, it's building a team and if you know the person well enough, you can be kinder to each other or the newcomers.

Although this manager describes her team's social interactions as an outgrowth of the already intimate nature of the social interactions that form part of the culture of nursing, the unit's social life outside of work depends on the personalities of the individuals involved. Some groups take more readily to group socializing than others. Likewise, while some managers find it natural and easy to offer enthusiastic praise for those who do their job, others find that they do not take naturally to this technique. Although this participant was aware of the advice nursing management literature offered, she could not easily adapt to this way of relating to staff. Her comments allude to some of the difficulties inherent in prescribing roles or procedures that constitute "good management practice":

...and I am sociable but I don't like fluffy talk but I find that I have to be "fluffy" sometimes and I don't...because I have high expectations of people, I don't tend to say "thank you very much" because I think that it's part of their job. But when I read the literature about management and leadership and all that one of the important things is acknowledging so I try to do that a little bit more and that's a little harder than trying to find something to get to know somebody by. To say, Wow! What a great job!" it's part of their job and so I have a harder time saying that. I may sound kind of fake if I do it...But I'm learning. I'm trying...I'm trying to do it more".

For this manager, it was a challenge to enact some aspects of the "recommended" management style; as noted above, each manager adapted her leadership philosophy and management style
to suit her personality and values. Each one gave respectful and supportive feedback to her employees, but each did this in a way that felt natural and worked with her own style.

**Advocacy**

Managers indicated that they were strong advocates for their nurses during times of change and when crises arose. On one occasion a participant felt that advocacy for her staff’s health and well-being meant taking a decision on their behalf, when she felt they were not able to judge the situation correctly:

...then people will...and I do correlate their overtime with their sick time and if someone has too much sick time with overtime then I will not use them for overtime. And I tell them why. I just feel that if they can’t make the decision not to burn the candle at both ends, then I have to make it for them. ‘Cause sometimes people work overtime for more money; often times they work overtime because they can’t say no.

Participants felt that they had a responsibility to intervene or advocate on behalf of employees when they saw a problem. In terms of nursing practice and patient care, it is also the manager’s responsibility, they noted, to advocate for staff when they need access to resources:

So we should be able to look after a patient who’s been having TPN but I don’t have anyone with TPN line right now. Last week I was asked to take a TPN patient, but only 1/3 of my nurses are certified like a year and two months ago. Anyone hired after that I didn’t certify central line is because in order to maintain competency you need to have enough critical mass and frequency too...so I said if I have enough volume of patients I will certify all my nurses. I will only do one unit...because if I do both units I’m diluting the volume and it’s not very good to maintain the competency. So that’s the kind of thing manager is deciding. Why is it the manager?...because it costs to maintain the competency because it’s a 4-hour education...nurses going to central line classes, they do pre-reading and they go to class for four hours and I have to pay them.

For these managers, advocacy also meant advocating for themselves. As the ever-changing health system meant increasingly heavier burdens, the managers had to know when to make an attempt to limit the load so they could at least try to provide quality environments for their staff members. Depending on the personality of the manager, the process of advocating for oneself could be hard; or, difficulties could stem from the way organizations limits the opportunities for their managers to express themselves, as this manager noted:

and I was made co-chair of the [a committee], and I have no time! I have no time to do that; I just kind of went and saw my director and said, “I can’t do all this! I just can’t.”
So I've been given somebody two days a week to help with all of the accreditation because I have to do it in all of my areas and I was able to increase my secretary's time an hour a day and it's still not enough but it's way better than what I had, so it's helped some...

...but that's a hard lesson to learn from someone like my generation because you know, the whole culture, the organizational culture, is “you just do the work and you don’t complain. And you put the hours in.” And I think for all of us it’s extremely hard. We equate needing help than admitting to failure. And it takes a long time before you’re finally able to say to yourself, it wouldn’t matter who was doing this job, they couldn’t do it. There’s too much work. I don’t care how good you are. Even if I camped here I wouldn’t get it all done. So once you reach that point where you can’t be manipulated that way, just by that code of silence where no one complains and everyone just keeps working themselves to death...and the ones that can’t tolerate it and just leave, and you know, that isn’t my belief. You can’t change anything by walking away from it, so I speak up. But it took me awhile. But now that I’ve done it once, it will be easier.

This manager’s acute observation, that the “code of silence” to which she refers is a form of institutionalized manipulation whereby nurse managers take on ever-increasing workloads, provides rare insight into one of the factors that has an profound effect on nurse manager’s jobs and lives, and consequently on the practice environment.

**Coaching and Mentoring**

Participants also acted as coaches and mentors to both their new and senior staff members. Coaching and mentoring are similar and often overlapping but not identical activities. A coach helps the team members stay on task and remain organized, exhorts them to get their work done, offers encouragement, and is generally “in their corner”. A mentor is a trusted advisor whose experience and wisdom is a model for neophytes attempting to learn their way in a new endeavor; a mentor offers strategic advice and encouragement and an empathetic ear. In a coaching capacity, the managers often facilitated their staff’s ability to take over responsibility for management tasks such as creating the rotation:

I am the facilitator. So I know all the rules...how many hours they’re suppose to work and all that so give that information to them and then they created their own rotation. So, you will talk...you could talk to my nurses...they are pretty content with how things are done and another thing is that it saves a lot of time for myself.
Although nurse managers were actively involved in coaching and mentoring their staff, also acting as student coaches and mentors, they felt it was necessary to exert a particular effort to promote a mentoring culture on the unit. As one participant noted, nursing culture does not tend to favor the nurturing and mentoring of students and new nurses. Some insisted on a balance between junior and senior nurses, in an attempt to change the attitude of the older nurses who tended not to be welcoming to new graduates. It seems that this attitude frequently occurs in the nursing culture and, as this manager said:

...but nurses will not be kind to newcomers......But, I think we need to change that attitude and therefore having...it starts from having nursing students and starts from being a mentor for young nurses and then, of course experience makes a big difference.

Nurse managers encouraged employees to make changes to traditional nursing culture to allow for teaching and coaching among their staff to assist new nurses. One manager thought it would remind them about themselves when they were juniors, and used a technique of matching a newcomer with an older experienced nurse as a mentor or a preceptor.

**Theme Three: Organizational and Staff Support**

Organizational support is especially important during times of change. It is also a factor in empowerment for decision making. The amount of organizational support employees have may depend on the ability of the nurse manager to advocate for her staff, and on her ability to communicate effectively. How staff perceived the level of organizational support also depended on the manager. Organizational resources and support, availability of resources, and availability of educational opportunities are sub-themes that explain the importance of organizational support in creating and maintaining a quality practice environment.

**Support from Senior Directors and Staff**

All of the managers in this study indicated that they receive support from their senior directors and they were empowered to make decisions that would benefit their staff and units and would result in quality patient outcomes. One manager noted:
I have great support within this site, I always go to the practice leader there and she's been very supportive. She's been very supportive so yeah...and the Chief Nursing Officer... has also been very supportive of my role. I think I feel reasonably supported but I think the nurses at the bedside are too far away from that...they wouldn't even know that we are supported...

This manager brings up an important point: the nurse manager often acts as the link between organizational directors and front-line staff, and in order to perform this mediatory role, she needs the support of both those she reports to and those who report to her. Some of the participating managers reportedly relished this role of mediator:

I believe I had a lot of trust from senior management and I am not interested in any position higher than manager. I tell them from the beginning that I'm not interested in a director's position is because if you take a director's position, you really do not have front-line contact and I really enjoy having that front-line contact just because my belief is that front line represents the organization. So I have...I do have real interest supporting and nurturing and enhancing the quality of front-line staff. So I think no director feels that, actually. [They know that] “____ is not going to take my job.” [The directors are not] going to worry about that.

The position of nurse manager as mediator between front-line staff and directors appears to be key to both the quality of the practice environment and to the success of the organization. Part of this mediatory process is disseminating information and feedback in both directions through organizational channels. Feedback is propagated at both the unit and organizational levels. Although organizational support is a critical and essential factor in any organization it seems that with the increasing work load for nurses, and with directors' work portfolios also large and increasing, managers are finding that the support they feel is crucial sometimes evaporates. Not just nurse managers are findings their workloads excessive; senior directors also have difficulty handling the pressures of directing huge portfolios, and some decide just to quit and walk away. When senior directors quit, the support they provide to nurse managers goes with them. This is an additional source of stress for nurse managers, as the following participant noted:

There's no point in just saying, “I need more help” or “I need more money.” You have to justify it and you have to have some rationale and you have to have some outcomes so that's
what I did. So I’m here and she quit (laughter). Unfortunately. That was very...that’s been very stressful. I’ve been away but she left while I was gone.

The disappearance of needed support that a trusted director offered is not the only source of stress when senior management structure and staffing changes. In addition, they have to cope with the stress associated with uncertainty and change, both in their own positions and in their support systems. Another manager described her reaction to this:

...The organization is...they’re not congruent right now because they’re telling us that they know we’re overworked but they’re restructuring and the new portfolios for the directors are impossible. They were impossible before. Now they’re even more impossible so many of them have chosen to leave and they’re not going to stay. But once the directors’ portfolios are all solidified, ours will also change. We know that change is coming and you know, someone said to me a couple of weeks ago, “Doesn’t that bother you?” I just said, “There just isn’t any point in being bothered about it. What is going to happen is going to happen and I’ll decide what I’m going to do when the time comes.”

Despite this participant’s trying not to be “bothered about” restructuring, most of the nurse manager participants in this study described the adverse effects of restructuring on their own work and stress loads. Participants described the ways stress contributed to both staff and senior directors making the decision to leave their jobs; it is therefore likely that many nurse managers do likewise. However, as I noted in the literature review, few studies have examined the issue of nurse manager retention, but participants’ comments suggest that there may be a substantial problem with nurse manager burnout on the horizon because they receive insufficient support to carry their enormous portfolios.

