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Best Practice Guidelines

July 2013

Developing and Sustaining Nursing Leadership Best Practice Guideline

Second Edition

RNAO
Registered Nurses' Association of Ontario
L'Association des infirmières et infirmiers autorisés de l'Ontario

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Greetings from Doris Grinspun

Chief Executive Officer, Registered Nurses' Association of Ontario

It is with great pleasure that the Registered Nurses' Association of Ontario (RNAO) releases this second edition of the *Leadership Best Practice Guideline*. This is one of nine best practice guidelines (BPGs) on healthy work environments developed by the nursing community. The aim of these guidelines is to provide the best available evidence to support the creation of healthy and thriving work environments.

Evidence-based best practice guidelines, when applied, 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 institutions that are making our vision for healthy work environment best practice guidelines a reality: the Government of Ontario for recognizing RNAO's ability to lead the program and providing generous funding; Irmajean Bajnok, Director, RNAO International Affairs and Best Practice Guidelines Programs, for her expertise and leadership in advancing the production of the guidelines; Nancy Purdy and Pam Pogue for their superb stewardship, commitment and, above all, exquisite expertise. Thank you also to Program Manager Althea Stewart-Pyne who provided leadership to the process and worked intensely to see that this BPG move from concept to reality. A special thanks to the BPG panel – we respect and value your expertise and volunteer work. To all, 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 in 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 colleagues from other health-care disciplines across each organization. We ask you to share this guideline with members of your team. There is much we can learn from one another.

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

Doris Grinspun, RN, MSN, PhD, LLD(Hon), O.ONT.

Chief Executive Officer

Registered Nurses' Association of Ontario

Table of Contents

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Stakeholder Acknowledgment

The Registered Nurses Association of Ontario wishes to acknowledge the following for their contribution in reviewing the second edition of *Developing and Sustaining Leadership* nursing best practice guideline and providing valuable feedback:

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* Terms marked with a G this document 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, with funding from the Ontario Ministry of Health and Long-Term Care (MOHLTC), and working in partnership with Health Canada's Office of Nursing Policy, started developing evidence-based best practice guidelines for creating healthy work environments[G] for nurses[G]. Just as in clinical work, creating healthy work environments should be based on the best evidence possible.

The Healthy Work Environments Best Practice Guidelines[G] project is a response to priority needs identified by the Joint Provincial Nursing Committee (JPNC) and the Canadian Nursing Advisory Committee (CNAC, 2002). 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* (RNAO, 2000) 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 the growing and aging population, advancing technology and more sophisticated consumerism. In Canada, health-care reform is currently focused on the primary goals identified in the Federal/Provincial/Territorial First Ministers' Agreement 2000 (Canadian Intergovernmental Conference Secretariat [CICS], 2000), and the Health Accords of 2003 (Health Canada, 2003) and 2004 (First Ministers, 2004):

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

Nurses are vital to achieving these goals. A sufficient supply of nurses is central to sustaining affordable access to safe, timely health care. Achievement of healthy work environments for nurses is critical to the safety, recruitment and retention of nurses.

Numerous reports and articles have documented the challenges in recruiting and retaining a healthy nursing workforce (Association of Colleges of Applied Arts and Technology [ACAAT], Council of Ontario University Programs in Nursing [COUPN], 2002; Canadian Nurses Association [CNA], 2002; Bauman et al., 2001; 2001; Nursing Task Force, 1999; RNAO, 2000). Some have suggested that the basis for the current nursing shortage is the result of unhealthy work environments (Dunleavy, Shamian & Thomson, 2003; Grinspun, 2000, 2010; Schindul-Rothschild, 1994). Strategies that enhance nursing workplaces are required to repair the damage left from a decade of relentless restructuring and downsizing.

There is a growing understanding of the relationship between nurses' work environments, patient/client[G] outcomes and organizational and system performance (Dugan et al., 1996; Estabrooks, Midodzi, Cummings, Ricker&Giovannetti, 2005; Lundstrom, Pugliese, Bartley, Cos & Guither, 2002). A number of studies have shown strong links between nurse staffing and adverse patient/client outcomes (American Nurses Association [ANA], 2000; Blegen & Vaughn, 1998; Kovner&Gergen, 1998; Person et al., 2004; Needleman, Buerhaus, Mattke, Stewart & Zelevinsky, 2002; Cho, Ketefian, Barkauskas & Smith, 2003; Needleman & Buerhaus, 2003; Sasichay-Akkadechanunt, Scalzi & Jawad, 2003; Sovie & Jawad, 2001; Tourangeau, Giovannetti, Tu& Wood, 2002; Yang, 2003). Evidence shows that healthy work environments yield financial benefits to organizations by reducing absenteeism, lost productivity and organizational health-care costs (Aldana, 2001) as well as costs from adverse patient/client outcomes (United States Agency for Health Care Research and Quality [USAHRQ], 2003).

Achieving healthy work environments for nurses requires transformational change, with "interventions that target underlying workplace and organizational factors" (Lowe, 2004a). We have developed these guidelines to enable that transformational change. We believe implementing them will make a difference for nurses, their patients/clients and for the organizations and communities where they practice. We believe a focus on creating healthy work environments will benefit not only nurses, but also other members of health-care teams[G]. But we also believe best practice guidelines can be implemented successfully only where there are adequate planning processes, resources, organizational and administrative supports and appropriate facilitation.

A healthy work environment is…	The Healthy Work Environments project has produced nine best practice guidelines
…a practice setting that maximizes the health and well-being of nurses, quality patient/client outcomes and organizational and system performance, including healthier communities.	■ 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 ■ Preventing and Managing Violence against Nurses in the Workplace ■ Preventing and Mitigating Nurse Fatigue in Health Care ■ Mitigating and Managing Conflict in Health-care Teams

Organizing Framework for the Healthy Work Environments Best Practice Guidelines Project

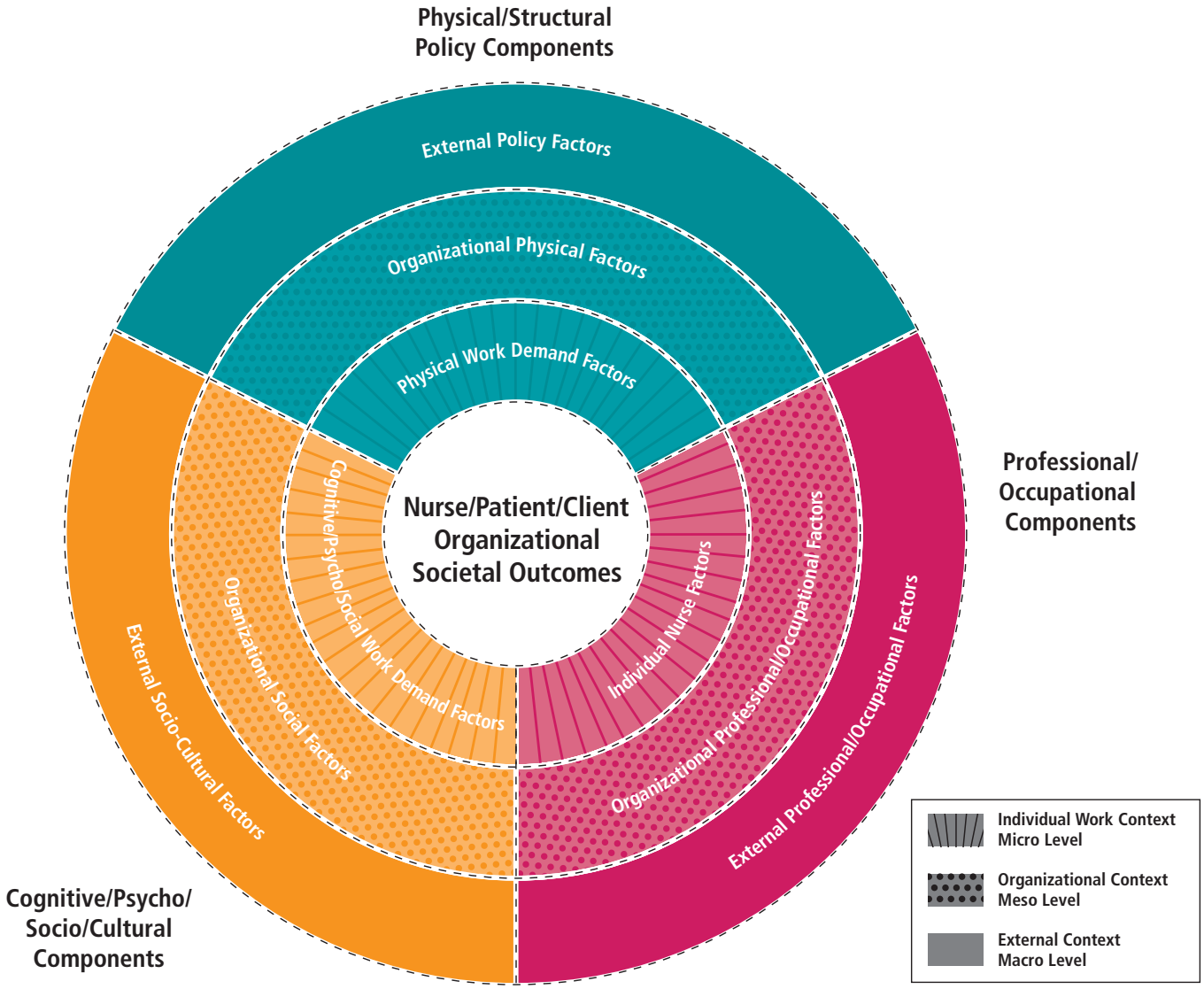

Figure 1. Conceptual Model for Healthy Work Environments for Nurses – Components, Factors & Outcomes[i-iii]

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 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, patients, organizations and systems, and society as a whole, including healthier communities. 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 work environments are essential for quality, safe patient care;
- 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.

vii Grinspun, D. (2010). The Social Construction of Nursing Caring. (Doctoral Dissertation, York University).

Physical/Structural Policy Components

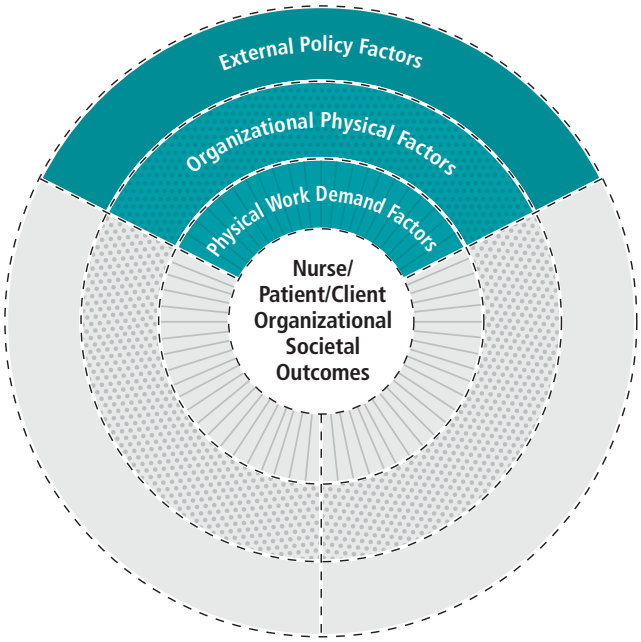

Figure 1A

Cognitive/Psycho/Socio/Cultural Components

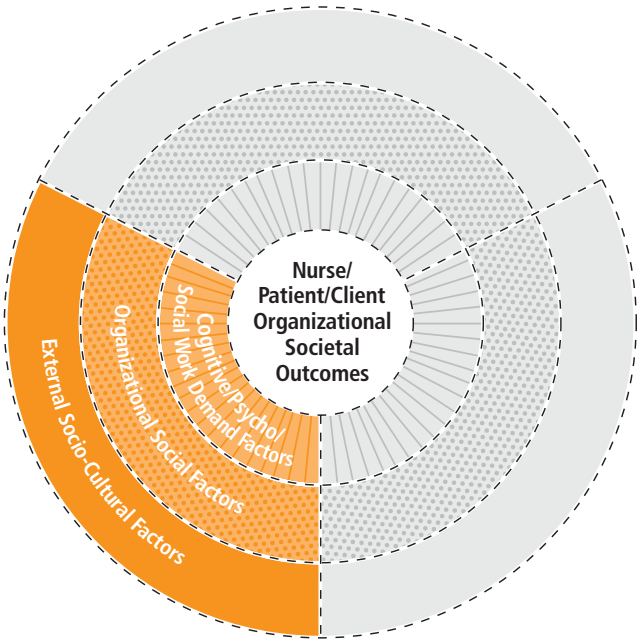

Figure 1B

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 policies, 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.

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

- 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 psychosocial 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 family work/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 socialization within and across disciplines and domains.

Professional/Occupational Components

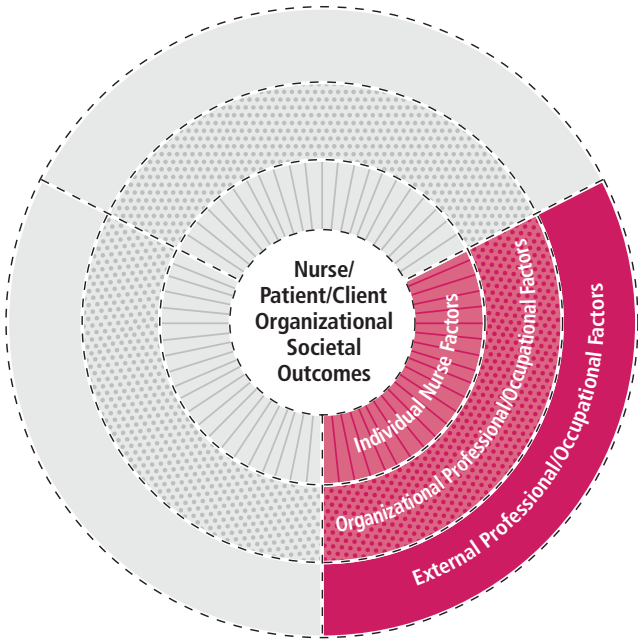

Figure 1C

Background Context of the Guideline on Developing and Sustaining Nursing Leadership

Nursing leadership[G] is a vital component in the delivery of patient care. It shapes the profession, facilitates policies on mentoring and evidence-based practice and helps navigate change in challenging times. Since this guideline was first published in 2006, additional evidence has emerged to support its recommendations and links to positive patient outcomes through leadership (Griffiths, Renz, Hughes, & Rafferty, 2009).

Effective leadership is important in all aspects of nursing — whether that nurse leader is an educator, developing future leaders, a researcher mentoring new researchers, an administrator providing support and guidance to staff, a point-of-care staff nurse providing exemplary care and sharing professional knowledge, or someone who provides direction and support to practice through policy development. Nurses providing leadership at the point-of-care are a critical part of the future of patient care and organizations committed to providing high-quality patient care say the most significant contribution for leaders today is to develop the leadership skills of others to support them to prosper and grow (Hendren, 2010, Kouzes & Posner, 2006). 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 (Squires, 2004).

The transformational leadership practices found in this second edition of *Developing and Sustaining Nursing Leadership* are supported by significant empirical evidence, including studies of leadership specific to staff nurses. In a recent provincial study, transformational leadership practices were linked to the leadership attributes of nurses at the point-of-care (Patrick, Laschinger, Wong & Finegan, 2011). Leadership practices reflected by nurses at the point-of-care included using their knowledge and clinical expertise to question the status quo, challenge process and question treatments. When nurses effectively communicate patient assessments, articulate outcomes of the assessments which concern them, or present patient perspectives to other members of the health-care team, they are inspiring a collaborative approach to patient care. When nurses clarify information for patients and their families, they are promoting a greater understanding of their illness and ensuring patients are empowered to make informed decisions about their care (Patrick et al., 2011).

The conceptual model developed in the original leadership guideline is still relevant, although we have made a few changes to reflect current evidence related to healthy work environments (refer to page 8 for a more detailed explanation of the conceptual model). Recent evidence suggests building relationships and trust must extend beyond intrapersonal and interdisciplinary relationships to include all partners in the health-care system, such as inter-organizational relationships. The other practice that has been revised is balancing competing values and priorities, which we expanded to reflect the need for leaders to manage the complexity of the health-care system and contribute to health-system transformation.

The context to support the expression of the leadership capabilities includes both organizational supports and personal resources. Organizational culture and climate was added as a relevant influence on leadership behaviour. Based on current literature, personal resources that influence leadership practices were expanded to reflect an emphasis on engaging in coaching and mentoring activities. Social supports were described more specifically to include both personal and professional supports.

Purpose and Scope

This guideline is intended to assist nurses and others performing both formal and informal nursing leadership roles from the point-of-care to the board room, across a variety of practice domains and settings. It identifies evidence-based leadership behaviour that nurses can implement individually and collectively to benefit patients, health-care team members, organizations, systems and health-care policy, research and education. Leadership practices that help create a healthy work environment can ultimately improve patient and client experiences and outcomes. Even point-of-care nurses, who may not see themselves as leaders, can adopt these practices in their **informal leadership** role and significantly improve their work environment and in turn, patient outcomes.

Purpose:

This best practice guideline has been developed for nurses in a variety of roles, domains of practice and practice settings. It identifies and describes:

- leadership practices that result in healthy outcomes for 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 addresses:

- knowledge, competencies and behaviour of effective leaders, in both formal and informal nursing leadership roles;
- educational requirements and strategies that can be used by formal and informal nursing leaders;
- policy changes at both the organizational and system levels needed to support and sustain leadership practices, including those at the point-of-care;
- implementation strategies and tools;
- evaluation criteria and tools; and
- future research opportunities.

Target Audience:

The guideline is relevant to nurses in:

- all roles including point-of-care nurses, administrators, educators, researchers and those engaged in policy work, and also 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

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. Refer to Appendix A, Implementation Strategies; the *Toolkit: Implementation of Best Practice Guidelines (Second Edition).*

2. Study the leadership 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.16), is critical to using the guideline effectively. We recommend that you spend time reading and reflecting upon the model as a first step.

3. 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.

4. 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.

5. Focus on the recommendations or behaviour 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 B**.

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.

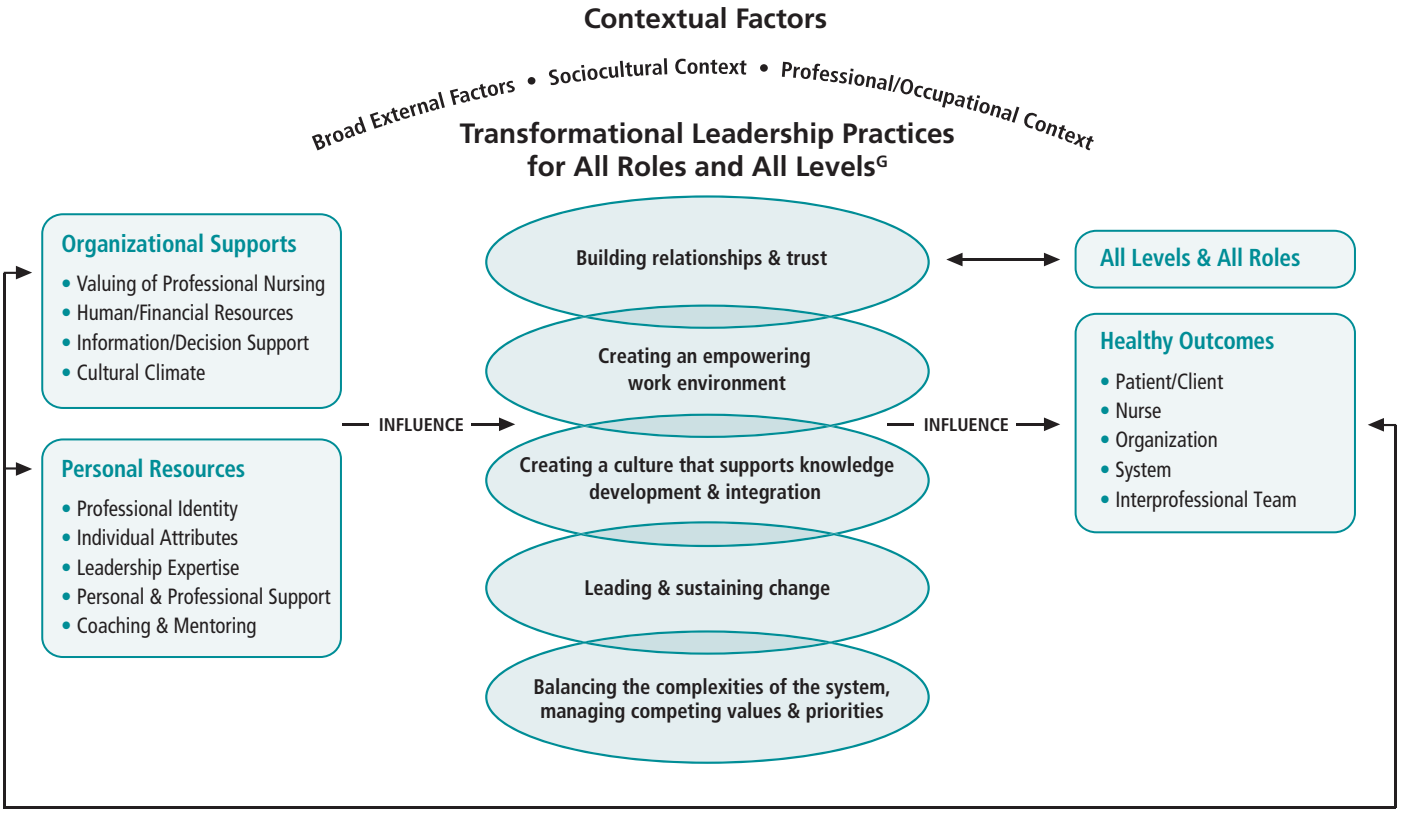

Figure 2. Conceptual Model for Developing and Sustaining Leadership

Overview of the 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,* which are fundamental for transforming nurses' work settings into healthy work environments. These practices can apply to all nursing roles and levels of leadership, including nurses providing direct care. Two predisposing factors, organizational supports and personal resources, influence each individual's ability to carry out leadership practices effectively. The five practices have been shown to result in positive outcomes for patients/clients, nurses and organizations (Bono, Foldes, Vinson, & Muros, 2007; Cummings, 2006; Cummings et al., 2010; Herold, Fedor, Caldwell, & Liu, 2008; Institute of Medicine of the National Academies [IOM], 2004; Stordeur, Vandenbergeh & D'hoore, 2000; Tomey, 2009; Weberg, 2010; Wong & Cummings, 2007). With feedback, those outcomes reinforce a positive workplace culture. All of this takes place in a context where policies, socio-cultural and professional and occupational factors influence how the predisposing factors, leadership practices and outcomes occur in nursing workplaces.

The five practices of transformational leaders:

1. *Building relationships and trust* is a critical leadership practice, the foundation on which the other practices rest. Relationships include those formed between individual nurses, on teams and in internal and external partnerships.
2. *Creating an empowering work environment* depends on respectful, trusting relationships among people in a work setting. An empowered work environment has access to information, support, resources, and opportunities to learn and grow, in a setting that supports professional autonomy and strong networks of collegial support.
3. *Creating a culture that supports knowledge development and integration* involves fostering both the development and dissemination of new knowledge and instilling a continuous-inquiry approach to practice, where knowledge is used to continuously improve clinical and organizational processes and outcomes.
4. *Leading and sustaining change* involves the active and participative implementation of change, resulting in improved clinical and organizational processes and outcomes.
5. *Balancing the complexities of the system, managing competing values and priorities* entails advocating for the nursing resources necessary for high-quality patient care, while recognizing the multiple demands and complex issues that shape organizational decisions. Proper use of evidence is the key.

Organizational Supports influence whether leadership practices will succeed and produce and strong, visible nursing leadership. They include:

- valuing nurses' critical role in providing patient/client care;
- supplying sufficient and appropriate human and financial resources;
- providing necessary information and decision support; and
- creating a culture and climate conducive to effective, efficient nursing care.

