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RNAO
Registered Nurses' Association of Ontario
L'Association des infirmières et infirmiers autorisés de l'Ontario
NURSING BEST PRACTICE GUIDELINES PROGRAM

Healthy Work Environments Best Practice Guidelines

Developing and Sustaining Nursing Leadership

Ontario

Greetings from Doris Grinspun Executive Director Registered Nurses' Association of Ontario

It is with great pleasure that the Registered Nurses' Association of Ontario (RNAO) releases the "Leadership Best Practice Guideline." This is one of a series of six Best Practice Guidelines (BPGs) on Healthy Work Environments (HWE), developed by the nursing community to date. The aim of these guidelines is to provide the best available evidence to support the creation of healthy and thriving work environments.

Evidence-based HWE BPGs, when applied, will serve to support the excellence in service that nurses are committed to delivering in their day-to-day practice. RNAO is delighted to be able to provide this key resource to you.

We offer our endless gratitude to the many individuals and organizations that are making our vision for HWE BPGs a reality. To the Government of Ontario and Health Canada for recognizing RNAO's ability to lead this program and providing generous funding. To Donna Tucker – project director from 2003 till 2005 – and Irmajean Bajnok – Director, RNAO Centre for Professional Nursing Excellence and the project's current director, for providing wisdom and working intensely to advance the production of these HWE BPGs. To each and all HWE BPG leaders and specifically for this BPG to Heather Laschinger, for providing superb stewardship, commitment and above all exquisite expertise: we could not have done this without you!

The nursing community, committed and passionate about excellence in nursing care and healthy work environments, has provided knowledge and countless hours on the creation, evaluation and revision of each guideline. Partnerships such as this one are destined to produce splendid results and create an evidence-based practice culture. Together, we are building learning communities – all eager to network and share expertise. The resulting synergy will be felt within the BPG movement and in workplaces.

Creating healthy work environments is both an individual and collective responsibility. Successful uptake of these guidelines requires a concerted effort by nurse administrators, staff and advanced practice nurses, nurses in policy, education and research, and health care colleagues from other disciplines across the organization. We ask that you share this guideline with members of the team. There is much we can learn from one another.

Together, we can ensure that nurses and all other health care workers contribute to building healthy work environments. This is central to ensuring quality patient care. Let's make health care providers and the people they serve the real winners of this important effort!

Doris Grinspun, RN, MScN, PhD (c), OOnt.

Executive Director
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The Registered Nurses' Association of Ontario (RNAO), with funding from the Ontario Ministry of Health and Long-Term Care and in partnership with Health Canada has embarked on a multi-year project of healthy work environments best practice guidelines development, pilot implementation, evaluation and dissemination that will result in guidelines developed by expert panels. This guideline was developed by an expert panel convened by the RNAO, conducting its work independent of any bias or influence from funding agencies. The panel was supported by members of the RNAO project team as listed below.

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* Throughout this document words marked with the symbol G can be found in the Glossary.

Background to the Healthy Work Environments Best Practice Guidelines Project

In July of 2003 the Registered Nurses' Association of Ontario (RNAO), with funding from the Ontario Ministry of Health and Long-Term Care (MOHLTC), working in partnership with Health Canada, Office of Nursing Policy, commenced the development of evidence-based best practice guidelines in order to create healthy work environments[G] for nurses. Just as in clinical decision-making, it is important that those focusing on creating healthy work environments make decisions based on the best evidence possible.

The Healthy Work Environments Best Practice Guidelines Project[G] is a response to priority needs identified by the Joint Provincial Nursing Committee (JPNC) and the Canadian Nursing Advisory Committee.[1] The idea of developing and widely distributing a healthy work environment guide was first proposed in *Ensuring the care will be there: Report on nursing recruitment and retention in Ontario*[2] submitted to MOHLTC in 2000 and approved by JPNC.

Health care systems are under mounting pressure to control costs and increase productivity while responding to increasing demands from growing and aging populations, advancing technology and more sophisticated consumerism.[3] In Canada, health care reform is currently focused on the primary goals identified in the Federal/Provincial/Territorial First Ministers' Agreement 2000,[4] and the Health Accords of 2003[5] and 2004[6].

- the provision of timely access to health services on the basis of need;
- high quality, effective, patient/client-centered and safe health services; and
- a sustainable and affordable health care system.

Nurses[G] are a vital component in achieving these goals. A sufficient supply of nurses is central to sustain affordable access to safe, timely health care. Achievement of healthy work environments for nurses is critical to the recruitment and retention of nurses.

Numerous reports and articles have documented the challenges in recruiting and retaining a healthy nursing workforce. [2, 7-11] Some have suggested that the basis for the current nursing shortage is the result of unhealthy work environments.[12-15] Strategies that enhance the workplaces of nurses are required to repair the damage left from a decade of relentless restructuring and downsizing.[3]

There is a growing understanding of the relationship between nurses' work environments, patient/client outcomes and organizational and system performance.[16-18] A number of studies have shown strong links between nurse staffing and adverse patient/client outcomes.[19-29] Evidence shows that healthy work environments yield financial benefits to organizations in terms of reductions in absenteeism, lost productivity, organizational health care costs[30] and costs arising from adverse patient/client[G] outcomes.[31]

Achievement of healthy work environments for nurses requires *transformational change,* with "interventions that target underlying workplace and organizational factors".[32] It is with this intention that we have developed these guidelines. We believe that full implementation will make a difference for nurses, their patients/clients and the organizations and communities in which they practice. It is anticipated that a focus on creating healthy work environments will benefit not only nurses but other members of the health care team. We also believe that best practice guidelines can be successfully implemented only where there are adequate planning processes, resources, organizational and administrative supports, and appropriate facilitation.

The Project will result in six Healthy Work Environments Best Practice Guidelines

- Collaborative Practice Among Nursing Teams
- Developing and Sustaining Effective Staffing and Workload Practices
- Developing and Sustaining Nursing Leadership
- Embracing Cultural Diversity in Health Care: Developing Cultural Competence
- Professionalism in Nursing
- Workplace Health, Safety and Well-being of the Nurse

> *"A healthy work environment is…*
>
> *…a practice setting that maximizes the health and well-being of nurses, quality patient/client outcomes, organizational performance and societal outcomes."*

Organizing Framework for the Healthy Work Environments Best Practice Guidelines Project

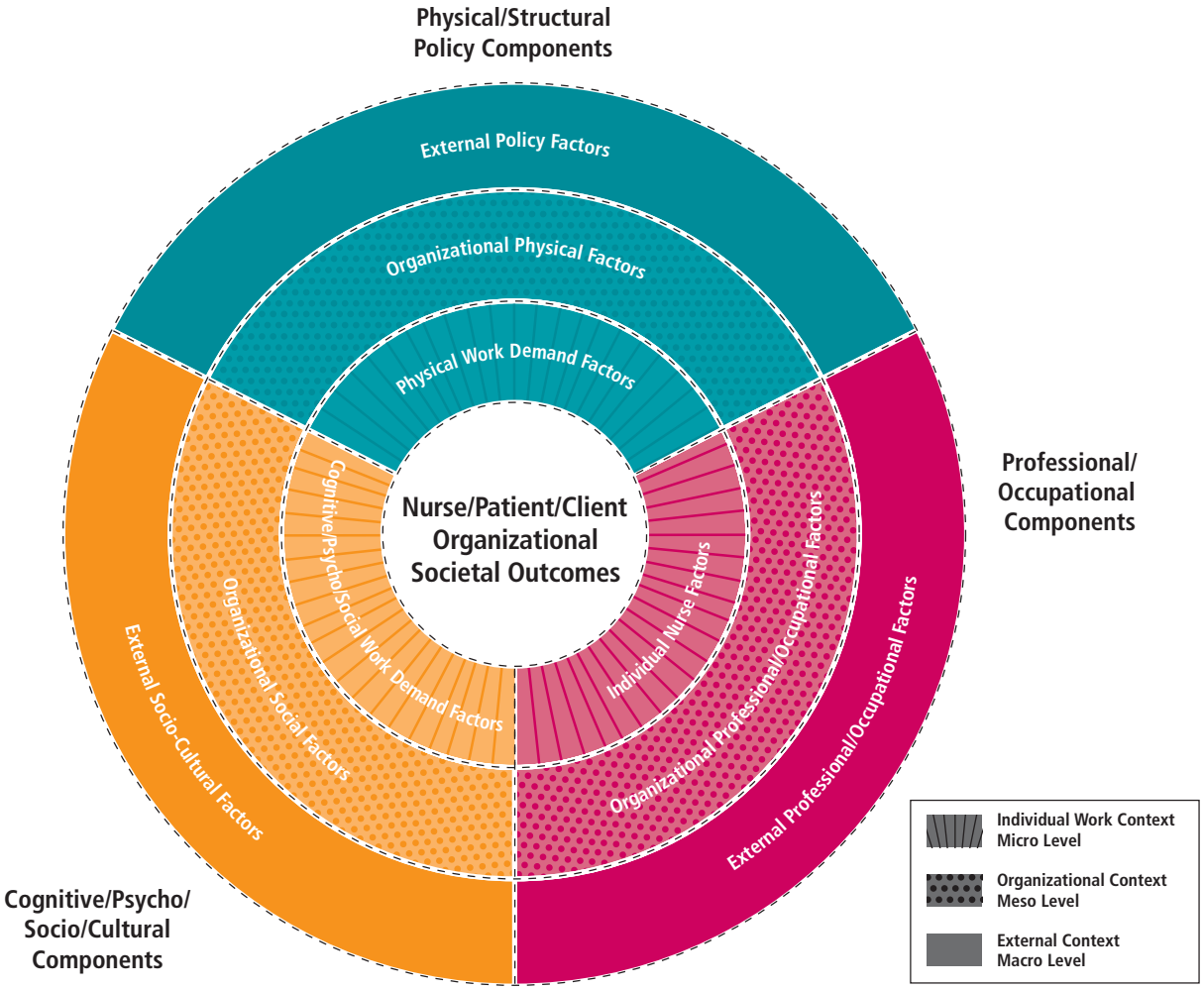

Figure 1. Conceptual Model for Healthy Work Environments for Nurses – Components, Factors & Outcomes[i-iii]

A healthy work environment for nurses is complex and multidimensional, comprised of numerous components and relationships among the components. A comprehensive model is needed to guide the development, implementation and evaluation of a systematic approach to enhancing the work environment of nurses. Healthy work environments for nurses are defined as practice settings that maximize the health and well-being of the nurse, quality patient/client outcomes, organizational performance and societal outcomes.

The Comprehensive Conceptual Model for Healthy Work Environments for Nurses presents the healthy workplace as a product of the interdependence among individual (micro level), organizational (meso level) and external (macro level) system determinants as shown above in the three outer circles. At the core of the circles are the expected beneficiaries of healthy work environments for nurses – nurses, patients, organizations and systems, and society as a whole, including healthier communities.[iv] The lines within the model are dotted to indicate the synergistic interactions among all levels and components of the model.

The model suggests that the individual's functioning is mediated and influenced by interactions between the individual and his/her environment. Thus, interventions to promote healthy work environments must be aimed at multiple levels and components of the system. Similarly, interventions must influence not only the factors within the system and the interactions among these factors but also influence the system itself.[v,vi]

The assumptions underlying the model are as follows:

- healthy healthy work environments are essential for quality, safe patient care;
- the the model is applicable to all practice settings and all domains of nursing;
- individual, organizational and external system level factors are the determinants of healthy work environments for nurses;
- factors at all three levels impact the health and well-being of nurses, quality patient outcomes, organizational and system performance, and societal outcomes either individually or through synergistic interactions;
- at each level, there are physical/structural policy components, cognitive/psycho/social/cultural components and professional/occupational components; and
- the professional/occupational factors are unique to each profession, while the remaining factors are generic for all professions/occupations.

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i Adapted from DeJoy, D.M. & Southern, D.J. (1993). An Integrative perspective on work-site health promotion. *Journal of Medicine,* 35(12): December, 1221-1230; modified by Lashinger, MacDonald and Shamian (2001); and further modified by Griffin, El-Jardali, Tucker, Grinspun, Bajnok, & Shamian (2003)

ii Baumann, A., O'Brien-Pallas, L., Armstrong-Stassen, M., Blythe, J., Bourbonnais, R., Cameron, S., Irvine Doran D., et al. (2001, June). *Commitment and care: The benefits of a healthy workplace for nurses, their patients, and the system.* Ottawa, Canada: Canadian Health Services Research Foundation and The Challenge Foundation.

iii O'Brien-Pallas, L., & Baumann, A. (1992). Quality of nursing worklife issues: A unifying framework. *Canadian Journal of Nursing Administation,* 5(2):12-16.

iv Hancock, T. (2000). The Healthy Communities vs. "Health". *Canadian Health Care Management,* 100(2):21-23.

v Green, L.W., Richard, L. and Potvin, L. (1996). Ecological foundation of health promotion. *American Journal of Health Promotion,* 10(4): March/April,270-281

vi Grinspun, D., (2000). *Taking care of the bottom line: shifting paradigms in hospital management.* In Diana L. Gustafson (ed.), *Care and Consequence: Health Care Reform and Its Impact on Canadian Women.* Halifax, Nova Scotia, Canada. Fernwood Publishing.

Physical/Structural Policy Components

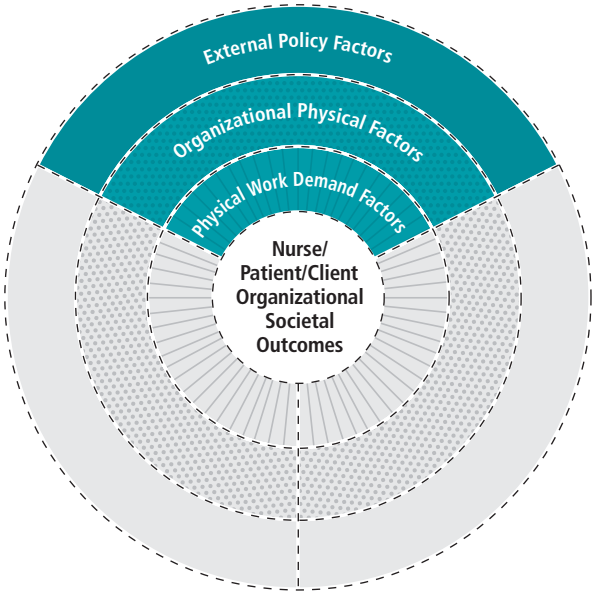

Figure 1A

Physical/Structural Policy Components

- At the individual level, the Physical Work Demand Factors include the requirements of the work which necessitate physical capabilities and effort on the part of the individual.[vii] Included among these factors are workload, changing schedules and shifts, heavy lifting, exposure to hazardous and infectious substances, and threats to personal safety.
- At the organizational level, the Organizational Physical Factors include the physical characteristics and the physical environment of the organization and also the organizational structures and processes created to respond to the physical demands of the work. Included among these factors are staffing practices, flexible, and self-scheduling, access to functioning lifting equipment, occupational health and safety polices, and security personnel.
- At the system or external level, the External Policy Factors include health care delivery models, funding, and legislative, trade, economic and political frameworks (e.g., migration policies, health system reform) external to the organization.

vii Grinspun, D. (2000). *The Social Construction of Nursing Caring,* (unpublished doctoral dissemination proposal).

Cognitive/Psycho/Socio/Cultural Components

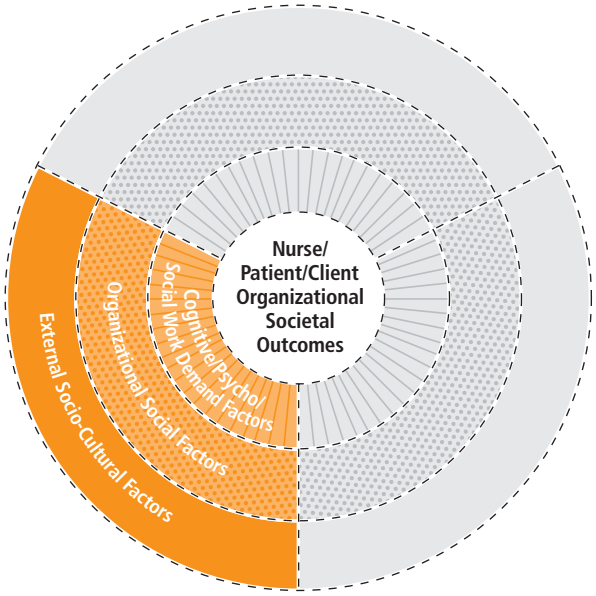

Figure 1B

Cognitive/Psycho/Socio/Cultural Components

- At the individual level, the Cognitive and Psycho-social Work Demand Factors include the requirements of the work which necessitate cognitive, psychological and social capabilities and effort (e.g., clinical knowledge, effective coping skills, communication skills) on the part of the individual.[vii] Included among these factors are clinical complexity, job security, team relationships, emotional demands, role clarity, and role strain.
- At the organizational level, the Organizational Social Factors are related to organizational climate, culture, and values. Included among these factors are organizational stability, communication practices and structures, labour/management relations, and a culture of continuous learning and support.
- At the system level, the External Socio-cultural Factors include consumer trends, changing care preferences, changing roles of the family, diversity of the population and providers, and changing demographics – all of which influence how organizations and individuals operate.

Professional/Occupational Components

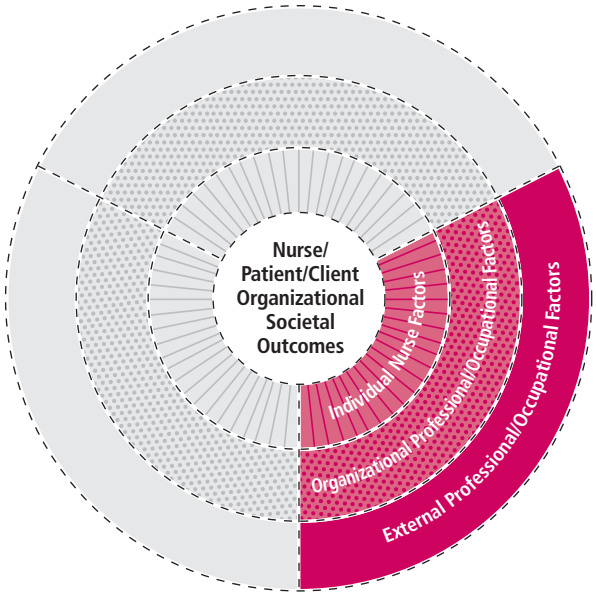

Figure 1C

Professional/Occupational Components

- At the individual level, the Individual Nurse Factors include the personal attributes and/or acquired skills and knowledge of the nurse which determine how she/he responds to the physical, cognitive and psycho-social demands of work.[vii] Included among these factors are commitment to patient care, the organization and the profession; personal values and ethics; reflective practice; resilience, adaptability and self confidence; and familywork/life balance.
- At the organizational level, the Organizational Profession/Occupational Factors are characteristic of the nature and role of the professional/occupation. Included among these factors are the scope of practice, level of autonomy and control over practice, and intradisciplinary relationships.
- At the system or external level, the External Professional/Occupational Factors include policies and regulations at the provincial/territorial, national and international level which influence health and social policy and role socializatio within and across disciplines and domains.

Background Context of the Guideline on Developing and Sustaining Nursing Leadership

In the last 20 years, we have witnessed an unprecedented rate of change in health care, with reforms targeted largely at containing costs while trying to enhance or maintain outcomes. Over this time period there has been a dramatic reduction in the number of formal leadership positions in nursing. Between 1994 and 2002 in Canada, there was a loss of 6,733 managerial positions – a 29% reduction.[1, 33-35] For those who do remain in leadership positions, role expansion and multiple, competing demands leave little time to support and mentor new leaders.[36] Canada has an increasingly diverse nursing workforce[37] as a result of globalization and movement of nurses internationally. Nurse leaders need to be able to foster growth and mentor future leaders across a diverse workforce.

Program management structures have resulted in the dismantling of traditional professional department structures that typically support professional practice, and facilitate nurturing the next generation of nursing leaders.[38] Changes in the role of the chief nurse to a consultative staff position present additional challenges because they mean that the leader must rely on influence and highly developed skills of persuasion rather than direct authority over resource allocation decisions that impact nursing practice and quality of care to patients/clients.[38] Clifford noted that, as health care organizations move from a professional orientation to a business orientation, the need to pay attention to the business side is not in question, but rather how leaders hold the balance and provide professional leadership.[36]

Effective nursing leadership is important in all nursing roles whether the nurse practices in the field of education developing future leaders, as a researcher who mentors new researchers, as an administrator who provides support and guidance to staff, as a practitioner who provides exemplary care and shares professional knowledge, or as one who provides direction and support to practice through policy development. For new graduates leadership includes learning how to delegate and supervise others. For more experienced nurses, leadership incorporates precepting, mentoring, administrative duties such as scheduling and being in charge, and professional activities such as committee work.[39]

The quality of nursing professional leadership has been linked with achieving good patient/client care and with the recruitment and retention of nursing staff.[40-42] The magnet hospital[G] studies conducted by Kramer and Schmalenberg in the United States between 1985 and 2001 reported having a supportive nurse manager to be one of the essential elements of "magnetism" and important to creating trust in the workplace.[40,41] Not only did magnet hospitals have better nursing recruitment and retention rates, they achieved lower patient/client mortality rates.[43] Similarly Boyle, studying characteristics of nurses' work environments at the unit level, found associations between magnet-type traits of autonomy and collaboration[G] and improved outcomes for patients/clients (lower failure to rescue and lower urinary tract infection rates).[44] High levels of leadership support were associated with low levels of pressure ulcer prevalence and lower death rates.