**Availability of Resources**

When the organizational resources that nurses need for patient care are available, the results are efficiency, positive patient outcomes, and decreased staff frustration. A participant contributed these comments about her efforts to secure resources:

We had, for instance, only one bladder scanner on the first floor so when I did nursing practice actually ...we didn’t use bladder scanning but now I think ... the change is that you use [the] least invasive procedure and make sure [to] select the procedure with the most comfort. So now nurses are doing bladder scanning to see whether patient is retaining urine so ... I bought one each [...] one bladder scanner is $16,000.00...it’s a lot
of money but when I bought [it], I was calculating the time nurses [spend to] phone someone to go and pick up that bladder scan from 1st floor, wait and then do it and send it back...we could go for a month and you could recoup that money. Not only that, it’s not [a] cost-efficient way to use skilled nursing time...for waiting”.

This manager used her discretionary powers to ensure her staff had the resources they needed to improve patient care; her solution also saved the institution money in the long run. Another manager empowered her nurses to use their own discretion to order certain types of needed equipment to improve efficiency:

...they just informed me that they needed more Dinamaps with oximeter. I said, “Well, order them! Order whatever you think would make your life easier, so that you are not running around looking for a Dinamap every time you need to take a measurement.”

Although this manager encouraged her staff to order the resources they need, she expected them to understand the economic realities of the situation, and to take care of the equipment they used:

...To me they need it. Now the thing is that they have to look after it as well. They can’t just leave it there and somebody trample on the cuff thing, so I do expect [them to] look after that too.

This manager had clearly developed enough trust in her staff to allow them to make certain decisions about the available resources. That is, she had educated them to understand when it is appropriate to decide to invest in equipment rather than wasting time, and provided an appropriate combination of autonomy and support for their informed decision-making.

Education

In addition to the kind of on-the-job learning through the role-modeling, trust development, coaching, and mentoring that a skilled manager deploys with her staff, more formal forms of continuing education are required, and monitoring the need for such education is the responsibility of managers. Participants in this study identified continuing education for their staff as a priority, as this manager note:

So the things that I try to do from my own to support my own practice environment are certainly we try to provide members with in-service as an on-going education for staff so every month we do infection control in-services, pharmacy in-services. There’s also
an orientation every month and we encourage staff to participate in orientation if they can. We also attend nursing rounds once a month so we bring in an expert on something and we try to provide lunch for the nurses so they come, so they get information on what's going on in nursing so from my perspective that goes with some of the things I needed.

Despite the time pressures that limit nurse managers’ ability to spend as much time with staff as they would like, most felt that it was important for managers make the time to oversee staff interactions with one another and with patients, to ensure that their staff is capable of and trained for assigned tasks, and to provide training or knowledge development where and when necessary. The arrival of increasing numbers of LPNs on the unit presents such a challenge for nurse leaders, as noted earlier. This development puts another burden on the manager who must ensure they have mentoring and an appropriate level of supervision so they can develop the skills and knowledge to practice:

They’re new too in their practice so...and we’ve only ... three...one had been practicing as an LPN for awhile but in a healthy role, not in an autonomous role. And that’s the old model where you can team together – two RNs to one LPN - who work together. And would give all the meds and the LPN would do the basic care needs of the patient. But that’s not the model anymore. The LPN can give meds, they can do a glucometer, they can do everything, but for a stable patient. So, for us, our patients...a lot of them tend to be unstable at any time which, for now, we are really realizing...we are really, really realizing this, because even the ones who we thought were stable, are not.

Thus, the shifting RN-LPN ratios mean that nurse managers have the additional burden of training LPNs to ensure they are able to do their jobs properly and safely. One of the strategies managers used to deal with such issues is to ensure that educational resources are available to assist staff in weathering changes in the practice environment.

Participants also stated that they were involved with and supportive of nursing students, who they were careful to make welcome. One manager said:

...they're a tight family, particularly on this unit. Students love coming here, Floats love coming here. I hear that all the time... any student that comes to my floor I meet with them and I tour them around and...I spend an hour with them...try to get to know them a little and match them up with good preceptors that suits where they’re at and make them feel welcome.

A manager's own educational experience may influence her attitude towards students:
...in here we do quite a number of in-services and teaching and we do try to support people who want to...I'm very supportive of people going to school. I'm also very supportive of students and it's comes back to me in spades because I had such horrible training that I swore I was never going to be...treat a student the way I was treated and so I've always been very open to having students.

Thus, managers promoted an atmosphere of learning by sharing new information and trends with their staff. They also effectively used the available resources in their organization to support more education and encourage professional achievement.

Finally, managers encouraged professional and personal growth and development to improve practice. They also noted that institutional support for their own personal and professional growth and development assisted participants in managing the changes they faced every day in their practice environment. Availability of leadership workshops and continuing education for leaders and managers helped to widen their vision, and to develop improved strategies to deal with the challenges of the rapidly changing health care system.

Summary

I have presented the findings of this research study in three main sections that correspond to the themes, “Establishing a Trust Relationship,” “Leadership Philosophy and Style,” and “Organizational and Staff Support.” I chose these themes as my understanding of nurse managers' experiences evolved during the collection and analysis of the data. Within each theme I organized the material into sub-themes that helped to clarify and explain the complex process those managers encountered in their efforts to create and maintain a quality practice environment. The themes and sub-themes presented in this chapter are interrelated; they also represent one way to view the processes by which nurse managers strive to create a quality practice environment in challenging circumstances. In the subsequent discussion of these findings, I have reorganized again into a different arrangement of themes and sub-themes in an attempt to present the material in a form that could benefit future nurse managers to
enhance their career path and help in establishing a practice environment in which nurses can practice safely and adequately.
CHAPTER FIVE: DISCUSSION AND IMPLICATIONS

The findings of this research study relate to the efforts of nurse managers to create and maintain quality practice environments. The discussions that participating managers supplied contain substantial and critical details of their successes and challenges. Collectively, the themes and sub-themes that arose during my analysis of the data obtained during the interviews with participants establish a way of perceiving the complex process whereby today's nurse managers try to create and maintain a quality practice environment. I have organized the following discussion of the findings somewhat differently than the previous chapter in which I presented the results. The idea of this reorganization is to shed more light on the various factors that the nurse managers revealed were of interest to themselves and that they considered to be important components of the process of managing nurses in the present health care context. This discussion is divided into four sections: trust in the practice environment, the role of nurse managers, personal and leadership attributes, and practice issues.

Trust in the Practice Environment

The first and overarching theme of trust was one to which participants continuously returned. They emphasized the importance of trust, describing it as a critical component in successful relationships: in nursing management, trust creates a foundation for interactions between managers and their employees. Trust is also the basis for the mutual commitment of all members of the nursing team to care for patients and meet their health needs, thereby meeting the organizational goals and mission. However, for the nurse manager establishing trust with her staff is a complex process. Participants recognized the dynamic nature of the trust relationship and remained aware that their actions and words were continuously part of the ongoing evolution of the process.
Foundations for trust in the practice environment — openness and honesty, effective communication, role identification, self-knowledge, respect, support, fairness, correspond to some of the sub-themes presented in the findings. As the managers told their stories, it became apparent that all of the factors that relate to the ways in which managers establish trust are interrelated and interwoven, but are also interconnected with a number of factors external to these relationships. That is, the trust relationship between manager and staff exists in the context of the practice setting, which in turn resides in the larger context of the organization; the organization itself responds to political, sociological, historical, economic, and demographic forces. Moreover, as numerous researchers have noted, the effects of several decades of health care cutbacks and reforms have eroded staff nurses’ trust in their organizations (Laschinger et al, 2000), and the nurse manager’s clear mandate is to create a quality practice environment — but in a context that one might arguably describe as somewhat hostile to trust. Moreover, the nurse manager position between her staff and the senior administrators and directors of the institution is unique. She is the link between the front line and the senior staff, neither of which group has direct, regular contact with the other except through the nurse manager. She must therefore represent the concerns and needs of each group to the other. This is a delicate balancing act, at best, it relies on established and constantly renewed trust between the nurse manager and each group, neither of which, by the manager’s report, knows much about the others’ needs, nor is always inclined to put their trust in them. Indeed, the needs or desires of staff and directors often conflict, for example when the organization is downsizing. The nurse manager, if both sides trust her, is often able to take actions that can help to both sides to come together or to understand each other’s needs and goals. These actions in themselves also help to reinforce the trust relationships.
Trust and Maturity

Participants pointed out that the process of trying to establish trust was one that involved elements of risk and personal vulnerability. One of the attributes that managers exhibited that helped them to weather such risks was maturity. Among the examples of risks participants offered were the risk of disclosing confidential organizational information that would have a direct impact on staff, whereby a manager might feel the brunt of her employees' anger or frustration; or, when a staff member shared personal information in confidence, the manager had to proceed with caution. There were complicating contextual factors as well: one aspect of the context in which managers practice is the historical, hierarchical management structure of hospitals. Managers described having to work to overcome staff hostility to management in general, based on old resentments – and in some cases, new grudges based on the actions of a manager's immediate predecessors. It is apparent from their stories that the managers found the capacity to rise above these kinds of hostilities, and persevere until they had re-established trust, or created it where none had existed before. The managers described a variety of techniques and skills that they used, and the value systems that guided them, but one quality that none of them articulated but that is clear from their stories is that each of these managers demonstrates a significant maturity in the face of difficulty. They were able to take the long view, avoid taking their staff's hostile responses personally, and act with wisdom and forethought – and in keeping with their own values and vision. In essence, maturity is an accumulation of self-knowledge such that one is able to trust in oneself. Perhaps this leadership quality, self-trust, is the foundation of the interpersonal trust that each participant stressed as crucial to success as a nurse manager.