Kotter (1996) and Schein (2004) define organizational culture as the deep-rooted beliefs, values, and assumptions widely shared by organizational members, which powerfully shape the identity and behavioural norms of a group. To change an organization, employees must come together in teams or microsystems to leverage specialization to deliver organizational

priorities. Each organization has a distinctive culture, a combination of the impact of its founders, history, successes, crises and current leadership. Organizations also have routines and rituals, the "way we do things" (Kotter, 1996, p. 14), which shape individual behaviour. As organizations transition to deal with change, they need teams to shift their mindsets. "[Organizational] culture is to organizations as mindset is to individuals" (Anderson & Ackerman Anderson, 2001, p. 98).

Organizational culture is the context in which nursing leadership and behavior are enabled, enacted and evaluated (or not). Culture matters because leadership education without a cultural context is not likely to bring much-needed change to our health-care system.

Personal resources are the attributes and resources individuals bring to their leadership roles that influence their success, and include:

- professional identity;
- health and resilience;
- leadership expertise, education and experience;
- coaching and mentoring to support ongoing leadership development; and
- personal and professional supports.

Our conceptual model for developing and sustaining leadership is based on literature focused on how leadership behaviour can lead to a healthy work environment and healthy outcomes for the patient/client, nurse, team, organization and the system. Since the first edition of this guideline, however, another framework for leadership has been released. The *LEADS in a Caring Environment Leadership Capabilities Framework*, developed by the Canadian College of Health Leaders, (Dickson, 2008), is based on literature focused on the capabilities needed to manage complex issues and create change to transform the health-care system (refer to page 116 for further details). It has been adopted by several Canadian health-care organizations. We compared the LEADS framework to our model (refer to **Appendix C**) and found most dimensions of leadership and associated capabilities were present in both. Only three capabilities were not addressed in our model: building teams, building partnerships and collaborations to achieve results, and critical thinking for systems transformation. We have added them to our model in this edition (see page 121).

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 organizational culture, values and supporting resources
- Is shaped by the personal resources and uniqueness of each individual
- Is influenced by policy, sociocultural and professional/occupational contexts

Leadership at the point-of-care

We believe the leadership potential of point-of-care nurses is an untapped resource, essential for effective nursing practice, which deserves more investigation. For 30 years, researchers have focused primarily on the behaviour, traits and outcomes of nurses in formal management positions. But Doran et al. (2012) argue it is critical we consider leadership as a learned behaviour, with specific competencies, rather than a formal role or personality trait. Although over the years there have been numerous publications calling for distributed nursing leadership throughout organizations, very few investigators have studied the leadership behaviour and

associated outcomes of nurses in non-management, point-of-care nursing roles (CNA, 2012; IOM, 2004,2010;Porter-O'Grady, 2002, 2011).

With a grant from the Government of Ontario, researchers from the Nursing Health Sciences Research Unit at the University of Toronto prepared a report identifying leading practices and programs to develop leadership among health professionals at the point-of-care. The research team reviewed literature from around the world on developing leadership in health professionals to identify programs and practices, leadership competencies of point-of-care staff, as well as looking at the impact of point-of-care leadership on both healthy work environments and the quality of patient care. The team also spoke with key informants. The report described point-of-care nurses as "a valuable source of expertise for improving care and a vast source of untapped leadership potential" (Doran et al., 2012).

Based on the evidence they gathered, the authors concluded developing nursing leadership at all levels will be important as health-care systems and organizations become more complex and resources become more restrained. However, the researchers say that while opportunities do exist for point-of-care nurses to develop leadership skills, they are not equally available to all (Doran et al., 2012). Also, there is a lack of evidence or systematic analysis regarding which leadership development programs for point-of-care nurses are most effective, and essential competencies for them have not been specified (Cummings et al., 2008). To date, the types of leadership skills emphasized in leadership programs for point-of-care professionals include effective communication, project implementation, change management, interprofessional collaboration, research analysis and improving processes of care (Doran et al., 2012). Leadership development programs should also focus on mentorship to build confidence and empower others.

Point-of-care leadership initiatives can have a positive impact on clinical practice and work environments by increasing job satisfaction and nurse retention, but sustained impacts over a longer time have not been evaluated (Abraham, 2011; Krugman & Smith, 2003;Morgan & Konrad 2008;). In a 2011 study using Kouzes and Posners model of transformational leadership, the psychometric properties of a newly developed tool to measure staff nurses' clinical leadership were tested. Findings from the study of 480 acute-care nurses across Ontario provided preliminary evidence for construct validity of a new measure of staff-nurse clinical leadership (Patrick, Laschinger, Wong, & Finegan, 2011). The authors found staff nurses need empowering work environments to show clinical leadership behaviour while providing direct patient care. Carter et al. (2010) said structures need to be considered that would consistently enable advanced practice nurses to provide clinical leadership while providing direct care.

Point-of-care leadership is usually initiated to improve patient care. Several such programs, developed, implemented and evaluated for their impact on job satisfaction, employee morale and retention, are reported on by Doran et al. (2012). They found job satisfaction and retention improve initially but over time the results are not as promising, indicating a need to address sustainable leadership programs. *Keeping patients safe: Transforming the work environment of nurses* (IOM, 2004), described nurses as essential for achieving continuity of patient-centred care, and for ensuring effective communication among health-care team members. Manojlovich and Talsma (2007) suggest patient safety depends on staff nurses showing leadership behaviour that enables effective communication and collaboration with other health-care team members, to ensure access to resources needed for timely care. Patrick et al. (2011) say clinical leadership is a process embedded in the professional practice behaviour of staff nurses.

Cook (2001) maintains the most significant leaders for improving direct care are the people providing it, and suggests staff nurses improve care by influencing others with their transformational leadership behaviour. Continued research is needed to measure the impact of point-of-care leadership, nurse led quality improvement and other initiatives aimed at improving patient care. It is difficult to measure patient outcomes solely attributed to clinician leadership initiatives. Doran and colleagues (2012) said evaluation strategies specifically to measure patient outcome should be part of designing leadership programs for point-of-care nurses, and called for evaluation data to be collected pre and post implementation and over time. Doran and her team also recommend assessing the cost benefits of leadership programs and communicating evaluation results to stakeholders over time. Refer to "*Leading practices and programs for developing leadership among health professionals at the point-of-care*" (Doran et al., 2012) for a detailed review of evidence on point-of-care leadership. We use some of the practices recommended in the Doran report as examples in this guideline.

Summary of Recommendations

Leadership Recommendations	
1.0	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 or contribute to an empowering work environment.
1.3	Nurse leaders create or contribute to an environment that supports knowledge integration.
1.4	Nurse leaders lead, support and sustain change.
1.5	Nurse leaders balance the complexities of the system, identifying and managing competing values and priorities.
Personal Recommendations	
2.0	Nurse leaders continually develop their personal resources for effective leadership.
2.1	Nurse leaders exhibit a strong professional nursing identity.
2.2	Nurse leaders reflect on and take responsibility for the growth and development of their own leadership expertise.
2.3	Nurse leaders act as coaches and mentors to develop leadership expertise in others and further develop their own professional skills.
2.4	Nurse leaders cultivate professional and personal social supports.
2.5	Nurse leaders exhibit a strong professional nursing identity.
2.6	Nurse leaders reflect on and take responsibility for the growth and development of their own leadership expertise.

Education Recommendations	
3.0	Educational programs provide formal and point-of care opportunities for leadership development for nurses.
3.1	Nursing leadership programs incorporate evidence-informed models and theories.
3.2	Nursing leadership programs offered through undergraduate, graduate and continuing education include formal and point-of care opportunities for leadership
Organization And Policy Recommendations	
4.0	Health-service organizations provide supports for effective nursing leadership
4.1	Health-service organizations demonstrate respect for nurses as professionals and their contribution to care.
4.2	Health-service organizations respect nurses as individuals.
4.3	Health-service organizations plan and provide opportunities for growth, advancement and leadership development, not only for nurses in formal leadership positions but also for nurses at the point-of-care.
4.4	Health-service organizations support empowerment, enabling nurses to be responsible and accountable for their professional practice.
4.5	Health-service organizations provide timely access to information, decision-support systems and the resources necessary for care.
4.6	Health-service organizations promote and support teams, collaborations and partnerships.
4.7	Health-service organizations support leaders to assist and facilitate change.
4.8	Health-service organizations give managers spans of control that enable effective nursing leadership.
4.9	Health-service organizations invest in training and succession planning to develop future leaders.

Structural Recommendations	
5.0	Governments develop policies and provide resources that support effective leadership.
5.1	Governments in all provinces and territories establish a senior nurse leader as a policy advisor.
5.2	Governments in all provinces and territories provide links among these nurse leaders.
5.3	Governments in all provinces and territories establish a nursing advisory council.
5.4	Governments in all provinces and territories establish, fund and maintain programs for nursing leadership development.
5.5	Governments in all provinces and territories establish, fund and maintain programs of nursing leadership research.
6.0	Researchers partner with governments and educational and health-service organizations to conduct nursing leadership research.
6.1	Researchers study the impact of nursing leadership on nurses, patients/clients, organizations and systems.
6.2	Researchers develop, implement and evaluate a leadership intervention based on the Conceptual Model for Developing and Sustaining Nursing Leadership.
6.3	Researchers conduct research on health human resources planning for nursing leadership roles.
6.4	Researchers conduct research on nursing leadership education and development.
7.0	Health-service and educational accreditation bodies incorporate into their standards this guideline's organizational support recommendations for formal and informal leaders.

Sources and Types of Evidence on Developing and Sustaining Nursing Leadership

Sources of Evidence

Our search for evidence in the leadership literature yielded meta-synthesis, systematic reviews[G] of the literature, descriptive correlation studies[G], qualitative studies[G] and expert opinion, but few controlled intervention-based studies. This is consistent with the challenges of conducting controlled studies in organizations (Cummings, 2006; Cummings et al., 2008; Patrick & White, 2005). Although this guideline is written for nurses in all settings and all roles, the majority of the studies we found were conducted in urban hospitals and few involved leadership at the point-of-care. Studies in other settings such as community and long-term care were included in the guideline when they were available and appropriate, but further research in those settings is needed.

Developing the original best practice guideline: The Joanna Briggs Institute (JBI) of Australia conducted a systematic review of leadership literature up to December 2003. JBI followed a seven-step process, beginning with broad search terms and developing a protocol. Further search terms for the review were validated by the review's panel chair. The search process was deemed relevant to the review and based on the titles and abstracts articles were retrieved and assessed for relevance. Those that met the inclusion criteria were grouped by type (e.g. qualitative, experimental) and assessed by two independent reviewers for methodological quality, using a critical appraisal instrument selected according to the study type. The instruments used are part of the system for unified management, assessment and review of information —software designed to manage, appraise, analyze and synthesize data. (For further detail and the overall results of the review see **Appendix D**).

A critical review of leadership literature from January 2004 to July 2005 was 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 by title and abstract that the search identified and those selections were validated by the panel chair, retrieved and further assessed for relevance. Relevance was based on whether studies addressed leadership in nursing or similar populations of knowledge workers or interdependent teams, or looked at relationship-based leadership styles. Studies deemed relevant were assessed by the master's prepared nurse for quality based on methods, instruments, sample, analysis, whether conclusions were congruent with findings and the study's clarity. A summary of abstracts, findings and recommendations for inclusion or exclusion of the studies from the guideline was validated by the panel. Additional literature identified by panel members was reviewed for relevance and quality by the panel.

Revision Process:

The Registered Nurses' Association of Ontario made a commitment that this practice guideline would be based on the best-available evidence. In order to meet this commitment, a monitoring and revision process was established for each guideline. The panel of nurses assembled to review this guideline was comprised of members from the original development panel as well as other individuals with particular expertise in leadership from various academic and practice settings.

Literature review

The review of the literature was guided by the following questions:

- What leadership attributes lead to a quality work environment in health care?
- What is the impact or influence work environment has on 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 to, but are not limited to, organizational culture and valuing of nursing, financial and human resources supports for leaders, span of control, and presence/absence of nurse leaders at senior levels and communication and reporting structures).

The search of electronic databases was subsequently conducted by an information specialist (library science), who provided further consultation as needed on refining search terms.

Databases

Medline, CINAHL, Embase, PsychInfo and Cochrane databases.

Search terms

- Authentic leadership
- Autonomy and leadership
- Clinical leadership
- Continuity and tenure of leadership
- Emotional intelligence
- Empowerment
- Environment
- Followership
- Leadership
- Leadership development
- Leadership and practice environment
- Leadership styles
- Leadership traits
- Organizational change
- Organizational culture

- Organizational structure and leadership
- Patient/client outcomes and leadership
- Patient/client satisfaction and leadership
- Power and leadership
- Span of control
- Transformational leadership
- Trust, commitment and leadership
- Work satisfaction and leadership
- Health care

Inclusion criteria: research publications of studies using qualitative and quantitative designs including systematic reviews, meta-analyses and meta-syntheses published between January, 2005 and December, 2011.

Exclusion criteria: theses and dissertations, grey literature, non-research publications and non-English material.

Search Results

A total of 1,310 abstracts were identified. After duplicates were removed, abstracts were screened for inclusion or exclusion by a master's prepared research assistant. That review produced 431 studies to be assessed for eligibility, relevance and quality. With input from the review panel, 51 full-text articles were selected and included in the update of the guideline. Material from the personal files of the panel members (including literature published up to June 2012) was also included using the same selection criteria.

In addition to the systematic process used to identify relevant evidence, a secondary search was completed in the summer of 2012 to obtain further data on leadership at the point-of-care in response to a request from senior leaders in Ontario. Resource constraints prevented a full systematic process to identify that literature. A total of 30 abstracts were identified using the search term "clinical nursing leadership," 10 of which met the inclusion criteria and were used in this guideline.

Review findings

The review of literature published since June, 2006 did not support dramatic changes to the recommendations, although some refinement of the conceptual model and some of the recommendations was needed and additional evidence substantiating recommendations was included.

Rating the evidence

Current practice in creating best practice guidelines involves identifying the strength of the supporting evidence (Moynihan, 2004). The prevailing systems of grading evidence rate systematic reviews of randomized controlled trials as the gold standard (Pearson et al., 2004). Other authors argue that randomized controlled trials are a good experimental design in some but not all circumstances, and may not necessarily be superior (Cartwright, 2007; Grossman & MacKenzie, 2005). The methods of randomized trials are not suited to all research, particularly where subjects cannot be randomized or variables already exist or are difficult to isolate. This is particularly true of behavioural and organizational research where continuously changing structures and processes make controlled studies difficult to design. Moreover, health-care professionals are concerned with more than cause and effect and recognize a wide range of approaches can generate knowledge for practice. We rated the evidence in this guideline using an adaptation of the "traditional levels" of evidence used by the Cochrane Collaboration

(CCNET, 2006) and the Scottish Intercollegiate Guidelines Network guideline (SIGN, 2005). 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	Type of Evidence
A	Controlled studies, meta-analyses
A1	Systematic Review
B	Descriptive correlational studies
C	Qualitative studies
D	Expert opinion
D1	Integrative Reviews
D2	Critical Reviews

All recommendations within the guideline are supported by a discussion of evidence and a list of competencies for the recommendation. Each competency is listed with an example of the sample behavior that leads to demonstrating the competency. All of the related Core Competencies and Sample Behaviour have been drawn from a range of A to D level evidence with the majority being type C and D

Recommendations for Leadership Practice

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

Transformational and relationship-based leadership leads to:

- Increased job satisfaction for nurses (Altieri, 1995; Boumans & Landeweerd, 1993; Chiok Foong Loke, 2001; Cummings, Hayduk & Estabrooks, 2005; Cummings et al., 2010; Long, 2004; McCutcheon, 2004; McGilton, McGillis Hall, Pringle, O'Brien-Pallas&Krejci, 2004; McDaniel & Wolf, 1992; Medley & Larochelle, 1995; McNeese-Smith, 1997; Morrison, Jones & Fuller, 1997; Peck, 1988; Weberg, 2010)
- Increased satisfaction with the leader (Boumans & Landeweerd, 1993; Cummings et al., 2005; Cummings et al., 2010; Long, 2004)
- Increased quality of life for nurses (Robertson, 1991)
- Increased empowerment of nurses (Cummings et al., 2010; Morrison et al., 1997; Laschinger, Wong, McMahon & Kaufmann, 1999; Gullo & Gerstle, 2004)
- Decreased absenteeism (Cummings et al., 2010; Kouzes & Posner, 1995)
- Increased organizational commitment (Avolio, Zhu, Koh, & Bhatia, 2004; Chiok Foong Loke, 2001; Cummings et al., 2010; Leach, 2005; McNeese-Smith, 1997; Kouzes & Posner, 1995)
- Increased retention of nurses (Kouzes & Posner, 1995; McCutcheon, 2004; Taunton, Boyle, Woods, Hansen & Bott, 1997; Volk & Lucas, 1991; Wong & Cummings, 2007)
- Increased perceived unit effectiveness (Altieri, 1995; Cummings et al., 2010; Peck, 1988; Volk & Lucas, 1991)
- Increased ability to lead a diverse workforce (Volk & Lucas, 1991)
- Increased staff emotional health and decreased staff burnout (Broome, Knight, Edwards, & Flynn, 2009; Corrigan,Lickey, Campion & Rashid, 2000; Cummings et al., 2005; Cummings et al., 2010)
- Increased patient quality of life (Corrigan et al., 2000)
- Increased patient satisfaction (Corrigan et al., 2000)
- Improved patient/client outcomes (such as decreased use of restraints, fewer fractures, low prevalence of complications, immobility, mortality, and adverse patient outcomes (Anderson, Issel & McDaniel, 2003; Wong & Cummings et al., 2007)

Discussion of evidence

Burns (1978) was the first person to describe a relationship-based style of leadership now commonly referred to as *transformational leadership.* Pielstick (1998) completed a meta-ethnography of the literature on transforming leadership covering 20 years of research that followed that publication. He clustered the published work into five areas: *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-modelling, mentoring, coaching, engaging in moral reasoning, strategic planning and team building), all of which are based on a solid foundation of *character* (principle-centred, demonstrating fairness, integrity, respect, passion, and commitment to learning), to achieve a shared vision. Levasseur (2004) did a meta-analysis of primary research studies on transformational leadership,

which included seven experimental studies and 27 correlational studies. It confirmed positive relationships between transformational leadership and increased staff job satisfaction and performance. Transformational leadership from formal leaders is increasingly identified as creating a positive context for clinical practice, affecting both staff and patient outcomes (Cummings et al., 2010).

Kemerer (2003) observed that how health-care leaders behave 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) prefer relationship-focused leadership styles and behaviour consistent with transformational leadership (Cummings, et al., 2005; Fox, Fox & Wells, 1999; Pederson, 1993; Upenieks, 2003a; Ward, 2002). A study of nurse supervisors conducted in an Ontario long-term care setting found unlicensed personnel supervised by both registered nurses and registered practical nurses reported higher job satisfaction and less job stress when they felt supported by their supervisors (McGillis Hall et al, 2005). In an urban hospital, Marville–Williams (2007) sought to understand what creates the ideal environment for teams to deliver patient-centred care. Participants, including nurses and other health professionals said the most important managerial support was verbal recognition for a job well done.

Transformational leadership is the type most often reported in magnet hospitals (Ward, 2002). In an integrative literature review on transformational leadership, Gasper (1992) found transformational leadership produces a higher level of organizational effectiveness, and influences others to behave similarly. The review also found that people who worked with transformational leaders had a greater sense of affiliation and more intellectual stimulation, viewed their leader as more approachable, and felt their interactions were of higher quality. In contrast, transactional leaders are more focused on completing tasks than building relationships, and ensure performance through reward and punishment (Cummings et al., 2010).

Transformational leadership styles have been linked with positive outcomes for nurses (Pearson et al., 2004). Although there are few studies that examine the role of nursing leadership on patient and client outcomes (Patrick & White, 2005), there is growing evidence linking nursing satisfaction and nursing professional practice with improved care (Scott, Sochalski & Aiken, 1999).

From our review of the literature, we identified five transformational leadership practices that result in healthy outcomes for nurses, patients and 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 the complexities of the system, managing competing values and priorities.

We have linked each of these leadership practices with specific behavior identified in our literature review. The leadership practices, and evidence associated with the core competencies are discussed for both formal and informal leadership roles.

It is important for all leaders to model values through action, open communication, being visible and using participative decision making.

~ Baird & St-Amand (1995)

Leadership Practice Recommendation 1: Build Relationships and Trust

1.1 Nurse leaders build realtionships and trust.

Trust in leaders, and positive relationships with them, lead to:

- Increased job satisfaction for nurses (Broome et al., 2009;Laschinger, 2004)
- Decreased emotional exhaustion (Cummings, 2004; Laschinger, 2004)
- Decreased burnout (Broome et al., 2009)
- Increased perceptions of quality of care and staffing adequacy (Laschinger, 2004)
- Increased organizational commitment (Dirks & Ferrin, 2002; Hood & Smith, 1994; Laschinger, 2004; Leach, 2005)
- Increased job performance (Cummings, 2004); motivation and willingness to work hard (Kouzes & Posner, 1995)
- Decreased absenteeism (Leach, 2005)
- Decreased intent to turnover (Dirks & Ferrin, 2002; Laschinger, 2004; Hanna, 1999; Mayer, Davis & Shoorman, 1995)
- Increased fiscal performance (Mayer et al., 1995)
- Ability to lead a diverse workforce (Harvard Business Review, 2001)
- Increased perception of the leader's credibility (Leach, 2005)

Trust is the highest form of human motivation. It brings out the very best in people.

~ Stephen Covey (1990)

Discussion of evidence

The belief that establishing trust is a necessary condition of successful leadership has prevailed for at least four decades (Dirks & Ferrin, 2002). Trust, along with fairness and respect, are the key values that lead to healthy organizations (Lowe, 2004). Trust is highly correlated with transformational leadership styles (Dirks & Ferrin, 2002). Respect for others and fairness is frequently identified as traits of transformational leaders (Fox et al., 1999) and has been linked to trust (Mishra & Spreitzer, 1998). In a study by Marville-Willaims (2007), staff identified the need for manager support as a demonstration of respect. Broome and colleagues report leader behaviour plays a role in shaping work responses and director leadership emerged as a key factor in burn-out ratings (Broome et al, 2009). When nurses feel respected, the results are higher job satisfaction, trust in management, lower emotional exhaustion and higher nurse ratings of quality of care and staffing adequacy (Laschinger, 2004; Cummings et al., 2010).

The relationship between a creative work climate and better job satisfaction is strong, according to at least two studies (Sellgren, Kajermo, Ekvall, & Tomson, 2009; Sellgren, Ekvall & Tomson, 2008). How managers behave in a work climate where there are trusting relationships was related to job satisfaction, as were leadership styles demonstrating empathy (Skinner & Spurgeon, 2005). Trusting relationships are likely needed for empathy to be conveyed and received.

Shea (2001) said health care is in a state of permanent white water and trust and relationships are necessary in times of high ambiguity, uncertainty and complexity. Organizational change affects workplace relationships that are essential to making things work.

Trust supports good interpersonal relationships (Laschinger, 2004; Nespoli, 1991). Establishing trust in leaders has been linked to their integrity, perceived influence, skill and the extent to which they demonstrate care and concern for others (Pielstick, 1998), including willingness to help others to grow personally and professionally (Nespoli, 1991).

Nurses identify strongly with their profession and trust in leaders often reflects the degree to which the leader demonstrates commitment to nursing values (Bunderson, 2001). Rousseau and Tijorwala (1999) found that nurses were less supportive of organizational change they felt was driven by financial or political reasons rather than the need to improve patient and client care. Nurses were more accepting of change when they trusted the leader.