Current reports such as the Romanow *Commission on the Future of Health Care in Canada,* [45] the 2003 First Ministers' Health Accord,[5] the Academy of Canadian Executive Nurses paper on leadership,[38] and the Canadian Nurses Association report on *Nursing Leadership Development in Canada* [46] all draw attention to the importance of strengthening nursing leadership in Canada – for both quality patient/client outcomes and sustainability of nursing human resources. *Listening for Direction II,*[47] a recent publication by the Canadian Health Services Research Foundation reporting on a national consultation, identified the "nurturing of professional leaders" as a priority along with the need to identify:

- key attributes of outstanding leaders in and outside health care;
- specific leadership skills needed in health care;
- effective training/experiential foundations for developing future health care leaders; and
- an evaluation process to determine the impact of healthy workplaces on patient/client outcomes.[47]

Purpose and Scope of this Document

Purpose:

We have developed this best practice guideline to identify and describe:

- leadership practices that result in healthy outcomes for nurses, patients/clients, organizations and systems;
- system resources that support effective leadership practices;
- organizational culture, values and resources that support effective leadership practices;
- personal resources that support effective leadership practices; and
- anticipated outcomes of effective nursing leadership.

Scope:

This guideline therefore addresses:

- knowledge[G], competencies and behaviours of effective leaders;
- educational requirements and strategies;
- policy changes at both the organizational and system levels needed to support and sustain leadership practices;
- implementation strategies and tools;
- evaluation criteria and tools; and
- future research opportunities.

Target Audience

The guideline is relevant to nurses in:

- all roles including clinical nurses, administrators, educators, researchers and those engaged in policy work as well as to nursing students;
- all domains of nursing (clinical practice, administration, education, research and policy); and
- all practice settings.

The guideline will also be helpful for:

- inter-professional team members;
- non-nursing administrators at the unit, organizational and system level;
- policy makers and governments;
- professional organizations, employers and labour groups; and
- federal, provincial and territorial standard setting bodies.

> *"If your actions inspire others to dream more, learn more, do more and become more, you are a leader."*
>
> *John Quincy Adams*
> *1767-1848*

How to Use This Document

Professional standards require that nurses in all roles demonstrate leadership[G] behaviours. Nurses in clinical practice roles as well as those in other formal or informal leadership roles enact these behaviours in relation to patients/clients, nurse colleagues, other members of the health care team, students and in mentor/mentee relationships. The guideline provides a comprehensive approach to leadership. It is not intended to be read and applied all at once, but rather, to be reviewed and with reflection over time, applied as appropriate for yourself, your situation or your organization. We suggest the following approach:

1. **Study the model:** The leadership best practice guideline is built on a conceptual model of Leadership that was created to allow users to understand the relationships between and among the key factors involved in nursing leadership. Understanding the model, which is described in Figure 2 (p. 22), is critical to using the guideline effectively. We recommend that you spend time reading and reflecting upon the model as a first step.

2. **Identify an area of focus:** Once you have studied the model, we suggest that you identify an area of focus for yourself, your situation, or your organization – an area that you believe needs attention to strengthen the effectiveness of leadership.

3. **Read the recommendations and the summary of research for your area of focus:** For each major element of the model, a number of evidence-based recommendations are offered. The recommendations are statements of what leaders *do*, or how they *behave* in leadership situations. The literature supporting those recommendations is briefly summarized, and we believe that you will find it helpful to read this summary to understand the "why" of the recommendations.

4. **Focus on the recommendations or desired behaviours that seem most applicable for you and your current situation:** The recommendations contained in this document are not meant to be applied as rules, but rather as tools to assist individuals or organizations to make decisions that improve their nursing leadership, recognizing each organization's unique culture, climate and situational challenges. In some cases there is a lot of information to consider. You will want to explore further and identify those behaviours that need to be analyzed and/or strengthened in your situation.

5. **Make a tentative plan:** Having selected a small number of recommendations and behaviours for attention, turn to the table of strategies and consider the suggestions offered. Make a tentative plan for what you might actually *do* to begin to address your area of focus. If you need more information, you might wish to refer to some of the references cited, or to look at some of the evaluation instruments identified in Appendix D.

6. **Discuss the plan with others**: Take time to get input into your plan from people whom it might affect or whose engagement will be critical to success, and, from trusted advisors, who will give you honest and helpful feedback on the appropriateness of your ideas. This is as important a phase for the development of individual leadership skills as it is for the development of an organizational leadership initiative.

7. **Revise your plan and get started**: It is important to get started and make adjustments as you go. The development of effective nursing leadership practices[G] is a life-long quest; **enjoy the journey!**

Conceptual Model for Developing and Sustaining Leadership

The Conceptual Model for Developing and Sustaining Leadership organizes and guides the discussion of the recommendations. It provides a model for understanding the leadership practices needed to achieve healthy work environments and the organizational supports and personal resources that enable effective leadership practices.

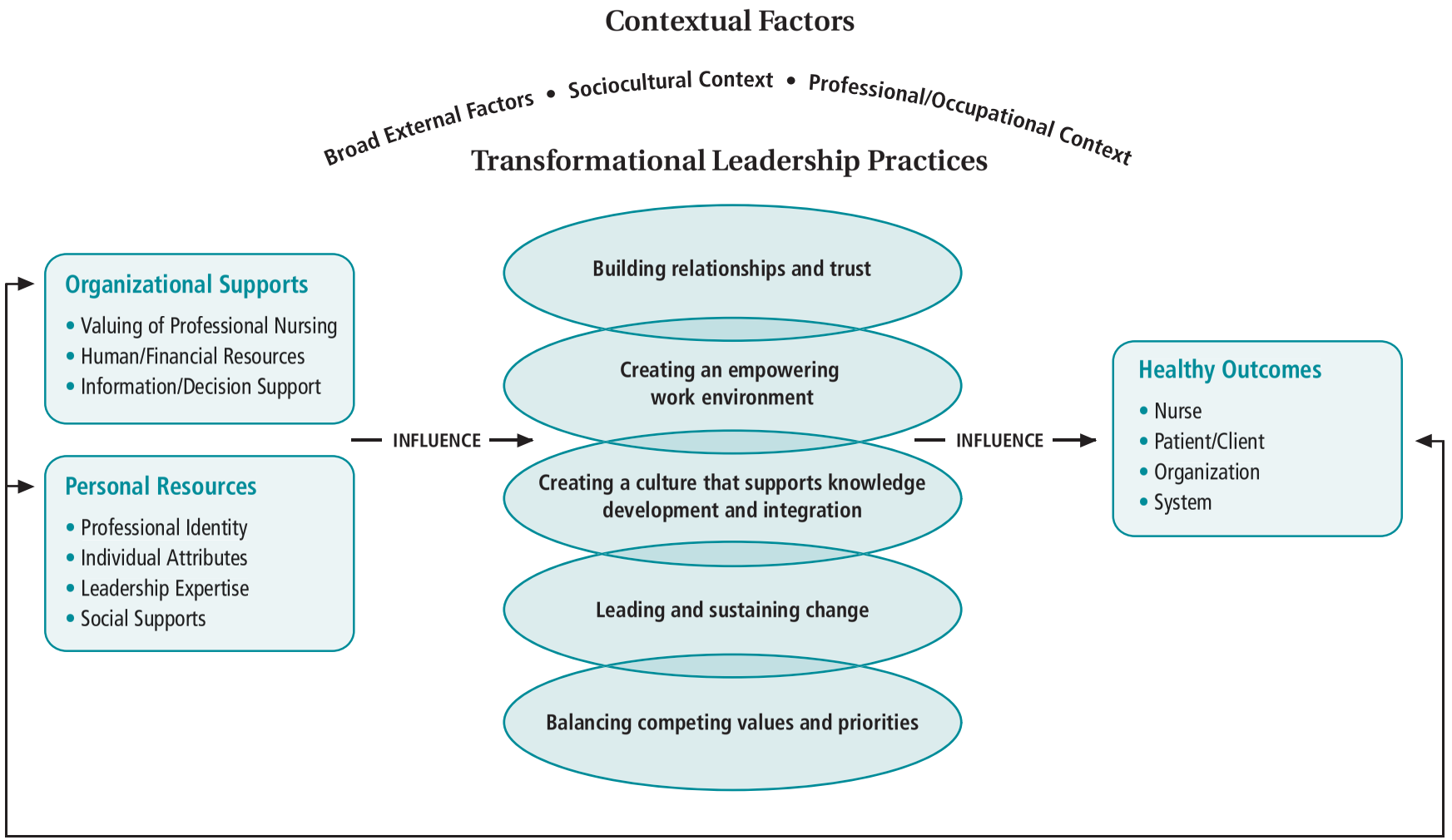

Figure 2 – Conceptual Model for Developing and Sustaining Leadership

Overview of Conceptual Model for Developing and Sustaining Leadership

The core of the Conceptual Model for Developing and Sustaining Leadership (Figure 2) consists of five evidence-based *Transformational Leadership Practices* that are fundamental to transforming nurses' work settings into healthy work environments for nurses. The predisposing factors of *Organizational Supports* and *Personal Resources* influence the ability of the leader to carry out the leadership practices effectively. The leadership practices have been shown to result in positive outcomes for patients/clients, nurses and organizations.[48, 49] The outcomes in turn through a feedback loop reinforce a positive workplace culture. All of this takes place within a larger *environmental context* where policies, sociocultural and professional/occupational factors influence the way in which the predisposing factors, the leadership practices and the outcomes are enacted within nursing workplaces.

The five *Transformational Leadership* Practices:

1. *Building Relationships and Trust* is a critical leadership practice that provides the foundation upon which the remaining practices rest.
2. *Creating an Empowering Work Environment* depends on respectful trusting relationships among members of the work setting. An empowered work environment entails having access to information, support, resources, and opportunities to learn and grow within a setting that supports professional autonomy and strong networks of collegial support.
3. *Creating an Environment that Supports Knowledge Development and Integration* involves fostering both the development and dissemination of new knowledge and the instillation of a continuous inquiry approach to practice within the work setting. This knowledge is used to inform efforts to continuously improve both clinical and organizational processes and outcomes.
4. *Leading and Sustaining Change* involves taking a proactive and participative approach to implementing change that results in improved clinical and organizational processes and outcomes.
5. *Balancing Competing Values and Priorities* entails advocating for necessary nursing resources to ensure high quality patient care while recognizing the multiple demands that must be addressed in organizational decision-making.

Oganizational Supports influence the successful implementation of the leadership practices and strong, visible nursing leadership. These supports include:

- valuing nurses' critical role in the provision of patient/client care;
- supplying sufficient and appropriate human and financial resources; and
- providing necessary information and decision support.

The *Personal Resources* individuals bring to their leadership roles include a number of personal attributes and resources that influence their success in implementing the five leadership practices. *Personal Resources* include:

- professional identity;
- leadership expertise, education and experience;
- individual attributes such as health and resilience; and
- social supports including the persons and relationships that provide support.

Effective nursing leadership:

- Is an essential ingredient in achieving a healthy work environment for nurses
- Influences and contributes to a healthy organization and a healthy community
- Is influenced by the organizational culture, values and supporting resources
- Is shaped by the personal resources and the uniqueness of each individual
- Is influenced by policy, sociocultural and professional/occupational contexts

Summary of Recommendations

	RECOMMENDATION
Transformational Leadership Practices Recommendations	**1. Nurse leaders use transformational leadership practices to create and sustain healthy work environments.**
	1.1 Nurse leaders build relationships and trust.
	1.2 Nurse leaders create an empowering work environment.
	1.3 Nurse leaders create an environment that supports knowledge and integration.
	1.4 Nurse leaders lead and sustain change.
	1.5 Nurse leaders balance competing values and priorities.
Organizational Supports Recommendations[G]	**2. Health service organizations* provide supports for effective nursing leadership.**
	2.1 Health service organizations demonstrate respect for nurses as professionals and their contribution to care.
	2.2 Health service organizations demonstrate respect for nurses as individuals.
	2.3 Health service organizations provide opportunities for growth, advancement and leadership.
	2.4 Health service organizations support a culture of empowerment to enable nurses to have responsibility and demonstrate accountability for their practice.
	2.5 Health service organizations provide access to information/decision support systems and necessary resources for patient/client care.
	2.6 Health service organizations promote and support collaborative relationships.
	2.7 Health service organizations establish scopes of responsibility and accountability that enable effective nursing leadership practices.
	2.8 Health service organizations have a strategic plan for nursing leadership development.
Personal Resources Recommendations	**3. Nurses leaders continually develop their personal resources for effective leadership.**
	3.1 Nurse leaders exhibit a strong professional nursing identity.
	3.2 Nurse leaders reflect on and work to develop their individual leadership attributes.
	3.3 Nurse leaders take responsibility for the growth and development of their own leadership expertise and mentor others to develop leadership expertise.
	3.4 Nurse leaders cultivate professional and personal supports.

*Health service organization recommendations are the responsibility of the senior team, including the board, senior management and the senior nurse leader.

Summary of Recommendations Cont'd

	RECOMMENDATION
System Recommendations[G] *Governments*	4. Governments develop policies and provide resources that support effective leadership.
	4.1 Governments establish an identifiable senior nurse leader position in a policy advisor role in all provinces and territories.
	4.2 Governments establish a national linking mechanism for these roles.
	4.3 Governments establish a nursing advisory council in all provinces and territories.
	4.4 Governments establish and maintain a program of nursing leadership research.
System Recommendations[G] *Researchers*	5. Researchers partner with governments and educational and health service organizations to conduct nursing leadership research.
	5.1 Researchers study the impact of nursing leadership on nurse, patient/client, organizational and system outcomes.
	5.2 Researchers develop, implement and evaluate a leadership intervention based on the *Conceptual Model for Developing and Sustaining Leadership*.
	5.3 Researchers conduct research on health human resources planning for nursing leadership roles.
	5.4 Researchers conduct research on nursing leadership education and development.
System Recommendations[G] *Accreditation Bodies*	6. Accreditation bodies of health service and educational organizations incorporate the organizational support recommendations contained in this guideline into their standards.
System Recommendations[G] *Education*	7. Educational programs provide formal and informal opportunities for leadership development for nurses.
	7.1 Nursing leadership programs incorporate key concepts of the *Conceptual Model for Developing and Sustaining Leadership.*
	7.2 Nursing leadership programs offered through undergraduate, graduate and continuing education include formal and informal opportunities for leadership experience.

Sources and Types of the Evidence on Developing and Sustaining Nursing Leadership

Sources of Evidence

The results of the search for evidence in the literature on leadership yielded meta-analyses, descriptive correlational studies, qualitative studies and expert opinion, but few controlled studies. This is consistent with the challenges of conducting controlled studies in organizations and similar to a recent review of the nursing leadership[G] literature conducted by Patrick and White.[50] Although this guideline is written for nurses in all settings, the majority of the studies found were conducted in urban hospitals. Studies conducted in other settings such as community and long-term care were included in the guideline when available and appropriate, but further research in these practice settings is needed.

Sources included

- A systematic review of the literature on leadership up to December 2003 conducted by the Joanna Briggs Institute (JBI) of Australia.

  JBI followed a seven-step process that commenced with broad search terms and the development of a protocol, and further search terms for the review that were validated by the Panel Chair. Studies identified through the search process that were deemed relevant to the review based on the title and abstract were retrieved and further assessed for relevance. Studies that met the inclusion criteria were grouped according to study type (e.g., qualitative, experimental) and assessed by two independent reviewers for methodological quality using a critical appraisal instrument selected from a suite of instruments according to the study type. The instruments used are part of the System for Unified Management, Assessment and Review of Information – software specifically designed to manage, appraise, analyze and synthesize data. (For further detail and the overall results of the review see Appendix C).

- A critical review of the literature on leadership from January 2004 to July 2005 conducted by the Panel using the same search terms and databases as the JBI review.

  A Master's prepared nurse assessed the relevance of studies identified through the search process based on the title and abstract. These selections were validated by the Panel Chair. These studies were retrieved and further assessed for relevance. Relevance was based on studies that addressed leadership in nursing or similar populations of knowledge workers or interdependent teams and studies of relationship based leadership styles. Studies deemed relevant were assessed by the Master's prepared nurse for quality based on methods, instruments, sample, analysis, conclusions congruent with findings and study clarity. A summary of abstracts, findings and recommendations for inclusion in or exclusion of the studies from the guideline was validated by the Panel.

- Additional literature identified by Panel Members that was reviewed for relevance and quality by the Panel Members.

Rating of Evidence

Current practice in creating best practice guidelines involves identifying the strength of the supporting evidence. [51] The prevailing systems of grading evidence rate systematic reviews of randomized controlled trials (RCT) as the "gold standard".[52] However, not all questions of interest are amenable to the methods of RCT particularly where the subjects cannot be randomized or the variables of interest are pre-existing or difficult to isolate. This is particularly true of behavioural and organizational research in which controlled studies are difficult to design due to continuously changing organizational structures and processes. Health care professionals are concerned with more than cause and effect relationships and recognize a wide range of approaches to generate knowledge for practice. The evidence contained in this guideline has been rated using an adaptation of the "traditional levels" of evidence used by the Cochrane Collaboration[53] and the Scottish Intercollegiate Guidelines Network guideline.[54] Part of this adaptation includes use of the term "type of evidence" rather than "level" in keeping with the comprehensive nature and topic of this guideline.

Evidence Rating System – Table 1

Type of Evidence	Description
A	Evidence obtained from controlled studies, meta-analyses
A1	Systematic Review[G]
B	Evidence obtained from descriptive correlational studies[G]
C	Evidence obtained from qualitative research[G]
D	Evidence obtained from expert opinion
D1	Integrative Reviews
D2	Critical Reviews

> *"Managers should search for and apply emprical evidence from management research in their practice, similar to their clinical colleagues."*
>
> *Institute of Medicine* [48]

Leadership Practice Recommendations[G]

1.0 Nurse leaders use transformational leadership[G] practices to create and sustain healthy work environments.

Transformational and relationship based leadership styles lead to:

- **Increased job satisfaction for nurses**[55-66]
- **Increased satisfaction with the leader**[56, 64, 66]
- **Increased quality of life for nurses**[67]
- **Increased empowerment of nurses**[62, 68, 69]
- **Decreased absenteeism**[70]
- **Increased organizational commitment**[57, 60, 70-72]
- **Increased retention of nurses**[65, 70, 73, 75]
- **Increased perceived unit effectiveness**[55, 63, 75]
- **Increased ability to lead a diverse workforce**[75]
- **Increased staff emotional health**[64] **and decreased staff burnout**[76]
- **Increased patient quality of life**[76]
- **Increased patient satisfaction**[76]
- **Improved patient/client outcomes (such as decreased restraint use, fewer fractures, low prevalence of complications immobility)**[77]

Discussion of Evidence[a]

Kemerer[78] observed that the behaviours of health care leaders beyond their competencies – that is, what they say and do in interactions with others to achieve outcomes – is what matters. Nurses (both staff and formal leaders) show preference for relationship-focused leadership styles and behaviours consistent with transformational leadership.[64, 79-82] A study of nurse supervisors conducted in an Ontario long-term care setting revealed similar findings. The unlicensed personnel supervised by both the Registered Nurses and Registered Practical Nurses, and, the supervisors themselves, reported higher job satisfaction and less job stress when they felt supported by their supervisors.[83]

The type of leadership most often reported in magnet hospitals was transformational leadership.[82] In an integrative literature review on transformational leadership Gasper[84] found that this style of leadership produces higher level of organizational effectiveness, and that the behaviours influenced others to behave in a similar fashion through a cascading effect. They found that individuals working with transformational leaders had greater sense of affiliation and more intellectual stimulation. The transformational leader was viewed as more approachable, and interactions were perceived to be of higher quality.

a Type of Evidence
There is "A" type evidence to support this recommendation

Burns[85] was the first person to describe a relationship-based style of leadership now commonly referred to as *transformational leadership*. Pielstick[86] completed a meta-ethnography of the literature on transforming leadership which included the 20 years following Burns' 1978 publication. The published work clustered into the five areas of *communication* (listening, setting expectations), *building interactive relationships* (showing respect, being friendly and supportive, participatory decision-making, managing conflict), *community* (building a culture of belonging through relationships based on values of dignity, honesty, fairness[G], integrity), and *guidance* (providing learning opportunities, role-modeling, mentoring, coaching, engaging in moral reasoning, strategic planning and team building), all of which are based on a solid foundation of *character* (principle-centered demonstrating fairness, integrity, respect, passion, and commitment to learning), to achieve a shared vision. Levasseur[87] completed a meta-analysis of primary research studies on transformational leadership which included seven experimental studies and 27 correlational studies and confirmed positive relationships between transformational leadership and increased staff job satisfaction and performance.