Trust, Mistrust and Change

The literature strongly supports the participants' contention that a quality practice environment must be based on trust and cannot exist without it. Particularly during times of
substantial change, trust is needed for an organization’s productivity and successful outcomes; it is ironic, then, that trust can be one of the first casualties when change occurs. As Laschinger, Finegan, Shamian, and Casier (2000) note, the largest group that has been adversely affected during downsizing is the nurses, and as a result they don’t trust their health care system, either with respect to their own well-being, or to that of their patients. As Laschinger et al. indicate, mistrust results when an organization’s administration withholds information from employees, allocates resources inconsistently, or fails to support its employees. The nurse managers who participated in this study believed in honestly and openly sharing organizational information with employees in an effort to rebuild trust with nurses who felt betrayed by their institution and the system. They found the nurses accumulated antagonism that made their jobs as managers much more difficult when trying to develop trust. As Robbins and Langton (2001) indicate, “Trust is fragile. It takes a long time to build, can be easily destroyed, and is hard to regain” (p. 261). Study participants offered examples of their interactions with their often wary staff members. These narratives illustrated the need for a manager to be fair, honest, consistent, reliable, persistent, respectful, supportive, and proactive. Just as important, too, was their need to be perceived as having these qualities. Thus, through a series of well-thought out and integrated actions and responses, the managers systematically worked towards re-establishing damaged manager-employee trust. The final, crucial factor in this relationship-building process was patience, as the employees were often difficult to win over and seemingly determined to prove themselves correct in their belief that management was not trustworthy.

**Trust and Testing**

Testing behaviour was one of the manifestations of employees’ derailed ability to trust. Several managers noted the persistence of such behaviour, and chose to interpret testing as an opportunity for relationship-building and reinforcement of trust. They recognized their employees’ constant testing of the manager’s authority, character, or empathy as their
employees seeking to prove that the manager was trustworthy. Participants' insight that testing behaviour must be seen in a positive light, and as an opportunity, is important: testing – even when it appears aggressive or hostile – helps employees to learn about their manager's personal and professional qualities, her values, skills, and experience, and her willingness to do her utmost for them. Each time a manager is tested, and demonstrates her leadership qualities, her staff registers her response and potentially moves closer to trust.

**Mutual Trust among Team Members**

Trust has many layers, as well. Some are basic, straightforward, and relatively easy to accomplish, using strategies such as explaining reasons, including staff in decision-making, and making decisions as fairly as possible for all concerned. Others require more experience, perception, and skill. For example, when managers identified practice and personal issues or problems, sometimes they decided on a perhaps riskier but ultimately more beneficial response than stepping in themselves to take up the issue with those involved. In some cases, they delegated such a task to a team representative and trusted that person to act appropriately, and to make decisions for the team. In choosing this option of delegating authority, the nurse managers fostered trust and helped to disseminate trust throughout the organization. They were conscious of the fact that the choice of representative must be an appropriate one, so that the team would feel able to trust both the representative and the manager's ability to recognize potential leadership abilities. Promoting mutual trust and rewarding leadership attributes, the nurse managers suggested, were part of their efforts to establish a quality practice environment.

**Personal and Leadership Attributes**

In addition to trust, another significant thematic thread running through the managers' discussions was the personal and leadership qualities they brought to their management roles. Participants described a wide range of circumstances in which they deployed their specific
skills and abilities, and showed pride in the quality of their teams, units and programs. They tended to be somewhat modest about their own qualities, attributes and accomplishment; however, it was clear that each of the managers exhibited a number of excellent leadership qualities, as well as many admirable personal attributes. Certainly, their stories alluded to their ability to be supportive, respectful, collaborative, honest and fair; they also displayed qualities that one might describe as aspects of maturity: self-knowledge, self-respect, intuition, insight, confidence, steadiness, integrity, and patience.

**Intuition and Insight**

These managers' descriptions of their interactions with team members illustrate not only the science, but also the art, of nursing management. For example, one manager described her strategy for dealing with excessive sick leave, but in the process revealed the extent to which she is able to rely on her intuition and insight to get at hidden issues. She explained, “If the nurse responds and says there’s not a problem, well I have to push it and say, ‘yes, there is...and we have to work on that.’” She continued, “If she responds in a genuinely quite shocked way, then I can really help her around some strategies that she might use to help her in that matter.” This manager’s remarks also demonstrate her confidence in her intuition. We can infer that, based on this confidence as well as the trust relationship she had established, she could gently exert her influence to facilitate constructive change in her employee. Some of the managers were comfortable undertaking a therapeutic role in facilitating such change, others relied on their ability to identify the necessary resource and ensure that the employee made use of it.

**Self-knowledge and Individual Style**

A striking characteristic the participants had in common was their understanding, both conscious and intuitive, of the need to individualize and personalize their approach to the job. For example, some said that they were comfortable in sharing their (and their organization’s)
vision, goals and expectations, a strategy that is prescribed in the nursing management literature; they included the proviso, though, that they felt it essential first to establish that there is an appropriate match between the values of the individual and those of the organization. In addition, although some managers mentioned the management and leadership literature, they did so mainly when describing some way in which they felt they were diverging from recommended or accepted management practice, or needed to explain their approach to a situation. One of the additional ways, then, that these managers demonstrated their self knowledge and intuitive abilities was in recognizing when and how to adapt theory to the reality of practice, particularly when fine-tuning leadership style and management strategies to fit their own personalities, values, and comfort levels. These participants, it is interesting to note, demonstrated a strong desire to be excellent managers while remaining absolutely true to their own natures. One manager’s comments in particular alluded to some of her difficulties with prescribed roles or procedures that constitute accepted “good management practice”, but felt uncomfortable to her. She described herself as adverse to what she called “fluffy talk”, although she felt she was personable and sociable. She did not feel comfortable, as some of the other participants did, in lavishing praise on her staff for a job well done. Nonetheless, her staff knew she appreciated them, she thought. This manager’s comments attest to the fact that to know oneself is an important aspect of developing an honest administrative style. Not all management styles and techniques suit all individuals, and as this participant points out, trying to adopt a style that is a bad fit ultimately appears “fake” – and no one trusts a fake. This manager acknowledges her idiosyncrasies, and opts for an honest presentation of self rather than a prescribed technique that she feels she could not carry off successfully. Many managers are able to learn new styles and techniques that seem awkward at first, but gradually come to feel natural and comfortable. However, sometimes a technique is unsuited to the individual, in which case, as participants noted, it may be wise to abandon it.
Communication and the "Open Door"

No matter what their communication and management styles, the study participants believed in sharing information with their staff members and collaborating with them to deal with problems in the practice environment that could affect the quality of patient care. Each participant stressed that having an open door policy was an excellent initiative that promoted trust but also assisted the managers in keeping track of what was going on in their units. By listening carefully to staff issues and concerns, they were able to respond to issues and problems as they arose, and could also do their best to mitigate the effects on their practice environments of ongoing changes in the health care system. The strategies they used conformed, in general, to those that characterize the relationship-building interaction model (RBI) (Moore, 2004), albeit with their own individual stamp. One manager, for example, was unable to manage communications with her large staff because of the size of her portfolio. Her solution was to create an email network that substituted electronic communication for many the face-to-face meetings she wanted to have. In the fast-changing health care system, a simple desire to communicate, or the ability to do so well, is not enough: these managers demonstrated that another attribute of a good communicator is the ability to devise creative solutions to communications problems.

Consistency and Fairness

The managers noted that they remained always aware of the confidentiality of the information their employees shared, and made certain that their nurses knew the manager would honor their confidentiality. When a response was needed, though, they always differentiated between gossip (which they would not tolerate) and documented evidence; this was something participants particularly emphasized. They insisted on documentation when dealing with and negotiating issues with employees. Thus, staff members knew their manager would deal fairly with them, and that she would not respond to unfounded accusations, hearsay,
or gossip. This sense of fairness or justice permeated many of the anecdotes the managers related. They seemed to agree that nothing else could undermine trust the way a sense of injustice can.

**Flexibility and Resilience**

While consistency is a managerial attribute that can promote trust, it seems that in some circumstances, so does is flexibility. One participant alluded to previous managers whose leadership and management styles had differed greatly from her own and whom the staff had mistrusted (and possibly disliked): certainly, a barrier to trust can be employees who generalize their negative expectations of previous managers. The strategy the manager adopted here was to indicate that she was prepared to be flexible and would permit some negotiation and input into the development of her role in that context. Thus, she managed to differentiate herself from previous managers, and to demonstrate that her tenure would be unique and could be judged on its merits, not in reference to others. The capacity to be flexible and adaptable seems particularly apt in a context such as today's health care system, in which change seems relentless and inevitable. Porter-O'Grady (2003b) suggests that we are in a new era of increasing changes and demands and those leaders also need to demonstrate a wide range of new skills to meet the challenges of this ever changing health care system. In addition, they need to enable their nurses to be resilient and help them to adapt their practice in order to embrace emerging realities in the practice environment.

**Promoting Autonomy**

The changing practice environment permeates any discussion of nursing today; the expansion of nurse managers' portfolios is one of the artifacts of the changes. As a simple survival strategy, nurse managers must develop ways to ensure their own workloads do not overwhelm them. One way to accomplish this, and one that promotes other positive work environment attributes, is allowing staff as much autonomy as possible. Participants
demonstrated a willingness to allow their nurses to be autonomous when appropriate. With the pressures of huge workloads for nurse managers, facilitating staff autonomy helped participants to ensure the discharge of their units’ many responsibilities. In addition, as the literature attests, autonomy is one of the ways to promote job satisfaction for nurses (Laschinger, Almost, & Tuer-Hodes, 2003). The example one of the participants offered – encouraging the nurses to create their own rotation – was an excellent example of a win-win situation. This approach allowed the nurses to work out a schedule that they would be able to live with, and the nurse managers is relieved of the burden of creating a rotation, freeing her to accomplish other pressing tasks. The manager’s experience suggested that a supervisor's imposed rotation produces many disgruntled nurses and takes a great deal of her time to complete; a rotation completed by the nursing staff means happier nurses and contribute to distributed autonomy.