Evidence suggests not only the individual behaviour of leaders is important but also the culture, climate and values of the organization (Laschinger, 2004). A 1995 study of nine Canadian benchmark[G] organizations found that building trust is not a simple or rapid process, but rather comes from being customer focused, quality driven and respectful of colleagues. In those organizations, leaders who modeled their values through their actions and demonstrated open communication and participative decision-making, particularly in situations of conflict, were very important to creating a climate of trust. Visibility and access to leaders was also important (Baird & St-Amand, 1995).

Visibility continues to be seen as important in leaders. Communication (including appreciation and recognition, enabled by respect and empathy), can optimize the visibility of nursing leadership (Anderson & Mano, 2011).

How Trust is Lost	How to Repair Lost Trust
■ Act and speak inconsistently ■ Seek personal rather than shared gain ■ Withhold information ■ Lie or tell half-truths ■ Be close minded ~ Lewicki& Bunker (1996)	■ 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 (2004)

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.

~ Drucker (1990)

Core Competencies	Sample Behaviour	Relevance for Point-of-Care Leadership
1.1.1 Nurse leaders demonstrate and model integrity and fairness (Bowman, 2004; Bunderson, 2001; Covey, 1990; Drucker, 1990; Gasper, 1992; Hanna, 1999; Harvard Business Review, 2001; King, 2000; Leach, 2005; Levasseur, 2004; Lewicki & Bunker, 1996; Mayer & Gavin, 1999; Mayer et al., 1995; Mishra & Spreitzer, 1998; Nespoli, 1991; Perra, 2000; Rousseau & Tijorwala, 1999; Shea, 2001; Storr, 2004; Upenieks, 2002a, 2003a; Wieck, Prydun & Walsh, 2002)	■ Reflect on own values and goals; share them openly (Gillespie & Mann, 2004; Hanna, 1999; King, 2000; Levasseur, 2004; Severinsson & Hallbeerg, 1996; Six, 2004; Walston & Kimberly, 1997) ■ Set clear, high performance standards (Baird, 1995; Leach, 2005; Levasseur, 2004; Nespoli, 1991; Parsons & Stonestreet, 2002) ■ Take responsibility and admit mistakes openly (Six, 2004; White, 2000) ■ Keep commitments (McGilton et al., 2004; Nespoli, 1991; Skarlicki & Dirks, 2002; Upenieks, 2003a) ■ Consistently display ethical behaviour (Lowe, 2004; Mayer et al., 1995; Rousseau & Tijorwala, 1999; King, 2000; Perra, 2000) ■ Gather data and look at all sides of issues (Upenieks, 2003a) ■ Make policies and practices explicit and transparent and apply them consistently (Skarlicki & Dirks, 2002)	■ Reflect on own values and goals; share them openly (Gillespie & Mann, 2004; Hanna, 1999; Levasseur, 2004; King, 2000; Severinsson & Hallbeerg, 1996; Six, 2004; Walston & Kimberly, 1997)

Core Competencies	Sample Behaviour	Relevance for Point-of-Care Leadership
1.1.2 Nurse leaders demonstrate care and respect and personal concern for others (Bauman et al., 2001; Burns, 1978; Dirks & Ferrin, 2002; Ferguson-Pare, 1998; Gasper, 1992; King, 2000;Lowe, 2004; Mayer & Gavin, 1999; Severinsson, 1996; Skarlicki & Dirks, 2002; Skinner & Spurgeon, 2005; Upenieks, 2003a)	■ Seek and acknowledge multiple perspectives and opinions (Antrobus & Kitson, 1999; Gillespie & Mann, 2004; Nespoli, 1991; Perra, 2000; Severinsson & Hallbeerg, 1996; Skarlicki & Dirks, 2002) ■ Listen without judgment or criticism (Severinsson, 1996) ■ Seek to understand what matters to others and respond appropriately (Nespoli, 1991; Lowe, 2004Severinsson & Hallbeerg, 1996) ■ Share knowledge of system issues and perspectives and problems openly and honestly (McGilton et al., 2004; Ray, Turkel & Marino, 2002; Ward, 2002; White, 2000) ■ Acknowledge the value of others and celebrate their successes (Englebart, 1993; King, 2000; Leach, 2005; Skarlicki & Dirks, 2002; Tucker Scott, 2004; Upenieks, 2003a; White, 2000) ■ Respect and model work-life balance (Fletcher, 2001; Upenieks, 2003a; Parsons & Stonestreet, 2002)	■ Ensure patients' and families' needs are assessed and effectively communicated and coordinated (Reid & Dennision, 2011) ■ Are advocates for patients, families and other point-of-care providers (Reid & Dennision, 2011)
1.1.3 Nurse leaders create a sense of presence and accessibility (Bousfield, 1997; Ferguson-Paré, 1998; Fletcher, 2001; Severinsson & Hallbeerg, 1996; Tucker Scott, 2004; Upenieks, 2003a; Ward 2002)	■ Communicate and make personal contact frequently (Bunderson, 2001; Gillert & Chuzischvili, 2004; Skinner & Spurgeon, 2005) ■ Maintain visibility and accessibility to others (Baird & St-Amand, 1995; Ray et al., 2002; Registered Nurses Association of British Columbia, 2001; Severinsson & Hallbeerg 1996)	■ Routinely interact with patients to monitor, assess and prioritize patient needs (Reid & Dennision, 2011) ■ Provide evidence-based discharge education to improve clinical outcomes and decrease re-admissions (Ott et al., 2009)
1.1.4 Nurse leaders communicate effectively	■ Communicate clearly, openly, honestly and frequently (Cadman & Brewer, 2001; Ferguson-Paré, 1998; Ingersoll, Fisher, Ross, Soja & Kidd, 2001; McGilton et al., 2004) ■ Listen interactively and demonstrate understanding of the opinions of others (Antrobus & Kitson1999; Gillert & Chuzischvili, 2004; Nespoli,1991; Perra,2000; Severinsson & Hallbeerg, 1996; Tucker Scott, 2004; Ward, 2002;) ■ Develop and use skills in cross-cultural communication (Grinspun, 2000)	■ Communicate patient findings based on clinical assessment (Reid & Dennision, 2011) ■ Communicate with the patient, family and interprofessional team to determine needs and changes other than those specific to the patient's medical diagnosis (Reid & Dennision, 2011) ■ Develops and utilizes communication skills targeted to teams, lateral integration of care needed for safe patient care (Reid &Dennision, 2011)

Core Competencies	Sample Behaviour	Relevance for Point-of-Care Leadership
1.1.5 Nurse leaders manage conflict effectively (Bunderson, 2001; Drucker, 1990; Dunham-Taylor, 1995; Fox et al., 1999; Walston & Kimberly 1997)	■ Understand the constructive and destructive effects of conflict ■ Acknowledge and address the conflict; develop and use a range of conflict resolution skills (Lambert & Nugent, 1999)	■ Utilizes evidenced-based practices and organizational resources to address conflict (Reid & Dennision, 2011) ■ Advocates for patient and other point-of-care providers using conflict resolution skills (Reid & Dennision, 2011)
1.1.6 Nurse leaders build and promote collaborative relationships and teamwork (CNO, 2002; Disch, Walton & Barnsteiner, 2001; Englebar, 1993; King, 2000; Kouzes & Posner, 1995; Lambert & Nugent, 1999; Registered Nurses Association of British Columbia, 2001; Storr 2004; Ward, 2002)	■ Seek and acknowledge broad input (Bunderson, 2001; Cadman & Brewer, 2001; Englebart, 1993 ;) ■ Recognize the legitimacy of other's interests and discuss how interests are aligned (Gelinas & Manthey, 1997; Skarlicki & Dirks, 2002; Six, 2004) ■ Explore uncertainties and fears (Porter O'Grady, 1992) ■ Build consensus[G] ■ Give and receive help and assistance ■ Evaluate effectiveness of working together	■ Participate as leaders for nursing on interprofessional teams (Reid & Dennision, 2011) ■ Advocate for patient with the interprofessional team (Reid & Dennision, 2011) ■ Work collaboratively on nursing and interprofessional teams (Reid & Dennision, 2011)
1.1.7 Nurse leaders demonstrate passion and respect for the profession of nursing, its values knowledge and achievements (Clifford, 1998; Ferguson-Paré, 1998; Ferguson-Paré, Mitchell, Perkin & Stevenson, 2002;Gillespie & Mann, 2004; Nespoli, 1991; Ray et al., 2002; Registered Nurses Association of British Columbia, 2001; Thompson & Bunderson, 2003; Tucker Scott 2004; Upenieks, 2003a; Ward, 2002)	■ Demonstrate strong commitment to caring, justice, honesty, respect and integrity (White, 2000) ■ Advocate for quality care and quality practice settings placing patients/clients first (Clifford, 1998; CNO, 2002; Ferguson-Paré et al., 2002; Hanna, 1999; Storch, Rodney, Pauly, Brown, & Starzomski, 2002; Upenieks 2003a; Ward, 2002; Storch et al., 2002; White, 2000 ;) ■ Acknowledge and promote nurses' contribution to patients/clients, organizations and communities (Antrobus & Kitson, 1999; Clifford, 1998; Nespoli, 1991; Storch et al., 2002; Upenieks, 2003; Ward, 2002)	■ Assume responsibility for specific patients based on scope of practice for the nursing profession (Reid & Dennision, 2011) ■ Understand the influence the nurse has on patients and delivers care in a professional non-hierarchical manner (Reid & Dennision, 2011) ■ Actively participates in professional activities to enhance skills and acquire new knowledge (Reid & Dennision, 2011)

Core Competencies	Sample Behaviour	Relevance for Point-of-Care Leadership
1.1.8 Nurse leaders demonstrate role competence (Boyle, Bott, Hansen, Woods & Taunton, 1999; Gillespie & Mann, 2004; Mayer et al., 1995)	■ Maintain and apply current knowledge of nursing science, leadership and other relevant knowledge (Bousfield,1997; Severinsson, 1996) ■ Address concerns and issues (Adams, 1994; CNO, 2002; Fletcher, 2001; Levasseur, 2004; Nespoi,1991;Upenieks,2003a) ■ Participate actively in decision-making opportunities ■ Take responsibility for actions and outcomes ■ Communicate successes to create confidence (McGillis et al., 2005; Skarlicki & Dirks, 2002)	■ Apply evidenced-based practices at the point-of-care while assessing, implementing and evaluating care (Reid & Dennision, 2011)

Suggested strategies for building relationships and trust

Individual strategies

- Have an open door policy; post when you'll be available
- Practice management by walking around and spend time on the unit (Fletcher, 2001; McGilton et al., 2004; Peters& Waterman, 1982; Ray et al., 2002; Upenieks, 2002b)
- 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 (Kofman, 1994)
- Communicate support to staff by determining and clarifying what they expect of their leaders (Kramer, Schmalenberg & Maguire, 2004)
- Provide ongoing informal feedback for jobs well done
- Learn mentorship skills (Doran et al., 2012)
- Volunteer to become a mentor and also a mentee (Doran et al., 2012)
- Learn about interprofessional practice and how to facilitate team-based work (Doran et al., 2012)
- Particpate in RNAO clinical practice fellowships (Doran et al., 2012)
- Learn project management skills and volunteer to participate or lead a project or change initiative
- Support change initiatives and actively discuss projects and change initiatives with colleagues
- Learn about and implement interprofessional councils (Wesorick, Shyiparski, Troseth, Wyngarden 1998)
- Volunteer to be council member or leader for your unit (Brody, Barnes, Ruble, & Sakowski, 2012).
- Talk with colleagues about what matters to them and bring it forward at council meetings (Wesorick et al., 1998)
- Share information with colleagues after council meetings and take their perspective back to council (Wesorick et al., 1998)
- Recognize contributions (Patrick, 2011)
- Build a network of advisors and informants who will provide an honest and unbiased perspective when you need information and advice (Joni, 2004)

Team/Unit/Organization Strategies

- Create a collective vision and values statement for the team/unit/organization (Gillespie & Mann, 2004) 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) (Recker, Bess & Wellens, 1996)
- Do regular performance appraisals
- Design interview guides for hiring for leadership positions, incorporating questions about respect for individuals and the value of nursing
- Formalize recognition for nurses who demonstrate excellence in practice with awards, certificates, newsletter articles and events during Nursing Week to recognize achievements
- Establish a council infrastructure. The idea comes from the work of Bonnie Wesorick, a specialist in creating healthy workplaces for nurses. She and her team describe council infrastructures as a safe place to learn, develop, and practice leadership skills, including learning to build relationships through dialogue, appreciative enquiry, conflict management, and polarity management. Council infrastructures are a place where point-of-care leaders engage in decision making with managers. Councils can work in numerous areas, including healthy work environments; patient safety; quality improvement; strategies for recruitment and retention; improving patient-client satisfaction; use of resources, enhancing competency and even connecting with other health care organizations. Council infrastructures are also important in integrating evidence-based practices across disciplines (Wesorick et al.1998; Wesorick & Shiparski,1997)

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
- Learn and practice skills of dialogue
- Learn and practice the skills of polarity management — a method for handling issues that are not problems with potential solutions, but rather dilemmas that can only be managed
- Focus on what's possible, not what's wrong (Wheatley, 2002)
- 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 process for evaluating possible solutions
- Refer to RNAO "Managing and Mitigating Conflict in Health-care Teams" (2012) available at rnao.ca/bpg

Leadership Practice Recommendation 2: Empower Staff

1.2 Nurse leaders create or contribute to an empowering work environment.

Empowerment in the workplace leads to:

- Increased job satisfaction for nurses (Cummings et al., 2010; Hatcher & Laschinger, 1996; Huffman, 1995; Laschinger, Finegan, Shamian & Casier, 2000; Laschinger, Almost & Tuer-Hodes, 2003; Laschinger & Havens, 1996; Roche & Duffield, 2010; Upenieks, 2003b; Whyte, 1995)
- Improved occupational mental health (Baguley,1999; Hatcher& Laschinger,1996; Hatcher, 1993; Howard, 1997; Laschinger & Havens, 1997; Laschinger et al.,1999; McBurney, 1997; O'Brien, 1997)
- Increased perception of autonomy and control over nursing practice (Cummings, 2004; Huffman, 1995; Laschinger & Havens,1996; Laschinger & Havens,1997; Laschinger, Sabiston & Kutszcher, 1997)
- Increased staff motivation (Kanter, 1979; Peachy, 2002)
- Increased respect and appreciation for the leader (Nespoli, 1991)
- Improved organizational commitment (Beaulieu, Shamian, Donner & Pringle, 1997; Dubuc, 1995; Howard, 1997; McDermott, Laschinger & Shamian, 1996; McKey, 2002; Peachy, 2002; Tucker & Edmondson, 2003; Wilson &Laschinger, 1994)
- Improved work effectiveness and performance (Laschinger & Havens, 1996; Laschinger & Havens, 1997; Laschinger, Finegan, & Shamian, 2001a; Laschinger et al.,1999; Peachy, 2002; Tucker & Edmondson, 2003)
- Improved retention of staff (Gokenbach, 2004; Govers, 1997; Laschinger, Finegan & Shamian, 2001b; Laschinger, Finegan, Shamian & Wilk, 2000; McKey, 2002; Upenieks, 2003b)
- Improved patient outcomes (Boyle, 2004)

Discussion of evidence

The need to create and sustain empowered work environments for nurses is a common theme in nursing leadership literature (Govers, 1997; Laschinger et al., 2000; Laschinger et al., 2001b; Upenieks, 2003b). Empowerment occurs over time (Erickson, Hamilton, Jones & Ditomassi, 2003), has been linked to trust (Laschinger et al., 2000) and is thought to occur when an organization sincerely engages its staff with mutual interest and intention to promote growth. Organizational characteristics and culture are more useful in understanding empowerment than personality factors, individual attitudes and job effectiveness (Hatcher & Laschinger, 1996). Both empowerment and satisfaction are directly related to employees' circumstances in the workplace (Hatcher & Laschinger, 1996; Upenieks, 2003b).

It takes a combination of organizational conditions and leadership styles to empower staff. Social structures in the workplace influence employee attitudes and behaviour (Kanter, 1993) as do structural factors, such as access to information, receiving support, access to necessary resources to the job, and opportunities to learn and grow (Kanter, 1993).

Manojlovich (2005) found a strong direct relationship between how nurses perceive their manager's ability to mobilize necessary resources and their sense of empowerment. That study also showed nurses had a greater belief in their own capabilities when they had strong nursing leadership, which they did not feel if they perceived nursing leadership to be weak.

Skelton Green (1996) found nurses who served on hospital committees reported increased job satisfaction and decreased intent to leave, while Erickson et al. (2003) found nurses who were members of governance committees reported higher empowerment. Beaulieu et al. (1997) studied empowerment and commitment of nursing staff and nursing managers in two long-term-care facilities in Ontario. They found managers who reported adequate access to information, support and resources were significantly more empowered and committed to their organizations than staff nurses. In a study of nurse managers in Finland, Suominien and colleagues (2005) found a highly significant relationship between empowerment and low stress levels.

Transformational leaders empower nurses through ongoing dialogue, by sharing their vision and values, and motivating others to share them and make them a reality (Conger & Kanungo, 1988; Dunham & Fisher, 1990; McKay, 1995). Empowering leaders give purpose and meaning to work by promoting the value of nursing and creating access to formal and informal power structures, which are significant predictors of access to empowerment in the workplace (Dubuc, 1995; Huffman, 1995; McKay, 1995; Whyte, 1995).

Roles that have discretionary decision-making, visibility, and relevance in the organization give formal power. Informal power emerges from political alliances and interactions with peers (Kanter, 1993). Alliances — with peers, superiors and subordinates — further influence empowerment (Laschinger et al., 2001b).

Empowering leaders create conditions for effective and empowered work by designing roles that let staff participate in making decisions and by optimizing opportunities for autonomy, personal and professional growth (Kanter, 1993). Empowered staff has been linked to improved customer focus, products and services, organizational competitiveness and quality of work life (Howard, 1997).

Optimizing their ability to make decisions at the point-of-care is an example of empowering nurses at work, and is necessary for them to gain control over their work (Davidson, Elliott, & Daly 2006; Duffield, Roche, O'Brien-Pallas, Catling-Paull & King, 2009). Another example would be optimizing their scope of practice at the point-of-care in all settings (CNA, 2012).

> ***Nursing leadership development at all levels is increasingly important as health care systems and organizations become more complex and resources become more restrained.***
>
> ~ (Doran et al., 2012)

Core Competencies	Sample Behaviour	Relevance for Point-of-Care Leadership
1.2.1 Nurse leaders understand and practice the concepts and principles of empowering behaviour	■ Critically reflect on personal use of empowering behaviour ■ Seek feedback on their own behaviour ■ Share power with others	■ Critically reflect on personal use of empowering behaviour (Reid & Dennision, 2011) ■ Seek feedback on their own behaviour (Reid & Dennision, 2011) ■ Share power with others (Reid & Dennision, 2011)
1.2.2 Nurse leaders optimize nurses' opportunities for autonomy and personal and professional growth.	■ Demonstrate confidence in others by delegating effectively (CNO, 2002; Hui, 1994; McGilton et al., 2004; Nespoli, 1991; Upenieks, 2003a; Walston& Kimberly, 1997). ■ Coach, mentor and guide (CNO, 2002; Ferguson-Paré et al., 2002; Gelinas & Manthey, 1997; Pederson, 1993; Upenieks, 2003a, 2003c) ■ Provide both negative and positive feedback constructively (Parsons & Stonestreet, 2002; Six,2004; Tucker Scott, 2004) ■ Use experience as a learning opportunity (CNO, 2002; DeLong & Fahey, 2000; Garvin,1993) ■ Provide opportunities for development of knowledge, skills and judgment. (Bousfield, 1997; DeLong & Fahey, 2000; Englebart, 1993; Ferguson-Paré, 1998; Gasper, 1992; Nespoli, 1991; Severinsson, 1996; Upenieks 2003a) ■ Encourage use of judgment, risk taking and innovation (Ballein Search Partners 2003; Upenieks 2002a) ■ Develop policies and processes that enable full scope of practice (Chiok Foong Loke, 2001)	■ Leads education for patients through the use of appropriate teaching resources (Reid & Dennision, 2011) ■ Uses experience as a learning opportunity (CNO, 2002; DeLong & Fahey, 2000; Garvin,1993) ■ Coaches, mentors and guides (CNO, 2002; Ferguson-Paré et al., 2002; Gelinas & Manthey, 1997; Pederson, 1993; Upenieks, 2003a, 2003c) ■ Provides both negative and positive feedback constructively (Parsons & Stonestreet, 2002; Six, 2004; Tucker Scott, 2004)

Core Competencies	Sample Behaviour	Relevance for Point-of-Care Leadership
1.2.3 Nurse leaders optimize access to and use of data and information required to function effectively (Upenieks, 2002a)	■ Share personal and organizational vision and values (Cadman & Brewer, 2001; Ferguson-Paré, 1998; Hanna, 1999; Ingersoll et al., 2001; King, 2000; Lageson, 2001; Levasseur, 2004; Nespoli, 1991; Walston & Kimberly, 1997) ■ Share information about ongoing organizational initiatives and future plans (Ray et al., 2002; Upenieks, 2002a) ■ Critically apply knowledge grounded in nursing theory and research (Antrobus & Kitson, 1999; Clifford, 1998; CNO, 2002; Upenieks, 2002a) ■ Foster development, sharing and application of knowledge and evidence-based strategies (Antrobus & Kitson, 1999; Davenport, DeLong & Beers, 1998; Ferguson-Paré et al., 2002) ■ Share expertise and facilitate access to expertise of others (IOM, 2004)	■ Utilizes systems and technology at the point-of-care to facilitate evidenced-based care and improved outcomes for patient/client (Reid & Dennision, 2011) ■ Monitors and collects indicators to assess the safety and quality of patient/client care (Reid & Dennision, 2011)
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 (Antrobus & Kitson, 1999; Pederson, 1993) ■ Tailor leadership styles to individuals and situations (Cardin, 1995; Ferguson-Paré, 1998; Pederson, 1993) ■ Create structures and processes that enable interactions ■ Support nurses affected by work events or experiences	■ Acts as liaison person between interprofessional team members and consultant for other nurses (O'Connor,Theol & Chapman, 2008)

Core Competencies	Sample Behaviour	Relevance for Point-of-Care Leadership
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 resources (Aiken, Sochalski& Lake, 1997; Hanna, 1999; McClure, Poulin, Sovie & Wandelt, 2002; Upenieks, 2002a) ■ Remove barriers to achieving outcomes (Upenieks, 2003a) ■ Provide and use necessary budgetary support, training time and decision support tools to accomplish goals and objectives (CNO, 2002; Ferguson-Paré et al., 2002; Ferguson-Paré, 1998; Registered Nurses Association of British Columbia, 2001; Upenieks, 2002a, 2003a; Strebel, 1996; Walston & Kimberly,1997) ■ Establish mechanisms to monitor and achieve manageable workloads ■ Respond to changing needs and priorities	■ Identifies ways to save costs at the point-of-care (Reid & Dennision, 2011) ■ Implements system-wide initiatives that improve quality, effectiveness and efficiency (Reid & Dennision, 2011) ■ Delegates and uses resources appropriately at the point-of-care (Reid & Dennision, 2011)
1.2.6 Nurse leaders enhance the meaningfulness of nursing work	■ Promote the contribution of nursing to patient/client and organizational outcomes (Clifford, 1998; Nespoli, 1991; Upenieks, 2002a, 2003a) ■ Design roles that have discretionary decision-making, visibility and are relevant to key organizational processes (Kanter,1993) ■ Create access to a network of alliances both in and external to the organization	■ Promote the contribution of nursing to patient/client and organizational outcomes (Clifford, 1998; Nespoli, 1991; Upenieks, 2002a, 2003a)
1.2.7 Nurse leaders enable participation in decision making (Campbell, Fowles & Weber, 2004; Erickson et al., 2003; Ferguson-Paré, 1998; Hanna, 1999; Nespoli, 1991; Robinson, 2001; Skelton Green, 1996)	■ Solicit broad input from others (Ferguson-Paré, 1998; Hanna, 1999; Nespoli,1991) ■ Create structures and processes that enable participation in decision-making ■ Honour decisions with support (Robinson, 2001)	■ Provides and acquires appropriate information for decisions relevant to the patient/client (Reid & Dennision, 2011) ■ Is an advocate for patients and their families in the hospital and with other community-based services (O'Connor et al., 2008)