Transformational leadership styles have been linked with positive outcomes for nurses.[52] Although there are few studies that examine the role of nursing leadership and patient/client outcomes[50], there is growing evidence linking nursing satisfaction and nursing professional practice with improved patient/client care.[88]

From our review of the literature, we identified the following five transformational leadership practices that result in healthy outcomes for nurses, patients/clients, organizations and systems:

- building relationships and trust;
- creating an empowering work environment;
- creating an environment that supports knowledge development and integration;
- leading and sustaining change; and
- balancing competing values and priorities and demands.

We have linked each of these leadership practices with specific behaviours sourced from our review of the literature.

> *"It is important for leaders to model values through action, open communication, being visible and using participative decision-making."*
>
> *Baird & St-Amand*[89]

1.1 Nurse leaders build relationships and trust.

Trust in leaders and positive relationships with leaders lead to:

- **Increased perceptions of the leader's credibility**[71]
- **Increased job satisfaction for nurses**[90]
- **Decreased emotional exhaustion**[90,91]
- **Increased perceptions of quality of care and staffing adequacy**[90]
- **Increased organizational commitment**[71,90,92,93]
- **Increased job performance;**[91] **motivation and willingness to work hard**[70]
- **Decreased absenteeism**[71]
- **Decreased intent to turnover**[90,92,94,95]
- **Increased fiscal performance**[95]
- **Ability to lead a diverse workforce**[96]

Discussion of Evidence[b]

> *"Trust is the highest form of human motivation. It brings out the very best in people."*
>
> *Stephen Covey* [97 p.178]

The belief that the establishment of trust is a necessary condition of successful leadership has prevailed for at least four decades.[92] Trust, along with fairness and respect are the key values that lead to healthy organizations.[32] Trust is highly correlated with transformational leadership styles.[92] Respect for the worth of others and fairness are values that are frequently identified as traits of transformational leaders[79] and have been linked to trust.[98] When nurses feel that they are respected the results are higher job satisfaction, trust in management, lower emotional exhaustion and higher nurse ratings of quality of care and staffing adequacy.[90]

Shea[99] observed that health care is in a state of permanent white water and noted that trust and relationships are necessary in times of high ambiguity, high uncertainty and high complexity. Organizational change affects critical workplace relationships that are essential to making things work.

Trust supports good interpersonal relationships.[90, 100] The establishment of trust in leaders has been linked to the leader's *integrity, perceived influence and skill* and the extent to which the leader *demonstrates care and concern for the interests of others,*[86] which includes the willingness to help others to grow personally and professionally.[100]

b Type of Evidence

There is "A" type evidence to support Building Relationships and Trust as an essential element of effective nursing leadership practice. All of the related Core Competencies and Sample Behaviours have been drawn from a range of A to D type evidence with the majority being type C and D.

Nurses identify strongly with their profession and the trust of leaders often reflects the degree to which the leader demonstrates commitment to the values of nursing.[101] Rousseau and Tijorwala[102] found that nurses were less supportive of organizational change considered to be driven by financial or political reasons versus improvement in patient/client care and were more accepting of the change when they had trust in the leader.

There is evidence to suggest that not only are the individual behaviours of leaders important but also the culture, climate and values of the organization.[90] A 1995 study of nine Canadian benchmark[G] organizations revealed the importance of leaders who model values through actions and demonstrate open communication and participative decision-making, particularly in situations of conflict. Each organization recognized the importance of competence and therefore provision of training as a condition of trust. Visibility and access to leaders was named as important. Conclusions from this study were that building trust is not a simple or rapid process, but rather comes from being customer focused, quality driven and respectful of colleagues.[89]

How Trust is Lost

- Act and speak inconsistently
- Seek personal rather than shared gain
- Withhold information
- Lie or tell half-truths
- Be close-minded

Lewicki & Bunker[103]

How to Repair Lost Trust

- Acknowledge that trust has been broken
- Determine what it was about and the cause
- Admit that it occurred
- Accept responsibility
- Offer to make amends

Bowman[104]

> *"The leaders who work most effectively, it seems to me, never say "I." And that's not because they have trained themselves not to say "I." They don't think "I." They think "we"; they think "team." They understand their job to be to make the team function. They accept responsibility and don't sidestep it, but "we" gets the credit . . . This is what creates trust, what enables you to get the task done."*
>
> *Peter Drucker* [105 p.14]

Table 1.1 Core Competencies[G] – and Sample Behaviours[G] – for Building Relationships and Trust

CORE COMPETENCIES	SAMPLE BEHAVIOURS
1.1.1 Nurse leaders demonstrate and model integrity and fairness.[71, 81, 84, 87, 94-111]	• Reflect on own values and goals; share them openly[87, 94, 106,117-120] • Set clear, high performance standards[71, 87, 89, 100, 121] • Take responsibility and admit mistakes openly[112,118] • Keep commitments[58, 81, 100, 122] • Display ethical behaviour consistently[32, 94, 102, 106, 107] • Gather data and look at all sides of issues[81] • Make policies and practices explicit and transparent and apply them consistently[122]
1.1.2 Nurse leaders demonstrate care,[84,92,108,122] respect, [9, 32, 84,106,122] and personal concern for others.[32, 81, 84, 106, 113, 124, 125]	• Seek and acknowledge multiple perspectives and opinions[100, 107, 120, 122, 124, 126] • Listen without judgment or criticism[124] • Seek to understand what matters to others[100, 117] and respond appropriately[32] • Share knowledge of system issues and perspectives[112] and problems[58] openly and honestly[82, 127] • Acknowledge the value of others and celebrate their successes[71, 81, 106, 112, 122, 128, 129] • Develop and implement policies and processes that promote the health, safety and personal well-being of nurses • Respect and model work-life balance[81, 121, 130]
1.1.3 Nurse leaders create a sense of presence and accessibility.[81, 82, 113, 117, 129, 129-131]	• Communicate and make personal contact frequently[101, 125, 132] • Maintain visibility and accessibility to others[82, 89, 117, 123, 127]
1.1.4 Nurse leaders communicate effectively.	• Communicate clearly, openly, honestly and frequently[58, 113-115] • Listen interactively[82, 129, 132] and demonstrate understanding of the opinions of others[100, 107, 117, 126] • Develop and use skills in cross-cultural communication[13]
1.1.5 Nurse leaders manage conflict effectively. [74, 79, 101, 105, 119]	• Understand the constructive and destructive effects of conflict • Acknowledge and address the conflict • Develop and use a range of conflict resolution skills[133]
1.1.6 Nurse leaders build and promote collaborative relationships and teamwork.[70, 82, 106, 111, 123, 128, 133-135]	• Seek and acknowledge broad input[95, 101, 114] • Recognize the legitimacy of others' interests[118] and discuss how interests are aligned[122, 136] • Explore uncertainties and fears[137] • Build consensus[83, 137] • Give and receive help and assistance[118] • Evaluate effectiveness of working together[138]

CORE COMPETENCIES	SAMPLE BEHAVIOURS
1.1.7 **Nurse leaders demonstrate passion and respect for the profession of nursing, its values,[120] knowledge and achievements.**[36, 38, 81, 82, 100, 113, 123, 127, 129, 139]	• Demonstrate strong commitment to caring, justice, honesty, respect and integrity[112] • Advocate for quality care and quality practice settings[36, 38, 81, 82, 94, 112, 134, 140] placing patients/clients first[112, 140] • Acknowledge and promote nurses' contribution to patients/clients, organizations and communities[36, 81, 82, 100, 126, 140] • Articulate nursing issues boldly • Support development of professional nursing knowledge
1.1.8 **Nurse leaders demonstrate role competence.**[95, 120, 141]	• Maintain and apply current knowledge of nursing science, leadership and other relevant knowledge[124, 131] • Address concerns and issues[81, 87, 100, 130, 134, 142] • Participate actively in decision-making opportunities • Take responsibility for actions and outcomes • Communicate successes to create confidence[83, 122]

Planning for Success – Suggested Strategies[G] in Building Relationships and Trust

Individual Strategies

- Maintain an "open door" policy and post times of availability
- Practice management by walking around,[127, 130, 143] spending time on the unit[58, 144]
- "Check-in" at meetings and open forums to hear issues and concerns and what's going on in people's lives to foster relationships and provide support[145]
- Communicate support to staff by determining and clarifying what staff expect of leaders[146]
- Provide ongoing informal feedback for a job well done
- Build a network of advisors and informants who will provide an honest and unbiased perspective when seeking information and advice[147]

Team/Unit/Organization Strategies

- Create a collective vision and values statement for the team/unit/organization[120] and work with the team to develop behavioural standards to reflect that vision
- Design clear accessible role descriptions, including leadership responsibilities
- Design responsibility grids detailing duties and levels of accountability e.g., input versus decision-making[148]
- Complete regular performance appraisals
- Design interview guides for hiring individuals into leadership positions that incorporate questions related to respect for individuals and the value of nursing
- Initiate formal recognition programs such as certificates, newsletter articles that feature nurses who demonstrate excellence in practice; recognition awards/events during Nursing Week to recognize achievements
- Establish a council to examine and establish strategies for issues related to nursing recruitment and retention such as work/life balance
- Incorporate skill-based empathy training into leadership development programs[125]

Learn to Manage Conflict

- Encourage a free exchange of ideas, feelings and attitudes to cultivate an atmosphere of trust
- Clarify issues surrounding values, purposes and goals
- Focus on what's possible, not what's wrong[149]
- Search for alternative ways to resolve the problem
- Investigate the use of appreciative inquiry[G]
- Ask for help from outside sources as needed
- Set up a means for evaluation of possible solutions

1.2 Nurse leaders create an empowering work environment.

Empowerment in the workplace leads to:

- **Increased job satisfaction for nurses**[150-156]
- **Improved occupational mental health**[68,151,157-162]
- **Increased perceptions of autonomy and control over nursing practice**[91, 152, 153, 162, 163]
- **Increased staff motivation**[164, 165]
- **Increased respect and appreciation for the leader**[100]
- **Improved organizational commitment**[159, 165-171]
- **Improved work effectiveness and performance**[68, 153, 162, 165, 170, 172]
- **Improved retention of staff**[155, 166, 173-176]
- **Improved patient outcomes**[44]

Discussion of Evidence[c]

The need to create and sustain empowered work environments for nurses is a common theme in nursing leadership literature[155, 173-175] and has been linked to trust.[150] Empowerment is thought to occur when an organization sincerely engages its staff and progressively responds to this engagement with mutual interest and intention to promote growth. Empowerment is a way of being that occurs over time.[177] It is based on the premise that factors such as organizational characteristics and culture are more useful than personality factors in understanding individual attitudes and job effectiveness.[151] The level of job empowerment and satisfaction is directly related to the circumstances experienced by the employee in the workplace.[151, 155]

Empowerment is a combination of organizational conditions and leadership style that together empower staff. Social structures in the workplace influence employee attitudes and behaviours.[178] Structural factors, in the work setting such as having *access to information, receiving support, having access to the resources necessary to the job, and having the opportunity to learn and grow* are foundational to empowerment.[178] Manojlovich[179] found a strong direct relationship between nurses' perceptions of their manager's ability to

c Type of Evidence

There is "A" type evidence to support Creating an Empowering Work Environment as an essential element of effective nursing leadership practice. All of the related Core Competencies and Sample Behaviours have been drawn from a range of A to D type evidence with the majority being type B and C.

mobilize necessary resources and empowerment that results from having access to these resources. This study demonstrated a link between empowerment and enhanced professional practice which was affected by the nurses' beliefs in their own capabilities when strong nursing leadership is present. This relationship was not present when nursing leadership was perceived as weak.

Skelton Green[180] found that nurses who were members of hospital committees reported increased job satisfaction and decreased intent to turnover. Erickson et al.[177] reported higher empowerment scores for nurses who were members of governance committees. Beaulieu et al.[167] studied empowerment and commitment of nursing staff and nursing managers in two long-term care facilities in Ontario. They found that managers in the study were significantly more empowered and committed to their organizations than the staff nurses. The managers in the study reported adequate access to information, support and resources. In a study of nurse managers in Finland, Suominien et al.[181] found a highly significant relationship between empowerment and low stress levels.

Transformational nurse leaders enable empowerment [182, 183] by sharing their vision and values in ongoing dialogue with nurses. Empowerment occurs when the vision and direction are clear. Nurse leaders empower others by motivating them to share in the vision and make it a reality.[184] Empowering leaders provide purpose and meaning to the follower's work by promoting the value of nursing and creating access to formal and informal power structures.

Formal and informal power have been found to be significant predictors of access to empowerment structures in the workplace.[152, 154, 168, 183] Roles that have discretionary decision-making, visibility, and relevance within the organization enable the acquisition of *formal power*. *Informal power* emerges from political alliances and interactions with peers.[178] Alliances with peers, superiors and subordinates within the organization further influence empowerment.[174]

Empowering leaders create the structural conditions for work effectiveness and empowerment by designing roles that enable participation in decision-making and by optimizing opportunities for autonomy and personal and professional growth of staff.[178] Empowered staff have been linked with improvements in customer focus, quality of products and services, organizational competitiveness and quality of work life.[159]

> *"My personal goal is to get nurses the tools they need to do their job well. I'm not taking care of patients – they are. My job is to take care of them so that they can take care of the patients."*
>
> *Upenieks [109 p.630]*

Table 1.2 Core Competencies and Sample Behaviours for Creating an Empowering Work Environment

CORE COMPETENCIES	SAMPLE BEHAVIOURS
1.2.1 Nurse leaders understand and practice the concepts and principles of empowering behaviours.	• Critically reflect on personal use of empowering behaviours • Seek feedback on their own behaviours • Share power with others
1.2.2 Nurse leaders optimize nurses' opportunities for autonomy and personal and professional growth.	• Create a learning environment that enables reflective practice[G] and shared accountability • Demonstrate confidence in others by delegating effectively[58, 81, 100, 119, 134, 185] • Coach, mentor and guide[38, 80, 81, 134, 136, 186] • Provide both negative and positive feedback constructively[118, 121, 129] • Use experience as a learning opportunity[134,187, 188] • Provide opportunities for development of knowledge, skills and judgment[81, 84, 100, 113, 124, 128, 131, 187] • Encourage use of judgment, risk taking and innovation[109, 189] • Develop policies and processes that enable full scope of practice[57]
1.2.3 Nurse leaders optimize access to and use of data and information required to function effectively.[109]	• Share personal and organizational vision and values[87, 94, 100, 106, 113-116, 119] • Share information about ongoing organizational initiatives and future plans[109, 127] • Critically apply knowledge grounded in nursing theory and research[36, 109, 126, 134] • Foster development, sharing and application of knowledge and evidence-based strategies[38, 126, 190] • Share expertise and facilitate access to expertise of others[48]
1.2.4 Nurse leaders create the conditions for nurses to access and use support, feedback and guidance from superiors, peers and subordinates.	• Seek to understand thinking, learning and working styles of others[80, 126] • Tailor leadership styles to individuals and situations[80, 113, 191] • Create structures and processes that enable interactions • Support nurses affected by work events or experiences
1.2.5 Nurse leaders facilitate nurses' access to and appropriate use of resources – the materials, money, supplies, equipment and time necessary to fulfill their roles.	• Minimize bureaucratic constraints to access resources[42, 94, 109, 192] • Remove barriers to achieving outcomes[81] • Provide and use necessary budgetary support, training,[193] time and decision support tools to accomplish goals and objectives[38, 81, 109, 113, 119, 123, 134] • Establish mechanisms to monitor and achieve manageable workloads • Respond to changing needs and priorities
1.2.6 Nurse leaders enhance the meaningfulness of nursing work.	• Promote the contribution of nursing to patient/client and organizational outcomes[36, 81, 100, 109] • Design roles that have discretionary decision-making, visibility and are relevant to key organizational processes[178] • Create access to a network of alliances both within and external to the organization
1.2.7 Nurse leaders enable participation in decision-making.[94, 100, 113, 177, 180, 194, 195]	• Solicit broad input from others[94, 100, 113] • Create structures and processes that enable participation in decision-making • Honour decisions with support[194]

Planning for Success – Suggested Strategies for Success in Creating an Empowering Work Environment

Individual Strategies

- Practice reflection by keeping a personal journal
- Seek comprehensive feedback to understand how others perceive behaviours
- Review the literature on transformational leadership
- Employ a professional coach and/or seek out a mentor and meet regularly

Team/Unit Strategies

- Establish formal and informal leadership roles at the practice level such as clinical resource, project leader or rounds leader
- Facilitate rotation of charge roles
- Enable nurses' participation in patient care conferences and committees
- Enable access to Employee Assistance Programs, support groups, post-incident discussion support
- Provide growth opportunities that offer learning and visibility such as attending board or committee meetings[196] or attendance at leadership development courses/conferences
- Organize facilitated groups to share leadership experiences and strategies
- Build others belief in their capabilities through orientation programs, skills training, role modeling and positive feedback[179]
- Establish quality improvement teams to respond to staff concerns
- Articulate and share the evidence linking nursing to positive patient/client outcomes
- Share and act on valid and reliable workload data
- Schedule regular breakfast or coffee meetings with the manager/director/vice-president
- Hold "town hall" meetings[197]
- Conduct regular performance appraisals and establish a peer review process

Organization Wide Strategies

- Simplify decision-making structures and processes
- Consider complexity of work, diversity of work group and number of people when determining nurse to leader ratios in the structuring of work groups
- Establish shared governance structures and processes such as nursing practice councils and unit-based councils to govern nurses' scope of practice[198]
- Appoint staff nurses to product review committees
- Communicate the work of nursing practice committees regularly through newsletters, open forums,[144] web-based technology
- Provide a diversity training, support and accountability program for all nurses
- Establish mentoring and preceptorship programs[198]
- Provide externships for student nurses
- Provide internships for both new graduates and experienced nurses

1.3 Nurse leaders create an environment that supports knowledge development and integration.

Creating an environment that supports knowledge development and integration leads to:

- **Increased job satisfaction for nurses**[60, 107, 199]
- **Increased work effectiveness**[107,155, 200]
- **Increased empowerment**[113, 171, 199] **and autonomy**[113]
- **Enhanced quality of practice and care and accountability**[107]
- **Enhanced personal and professional growth of staff** [124, 131, 201] **and clinical leadership**[38]
- **Increased desire to continue education**[81]
- **Enhanced staff relationships**[100]
- **Increased trust in the leader**[170, 188] **and organization**[186]
- **Enhanced success of planned change**[119, 193]
- **Increased organizational commitment**[107]
- **Decreased intent to leave**[128, 199]

Discussion of Evidence[d]

The ongoing acquisition and management of knowledge has been identified as one of the intrinsic characteristics of high-performing organizations.[186] Learning organizations are skilled at acquiring and disseminating knowledge while modifying behaviour to reflect new knowledge.[186, 187] Senge[202] defines a learning organization as one "where people continually expand their capacity to create the results they truly desire, where new and expansive patterns of thinking are nurtured, where collective aspiration is set free, and where people are continually learning how to learn together." (pg. 3). For this to occur, organizations need to discover how to tap people's commitment and capacity to learn at *all* levels.