**Vigilance**

In other circumstances, autonomy can be counterproductive or even harmful, and strategic intervention followed by close supervision is essential. One of these circumstances is when an employee exhibits signs of personal problems such as substance abuse or addition. As Brennan (1991) recommends, a manager must be alert to any changes in her employees' behaviour, such as signs of increased absenteeism, inability to perform tasks, inability to meet schedules, or an increase in errors (i.e. incorrect drug count). The nurse manager must be vigilant, and carefully document the identified problem, which may be occurring away from public view. As the managers in this study noted, intervening in an appropriate way may be helpful as it can induce the nurse to seek help for her problems. The use of proper communication techniques – tact and sensitivity are key – are necessary when dealing with sensitive issues such as drug or alcohol abuse. The nurse manager is in an influential position to persuade the impaired nurse to seek help and assistance; the alternatives, employee termination and union notification, could ruin a nurse’s career future. With an appropriate and
timely intervention, the nurse manager may be able to help the impaired nurse and re-establish the quality of the practice environment.

**Cultural Sensitivity**

Another instance when intervention is urgently needed is when cultural prejudice precipitates conflict. One of the managers described a situation that poisoned her practice environment for some time. At first the manager thought she was dealing with a simple but violent personality clash. Eventually, however, she was able to get at the underlying issue, which turned out to be an entrenched, intense bigotry on the part of one employee towards another. Repeated attempts to prevail upon those involved to behave professionally and ethically were completely ineffectual. In fact, the manager's initial attempts to resolve the problem merely drove it underground. The manager in this case had to refer the matter to a higher authority (the Human Rights Commission). By using the appropriate resources, the manager was able to handle a situation that was negatively affecting the practice environment. This incident acted was of concern to the nurse manager involved, particularly considering the multicultural context of Canadian culture and therefore of the Canadian nursing practice environment. The nurse manager in this case became alert to such issues and subsequently made an effort to detect and avoid other potential clashes. She tried to educate her employees so they could learn more about each other's cultural differences and uniqueness. In addition, however, she also imposed her strict standards of tolerance and encouraged respect among her staff members, noting that "there's still a basis of respect of each other as a human being".

Other nurse managers made note of their efforts to promote tolerance and understanding, sometimes through social channels such as celebrating different cultures during their particular holidays; sometimes encouraging social get-togethers such as potluck dinners so that staff could be introduced to each other's culture differences in a positive and
supportive way. These efforts outside the workplace environment promoted a more positive practice environment as well.

Boundaries: Knowing when to Intervene and when to Quit

The above example illustrates two important leadership attributes: the ability to deal with multi-cultural environments with tact and resolution, and in addition, the ability to recognize when a problem is simply too large, entrenched, or volatile for the manager to handle. One manager related her thoughts on another aspect of “knowing when to quit”. She described her realization that she sometimes needed to abandon her attempts to fix her problem employees and to instead spend more time developing the potential of her “stars”. This participant recognized that at a certain point, a manager is simply wasting her energy on nurses who will not take responsibility for themselves and their problems. Insight, maturity, experience, and a realistic attitude all converged in this manager’s understanding of the capabilities and potential of her staff, as well as their limits and deficiencies. This process, which Kerfoot (2001) calls “weeding”, is one in which leaders address those problems early to prevent the damage of the other “flowers” in the work environment that tries to flourish and bloom, or these treasures will leave or be immobilized (p. 339).

This management attribute – the ability and willingness to define, maintain, and act in accordance with one’s boundaries – is an important one. This study’s participants all had a clear sense of their own boundaries, capacities, and limitations: they knew when not to get overly involved in fruitless efforts to fix a hopeless cause, when a situation was a waste of time, and when to quit and move on.

A “Moral Compass”: Dealing with Right and Wrong:

Perra (2000) suggests that a manager should have “a moral compass”; by incorporating a sense of right and the wrong into their work environment, managers can transform the organizational vision into reality (p.60). One participant’s sense of right and wrong led her to
reject the old hierarchical model of a manager at the apex of the triangle, supported by employees below. Instead, she described her participative leadership style as managing from the bottom of a triangle. In general, this study’s participants espoused positive values that seemed to permeate all aspects of their management style.

**Honest Presentation of Self**

Finally, one of the points that participants reiterated was that they had to be honest with their staff in terms of specific information they needed to impart, but also had to be honest about who they were as people as well as managers. The result, each felt, was that by being true to oneself and integrating management styles honestly with personality and values, she was able to present not as a person playing a “trusted manager” role, but as a truly trustworthy individual who is also a manager. This, they all felt, made an important contribution to the quality of the practice environment as it set the standard for appropriate and honest behaviour for all staff members.

**Role of Nurse Managers**

Participants’ narratives revealed thematic links between the nurse manager’s role and the strategies, issues, contexts, styles and attributes related to maintaining a quality practice environment. These aspects of the nurse manager’s role include leadership, empowerment, support, mediation, advocacy, coaching, and mentorship, all of which correlate with sub-themes from the previous chapter.

**Defining the Roles**

Participants explained that in part because of their workloads, they had to define for their staff exactly what constituted the manager’s role. They specified what they could and could not do given time and budget constraints. Therefore, employees would know when and how their manager could support them, and when she would have her hands tied. The role of the manager as a leader, though, is not just to let employees know where things stand: she must
also nurture opportunities for employees’ growth and development. Thus, these managers promoted autonomy and were able to turn a challenging circumstance into an opportunity. Instead of relying totally on the manager (and risking shock and disappointment when things did not go well), employees learned to develop their self-reliance, knowing that they still had their manager as a back-up when necessary.

The Participative Manager

Nurse managers must also know their staff personally, and be able to identify both their strengths and weak points. They must also bring these to the attention of employees when they affect practice or the work setting, and negotiate ways of capitalizing on abilities and improving areas of weakness. Using these techniques, participants showed their staff that they were concerned about their personal and professional well-being and development. Adopting the role of the participative or collaborative manager, they avoided some of the pitfalls of hierarchal relations by approaching staff as a colleague whose role it was to help them grow professionally within their own roles.

Empowerment

Another aspect of the role of the nurse manager is empowerment. One participant described a dilemma she encountered when her portfolio was expanded to include some free-standing clinics that had previously enjoyed a considerable amount of autonomy. She felt she had to walk a fine line between not doing enough for them (so they would think she was a “typical” manager who didn’t do her job) or micro-managing them (so they would think she had no respect for their ability to manage themselves). In her straightforward way, she let them know that her management style was to empower them to manage what they could, but to also arrive at clearly defined the roles for each of the parties so that they would not ‘step on one another’s toes’. Mutual respect and a clear appreciation of professional boundaries was important, participants felt, to a high-quality practice environment.
Coaching and Mentoring

In their efforts to prevent problems and personal issues from affecting the practice environment, participants in this study felt a responsibility to coach and mentor their staff, and extended this generosity to students who came to the nursing units. These activities are a vital contribution to a quality practice environment in these times of rapid change in health care. Coaching and mentoring new and even senior experienced staff is rewarding and productive; being the recipient of such attentions fulfills the desire of all human beings to be heard, understood, and guided without being judged (Eggers & Clark, 2001). It also provides not only support but also a push to encourage improvements in skills and attitude. Donner, Wheeler, and Waddell (1997), in a study that explored staff nurses' perceptions about the role of the nurse managers in career development and the strategies they used, define coaching as the “ongoing, face-to-face process by which the managers and employees collaborate to achieve increased job knowledge, improved skills in carrying out job responsibilities, a strong and more positive working relationship and opportunities for personal as well as professional growth for employees” (p.15). These researchers indicate also that coaching is a combination of teaching, training and counseling, and it involves helping staff members take control of their careers and plan their futures in nursing.

Participants in this study noted that the human touch is very important to develop and strengthen a trust relationship with their employees and that coaching and mentoring is an important way to accomplish this. As Donner and colleagues (1997) suggest, the effectiveness of career coaching may be related to the quality of the relationship between the manager and the nurse, as this relationship is important to reduce the staff nurses stress level and enable them to focus on their strengths, goals, and abilities. Thus, trusted nurse managers, such as participants in this study appear to be, are important elements in providing the coaching and mentoring guidance staff nurses need.
**Practice Issues**

Thematic issues related to the practice environment included identifying and resolving problems, communication, mediating between staff and administration, change fatigue, and the stress of work overload; these issues are interconnected with many of the other themes and sub-themes presented in the results.

**Identifying and Resolving “Hassles”**

When practice and personal issues — “hassles” as Beaudoin and Edgar (2003) call them — remain unresolved, they can have a negative effect on nurses’ personal and professional lives, and the quality of their work environment. This leads to frustration and stress that in turn affect job satisfaction and the quality of care the affected nurses provide. The ability of the nurse managers in this study to identify and recognize the presence of these factors was a very important contributor to their success. Unless managers address problems as they arise, they will affect quality care provision and the quality of practice and work life, leading to nurse dissatisfaction, frustration, burnout and increased turnover and absenteeism. These personal and practice issues emerged as sub-themes in the results and were the subject of a number of participants’ anecdotes. Such issues arise due to hospital downsizing and financial constraints, cuts in some hospital services, nursing shortages, increase in the LPN to RN ratios, increases in workloads and demands, and increased patient acuity and aging.

Beaudoin and Edgar (2003), in a departure from the usual consensus in the literature about how practice issues are best handled, contend that the organizational administration should eliminate or deal with these “hassles”, exert greater effort in addressing these factors, provide resources, enhance communication with their staff, identify clear job and role identification guidelines, and provide a supportive and encouraging environment. In fact, as the
literature confirms nurse managers were responsible in large part for discovering and dealing with personal and practice issues.