Suggested Strategies for Successfully Creating an Empowering Work Environment

Individual strategies

- Engage in continuous learning (Patrick, Laschinger, Wong & Finegan, 2011)
- Question the status quo (Patrick et al., 2011)
- Debrief successes and failures (Patrick et al., 2011)
- Participate in setting a vision or collective purpose (Patrick et al., 2011)
- Participate in finding common ground (Patrick et al., 2011)
- Share information and resources (Patrick et al., 2011)
- Build trusting relationships (Patrick et al., 2011)
- Create shared values (Patrick et al., 2011)
- Achieve small wins (Patrick et al., 2011)
- Create supportive relationships (Patrick et al., 2011)
- Recognize contributions (Patrick et al., 2011)
- Practice reflection by keeping a personal journal
- Seek comprehensive feedback to understand how others perceive behaviour
- Review the literature on transformational leadership
- Employ a professional coach and/or seek out a mentor and meet regularly
- Attend educational events to learn more about leadership, project management, quality improvement
- Volunteer for leadership opportunities such as leading an initiative or participating as a team member on a quality or change initiative
- Volunteer to be part of a team to collect data about practice and make it visible through posters and engaging in everyday conversation about the results
- Participate in huddles and other patient safety initiatives
- Be a champion for integration of technology at the point-of-care

Team/Unit/Organization Strategies

- Establish formal and informal leadership roles at the practice level, such as clinical resource persons, project leaders or rounds leaders
- Facilitate rotation of charge roles
- Involve nurses in patient care conferences and committees
- Enable access to employee assistance programs, support groups, post-incident discussion support
- Provide opportunities for learning and visibility, such as attending board or committee meetings (CNA, 2003a) or leadership development courses/conferences
- Organize facilitated groups to share leadership experiences and strategies
- Build peoples' belief in their abilities through orientation programs, skills training, role modelling and positive feedback (Manojlovich, 2005)
- Establish quality-improvement teams to respond to staff concerns
- Share 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 (Apker et al., 2003)
- Conduct regular performance appraisals and establish a peer review process

Suggested Strategies for Successfully Creating an Empowering Work Environment

Organization-wide strategies

- Simplify decision-making structures and processes
- Consider the complexity of work, diversity, and number people when determining nurse-to-leader ratios in the structuring work groups
- Establish shared governance structures and processes, such as nursing practice councils and unit-based councils, to govern nurses' scope of practice (CNA, 2001)
- Develop strategies and policies to maximize nursing scope of practice (CNA, 2012)
- Appoint staff nurses to product-review committees
- Communicate the work of nursing practice committees regularly through newsletters, open forums (Upenieks, 2002b) and web-based technology
- Provide diversity training, support and accountability program for all nurses
- Establish mentoring and preceptorship programs (CNA, 2001)
- Provide internships for both new graduates and experienced nurses

Leadership Practice Recommendation 3: Build Knowledge

1.3 Nurse leaders create an environment that supports knowledge integration.

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

- Increased job satisfaction for nurses (Gifford, Zammuto, & Goodman, 2002; McNeese-Smith, 1997; Paterson, Henderson, Trivella, 2010; Perra, 2000)
- Increased work effectiveness (Collins, 2002; Perra, 2000; Upenieks, 2003b)
- Increased empowerment and autonomy (Ferguson-Paré,1998; Gifford et al., 2002; Wilson & Laschinger,1994)
- Enhanced quality of practice and care and accountability (Perra, 2000)
- Enhanced personal and professional growth of staff (Bousfield, 1997; Madison, 1994; Severinsson, 1996) and clinical leadership (Ferguson-Paré et al., 2002)
- Increased desire to continue education (Upenieks, 2003a)
- Enhanced staff relationships (Nespoli, 1991)
- Increased trust in the leader (Garvin, 1993; Tucker & Edmondson, 2003) and organization (Upenieks, 2003c)
- Enhanced success of planned change (Strebel, 1996; Walston & Kimberly, 1997)
- Increased organizational commitment (Perra, 2000)

Clinical leadership is a process of leadership embedded in the professional practice behaviour of staff nurses.

~ (Patrick et al., 2011)

Discussion of evidence

The ongoing acquisition and management of knowledge is an intrinsic characteristic of high-performing organizations (Upenieks, 2003c). Learning organizations are skilled at acquiring and disseminating knowledge while modifying behaviour to reflect new knowledge (Upenieks, 2003c; DeLong, & Fahey, 2000). Senge (1990) 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 (2003) clearly indicated the influence of leadership behaviour 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 (Tucker & Edmondson, 2003; Argyris & Schön, 1996). 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 (Donaldson & Rutledge, 1998; Upenieks, 2003c). DeLong and Fahey (2000) 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 behaviour, including the existing attitudes toward knowledge ownership, the changes needed to promote more collaborative use of knowledge, and internal communication patterns. Donaldson and Rutledge (1998) 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 (Donaldson & Rutledge, 1998).

Learning organizations take advantage of all sources of knowledge including internal creativity, knowledgeable experts in 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 (Garvin, 1993). 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 (Davenport et al., 1998).

Large health care organizations make decisions based on evidence that is not systematically gathered or assessed (Kovner, Elton & Billings, 2000). As Berwick (1996) 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, databases, 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 (Walshe & Rundall, 2001).

Nurses in formal leadership roles can create an environment that supports leadership development by providing access to leadership education as well as opportunities to practice learned leadership competencies (Paterson et al., 2008). Nurse leaders are also responsible for creating opportunities for point-of-care nurses to learn about nursing research and implement practices that are research based (Jeffs, MacMillan, McKey, & Ferris, 2009).

Core Competencies	Sample Behaviour	Relevance for Point-of-Care Leadership
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 (Ballein Search Partners, 2003) ■ Foster opportunities for individuals to think and learn (Tucker & Edmondson, 2003) ■ Foster nurse-to-nurse sharing of clinical and leadership expertise ■ Create opportunities for staff to assess work systems and devise new ones (Tucker & Edmondson, 2003) ■ Promote and support nursing research ■ Promote and support developing and using evidence-based guidelines (Kitson, Harvey & McCormack, 1998; Udod & Care, 2004) ■ Acknowledge the value of different modes of knowledge generation and uptake ■ Align incentives to reinforce and facilitate uptake of knowledge management practices (Davenport et al., 1998) ■ Manage personal growth by objectively challenging behaviour and beliefs (Gelinas & Manthey,1997)	■ Applies nursing process in leading the care of the patient/client (Reid & Dennision, 2011) ■ Provides opportunities to share knowledge on patient/client progress (Reid & Dennision, 2011) ■ Leads and shares interventions for patients and clients through patient-care conferences (Reid & Dennision, 2011) ■ Manage personal growth by objectively challenging behaviour and beliefs (Gelinas & Manthey,1997)
1.3.2 Nurse leaders provide technical, informational, and educational infrastructure to support learning (Ballein Search Partners, 2003; Davenport et al., 1998; Hansen, Nohria & Tierney, 1999; Ward, 2002)	■ Provide support for education and continuing career development (Ballein Search Partners, 2003; Kramer & Schmalenberg, 2002) ■ Create organizational partnerships that facilitate continuing education ■ Seek out and use knowledgeable experts in and external to the organization (Rycroft-Malone et al., 2002) ■ Provide access to a variety of literature and information (Udod & Care, 2004) ■ Encourage use of decision-support tools	■ Assesses reports, lab results, to evaluate patient/client status and shares knowledge with other team members (Reid & Dennision, 2011) ■ Consults with experts to achieve optimal care and outcomes for patient/client (Reid & Dennision, 2011)

Core Competencies	Sample Behaviour	Relevance for Point-of-Care Leadership
1.3.3 Nurse leaders create environments where communication is open, and teamwork and the contribution of others' knowledge is valued (Ballein Search Partners, 2003)	■ Examine internal communication patterns (Upenieks, 2003c) ■ Recognize cultural differences in communication and how perceptions of hierarchy may influence communication ■ Encourage collaborative problem solving (Pielstick, 1998; Upenieks, 2003c) ■ Establish structures and processes to encourage discussion of issues or ideas (Ballein Search Partners, 2003) ■ Promote flow of information and ideas at multiple levels through informal and formal practices ■ Showcase successes	■ Engages with other health-care professionals to improve efficiency in existing organizational processes (Ott et al., 2009) ■ Provides open, timely communication to patient/client and family and the interprofessional team (Reid & Dennision, 2011) ■ Recognizes patient/client family cultural differences in communication and the influence perceptions of hierarchy may have on communication (Reid & Dennision, 2011) ■ Encourages collaborative problem solving (Pielstick, 1998; Upenieks, 2003c)
1.3.4 Nurse leaders instill a learning approach for continuous quality improvement[G]	■ Provide effective feedback (DeLong & Fahey, 2000; Ferguson-Paré 1998; Ferguson-Paré et al., 2002; Gelinas & Manthey, 1997; Severinsson, 1996; Upenieks, 2003a) ■ Articulate, critically review, generate and validate knowledge through critical reflection on practice (Berwick, 1996; Titchen, 2000) ■ Inspire creative thinking ■ Engage management and staff in improving quality of care and ensuring effective allocation of resources (Ballein Search Partners,2003) ■ 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	■ Facilitates problem solving, decision making and improvement of patient flow (Ott et al., 2009) ■ Provides effective feedback (DeLong & Fahey, 2000; Ferguson-Paré 1998; Ferguson-Paré et al., 2002; Gelinas & Manthey, 1997; Severinsson, 1996; Upenieks, 2003a) ■ Engages interprofessional team in improving quality of care and ensuring effective allocation of resources (Ballein Search Partners, 2003) ■ Demonstrates a strong sense of individual responsibility for quality monitoring at point-of-care (Reid &Dennision, 2011) ■ Provides time for patient/family to discuss plan of care ■ Uses reflective practice to generate and validate knowledge (Reid & Dennision, 2011)

Core Competencies	Sample Behaviour	Relevance for Point-of-Care Leadership
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 (Ballein Search Partners, 2003) ■ Get frontline staff involved in benchmarking and developing best practices (Ballein Search Partners, 2003; Gifford, 2002) ■ Use data and quality frameworks for monitoring and decision making ■ Examine the best practices of other organizations and professions (Upshur, 1997) ■ Monitor results of changes and set up accountability mechanisms ■ Review and record past organizational successes and failures (Beaulieu, 1997)	■ Participates in benchmarking and implementing best practices (Ballein Search Partners, 2003; Gifford, 2002)

The most significant leaders for improving direct care are the individuals providing direct care.

~ (Cook, 2001)

Suggested strategies for creating an environment that supports developing and integrating knowledge

Individual strategies

- Show personal commitment to professional development by reviewing research and attending conferences
- Lead the team in discussions of research articles, case studies and clinical experiences
- Conduct and share research reviews to synthesize findings on clinical and management topics (Walshe & Rundall, 2001)
- Establish a roundtable or lunch group to discuss leadership experiences (Walshe & Rundall, 2001)
- Challenge your leadership knowledge by writing for a publication or presenting at a conference
- Raise questions about practice (Patrick et al., 2011)
- Continue learning about evidence-based best practices and champion their integration (Jeffs et al., 2009)
- Discuss how to evaluate practice with others and volunteer to collect data for evaluation
- Volunteer for practice improvement initiatives
- Participate in models of care that support learning (such as the 80/20 model, where learning is part of salaried work) and support colleagues to try them as well (Bournes & Ferguson-Pare, 2007)

Team and unit strategies

- Develop quality-improvement teams and councils
- Establish interprofessional project teams to foster learning and communication (Upenieks, 2003c)
- Encourage sharing of information at regular team meetings (Stone et al., 2002) or other forums, conferences and meetings (Garvin, 1993; Upenieks, 2003c)
- Foster nurse-to-nurse and interprofessional sharing of expertise through rounds
- Support continued education for staff through flexible scheduling and journal clubs
- Encourage staff to write a group article for publication or to do a presentation at a conference
- Conduct a needs assessment and develop an education plan for the unit
- Establish annual learning plans

Organization-wide strategies

- Provide library services, including internet and search engines (Udod & Care, 2004)
- Provide tuition support and flexible scheduling to enable continuing education
- Partner with degree-granting programs to provide on-site education; engage in collaborative research projects (Rutledge & Donaldson, 1995)
- Conduct regular focus groups and surveys to track nursing practice processes and outcomes
- Create processes for non-punitive reporting of errors and near-misses
- Use best practice guidelines
- Create opportunities for staff to learn about research, quality improvement, project management, mentoring, patient-centred care and integrating evidence-based practice by dedicating a percentage of work hours to learning time (Bournes & Ferguson-Pare, 2007).
- Build/revise workload measurement tools to allow time for reflection and learning
- Make doing and using research part of job descriptions and strategic planning (Rutledge & Donaldson, 1995)
- Establish a nursing research committee and use evidence and research in the regular work of committees (Rutledge & Donaldson, 1995)
- Publish nurses' accomplishments in an annual report or news letter
- Develop and provide open access to reports on nursing quality by tracking data on nurse-sensitive indicators (Bethune, 2005)

Leadership Practice Recommendation 4: Lead and Sustain Change

1.4 Nurse leaders lead, support and sustain change.

Effective change-management leadership leads to:

- Increased employee acceptance of change (Barry-Walker, 2000; Ingersoll et al., 2001; Katz, 1982; Rousseau & Tijorwala, 1999)
- Increased achievement of the change (Kramer &Schmalenberg, 2002; Leach, 2005; Strebel, 1996; Upenieks, 2003a)
- Higher-performing teams (Cummings et al., 2005; Gil, Rico, Alcover, Barrasa, 2005; Leach, 2005; Perra, 2000)
- Increased productivity (Leach, 2005; Perra, 2000)
- Lower absenteeism (Leach, 2005; Perra, 2000)
- Increased job commitment (Barry-Walker, 2000; Ingersoll et al., 2001; Katz, 1982; Rousseau & Tijorwala, 1999)
- Increased organizational commitment (McNeese-Smith, 1997; Perra, 2000)
- Increased staff motivation and willingness to work hard (McNeese-Smith, 1997; Perra, 2000)
- Increased job satisfaction (Cummings et al., 2005; Gil et al., 2005; McNeese-Smith, 1997; Perra, 2000)

Discussion of evidence

Nurse leaders are the key to successfully changing organizations. In a Canadian study on the effects of hospital restructuring, nurses reported fewer negative effects when they felt their leaders used a relationship-based democratic style (Cummings et al., 2005). A U.S. study by Gullo and Gerstle (2004) found when middle managers showed transformational leadership during restructuring, staff nurses reported an above-average sense of empowerment; however, they found no relationship between transformational style and job satisfaction during restructuring. In a study of hospital teams in Spain, Gil et al. (2005), found transformational and charismatic leadership styles were strongly correlated with job satisfaction and team performance, and influenced by the team's belief in its own effectiveness.

Change begins when a nursing leader develops a vision that challenges assumptions, structures and processes in the organization (Kanter, 1999; Leach, 2005; McNeese-Smith, 1995; Shea, 2001; Upenieks, 2003a). To build a critical mass of support for the vision, it must be developed and then shared with other stakeholders (Block, 1987; Kramer & Schmalenberg, 2002; Tucker, 2004).

Vision successfully becomes change when nurse leaders engage staff by creating structures and opportunities that gets them involved in all phases of the change process (Collins, 2002; Knox & Irving, 1997a). Leaders who demonstrate genuine commitment to change (Kanter, 1999; Knox & Irving, 1997b) and act as role models for risk-taking and innovation are better able to achieve the intended goals (Leach, 2005; Kramer & Schmalenberg, 2002; Upenieks, 2003a).

There is a body of research that points to the need for ongoing communication across all levels of the organization (Ingersoll et al., 2001; IOM, 2004; Knox & Irving, 1997b; Rousseau &Tijorwala, 1999). Open communication may make employees more accepting of the change and more committed to their jobs (Barry-Walker, 2000; Ingersoll, et al., 2001; Katz, 1982; Rousseau & Tijorwala, 1999). Effective strategies include asking staff for feedback on their perception of the change (Heifetz & Laurie, 2001; Ingersoll, et al., 2001; Knox & Irving, 1997a). Information should be tailored to the unique context for individuals at different levels of the organization (Skinner & Spurgeon, 2005; Upenieks, 2003a). Updates on measurable goals and progress reports should be given at regular intervals (Walston & Kimberly, 1997).

Some system changes may cause nurses moral distress, which needs to be recognized and addressed (Bell & Breslin, 2008). Ethics education and debriefings by nurse leaders assist health-care providers to manage moral distress (Bell & Breslin, 2008).

Strebe (1996) suggests leaders often under-estimate the learning necessary to support change. Quality and efficiency are more likely to be maintained where there are adequate time and resources for education (Knox & Irving, 1997b; Walston& Kimberly, 1997). It is important to tailor resources to the magnitude of the expected change (Kanter, 1999; Walston & Kimberly, 1997).

Employees cope better with change when nurse leaders build trust and offer ongoing support (Leana &VanBuren, 1999) by being present and visible where the change is occurring (Shea, 2001), and by listening and responding to emotions and reactions of staff (Block,1987; Greenberg, 1996). However, for change to be effective and sustained, leaders must have strategies to embed a new initiative in ongoing operations.

Core Competencies	Sample Behaviour	Relevance for Point-of-Care Leadership
1.4.1 Nurse leaders create a shared vision for ongoing change with stakeholders and experts (Ferguson-Paré, 2002; Kramer &Schmalenberg, 2002; Leach, 2005; McNeese-Smith, 1995; Perra, 2000)	■ Reflect on personal attitudes and skills on change and change management ■ Question the status quo and challenge assumptions, values, structures and processes (Leach, 2005; McNeese-Smith, 1995; Upenieks, 2003a) ■ Scan the environment to identify demographic and policy changes outside the organization (Englebart,1993; Shea, 2001) ■ Collect information that suggests new approaches (Kanter, 1999) ■ Critically apply the evidence to change initiatives ■ Make connections with partners who can help extend thinking and approaches used in the organization (Kanter, 1999)	■ Is an advocate and assessor for patients, clients and staff (O'Connor et al., 2008) ■ Effects change through advocacy for patients and clients (Reid & Dennision, 2011) ■ Challenges assumptions to reflect patient-centred care (Reid & Dennision, 2011) ■ Reflects on personal attitudes and skills regarding change and change management (Reid & Dennision, 2011) ■ Critically applies evidence to change initiatives (Reid & Dennision, 2011)
1.4.2 Nurse leaders engage others by sharing the vision for ongoing change (Ferguson-Paré et al., 2002; Harvard Business Review, 2001; Leach, 2005; McNeese-Smith, 1995; Perra, 2000)	■ Build strategic relationships and partnerships (Englebart, 1993) ■ Build coalitions for change (Gil et al., 2005), including agreement from a critical mass of people (Shea, 2001) ■ Reframe change due to crisis as an opportunity instead of a threat (Kanter, 1999) ■ Demonstrate commitment to the change (Huy, 2002; Lowe, 2004)	■ Facilitate communication with health-care service providers outside of hospital (O'Connor et al., 2008) ■ Demonstrate commitment to the change (Huy, 2002; Lowe, 2004)

Core Competencies	Sample Behaviour	Relevance for Point-of-Care Leadership
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 they are aligned (McNeese-Smith, 1995) ■ Involve people affected by the change in the change process (Cummings, 2005; Lowe, 2004; Macy, Peterson & Norton, 1989) ■ Engage stakeholders to build ownership for change (Knox & Irving, 1997a) ■ Identify key supporters, influencers and champions for change (Kanter, 1999) ■ Demonstrate respect and recognition for the expertise and individual talents that contribute to the change (Knox & Irving, 1997a) ■ Encourage a belief that change can happen; build a sense of possibility (Pielstick,1998) ■ Encourage people to take risks and innovate; be a role model for both (CNO, 2002; Kanter, 1999; Kramer & Schmalenberg, 2002; Leach, 2005; Registered Nurses Association of British Columbia, 2001; Upenieks, 2003a) ■ Examine lessons learned regardless of outcomes	■ Participate in strategic planning for the ward or specialty area (O'Connor et al., 2008) ■ Respects and recognizes the expertise and individual talents that have contributed to the change (Knox & Irving, 1997a)
1.4.4 Nurse leaders provide communication throughout the change process	■ Translate and interpret nursing issues to inform with and influence individuals indifferent contexts (e.g., clinical, executive, academic and political) (Skinner & Spurgeon, 2005; Upenieks, 2003a) ■ Update communication regularly (Barry-Walker, 2000; Katz,1982) ■ Share information on economic and policy factors behind the change (Knox & Irving, 1997b) ■ Provide adequate information for decision-making during the change ■ Provide ongoing progress reports (Knox & Irving,1997b)	■ Provides expert advice and connects with health services (O'Connor et al., 2008) ■ Provides regular communication to patients, clients and families on changes that may influence care (Reid & Dennision, 2011)

Core Competencies	Sample Behaviour	Relevance for Point-of-Care Leadership
1.4.5 Nurse leaders develop and implement mechanisms for feedback, measurement and redesign during the change (Goodman, 2001; Walston & Kimberly,1997)	■ Identify measurable goals and mechanisms to track progress (Lowe, 2004; Walston & Kimberly,1997) ■ Solicit feedback and staff perceptions of the change both formally and informally (Heifetz & Laurie, 2001; Ingersoll et al., 2001; Knox & Irving, 1997a) ■ Pace changes and set priorities for redesign activities to allow sufficient time for adaptation (Ingersoll et al., 2001) ■ Structure opportunities for ongoing feedback and use active listening techniques ■ Negotiate and mediate solutions to issues arising from the change ■ Remove barriers to achieving outcomes and take responsibility for outcomes (Pederson,1993) ■ Discuss role conflict, ambiguity and how roles and responsibilities will change (Ingersoll et al., 2001; Kroposki, Murdaugh, Tavakoli & Parsons,1999) ■ Celebrate milestones (Ingersoll et al., 2001; Kanter,1999)	■ Solicits feedback using approved methods i.e. patient/client survey (Reid & Dennision, 2011) ■ Works with inter-professional team to provide feedback on changes (Reid & Dennision, 2011)
1.4.6 Nurse leaders support, coach and mentor others to succeed with the change.	■ Build trust and offer support to enhance collective action toward the change (Leana & VanBuren,1999) ■ Be truthful about personal ambivalence, reservations and commitment to the change (Shea, 2001) ■ Stay close to the experience of staff, in proximity to the change (Shea, 2001)	■ Engages with new staff and assists them in learning to anticipate patient needs related to the change (O'Connor et al., 2008)

Suggested strategies for leading and sustaining change

Individual strategies

- Seek input from frontline workers and engage them in the process
- Recognize contributions to small steps of the change (Patrick et al., 2011)
- Create shared values to anchor the change (Patrick et al., 2011)
- Understand and acknowledge that the uptake of change varies from individual to individual
- Work with colleagues in human resources, finance and quality improvement to get data to track outcomes of change
- Conduct a stakeholder analysis to determine who can promote or inhibit change (Block, 1987; Shea, 2001)
- Gather perspectives from stakeholders about how the change can be meaningful to them (Tourangeau et al., 2002)
- Be patient and open to opportunities to advance change (Cummings & McLennan, 2005)
- Develop a support network to sustain personal energy through the change process (McDowell, 2004)

Team and unit strategies

- Engage nurses in building a vision
- Share both the vision and the tactics of the change at open forums and through technology (McDowell, 2004)
- Offer skills training for new tasks and focus on strengths to build team confidence about managing the change (Gil et al., 2005)
- Discuss similar initiatives that were unsuccessful to identify what should be done differently (McDowell, 2004)

Organization strategies

- Communicate at regular intervals using multiple methods and strategies (Ingersoll et al., 2001; Lowe, 2004; Rousseau & Tijorwala, 1999)
- Link change to the organization's strategic goals (Lowe, 2004)
- Use communication strategies such as newsletters, meetings, open forums and one-on-one meetings between staff and leaders throughout the change process (Walston & Kimberly, 1997)
- Consult early and often with staff and labour groups
- Offer change-management workshops, including delegation and managerial skills (Walston & Kimberly,1997) and team-building skills (Gelinas & Manthey,1997; Ingersoll et al., 2001)
- Use implementation manuals (McDowell, 2004) to increase consistency (Heller, 2003)
- Use evaluation data from employee surveys and focus groups to track both processes and outcomes and inform decisions (Lowe, 2004)

Helping others cope with the effects of change

- Listen to their concerns and be empathetic, not judgmental
- Attend to the individual's personal and work-related concerns
- Focus on the event and the associated emotions
- Help individuals to own their feelings rather than depersonalizing them by intellectualizing
- Provide encouragement and thanks by sending a card or a small token such as flowers (Cummings & McLennan, 2005)

Leadership Practice Recommendation 5: Balance Complexities

1.5 Nurse leaders balance the complexities of the system, identifying and managing competing values and priorities.

Balancing the complexities of the system and managing competing values and priorities leads to:

- Decreased stress for nurses (Lindholm, Dejin-Karlsson, Östergren & Udén, 2003)
- Increased perceptions of their value (Cronkhite, 1991; Fletcher, 2001; Gelinas & Manthey, 1997; Ray et al., 2002) and self-image (Gaudine & Beaton, 2002; Mohr & Mahon, 1996).
- Increased job satisfaction for nurses and their leaders (Barry-Walker, 2000; Fletcher, 2001; Gelinas & Manthey, 1997).
- Decreased disengagement from work (Fenton, 1988; Mohr & Mahon, 1996)
- Decreased intent to leave the organization or nursing (Corley, 1995; Corley, Elswick, Gorman & Clor, 2001; Gaudine & Beaton, 2002)
- Increased trust in leaders (Fletcher, 2001; Gelinas & Manthey, 1997)

Discussion of evidence

Publicly funded health-care systems are complex and face pressure on all sides, including limits on budgets, increasing demand (particularly from the growing prevalence of chronic disease), concerns about quality, the shift to patient-centred care and the need for health-care workers to find solutions to system problems (MacLeod, 2010).