In a study of hospitals, Tucker and Edmondson[170] clearly indicated the influence of leadership behaviours on willingness to report mistakes. Transformational leaders significantly affect organizational learning values by creating an atmosphere of openness and psychological safety – two factors that are crucial for effective organizational learning.[170, 203] The creation of a learning organization first requires an organizational commitment to learning through the establishment of an environment conducive to knowledge creating, sharing, and use.[186, 204] DeLong and Fahey[187] investigated how 24 companies initiated and managed knowledge-related projects. Their study found that culture shaped assumptions about the importance of knowledge, defined the relationships between levels of knowledge, created a context for social interaction and shaped the creation and adoption of new knowledge. The first step was assessing the different aspects of culture most likely to influence knowledge-related behaviours, including the existing attitudes toward knowledge ownership, the changes needed to promote more collaborative use of

d Type of Evidence

There is "B" type evidence to support Creating an Environment that Supports Knowledge Development and Integration as an essential element of effective nursing leadership practice. All of the related Core Competencies and Sample Behaviours have been drawn from a range of B to D type evidence with the majority being type C and D.

knowledge, and internal communication patterns. Donaldson and Rutledge[204] reviewed six projects that had been undertaken to focus on nursing research diffusion and utilization. Factors that influenced the ability to successfully adopt new knowledge into practice included participation in continuing education, access to information and literature, sanctioned time to participate in research and availability of colleagues with advanced education to facilitate knowledge transformation.[204]

Learning organizations take advantage of all sources of knowledge including internal creativity, knowledgeable experts within the organization, the best practices of other organizations and external experts. Systematic searching for and testing of new knowledge is done using the scientific method to produce incremental gains in knowledge access.[188] Knowledge is spread quickly and efficiently throughout the organization. Ideas having the greatest impact are shared broadly and transferred through multiple channels to enhance application, including written and verbal reports, and education and training programs. The motivation to create, share and use knowledge is a critical success factor that is enhanced by long-term incentives being linked to both the general evaluation and compensation structure of the organization.[190]

Large health care organizations make decisions based on evidence that is not systematically gathered or assessed.[205] As Berwick[206] points out, measurement helps one know if a particular innovation should be kept, changed, or rejected. However, most organizations leave too little time for reflection on work. Evidence-based management cooperatives exist to create organizations at the health system level that bring together managers, consultants, and researchers with a common mission of improving health care management, data bases, and organizational performance. A team of professionals is assembled to understand better the problems involved in effective health care management and develop more effective approaches to managing health systems. This creates an evidence-based culture that supports and encourages innovation, experimentation, data collection and analysis and the development of critical appraisal skills among managers.[207]

> *"For confidence, nurses have to continually learn. For a professional, that means that they need to advance their practice through continuing education, research, as well as attending professional and national conferences. Research is extremely important if the nursing profession is going to continue being professional."*
>
> *Upenieks*[109 p.630]

Table 1.3 Core Competencies and Sample Behaviours for Creating an Environment that Supports Knowledge Development and Integration

CORE COMPETENCIES	SAMPLE BEHAVIOURS
1.3.1 Nurse leaders foster norms and practices that support broad participation in knowledge development, sharing, and dissemination.	• Cultivate a work environment that actively encourages innovation and evaluation[189] • Foster opportunities for individuals to think and learn[170] • Foster nurse-to-nurse sharing of clinical and leadership expertise • Create opportunities for staff to assess current work systems and devise new ones[170] • Promote and support the conduct of nursing research • Promote and support the development and use of evidence-based guidelines[208, 209] • Acknowledge the value of different modes of knowledge generation and uptake • Align incentives to reinforce and facilitate uptake of knowledge management practices[190] • Manage personal growth by objectively challenging behaviours and beliefs[136]
1.3.2 Nurse leaders provide technical, informational, and educational infrastructure to support learning.[82, 189, 190, 210]	• Provide support for education and continuing career development[189, 211] • Create organizational partnerships that facilitate continuing education • Seek out and use knowledgeable experts within and external to the organization[212] • Provide access to a variety of literature/information[209] • Encourage the use of decision support tools
1.3.3 Nurse leaders create an environment of open communication and teamwork and valuing of the contribution of others.[189]	• Examine internal communication patterns[186] • Recognize cultural differences in communication and the influence perceptions of hierarchy have on communication • Encourage collaborative problem solving[36, 186] • Establish structures and processes to encourage discussion of issues or ideas[189] • Promote flow of information and ideas at multiple levels through informal and formal practices • Showcase successes
1.3.4 Nurse leaders instill a learning approach for continuous quality improvement.[G]	• Provide effective feedback[38, 81, 113, 124, 134, 136, 187] • Articulate, critically review, generate and validate knowledge through critical reflection on practice[206, 213] • Inspire creative thinking • Engage management and staff in improving quality of care and ensuring effective allocation of resources[189] • Enable nurses to take action • Instill a strong sense of individual responsibility for quality monitoring • Provide time to discuss and address underlying causes of problems • Use critical reflection to generate and validate knowledge
1.3.5 Nurse leaders establish mechanisms for continuous monitoring of organizational process and changes.	• Promote use of nursing-related performance and client outcome measures in benchmarking[189] • Support frontline staff involvement in benchmarking and developing best practices[189, 199] • Use data and quality frameworks for monitoring and decision-making • Examine the best practices of other organizations and professions[214] • Monitor results of changes and set up accountability mechanisms • Review and record past organizational successes and failures[167]

Planning for Success – Suggested Strategies for Creating an Environment that Supports Knowledge Development and Integration

Individual Strategies

- Personal commitment through ongoing professional development by review of research, relevant journal articles and attendance at conferences
- Lead discussions of research articles, case studies and clinical experiences at team meetings
- Conduct and share research reviews to synthesize findings on selected clinical and management topics[207]
- Establish roundtable/lunch group for discussions on leadership topics and experiences[207]
- Challenge your own learning by writing for publication or presenting at a conference

Team/Unit Strategies

- Develop quality improvement teams and councils
- Establish interprofessional project teams to foster learning and communication[186]
- Encourage open sharing of information by scheduling regular team meetings;[215] holding open forums, conferences and meetings[186, 188]
- Foster nurse to nurse and interprofessional sharing of expertise through unit rounds
- Provide support for staff to continue their education through flexible scheduling and journal clubs
- Support staff in the writing of a group article for publication or presenting at a conference
- Conduct a needs assessment and develop an education plan for the unit
- Establish the use of annual learning plans

Organization Strategies

- Provide access to library services, internet and search engines[209]
- Provide tuition support and flexible scheduling policies to enable continuing education
- Partner with degree-granting programs to provide on-site programs and engage in collaborative research projects[216]
- Conduct regular focus groups and surveys to track nursing practice processes and outcomes[212]
- Create processes for non-punitive reporting of errors and near misses
- Use best practice guidelines
- Build/revise workload measurement tools to allow time for reflection and learning
- Integrate participation in, and the use of, research into role descriptions and nursing strategic planing[216]
- Establish a nursing research committee and commit to the use of evidence/research in existing committees[216]
- Publish nursing annual report and/or nursing newsletter detailing nurses' accomplishments
- Develop and provide open access to a nursing quality report that aggregates data on nurse-sensitive indicators[217]

> *"She is a powerful leader; she uses data to make her point."*
>
> *Upenieks*[144 p.180]

1.4 Nurse leaders lead and sustain change.

Effective leadership for change management leads to:

- **Increased employee acceptance of the change**[102, 115, 218, 219]
- **Increased achievement of the desired change**[71, 81, 193, 211]
- **Higher performing teams**[64, 71, 107, 220]
- **Increased productivity**[71, 107]
- **Lower absenteeism**[71, 107]
- **Increased job commitment**[102, 115, 218, 219]
- **Increased organizational commitment**[60, 107]
- **Increased staff motivation and willingness to work hard**[60, 107]
- **Increased job satisfaction**[60, 64, 107, 220]

Discussion of Evidence[e]

Nurse leaders play a key role in the successful implementation of change within organizations. In a Canadian study of the effects of hospital restructuring, nurses reported fewer negative effects when they perceived that their leaders used a relationship-based democratic style.[64] A study completed in the United States by Gullo and Gerstle[69] found that when middle managers displayed characteristics of transformational leadership during restructuring, staff RNs reported an above average sense of empowerment[G]. They found no relationship between a transformational style and job satisfaction during restructuring and suggested the need for further study of how to lead nurses through change. In a study of hospital teams in Spain, Gil et al,[220] found that change-orientated leadership (transformational and charismatic leadership styles) was strongly correlated with job satisfaction and team performance, and influenced by the team's belief in its own effectiveness.

The change process begins with the nursing leader developing a vision for the change that is derived from a scan of the environment. The nurse leader challenges existing assumptions, structures and processes within the organization.[71, 81, 99, 221, 222] A vision is developed and then shared with other stakeholders[G] in order to build a critical mass of support for the change.[129, 211, 223]

Successful change occurs when nurse leaders engage staff by providing structures and opportunities for involvement during all phases of the change process.[200, 224] Leaders who demonstrate genuine commitment to the change[222, 225] and role model risk-taking and innovation are better able to achieve the intended goals of the change.[71, 81, 211]

e Type of Evidence

There is "C" type evidence to support Leading and Sustaining Change as an essential element of effective nursing leadership practice. All of the related Core Competencies and Sample Behaviours have been drawn from a range of B to D type evidence with the majority being type B and C.

A body of research points to the need for ongoing communication across all levels of the organization.[48, 102, 115, 225] Open communication may lead to employee acceptance of the change and increased job commitment.[102, 115, 218, 219] Effective communication strategies include soliciting staff feedback and perceptions of the change.[115, 224, 226] Information needs to be shared in a way that is relevant to the unique context for different individuals at all levels of the organization[81, 125] The need for information includes communication of measurable goals and progress reports at regular intervals.[119]

Strebe[193] suggests that leaders often under-estimate the learning needs necessary to support change. If adequate time, resources and educational opportunities are negotiated, it is more likely that the quality and efficiency of the services will be maintained.[119, 225] Resources required to achieve the goals of the change initiative should be aligned with the magnitude of the expected change in practice, process, or culture.[119, 222] Employees are better able to succeed with change when nurse leaders build trust and offer ongoing support[227] by being present and visible at the level where the change is occurring[99] and by listening and responding to the emotions and reactions of staff.[223, 229] For change to be effective and sustained over time, strategies are needed to embed the new initiative within ongoing operations of the organization.

Table 1.4 Core Competencies and Sample Behaviours for Leading and Sustaining Change

CORE COMPETENCIES	SAMPLE BEHAVIOURS
1.4.1 Nurse leaders create a shared vision for ongoing change with stakeholders and experts.[38, 71, 107, 211, 221]	• Reflect on personal attitudes and skills regarding change and change management • Question the status quo and challenge assumptions, values, structures and processes[71, 81, 221] • Scan the environment to identify demographic and policy changes that are occurring external to the organization[99, 128] • Actively collect information that suggests new approaches[222] • Critically apply the evidence to change initiatives • Make connections with partners who can help extend the thinking and approaches used within the organization[222]
1.4.2 Nurse leaders engage others by sharing the vision for ongoing change. [38, 71, 96, 107, 221]	• Build strategic relationships and partnerships[128] • Build coalitions for change[220], accumulating sufficient agreement from a critical mass of people[99] • Reframe a change due to crisis as an opportunity instead of a threat[222] • Demonstrate commitment to the change[228, 231]
1.4.3 Nurse leaders involve stakeholders and experts in planning, designing and redesigning the change.	• Seek input from staff and labour groups early in the process • Bring together people at many levels to talk about shared goals and ensure goals are aligned[221] • Involve the people who are affected by the change in the change process[64, 230, 231] • Identify expected behaviours clearly • Engage stakeholders to build ownership for the change[224] • Identify key supporters, influencers and champions for the change[222] • Demonstrate respect and recognition for the expertise and individual talents that have contributed to the change[224] • Encourage a belief that changes can be made and build a sense of possibility[86] • Encourage considered risk taking and innovation, and role modeling these attributes[71, 81, 123, 134, 211, 222] • Examine lessons learned regardless of outcomes

CORE COMPETENCIES	SAMPLE BEHAVIOURS
1.4.4 Nurse leaders negotiate for the required budgetary support for the educational processes,[136, 193, 226] decision support and other resources required to achieve the goals of the change initiative.[113, 119]	• Invest in the time and resources required for the change as well as for related changes required to create the shift in culture, strategy, process and policy[222] • Quantify the new knowledge needs and behavioural expectations to support the change[193] • Implement varied learning opportunities to meet the knowledge needs at various time points
1.4.5 Nurse leaders provide ongoing communication throughout the change process.	• Translate and interpret nursing issues to effectively communicate with and influence individuals within each unique context (e.g., clinical, executive, academic and political)[81,125] • Update communication regularly[218, 219] • Include information regarding economic and policy factors that are behind the change[225] • Provide adequate information to assist with decision-making during the change • Provide ongoing progress reports of change initiative[225]
1.4.6 Nurse leaders develop and implement mechanisms for feedback, measurement and redesign during the change.[119, 232]	• Identify measurable goals and mechanisms to track progress[119, 231] • Solicit feedback and staff perceptions of the change both formally and informally[115, 224, 226] • Pace the changes planned and set priorities for redesign activities to allow sufficient time for adaptation[115] • Structure ongoing opportunities for feedback (formal/informal) and use active listening techniques • Negotiate and mediate solutions to issues which arise during the change process • Remove barriers to achieving outcomes and take responsibility for outcomes[80] • Develop contingency plans to manage unexpected challenges to the change project • Manage the conflict that can arise from change • Address role conflict and ambiguity and discuss how roles and responsibilities will change[115, 233] • Revise tactics and redesign the change project based on outcomes and feedback through all phases of the change initiative • Celebrate the achievement of milestones[115, 222]
1.4.7 Nurse leaders support, coach and mentor others to succeed with the change.	• Build trust and offer support to enhance collective action toward the change[227] • Avoid overselling and overcompensating • Be truthful about personal ambivalences, reservations and commitment to the change[99] • Stay close to the experience of the followers, in proximity to where the change is occurring[99]
1.4.8 Nurse leaders sustain attention to the change initiative throughout all stages of the change.[234]	• Embed the new initiative within ongoing operations[119] • Assess ongoing issues/activities of the leader and the follower and determine when intervention is needed[99] • Speak truthfully about the change – things are not likely to 'calm down' as more change is always coming[99]

Planning for Success – Suggested Strategies for Leading and Sustaining Change

Individual Strategies

- Understand and acknowledge that the uptake of change varies from individual to individual
- Work with colleagues in Human Resources, Finance and Quality Improvement to gain access to data to track the outcomes of change
- Conduct a stakeholder analysis to determine those who can promote or inhibit the change[99, 223]
- Learn about the perspectives of each stakeholder and how the change can be meaningful to them[23]
- Be patient and open to opportunities to advance the change[235]
- Develop a support network to sustain personal energy throughout the change process[236]

Team/Unit Strategies

- Engage nurses in building a vision
- Share both the vision and the tactics of the change at open forums and through the use of technology[236]
- Build team confidence in the team's ability to manage the change through skills training for new tasks, teamwork[220] and focusing on strengths
- Discuss similar initiatives that were unsuccessful about what could be done differently[236]

Organization Strategies

- Communicate at regular intervals using multiple methods and strategies[102, 115, 231]
- Link change plans to the organization's strategic goals[231]
- Plan communication strategies such as newsletters, meetings, open forums and one-on-one meetings between staff and leaders throughout the change process[119]
- Consult early and often with staff and labour groups
- Offer change management workshops that include delegation and managerial skills,[119] team-building skills[115, 136]
- Use implementation manuals[236] throughout the process to increase consistency[234]
- Use evaluation data from employee surveys and focus groups to track both processes and outcomes and inform decisions[231]

Helping Others to Cope with the Effects of Change

- Listen to their concerns and be empathetic rather than judgmental
- Attend to the individual's personal and work-related concerns
- Focus on the event and the associated emotions
- Help individuals to own these feelings and not depersonalize them by intellectualizing
- Verbalize confidence that action by the individual is possible and help them to develop a sense of confidence and hope[230]
- Provide encouragement and thanks by sending a card or a small token such as flowers[235]

1.5 Nurse leaders balance competing values and priorities.

Balancing competing values and priorities leads to:

- **Decreased stress for nurses**[237]
- **Increased perceptions of their value**[127, 130, 136, 238] **and self-image**[239, 240]
- **Increased job satisfaction for nurses and their leaders**[130, 136, 218]
- **Decreased disengagement from work**[240, 241]
- **Decreased intent to leave the organization or nursing**[239, 242, 243]
- **Increased trust in leaders**[130, 136]

Discussion of Evidence[f]

Nurses and their leaders are frequently faced with a wide range of competing priorities and demands including the needs of individuals, families, professionals and the overall organization.[239, 244] Ultimately, choices about what takes precedence and which course of action to follow must be made and may create an ethical dilemma for nurses and nurse leaders particularly when decisions are influenced by professional expectations, organizational politics or hierarchal power structures. Splane and Splane[245] noted that nurses in senior policy roles were similarly challenged by "competing considerations" (p. 158). Posner, Kouzes and Schmidt[246] found that value congruence between managers and their organizations is linked to perceptions of personal success, organizational commitment and commitment to ethical behaviour, and sets a climate for discussion of issues based on values.

Nurses are socialized to believe in providing care that is best for each patient/client[247] and the value of their professional knowledge in contributing to positive patient/client outcomes. Lageson[248] found a significant relationship between the first line manager's focus on meeting patient/client care needs and nurses' job satisfaction. Lack of congruence between nurses' values and beliefs and organizational values and decisions can lead to ethical distress.[G 249]

Balancing cost and quality care, manifested in issues such as staffing and rationalization of supplies is a major issue for nurse leaders.[112,127,140, 189, 238, 239, 242] Nurse leaders are expected to speak for nursing and uphold its values, advocating for both patients/clients and staff, despite fiscal restraints.[36, 38, 94, 100, 113, 134, 187] When nurses perceive that the organization and its leaders place a greater value on cutting costs than providing quality care, the result is decreased trust in leadership, decreased job satisfaction,[127, 130, 136, 218] increased stress,[237] decreased perceptions of worth, decreased organizational loyalty and increased intent to leave.[127]

Relationships with physicians, administrators and other health care team members can be a source of distress in organizations where there is preferential treatment of physicians or disrespect for nurses and their knowledge. Support for open dialogue[140, 250] which extends to the governance level of the organization[239] is important as many of the issues are related to relationships.[244]

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f Type of Evidence

There is "C" type evidence to support Balancing Competing Values and Priorities as an essential element of effective nursing leadership practice. All of the related Core Competencies and Sample Behaviours have been drawn from a range of C to D type evidence.

Values and beliefs will vary somewhat within the nursing team as well. Of the Registered Nurses working in Canada in 2002, 6.9% were internationally educated.[251] Nurses belonging to various generations and ethno-cultural backgrounds have different work ethics and attitudes,[110] yet need to work together as a cohesive team to achieve positive outcomes for clients.[112] Cronkhite[238] found that nurse leaders who identified with patients/clients and nurses had more conflicts in their relationships at the senior level of the organization; those who were viewed to be organizational advocates had more conflicts with younger nurses.

The role of the nurse leader is to promote and establish a practice environment that balances multiple demands and perspectives so that nurses can provide quality care. Transformational leaders are said be of high moral character.[252] Nurse leaders are expected to be a "moral compass", raising concerns[140] when competing demands are likely to negatively impact the quality of patient/client care. Nurse leaders must first reflect on their own values[112, 140, 239, 241, 250] before they can recognize the values and ethics underlying situations and deal effectively with the issue.[250] Gathering information and appraising the situation[112, 127, 253] are critical as many of the issues are rooted in context.[244] Storch[140] describes the importance of knowing when to "draw the line", understanding when to push and when to hold back.

Communicating the rationale for the selected actions, taking an active role in securing the necessary resources[250] and ongoing monitoring of the effects of the decision are part of the leader's role. Leaders help others to see situations not always as a choice between opposites, but as decisions between these choices that need to be optimized over time[254] by shifting emphasis and action as needed. For example, at some times nurse leaders may elect to put resources into nurse educator positions to support nurses in improving practice; at other times to add direct care positions.

Table 1.5 Core Competencies and Sample Behaviours for Balancing Competing Values and Priorities

CORE COMPETENCIES	SAMPLE BEHAVIOURS
1.5.1 Nurse leaders identify and acknowledge values and priorities.[112, 140, 239, 240, 250]	• Use values clarification to identify own values, values of others and the values of organization[110, 112, 140, 238, 239, 253] • Separate personal values from professional responsibilities[239] • Share and communicate vision, values and priorities explicitly[38, 87, 110, 112, 238, 255] • Articulate a process to define the values and vision of nursing within an organization[140] • Understand that values evolve over time in response to life experiences[256]
1.5.2 Nurse leaders acknowledge and incorporate multiple perspectives in decision-making.[112, 253-255]	• Gather information from multiple sources • Use decision support tools[136] • Identify and communicate the values that underpin the decision[112] • Display sensitivity to multiple pressures including finances, power and politics[253] • Identify the consequences of emphasizing one perspective over another[250, 255] • Use clinical and professional nursing knowledge in decision-making[112, 257] • Identify ethical and moral issues[140] • Know when to speak up and when to pull back[140, 129]

CORE COMPETENCIES	SAMPLE BEHAVIOURS
1.5.3 Nurse leaders help others to understand conflicting perspectives and decisions.	• Acknowledge and name conflicting perspectives[140, 254, 255] and identify their interdependencies[254] • Assist others with values clarification and support them to express their values and views[112, 140, 239, 249] • Understand that cultural diversity influences perspectives • Discuss why one perspective is valued/selected over another[255] • Create shared accountability and build collaborative relationships[112, 134, 253-255] • Help others to understand the business aspects of health care[112] • Learn about and communicate resource constraints – equipment, staff
1.5.4 Nurse leaders employ strategies to advance priority initiatives while maintaining other valued initiatives and perspectives.	• Develop flexible practices to be able to respond to changing priorities[254] • Promote and reward flexibility and innovation related to achieving balance[254] • Focus on goals and what can be achieved[239] • Explore alternative ways to address challenges[134]such as use of technology or redesign[112]
1.5.5 Nurse leaders advocate for the necessary resources to accomplish goals and objectives.[250]	• Provide data to demonstrate need for resources • Provide required staffing, supports, time and equipment[38, 81, 123, 134, 155] • Align resources with priorities and professional standards over the long term[81, 250]
1.5.6 Nurse leaders demonstrate accountability and take responsibility for outcomes.	• Monitor effects of decisions on patients/clients and staff,[130, 253] and on resource allocation and quality[112, 255] • Identify and monitor indicators of imbalance[254] • Identify the people most sensitive to negative[254] impacts and seek frequent feedback • Promote the accountability of others

Planning for Success – Strategies for Balancing Competing Values and Priorities

Individual Strategies

- Use self-reflection to identify personal values
- Use ethical frameworks to assist with clarification and decision-making
- Focus on research studies, patient/client outcome data and current literature to support staffing, skill mix and hours of care[109]
- Educate board members and other members of the management team about the link between nursing work environments and patient/client outcomes, including staffing levels and patient/client outcomes[48, 140]
- Form alliances with like-minded groups and individuals
- Check fit between personal philosophy and beliefs of organization before accepting role[128]

Team/Unit/Organization Strategies

- Develop and uphold a philosophy and mission statement that speaks to the value of nursing and places patients/clients first
- Establish shared governance models to encourage sharing of information and decision-making
- Establish utilization review committees to address resource allocation[258]
- Establish forums for discussion of ethical concerns including formal and informal ethics rounds and discussions and ethics committees[140, 239, 258, 259]
- Develop whistleblowing[G 198] policies

Organization Recommendations[G]

2.0 Health service organizations provide support for effective leadership.

Organizational Supports for Effective Leadership include: [156, 173]

- **Organizational culture that respects and supports professional nursing**
- **Access to formal power – positional power; access to resources, information, and practice autonomy**
- **Access to informal power – networks and relationships**
- **Advancement Opportunities – support for professional growth and development and leadership opportunities**
- **Respectful and collaborative teamwork**

Discussion of Evidence[g]

Although Pearson et al.[52] reported that there is limited high quality research on the direct impact of work environments on developing and sustaining nursing leadership, there is evidence that describes the influence of the work environment on nursing leadership. Participants in a Canadian study by Jeans and Rowat[260] which included nurse executives, managers and staff reported that the enablers and barriers to acquiring leadership competencies included supportive work environments, clear and reasonable expectations, balanced work/life, reasonable workload, and accessibility to management education programs.