Managers and leaders in this study, as is typical of most of their colleagues, had taken on their prescribed task of identifying the presence of professional and practice deficiencies in their nurses. To have an impaired nurse among one's staff means either tolerating her effect on the practice environment (finding ways to compensate for the nurse’s declining productivity and the other staff nurses’ frustrations) or mitigating the problem. Unfortunately, unless and until the problem is resolved satisfactorily, it can be difficult to ensure safety and maintain quality patient care. Brennan (1991) notes 5%-6% of nurses are or will become alcohol dependent, and one in seven nurses is at risk of becoming chemically dependant. Moreover, the tendency of nurses to become drug dependant is 50% greater than in the general population (Brennan). The timely and appropriate interventions of nurse managers in such cases are extremely important, as these interventions are needed to ensure patient safety and quality care as well as staff satisfaction and performance.

**Coping with Change Fatigue**

One of the most pressing of current practice issues is change fatigue (Zboril-Benson, 2002). Study participants described various ways in which they could be instrumental in alleviating some of the stresses of ongoing health care reforms and changes. Managers recognized, evaluated, and addressed a range of practice issues, despite their overwhelmingly heavy workloads. One such example offered was the introduction of new programs such as LPNs to some of the health programs. This meant frustration and work overload for the RNs because neither they nor the LPNs knew the scope of practice for LPNs, and because the new LPNs had critical thinking and problem-solving skills that were inadequate for the tasks they needed to perform. It fell to the nurse manager to bring everyone up to speed in this case. Staffing changes and other economic decisions not only affect workload and morale on the
front lines; such decisions that are made at an institutional level without consultation with nurse managers (who in turn would consult with their staff) typically end up having unanticipated, deleterious effects on the practice environment, and perhaps also on patient care. These decisions affect nurse managers directly, usually by increasing the workload or decreasing resources, but also indirectly, because most of the responsibility for mitigating the effects on the practice environment will fall to the nursing manager.

The literature contains a great deal of research into the phenomenon of change fatigue and the detrimental effects of cost-cutting reforms are well documented. The results of this study suggest that some nurse managers’ communication strategies were effective in combating change fatigue and promoting resilience. For example, one manager explained that although much of what was happening at the institutional level was out of her control, but she made certain her staff knew that she always gave them all the information she had, so they were better able to cope. For example, when the manager returned from a meeting with bad news about pending effects of more cost-saving measures, she let them know immediately, even though the decision was not yet official. Above all, she felt they had a right to be thoroughly prepared. Such interactions with her staff were trust-building, based on her reliability in providing them with information. It is also interesting to note, however, that on another level her strategies meant she was able to build up a considerable capacity for resilience in her staff, even in the face of constant, and often unpleasant, change. In a larger sense, then, this manager’s anecdote served to illustrate a manager’s role in helping her staff with personal growth, so that their resilience could help to mitigate the negative effects of the ongoing changes.

The nurse manager herself has also needed to be resilient in the face of constant change. Dixon (1999) suggests the necessity of balance in managers’ lives, and participants found that this was something to strive for but was difficult to achieve. Most found it
challenging to manage their extremely heavy workloads without impinging on their personal lives, and in the end, probably both suffered. One of the most successful strategies for trying to balance work obligations with personal life was to be found in the managers’ self-advocacy. That is, when the workload became entirely too much, the managers finally had to go to their own supervisors, and say, “enough”.

Staff vs. Management: Easing Hostility

Participants noted that one of the barriers to achieving a quality practice environment, particularly in the initial stages of their management tenures, was staff’s sometimes adversarial or antagonistic attitude towards management. They encountered staff members who felt that as part of the organization’s management team, the manager might betray staff members or support the organization’s interest rather than that of nurses. One example that illustrated this was staff members reporting directly to the manager’s superior, over her head. With patience, the manager was able to allay her nurses’ feeling of mistrust; she insisted that they first come to her to give her the opportunity to address their concerns. The manager showed her insightfulness by recognizing that the passive-aggressive actions of her staff were not personal, but rather resulted from her staff’s sense of grievance based in historical hierarchies rather than on her own, more participative, management practices. Other managers also demonstrated similar insights into hostile responses by staff members. One such response was typically to bring in a union representative every time the manager attempted to address an issue with one of her nurses. The manager’s strategy was to defuse the antagonistic atmosphere using her management and communication skills, and eventually turned the union representative into an ally. Her appropriate and positive interactions with the union resulted in a transformed relationship. By modeling collaboration rather than confrontation as a cultural style within the unit, and through positive interactions, this manager ensured that the union was a useful
resource for her staff rather than a divisive tool for disgruntled and hostile employees, thereby enhancing the practice environment.

Managers also need to know when to "turn the other cheek"; that is, it was important for them to avoid taking some of their staff's behaviour personally. One manager described the initial, difficult stages of her manager's job: her employees talked constantly behind her back and went over her head to complain. This manager apparently had enough experience or wisdom (or both) to understand that she would have to weather her staff's initially inappropriate responses to her arrival as part of the process of building trust. To have reacted aggressively would have fed their suspicions. Instead, she let them know that they were dealing with a person, and that she had feelings: she told them in an honest way, without hostility, how their malicious talk was hurtful to her. Eventually she reported that her staff stopped whispering behind her back and grew to appreciate her as a manager and a person. Another interesting subtext is contained in her remark that they had "...never done that for a manager before". We can infer from this that the manager was better able than her predecessors, although in the same job, and presumably with qualifications the institution had also judged satisfactory, to develop a rapport with her staff. Although this study did not include as participants any managers who felt that a quality practice environment was beyond their capacity to create or maintain, this manager's comment shows that it is nevertheless possible to accumulate some insights into such scenarios, and to understand how nurse managers fail, as well as how they succeed. We can infer here that the former manager failed to establish a trusting relationship and a quality practice environment, whereas the new manager created an improved practice environment, due at least in part to her successful communication and trust-building techniques.

When staff members behaved unethically or unprofessionally toward their managers, managers were able to perceive that the criticism or slight may result from displaced anger.
They were able to recognize that although their staff members may have acted improperly, the fact that the health care system was in a constant state of change and the threat of layoffs was always looming meant their staff were acting out their feelings of insecurity and aggression. Snow (2001) suggests that managers and leaders need special skills to be able to manage in turbulent times such as these. According to Snow, the most important element of leadership is emotional intelligence, which she defines as “the capacity for recognizing our own feelings and those of others, for motivating ourselves, for managing emotions well in ourselves and in our relationships” (p.441). She suggests that organizations need to look for leaders with these abilities. By being emotionally intelligent, Snow contends, nurse leaders and managers will be able to gain and strengthen trust, improve performance and team work, increase motivation and enhance innovation in the nursing group.

So Many Units, So Little Time

Managers said a major practice issue was the difficulty they had in finding the time to supervise staff in person, and to lend their support and skills. They found it a challenge to be visible as much as they wanted or even to be present in the unit to the extent they thought necessary. Some had difficulty finding time to meet with their staff members regularly enough, and expressed regret that their workload interfered with their leadership philosophy and values.

One of the participating managers could have spoken for all of them when she noted, “our span of control is too large...it’s very hard to be present in ten places at once”. Although her statement may sound like hyperbole, in fact she meant her statement literally: this manager had responsibility for ten groups of people in ten different locations. As this participant’s legitimate complaint so clearly reminds us, health care reforms have had severe, adverse effects on nurse managers and on the practice environment. Not only have managers’ portfolios increased to overwhelming proportions, but expectations for managers have risen sharply at the same time. The workload for both nurse managers and nurses has increased exponentially, but
managers are also responsible for mitigating the effects of these reforms on their large and
ever-increasing staff. It takes an extraordinary, and extraordinarily dedicated, individual to rise
to these challenges in the current practice contexts.

Summary

Trust was the main and overriding theme resulting from this study. Trust was
interrelated with and could be found as component of all other themes and sub themes. It is the
foundation of any relationship that could exist in any practice environment and a core element
in the leadership style and philosophy of the nurse manager. By virtue of their leadership
attributes, nurse managers in this study were able to identify personal and practice issues that
had an effect on the their practice environment, and by addressing these issues using
appropriate communication styles and problem management techniques, they were able to
mitigate somewhat a few of the profound effects of health care reform and cost-cutting at the
unit level. Their stories reveal that, despite their efforts, they are unable to consistently create
or maintain the “quality practice environment” that the literature describes and that their
organizational values embrace only theoretically. Although this quality practice environment
might not exist in the overall organization, the managers persisted in trying to create it in their
environment. With patient safety as a core issue, nurse managers tried their best to provide the
best management they could and worked hard to advocate for their staff in order to achieve
quality care and positive outcomes. However, patient outcomes are only one component of the
practice environment. Managers and their nurses continue to suffer overload, burnout, stress,
change fatigue, job stress-related illness, and dissatisfaction. Despite the exemplary effort of
these nurse managers, these aspects of practice environment remain problematic, and detract
from a quality workplace for nurses.
CHAPTER SIX: CONCLUSIONS AND RECOMMENDATIONS

Conclusions

In the process of collecting analyzing and presenting the results and findings of this study, I have gone through a series of steps in thinking and rethinking the issues, looking for patterns in the data, and endeavoring to analyze and present the study findings in such a way as to represent the perceptions and experiences of the study sample without imposing my personal beliefs and biases.