As a result, nurses and their leaders frequently face a wide range of competing priorities and demands from individuals, families, professionals and the overall organization (Gaudine & Beaton, 2002; Oberle & Tenove, 2000). Ultimately, choices about what should take precedence and which course of action to follow must be made. Some 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 (1994) noted nurses in senior policy roles were similarly challenged by "competing considerations" (p.158). Posner, Kouzes and Schmidt (1985) found similar values between managers and organizations is were linked to perceptions of personal success, organizational commitment and commitment to ethical behaviour, allowing discussions of issues based on values and an appreciation and understanding of the complexity of health-care environments.

Nurses believe in providing care that is best for each patient/client (Jameton, 1984) and in the value of their professional knowledge in contributing to positive outcomes for patients or clients. Lageson (2004) found a significant relationship between

the point-of-care manager's focus on meeting patient/client care needs and nurses' job satisfaction. Lack of congruence between nurses' values and beliefs and those of the organization they work for can lead to ethical distress[G] (CNA, 2003).

Balancing cost and quality care (in issues such as staffing and use of supplies) is a major issue for nurse leaders (Ballein Search Partners, 2003; Corley, 1995; Cronkhite, 1991; Gaudine & Beaton, 2002; Ray et al., 2002; Storch et al., 2002; White, 2000).Nurse leaders are expected to speak for nursing and uphold its values and advocate for both patients or clients and staff, despite fiscal restraints (Clifford, 1998; CNO, 2002; DeLong, & Fahey, 2000; Ferguson-Paré et al., 2002; Ferguson-Paré, 1998; Hanna, 1999; Nespoli, 1991). If nurses feel their organization places greater value on cutting costs than providing quality care, the result is decreased trust in leadership, decreased job satisfaction (Barry-Walker, 2000; Fletcher, 2001; Gelinas & Manthey, 1997; Ray et al., 2002), increased stress (Lindholm et al., 2003), decreased perceptions of worth, decreased organizational loyalty and increased intent to leave(Ray et al., 2002). This complicates decisions leaders make with multiple potential consequences for every option.

Relationships with physicians, administrators and other members of health-care teams can be a source of distress. Sometimes, physicians get preferential treatment or there is a lack of respect for nurses and their knowledge. But support for open dialogue (May, Hodges, Chan & Avolio, 2003; Storch et al., 2002) varies on nursing teams as well. Of the registered nurses working in Canada in 2008, 8.3 per cent were internationally educated (CNA, 2011). Nurses from different generations or ethno cultural backgrounds have different work ethics and attitudes (Wieck et al., 2002); yet need to work together as a cohesive team (White, 2000). Cronkhite (1991) found that nurse leaders who saw identified closer with the needs of patients/clients and nurses had more conflicts in their relationships with senior levels of the organization; those who were viewed to be advocates for the organization had more conflicts with younger nurses.

A nurse leader's role is to promote and establish a practice environment that manages complexity and balances multiple demands and perspectives so nurses can provide quality care. Transformational leaders are said be of high moral character (Bass & Avolio, 1990). Nurse leaders are expected to be a moral compass, raising concerns (Storchet al., 2002) when competing demands are likely to damage the quality of patient and client care. Nurse leaders must reflect on their own values before they can recognize the values and ethics underlying situations and deal effectively with the issue (Fenton, 1988; Gaudine & Beaton, 2002; May et al., 2003; Storch et al., 2002; White, 2000). Gathering information and appraising the situation are critical (Norrish & Rundall, 2001; Ray et al., 2002; White, 2000), as many issues are rooted in context (Oberle & Tenove, 2000). Storch et al. (2002) describe the importance of knowing when to draw the line, when to push and when to hold back.

Communicating the rationale for an action, securing the necessary resources (May et al., 2003) and monitoring the effects of a decision are part of the leader's role. Leaders help others see that situations are not always a choice between opposites, but may be decisions to be optimized over time (Hurst, 1996) by shifting emphasis and action as needed. For example, at some times nurse leaders may put resources into nurse educator positions to help nurses improve their practice; another time, the decision might be to add direct-care positions. Either is part of a delicate balancing act to seek the best possible outcomes for both patients and staff. Barry Johnson describes this type of problem as a dilemma or polarity, where no single solution will address the complex problem. Instead, they must be managed (Johnson, 1996).

Core Competencies	Sample Behaviour	Relevance for Point-of-Care Leadership
1.5.1 Nurse leaders identify and acknowledge values and priorities (Gaudine & Beaton, 2002; May et al., 2003; Storch et al., 2002; White, 2000).	■ Use values clarification to identify own values, values of others and the values of organization (Cronkhite, 1991; Gaudine & Beaton, 2002; Norrish & Rundall, 2001; Storch et al., 2002; White, 2000; Wieck et al., 2002) ■ Separate personal values from professional responsibilities (Gaudine & Beaton, 2002) ■ Share and communicate vision, values and priorities explicitly (Cronkhite, 1991; Ferguson-Paré et al., 2002; Heeley, 1998; Levasseur, 2004; White, 2000; Wieck et al., 2002) ■ Articulate a process to define the values and vision of nursing in an organization (Storch et al., 2002) ■ Understand that values evolve over time in response to life experiences (Rokeach, 1973)	■ Use values clarification to identify own values, values of others and the values of organization (Cronkhite, 1991; Gaudine & Beaton, 2002; Norrish & Rundall, 2001; Storch et al., 2002; White, 2000; Wieck et al., 2002) ■ Separate personal values from professional responsibilities (Gaudine & Beaton, 2002)
1.5.2 Nurse leaders acknowledge and incorporate multiple perspectives in decision-making (Heeley, 1998; Hurst, 1996; Norrish & Rundall, 2001; White, 2000)	■ Gather information from multiple sources ■ Use decision-support tools (Gelinas & Manthey,1997) ■ Identify and communicate the values that underpin the decision (White, 2000) ■ Be sensitive to multiple pressures including finances, power and politics (Norrish & Rundall, 2001) ■ Identify the consequences of emphasizing one perspective over another (Heeley,1998; May et al., 2003) ■ Use clinical and professional nursing knowledge in making decisions (Krecji, 1999; White, 2000) ■ Identify ethical and moral issues (Storch et al., 2002) ■ Know when to speak up and when to pull back (Krecji, 1999; Tucker Scott, 2004)	■ Seeks confirmation of professional decisions by consulting peers (O'Connor et al., 2008)

Core Competencies	Sample Behaviour	Relevance for Point-of-Care Leadership
1.5.3 Nurse leaders help others to understand conflicting perspectives and decisions	■ Acknowledge and name conflicting perspectives (Heeley, 1998; Hurst, 1996; Storch et al., 2002) and identify their interdependencies (Hurst, 1996) ■ Assist others with clarifying and expressing values and views (CNA, 2003; Gaudine & Beaton, 2002; Storch et al., 2002; White, 2000) ■ Understand that cultural diversity influences perspectives ■ Discuss why one perspective is valued or selected over another (Heeley, 1998) ■ Create shared accountability and build collaborative relationships (CNO, 2002; Heeley, 1998; Hurst, 1996; Norrish & Rundall, 2001; White, 2000) ■ Help others understand the business aspects of health care (White, 2000)	■ Provides advice on appropriate care (O'Connor et al., 2008)
1.5.4 Nurse leaders employ strategies to advance priority initiatives while maintaining other valued initiatives and perspectives	■ Develop flexible practices to respond to changing priorities (Hurst, 1996) ■ Promote and reward flexibility and innovation related to achieving balance (Hurst, 1996) ■ Focus on goals and what can be achieved (Gaudine & Beaton, 2002) ■ Explore alternative ways to address challenges (Thompson & Bunderson, 2003) such as using technology (White, 2000)	■ Shares expertise and provides insight on new care techniques (O'Connor et al., 2008) ■ Leads patient care by setting priorities and adjusts care to reflect them (Reid &Dennision, 2011)
1.5.5 Nurse leaders advocate for the necessary resources to accomplish goals and objectives (May et al., 2003)	■ Provide data to demonstrate need for resources ■ Provide required staffing, supports, time and equipment (CNO, 2002; Ferguson-Paré et al., 2002; Registered Nurses Association of British Columbia, 2001; Upenieks, 2003a, 2003b) ■ Align resources with priorities and professional standards over the long term (May et al., 2003; Upenieks, 2003a)	■ Facilitates debriefing sessions for staff and contributes to their knowledge (O'Connor et al., 2008) ■ Collects data to advocate for resources (Reid & Dennision, 2011) ■ Identifies equipment and staffing needs (Reid & Dennision, 2011)

Core Competencies	Sample Behaviour	Relevance for Point-of-Care Leadership
1.5.6 Nurse leaders demonstrate accountability and take responsibility for outcomes	■ Monitor effects of decisions on patients/clients and staff resources and quality (Fletcher, 2001; Heeley, 1998; Norrish & Rundall, 2001, White, 2000) ■ Identify and monitor indicators of imbalance (Hurst, 1996) ■ Identify the people most sensitive to negative impacts and seek frequent feedback (Hurst, 1996) ■ Promote the accountability of others	■ Monitor effects of decisions on patients and clients

Recommendations for Personal Resources

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

It is important for organizations to understand and value the personal resources nurses have to offer. Similarly, nurses need to be aware of their strengths to be able to assess, shape and draw on them. Our literature review found several studies on personal resources that support effective leadership, including professional identity;[G] individual characteristics[G] such as ethno cultural identity[G], emotional intelligence, coping skills, resilience and flexibility; leadership expertise[G] including knowledge, years of experience and formal, advanced education; and social supports[G], which include mentors, supportive colleagues, friends and family. Laschinger et al. (2012) found personal factors had a greater influence on nurses' aspirations for a management role than situational factors. Younger nurses who were baccalaureate-prepared and had greater self-confidence in their leadership abilities had stronger leadership aspirations.

Wood-Allen (1998) identified five factors that influence leadership style – self-confidence, innate leadership tendencies, progression of experience, influence by significant people, and personal life factors. Strasen (1992) 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 (1995) describe individual characteristics that mark a positive self-concept, including ability to cope with disappointments, future orientation and emotional intelligence.

The LEADS in a Caring Environment Leadership Capabilities Framework

The 'LEADS in a Caring Environment Leadership Capabilities Framework' is a research-based leadership model developed by researchers at Royal Roads University (Dickson, 2008). The framework was developed for health care to drive change needed because of funding pressures, public expectations, and technologic change. It has been adopted or endorsed by several Canadian health-care leader organizations. The framework has provided updated research evidence and support for many elements of this best practice guideline, and we will briefly describe it because it supports the personal resources section

The acronym 'LEADS' represents five domains of effective health leadership: leads self, engages others, achieves results, develops coalitions and systems transformation (Dickson, 2008). The model outlines how both leadership and management capabilities work together to create and sustain change. The model takes a distributed leadership approach — the capabilities apply to any individual regardless of position or title, and can be applied across formal and informal nursing roles.

The common thread uniting health-care professionals is care about health for oneself and others. Caring means delivering the best service with compassion, respect and empathy; the leader's job is to champion and promote caring and design programs to support health and wellness of leaders, employees and citizens.

The model combines caring with being and doing to create leadership. Caring is the identity of the health care system, the "why" of leadership in the Canadian health sector. Effective leaders combine caring with who they are (being) and how they act (doing). Being reflects a leader's values, beliefs, assumptions, personality, character, sense of purpose and commitment, knowledge and ethics. These elements of "being" support that person's actions; "doing" is how being is acted on. When caring is combined with doing, authentic leadership comes to life in action and leaders are capable of influencing the actions of others to create meaningful change (Dickson, 2008).

Lead self: Self-motivated leaders are self aware (aware of their assumptions, values, principles, strengths and limitations), manage themselves (take responsibility for their own performance and health), develop themselves (actively seek opportunities and challenges for personal learning and character building and growth), and demonstrate character (model qualities such as honesty, integrity, resilience and confidence).

Engage others: Leaders foster the development of others and support and challenge them to achieve professional and personal goals. They contribute to healthy organizations and create engaging environments where others have meaningful opportunities to contribute and ensure that resources are available to fulfill their expected responsibilities. They communicate effectively by listening and encouraging an open exchange of information and ideas using appropriate communication. Leaders build teams and facilitate environments of collaboration and cooperation to achieve results.

Achieve results: Goal-oriented leaders set direction and inspire vision by identifying, establishing and communicating clear and meaningful expectations and outcomes as well as strategically aligning decisions with vision, values, and evidence. They take action to implement decisions and act in a manner consistent with the organizational values to yield effective, efficient public-centred service. They measure and evaluate outcomes. Leaders hold themselves and others accountable for the results achieved against benchmarks and correct the course as appropriate. Leaders create connections, trust and shared meaning with individuals and groups.

Develop coalitions: Collaborative leaders purposefully build partnerships and networks to create results. They create connections, trust and shared meaning with individuals and groups and demonstrate commitment to customers and service. Leaders facilitate collaboration, cooperation and coalitions among diverse groups and perspectives aimed at learning to improve service. They mobilize knowledge and employ methods to gather intelligence, encourage open exchange of information, and use quality evidence to influence action across the system. Leaders navigate socio-political environments and are politically astute. They negotiate through conflict and mobilize support.

Systems transformation: Successful leaders demonstrate systems and critical thinking. They think analytically and conceptually, questioning and challenging the status quo to identify issues, solve problems and design and implement effective processes across systems and stakeholders. Leaders encourage and support innovation and create a climate of continuous improvement and creativity aimed at systemic change. They orient themselves strategically to the future and scan the environment for ideas, best practices, and emerging trends that will shape the system. Leaders champion and orchestrate change and actively contribute to change processes that improve health service delivery.

Change

Leaders are both the initiator and the recipient of change. Indeed, the concept of leadership has no meaning except in the context of change. While management is a set of skills and abilities to minimize unpredictability and bring stability to a system, leadership is the capability of responding to and shaping change. The proper mix of the two is what maintains equilibrium between forces creating change, and those resisting it. As the forces for change expand and grow, then leadership is needed to envision and shape the future of that change. The LEADS in a Caring Environment Framework can be used as a guide for leaders wishing to shape change and is consistent with aspects of the nursing leadership BPG discussing change, thus providing additional evidence and support for change strategies and processes (see **Appendix C**).

There is a more comprehensive discussion of the LEADS framework on the website of the Canadian College of Health Leaders http://www.cchl-ccls.ca/default_conferences.asp?active_page_id=6492.

2.1 Nurse leaders exhibit a strong professional identity.[G]

Discussion of evidence

Apker et al. (2003) found manager support predicted nurses' commitment to their organizations but not to the profession. That contrasts to support from co-workers, which does predict professional commitment. They explain that managers in the study, given their focus on administrative duties, were seen more as representatives of the hospital than of the profession.

Effective nurse leaders are passionate about nursing (Upenieks, 2003b). They have a clear understanding of what it means to be a nurse and a member of the profession. This identity evolves through education, work socialization and the influence of mentors (Blais, Hayes, Kozier& Erb, 2002; Hinshaw, 1986). The socialization process includes developing critical values, including commitment to quality care and quality practice settings (CIHI, 2002; CNO, 2002; Ferguson-Paré et al., 2002; Mayer et al., 1995; Upenieks, 2003a; White, 2000) while placing patients/clients first (Storch et al., 2002; White, 2000). Other values include commitment to caring, justice, honesty, respect and integrity (Rousseau & Tijorwala, 1999), education, professional autonomy and respect for others (Blais et al., 2002). These traits are similar to those of transformational leaders (Pielstick, 1998). Nurse leaders demonstrate passion and respect for the profession of nursing, its values, knowledge and achievements (Clifford, 1998; Ferguson-Paré et al., 2002; Ferguson-Paré, 1998; Nespoli, 1991; Pederson, 1993; Registered Nurses Association of British Columbia, 2001; Scott et. al., 1999; Thompson & Bunderson, 2003; Tucker, 2004; Upenieks, 2003b) by speaking to the contribution of nursing to client/patient outcomes (Antrobus & Kitson, 1999; Storch et al., 2002). Effective nurse leaders value and use both clinical and professional nursing knowledge in making decisions (Krecji, 1999; White, 2000). They are active in professional organizations (Fletcher, 2001; Krugman, 1989; Scott et al., 1999; Storch et al., 2002; Tucker, 2004).

> ***She is a powerful leader; she uses data to make her point.***
>
> ~ Upenieks (2002)

Why does strong professional nursing identity matter for nursing leaders? Increasingly they must be able to articulate (and assist others to articulate) the positive impact of professional nursing services on the patient experience, and of data and research evidence on patient outcomes. Staff satisfaction and retention of nursing staff are increasingly linked to more experienced staff and better patient outcomes such as patient satisfaction, lower mortality adverse events and complications and greater safety (Wong & Cummings, 2007).

2.2 Nurse leaders reflect on and take responsibility for the growth and development of their own leadership expertise

Discussion of evidence

When nurses and their leaders are asked about the attributes of effective leaders, they consistently mention communication and listening skills (Bousfield, 1997; Ferguson-Paré, 1998; Jeans & Rowat, 2005; Pearson et al., 2004; Perra, 2000; Scott et al., 1999). Effective nurse leader's exhibit resilience, persistence and hardiness (Ballein Search Partners, 2003; Duxbury& Higgins, 2003; IOM, 2004; Nespoli, 1991; Waite & Richardson, 2004; Ward, 2002) also described as traits of transformational leaders (McGillis Hall et al., 2005) and part of self-esteem and confidence (Waite & Richardson, 2004). In a study of mid-level nurse managers, Judkins (2004) found a high level of hardiness was a strong predictor of low levels of stress and said hardiness can be learned. Sullivan, Bretschneider and McCausland (2003) found resilience and humour led to preserving the leader's commitment and avoiding apathy during difficult times. Self-reflection and knowledge of self are critical personal resources needed to support effective leadership (Conchie, 2004; Goleman, 1998; IOM, 2004; Perra, 2000; Ward, 2002).

Effective nurse leaders display flexibility (IOM, 2004; Upenieks, 2003a) and are comfortable with ambiguity, uncertainty and complexity (Snow, 2001; Snyderman, 1988; Ward, 2002; White, 2000) and are willing to take risks (Aldana, 2001; May et al., 2003; Ward, 2002). Effective nurses have been described as positive and approachable (IOM, 2004). Nurse leaders have identified the importance of working from a moral framework and internal strength and confidence in their own values and beliefs (Gaudine & Beaton, 2002; May et al., 2003; White, 2000) rather than being driven by security, power and prestige (Storch, et al., 2002; White, 2000). They display moral integrity, reflected in actions consistent with their beliefs (Gaudine &

Beaton, 2002; King, 2000; Pielstick, 1998; Upenieks, 2003a; Ward, 2002; White, 2000). Several authors note the importance of courage and risk taking (May et al., 2003; Storch, et al., 2002; White, 2000).

Upenieks (2002b) notes that clinical nurses prefer to work with powerful managers. Formal and informal powers are building blocks for empowerment (Goddard & Laschinger, 1997; Kanter, 1993) and personal power (Hatcher & Laschinger, 1996). In one study a nurse leader said they had a lot of power as a result of their role but also reported that power lies in oneself and is gained through self-confidence and inner strength (Upenieks, 2002a). Self-confidence has been identified as a trait of effective leaders (Collins & Holton, 2004; Upenieks, 2002a).

A study by Wieck et al. (2002) that matched the views of nurses under age 35 with older nurses showed the two groups mostly valued similar traits in leaders: honesty, communication skills, positive attitude and approachability. All of which have been linked with transformational leadership. The differences tended to be that younger workers seek leaders who are more nurturing, confidence building, motivational, knowledgeable and skilled at team building.

Many characteristics attributed to effective nurse leaders, such as self-knowledge, communication, relationship building, resilience, optimism and vision are consistent with emotional intelligence (Scott et al., 1999; Sullivan et al., 2003; Ward, 2002). This concept was originally described by Mayer and Salovey (1990) as ability to recognize the meaning of emotions and relationships and to reason and solve problems on this basis (Vitello-Cicciu, 2003). It was further described by Golemanet al. (2002) as involving self-awareness, self-management, social awareness**,** and relationship management. Goleman (1998) found emotional intelligence was twice as important for leadership excellence as technical skills and cognitive abilities. Both Golemanet al. (2002) and Salovey and Mayer (1990) suggest emotional intelligence can be developed.

Guidelines for emotional intelligence training programs are available (Goleman et al., 2002). Other studies positively link emotional intelligence with transformational leadership (Nicklin, 2001) and with effective leadership (Cadman & Brewer, 2001; Gasper, 1992; IOM, 2004; Snow, 2001). Cummings et al. (2005) found that leadership styles consistent with emotional intelligence (the 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.

Leading Self, one of the five domains of action in the LEADS in a Caring Environment Framework (Dickson, 2008), reflects the need for leaders to be not only self aware but also self–motivated, and to take responsibility for managing their own performance and health as well as to develop personally while increasingly demonstrating character qualities such as honesty, integrity, resilience and confidence.

> ***It is critical that we consider leadership as a learned behaviour with specific competencies rather than a formal role or personality trait***
>
> ~ (Doran, 2012)

2.3 Nurse leaders act as coaches and mentors to develop leadership expertise in themselves and others

Discussion of evidence

The development of leadership expertise has been described as a process (Dunham-Taylor, 1995) of developing competencies and behaviour over time through education, preceptorship and mentoring (Patrick & White, 2005). Blais et al. (2002) noted that nurses who improve themselves perform more effectively, and in turn promote a more positive image of nursing.