Some research has found relationships between empowerment in the workplace and effective nursing leadership.[151, 155, 261] Laschinger and Shamian[261] reported a strong link between the nurse managers' perceptions of empowerment and self-efficacy for leadership.

In a study comparing nurse leaders in both magnet and non-magnet organizations, Upenieks[82] identified specific organizational factors that support nurse leaders and that encourage clinical leadership by enabling nurses to use their expertise, knowledge and skills in clinical care. Although both magnet and non-magnet hospital nurse leaders agreed on the importance of these supports, magnet hospital nurse leaders reported they were better able to provide them.[155] Similarly, in a study conducted in a long-term care setting, McGilton et al.[58] found that RN and RPN leaders' ability to enact supportive leadership was affected by supports such as supplies, funding and staffing, clear role descriptions and sufficient clerical support and support from senior management.

Boyle and Kochinda[262] found that physicians' and nurses' perceptions of nursing leadership and problem solving between groups increased significantly following an intervention which involved training in collaborative communication that was attended by both the nurse and physician leaders in an ICU setting. Krugman[263] reported that a participative management climate characterized by group decision-making, interactive communication and decentralized control enhanced the nurse leader's occupational image and

g Type of Evidence
There is B, C, and D type evidence to support this recommendation.

sense of professionalism. These supports are consistent with Kanter's elements of structural empowerment[156] and are consistent with the attributes of professional practice environments that have been linked with positive outcomes for patients/clients and nurses.[43, 89, 264]

2.1 Health service organizations demonstrate respect for nurses as professionals and their contribution to care.

Discussion of Evidence[h]

> *"Organizations need to deliver the message that "Nurses are the most crucial asset and patient care is the most crucial outcome."*
>
> *Upenieks [81 p.462]*

A number of studies and reports have shown that nurses perceive lack of respect in the workplace.[1, 9, 140, 239 238] Visible demonstration of respect for nurses and fairness in the work environment has been linked to empowerment[90] and results in better interpersonal relationships and greater trust in leaders,[90] thus enhancing the leader's effectiveness. The contribution that nurses make to patient/client care,[112] particularly by senior management[64] resulted in nurses reporting lower emotional exhaustion, better emotional health and being better able to attend to important patient/client care needs.

Devine and Turnbull[265] conducted a series of focus groups across Canada in four major centers, asking nurses what defines a respectful environment. The respondents identified a number of indicators including:

- not expecting nurses to work "just anywhere" regardless of their education and experience;
- staffing levels sufficient to match the workload;
- inclusion of nurses in organizational decision-making;
- nurses being managed by people with a nursing background;
- zero tolerance for the abuse of nurses; and
- professional development opportunities.

Strategies for Success that Demonstrate Respect for Nurses as Professionals

- 2.1a **Designate a senior nurse leader role**
- 2.1b **Hire nurses as front line managers**
- 2.1c **Hire nurse leaders with appropriate education and credentials**
- 2.1d **Support the stability of nursing leadership**
- 2.1e **Recognize nurses' contributions to patient and organizational outcomes**

h Type of Evidence
There is B, C and D type evidence to support this recommendation.

2.1a Designate a senior nurse leader role at the executive level of the organization.

Discussion of Evidence[i]

Nurse leaders play an important role in designing systems of care delivery that enable participation in clinical and organizational decision-making, resulting in improved practice and better patient/client care.[36, 43] Delivery systems that fail to provide satisfaction for providers and patients/clients have been identified as a major factor in two national nursing shortages in the United States in the late 1980s.[36]

A number of nursing reports and authors have recommended designating senior nurse leadership positions at the executive level that have accountability for nursing practice and operations and have input at the governance level.[1, 36, 48, 123, 266, 267] In the Province of Quebec, provincial legislation requires that all health care organizations have a director of nursing care who is a nurse and that every institution with five or more nurses has a council of nurses responsible to the board of directors.[268] In the Province of Ontario, governance bodies are required to pass by-laws that set out procedures for the appointment of a nurse as the chief nursing executive[G] of the hospital along with the function and responsibilities of the role.[269] In a study of the progress on the recommendations cited in the Canadian Nursing Advisory Committee[1] report *Our Health, Our Future: Creating Quality Workplaces for Canadian Nurses,* Maslove and Fooks[270] reported that although many organizations have senior leadership positions for nursing, these individuals are not always part of the senior management team.

Leadership, along with sufficient resources and control over the practice setting have been shown to be predictive of nurses' job satisfaction and retention and to lead to better quality of care.[271] Having a nurse participate at the highest level of the organizational decision-making is an attribute of magnet hospitals and is an eligibility requirement for Magnet accreditation.[266] When the senior nurse leader is highly visible and accessible to staff, it helps to foster recognition of nurses' work and provides nurses with the opportunity to express their views.[36] The Revised Nursing Work Index instrument,[272] a measure of the characteristics of professional nursing practice environments, includes questions about the presence of a chief nursing executive "who is highly visible and accessible to staff" and "who is equal in power and authority to top level hospital executives".

The Institute of Medicine Report[48] links nurses' work environments to patient/client safety and recommends that organizations have nurse leaders at all levels of management, both organization-wide and at the patient/client care level. The authors of this report indicate that although they did not find evidence supporting a particular organizational structure for nursing leadership, they recommend "well-prepared clinical nursing leadership at the most senior level of management" (p. 134). Clifford[36] supports the need for the senior nurse leader to have open access to nursing leadership roles across the organization to be able to define a common direction for nursing care. The role of this leader is to participate in executive decisions, represent nursing staff, facilitate communication with nurses, facilitate input of nurses into design of work processes and work flow and to provide the resources needed to support nursing knowledge

i Type of Evidence
There is B, C, and D type evidence to support this recommendation.

and information needs.[48] Clifford[36] expressed the need for clinical staff to be able to connect to the larger organization through the senior nurse leader because of the loss of traditional nursing departments. This is especially true in organizations that have adopted a program management structure.

Clifford[36] noted that the senior nurse leader needs to have access to appropriate role partners such as medicine, the chief executive officer and the chief financial officer. Burner[273] found that placement of the chief nursing officer in the organization had an effect on nurse-physician relationships and the safety and competence of nursing care. Crossley[274] reported that the level of role conflict and role ambiguity declined consistently for senior nurse leaders when there was a close link to the governing body of the organization.

2.1b Hire nurses into first line manager roles where the primary focus of service delivery is nursing care.

Discussion of Evidence[j]

Several reports have recommended that where the primary focus of service delivery is to provide nursing care and/or the critical mass of staff are nurses, the front-line manager should be a nurse.[1, 9, 123, 267] Nursing is a practice discipline, a profession supported by standards, education of new practitioners, and the conduct of research and application of evidence. Leadership in the context of core nursing values and beliefs is necessary to support the practice of nursing.[38] Nightingale held the view that "only those trained as nurses are qualified to govern or train other nurses".[275]

Restructuring and program management structures in organizations have resulted in the disappearance of traditional nursing departmental structures[38] and an identifiable nursing leader. Clifford[36] found that the ongoing substantial changes in health care organizations and significant workloads have affected clinical staff who look to leaders for consultation and a leader who can monitor both quality of care and staff development needs. Clifford[36] found that when nurse managers reported to non-clinical managers their work was compounded by having to explain aspects of their roles to a person who does not have a clinical background. In a series of six focus groups conducted in three major Canadian cities, staff nurses reported that non-nursing managers do not understand or appreciate their concerns related to patient/client care and operational issues.[265] Baumann et al.[9] noted that without professional leadership, poor nursing practice may go unnoticed.

j Type of Evidence
There is C and D type evidence to support this recommendation.

2.1c Hire individuals for nursing roles that have the appropriate education, experience and credentials for the role.

Discussion of Evidence[k]

The American Association of Colleges of Nursing[267] recommends hiring individuals for nursing leadership roles that have appropriate education and credentials (e.g., required certification or advanced educational preparation) required for their roles. Several studies noted that nurse leaders with advanced education were considered more effective in their roles.[55, 75, 80, 112, 276]

2.1d Acknowledge and promote the importance of nursing stability

Discussion of Evidence[l]

Stability of nursing leadership supports personal relationships, trust and open communication among leaders and staff and among leaders and their colleagues[277, 278] ultimately resulting in sharing of knowledge.[278] The informal power of nurse leaders, which has been linked to empowerment[178] and the nurse leader's effectiveness is derived from credibility and alliances with people in the organization,[109] both of which develop over time. A systematic review of research studies that examined the effects of restructuring on nurses, demonstrated decreased satisfaction with their supervisor as a result of changes in the relationship and loss of trust with administration.[279]

Frequent turnover of nursing leadership in the organization is unsettling for staff[280] and is likely a sign of an unhealthy work environment. An organization's commitment to leadership stability indicates a commitment to nursing and confidence by senior management in nursing leaders to manage nursing. This commitment may be perceived as a safety net for risk-taking by nurse leaders. Consistent leadership enhances the nurse leader's ability to know their staff and colleagues and patient/client care issues more closely, and enhances the organizations' ability to launch multiple year strategies and see them through.[280]

In a study of nursing homes, Anderson et al.[281] found that the tenure of the director of nursing was a strong predictor of lower turnover among Registered Nurses and Licensed Vocational Nurses. This finding suggests that the longer the leader is in the job, they are better able to connect with staff, to foster job commitment, and to learn more about the organization and its nurses for more effective management. A related study found that the tenure of the nurse leader resulted in improved patient/client outcomes.[78] Given the dynamic nature and frequent changes of personnel and structures within organizations, there is a need for strategies to maintain continuity of leadership within organizations.

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k Type of Evidence
There is C and D type evidence to support this recommendation.

l Type of Evidence
There is B, C and D type evidence to support this recommendation.

Planning for Success – Suggested Strategies for Success

- Establish shared leadership models such as shared governance[282]
- Establish teams of professionals working in a fluid matrix[283]
- Develop a succession plan for nursing leadership[282]
- Use available opportunities to speak to the importance of a stable environment in supporting nurses' ability to provide quality care

2.1e Recognize and demonstrate valuing of nurses and their contribution to patient/client and organizational outcomes.

Discussion of Evidence[m]

An organizational culture[G] that values quality care and demonstrates valuing of nurses and their contribution to care is an important support for nurse leaders.[112] Turnbull and Devine[265] reported that the recognition of nurses' contributions is an indicator of respect for nurses. In a study comparing magnet and non-magnet leaders and their organizations, 86% of the nurse leaders in the magnet organizations reported strong administrative support for nurses. The senior administration teams in these organizations recognized the importance of nurses' roles, particularly the value in close observation and care of patients/clients. Nurse leaders in the magnet organizations reported the positive influence they had achieved in their organizations while nurse leaders in the non-magnet organizations reported that they spent considerable energy articulating the importance of nursing to the organization.[81]

Strategies for Success

- Establish and maintain an infrastructure for practice support such as nursing governance committees, advanced practice roles, nurse scientists, designated roles with separate accountability for professional practice[267]
- Differentiate nurses' practice roles based on experience, education and certification (clinical ladders[155, 267])
- Maximize nurses' scope of practice and reduce non-nursing tasks[1, 270]
- Create compensation and reward systems that recognize role distinctions that reflect experience, education, advanced credentials, responsibility and performance[198. 265, 267]
- Recognize professional and educational credentials on nametags and reports[267]
- Include nurses in media events, public relations announcement, strategic planning[267]
- Provide rewards for exceptional achievements and hold awards ceremonies to acknowledge the achievement
- Publish a nursing annual report or feature nursing in the organization's annual report[267]

m Type of Evidence
There is B, C and D type evidence to support this recommendation.

2.2 Health service organizations demonstrate respect for nurses as individuals.

Discussion of Evidence[n]

Respect for nurses in the workplace has been linked with autonomy.[90] Lack of respect has been linked with stress and decreased job satisfaction.[90] Nurses reported that expecting nurses to be available to work overtime and extra shifts, regardless of personal circumstances is disrespectful.[265] The average age of nurses in Canada is 44.5 years and one in three is 50 years or older.[284] Duxbury and Higgins[285] found that employees with dependent care responsibilities reported poorer physical and mental health than those without child or elder care duties. These individuals are part of the "sandwich generation" who are likely caring for aging parents, while at the same time have children living at home. Organizations need to find creative ways to encourage older nurses to remain in the workforce and to be available to share their clinical expertise and mentor and encourage younger nurses.

There are concerns that the emerging workforce may not be attracted to leadership positions in health care[110, 285] Younger workers describe the desire for work/life balance.[110] Leadership positions tend to be characterized by increasing job demands[255] and long working hours without adequate clerical supports.[1, 253] Duxbury and Higgins[285] reported that female managers and professionals are more likely than females in other positions to report high levels of burnout. Wieck et al.[110] noted the importance of nurturing young people if they are to become tomorrow's nursing leaders.

Respect for individuals in the workforce incorporates diversity in its broadest sense including cultural and ethnic diversity. Hemman[287] found that ethnicity was poorly documented in the literature, although Redmond[287] reported that 70% of the nurse executives were European-American and 3% were African-American. In a survey of Hispanic nurses in the U.S. completed by Villarruel and Peragallo,[288] respondents reported the importance of role models and mentors in nurturing and supporting leadership skills. Although the importance of both Hispanic and non-Hispanic mentors was noted, the importance of having a mentor that reflects one's ethnicity was reported not only in this study but by participants in a Canadian study by Tucker Scott[129]. Tucker Scott noted that racial and ethnic minorities continue to be under-represented in nursing education programs and therefore in the workforce and particularly at the supervisory level. In other studies, managers of colour have reported less satisfaction with the quality of opportunity and interpersonal relationships in the workplace.[289, 290, 292]

n Type of Evidence
There is B, C and D type evidence to support this recommendation.

Planning for Success – Suggested Strategies

- Establish alternative work arrangements[285] including flexible scheduling, flex-time policies and telework
- Offer a variety of shift lengths including 8, 10 and 12 hours
- Provide child care services
- Provide limited number of days of paid leave per year for child care, elder care or personal problems[285]
- Examine organizational "cultural competence" and barriers to leadership for visible minorities – see RNAO Healthy Work Environments Best Practice Guideline on *Embracing Cultural Diversity in Health Care: Developing Cultural Competence* (publication pending 2006)
- Tailor professional development programming to a variety of learning needs
- Use technology to offer professional development/in-service sessions throughout the 24-hour period
- Offer coaching and mentoring to boost the confidence of younger, less experienced staff[111]

2.3 Health service organizations provide opportunities for growth, advancement and leadership.

Discussion of Evidence[o]

Opportunities for growth and advancement have been identified as important not only for the support of professional and clinical leadership, but also for the personal development of those in formal leadership roles.[264] Links have been reported between growth opportunities and empowerment.[155,156,174] Opportunities for growth and development were found to be important aspects of magnet hospitals.[88, 156, 264] Upenieks[155] found that leaders in both magnet and non-magnet hospitals were focused on similar elements such as visibility, provision of staffing and equipment, but magnet hospital leaders showed greater focus on additional educational services.

Planning for Success – Suggested Strategies

- Build time for education and replacement staffing into nursing budgets
- Establish orientation and preceptorship programs[198, 267]
- Support continuing education through tuition support and flexible staffing[198, 267]
- Establish linkages with academic institutions to develop clinical teaching units, on-site continuing education and collaborative research[267]
- Provide internships for new graduates[267]
- Support evidence-based practice through access to library, internet and best practice guidelines
- Involve nurses in the planning for professional development programs[198]
- Support career planning through performance appraisals tools and processes
- Promote and support membership in nursing specialty organizations
- Promote completion of Canadian Nurses' Association certification by specialty

o Type of Evidence
There is B, C and D type evidence to support this recommendation.

2.4 Health service organizations support a culture of empowerment to enable nurses to have responsibility and accountability for their professional practice.

Discussion of Evidence[p]

Autonomy and input into decision-making have been linked to both staff and leader empowerment and positive outcomes for patients/clients and nurses.[38, 88, 112, 141, 156, 195, 197, 264] Autonomy, control and collaboration have been linked with trust in management[292] and associated with job satisfaction and perceptions of patient/client care quality.[271] Nurse leaders reported that participation in decision-making is vital to establishing nursing leadership throughout the organization.[109] In a study of hospital middle managers in Ireland, Carney[293] found that flat organizational structures facilitated their involvement in organizational strategy development and enhanced communication. This resulted in perceptions of greater management cohesion and more effective communication by the nurse managers reporting to them. The middle managers who felt excluded from strategic involvement reported feelings of being controlled and isolated. Dunham-Taylor[74] found that positive leadership behaviours increase as organizations become more participative. In a study of magnet organizations, nurse leaders reported the importance of backing nurses' decisions,[155] but non-magnet leaders reported having less certainty about degree of control in decision-making that nurses should have.[81]

Shared governance is a strategy that can be useful in supporting staff leadership and input into decision-making. Following an integrative review of the literature that spanned 1988 to 1998, O'May and Buchan[294] concluded that although shared governance is not a "one dose fix" (p. 296), it does result in many positive outcomes including increased perceptions of management effectiveness, increased development of staff, increased growth in skills, increased staff expertise and career development. They emphasized the need to provide education and staff support, mentorship, time to free staff to participate, and to set the boundaries of the decision-making latitude of staff groups and committees. Upenieks[295] completed a critical analysis of a number of intervention studies published from 1994 to 1997 using shared governance models and concluded that the implementation of shared governance enhanced job satisfaction, increased personal power, and nurse accountability and improved the work environment. Song et al. [296] found that shared governance resulted in increased job satisfaction for nurses. In a case-controlled intervention study conducted in an Emergency Department, Gokenbach[176] found that an empowerment intervention in the form of a nurse council with clear boundaries for decision-making resulted in a significant reduction and stabilization of nurse turnover.

Planning for Success – Suggested Strategies

- Design flat organizational structures that decentralize decision-making[144, 267, 293]
- Establish nursing representation on decision-making bodies that govern policy and operations, including those that hire new staff"[176, 265, 267] and particularly those that address finance, strategic planning and quality improvement[267, 297]
- Establish shared governance [294-296]
- Establish structures for nurses in direct care roles to provide input through a discipline specific structure such as a nursing council[198]
- Provide education and support and clear boundaries for decisions to enable participation in decision-making structures
- Establish policies and protocols that enable nurses to address ethical concerns and whistleblowing[198]
- Establish policies and protocols that enable nurses to address professional practice issues[198]
- Maximize nurses' scope of practice in all roles within the organization[198]
- Hold open discussion forums on a regular basis[187]

p Type of Evidence
There is B, C and D type evidence to support this recommendation.

2.5 Health service organizations provide timely access to information, effective information and decision support systems,[G] and necessary resources for patient/client care.

Discussion of Evidence[q]

Decision support tools such as utilization review tools and systems for analysis of practice processes and issues, patient/client outcomes, patient/client safety concerns, and computerized documentation and workload measurement tools are important supports for nursing practice and leadership.[267]

Access to information is a signal for being "in the know"[162] and having timely information about organizational decisions and policy changes has been linked to empowerment.[144, 162] Nurse leaders reported the importance of having sufficient information to carry out their role responsibilities.[109]

Providing the necessary resources for patient/client care is a strong signal of respect for nurses and the importance of their contribution to the organization.[187, 298] Resources for equipment, supplies, assistive help and technology are necessary to support quality care and clinical leadership. Laschinger et al.[156] found a link between resources, empowerment and autonomy. The extent to which a nurse leader is able to provide nurses with the necessary tools to do their work is a measure of the effectiveness of the nurse leader and her/his power.[187]

Having the necessary *staffing resources* that take into account complexity of care[267] is fundamental to the achievement of quality patient/client care and support for development of clinical leadership skills. Access to adequate staff resources has been shown to predict nursing job satisfaction, improve retention and increase quality of care.[271] Upenieks[81] found that magnet organizations had higher ratios of professional staff than non-magnet organizations.