The Study in Brief

The quality practice environment, to me, is an interesting and important issue, particularly considering the changes the Canadian health care system is going through. With the challenges of budget cuts, hospital closures and merging, increased work loads, and increased patient age and acuity, I felt that an exploration of this topic was timely and would make a contribution to our knowledge. In particular, I became interested in learning more about the experience of nurse managers because the gap in the literature with respect to the perspective of nurse managers co-exists with a consensus that this group bears a significant responsibility for the practice environment. I took the road of exploring this topic through qualitative research and interpretive descriptive analysis, as this method lends itself well to analyses of human phenomena of interest to nursing researchers and professionals. In the process of conducting the research, I interviewed and listened to nurse managers in one of the acute care settings in the greater Vancouver area and set about trying to better understand and explore their attempts to create and maintain a quality practice environment for their staff nurses. The discussions these managers supplied revealed interesting and important issues and some unexpected insights. A review of the literature and a comparison of the findings with this body of research produced further issues of interest. An extremely important issue for nurse managers, and the issue that the participants raised the most during their interviews, was that of
trust. The first theme thus is establishing a trust relationship, with sub-themes that relate to interactions between managers and staff that establish and reinforce mutual trust, including open and honest communication, role identification and self knowledge, strategies for dealing with personal issues, and fairness in dealing with employees. Managers sought to promote trust, which allows interactions to occur in a healthy and positive practice environment. Another important theme was the leadership philosophies and styles of the nurse managers who participated in this study. Despite their diversity with respect to personalities, abilities, experience and interests, they nevertheless all shared an interest in improving and enhancing the quality of patient care and the practice setting for their nurses and demonstrated superlative leadership skills. Although there were differences in leadership styles, participative style of leadership seemed to be a style most favoured; the participants believed in fostering a supportive and respectful relationship with staff, acted as coaches, mentors, and advocates for their nurses. The third theme related to organizational support, the availability of which depended in part on the ability of the nurse manager to advocate for her staff, and on her ability to communicate effectively. How staff perceived the level of organizational support also depended on the manager. Organizational resources and support, availability of resources, and availability of educational opportunities are sub-themes that explain the importance of organizational support in creating and maintaining a quality practice environment.

In particular, it has been interesting to discover that, despite all their efforts, the nurse managers who participated in this study contend that quality practice environments do not exist in this current time of challenges and changes. Their perception suggests that it may even be inappropriate to use this term, or refer to this concept as a reality at present, as it seems the quality of the practice environment is extremely compromised. Moreover, it is compromised by factors that are, to a great extent, not within the control or area of responsibility of nurse managers.
The results of this study do suggest that the participating managers exerted substantial efforts to create a quality environment for their staff, at least in their practice areas. The processes they have had to go through have not been easy, but they brought tremendous skill, enthusiasm, and dedication to their task. Their goal was, as Max Depree (1989, p.126, cited in Whiley, 2001) proposes, is to “create an environment that encourages an open community, welcomes all, is kind to the user, changes with grace...enables this community to reach continually toward its potential...is open to surprise, is comfortable with conflict, and has flexibility” (p.365). Depree’s description could, with slight adjustments apply admirably to the nurse managers in this study; it unfortunately describes a goal that, at least to the nurse managers in this study, remains elusive. In retrospect, it is apparent that the interpretive products of this descriptive study “depart slightly from the research question” (Thorne et al. 2004, p. 15). It is now also apparent that the reasons for this have arisen out of the original impetus for the study; that is, the overemphasis of the literature on the perspectives of other samples other than nurse managers has resulted in a significant consensus that nurse managers are the crucial protagonists in the ongoing story of the quality practice environment. Thus, I framed the research question in keeping with this consensus, and the assumptions it embodies, or seems to embody: that quality practice environments exist, and that nurse managers can create and maintain them. The picture appears to be much more complex than this, and these assumptions would perhaps be better avoided in subsequent research if we are to improve our understanding of the practice environment phenomenon and of nurse manager’s perceptions of it.

The Reality of Practice vs. the Concept of the Quality Practice Environment

Nurse manager portfolios are much too large. This is a believable claim, but vague and it may be helpful to ground it in actual numbers. Canadian statistics gathered in the last two census polls indicated that in 1991 there were 19,155 head nurse or supervisors who were
managing 230,210 nurses, and in 2001 the number of head nurses had dropped by almost the half to 9,905 but the managers were still supervising almost the same number of nurses (232,020) (Statistics Canada 1991; 2001). These numbers make it clear that nurse managers are now doing twice as much supervising, at least, as they were a little over a decade ago. Managers in 1991 had already taken on substantially increased portfolios as health care reform affected the nursing work place. Now, the stress of coping with the doubled workload has increased at least in proportion with the burden on the shoulders of those managers. These statistics along with the testimony of the participating nurse managers, who have told some of their stories in this study, are indicators that the reality of a quality practice environment for nurses in the present health care system is probably doubtful, at best. As one of the participant’s comments testifies, the concept of a quality practice environment is embedded in the vision and values of the organization, but as an abstraction: it has not been enacted. The reality is an overstressed and overburdened nursing staff supervised by overstressed and overburdened managers who try to believe in the vision and values of their organizations and who struggle to make some semblance of a quality work environment possible for their staff members while ensuring quality patient care is maintained.

The fact that nurse managers have portfolios so unmanageably large is a pivotal issue, since the consensus in the literature is that the presence of the nurse manager is important to the maintenance of a quality practice environment. However, nurse managers report that they are less and less able to be present and visible on the unit when they want to be, because of the size of their portfolios and workloads. This is one of the examples of the un-enacted institutional vision: the nurse manager must be present to create a quality practice environment, but her portfolio (the size and complexity of which is mandated by the institution) is so large that the task is virtually impossible.
Insufficient time to do their jobs is a major issue but not the only one: the external pressure generated by institutional and organizational decisions is immense and no nurse manager can shield her staff from the effects of these ongoing reforms, nor the persistent effects of past reforms. External pressures such as political, social, and demographic, also affect the health care environment.

The Exodus of Nurse Managers

The rate at which nurses, including nurse managers and even directors, are leaving the profession speaks volumes about the stresses health care reform has precipitated. This exodus seems to allude also to the possibility that the departing nurse managers are giving up on the task that the literature prescribes for them: “creating and maintaining a quality practice environment”. In fact, despite demonstrating all of the prescribed qualities and tremendous dedication, the nurse managers in this study admitted that, notwithstanding their efforts – and these efforts seem prodigious – the current context in which nursing takes place precludes the possibility that they can create, let alone maintain, a practice environment that they could truthfully deem “quality”.

The Potentially Insidious Nature of Prescriptions for Leadership

Particularly in the business-derived management literature, and in nursing studies that rely on business management theories, there are ongoing calls for inspirational leadership as a solution for organizational problems. Such prescriptions are, on the surface, plausible-sounding, and certainly have convinced many. However, the findings of this study suggest that these exhortations to managers to inspire their staff are in some ways quite problematic, given the realities of nurse managers’ overwhelming workloads. These prescriptions for leadership may lead to the investment in the role of nurse manager with a disproportionate amount of responsibility for staff morale, satisfaction, productivity, and commitment. The potential pitfalls are that an overemphasis on inspirational leadership can be used as an organizational or
institutional strategy for giving nurse managers an inordinate amount of responsibility for creating and maintaining a quality practice. Once nurse managers are invested with this responsibility, they are then positioned also for blame when the goal is not achieved. This is arguably the case now. The research has focused on the role of nurse managers in creating a quality practice environment; unanimously the researchers agree that this group has an extremely important role, and the underlying assumption — that organizational deficiencies can be made up by the extraordinary abilities of a few leaders — gets lost in the shuffle. The organizational deficiencies are important, and any expectation that extremely inspiring nurse managers can or should compensate for these, is misplaced. Inspired leaders, it is true, can induce people to rise to extraordinary challenges. However, in response to this inspirational leadership argument, it might be appropriate to ask why nurses should be working under such arduous conditions that they require an inspirational manager.

Towards the Next Steps

These conclusions, first, that truly quality practice environments may not really be possible given the contexts in which nurses practice today, and second, that the efforts of nurse managers may not be sufficient to create them, were not among the expected outcomes of this research. Indeed, in hindsight it is clear that the research question itself embodies the twin assumptions that quality practice environments exist, and that they do so largely through the efforts of nurse managers to create and maintain them. These findings, somewhat unexpected though they are, point to some important implications for nursing research and nursing management practice, and lead to recommendations for both nursing research and practice.

Implications and Recommendations

A number of the following implications and recommendations arise out of the fact the participants felt that a quality practice environment was illusory, others relate to the nature of
the role of nurse managers, and still others focus on particular strategies that nurse managers employ in their attempts to create a quality practice environment, or to improve the poor quality of the work environment.

Addressing the Absence of the Nurse Manager's Voice from the Literature

One of the major implications of this study's findings relates to the fact that the role of nurse manager has expanded to nearly unmanageable proportions, as portfolios have gotten larger while resources have dwindled. The extant literature, based largely on research that examines the perceptions of staff nurses, contains compilations of the existing and potential ways that a nurse manager could or should fulfill her role; the list is already long, and growing. Participants have helped to shed some light on the myriad aspects of this role from the perspective of managers themselves, and their insights can help to guide other managers and leaders to better understand their own role in creating a quality practice environment, and point to future directions for research. It is clear from their narratives and interpretations — despite their modesty in describing their own considerable gifts and accomplishments — that only very experienced, mature, wise, gifted, and highly motivated individuals are likely to take on the role, let alone succeed in it. Even success, as these managers have had to learn to frame it, consists not of a quality practice environment, but of the best one can do in the challenging context of today's health care system. Further exploration of the perspective of nurse managers can help us to better understand the evolution of the nurse manager role. It is perhaps not surprising that research, having neglected the voice of the nurse manager, has pointed to her as the party who bears responsibility for solving one of the pressing issues in health care today. After all, if one asks employees who in the organization could improve their lot, they will no doubt point to their managers. If one asks senior administrators and directors who can improve staff productivity and patient outcomes, they will in all likelihood point to their managers. Nurse managers have been an easy target for the burden of responsibility
because they are in the middle, and because their voices are almost silent in the literature. If researchers were to ask nurse managers the same questions, they may not join the nearly unanimous chorus and say, "Only we can!" It remains for further research to determine what their answer might be, but indications are that this group would favor a pro-active, organization-wide, collaborative response. Whatever the result of further research into this important question, the greater our understanding, the easier it will be to deploy the available resources to best advantage so the support and resources will be available to create and maintain quality practice environments. In addition to this recommendation for further research into this area from the perspective of nurse managers, there are some practical measures that could be taken that would support practice. Participants alluded to a number of issues that I present here in the form of recommendations to support practice: integrate the efforts of the education departments with those of the nurse managers; provide expanded access to career development, institutional and external support (i.e. from directors and human resources, or external expertise); foster strong and positive strategic alliances with union representatives; and develop more efficient and informed means to deploy existing resources.