Participants in studies in which nurses and their leaders were asked about the qualities of effective leaders identified years of experience (Pearson, et al., 2004; Pederson, 1993; Severinsson & Hallbeerg, 1996), advanced nursing education (Leach, 2005; Reyna, 1992; Tucker, 2004; Volk & Lucas, 1991; White, 2000) and breadth of knowledge (Chiok Foong Loke, 2001;Pearson et al., 2004).Altieri (1995) found that nurse executives with graduate education had higher transformational scores than those with lesser education. Gelinas and Manthey (1997) 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 grounded in clinical nursing (Antrobus & Kitson, 1999; Reyna, 1992; Tucker, 2004) in order to have credibility with colleagues and to understand both the content and context of care, systems and organizations (Ferguson-Paré et al., 2002). Antrobus and Kitson (1999) emphasize the need for nursing knowledge to be a central component of leadership development programs so nurse leaders can both develop nursing practice and explicate nursing knowledge.

Nurse Managers in a Finnish study (Suominen, Savikko, Puukka, Doran, & Leino-Kilpi, 2005) said they needed 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 wanted to learn about research (Udod & Care, 2004). A number of authors have reported the importance of a strong business sense (Antrobus & Kitson, 1999; Gelinas & Manthey, 1997) and being able to use quantitative data to justify staffing and be seen as credible by the leadership team (Upenieks, 2002a). Middle and point-of-care managers indicate that if their senior nurse leaders utilized quantitative data knowledgeably they in turn found their own use of financial data in decision-making improved (Upenieks, 2002a).

Nurse leaders need broad knowledge about:

- Professional nursing (Bousfield, 1997; Ferguson-Paré et al., 2002; Pearson et al., 2004; Severinsson & Hallbeerg, 1996; Wolf, 1996)
- Leadership (Bousfield, 1997; Ferguson-Paré et al., 2002; Ferguson-Paré, 1998; Jeans & Rowat, 2005; Severinsson & Hallbeerg, 1996; Wolf, 1996)
- Philosophy (Pearson et al., 2004)
- Ethics literature and ethics (Silva, 1998; Storch et al., 2002)
- Group processes (Pearson et al., 2004) and team building (Gelinas & Manthey, 1997)
- Human and moral development (Pearson et al., 2004)
- Business and management knowledge (Antrobus & Kitson, 1999; Gelinas & Manthey, 1997; Krecji, 1999; Upenieks, 2003b; White, 2000; Wolf, 1996)
- Change management (Gelinas & Manthey, 1997)
- Team building (Jeans & Rowat, 2005)
- Leading a diverse workforce (Srivastava, 2005)
- Research and research use (Udod & Care, 2004)

Coaching is a useful strategy for building leadership skill, according to several studies. According to Donner and Wheeler (2009), coaching involves "a collaborative relationship, undertaken between a skilled facilitator (coach) and a willing individual (client). It is time limited and focused and uses conversation to help clients (individuals or groups) achieve

their goals" (p.9) we found limited research-based evidence to support implementing a coaching program, although we searched beyond the original literature reviewed. One study said a formal peer coaching program offered to staff over four years in a large academic health centre developed leadership skills related to communication, effective listening and staff engagement (Sabo, Duff, & Purdy, 2008). McNally and Lukins (2006) conducted an evaluation of a coaching program provided over six months to clinical managers and directors (individually and in groups). All participants reported more competence and confidence in their role as a result of the program and more than half intended to continue in their leadership role.

Mentorship in health care and specifically for nursing is increasingly acknowledged as critical for preparing new leaders. Mentorship is viewed as a key component of career planning, a tool for professional development that has a positive impact on job satisfaction, retention and succession planning (Cooper& Wheeler, 2010; CNA, 2004; Cummings et al., 2008). Mentorship is needed for emerging nursing leaders in clinical, administrative, research and education roles, with attention to the need to integrate technology in all areas of nursing practice and to enable mentorship itself.

Theoretical foundations for mentorship are anchored in a number of relational theories. Cooper and Wheeler (2007) have created a five-phase mentoring relationship model, which can be used to guide mentoring relationships in all nursing roles and for leadership succession planning (Redman, 2006).

Taylor, Sylvestre & Botschner (1998) noted that people who believe they have access to social supports from others live healthier lives, and cope more effectively with stress. Nurse leaders have identified mentors as important supports in the development and sustainability of their leadership ability (Ballein Search Partners, 2003; Cronkhite, 1991; Gaudine& Beaton, 2002; Madison, 1994; Tucker, 2004; Walsh & Clements, 1995; Ward, 2002; White, 2000). In a study of senior nurse administrators, Madison(1994) found that 97 per cent of the respondents attributed change in their professional/personal lives to having a mentor, 74 per cent said it changed their self-confidence and 65 per cent that it increased 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 conducted by Allen, Eby, Poteet, Lentz, and Lima (2004) showed both mentoring related to learning about an organization and its opportunities and mentoring that provides interpersonal support have resulted in positive outcomes such as increased compensation, promotions and career and job satisfaction. In a study of staff by Walsh and Clements (1995), 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 (Jeans & Rowat, 2005).

2.4 Nurse leaders cultivate professional and personal social supports.

Discussion of evidence

Scott et al. (1999) and Storch et al. (2002) said it is important for nurses to be actively involved in professional organizations, which helps people stay abreast of nursing issues and to access peer support. In a study of established leaders (Tucker, 2004), participants said both mentors and involvement in professional organizations and networks kept them informed about issues and trends and helped them develop political skills.

Nurse leaders reported the importance of support from friends, spouses, families and colleagues (Cronkhite, 1991; Fenton, 1988; Gaudine & Beaton, 2002; Ward, 2002) — particularly colleagues with transformational qualities (Ward, 2002). Lindholm et al. (2003) studied relationships among professional networks, psychosocial resources and self-rated health. They found nurse managers with high job demands, low professional networks, low social participation or low emotional support were more likely to give themselves a low rating for 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 support is sufficient and further exploration of the factors contributing to low self-rated health is necessary.

Upenieks (2002a) said cohesive nursing teams, that share common goals, are dedicated to the organization and each other, and work interdependently as a team, are supports for nursing leadership.

Education Recommendations

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

Discussion of evidence

A number of reports have called for more leadership development opportunities (Canadian Nursing Advisory Committee, 2002; Bauman et al., 2001).

Leadership skills are needed in all areas and roles of nursing. The Canadian Nursing Advisory Committee (2002) said not enough nurses are moving into management and leadership positions. Laschinger et al. (2012) anticipated a shortfall of 4,200 nurse managers in the next decade. Traditionally nurse leaders were promoted from the ranks of general duty staff, usually because 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.(2002) concluded their emphasis on entrepreneurial opportunities, short-term employment and work-life balance might mean those individuals would not be attracted to life-long health care careers, and particularly not to leadership positions.

Kilty's (2003) review paper on Nursing Leadership Development in Canada details the resources and programs available for developing nursing leaders. Many undergraduate programs for nurses include specific leadership 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 few focus on nursing leadership at the masters level. At the time of publication of the original BPG on leadership, there was only one stand-alone program for nursing leadership development in Canada — the Dorothy M. Wylie Nursing Leadership Institute (Simpson, Skelton-Green, Scott & O'Brien-Pallas, 2002). Since that time, a number of formal programs have been launched and evaluated.

Lee et al. (2010) examined the effects of a leadership development initiative on nurse manager burnout. The educational program resulted in a greater use of transformational leadership practices which, in turn, was associated with less emotional exhaustion and cynicism. The ability to manage one's workload remained a significant predictor of causing burnout, but the sense of community and support networks developed during the educational program had only a limited effect. Based on their review of the program, the authors recommended strategies for enhancing development of leadership skills:

- complement educational sessions with professional leadership coaching and mentoring
- encourage positive role modelling
- provide release time for educational development
- articulate clear expectations of how the curriculum will translate into practice behaviour
- include the opportunity to apply what they have learned (Lee et al., 2010).

MacPhee used a longitudinal design to follow attendees of the British Columbia Nursing Leadership Institute (BCNLI, 2007–10). The participants were mainly first-line managers who had less than three years leadership experience. The institute

included a four-day residency program, where participants developed a change project they implemented after the event and later presented at a one-year follow-up (MacPhee & Bouthillette, 2008). The authors concluded nurse leaders can develop skills to manage change successfully in their organizations, even in the face of considerable resource shortages.

Maslove and Fooks (2004) said that although leadership development programs are available for nurses once they are managers, few programs are available for point-of-care staff. A staff nurse leadership program, studied over a four-year period, demonstrated positive changes in the nurses' leadership behaviour. The program included role playing, feedback and mentors and was tied to personal goals and performance review. Patients/clients and families reported enhanced trust and improved satisfaction with care. The nurses reported personal 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 (Wolf, 1996).

Cunningham and Kitson (2000a, 2000b) evaluated a clinical leadership development program in which the focus was practical, experiential and work-based, with an emphasis on skills acquisition and attitudes, values and behaviour 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, an enhanced patient/client-centred approach and improved leader confidence.

3.1 Nursing leadership programs incorporate evidence-informed models and theories.

Discussion of evidence

Based on a group of 24 studies that evaluated the impact of leadership style on nursing job satisfaction, Cummings et al. (2010) recommend using theories and models that focus on people and relationships, such as transformational and resonant leadership. In another systematic review by Wong and Cummings (2007), the authors suggested transformational leadership, used as an organizational strategy, could enhance positive patient outcomes. Weberg (2010) said there is sufficient evidence that transformational leadership practices can reduce staff exhaustion and burnout and increase both job satisfaction and organizational commitment. Similarly, Doran et al. (2012) also support the use of frameworks based on transformational leadership or relational models for nurses in clinical practice roles. That would include LEADS in a Caring Environment (Dickson, 2008), Kouzes and Posner's leadership model, Transformational Leadership, and Human Becoming, (Kouzes and Posner1988; 1995).

Based on the literature reviewed for this guideline and the consensus of the expert panel, the Conceptual Model for Developing and Sustaining Leadership (refer to Figure x on page 90) can also be used to guide the development of leadership educational programs since the model highlights transformational practices.

Key concepts to be explored in educational programs to develop nursing leadership:

- 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 health professions and their influence on the nursing profession
- Health and social policy development 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 nurses and service delivery
- Current and emerging issues and priorities for health service and policy

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

Discussion of evidence

Formal leadership-development programs have demonstrated positive outcomes. Collins (2002) conducted a meta-analysis of managerial leadership programs from 1982 to 2002 and found formal leadership programs to be effective for knowledge outcomes. In evaluating a nurse manager leadership program, Wolf (1996) 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.

Suggested strategies for developing leaders

- 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 for mentors and mentees to attend together
- Schedule support and discussion groups for new leaders or individuals involved in leading change or new projects with experienced leaders to share strategies and ideas

Strategies for managing complexity and balancing competing values and priorities

Individual strategies

- Use self-reflection to identify personal values
- Use ethical frameworks to assist with clarification and decision-making
- Use research studies and patient and client outcome data to support staffing, skill mix and hours of care (Upenieks, 2002a)
- Educate board members and the management team about the link between nursing work environments and patient/client outcomes, including the impact of staffing levels (IOM, 2004; Storch, et al., 2002)
- Form alliances with like-minded groups and individuals
- Check fit between personal philosophy and beliefs of organization before accepting role (Englebart,1993)

Team, unit and organization strategies

- Develop and uphold a philosophy and mission statement that values nursing and places patients and clients first
- Introduce governance models that encourage sharing information and decision-making (Rosengren, Bondas, Nordholm, & Nordstrom, 2010)
- Create committees to review resource allocation (Renz & Eddy, 1996)
- Establish forums for discussing ethical concerns, including formal and informal ethics rounds and ethics committees (Gaudine & Beaton, 2002; Renz& Eddy, 1996; Silva, 1998; Storch et al., 2002)
- Develop whistleblowingG policies (CNA, 2001; Erickson, et al., 2003)
- Identify polarities in complex situations and map out strategies for managing them (Johnson, B. 1996)

Organization Recommendations

4.0 Health-service organizations provide supports for effective nursing leadership.

Organizational supports for effective leadership include:

- Organizational culture that respects and supports professional nursing
- Access to formal power through positions, access to resources, information, and autonomous practice
- Access to informal power through networks and relationships
- Support for professional growth and development and leadership opportunities
- Respectful and collaborative teamwork (Laschinger et al., 2003; Laschinger et al., 2004)

Discussion of evidence

Although Pearson et al. (2004) reported finding limited high-quality research on the direct impact of work environments on developing and sustaining nursing leadership, there is some evidence on it. Participants in a Canadian study by Jeans and Rowat (2005), which included nurse executives, managers and staff, reported enablers to acquiring leadership competencies including supportive work environments, clear and reasonable expectations, balanced work/life, reasonable workload and access to management education programs.

Some research has found a relationship between empowerment in the workplace and effective nursing leadership (Hatcher & Laschinger, 1996; Laschinger and Shamian, 1994; Upenieks, 2003b). Laschinger and Shamian (1994) reported a strong link between nurse managers' perceptions of empowerment and self-efficacy for leadership. In 2004, Laschinger, Almost, Purdy and Kim found empowered work environments, with access to support, resources, strong interpersonal relationships and opportunities for growth, were associated with lower nurse manager burnout and better physical and mental health. This study also found managers needed ongoing education to develop in their roles.

In a study comparing nurse leaders in magnet and non-magnet organizations, Upenieks (2003a) identified specific organizational factors (Table 1) that support nurse leaders and encourage clinical leadership by enabling nurses to use their expertise, knowledge and skills in clinical care. Similarly, a study conducted in a long-term care setting, McGilton et al. (2004) found that RN and RPN leaders' ability to be supportive was affected by supplies, funding and staffing, clear role descriptions and sufficient clerical support and support from senior management.

Boyle and Kochinda (2004) found physicians' and nurses' perceptions of nursing leadership and problem solving among groups improved significantly following an training in collaborative communication attended by both nurse and physician leaders.

Krugman (1989) reported that a participative management climate characterized by group decision making, interactive communication and decentralized control enhanced the nurse leader's occupational image and sense of professionalism. That is consistent with Kanter's elements of structural empowerment (Laschinger et al., 2003) and the attributes of professional practice environments linked to positive outcomes for patients, clients and nurses (Aiken, Smith, & Lake, 1994; Baird & St-Amand, 1995; Upenieks, 2002c).

Deductive Analysis Categories	Consistent With Magnet Hospital Characteristics
Central Category	**Definition**
1. Supportive organizational climate	Hospital administration values quality patient care and nursing excellence and places high value and priority on the nursing service. The hospital environment supports professional nursing practice.
2. Collaborative nurse-physician relationships	Nurses and physicians work as a team, using each other's expertise to provide quality patient care, and there is joint intellectual effort in delivering quality patient care.
3. Autonomous Climate	Nurses are given command of their expert knowledge and allowed accountability and authority in decision making. Nurses are empowered to pursue their professional knowledge and skills on behalf of patient care.
4. Clinical ladders/continuing education	The opportunity for nursing advancement in the organizational structure. Nurses are provided with nursing development courses and/or supported/reimbursed in pursuing higher education.
5. Participatory management	Decision making is decentralized to the unit level (i.e., decisions regarding scheduling and use of resources), and nurses are given as much discretion as possible for organizing care.
6. Adequate staffing	There are sufficient staffing ratios for the nursing units based on acuity

Table 1. Specific Organizational Factors that Support Nurse Leaders and Encourage Clinical Leadership

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

Discussion of evidence

A number of studies and reports show nurses feel a lack of respect in the workplace (Bauman et al., 2001; Canadian Nursing Advisory Committee, 2002; Cronkhite, 1991; Gaudine & Beaton, 2002; Storch et al., 2002). Visible demonstrations of respect for nurses and fairness at work have been linked to empowerment (Laschinger, 2004) and results in better interpersonal relationships and greater trust in leaders (Laschinger, 2004), which enhance the leader's effectiveness. The contributions nurses make to patient and client care (White, 2000) result in them reporting lower emotional exhaustion, better emotional health and being better able to attend to important patient/client care needs.

Devine and Turnbull (2002) conducted a series of focus groups in four major Canadian centres, asking nurses what defines a respectful environment. They answered:

- 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 demonstrating respect for nurses as professionals

4.1a. Appoint a senior nurse leader at the executive level

4.1b. Hire nurses as point-of-care managers

4.1c. Hire nurse leaders with appropriate education and credentials

4.1d. Support the stability of nursing leadership

4.1e. Recognize nurses' contributions to patient and organizational outcomes

4.1f. Develop and encourage transformational leaders with resonant leadership styles: visionaries, coaches, affiliative, and democratic

4.1a. Appoint a senior nurse leader at the executive level

Discussion of evidence

Nurse leaders have an important role designing systems of care that let nurses participate in clinical and organizational decision-making for better care (Aiken et al., 1994; Clifford, 1998). Systems that failed to ensure satisfaction for providers and patients or clients were identified as major factors in two national nursing shortages in the United States in the late 1980s (Clifford, 1998).

A number of nursing reports and authors recommend designating nurse executive positions, with accountability for nursing practice and operations and input on governance (American Association of Colleges of Nursing [AACN], 2002; Bliss-Holtz, Winter & Scherer, 2004; Canadian Nursing Advisory Committee, 2002; Clifford, 1998; IOM, 2004; Registered Nurses Association of British Columbia, 2001). In the Province of Quebec, provincial legislation requires all health care organizations to have a nurse as director of nursing care, and every institution with five or more nurses must have a council of nurses responsible to the board of directors (Government of Quebec, 1994).

In the Province of Ontario, governance bodies must pass by-laws for appointing a nurse as chief nursing executive[G] and the responsibilities of the role (Public Hospitals Act, 1990). In a study of the progress on the recommendations cited in the Canadian Nursing Advisory Committee report *Our Health, Our Future: Creating Quality Workplaces for Canadian Nurses,* Maslove and Fooks (2004) reported that although many organizations have senior leadership positions for nursing, those appointed are not always part of the senior management team.

Leadership positions, with sufficient resources and control over practice, have been shown to be predictive of nurses' job satisfaction and retention and to lead to better quality of care (Aiken et al., 2001). Having a nurse at the highest level of organizational decision-making is an attribute of magnet hospitals and is an eligibility requirement for magnet accreditation (Bliss-Holtz et al., 2004). A highly visible and accessible senior nurse leader helps foster recognition of nurses' work and provides nurses with the opportunity to express their views and feel more empowered (Clifford, 1998; Matthews, Lashinger & Johnstone, 2006). The Revised Nursing Work Index Instrument, measures characteristics of professional nursing environments, including the presence of a chief nursing executive who is highly visible, accessible to staff, and equal in power and authority to top level hospital executives (Aiken & Patrician, 2000).

The Institute of Medicine Report (IOM, 2004) links nurses' work environments to patient/client safety and recommends organizations have nurse leaders at all levels of management. The authors of this report did not find evidence to support a particular organizational structure for nursing leadership, but recommend "well-prepared clinical nursing leadership at the most senior level of management" (p. 134). Clifford (1998) supports the need for the senior nurse leader 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 and information needs (IOM, 2004). Clifford (1998) said clinical staff should 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 a program management structure.

Clifford (1998) noted that the senior nurse leader needs access to partners such as the medical chiefs in each program, the chief executive officer and the chief financial officer. Burner (1983) 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 (1993) reported role conflict and ambiguity declined consistently for senior nurse leaders who worked closely with the governing body of the organization.

4.1b. Hire nurses for point-of-care manager roles where the primary focus is nursing care.

Discussion of evidence

Several reports recommend that where an organization's primary focus is nursing care or a critical mass of staff are nurses; the point-of-care manager should be a nurse (AACN, 2002; Bauman, et al., 2001; Canadian Nursing Advisory Committee, 2002; Registered Nurses Association of British Columbia, 2001). Nursing is a practice discipline, a profession supported by standards, education of new practitioners, research and use of evidence. Leadership should contextualize core nursing values and beliefs of nursing (Ferguson-Paré et al., 2002). Nightingale believed "only those trained as nurses are qualified to govern or train other nurses" (Woodham-Smith, 1951).

Restructuring and program management have eradicated traditional nursing departmental structures (Ferguson-Paré et al., 2002) and identifiable nursing leaders in many organizations. Clifford (1998) found ongoing changes in health care organizations and significant workloads have affected clinical staff. They look to leaders for consultation and want a leader who can monitor both qualities of care and staff-development needs. Clifford (1998) found nurse managers who report to non-clinical managers have to explain the clinical aspects of their roles. In a series of six focus groups conducted in three major Canadian cities, staff nurses reported non-nursing managers do not understand or appreciate their concerns related to patient and client care and operational issues (2002). Baumann et al. (2001) noted that without professional leadership, poor nursing practice may go unnoticed.

4.1c. Hire individuals with appropriate education, experience and credentials for nursing roles.

Discussion of evidence

The American Association of Colleges of Nursing (2002) recommends hiring people with the appropriate education and credentials (e.g. required certification or advanced educational preparation) for senior and specialty specific nursing roles. Several studies noted that nurse leaders with advanced education were considered more effective in their roles (Altieri, 1995; Pederson, 1993; Reyna, 1992; Volk & Lucas, 1991; White, 2000).

4.1d. Acknowledge and promote a stable nursing leadership

Discussion of evidence

A stable nursing leadership supports personal relationships, trust and open communication among leaders, their colleagues and staff, ultimately resulting in sharing of knowledge (Bryman, Brensen, Beadswoth, Ford & Keil, 1987; Coff & Rousseau, 2000). The informal power of nurse leaders, which has been linked to empowerment, and their effectiveness, are derived from credibility and alliances with people in the organization (Kanter, 1993; Upenieks, 2002a), both of which develop over time. A systematic review of research studies on restructuring found nurses felt decreased satisfaction with their supervisor as a result of changes in the relationship and loss of trust with administration (Coile, 1999).

Frequent turnover of nursing leadership in an organization is unsettling for staff (Cummings & Estabrooks, 2003) and is likely a sign of an unhealthy work environment. An organization's commitment to leadership stability reflects commitment to nursing and confidence by senior management in nursing leaders, which they may perceive as a safety net for risk taking. Stable positions lead to nurse leaders who know their staff, colleagues and patient/client care issues better, and enhance the organizations' ability to launch multi-year strategies and see them through (Cummings & Estabrooks, 2003).

In a study of nursing homes, Anderson, Corazzini and McDaniel (2004) found that the tenure of the director of nursing was a strong predictor of turnover among registered nurses and licensed vocational nurses. That suggests longer-serving leaders are better able to connect with staff, foster job commitment and learn more about the organization and its nurses for more effective management.

A related study found the tenure of the nurse leader resulted in improved patient/client outcomes (Kemerer, 2003). Given the frequent changes of personnel and structures in organizations, strategies to maintain stable leadership are needed.

Strategies for stable nursing leadership

- Establish shared leadership models such as shared governance (CNA, 2005)
- Establish teams of professionals working in a fluid matrix (Lemire Rodger, 2005)
- Develop a succession plan for nursing leadership (CNA, 2005)
- Talk about the importance of a stable environment in supporting nurses' ability to provide quality care

4.1e. Recognize and value the contribution of nurses to patient, client and organizational outcomes.

Discussion of evidence

An organizational culture[G] that values quality care and shows that it values its nurses is an important support for nurse leaders (White, 2000). Turnbull and Devine (2002) reported recognition of nurses' contributions is an indicator of respect for nurses. In a study comparing magnet and non-magnet leaders and their organizations, 86 per cent 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 of close observation and care of patients. Nurse leaders in magnet organizations reported the positive influence they had achieved in their organizations, while nurse leaders in non-magnet organizations spend considerable energy articulating the importance of nursing to the organization (Upenieks, 2003a).