Planning for Success – Suggested Strategies

- Establish mechanisms to communicate nursing and other organizational initiatives e.g., nursing newsletter, video clips on intranet
- Use email systems and web-based technology to provide current, timely information about nursing and corporate initiatives and events
- Hold open forums to share information
- Provide technical and clerical support to nurse managers and leaders to free up time to work with staff, patients/clients and families[260]
- Involve staff in developing and ongoing maintenance of workload measurement tools and discuss data regularly at meetings and see RNAO Healthy Work Environments Best Practice Guideline *Developing and Sustaining Effective Staffing and Workload Practices* (publication pending 2006)

q Type of Evidence
There is B, C and D type evidence to support this recommendation.

2.6 Health service organizations promote and support collaborative relationships.

Discussion of Evidence[r]

Collaborative relationships within organizations enhance trust[71] and empowerment[162] which influence developing and sustaining nursing leadership. Nurse leaders can enhance their own credibility and that of nursing, with their colleagues through discussion and relationship building to better understand each others challenges.[112, 140, 244]

Positive relationships with physicians is an attribute of magnet institutions.[89] Collaborative relationships with physicians can lead to mutual respect for each others' knowledge and knowledge sharing[144], which ultimately contributes to empowerment and enhanced clinical leadership.[144] Upenieks[144] found that teamwork was more prevalent at magnet hospitals, and non-magnet leaders reported slightly negative nurse-physician relationships.[821]

Upenieks[109] reported the importance of a collaborative management team within nursing as a support to developing and sustaining nursing leadership. A team that provides creative cooperation, empathetic communication, understanding and collaboration was seen as an important support in achieving organizational goals and effective leadership. Disch et al.[135] reported that collaboration between nursing administrative and nursing clinical leaders can be an invaluable partnership to enhance clinical leadership among nurses.

Nurse leaders reported that collaborative working relationships across the organization and from the senior team enhanced their effectiveness.[109]

Planning for Success – Suggested Strategies

- Establish interprofessional practice councils[198]
- Build time for collaboration into workload planning[48]
- Hold interprofessional meetings and rounds[109] with rotating responsibility for leading and teaching
- Establish a code of conduct and communication process for the interprofessional team
- Design and implement care maps and pathways[48]
- Establish interprofessional team peer review processes for adverse patient care events[267]
- Provide training in cross-cultural communication and conflict to enhance collaboration[135]
- Establish nursing management forums for mutual problem solving and information sharing
- Design workspaces to include shared lounges for informal interaction and private areas for consultation[48]
- Collaborate with a wide range of partners such as research groups, educational institutions, other providers and professional organizations
- See RNAO Healthy Work Environments Best Practice Guideline *Collaborative Practice Among Nursing Teams* (publication pending 2006)

r Type of Evidence
There is B, C and D type evidence to support this recommendation.

2.7 Health service organizations establish scopes of responsibility and accountability that enable effective leadership practices.

Discussion of Evidence[s]

A common cost-reduction strategy has been the reduction of management positions despite findings by The Gallup Organization[299] over a 25-year period that the manager and employee relationship is important to engaging and retaining employees. In 1956, Urwick,[300] writing in the *Harvard Business Review* noted that when a leader has a wide span of control[G], those individuals who seek contact with the leader will be frustrated in trying and will conclude that the leader is too busy to get to know them and understand their concerns. In a study of 14 hospitals undergoing reengineering, Walston and Kimberley[119] found that increased spans of control resulted in less involvement of staff in the planning and design of change, less information about the design of the change and decreased success in achieving the intended change.

Mullen et al.[301] found that as the span of control for supervisors grows larger, leaders were more likely to focus on tasks versus relationships and team members were more likely to be dissatisfied. A study from the chemical industry[302] showed that larger spans of control resulted in less monitoring by supervisors and significantly higher rates of unsafe behaviour and accidents. In the airline industry Gittell[303] found that small spans of control improved the strength of problem solving, mutual respect, shared goals and shared knowledge, and more timely communication between group members.

McCutcheon[65] found that the wider the span of control of nursing managers, the higher the unit staff turnover rate and for every increase of 10 in the span of control, the predicted unit staff turnover rate increased by 1.6%. As well, as the span of control increased, the positive effects of supportive leadership styles (transformational and transactional) on nurses' job satisfaction decreased and the negative effect of less supportive styles increased.

Cathcart et al.[304] found that employee engagement scores declined with an increase in span of control. These findings held within all categories of the demographic factors tested including tenure, work status, (full-time, part-time, casual), contract status (union, non-union) position (management, non-management) and job type (patient/client care, non-patient/client care). The engagement scores dropped most noticeably when the work groups grew larger than 15 and again, when groups grew larger than 40. The organization created additional management positions in four areas where nurse managers had direct accountability for more than 80 employees and one year later observed a positive change in engagement scores.

s Type of Evidence
There is B, C and D type evidence to support this recommendation.

2.8 Every health service organization has a strategic plan for nursing leadership development.

Discussion of Evidence[t]

Lack of leadership development opportunities can be a factor in the turnover of both nurses and their leaders.[280] Antrobus and Kitson[126] suggested that there is little incentive for aspiring nurse leaders to remain in direct practice versus moving to more visible leadership roles in academia, management or policy. They noted the need to advocate for career paths for direct practice that include clinical leadership development. These same authors emphasized the importance of developing both political and corporate skills in order to equip nurses to "work on even footing" and have a voice.

Although a number of studies[305-310] reported positive outcomes associated with formal leadership development programs, several authors[306, 307, 310, 312, 113] emphasized that new leaders also need to have opportunities to practice their new skills. Positive outcomes were demonstrated in a small, pilot intervention study of a competency-based orientation program for new graduates that incorporated multi-media learning strategies and the opportunity to practice new skills in leading seminars and rounds.[312] Participants in the intervention group demonstrated earlier readiness for leadership roles and greater leadership competencies.

In a study of a staff nurse leadership program[306] the supports needed were identified as: a critical mass of colleagues attending the program; mentors; and role-modeling of leadership behaviours by managers, clinical nurse specialists and other colleagues. Barriers were identified as: workload, turnover, lack of responsibility, insufficient goal setting with management, being new, and negative feedback when trying new behaviours.

A number of authors have identified the need for succession planning[G 196, 200, 307-309, 311] including moving nurses through management experiences and into formal leadership positions.[1] Nurse leaders reported that diverse leadership opportunities such as committee involvement and latitude for decision-making were important to their leadership development.[187]

Planning for Success – Suggested Strategies

- Develop a succession plan that moves nurses through leadership experiences[196, 200, 308-310,312]
- Provide leadership development programs[313] that include needs assessments and training objectives that are targeted to addressing the obstacles that exist within the organization[314]
- Provide access to external leadership programs[260]
- Incorporate live or videotaped models into leadership programs[311]
- Reinforce new behaviours through positive feedback[306]
- Conduct performance appraisals that incorporate comprehensive feedback[313]
- Provide opportunities to interact with leaders at least two-ranks up[311]
- Establish mentoring and coaching programs[260, 308, 313] including access to formal career coaches
- Create leadership roles for nurses such as educators or project leaders[109]
- Promote from within[109]
- Support nurses to participate on task forces and committees both internally and externally[163,196,313]
- Collaborate with educational institutions to provide leadership programs and opportunities for students[314]

t Type of Evidence
There is B, C and D type evidence to support this recommendation.

Personal Resources Recommendations

3.0 Nurse leaders continually develop their personal resources for effective leadership.

In a review of the literature several studies identified a number of personal resources that are supportive of effective leadership practices. It is important for organizations to understand and value the personal resources that nurses bring to the practice setting and find creative ways to lend support. Similarly, nurses need to be aware of these strengths to be able to assess, shape and draw on them. Personal resources include the nurse leader's *professional identity*,[G] *individual characteristics*[G] such as ethnocultural identity[G], emotional intelligence, coping skills, resilience and flexibility; *leadership expertise*[G] including knowledge, years of experience and formal, advanced educational preparation; and *social supports*[G] which include mentors, supportive colleagues, friends and family.

Wood-Allen[315] identified five factors that influence leadership style – self-confidence, innate leadership tendencies, progression of experience, influence by significant people, and personal life factors.

Strasen[317] discusses "professional self-concept" or professional identity as the set of beliefs and images held to be true as a result of professional socialization and notes it is based on individual self-concept, with one affecting the other. Strader and Decker[318] describe individual characteristics that mark a positive self-concept, including ability to cope with disappointments, future orientation and emotional intelligence[G].

3.1 Nurse leaders exhibit a strong professional identity.

Discussion of Evidence[u]

Apker et al.[197] found that although manager support predicted nurse organizational commitment, it was not predictive of commitment to the profession. This is in contrast to support from co-workers that was predictive of professional commitment. They offer the explanation that managers at the study hospital were seen to be more as representatives of the hospital rather than of their profession, given their focus on administrative duties.

Effective nurse leaders are passionate about nursing.[155] They have a clear understanding of what it means to be a nurse and a member of the nursing profession. This identity evolves through education, the work socialization process and through the influence of mentors.[319, 320] The socialization process requires the development of critical values including commitment to quality care and quality practice settings[35, 38, 81, 95, 112,134] while placing patients/clients first.[112,140] Other values include commitment to caring, justice, honesty, respect and integrity, [102] education, professional autonomy and respect for others.[319] These are traits similar to those attributed, to transformational leaders.[86]

u Type of Evidence
There is C and D type evidence to support this recommendation.

Nurse leaders demonstrate their passion and respect for the profession of nursing, its values, knowledge and achievements[36, 38, 80, 88, 100, 113, 123, 129, 139, 155] by speaking to the contribution of nursing to client/patient outcomes.[126, 140] Effective nurse leaders value and use both their clinical and professional nursing knowledge in decision-making.[112, 257] They are active in nursing professional organizations.[88, 129, 140, 263, 130]

> *"I am a nurse in a leadership role."*
>
> *Tucker Scott, p. 101*[129]

3.2 Nurse leaders reflect on and work to develop their individual leadership attributes, skills and competencies.

Discussion of Evidence[v]

When nurses and their leaders are asked about the attributes of effective leaders, *communication and listening skills* are consistently reported.[52, 88, 107, 113, 131, 260] Effective nurse leaders exhibit *resilience, persistence and hardiness.*[48, 82, 100, 189, 285, 322] which have been described as traits of transformational leaders[83] and have been linked to self-esteem and confidence.[322] In a study of mid-level nurse managers, Judkins[323] found that high hardiness was a strong predictor of low levels of stress and noted that hardiness can be learned. Sullivan et al.[324] found that resilience and employing humour led to preserving the leader's commitment and avoiding apathy during difficult times. The ability to practice *self-reflection* and have *knowledge of self* are critical personal resources needed to support effective leadership.[48, 82, 107, 325, 326]

Effective nurse leaders display a degree of *flexibility*[48, 81] have *comfort with ambiguity, uncertainty and complexity*[82, 112, 327, 328] and are willing to *take risks*[30, 82, 250] Effective nurses have been described as positive and approachable.[48] Nurse leaders have identified the importance of working from a moral framework and internal strength and confidence in their own values and beliefs[112, 239, 250] rather than being driven by security, power and prestige.[112, 140] They display *moral integrity*, which is reflected in actions that are consistent with their beliefs.[81, 82, 86, 106, 112, 239] Several authors note the importance of courage and risk taking.[112, 140, 250]

Upenieks[144] notes that clinical nurses have reported that they prefer to work with managers who are powerful. Formal and informal power are building blocks for empowerment[178, 329] and personal power.[151] In a study of nurse leaders, participants reported that they had a lot of power as a result of their role. However, they also reported that power lies within oneself and is gained through self-confidence and their inner strength.[109] Self-confidence has been identified as a trait of effective leaders.[109, 316]

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v Type of Evidence
There is C and D type evidence to support this recommendation.

A study by Weick et al.[110] that matched the views of the members of an emerging nursing workforce (under age 35) with those over age 35, showed that the two groups, for the most part valued similar traits of leaders, all of which have been linked with transformational leadership. Both groups valued honesty, communication skills, positive attitude and approachability. The differences tended to be that younger workers seek leaders who are more nurturing, confidence building, motivational, knowledgeable, and skilled at teambuilding.

Many of the characteristics attributed to effective nurse leaders such as self-knowledge, communication, relationship building, resilience and optimism[330] and vision[82, 88, 324] are consistent with emotional intelligence (EI). This concept was originally described by Salovey and Mayer [331] as an ability to recognize the meaning of emotions and relationships, and to reason and to solve problems on this basis. [332] EI was further described by Goleman et al.[333] as involving *self-awareness, self-management, social awareness*, and *relationship management*. Goleman[327] found that EI was twice as important as technical skills and cognitive abilities in leadership excellence. Both Goleman et al.[333] and Salovey and Mayer[331] suggest that EI can be developed. Guidelines for developing training programs for EI are available.[333]

Other studies have shown that EI is positively associated with transformational leadership[298] and linked with effective leadership.[48,84,114,328] Cummings et al.[64] found that leadership styles consistent with EI (labeled as resonant styles) mitigated the effects of hospital restructuring on nurses, while dissonant styles intensified the impact. Resonant leadership styles resulted in significantly less emotional exhaustion and psychosomatic symptoms, better emotional health, greater workgroup collaboration and teamwork with physicians, more satisfaction with their jobs, and fewer unmet patient/client care needs for nurses than did dissonant leadership styles.

> *"Nurse leaders perceived that their innate tendencies had shaped their leadership style."*
>
> *Upenieks p.188[144]*

3.3 Nurse leaders take responsibility for growth and development of their leadership expertise and mentor others to develop leadership expertise.

Discussion of Evidence[w]

Blais et al.[319] note that nurses who improve themselves perform more effectively, and in turn, promote a more positive image of nursing. The development of leadership expertise has been described as a process[74] of developing competencies and behaviours over time through education, preceptorship and mentoring.[50] Participants in studies in which nurses and their leaders were asked about the qualities of effective leaders identified years of experience,[52, 80, 117] advanced nursing education[71, 75, 112, 129, 276] and breadth of knowledge as important.[52, 57] Altieri[55] found that nurse executives with graduate education had higher transformational scores than those with lesser education. Gelinas and Manthey[136] noted that nurse leaders are responsible for managing their own professional development, and identified the need for nurse leaders to have the ability to lead across cultural and work unit boundaries and to facilitate teamwork and change.

A number of studies and authors address the ongoing professional development needed to enhance leadership expertise. Particular emphasis is placed on nurse leaders having knowledge that is grounded in clinical nursing[126, 129, 276] in order to have credibility with colleagues and to understand both the content and context of care, systems and organizations.[38] Antrobus and Kitson[126] emphasize the need for nursing knowledge as a central component of leadership development programs so that nurse leaders can not only develop nursing practice, but also explicate nursing knowledge.

Nurse managers in a Finnish study[181] reported the need for training to enhance their skills in research, leadership and working in groups to carry out problem solving. Similarly, in a study of Canadian managers, participants reported learning needs related to research.[209] A number of authors have reported the importance of a strong business sense[126, 136] and being able to use quantitative data to justify staffing and to be seen as credible by other members of the leadership team.[109] Middle and first-line managers reported that where the senior nurse leaders had this skill, they were gaining the ability to use financial data in their own decision-making.[109]

Nurse leaders need broad knowledge in the following areas:

- **professional nursing** [38,52,117,131,307]
- **leadership**[38, 113, 117, 131, 260, 307]
- **philosophy**[52]
- **ethics literature and ethics**[140, 259]
- **group processes**[52] **and team building**[136]
- **human and moral development**[52]
- **business and management knowledge**[112, 126, 136, 155, 257, 307]
- **change management**[136]
- **teambuilding**[260]
- **leading across a diverse workforce**[334]
- **research and research utilization** [209]

w Type of Evidence
There is C and D type evidence to support this recommendation.

3.4 Nurse leaders cultivate professional and personal social supports.

Discussion of Evidence[x]

Taylor et al.[335] noted that people who believe they have access to social supports from others live healthier lives, and to be able to cope more effectively with stress. Nurse leaders have identified mentors as important supports in the development and sustainability of their leadership ability. [82, 112, 129, 201, 189, 238, 239, 336.] In a study of senior nurse administrators, Madison[201] found that 97% of the respondents attributed change in their professional/personal lives to having a mentor, 74% attributed a change in self-confidence and 65% attributed a change in self-awareness. Other changes reported included increased risk-taking, enhanced global thinking, increased self-esteem and job enrichment, professional growth and improved performance as a manager. A meta-analysis[G] conducted by Allen et al.[337] showed that both mentoring related to learning about the organization and gaining exposure to opportunities and mentoring that provides interpersonal support have resulted in positive outcomes such as compensation, promotions and career and job satisfaction. In a study of staff by Walsh and Clements[336] participants reported increased self-confidence and increased self-esteem as a result of a mentoring relationship. Staff nurses included access to mentors in their top five ratings of supports for developing leadership competencies.[260]

Scott et al.[88] and Storch et al.[140] noted the importance of active involvement in nursing professional organizations, which is likely to be helpful not only to keep apprised of current nursing issues but also to access peer support. In a study of established leaders,[129] participants reported the importance of mentors and involvement in professional organizations and networks not only to be informed about issues and trends, but to develop political skills.

Nurse leaders reported the importance of support from friends, spouses, families and colleagues,[82, 238 239, 241] – particularly colleagues with transformational qualities.[82] Lindholm et al.[237] studied the relationships among professional networks, psychosocial resources and self-rated health. The study showed that nurse managers with high job demands, low professional networks, low social participation or low emotional support had increased odds for low self-rated health. However, nurse managers with exceptionally high job demands had elevated odds for low self-rated health regardless of the level of psychosocial support or professional networks. These authors suggest that nurse managers' job demands may be beyond a level where available support is sufficient and that further exploration of the factors contributing to low self-rated health is necessary.

Upenieks[109] reported the importance of cohesive nursing teams (who share common goals, are dedicated to the organization and each other, and work interdependently as a team) as a support for nursing leadership.

x Type of Evidence
There is C and D type evidence to support this recommendation.

System Recommendations

Recommendations for Governments

4.0	Governments develop policies and provide resources that support effective nursing leadership.

4.1 **Establish and sustain an identifiable senior nurse leader position in a national policy advisor role and in all provinces and territories.**
4.2 **Establish a national communication mechanism for these roles.**
4.3 **Establish a nursing advisory council in all provinces and territories.**

Discussion of Evidence for 4.1, 4.2, 4.3[y]

The Institute of Medicine report, *Keeping Patients Safe: Transforming the Work Environments of Nurses*[48] recommends having a senior nurse leader at the highest level of organizations because of patient/client safety issues, and of nurses' skills as integrators of clinical care at the institutional level. The role of the senior nurse leader is no less important at the level of government decision-making and health policy development. Two major nursing reports addressing the work environment of nurses, *Commitment and Care* [9] and *Our Health, Our Future: Creating Quality Workplaces for Canadian Nurses,*[1] recommended having nurse leaders in senior policy roles across the country. In reporting on the progress of the recommendations made by the Canadian Nursing Advisory Committee, Maslove and Fooks[270] noted that at the time of their publication (July, 2004), eight of the 10 provinces had a provincial senior nurse leader position.

Splane and Splane[245] completed an international study of national Chief Nursing Officers and acknowledged the importance of having these roles in sub-national jurisdictions such as provinces and states. These authors completed a historical review of the national role through review of the literature and discussion with key international informants. They concluded that the role had demonstrated effectiveness in: influencing policy formation; promoting optimal utilization of nurses; promoting nursing standards and education to improve patient/client safety; promoting nursing research; public speaking to educate others about nursing; promoting human rights and the importance of policy that supports the determinants of health; and advancing nursing as a respected human service. They also noted the importance of this senior leader in having links with national labour groups, professional organizations and two-way communication with nurses in all settings. They noted that although the majority of policy involvement was related to nursing standards, education and research, nursing recruitment and retention, and nurses' workplace conditions, there has been considerable influence on policies related to determinants of health such as universality of health programming and socio-economic status.

y Type of Evidence
There is C and D type evidence to support these recommendations.

Although nursing is trusted by the public,[338] the profession is not well understood[126] and nurses have frequently described feeling a sense of voicelessness.[140, 239, 339] Clifford[36] found consistently that nurses expressed the need to have someone who understands their practice at the highest level of organizations – advocating for what they do on behalf of patients/clients and families. A nurse leader in a senior government position is well positioned to develop strategies to teach the public and government about the role and contribution of nurses to patient/client and system outcomes.[88, 245] Nurses have reported that providing this type of education is crucial to enhancing respect for nurses.[265] Having a senior nurse leader in a policy role is an opportunity for governments to demonstrate visible support for nursing and serve as a role model for other organizations by maintaining this position.[245]

Having a senior nurse leader in a policy role is an opportunity for policy makers to better understand patient/client care issues and obtain expert nursing input for health policy direction and patient/client programming. Splane and Splane[245] noted that this is particularly important given the growth of "generalist" administrators in health care (p. 163) who have knowledge of business and public administration, but lack specialized knowledge of patient/client programs and the professional values and methods through which program goals are met. Two studies[126, 245] reported that senior nurse leaders played a role in translating nursing practice terminology, priorities, and potential impacts to those of the political context to reconcile a divide between the two, due largely to philosophical and language differences. This is similar to the essential role that senior nurse leaders play in interpreting and integrating nursing with senior administration and the governing body of organizations. Antrobus and Kitson[126] noted that this interpretation role is largely undertaken by individual nurse leaders and suggest that collectives in the form of nursing policy units could be valuable in analyzing and informing health policy.