Investigating the Mediatory Role of the Nurse Manager

Another important implication suggested by the study's findings arises in part from participants' insights into the unique context of the nurse manager's role. As participants pointed out, one of the crucial aspects of the managing role is mediatory, standing as they do between front-line staff and senior organizational administrators. One manager commented, "...the first thing you have to do is make sure that these employees that you hire - their education or preparation and their ... nursing philosophy, match [es] with your philosophy [and] the philosophy of the unit [and the] mission of the hospital". This manager continued, "if you take a director's position, you really do not have front-line contact and [...] my belief is that [the] front line represents the organization" and also noted, "front-line staff really make the
difference because they're the ones dealing with the public... and if front-line staff provide quality care, patients will receive quality care”. As this participant's remarks attest, the nurse manager is not just the bridge for communications between organizational directors and the front-line staff with which they have little or no contact. Managers are also responsible for trying to ensure that there is real and workable consistency between the nursing philosophy of bedside nurses and the institutional mission. These comments allude to a substantial responsibility that nurse managers seemingly must undertake, and as such the role of nurse manager as a mediator and facilitator of communication between bedside nurses and senior management is an area that deserves further investigation. The literature strongly supports the notion that the nurse manager has a great responsibility for creating and maintaining quality practice environments; very little research explores the specific challenges and opportunities inherent in this particular aspect of the nurse manager's role: to bridge the substantial gulf between the “front lines” and the organizational directorship. More research that examines the specific nature of this role is urgently needed. In particular, research that focuses on, or at a minimum includes, the perspective of nurse managers will help nursing and health care researchers to better understand the complexities and burdens of nurse managers' interactions with directors and staff.

Exploring the Individualizing of Managerial Style

The determination to integrate their personal attributes with their management and leadership styles was an outstanding feature of each participant's characteristic style of managing. Although it is not possible to generalize these findings to all nurse managers, the fact that all the study participants exhibited this trait suggests an interesting avenue of investigation. Further examination of the phenomenon of this individualizing of the nurse manager's style is perhaps warranted, and may yield interesting results, particularly since the literature has a strong tendency to generalize. A related issue is the allusion managers made to...
the need for flexibility and resilience in their approaches to management. More investigation of these attributes and their application by nurse managers in the context of the quality practice environment could yield interesting results.

The Question of Cultural Sensitivity

Nurse managers articulated their beliefs that managers and staff need to understand and respect cultural differences, beliefs and values as they influence nursing practice and communication. As Hustig (1995) suggests, one should address cultural issues by beginning with oneself through "identifying personal beliefs and behaviours that are linked to the underlying cultural core" (p.26). It is important to move away from cultural ethnocentricty which is "the belief that one's culture is superior in every way to all others" (Haviland, 1989 as cited in Hustig, p.26). Some participants mentioned social activities that contributed to team-building, but made no mention of possible cultural aspects of these events, although they were always aware of culture differences. They tried to educate their employees about each other and encourage the need to respect each other. English as a second language may act as a barrier to communication between nurses or with patients during care, and the manager must oversee such interactions and be aware of the sensitivity of her role in such cases. Participative managers can also alter the practice environment by decreasing their staff's perceptions of powerlessness in the face of managerial control, and by responding to cultural and ethnic needs of staff. Managers can ensure that all staff members of all ethnic groups are empowered to participate in decision making that affects the practice environment. Support for cultural diversity is important and essential in providing quality care to the increasingly culturally diverse patient population (Staten et al, 2003). Nurse managers are responsible for overseeing intercultural nurse-patient and nurse-nurse interactions to ensure patient safety and a quality practice environment, but if the managers in this study are typical, they may do so without specific training or skills in this regard.
The nurse managers in this study did not discuss whether they had dealt with personal biases or prejudices of their own, but seemed to have an adequately developed degree of cultural sensitivity. In at least one instance, however, a manager was not familiar with the particular interaction between cultures that had led to severe interpersonal conflict when transplanted to the Canadian context. This suggests that without specific information about the potential cultural conflicts involved in having staff from diverse cultures working together, it can be difficult for managers to grapple with the underlying issues, in addition to the surface manifestation, of the issues that result in cultural conflict. Managers must be able to identify such issues and understand them before they can control them or work around them. First, we need to know more about the ways in which nurse managers perceive their multi-cultural environments, and about the particular strategies they deploy in handling cultural conflicts involving staff, patients, or both. Given the strongly multicultural nature of the Canadian practice environment, it could be helpful for nurse managers to have access to information about intercultural interactions and potential conflicts, and access also to cultural sensitivity training for themselves and their staff.

Innovations in Communication

The literature investigates at length the various styles of communications that are recommended for nurse managers (O'Connor, 2001; Porter-O'Grady, 2003a). However, although the use of technology in communications is a growing trend, the nursing literature did not reveal any discussions or analyses of managers' use of specific communication technologies such as established and emerging electronic media. Research does not necessarily keep pace with the creative adaptations we may make or the uses to which we put technological developments. This may be an interesting avenue for investigation in nursing management studies, with the challenge of managing staff in the traditional, face-to-face way becoming more difficult for nurse managers to accomplish. These new media, such as email,
electronic bulletin boards, newsgroups, and chatrooms, are certainly to be recommended to
nurse managers hard-pressed for time but still trying to maintain contact with staff, and perhaps
as their experience develops research will follow suit and explore the subject.

Research into communication styles and popular and specialty publications that
describe new styles of or strategies for communication are, it seems, a growth industry.
Occasionally, some of these offerings have something of potential interest to nursing, and some
focus on applications of theories to nursing. One such example is a relatively recent publication
that explores the notion of communication as conversation (O'Connor). I include a synopsis of
O'Connor's theory as a set of recommendations to nurse managers that may be a useful way of
framing their communications. O'Connor cites Whyte as advising and teaching nurse leaders
that "the conversation is not about the work, it is the work itself" (p.405). O'Connor proposes
four levels of communications in the form of "conversations": conversations about the future,
with the organization, with colleagues, and with the self. These four levels of communication, I
believe, correlate with the ways the participants in this study communicated. These
recommendations come with the proviso, however, that such a framework for communications
cannot be made to constitute a further burden on nurse managers. Rather, these suggestions
would be best implemented if and when nurse managers have manageable portfolios and
therefore have time and energy available.

First, conversations about the future, according to O'Connor, entail a vision to look at
the future and trying to get a glimpse of the big picture. With the increasing demand on nursing
and the shortage of nurses, nurse leaders and managers are in a position to mentor and coach
the new generation of nurses. They must help and set goals for the future treasure by
supporting more education, and advocating for increased access to nursing program,
scholarships, and educational opportunities. It is in the hands of nurse leaders and managers to
negotiate these opportunities with the organization, because nurse leaders have contact with
the staff members and know the deficiencies, the demands, and the needs of their staff and patients. Second, conversation with the organization focuses on the relationship between the employer and the members of the organization. The nursing managers in this study evaluated the mission, vision, and values of their organization to ensure that their own vision and their employees' values matched those of the organization; this process is one that O'Connor would support. She claims that with current fiscal constraints in the health care system, personal core values might change and could be compromised because of the environment in which one works; the participants in this study argue convincingly that this is already the case. There may be potential in this conversation for engaging the organization in the process of converting conceptual and theoretical models (as per the quality practice environment) into reality.

The third level of conversation is with colleagues or the work group. O'Connor suggests that this kind of conversation enhances productivity, creativity, and enthusiasm in the workplace. Certainly, this is one of the ways in which participating nurse managers in this study tried to communicate with their staff in an effort to foster participation and cooperation, both of which are good for staff satisfaction and retention. The last kind of conversation is the conversation with self. Whyte (cited in O'Connor 2001) claims that this is the basis for all other conversations. O'Connor claims that if one is not honest in one's communications with oneself, it will not be possible to create an environment of openness and honesty in the practice environment. This too, correlates with the nurse managers who demonstrated that self-knowledge was the basis for many of their positive personal attributes.

Towards an Integration of Institutional Vision and Front-Line Realities

The participating managers described their concerted efforts to be fair to their staff, as part of trying to build trust. This is an example of one of the many ways in which the managers tried to create a quality practice environment. Their efforts are fully in keeping with the stated and implicit vision and mission of the organization. Yet, the organizations constant decisions to
cut costs and restructure the hospital create a series of direct and indirect effects that manifest at the level of staff nurses as profoundly unfair. Thus, the organization undermines its own vision and mission through its actions. The results of this study illustrate a number of similar circumstances in which the organization takes actions that further one of its needs while essentially sabotaging some of its other aims. The implications of these internal conflicts are that as long as these conflicts between vision and reality remain unexamined and uncorrected, nurse managers will be unlikely to be able to accomplish or successfully contribute to the expressed aims of the organization. My specific recommendation in this regard is that research that focuses on these internal contradictions be a priority, lest the efforts of nurse managers continue to succumb to this perhaps inadvertent but harmful paradox.