Strategies for recognizing nurses' value

- Establish and maintain practice supports such as nursing governance committees, advanced practice roles, nurse scientists, designated roles with separate accountability for professional practice (AACN, 2002)
- Differentiate nurses' practice roles based on experience, education and certification clinical ladders (AACN, 2002; Upenieks, 2003b)
- Maximize nurses' scope of practice and reduce their non-nursing tasks (Canadian Nursing Advisory Committee, 2002; Maslove & Fooks, 2004)
- Create compensation and reward systems that recognize experience, education, advanced credentials, responsibility and performance (AACN, 2002; CNA, 2001; Devine & Turnbull, 2002)
- Put professional and educational credentials on nametags and reports (AACN, 2002)
- Include nurses in media events, public relations announcements and strategic planning (AACN, 2002)
- Provide rewards for exceptional achievements and hold awards ceremonies to acknowledge them
- Publish a nursing annual report or feature nursing in the organization's annual report (AACN, 2002)

4.1f. Develop and promote transformational leaders with resonant leadership styles: visionary, coaching, affiliative, and democratic

In the early 2000s, Cummings and colleagues investigated the effect of leadership styles on the experiences of point-of-care nurses affected by hospital restructuring in Alberta (Cummings et al., 2005). They used the Emotional Intelligence (EI) leadership style typology (Goleman, Boyatzis, & McKee, 2002). It identifies six leadership styles, four of which they term "resonant" because they demonstrate high levels of EI. The four resonant styles are: visionary, coaching, affiliative, and democratic. Resonant leaders' are in tune with their own and others' feelings as they build harmony and positive working climates (Cummings et al., 2005, p 5). In the Cummings study, nurses working with resonant leaders reported significantly less emotional exhaustion and psychosomatic symptoms, better emotional health, greater workgroup collaboration and teamwork with physicians, more satisfaction with supervision and their jobs, and fewer unmet patient-care needs than nurses working for non-resonant or dissonant leaders. As the authors note, "these findings have implications for future hospital restructuring, accountabilities of hospital leaders, the achievement of positive patient outcomes, the development of practice environments, the emotional health and well-being of nurses, and ultimately patient care outcomes" (Cummings et al., 2005, p. 11).

A subsequent systematic review of the literature (Cummings, 2006) reinforced the value of nurse leaders using emotionally intelligent behaviour to develop meaningful collaborative relationships thereby building trust and supporting nurses to manage stress in their work environments. Behaviour that shows emotional intelligence is consistent with some aspects of transformational leadership (Brown & Moshavi, 2005).

4.2 Health-service organizations respect nurses as individuals.

Discussion of evidence

Respect for nurses in the workplace has been linked to autonomy (Laschinger, 2004). Lack of respect has been linked with stress and decreased job satisfaction (Laschinger, 2004). Nurses reported that expecting them to be available to work overtime and extra shifts, regardless of personal circumstances, is disrespectful (Devine & Turnbull, 2002). The average age of nurses in Canada is 44.5 years, and one in three is 50 years or older (Canadian Institute for Health Information [CIHI], 2004). Duxbury and Higgins (2003) found that employees with dependent care responsibilities reported poorer physical and mental health than those without child or elder care duties. These individuals are likely part of the sandwich generation, caring for aging parents at the same time that they have children at home. Organizations need to find creative ways to encourage older nurses to remain in the workforce to be available to share their clinical expertise mentor and encourage younger nurses.

There are concerns that younger workers may not be attracted to leadership positions (Duxbury, L., & Higgins, 2003; Wieck, et. al., 2002).Younger workers are looking for work/life balance (Wong et al., 2012) while leadership positions tend to be characterized by increasing demands (Heeley, 1998); long working hours and inadequate clerical supports (Canadian Nursing Advisory Committee, 2002; Norrish & Rundall, 2001). Duxbury and Higgins (2003) reported that female managers and professionals are more likely than females in other positions to report high levels of burnout. Wieck et al. (2002) and Laschinger, Wong, Grau, Read, Pineau and Stam (2012) noted the importance of nurturing young people if they are to become tomorrow's nursing leaders.

Respect for individuals in the workforce should incorporate diversity in its broadest sense, including cultural and ethnic diversity. Hemman (2000) found ethnicity poorly documented; Redmond (1995) reported that 70 per cent of the nurse executives were European-American and 3 per cent were African-American. In a survey of Hispanic nurses in the U.S. by Villarruel and Peragallo (2004), 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 who reflects one's ethnicity was reported in this study. Tucker Scott (2004) noted that racial and ethnic minorities continue to be underrepresented in nursing education programs and therefore in the workforce, particularly at the supervisory level. In other studies, managers of colour have reported less satisfaction with the equal opportunity and interpersonal relationships in the workplace (Dreachslin, 2002; Laschinger, Shamian & Thomson, 2001; Redmond, 1995).

Suggested strategies for demonstrating respect for nurses

- Allow alternative work arrangements (Duxbury & Higgins, 2003) including flexible scheduling, flex-time policies and telework
- Offer a variety of shift lengths including 8, 10 and 12 hours
- Provide childcare
- Provide a limited number of days of paid leave per year for child care, elder care or personal problems (Duxbury & Higgins, 2003)
- Examine cultural awareness and barriers to leadership for visible minorities — see the RNAO Healthy Work Environments Best Practice Guideline on *Embracing Cultural Diversity in Health Care: Developing Cultural Competence* (RNAO, 2007)
- Tailor professional development programs to a variety of learning needs
- Use technology to offer professional development or in-service sessions throughout the 24-hour period
- Offer coaching and mentoring to boost the confidence of younger, less-experienced staff (Storr, 2004)

4.3 Health-service organizations plan and provide opportunities for growth, advancement and leadership development

Discussion of evidence

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 and for those who lead at the point-of-care (Cummings et al., 2008; Griffiths et al., 2009; Laschinger et al., 2004; Patrick et al., 2011; Tagnesi, Dumont & Rawlinson, 2009; Upenieks, 2002c). Links have been reported between growth opportunities and empowerment (Laschinger et al., 2003; Laschinger, et al., 2001b; Upenieks, 2003b). Opportunities for growth and development were found to be important aspects of magnet hospitals (Laschinger et al., 2003; Scott et al., 1999; Upenieks, 2002c). Upenieks (2003b) found that leaders in both magnet and non-magnet hospitals were focused on elements such as visibility, provision of staffing and equipment, but magnet hospital leaders showed greater focus on educational services. The opportunity for leadership development has also been found to mitigate the effects of burnout and emotional exhaustion (Laschinger et al., 2004; Lee et al., 2010). Budget restraints, lack of time (especially time release) and workload have been identified as significant barriers to providing and achieving leadership development (O'Neil, Morjikian, Cherner, Hirschkorn & West, 2008; Marville-Williams, 2007)

4.4 Health-service organizations support empowerment, enabling nurses to be responsible and accountable for their professional practice.

Suggested strategies for supporting empowerment

- Design flat organizational structures that decentralize decision making (Carney, 2004; Englebart, 1993; Mohr & Mahon, 1996)
- Put nurses on bodies that govern policy and operations, including hiring, (Cronkhite, 1991; Gokenbach, 2004; Mohr & Mahon, 1996) finance, strategic planning and quality improvement (Bliss-Holtz et al., 2004; Mohr & Mahon, 1996)
- Share governance (Devine & Turnbull, 2002; Krugman, 1989; Upenieks, 2002c)
- Establish nursing councils or other structures for nurses to provide input (Erickson et al., 2003)
- Establish policies enabling nurses to address ethical concerns or 'blow the whistle.' (Erickson et al., 2003)
- Establish protocols for addressing professional nursing practice issues (Erickson et al., 2003)
- Maximize nurses' scope of practice in all roles in the organization (Erickson et al., 2003)
- Hold open discussion forums on a regular basis (Dubuc, 1995)

Discussion of evidence

Having autonomy and input into decision-making makes both staff and lead nurses feel empowered, and results in positive outcomes for patients/clients and nurses (Apker et al., 2003; Boyle et al., 1999; Campbell et al., 2004; Cummings et al., 2008; Duffield et al., 2009; Ferguson-Paré et al., 2002; Laschinger et al., 2003; Scott et al., 1999; Tomey, 2009; Upenieks, 2002c; White, 2000). Autonomy, control and collaboration are linked to trust in management (Cummings et al., 2010; Laschinger et al., 2001) and are associated with job satisfaction and perceptions of quality of care (Aiken et al., 2001). Nurse leaders report that participating in decisions is vital to establishing nursing leadership (Upenieks, 2002a). In a study of hospital middle managers in Ireland, Carney (2004) found flat organizational structures encouraged nurses' involvement in developing organizational strategy and enhanced communication. It also led to a greater sense of management cohesion and more effective communication by nurse managers. Middle managers, who felt excluded from strategic involvement, reported they felt controlled and isolated. Dunham-Taylor (1995) found that positive leadership behaviour increases when organizations become more participative. In a study of magnet organizations, nurse leaders reported the importance of backing nurses' decisions (Upenieks, 2003b), but non-magnet leaders were less certain about what degree of control nurses should have in decision-making (Upenieks, 2003a).

Shared governance can be useful in supporting staff leadership and input into decision-making. Following an integrative review of literature that spanned 1988 to 1998, O'May and Buchan (1999) concluded shared governance is not a "one dose fix" but it does result in many positive outcomes, including increased perceptions of management effectiveness, increased staff development, increased skills, increased staff expertise and career development. They emphasized the need to provide education and staff support, mentorship and time to participate. Upenieks (2000) did a critical analysis of intervention studies using shared governance models published from 1994 to 1997 and concluded it enhanced job satisfaction, increased personal power and nurse accountability and improved the work environment. Song, Daly, Trudy, Douglas and Dyer (1997) found shared governance resulted in increased job satisfaction for nurses. In a case-controlled intervention study conducted in an emergency department, Gokenbach (2004) found creating a nurse council with clear boundaries for decision-making resulted in a significant reduction in nurse turnover.

Health organizations and the clients they serve benefit from cultures that encourage empowerment in several ways: there is less turnover in staff (Anderson et al., 2004), employees have better mental and physical health (Arnetz & Blomkvist, 2007; Laschinger et al., 2004; Weberg, 2010), and clinical decision-making improves (Patrick et al., 2011; Tomey, 2009).

4.5 Health-service organizations provide timely access to information, decision-support systems and the resources necessary for care.

Discussion of evidence

Decision support tools, including utilization review tools and systems that analyse practice processes and issues, outcomes and safety, and computerized documentation and workload measurement tools, are important supports for nursing practice and leadership (AACN, 2002).

Access to information puts people "in the know" (Laschinger & Havens, 1997) and timely information about organizational decisions and policy changes is linked to empowerment (Upenieks, 2002a; Laschinger & Havens, 1997). Nurse leaders said having sufficient information to carry out their role responsibilities was important (Upenieks, 2002a). Nurse Managers reported greater role satisfaction (Patrick & Laschinger, 2006), lower burnout, and better mental and physical health when they had access to information (Laschinger et al., 2004).

Providing the necessary resources for patient/client care is a strong signal of respect for nurses and the importance of their contribution (DeLong, & Fahey, 2000; Nicklin, 2001). Resources for equipment, supplies, assistive help and technology are necessary to support quality care and clinical leadership. Laschinger et al. (2003) found a link between resources, empowerment and autonomy. The extent to which a nurse leader can provide nurses with the tools they need is a measure of the leader's effectiveness and power (DeLong, & Fahey, 2000).

Having the necessary staff for the complexity of care (AACN, 2002) is fundamental to delivering quality care and developing clinical leadership skills. Adequate staff resources predict nursing job satisfaction, improve retention and increase quality of care (Aiken et al., 2001). Upenieks (2003a) found that magnet organizations had higher ratios of professional staff than non-magnet organizations.

Clinical governance review ratings assess eight components of an organization's performance: risk management, clinical audit, research and education, patient involvement, information management, staff involvement, education and training and development (Shipton, Armstrong, West & Dawson, 2008). Leaders are more effective in organizations with higher ratings. Organizations that support training, appraisal and clinical governance are correlated to effective infection control in hospitals (Griffiths et al., 2009).

Suggested strategies for empowering nurses with information, decision supports and resources

- Design flat organizational structures that decentralize decision-making (Carney, 2004; Englebart, 1993; Mohr & Mahon, 1996)
- Include nurses on decision-making bodies for policy, operations and hiring (Cronkhite, 1991; Gokenbach, 2004; Mohr & Mahon, 1996) as well as finance, strategic planning and quality improvement committees (Bliss-Holtz et al., 2004; Mohr & Mahon, 1996)
- Share governance (Devine & Turnbull, 2002; Krugman, 1989; Upenieks, 2002c)
- Have direct-care nurses provide input through structures such as nursing councils (Erickson et al., 2003)
- Provide education and support for nurses to participate in decision-making structures
- Establish policies and protocols for nurses to address ethical concerns or to 'blow the whistle' (Erickson et al., 2003)
- Establish policies and protocols for nurses to address professional practice issues (Erickson et al., 2003)
- Maximize nurses' scope of practice in all roles (Erickson et al., 2003)
- Hold regular open discussion forums (Dubuc, 1995)

4.6 Health-service organizations promote and support teams, collaborations and partnerships.

Discussion of evidence

Collaborative relationships in organizations enhance trust (Leach, 2005) and empowerment (Laschinger & Havens, 1997; RNAO, 2006) which help develop and sustain nursing leadership. Nurse leaders can enhance the credibility of nursing and themselves by striving to understand their colleagues better through discussions and building relationships with them (Oberle & Tenove, 2000; Storch et al., 2002; White, 2000).

Nurses in magnet hospitals have positive relationships with physicians (Baird & St-Amand, 1995). Collaborating with physicians can lead to mutual respect for each others' knowledge and knowledge sharing (Upenieks, 2002b), which ultimately contributes to empowerment and enhanced clinical leadership (Upenieks, 2002b). Upenieks (2002b) found teamwork was more prevalent at magnet hospitals, and non-magnet leaders reported slightly negative nurse-physician relationships.

Upenieks (2002a) found a collaborative nursing management team was important for developing and sustaining nursing leadership. Teams with creative cooperation, empathetic communication, understanding and collaboration were important for achieving organizational goals and effective leadership. Dischet al. (2001) reported that collaboration between nursing administrative and clinical leaders can be invaluable in enhancing clinical leadership by nurses. Laschinger et al. (2004) connect strong interpersonal relationships with lower nurse manager burnout, as well as better physical and mental health.

Nurse leaders reported that collaborative working relationships across the organization and among the senior team enhanced their effectiveness (Cummings 2006; Griffiths et al., 2009; Upenieks, 2002a). Engaging others through teams, coalitions, collaborative partnerships and networks are key components of effective health-care leadership according to the Canadian College of Health leaders in the LEADs framework (Canadian College of Healthcare Leaders [CCHL], 2010)

Suggested strategies for promoting teams, collaborations and partnerships

- Establish interprofessional practice councils (CNA, 2001)
- Build time for collaboration into workload planning (IOM, 2004)
- Hold interprofessional meetings and rounds (Upenieks, 2002a) with rotating responsibility for leading and teaching
- Establish a code of conduct and communication for the interprofessional team
- Design and implement care maps and pathways (IOM, 2004)
- Establish interprofessional team peer-review for adverse patient care events (AACN, 2002)
- Provide training in cross-cultural communication and conflict resolution (Disch et al., 2001)
- Establish nursing management forums for problem solving and information sharing
- Have staff share lounges for informal interaction and build private areas for consultation (IOM, 2004)
- Collaborate with a wide range of partners including researchers, educational institutions, other providers and professional organizations
- See RNAO Healthy Work Environments Best Practice Guideline *Collaborative Practice Among Nursing Teams, 2006*

4.7 Health-service organizations support leaders to assist and facilitate change.

Discussion of evidence

The connection between transformational leadership and successful organizational change is increasingly apparent. Cummings (2006) found resonant leadership styles demonstrating high emotional intelligence and features of transformational leadership can mitigate the negative effects of hospital restructuring and lead to positive outcomes for patients. Herold et al. (2006) identified a significant positive effect between transformational leadership and individuals' commitment to change. In an intervention study in community care, managers and clinical leadership teams that set clinically relevant goals for change and combined relations-oriented, change-oriented and task-oriented leadership were more successful implementing clinical practice guidelines (Gifford et al., 2008; Gifford, Davies, Tourangeau, Lefebre, 2011; Gifford, Davies, Tourangeau, Woodend, Lefebre, 2013). Having access to clinical data, knowledge of barriers and supports, and being accountable for corporate initiatives were also associated with the successful change.

To create a climate of innovation and continuous improvement, leaders need support to think critically and analytically, questioning the status quo and orienting themselves strategically to the future (CCHL, 2010). A systematic review of leadership and quality improvement emphasized the importance of leadership commitment for success. The evidence showed certain leadership behaviour is associated with successful quality improvement, while other types are associated with failure. Quality improvement implementation was poor where leaders were passive and failed to provide resources and supports for clinical auditing; but committed, open-minded, communicative leaders with close working relations with staff who were strong advocates for change, were associated with success (Ovretveit, 2005). Similarily, an integrative literature review found three leadership activities influenced nurses' use of research evidence: managerial support, policy revisions, and auditing clinical practice. Nurses were less likely to use evidence where it was a low priority for management, where planning for care was not multidisciplinary and where performance appraisals did not include professional development (Gifford, Davies, Edwards, Griffin, Lybanon, 2007).

4.8 Health-service organizations give managers spans of control that enable effective nursing leadership.

Discussion of evidence

Cutting management positions is a common cost-reduction strategy despite findings by the Gallup Organization (Buckingham & Coffman, 1999) over a 25-year period that the relationship between managers and employees is important for engaging and retaining employees. In 1956, Urwick, writing in the *Harvard Business Review* noted that when a leader has a wide span of control, individuals seeking contact will be frustrated and conclude the leader is too busy to get to know them and understand their concerns. In a study of 14 hospitals undergoing re-engineering, Walston and Kimberley (1997) found increased spans of control for managers resulted in staff being less involved in planning and designing change, less information and decreased success in achieving the change.

Mullen, Symons, Hu and Salas (1989) found larger spans of control for supervisors made them more likely to focus on tasks than relationships, and team members were more likely to be dissatisfied. A study from the chemical industry (Hechanova-Alampay & Beehr, 2001) showed supervisors with larger spans of control did less monitoring; there were significantly higher rates of unsafe behaviour and accidents. In the airline industry, Gittell (2001) found small spans of control improved problem solving, mutual respect, shared goals and shared knowledge, and more timely communication between group members.

McCutcheon (2004) found the wider the span of control of nursing managers, the higher the turnover rate among unit staff. For every increase of 10 in the span of control, the predicted turnover rate increased by 1.6 per cent. As well, as the span increased, the positive effects of supportive leadership styles (transformational and transactional) on nurses' job satisfaction decreased, while the negative effect of less supportive styles increased. However, Meyer et al (2011) found nurses were more satisfied with the level of supervision they received from transformational managers, even those with wide spans of control around the clock as opposed to those receiving supervision from non transformational managers within structured hours (e.g. clinics). It may be that hours of work influence the ability of a manager to interact and thereby overcome some of the negative influence of wide spans of control.

Cathcart et al. (2004) found employee engagement scores declined with an increase in span of control. These findings held in all categories tested including tenure, work status, (full-time, part-time, and 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.

4.9 Health-service organizations invest in training and succession planning to develop future leaders.

Discussion of evidence

Lack of leadership development opportunities can be a factor in the turnover of both nurses and their leaders (Cummings & Estabrooks, 2003). Antrobus and Kitson (1999) suggested there is little incentive for aspiring nurse leaders to remain in direct practice, because there are more visible leadership roles in academia, management and policy. They called for including clinical leadership development in direct practice career paths. They also emphasized the importance of nurses developing both political and corporate skills so they can "work on even footing" and have a voice.

A number of studies reported positive outcomes associated with formal leadership development programs (Cherniss, Goleman, Emmerling, Cowan& Adler, 1998; Cummings et al., 2008; Cummings et al., 2010; Cunningham & Kitson, 2000a,

2000b; George et al., 2002; Tourangeau, Lemonde, Luba, Dakers & Alksnis, 2003; Wolf, 1996). Several authors, however, (Cherniss et al., 1998; Ferguson-Paré, 1998; George et al., 2002; Giber, Carter & Goldsmith, 2000; Wolf, 1996) emphasized new leaders need opportunities to practice their skills. One pilot study found an orientation program for new graduates that incorporated multi-media learning strategies and the opportunity to practice new skills in leading seminars and rounds was effective (Giber et al., 2000). Participants in the intervention group demonstrated earlier readiness for leadership roles and greater leadership competencies.

A study of a staff nurse leadership program (George et al., 2002) found these supports were needed: a critical mass of colleagues attending the program; mentors; and role-modelling of leadership behaviour by managers, clinical nurse specialists and other colleagues. Barriers included workload, turnover, lack of responsibility, insufficient goal setting with management, being new, and negative feedback when trying new behaviour.

A number of authors have identified the need for succession planning[G](CNA, 2003; Collins, 2002; Cunningham & Kitson, 2000a, 2000b; Jones, 2005; Wolf, 1996) including moving nurses through management experiences and into formal leadership positions (Canadian Nursing Advisory Committee, 2002; Doran et al., 2012; Laschinger, Wong, Grau, Read, Pineau Stam, 2012). Nurse leaders reported that diverse leadership opportunities such as committee involvement, charge nurse roles, latitude for decision-making and exposure to formal career planning opportunities were important to their leadership development (DeLong & Fahey, 2000; Laschinger et al., 2012).

System Recommendations

5.0 Recommendations for Governments.

5.1 Governments in all provinces and territories establish a senior nurse leader as a policy advisor .

5.2 Governments establish national communication among those advisors.

5.3 Governments in all provinces and territories establish a nursing advisory council.

5.4 Governments establish, fund and maintain programs for developing nursing leaders.

5.5 Governments establish, fund and maintain programs of nursing leadership research.

Discussion of evidence for 5.1, 5.2, 5.3

The Institute of Medicine (IOM) report, *Keeping Patients Safe: Transforming the Work Environments of Nurses* (IOM, 2004) 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* (Bauman et al., 2001)and *Our Health,Our Future: Creating Quality Workplaces for Canadian Nurses*(Canadian Nursing Advisory Committee, 2002), 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 (2004) noted that at the time of their publication, eight of the 10 provinces had a provincial senior nurse leader position.

In an international study, Splane and Splane (1994) said it was important to have chief nursing officers in sub-national jurisdictions such as provinces and states. The authors reviewed the national role through literature and discussion with key international informants. They found chief nursing officers promote optimal use of nurses, nursing standards and education to improve patient/client safety; promote nursing research; do public speaking to educate others about nursing; promote human rights and the importance of policy that supports the determinants of health; and they advance nursing as a respected human service. The authors said chief nursing officers have important links with national labour groups, professional organizations and two-way communication with nurses in all settings.

Chief nursing officers also influence policy, mainly on nursing standards, education and research, recruitment and retention and workplace conditions (Splane & Splane, 1994). However, they have also shown considerable influence on policies related to determinants of health such as universality of health services and socio-economic status.

Although nursing is trusted by the public (Leger Marketing, 2003), the profession is not well understood (Antrobus & Kitson, 1999) and nurses have frequently described feeling a sense of voicelessness (Gaudine & Beaton, 2002; Henderson, 2003; Storch et al., 2002). Clifford (1998) found consistently that nurses felt the need to have someone who understood their practice at the highest level of organizations, advocating for what they do on behalf of patients/clients and families. A senior nurse leader in government is well positioned to develop strategies to teach the public and government about the role and contribution of nurses (Scott et al., 1999; Splane & Splane, 1994). Nurses have reported that providing this type of education is crucial to enhancing respect for nurses (Devine& Turnbull, 2002). Having a senior nurse leader in a policy role is an opportunity for governments to demonstrate support for nursing (Splane & Splane, 1994).

Having a senior nurse leader in a policy role is also an opportunity for policy makers to better understand patient/client care issues and obtain expert nursing input for health policy and patient/client programming. Splane and Splane (1994)

noted this is particularly important given the growth of "generalist" administrators in health care 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 (Antrobus& Kitson, 1999; Splane & Splane, 1994) found senior nurse leaders play a role in translating nursing terminology, priorities, and potential impact to politicians. This is similar to their essential role in interpreting and integrating nursing with senior administration and the governing body in their organizations. Antrobus and Kitson (1999) said interpretation is largely done by individual nurse leaders and suggest nursing policy units could be valuable in analyzing and informing health policy.