Nursing issues are not necessarily perceived as a policy priority[112] and political agendas may take precedence.[126, 245] There is considerable evidence that links nurses' work environments and the impact on the quality of patient/client care. Health policy affects practice settings and ultimately patient/client and system outcomes. Through involvement of a senior nurse leader, health outcomes can be improved when nursing perspectives are built into budget and policy decisions that may impact the health of patients/clients. Having an accessible nursing expert who can provide advice on the potential impact of policy decisions on patient/client care is critical.[245] Splane and Splane[245] reported that nurses in senior policy roles played as important a role in preventing negative policy development as they did in initiating positive policy and working to support the implementation of existing policies in ways most favourable to patient/client care. Scott et al.[88] found that nurse leaders played a critical role in the process of restructuring. Splane and Splane[245] noted that the recruitment of nurses to senior roles in government, the voluntary sector and candidacy for election to parliament reflects acknowledgment of the value of nurses' leadership capacity, problem solving and managerial skills.

The establishment of supporting advisory groups for nurses in these policy roles has been recommended by both the Canadian Nursing Advisory Committee[1] and the Advisory Committee on Health Human Resources.[340] These groups are important to gain a broad range of stakeholder input to be able provide advice to the senior nurse and government to begin to shape policy. Further, there is a role for the advisory committees to discuss workplace and workforce issues and strategies and health human resources planning. Maslove and Fooks[270] reported that all of the Canadian provinces have a Nursing Advisory Committee with funded Nursing Strategies.

The federal Office of Nursing Policy (ONP) in Canada is responsible for advising Health Canada on the nursing perspective, representing nursing in various forums, contributing to health policy and program development, and working closely with the nursing community in developing advice to the government.[341] ONP provides a linking mechanism for provincial/territorial Chief Nursing Officers by coordinating meetings to discuss priority nursing issues. Together, the federal and jurisdictional senior nursing leaders discuss new evidence and link it to the priority nursing issues in order to recommend policy and strategies based on the best possible evidence.

4.4 Establish and maintain a program of nursing leadership research.

Discussion of Evidence[z]

Evidence that is readily accessible and can be directly translated into practice presents an important challenge in health care research.[342] Interventions studied in single studies under specific conditions may not be seen by end users as having applicability across settings. Thus replication of studies across populations and settings has been suggested.[342] Daly et al.[343] suggest that for research studies to be meaningful, all elements of the practice environment must be taken into account. They recommend that the best way to achieve this is through sequential studies that build on, and expand upon results of prior studies, such as would occur in a program of research.

Through a series of clinical studies, Daly et al.[343] found that a program of study provided a wider view of the variables of interest. They noted that starting off with a descriptive study and moving to an intervention study in a program of research permits testing of hypotheses using the appropriate variables and measures identified in earlier descriptive studies. They found that concentrating on an area of focus allowed their research team to develop a richer understanding of the phenomenon of interest, valid measures and relevant literature, and learn practical considerations for design of subsequent studies. They reported that a program approach to research resulted in increased confidence in their findings and helped them to avoid incorrect attribution of cause to a variable when studied in a single context.

Antrobus and Kitson[126] recommended the need for a program of nursing research. They noted that the study of leadership has had an internal focus in looking at the nature and purpose of leadership, leadership characteristics and the development needs of aspiring leaders. They recommend that the broader socio-political factors that influence leadership and how nursing leaders can shape policy needs to be examined.

z Type of Evidence
There is C and D type evidence to support this recommendation.

Recommendations for Researchers

5.0 Researchers partner with governments and educational and health service organizations to conduct nursing leadership research.

The Canadian Health Services Research Foundation (CHSRF)[344] stated that nursing human resources management and other workplace issues are critically important to nursing. They reported that a recent nursing consultation identified the need for strategies that address generational differences, related to expectations of work/life balance, full-time employment, and education and mentoring to support transitioning of new nurses into the work environment. They noted further, that the Foundation's creation of the nursing leadership, policy and research theme is a reflection of the importance of nurses' contribution to health care. The Nursing Research Fund was established in response to lobbying by nurses and nursing groups. The fund is designed to support research on recruitment and retention, management and the issues emerging from restructuring. CHSRF and the Canadian Institute of Health Research (CIHR) fund research projects, awards, research chairs, training centers and policy syntheses on nursing human resource issues.[270] A recent report on the progress of the recommendations of the Canadian Nursing Advisory Committee noted the need for further studies that address health and economic outcomes and translation of evidence into language that can be understood by decision makers in policy and administrative roles and the public.[270]

5.1 Conduct research on the impact of nursing leadership on nurse, patient/client, organizational and system outcomes.

Discussion of Evidence[aa]

Leadership is fundamental to the work environment of nurses and their leaders who are under increasing pressure to perform as organizations place more focus on managing costs.[48,83] Patrick and White[50] suggested the need for further research on the link between nursing leadership behaviours and patient/client and nurse outcomes to achieve recognition of the contribution of nursing to patient/client care. They noted that the majority of the published work is descriptive, with few experimental studies.

aa Type of Evidence

There is D type evidence to support this recommendation.

5.2 Develop, implement and evaluate a leadership intervention based on the *Conceptual Model for Developing and Sustaining Leadership* (Figure 2, pg 22).

Discussion of Evidence[bb]

Although the 2004 Institute of Medicine Report[48] states that managers, similar to their clinical colleagues should "search for and apply empirical evidence from management research in their practice" the report lists a number of barriers. The nature of management decision-making is such that the decisions are often made by groups involving negotiation or compromise and organizational constraints.[207] As well, training for managers in the use of evidence is not as consistent as it is for health care professionals.[207, 345] In a study of the nurse manager's role in evidence-based practice by Udod and Care,[209] participants identified a gap in their knowledge related to research and research utilization.

Not only has health care management research been limited by the level of funding it has received compared to management research in other industries, many organizations lack sufficient size and resources, including adequate data systems, to conduct and evaluate applied research.[119,205] Research funded by large health systems has been considered private and not widely shared.[205] Finally, evidence on effective management practices is difficult to locate, review and synthesize as a result of poor indexing.[205]

5.3 Conduct research on health human resources planning for nursing leadership roles.

Discussion of Evidence[cc]

Effective health human resource planning is critically important in the current environment of change.[346] The elimination of managerial positions between 1994 and 2002 in Canada[33-35] has resulted in wider spans of control for nurse leaders and fewer supports for nurses.[9, 284] Human resource planning needs to include planning for nursing leadership roles based on sound data. The Nursing Workforce Study[340] identified many deficiencies in national data bases such that many policy questions about nurse supply cannot be answered. Further, they recommended that human resource planning research needs to go beyond supply models and examine a variety of needs within jurisdictions to enable system planning. This recommendation was echoed by Baumann et al.[9] who recommended development of labour-market databases and human-resources forecasting tools.

bb Type of Evidence

There is D type evidence to support this recommendation.

cc Type of Evidence

There is D type evidence to support this recommendation.

5.4	Conduct research on nursing leadership education and development.

Discussion of Evidence[dd]

There is evidence that demonstrates that the nurses' relationship with the immediate supervisor is an important predictor of job satisfaction and intent to stay.[347-349] Thomson et al.[349] noted that, "at a time when nurses need leadership most the cadre is shrinking, leaving nurses with little day-to-day support and diminished access to those who are positioned within the hierarchy to advocate on their behalf" p. 26). Although Patrick and White[50] argue that it is difficult to operationalize leadership theories, they concede that educational interventions can increase leadership behaviours. Tourangeau et al.[305] found that a concentrated residential leadership program can strengthen leadership behaviours in both established and developing nurse leaders.

In a meta-analysis of research examining the effects of managerial leadership development programs, Collins and Holton[316] found that there was an emerging trend of transformational leadership but found little in terms of reporting on training or results. Further, they found few empirical studies to assess the outcomes of interventions such as coaching, mentoring or feedback. These authors recommend the need to track the return on investment of leadership development programs. Research in this area needs to further address the supports and barriers to interest and success in leadership roles, along with evaluation tools that address nursing leadership and performance.

Recommendations for Accreditation Bodies

6.0	Accreditation bodies of health service and educational organizations incorporate the organizational support recommendations contained in this guideline into their standards.

Discussion of Evidence[ee]

The quality of nursing leadership has been shown to determine the quality of the working environments in which nurses deliver care.[36, 88, 264] Clifford[36] advocates for the need to outline the duties and responsibilities of the senior nurse leader role within health service organizations as a standard, defined function with responsibility for nursing at the executive level. Having a nurse in a senior, influential role within the health service organization is a criterion of magnet accreditation and has been linked with positive outcomes in numerous studies. The Joint Commission on Accreditation of Health Care Organizations in the United States requires that nursing services are directed by a nurse executive with advanced education and management experience, who has responsibility for establishing and approving standards of practice, and nursing policies and procedures, and participates in quality improvement activities on an organization-wide basis[350].

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dd Type of Evidence

There is D type evidence to support this recommendation.

ee Type of Evidence

There is D type evidence to support this recommendation.

Education Recommendations[G]

7.0	Educational programs provide formal and informal opportunities for leadership development for nurses.

Discussion of Evidence[ff]

Leadership skill is needed in all areas of nursing, and in all roles in nursing. The Canadian Nursing Advisory Committee[1] noted that not enough nurses are moving into management and leadership positions. Traditionally nurse leaders were promoted from within the ranks of general duty staff, usually on the basis of superior clinical performance, with less emphasis on their ability to lead. After studying the desired traits of leaders in a population of nurses and students under age 35, Wieck et al.[110] conclude that because of an emphasis on entrepreneurial opportunities, short-term employment and work-life balance, these individuals may not be attracted to life-long health care careers, and particularly to leadership positions in nursing. These authors suggest the need to identify the preferred leadership behaviours that can be used for best practice models for educators and managers of younger nurses. Although there were some differences in perspectives between what younger nurses want from leaders, for the most part there was congruence with older workers, indicating that mentoring of emerging nurse leaders by experienced nurse leaders remains a viable strategy. A number of reports have recommended that there needs to be more opportunities for leadership development among nurses.[1, 9] Maslove and Fooks[271] note that although leadership development programs are available for nurses once they are managers, few programs are available for front-line staff.

Kilty's[46] review paper on *Nursing Leadership Development in Canada* details the available resources and programs related to nursing leadership development. The paper reports that many undergraduate programs for nurses include specific leadership and/or management courses – usually in third or fourth year. While a few universities offer post-basic leadership and management certificates or programs for nurses and other health care leaders, only a small number of universities were identified as having particular focus on nursing leadership at the Masters level. Presently there is only one stand alone offering for nursing leadership development in Canada – the Dorothy M. Wylie Nursing Leadership Institute.[351]

A staff nurse leadership program, studied over a four-year period, that used role play, feedback and mentors and was tied to personal goals and performance review, demonstrated positive changes in the nurses' leadership behaviours. Patients/clients and families reported enhanced trust and improved satisfaction with care. The nurses reported personal self-growth, improved self-confidence and assertiveness. They perceived themselves to be more effective, more organized and empowered. They reported perceptions of better relationships with colleagues and teamwork, enhanced negotiation skills and improved accountability and awareness of the health care system as a whole.[307]

Cunningham and Kitson[308,309] evaluated a clinical leadership development program in which the focus is practical, experiential and work-based, with an emphasis on skills acquisition and attitudes, values and behaviours needed to produce leaders. Transformational leadership was selected as the most appropriate leadership style. Outcomes from the program demonstrated increases in leadership capability by self-report and ward staff report, enhanced patient/client-centered approach to care and improved leader confidence.

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ff Type of Evidence
There is C and D type evidence to support this recommendation.

7.1	Nursing leadership programs incorporate key concepts of the Conceptual Model for Developing and Sustaining Leadership (Figure 2, pg. 22).

Discussion of Evidence[gg]

Based on the literature reviewed for this guideline and the consensus view of the expert panel, the following key concepts are essential building blocks for developing and sustaining nursing leadership.

At the broad system level:

- **The Canadian health care system, including the social, economic and political factors that impact this system at the national, provincial, and regional levels**
- **The political process including political persuasion and nurses' impact at all levels of governance**
- **The historical development of the health professions they interact with and influence the development of the nursing profession**
- **Health and social policy development[126] and reform at the national, provincial and local levels**
- **Current approaches to health service delivery models (e.g., managed care, managed competition)**
- **The roles of professional organizations and their influence on the nurse and service delivery**
- **Current and emerging issues and priorities for health service and policy**

At the organizational level:

- **Organizational theory and its application to health care delivery systems**
- **Health care delivery systems including managed care, managed competition**
- **Models of governance, particularly shared governance, empowerment**
- **Nursing workload models and continuous quality improvement**
- **Decision-making models including ethical frameworks[239]**
- **Legal framework for nursing practice**
- **Financial and budgeting concepts**
- **Cultural influences on leadership styles**

At the point-of-care level:

- **Relationship between knowledge acquisition/dissemination and empowerment**
- **Effective communication with individuals, groups, families and team-building strategies**

gg Type of Evidence

There is D type evidence to support this recommendation.

7.2	Nursing leadership programs offered through undergraduate, graduate and continuing education include formal and informal opportunities for leadership experience.

Discussion of Evidence[hh]

Formal leadership development programs have demonstrated positive outcomes. Collins[200] conducted a meta-analysis of managerial leadership programs from 1982 to 2002 and found formal training to be effective for knowledge outcomes, but the impact on organizational outcomes is not well known. In evaluating a nurse manager leadership program Wolf[307] found similar results and identified the need for participants to have more opportunity to practice their new skills and the need to identify long-term organizational outcomes.

Planning for Success – Suggested Strategies

- Support applications to, and placements for RNAO Advanced Clinical/Practice Fellowships[G]
- Include a leadership practicum component in basic, post-basic and graduate level education
- Design leadership education sessions that include a mentor and a mentee attending together
- Schedule support/discussion groups for new leaders or individuals involved in leading change or new projects with experienced leaders to share strategies and ideas

hh Type of Evidence
There is A, C and D type evidence to support this recommendation.

Process For Reviewing and Updating the Healthy Work Environments Best Practice Guidelines

The Registered Nurses' Association of Ontario proposes to update the Healthy Work Environments Best Practice Guidelines as follows:

1. Each healthy work environments best practice guideline will be reviewed by a team of specialists (Review Team) in the topic area to be completed every five years following the last set of revisions.
2. During the period between development and revision, RNAO Healthy Work Environments project staff will regularly monitor for new systematic reviews and studies in the field.
3. Based on the results of the monitor, project staff may recommend an earlier revision plan. Appropriate consultation with a team of members comprising original panel members and other specialists in the field will help inform the decision to review and revise the guideline earlier than the five-year milestone.
4. Six months prior to the five-year review milestone, the project staff will commence the planning of the review process by:
    a) Inviting specialists in the field to participate in the Review Team. The Review Team will be comprised of members from the original panel as well as other recommended specialists.
    b) Compiling feedback received, questions encountered during the dissemination phase as well as other comments and experiences of implementation sites.
    c) Compiling relevant literature.
    d) Developing a detailed work plan with target dates and deliverables.
5. The revised guideline will undergo dissemination based on established structures and processes.

Evaluation and Monitoring of Developing and Sustaining Nursing Leadership Guideline

Organizations implementing the recommendations in the Healthy Work Environments *Developing and Sustaining Nursing Leadership* Guideline are encouraged to consider how the implementation and its impact will be monitored and evaluated. The following table, based on the Conceptual Model for Developing and Sustaining Leadership (Figure 2, pg. 22) illustrates some examples of indicators for monitoring and evaluation. Many of these Indicators can be measured through use of one or more of the measures of concepts related to the leadership model as outlined in the inventory of these measures in Appendix D.

LEVEL OF INDICATOR	STRUCTURE	PROCESS	OUTCOME	MEASUREMENT
Objective	To evaluate the organizational supports that enable nurses to develop and demonstrate effective leadership practices and patients to experience effects	To evaluate organizational leadership processes and leadership behaviours related to the five leadership practices	To evaluate the impact of implementation of the guideline recommendations at all levels	To measure and monitor indicators of structures, processes and outcomes
Organization/Unit	Specific plans within the organization to implement the leadership guideline Structures consistent with recommendations related to organizational supports are evident in the organization such as: • Designated senior nurse leader role • Nurses in first line manager roles where nursing service delivery is primary • Span of Control for managers • Shared governance through nursing governance committees • Orientation and preceptorship programs that are comprehensive and tailored to new staff needs • Access to leadership development programs • Partnerships with educational institutions to provide formal leadership education • Role descriptions include expectations of leadership behaviours	Communication mechanisms established and used such as: • Newsletters • Open forums • Access to email Workload measurement tools in place and used appropriately to plan staffing Systems for monitoring results of effective leadership established and carried out e.g., • Nurse satisfaction • Sick time • Turn over • Length of time positions vacant Continuing education promoted through tuition support and flexible staffing Succession planning for leadership carried out	Organizational outcomes such as: • Turnover rates • Sick time • Stability of leadership staff • Retention rates	Human resources statistics, baseline and trends over time related to # of nurse managers relative to # of staff, turnover, sick time, retention of nursing staff in all roles Anticipated Turnover Scale (Hinshaw & Atwood) Nursing Assessment Survey (Maehr & Braskamp) Nursing Unit Cultural Assessment Tool (Coeling & Simms) Nursing Work Index (Aiken & Patrician) The Ottawa Hospital Model of Nursing Clinical Management Span of Control Decision Making Indicators (The Ottawa Hospital) # of persons studying advanced education Funds for Continuing education Practice Environment Scale of NWI (Lake) Professional Practice Environment Scale (Erickson et al.) Canadian Practice Environment Index (Estabrooks et al.) Perceived Nursing Work Environment (Choi et al.)

LEVEL OF INDICATOR	STRUCTURE	PROCESS	OUTCOME	MEASUREMENT
Nurse Leader	Availability of education and supports for nurse leaders and aspiring nurse leaders in all roles Numbers of nurses who access leadership opportunities Number of nurses who access leadership support and education	Nurses in all roles demonstrate leader competencies related to each of the 5 leadership practices evidenced through associated behaviours as outlined in the guideline Regular performance appraisal carried out including self-assessment Leadership behaviours are assessed as part of performance appraisal	Nurse outcomes such as: • Nurse satisfaction • Burnout • Motivation • Organizational commitment Student nurse outcomes such as: • Assessment of quality of learning experience • Satisfaction with nursing and learning experience	• Nurse Organizational Climate Description Questionnaire (Duxbury et al.) • Leadership Behaviour Description Questionnaire (Stogdill) • Leadership Practices Inventory (Kouzes and Posner) • Supportive Leadership Styles – Charge Nurse Support scale and Unit Manager Support Scale (McGilton et al.) • Six Dimension (6D) Scale of Nursing Performance (Schwirian) • Maslach Burnout Inventory (Maslach & Jackson) • Index of Work Satisfaction (Stamps & Piedmonte) • Organizational Commitment Scale (Porter et al.) • Nurse Job Satisfaction Scale (Hinshaw and Atwood) • Work Satisfaction Scale (Hinshaw and Atwood)
Patient/Client	Quality improvement programs are in place	Ongoing monitoring of effects of leader decisions on patients/clients, resource allocation and quality Processes for clients to provide feedback on care are explained to patients/clients and are accessible	Patient/client satisfaction with nursing care Documented patient/client feedback on nursing care Number of unresolved patient/client care issues	Satisfaction with Nursing Care Questionnaire (Eriksen)
Financial			Recruitment and retention cost savings Sick time cost savings Overtime cost savings	

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Appendix A: Glossary of Terms

Appreciative Inquiry (AI): A research perspective that is intended for discovering, understanding and fostering innovations in social-organizational arrangements and processes. It involves the search for the best in people, their organizations, and the relevant world around them. The aim of AI is to strengthen a system's capacity to maximize positive potential by focusing on what is working and what is positive in people and the organization.[352]

Benchmark: A standard by which something can be measured, compared or judged. Benchmarking involves measuring another organization's or person's product or service by specific standards and comparing it with one's own product or service.[353]

Chief Nursing Executive: The senior nurse employed by the organization who reports directly to the administrator and is responsible for nursing services provided.[269]

Collaboration: Stanhope and Lancaster (2000)[354] defined collaboration as "mutual sharing and working together to achieve common goals in such a way that all persons or groups are recognized and growth is enhanced" (pg. 33).

Consensus: A collective opinion arrived at by a group of individuals working together under conditions that permit open and supportive communication, such that everyone in the group believes he or she had a fair chance to influence the decision and can support it to others.

Continuous Quality Improvement: A management approach to improving and maintaining quality that emphasizes internally driven and relatively continuous assessments of potential causes of quality defects, followed by action aimed at addressing the identified defects of improving quality. Performance is usually measured against benchmarks or industry standards and this information is applied to improve program operations.
Retrieved October 6, 2005 from: http://www.qaproject.org/methods/resglossary.html and
Retrieved October 6, 2005 from: http://www.doe.k12.ga.us/schools/nutrition/qmgloss.asp

Core Competencies: The critical skills, knowledge, attributes and behaviours required to achieve leadership practices.
Retrieved October 6, 2005 from: http://www.mcgill.ca/hr/mcompensation/terms/ and
http://www.astd.org/astd/Resources/performance_improvement_community/Glossary.htm

Correlation Studies: Studies that identify the relationships between variables. There can be three kinds of outcomes: no relationship, positive correlation, and negative correlation.