Another organizational conflict is embodied in the problematic “inspirational leadership” question, which has important implications for nursing research. As discussed above, as long as research supports the notion that nurse managers are of extraordinary importance in maintaining a quality practice environment, the door is open to abuse of nurse managers in the form of exploitation of their commitment to their vocation. One manager illustrated this in a story in which she exposed as a subtle form of manipulation a “code of silence” that amounts to an unwritten rule that managers do not complain, no matter how enormous the workload becomes. This insight suggests that explorations are urgently needed into such institutional cultures that rely on manipulation and exploitation to compensate for organizational deficiencies. The recommendation with respect to this matter is that nursing researchers take a closer look at some of the implications of prescriptions for leadership, and at institutional cultures that rely on guilt and shame to ensure overwork.

Addressing the Time Crunch

As the results of this study suggest, despite the effort nurse managers exert in their efforts to create a quality practice environment, the changes and constraints of the health care
system have made time one of the primary concerns of the nurse managers in this study. They indicated they would able to apply and work on implementing change if they had time to think, and assess the implications and effects of proposed changes on their employees. As things now stand, nurse managers do not have time to accomplish many of their “essential” tasks. It is recommended that more nurse managers to be involved in research such as this one to understand more about their efforts in this process, how they must now spend their time, and how they believe their time would be best spent. As organizations move quickly towards more changes, it is recommended that they consult managers to determine their views on the best ways of applying these new changes in ways that allow for the promotion of core institutional values such as the maintenance of quality practice environments. Before they can maintain them, however, they must determine how to create them, and this determination must include extensive consultation with nurse managers so that their role in this process will be feasible within a manageable work load.

**Investigating Another Seldom-heard Voice: Organizational Directors**

Organizational directors are the main decision-makers in hospitals, yet this interesting group, too has been rarely addressed in research, or consulted in qualitative studies. There is a convergence between the tendency in the literature to rely on business management precepts, and the increasing preponderance of senior administrators who come from business backgrounds in fields completely unrelated to health care. An exploration of the role of these individuals in the presence or absence of quality work environments would be interesting and informative. We have a limited understanding of issues such as the extent to which directors advocate for their managers and what effect their roles during change and reconstruction have on the nursing practice environment.
Finally, a passion for nursing and a desire to impart this to their nurses was an important concern for the managers in this study. They felt that this emotional engagement with the work was part of the process of effecting positive changes in the practice environment, and indicated that being able to articulate their passion for nursing was essential if they wished to influence their staff members. Upenieks’s (2003) study suggests that powerful leaders are those who are passionate about nursing and are able to articulate that passion, who exhibit strong values, can share power with their staff by providing opportunities to exercise authority and share control in decisions that affect patient care. Certainly, this is the belief and the hope expressed in much of the literature. However, nurse managers’ efforts are increasingly hard to sustain as the health care system becomes more strained, and organizations impose more and more on that passion and drain that energy. Indeed, nurse leaders and managers may be, because of their central position in the organizational hierarchy, poised to play a critical role in future moves to turn the quality practice environment into a reality; their passion for nursing may be key to the implementation of organization initiatives and changes. However, the familiar tune researchers and organizations have sung for some time – “Nurse Managers will Make it All Right” – may have been making managers dance too strenuously and for too long. Increasingly, their fatigue is beginning to show, and a rising number are leaving the floor altogether. It is time research explored and included the voice of nurse managers, and composed a new tune that includes this important but hitherto neglected voice.
REFERENCES


APPENDIX A: INTERVIEW QUESTIONS

Trigger Questions

1. How would you describe a quality practice environment?

2. What are the strategies that you use in order to maintain the quality of the practice setting?

3. What are the difficulties that you encounter in maintaining a quality practice environment?

4. What are the supports that you have, or would like to have, for maintaining a quality practice environment?

5. What other strategies could you use at the current time to improve the practice environment?
APPENDIX B: INFORMATION LETTER TO THE ADMINISTRATION

University of British Columbia
School of Nursing

Exploring Nurse Managers' Experiences in Maintaining a Quality Practice Environment

To Whom It May Concern:

The purpose of this letter is to inform you about a research study to be conducted in your acute care setting.

I am a student in the MSN program at the University of British Columbia, and I am conducting a study to explore the experience of nurse managers in creating and maintaining a quality practice environment for their employees who are working in the acute care setting. I would like your permission to carry out interviews for the study with members of your organization. I also ask your assistance in referring to me potential, interested participants on your staff.

The proposed title of our research is “The Nurse Manager’s Perspective in Maintaining a Quality Practice Environment”. The purpose of this research study is to explore nurse managers’ or leaders’ experiences as they create and maintain a quality practice environment. We are interested in developing an understanding of the challenges managers experience in this process. The goal of the research is to collect information that will contribute to our understanding of this process, and to present practice-based knowledge that could benefit future nurse managers and leaders in maintaining a quality practice environment.

Participation in this study involves an interview that will last for approximately two hours. The interview will involve a discussion about the nurse managers’/leaders’ experiences in creating and maintaining a practice environment that ensures quality and positive outcomes for both nurses and patients. An information letter that explains the study purpose and significance will be sent to all interested participants prior to the interview. Participants will contact me to discuss a mutually agreeable time and location to conduct the interview. The interview will be audiotaped, and the researcher or a transcriptionist will transcribe the audiotaped interview into a written transcript. Once the audiotape is transcribed, participants will have the opportunity to review the transcript if they so choose. If needed, a follow-up interview can be arranged at the convenience of the participant.

There are no identified risks to this study. Participants will not receive any direct benefits or monetary compensation from participating in this study; however, this study will help to develop a better understanding of the efforts and challenges they experienced when maintaining high quality practicing conditions. Confidentiality and anonymity of all research participants will be maintained by assigning participants an ID number. I will remove all identifying information or names from the transcripts and names will not be recorded in typed transcripts or field notes used in any reports. No data or names that could identify participants will be used upon reporting or publishing results from this study. Information will not be shared with others who might identify participants. I may use this data for future presentations and publishing as needed. Any member of the research team who could access this data will have to sign agreements of confidentiality. The data will be kept with the research team and all research data will be kept in a locked filing cabinet with only the principal investigator having access to this cabinet.
APPENDIX C: INFORMATION LETTER TO PARTICIPANTS

University of British Columbia
School of Nursing

Exploring Nurse Managers Experiences in Maintaining a Quality Practice Environment

To Whom It May Concern:

The purpose of this letter is to inform you, as a potential participant, about a research study to be conducted in your setting.

I am a student in the MSN program at the University of British Columbia, and I am conducting a study to explore the experience of nurse managers in creating and maintaining quality practice environment for their employees who are working in the acute care setting.

The proposed title of our research is “The Nurse Manager’s Perspective in Maintaining a Quality Practice Environment”. The purpose of this research study is to explore nurse managers’ or leaders’ experiences regarding creating and maintaining a quality practice environment and the challenges those managers experience in this process. The goal of the researcher is to collect information that will contribute to our understanding of this process, and to present practice-based knowledge that could benefit future nurse managers and leaders in maintaining quality practice environment.

This study involves an interview that could last for approximately two hours. The interview will involve a discussion about your experiences in creating and maintaining a practice environment that ensures quality and positive outcomes for both nurses and patients. Prior to the interview, we will discuss a mutually agreeable time and location to conduct the interview. The interview will be audiotaped, and the researcher or a transcriptionist will transcribe the audiotaped interview into a written transcript. Once the audiotape is transcribed, you will have the opportunity to review the transcript if you so choose. If needed a follow-up interview might be arranged at your convenience.

There are no identified risks to this study. You have the freedom to choose either to participate or decline from this study without any obligation to the researcher or any jeopardy to your employment. You will not receive any direct benefits or monetary compensation from participating in this study; however, this study will help to develop a better understanding of the efforts and challenges that you experienced when maintaining high quality practicing conditions.

Confidentiality and anonymity of all research participants will be maintained by assigning participants an ID number. I will remove all identifying information or names from the transcripts and names will not be recorded in typed transcripts or field notes used in any reports. No data or names that could identify participants will be used upon reporting or publishing results from this study. Information will not be shared with others who might identify participants. I may use this data for future presentations and publishing as needed. Any member of the research team who could access this data will have to sign agreements of confidentiality. The data will be kept with the research team and all research data will be kept in a locked filing cabinet with only the principal investigator having access to this cabinet.
Potential Benefits

You may not receive any direct benefits from participating in this study. This study will however help to develop a better understanding of the nurse manager/leader role in creating and maintaining a quality practice environment.

Monetary Compensation

You will not be paid for participating in this study.

Confidentiality

All identifying information will be removed from the transcript and kept confidential and your name will not be used in any reports. Confidentiality and anonymity of all research participants will be maintained by assigning participants an ID number. Names of participants will not be recorded in typed transcripts or field notes, only ID numbers will be used. No data or names that could identify participants will be used upon reporting or publishing results from this study. Information will not be shared with others who might identify you. The data that result from this study may be used for future presentations and publishing as needed.

Any member of the research team who will have access to this data will have to sign agreements of confidentiality. The data will be kept with the research team, which consists of the researchers and a certified transcriptionist. Confidential information will not be exchanged via email. The investigator indicates all research data will be kept in a locked filing cabinet with only the investigator having access to this cabinet.

Contact for information about the study

If you have any questions, concerns, or desire further information with respect to this study you may contact any of the principal investigator or associates at the number listed above.

Contact for information about the rights of research subjects:

If you have any concerns about your participation or rights as a research subject, you may contact the Research Subject Information Line in the UBC Office of Research at (604) 822-8598.

Consent

Your participation in this study is entirely voluntary and you may refuse to participate or you may withdraw from this study at any time without any obligation to the researcher or any jeopardy to your employment. You can refuse to answer any questions you are not comfortable answering.

Your signature below indicates that you consent to participate in this study, that you have read the above information and have had an opportunity to ask questions to help you understand
what your participation would involve, and that you received a copy of this consent form for your own records.

Signature of Participant  Date

Printed Name of the Participant signing above.