Decision Support Systems: Computer technologies used in health care which allow providers to collect and analyze data. Activities supported include case mix, budgeting, cost accounting, clinical protocols and pathways, outcomes, and actuarial analysis.
Retrieved October 6, 2005 from: http://www.plexisweb.com/glossary/words/d.html

Emotional Intelligence: The ability to perceive accurately, appraise, and express emotion; the ability to access and/or generate feelings when they facilitate thought; the ability to understand emotion and emotional growth[355] and is thought to contribute to workplace success.[356]

Empowerment: The ability to mobilize human and material resources to get things done.[164] It is a process through which stakeholders influence and share control over development initiatives, and the decisions and resources which affect them.
Retrieved October 6, 2005 from: http://www.worldbank.org/afr/particip/keycon.htm

Education Recommendations: Statements of educational requirements and educational approaches/strategies for the introduction, implementation and sustainability of the best practice guideline.

Ethical distress: Involves situations in which nurses cannot fulfill their ethical obligations and commitments, or they fail to pursue what they believe to be the right course of action, or fail to live up to their own expectations of ethical practice.[357]

Ethnocultural Identity: The connection and interplay between ethnicity, culture and identity. It refers to the unique characterisitcs that distinguish us as individuals and identify us as belonging to a group.[358]

Fairness: The ability to make judgments free from discrimination or dishonesty.[359]

Healthy Work Environment: A healthy work environment for nurses is a practice setting that maximizes the health and well-being of nurses, quality patient/client outcomes and organizational performance.

Healthy Work Environment Best Practice Guidelines: Systematically developed statements based on best available evidence to assist in making decisions about appropriate structures and processes to achieve a healthy work environment.[360]

Individual Characteristics: Innate traits of individuals that will influence their evaluation of themselves, their environment and their capabilities, and consequently their behaviour.[361]

Integrity: The perception that the trustee adheres to a set of principles that the trustor finds acceptable[95] or does what they said they would do.[122]

Knowledge: Nursing practice is informed by various ways of knowing.[362] Empirical knowledge is science-based and includes facts, models, and theories. Aesthetic knowledge relates to the "art" of nursing, where knowledge comes from empathetic relationships that the nurse creates with clients. Ethical knowledge arises from theories and principles of ethics. Through a valuing process, clarification of situation, and advocacy, the nurse interprets an ethical perspective of care. Personal knowledge is concerned with knowing, encountering and actualizing of the concrete, individual self. One does not know about the self – one strives to know the self. This knowing is a standing in relation to another human being and confronting the human being as a person.[362]

Leadership: is a relational process in which an individual seeks to influence others towards a mutually desirable goal.

Leadership Expertise: Knowledge, skills and technical ability for leadership gained through formal education or experience.

Leadership Practices: In this guideline are a characteristic way of being or a set of related behvaiours that distinguish a successful nurse leader.

Magnet Hospital: A label originally given to hospitals in the United States in the early 1980s that were able to recruit and retain nurses despite a national nursing shortage. Now the term refers to designated facilities that have been certified by the American Nurses Credentialing Center for their excellence in nursing practice. They are recognized as institutions with better than average achievement of nursing job satisfaction and patient/client outcomes because of specific organizational characteristics.[88, 266]

Meta-analysis: The use of statistical methods to summarize the results of several independent studies, therefore providing more precise estimates of the effects of an intervention or phenomena of health care than those derived from the individual studies included in a review.[363]

Nurses: Refers to Registered Nurses, Licensed Practical Nurses (referred to as Registered Practical Nurses in Ontario), Registered Psychiatric Nurses, nurses in advanced practice roles such as Nurse Practitioners and Clinical Nurse Specialists.

Nursing Leadership: Leadership that is grounded or situated in nursing.[38]

Organizational Climate: Social, organizational, or situational influence on behaviour, reflected in overall performance or policies, practices and goals; how thing are done;[364] the aspects perceived as important by individual organization members.[365]

Organizational Culture: The underlying values, assumptions and beliefs in an organization.

Organization Recommendations: Statements of conditions required for a practice setting that enable the successful implementation of the best practice guideline. The conditions for success are largely the responsibility of the organization.

Patient/Client: Refers to the recipient(s) of nursing services. This includes individuals, (family member, guardian, substitute caregiver) families, groups, populations or entire communities. In education, the client may be a student; in administration, the client may be staff; and in research, the client is a study participant.[134,366]

Practice Recommendations: Statements of best practice directed at the practice of health care professionals that are ideally evidence-based.

Professional Identity: Behavioural or personal characteristics by which an individual is recognizable as a member of a group.[367] The extent to which the individual ascribes to the values and beliefs of the profession.[368]

Qualitative Research: Methods of data collection and analysis that are non-quantitative. Qualitative research uses a number of methodologies to obtain observation data or interview participants in order to understand their perspectives, world view or experiences.

RNAO Advanced Clinical/Practice Fellowships: The RNAO Advanced Clinical/Practice Fellowships (ACPF) is a nurse learning experience aimed at enhancing nursing skills in the following areas: Leadership, Clinical, and Best Practice Guideline Implementation with the primary goal of improving patient care and outcomes in Ontario. With support from the Nurse Fellow's Sponsor Organization, the nurse works with an experienced mentor/mentoring team in the desired area of focus. The ACPF is funded by the Government of Ontario. For more information visit www.rnao.org/acpf

Reflective Practice: An ongoing process that the nurse utilizes in order to examine his/her own nursing practice, evaluate strengths, and identify ways of continually improving practice to meet client needs. Questions useful in framing the reflective process include: "What have I learned?"; "What has been the most useful?; "What else do I need?"; "What practices can I share with others?".

Sample Behaviours: Examples of specific actions of individuals that demonstrate core competencies.

Social Supports: Social support refers to the transactions that occur within a person's social network that involve providing encouragement, sympathy, appreciation, or otherwise interacting with people in ways that support them emotionally.[297]

Span of Control: Number of persons who report directly to a single manager, supervisor, or leader and relates to the number of people not the number of full-time equivalent positions.[305]

Stakeholder: A stakeholder is an individual, group, or organization with a vested interest in the decisions and actions of organizations, who may attempt to influence these decisions and actions.[369] Stakeholders include all individuals or groups who will be directly or indirectly affected by the change. Stakeholders can be categorized as opponents, supporters, or neutrals.[370]

Strategies: Targeted actions and activities to achieve outcomes.

Succession Planning: A process that moves beyond "one-off'" replacement planning into a process of identifying and nurturing a pool of potential candidates for leadership positions.[196]

System Recommendations: Statements of conditions required to enable the successful implementation of the best practice guideline through out the system. The conditions for success are associated with policy development at a broader research, government and system level.

Systematic Review: Application of a rigorous scientific approach to the preparation of a review article.[371] Systematic reviews establish where the effects of health care are consistent, and where research results can be applied across population, setting, and differences in treatment and where effects may vary significantly. The use of explicit, systematic methods in reviews limits bias (systematic errors) and reduces chance effects, thus providing more reliable results upon which to draw conclusion and make decisions.[363]

Telework: Often referred to as telecommuting. Occurs when paid workers reduce their commute by carrying out all, or part of, their work away from their normal place of business.
Retrieved October 6, 2005 from: http://www.ivc.ca/definition.htm

Transformational Leadership: A Leadership approach in which individuals and their leaders engage in an exchange process that broadens and motivates both parties to achieve greater levels of achievement, thereby transforming the work environment.[85] Transformational Leadership occurs where the leader takes a visionary position and inspires people to follow.
Retrieved October 6, 2005 from:
http://changingminds.org/disciplines/leadership/styles/transformational_leadership.htm

Whistleblowing: A process whereby an individual reports misconduct in an organization to people or entities that have the power to take corrective action. Generally the misconduct is a violation of law, rule, regulation and/or a direct threat to public interest – fraud, health, safety violations, and corruption are a few examples.
Retrieved October 6, 2005 from: en.wikipedia.org/wiki/Whistleblowing

Appendix B: Guideline Development Process

In October of 2003, the Registered Nurses' Association of Ontario convened a panel of nurses with expertise in practice, research, policy, education and administration representing a wide of range of nursing specialties, roles and practice settings.

The panel undertook the following steps in developing the best practice guideline:

- The scope of the guideline was identified and defined through a process of discussion and consensus.
- Search terms relevant to developing and sustaining nursing leadership in all roles were sent to the Joanna Briggs Institute to conduct a broad review of the literature.
- An internet search of published guidelines related to Nursing Leadership was completed and yielded few results. The materials sourced were not specifically about the topic area and/or did not contain a sufficient description of the evidence to lend them to appraisal. It was thus agreed to use them as resource materials only.
- An evidence-based conceptual model was developed to organize the concepts and content within the guideline. The model has undergone an iterative process as the panel has worked with the literature review.
- A protocol including several focused questions was developed to guide the Joanna Briggs Institute in conducting a systematic review of the literature (See Appendix C for process followed and results).
- Additional literature was sourced by panel members.
- Through a process of discussion and consensus, recommendations for practice, education, and organizations and policy were developed.
- A draft guideline was submitted to external stakeholders for review and feedback. Stakeholders represented a variety of organizations and individuals from a variety of practice settings and roles with interest and expertise in leadership. External stakeholders were provided with specific questions for comment, as well as the opportunity to give overall feedback and general impressions.
- Revisions were made to the draft guideline, based on stakeholder feedback.
- The final guideline was presented for publication.

Appendix C: Process for Systematic Review of the Literature on Developing and Sustaining Nursing Literature Completed by the Joanna Briggs Institute

1. **Broad review of the literature using keywords associated with the broad topic of leadership entered into:**

   - CINAHL
   - Medline
   - Embase
   - PsychInfo

2. **Development of a protocol to direct a review to answer:**

   - What leadership attributes foster leadership and lead to a healthy work environment in health care?
   - What impact or influence does the work environment have in developing and sustaining nursing leadership to produce positive outcomes in the health care setting, i.e., what are the structures and processes that support and contribute to developing and sustaining effective nursing leadership? (Structures and processes refer, but are not limited to, organizational culture and valuing of nursing, financial and human resource supports for leaders, span of control, presence/absence of nurse leaders at senior level, and communication and reporting structures).

3. **Search Terms identified included:**

   - Autonomy and leadership
   - Clinical leadership
   - Continuity and tenure of leadership
   - Emotional Intelligence
   - Empowerment
   - Environment
   - Leadership
   - Leadership development
   - Leadership and practice environment
   - Leadership styles
   - Leadership traits
   - Management

- Management support
- Organizational change
- Organizational culture
- Organizational structures and leadership
- Patient/client outcomes and leadership
- Patient/client satisfaction and leadership
- Power and leadership
- Span of control
- Trust, commitment and leadership
- Work satisfaction and leadership
- Workplace

4. **The search strategy sought to find published and unpublished studies and papers limited to the English language. An initial limited search of CINAHL and MEDLINE was undertaken followed by an analysis of the text words contained in the title and abstract and of the index terms used to describe the article. A second-stage search using all identified keywords and index terms was then undertaken using the search terms listed above.**

   Databases searched in the second stage included:

   - ABI Inform Global (to December 2003)
   - CINAHL (1982 to December 2003)
   - Cochrane (to December 2003)
   - Current Contents Library (to December 2003)
   - Econ lit (to December 2003)
   - Embase (to December 2003)
   - ERIC (to December 2003)
   - MEDLINE (1966 to December 2003)
   - PsychINFO (to December 2003)
   - Social Sciences Abstracts (to December 2003)

   The search for unpublished studies included:

   - Dissertation Abstracts International (to December 2003)

5. **Studies identified during the database search were assessed for relevance to the review based on the information in the title and abstract. All papers that appeared to meet the inclusion criteria were retrieved and again assessed for relevance to the review objective.**

6. **Identified studies that met inclusion criteria were grouped into type of study (e.g., experimental, descriptive, etc.).**

7. **Papers were assessed by two independent reviewers for methodological quality prior to inclusion in the review using an appropriate critical appraisal instrument from the SUMARI package (System for**

the Unified Management, Assessment and Review of Information) which is software specifically designed to manage, appraise, analyze and synthesize data.

Disagreements between the reviewers were resolved through discussion and, if necessary, with the involvement of a third reviewer.

Results of Review

A total of 48 papers, experimental, qualitative and textual in nature, were included in the review. The majority of papers were descriptive and examined the relationships between leadership styles and characteristics and particular outcomes, such as satisfaction. Due to the diverse nature of these papers meta-analysis of the results was not possible. Eight syntheses were derived with key themes related to collaboration, education, emotional intelligence, organizational climate[G], professional development, positive behaviours and qualities, and the need for a supportive environment.[52]

Appendix D: Measures of Concepts Related to the Leadership Practices for Healthy Nursing Work Environments Model

Measures of Nursing Leadership

In a recent publication that incorporated work on the measurement of leadership, Patrick and White[50] chose to include only those instruments for the measurement of leadership behaviours that had been used in nursing research. This decision was based on the work of Leatt and Porter[298] who contend that health care has unique qualities that produce environments different from other industries. They further reported that they found few instruments that had been tested for reliability and validity and that most of the instruments were focused on perceptions of leadership versus performance or outcomes.

Huber et al.[372] conducted a comparative analysis of nursing administration tools which included instruments for measuring leadership. They developed standardized definitions of the concepts and identified sound and easy-to-use measures of autonomy, conflict, job satisfaction, leadership and organizational climate through an expert focus group consensus method. All team members had both research and content expertise.

The tools included in this guideline have been drawn from Huber,[373] Patrick and White,[50] and the University of Texas Repository of Nursing Administration Instruments[372] (www.sph.uth.tmc.edu/eriksen/) and were selected on the basis that they have been used in nursing studies and have acceptable reported reliability and validity. The tools are presented according to the key elements and components of the *Conceptual Model for Developing and Sustaining Leadership*.

CONCEPT	INSTRUMENT	AUTHOR
Leadership Practices		
Leadership Assessment		
Self-perceived efficacy	Head Nurse Self-Efficacy Scale	Evans[374]
Leader behaviours	Leadership Behaviour Description Questionnaire	Stogdill[375]
Leadership style	LEAD	Hersey & Blanchard[376]
Leader behaviours and actions	Leadership Practices Inventory – Self, Observer	Kouzes & Posner[377]
Leader behaviours/style	Multifactor Leadership Questionnaire	Bass & Avolio[252]
Leader behaviours/style	Multifactor Leadership Questionnaire – 5X	Bass[378]
Self-perceived behaviours	Nurse Practitioner Leadership Questionnaire	Jones et al.[379]
Supportive behaviours in long term-care	Supportive Leadership Styles – Charge Nurse Support Scale and Unit Manager Support Scale	McGilton et al.[380]
Staff nurse leadership performance	Six Dimension (6-D) Scale of Nursing Performance	Schwirian[381]

CONCEPT	INSTRUMENT	AUTHOR
Communication		
Nurses' perceptions of communication	Communication Assessment Questionnaire	Farley[382]
Nurses' satisfaction with communication	Communication Satisfaction Questionnaire	Pincus[383]
Perceived and ideal status of communication	ICA Communication Audit	Goldhaber & Rogers[384]
Communication factors	Organization Communication Scale	Roberts & O'Reilly[385]
Distributive justice/fairness – extent to which individuals perceive rewards	Distributive Justice Index	Price & Mueller[386]
Trust		
Trust of peers and managers	Interpersonal Trust at Work Scale	Cook & Wall[387]
Empowerment		
Nurses' perceptions of workplace empowerment	Conditions for Work Effectiveness Questionnaire I	Chandler[388]
Nurses' perceptions of workplace empowerment	Conditions for Work Effectiveness Questionnaire II	Laschinger[174, 389]
Nurses' perceptions of power in the work environment	Job Activities Scale	Laschinger[389, 390]
Nurses' perceptions of leader's empowering behaviours	Leader Empowering Behaviour Scale	Hui[185]
Nurses' perceptions of informal power in the work environment	Organizational Relationships Scale	Laschinger[389, 390]
Nurses' perceptions of power	Job Activities Scale	Laschinger[389]
Nursing Autonomy		
Meaningful work, competence, autonomy and impact	Psychological Empowerment Scale	Spreitzer[391]
Attitudes and behaviours of students	Autonomy: the Care Perspective Instrument	Boughn[392]
Nurses' perceptions of current and ideal autonomy/authority	Authority in Nursing Roles Inventory	Katzman[393]
Nurses' perceptions of autonomy	Clinical Autonomy Ranked Category Scale	Kramer & Schmalenberg[394]
Professional autonomy	Dempster Practice Behaviour Scale	Dempster[395]
Professional autonomy	Nursing Activity Scale	Schutzenhofer[396]
Nurses' perceptions of autonomy/authority	Nursing Authority and Autonomy Scale	Blanchfield & Biordi[397]
Decision involvement	Decisional Involvement Scale	Havens & Vasey[398]
Meaning of professional autonomy	Maas and Jacox Semantic Differential	Maas & Jacox[399]
Meaning of professional autonomy	Maas and Jacox Concept Interview	Maas & Jacox[399]
Autonomy in care/unit activities	Staff Nurse Autonomy Questionnaire	Blegen et al.[400]
Control over practice	Nursing Work Index – R	Aiken & Patrician[272]
Optimizing Competing Values & Priorities		
Moral distress	Moral Distress Scale	Corley et al.[243]
Decision-making/risk taking	Patient/client Care Administration Ethics Survey	Sietsema & Spradley[401]

CONCEPT	INSTRUMENT	AUTHOR
Organizational Supports		
Organizational Culture and Climate		
Type of climate (e.g., risk taking, challenge)	Creative Climate Questionnaire	Ekvall et al.[402]
Organizational and personal values	Harrison's Organizational Ideology Questionnaire	Harrison[403]
Organizational climate (e.g., reward, risk, support)	Litwin and Stringer Organizational Climate Questionnaire	Litwin & Stringer[404]
Organizational climate (e.g., support, innovation)	Modified Litwin and Stringer Organizational Climate Questionnaire	Mok & Au-Yeung[405]
Organizational climate	Nurse Organizational Climate Description Questionnaire	Duxbury et al.[406]
Organizational culture/job satisfaction	Nursing Assessment Survey	Maehr & Braskamp[407]
Organizational culture/style	Competing Values Framework Survey	Zammuto & Krakower[408]
Unit professional culture	Nursing Unit Cultural Assessment Tool 3	Coeling & Simms[409]
Bureaucracy, innovation & support	Organizational Climate Inventory	Wallach[410]
Organizational culture/thinking styles	Organizational Culture Inventory	Cooke & Lafferty[411]
Nurses' perceptions of job characteristics/work environment	Work Characteristics/Excitement Instrument	Simms et al.[412]
Professional Practice Environment		
	Nursing Work Index®	Aiken & Patrician[272]
	Practice Environment Scale of NWI	Lake[413]
	Professional Practice Environment Scale	Erickson et al.[414]
	Canadian Practice Environment Index	Estabrooks et al.[415]
	Perceived Nursing Work Environment	Choi et al.[416]
Span of Control		
	The Ottawa Hospital Model of Nursing Clinical Practice Clinical Management Span of Control Decision-Making Indicators	The Ottawa Hospital[417]

CONCEPT	INSTRUMENT	AUTHOR
Personal Resources		
Emotional Intelligence		
360 feedback instrument	Emotional Competence Inventory	Goleman[326]
Self-report assessment of personal qualities	Bar-On Emotional Quotient Inventory	Bar-On[418]
Test of EI ability	Multifactor Emotional Intelligence Scale	Mayer et al.[419]
Outcomes		
Burnout		
	Maslach Burnout Inventory	Maslach & Jackson[420]
Job Satisfaction		
	The Daphne Heald Research Unit Measure of Job Satisfaction	Traynor & Wade[421]
	Index of Work Satisfaction	Stamps & Piedmonte[422]
	McCloskey/Mueller Satisfaction Scare	Mueller & McCloskey[423]
	Minnesota Satisfaction Questionnaire	Weiss et al.[424]
	Nurse Job Satisfaction Scale	Hinshaw & Atwood[425]
	Work Satisfaction Scale	Hinshaw & Atwood[425]
Motivation/Job involvement		
	Motivation Tool – Kanungo	Kanungo[426]
Organizational Commitment		
	Organizational Commitment Questionnaire	Porter et al.[427]
Turnover		
	Anticipated Turnover Scale	Hinshaw & Atwood[428]
Patient Satisfaction		
	Satisfaction with Nursing Care Questionnaire	Eriksen[429]

Notes:

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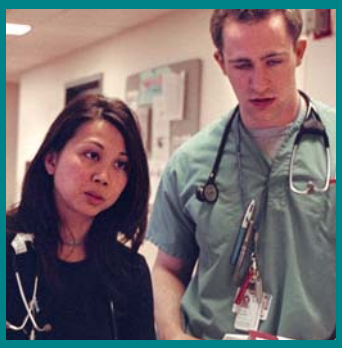

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