Although there is considerable evidence that links nurses' work environments to the quality of care, nursing issues are not necessarily perceived as a policy priority (White, 2000) and political agendas may take precedence (Antrobus& Kitson, 1999; Splane & Splane, 1994). A senior nurse leader involved in health policy can improve health outcomes by bringing nursing perspectives into budget and policy decisions. Having an accessible nursing expert who can provide advice on the potential impact of policy decisions on patient/client care is critical. According to Splane and Splane (1994), nurses in senior policy roles play as important a role in preventing negative policy development as they do in initiating positive policy and working to support the implementation of existing policies. Scott et al. (1999) found nurse leaders played a critical role in the process of restructuring. Splane and Splane (1994) 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.

In 2007, Laschinger and Wong examined the organizational and structural characteristics of nursing management roles in the acute-care sector. Senior nurse leaders reported high levels of influence and involvement in decisions particularly when they were part of the senior executive team, reported to the chief executive officer, and included chief nursing officer in their role (Laschinger & Wong, 2007). Roles were also enhanced if they had operational or line authority. Middle and point-of-care managers working with these types of senior nurse leaders felt more support for a professional practice environment and were more likely to report a higher quality of patient care (Laschinger & Wong, 2007). In a more recent qualitative study examining the role of hospitals with chief nursing officers in the United States, the chief nursing officers were identified as playing a broad and essential role in organizational performance (Disch, Dreher, Davidson, Sinioris & Waino, 2011),

Ontario boards of health were required to designate a chief nursing officer by January 2013 (Public Health Chief Nursing Officer Working Group [PHCNOWG], 2011). They were to be responsible for quality assurance and nursing practice leadership including accountability for ensuring public health nurses work to their full scope, making their organization more effective and improving population health (PHCNOWG, 2011). Where there already were chief nursing officers, a provincial report said they "contribute to broader health care system level discussions to inform policy, program and practice issues (particularly) where there are implications for public health and public health nursing "(PHCNOWG, 2011, p.6).

Advisory groups for nurses in policy roles has been recommended by both the Canadian Nursing Advisory Committee (2002) and the Advisory Committee on Health Human Resources (2000). The groups help provide a broad range of stakeholder input to the senior nurse and government as they 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 (2004) 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 (Health Canada, 2005). ONP coordinates meetings for provincial/territorial chief nursing officers to discuss nursing issues and evidence to recommend policy and strategies based on the best possible evidence.

5.4 Governments establish, fund and maintain a program of nursing leadership development.

5.5 Governments establish, fund and maintain a program of nursing leadership research.

Discussion of evidence for 5.4, 5.5

Evidence that is readily accessible and can be directly translated into practice presents an important challenge in health care research (Glasgow, Klesges, Dzewaltowski, Bull & Estabrooks, 2004). Single studies done under specific conditions may not be seen as applicable across settings, and replicating studies across populations and settings has been suggested (Glasgow et al., 2004). Daly, Douglas and Kelley (2005) suggest that for research studies to be meaningful, all elements of the practice environment must be taken into account. They recommend achieving that through sequential studies that build on results of prior studies, such as would occur in a program of research.

Through a series of clinical studies, Daly et al.(2005) noted that starting with a descriptive study and moving to an intervention study in a program of research permits hypotheses to be tested using appropriate variables and measures identified in earlier descriptive studies. They found focusing on one area allowed their research team to develop a richer understanding of the topic, valid measures and relevant literature, and learn practical considerations for designing subsequent studies. They reported that a program approach to research resulted in increased confidence in their findings and helped them to avoid incorrectly attributing cause to a variable studied in a single context.

Antrobus and Kitson (1999) recommended broader research into leadership in nursing. They noted leadership studies have been internally focused, looking at its nature and purpose, characteristics and the development needs of aspiring leaders. They suggested broader socio-political factors that influence leadership and how nursing leaders can shape policy should be examined.

Cummings et al. (2008) did a systematic literature review to determine, in part, the effectiveness of educational interventions in developing leadership behaviour in nurses. To address the ongoing issue of weak research design, the authors called for a more robust research agenda on interventions to develop and promote leadership. All this suggests a dedicated funded program of research on nursing leadership research is needed.

Recommendations for Researchers

6.0 Researchers study the impact of nursing leadership on nurse, patient/client, organizations and systems

Discussion of evidence

Leadership is fundamental to the work environment of nurses and their leaders, who are under increasing pressure to perform as organizations focus on controlling costs (IOM, 2004; McGillis Hall et al., 2005). Patrick and White (2005) and Cummings (2006) called for further research on the link between nursing leadership behaviour and patient and client and nurse outcomes, to gain recognition of the importance of nursing. They noted (Scott et al., 1999; Sullivan et al., 2003; Ward, 2002) of the published work is descriptive, with few experimental studies. In a systematic review of leadership and outcomes, Cummings et al. (2008) recommended several specific directions and methods for future research on nursing leadership:

- include observed measures of leaders' styles and behaviour
- design longitudinal and quasi-experimental studies with matched or random allocation to control and intervention groups
- use probability sampling
- include long-term outcomes (e.g. >18 months) as well as indicators of effective leadership
- explore in greater detail the relationship between traits and characteristics, such as levels of education, experience, sex/gender roles, and culturally influenced factors that enhance or develop leadership in nursing,
- use multivariate statistical procedures like hierarchical linear modeling (HLM) and structural equational modeling (SEM) to test models and theories of leadership, specifically causal relationships of the influence of factors or interventions on the development of leadership.
- use qualitative approaches to examine what enhances nursing leadership
- evaluate leadership development programs for point-of-care nurses

6.1 Researchers develop, implement and evaluate a leadership intervention based on the *Conceptual Model for Developing and Sustaining Nursing Leadership.*

Discussion of evidence

The 2004 report from the Institute of Medicine (IOM, 2004) says managers should "search for and apply empirical evidence from management research in their practice," but it lists a number of barriers to doing that. Management decisions are often made by groups and involve negotiation, compromise and organizational constraints (Walshe & Rundall, 2001). As well, training for managers in the use of evidence is not as consistent as it is for point-of-care health care professionals (Axelsson, 1998; Walshe & Rundall, 2001). In a study of the nurse manager's role in evidence-based practice by Udod and Care (2004), participants said they lack knowledge on research and its use.

Health-care management research has been limited by the level of funding it has received compared to management research in other industries, and many organizations lack the size and resources, including adequate data systems, to conduct and evaluate applied research (Kovner et al., 2000; Walston& Kimberly, 1997).Research funded by large health systems has been considered private and was not widely shared (Kovner et al., 2000).

6.2 Researchers conduct research on health human resources planning for nursing leadership roles.

Discussion of evidence

Effective health human resource planning is critically important in the current environment of change (Tomblin Murphy et al., 2003). The elimination of managerial positions between 1994 and 2002 in Canada has resulted in wider spans of control for nurse leaders and fewer supports for nurses (Bauman et al., 2001; CIHI, 2004; Lowe, 2004; CIHI, 2001; CIHI, 2002a, 2002b).

A study of over 1,000 Canadian acute-care nurse leaders found they had adapted to large spans of control, but most wanted to reduce their level of responsibility as they saw this as a potential threat to performance (Laschinger & Wong, 2007). The average number of direct reports was 71 with a range from seven to 264). These large spans of control and unreasonable workloads may make nurse leader roles less attractive and more difficult for recruitment.

Human resource planning needs sound data on nursing leadership. The Nursing Workforce Study (Advisory Committee on Health Human Resources, 2000) identified many deficiencies in national data bases that prevent questions about nurse supply being answered. They recommended research on human-resource planning go beyond supply models and examine system needs. This recommendation was echoed by Baumann et al. (2001), who recommended development of labour-market databases and human-resources forecasting tools.

6.3 Researchers conduct research on nursing leadership education and development.

Discussion of evidence

There is evidence that demonstrates nurses' relationship with their immediate supervisor is an important predictor of job satisfaction and intent to stay (Blegen, 1993; Irvine& Evans, 1992; Thomson, Dunleavy & Bruce, 2002). Thomson et al. (2002) noted "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 in the hierarchy to advocate on their behalf" (p. 26). Although Patrick and White (2005) argue it is difficult to operationalize leadership theories, they concede educational interventions can increase leadership behaviour. Cummings et al. (2010) agree leadership qualities can be developed through specific and dedicated educational activities (2008). Tourangeau et al. (2003) and McPhee and Bouthillette (2008) found a concentrated residential program can strengthen leadership behaviour in both established and developing nurse leaders.

In a meta-analysis of research examining the effects of managerial leadership development programs, Collins and Holton (2004) found an emerging trend of transformational leadership but little in terms of reporting on training or results. They also found few empirical studies to assess the outcomes of interventions such as coaching, mentoring or feedback. These authors recommend tracking return on investment for leadership-development programs. Research in this area needs to look more closely at supports and barriers to interest and success in leadership roles, and at evaluation tools for nursing leadership and performance.

Based on a more recent systematic review of the literature on educational interventions, Cummings et al. (2008) found transformational and other high-relational leadership styles, along with previous leadership experience, contributed to effective leadership. The authors recommended future research on outcomes of a variety of leadership-development interventions, to describe barriers and the impact of the program's length and type on enhanced leadership behaviour.

Recommendations for Accreditation Bodies

7.0 The above recommendations are incorporated into health service and educational accreditation standards.

Discussion of evidence

The quality of nursing leadership determines the quality of working environments where nurses deliver care (Clifford, 1998; Scott, et. al., 1999; Upenieks, 2002c). Clifford (1998) advocates for the job of the senior nurse leader in an organization to be a standard, defined function with responsibility for nursing at the executive level. Having a nurse in a senior, influential role in an organization is a criterion of magnet accreditation and has been linked with positive outcomes innumerous studies. The Joint Commission on Accreditation of Health Care Organizations (JC) in the United States requires nursing services to be 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 (JCAHO, 2005).

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 guideline development 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 and 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 & Monitoring of Guidline

Organizations implementing the recommendations in the Healthy Work Environments Leadership Best Practice 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),* 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 B**.

Level of Indicator	Structure	Process	Outcome	Measurement
Objective	To evaluate the organizational supports that enable nurses to develop and demonstrate effective leadership practices	To evaluate organizational leadership processes and leadership behaviour 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 in 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 behaviour	Communication mechanisms established and used such as: ■ Newsletters, open forums, access to email Workload measurement tools in place and used to 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, 1983-1985) Nursing Assessment Survey (Maehr & Braskamp, 1986) Nursing Unit Cultural Assessment Tool (Coeling & Simms, 1993) Nursing Work Index (Aiken & Patrician, 2000) The Ottawa Hospital Model of Nursing Clinical Management Span of Control Decision Making Indicators (The Ottawa Hospital, 2003) # of persons studying advanced education Funds for Continuing education Practice Environment Scale of NWI (Lake, 2002) Professional Practice EnvironmentScale (Erickson et al., 2004) Canadian Practice Environment Index (Estabrooks et al., 2002) Perceived Nursing Work Environment (Choi, Bakken, Larson, Du & Stone,2004)

Level of Indicator	Structure	Process	Outcome	Measurement
Nurse Leader	Availability of education and supports for nurse leaders and aspiring nurse leaders in all roles Number 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 behaviour as outlined in the guideline Regular performance appraisal carried out including self assessment Leadership behaviour 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, Henly, & Armstrong, 1982) Leadership Behaviour Description Questionnaire (Stogdill, 1963) Leadership Practices Inventory (Kouzes & Posner, 1988) Supportive Leadership Styles- Charge Nurse Support scale and Unit Manager Support Scale (McGilton, 2003) Six Dimension (6D) Scale of Nursing Performance (Schwirian, 1978) Maslach Burnout Inventory (Maslach& Jackson, 1986) Index of Work Satisfaction (Stamps & Piedmonte, 1986) Organizational Commitment Scale (Porter, Steers, Mowday, & Boulian, 1974) Nurse Job Satisfaction Scale (Hinshaw and Atwood, 1983-1985) Work Satisfaction Scale (Hinshaw and Atwood, 1983-1985)
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 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, 2005)
Financial			Recruitment and retention cost savings Sick time cost savings Overtime cost savings	

REFERENCES

Reference List

Abraham, P. (2011). Developing Nurse Leaders: A program enhancing staff nurse leadership skills and professionalism. *Nursing Administration Quarterly, 35*(4), 306 – 312.

Adams, C. (1994). Innovative behaviour in nurse executives. *Nursing Management*, *25*(5), 44-47.

Advisory Committee on Health Human Resources (2000).*The Advisory Committee on Health Human Resources*. The Nursing Strategy for Canada. October 2000. Retrieved May 13, 2005 from: http://www.hc-sc.gc.ca

Aiken, L., & Patrician, P., (2000). Measuring organizational traits of hospitals: The Revised Nursing Work Index. *Nursing Research*, *49,* 146-153.

Aiken, L., Clarke, S., Sloane, D., Sochalski, J., Busse, R., Clarke, H., et al. (2001). Nurses reports on hospital care in five countries. *Health Affairs*, *20*(3), 43-53.

Aiken, L., Smith, H., & Lake, E. (1994). Lower Medicare mortality among a set of hospitals known for good nursing care. *Medical Care*, *32*(5), 771-787.

Aiken, L., Sochalski, J., & Lake, E. (1997). Studying outcomes of organizational change in health services. *Medical Care, 35*(11), NS6-NS18.

Aldana, S. (2001). Financial impact of health promotion programs: A comprehensive review of the literature. *American Journal of Health Promotion*, *15*(5), 296-320.

Allen, T.D., Eby, L.T., Poteet, M.L., Lentz, E., Lima, L. (2004). Career Benefits Associated with Mentoring for Proteges: A Meta-analysis. *Journal of Applied Psychology, 89*(1), 127-136.

Altieri, L. (1995). Transformational and transactional leadership in hospital nurse executives in the commonwealth of Pennsylvania: A descriptive study. (Doctoral dissertation, George Mason University).

American Association of Colleges of Nursing (AACN) Task Force on Hallmarks of the Professional Practice Setting. (2002). *Hallmarks of the professional nursing practice environment. January, 2002*. AACN. Retrieved September 24, 2004 from: http://www.aacn.nche.edu/Publications/positions/hallmarks.htm

American Nurses Association [ANA]. (2000). *Nurse staffing and patient outcomes in the inpatient hospital setting*. Washington, DC: American Nurses Publishing.

Anderson, B. &Manno, M. (2010) Listening to nurse leaders: Using national database of nursing quality indicators data to study excellence in nursing leadership. *The Journal of Nursing Administration, 40*(4), 182-187.

Anderson, D., & Ackerman Anderson, L. (2001). *Beyond change management: Advanced strategies for today's transformational leaders.* San Francisco: Jossey Bass/Pfeiffer.

Anderson, R., Corazzini, K., & McDaniel, R. Jr. (2004). Complexity science and the dynamics of climate and communication: Reducing nursing home turnover. *The Gerontologist*, *44*(3), 378-388.

Anderson, R., Issel, L., & McDaniel, R., Jr. (2003). Nursing homes as complex adaptive systems: Relationship between management practice and resident outcomes. *Nursing Research*, *52*, 12-21.

Antrobus, S., & Kitson, A. (1999). Nursing leadership: Influencing and shaping health policy and nursing practice. *Journal of Advanced Nursing*, *29*(3), 746-753.

Apker, J., Zabava Ford, W., & Fox, D. (2003). Predicting nurses' organizational and professional identification: The effect of nursing roles, professional autonomy and supportive communication. *Nursing Economic$, 21*(5), 226-232.

Argyris, C., &Schön, D. (1996). *Organizational learning II: Theory, method and Practice*. Reading, MA: Addison Wesley.

Arnetz, B. &Blomkvist, V. (2007). Leadership, mental health, and organizational efficacy in health care organizations. Psychosocial predictors of healthy organizational development based on prospective data from four different organizations. *Psychotherapy & Psychosomatics, 76,* 242-248.

Association of Colleges of Applied Arts and Technology. (2001). *The 2001 environmental scan for the Association of Colleges of Applied Arts and Technology of Ontario*. Toronto, ON: Author.

Avolio, B.J., Zhu, W., Koh, W., & Bhatia, P. (2004) Transformational leadership and organizational commitment: Mediating role of psychological empowerment and moderating role of structural distance. *Journal of Organizational Behaviour*, *25*(8), 951-968.

Axelsson, R. (1998). Towards an evidence-based health care management. *International Journal of Health Planning and Management*, *13*, 307-317.

Baguley, K. (1999). Workplace Empowerment, Job Strain and Affective Organizational Commitment in Critical Care Nurses: Testing Kanter's structural theory of organizational behaviour. (Master's thesis, University of Western Ontario).

Baird, A., & St-Amand, R. (1995). *Trust within the organization part 2 – Building Trust*. Retrieved August 27, 2004 from: http://www.psccfp.gc.ca/publications/monogra/mono2_e.htm

Baker, C.M., Ogden, S.J., Prapaipanich, W., Keith, C.K., Beattie, L.C., Nickleson, L.E. (1999). Hospital consolidation. Applying stakeholder analysis to merger life-cycle. *Journal of Nursing Adminstration*, *29*(3), 11-20.

Ballein Search Partners. (2003). *Why senior nursing officers matter: A national survey of nursing executives*. Retrieved February 23, 2005 from Website of American Organization of Nurse Executives: www.hospitalconnect.com/aone/docs/03sno-survey.pdf

Barger, S. (2004). An academic-service partnership: Ideas that work. *Journal of Professional Nursing*, *20*, 97-102.

Bar-On, R. (1987). *Bar-On Emotional Quotient Inventory: User's manual.* Toronto, ON: Multi-health Systems.

Barry-Walker, J. (2000). The impact of system redesign on staff, patient and financial outcomes. *Journal of Nursing Administration*, *30*(2), 77-89.

Bass, B. (1995). *Multifactor Leadership Questionnaire*. Binghamton, NY: State University of New York.

Bass, B., &Avolio, B. (1990). The implications of transactional and transformational leadership for individual, team, and organizational development. *Research in Organizational Change and Development*, *4*, 231-272.

Bauman, A., O'Brien-Pallas, L., Armstrong-Stassen, M., Blythe, J., Bourbonnais, R., Cameron, S., et al. (2001).*Commitment and care – The benefits of a healthy workplace for nurses, their patients and the system.* Ottawa, ON: Canadian Health Services Research Foundation and the Change Foundation.

Beaulieu, R., Shamian, J., Donner, G., & Pringle, D. (1997). Empowerment and commitment of nurses in long-term care.*Nursing Economic$, 15*(1), 32-41.

Bell, J. &Breslin, J. M. (2008). Healthcare provider moral distress as a leadership challenge. *JONA's Healthcare Law, Ethics, & Regulation, 10*(4), 94-97.

Berwick D. (1996). Harvesting knowledge from improvement (editorial). *The Journal of the American Medical Association*, *275*, 877- 878.

Bethune, G. (2005). *Performance improvement: The leadership perspective. Excellence in Nursing Knowledge*. Retrieved 3/15/2005 from: *http://www.nursingknowledge.org/Portal/mian.aspx?PateIde=3514&IssueNo=7&ArticleNo*

Blais, K., Hayes, H., Kozier, B., &Erb, G. (2002). *Professional nursing practice concepts and perspectives* ,4th Edition. Upper Saddle River, NJ: Prentice Hall.

Blanchfield, K., & Biordi, D. (1996). Power in practice: A study of nursing authority and autonomy. *Nursing Administration Quarterly*, *20*(3), 42-46. 100

Blanzola, C., Lindeman, R., & King, M.L. (2004).Nurse internship pathway to clinical comfort, confidence, and competency. *Journal for Nurses in Staff Development, 2*(20), 27-37.

Blegen, M. (1993). Nurses' job satisfaction: meta-analysis of related variables. *Nursing Research*, *42*(1), 36-41

Blegen, M., & Good, C., Johnson, M., Maas, M., Chen, L., Moorhead, S. (1993). Preferences for decision-making autonomy, *Image: Journal of Nursing Scholarship*, *25*(4), 339-344.

Blegen, M., & Vaughn, T. (1998).A multi-site study of nurse staffing and patient occurrences.*Nursing Economic$, 16*(4), 196–203.

Bliss-Holtz, J., Winter, N., & Scherer, E. (2004). An invitation to magnet accreditation.*Nursing Management*, *35*(9), 36-42.

Block, P. (1987). *The empowered manager*. San Francisco, CA: Jossey-Bass.

Bono, J. E., Foldes, H. J., Vinson, G., &Muros, J. P. (2007). Workplace emotions: the role of supervision and leadership. *Journal of Applied Psychology, 92*(5)*,* 1357-1367.

Boughn, S. (1995).An instrument for measuring autonomy-related attitudes and behaviours in women nursing students.*Journal of Nursing Education*, *34*, 106-113.

Boumans, N., &Landeweerd, J. (1993). Leadership in the nursing unit: Relationships with nurses' well being. *Journal of Advanced Nursing*, *18*(5), 767-775.

Bournes, D.A. & Ferguson-Pare, M. (2007). Human becoming and 80/20.An innovative professional development model for nurses.*Nursing Science quarterly, 20*(3), 237 -253.

Bousfield, C. (1997). A phenomenological investigation into the role of the clinical nurse specialist.*Journal of Advanced Nursing*, *25*(2), 245-256.

Bowman, D.*The five best ways to build – and lose – trust in the workplace*. Retrieved September 24, 2004 from: http://www.ttgconsultants.com/articles/trustworkforce.html

Boyle S.M. (2004). Nursing unit characteristics and patient outcomes. *Nursing Economics, 3*(22) 111-119.

Boyle, D., Bott, M., Hansen, H., Woods, C., & Taunton, R. (1999).Managers' leadership and critical care nurses' intent to stay. *American Journal of Critical Care, 8(6), 361-371.*

Boyle, D.K.., & Kochinda, C. (2004). Enhancing collaborative communication of nurse and physician leadership in two intensive care units. *The Journal of Nursing Administration*, *34*(2), 60-70.

Branch, C., & Fraser, I. (2001). Can cultural competency reduce racial and ethnic health disparities? *Medical Care Research and Review*, *57*(1), 181-217.

Brody, A.A., Barnes,K., Ruble,C., Sakowski, J (2012). Evidence-based practice council's potential path to staff nurse empowerment and leadership growth. *Journal of Nursing Administration, 42*(1), 28-33.

Broome, K., Knight, D., Edwards, J., & Flynn.P. (2009). Leadership, burnout, and job satisfaction in outpatient drug-free treatment programs. *Journal of Substance Abuse Treatment,* 37(2), 160-170.

Bryman, A., Brensen, M., Beadswoth, A., Ford, J., &Keil, E. (1987). The concept of the temporary system: The case of the construction project. *Research in the Sociology of Organizations, 5*, 253-283.

Buckingham, M., & Coffman, C. (1999).*First break all the rules*. New York: Simon and Schuster.

Bunderson, J. (2001). How work ideologies shape the psychological contracts of professional employees: Doctors responses to perceived breach. *Journal of Organizational Behaviour*, *22*, 717-741.

Burner, O. (1983).The organizational structure of air force hospitals and its effect on management of nursing services. (Doctoral Dissertation, Claremont Graduate School).

Burns, J. (1978). *Leadership*. New York: Harper and Row.

Cadman, C., & Brewer, J. (2001). Emotional intelligence: A vital prerequisite for recruitment in nursing. *Journal of Nursing Management*, *9*(6), 321-324.

Campbell, S.L., Fowles, E.R., & Weber, B.J. (2004). Organizational structure and job satisfaction in public health nursing.*Public Health Nursing*, *6*(21), 564-71.

Canadian College of Healthcare Leaders [CCHL]. (2010). *The LEADS in a Caring Environment Capabilities Framework*. Retrieved from http://www.leadersforlife.ca/.

Canadian Health Services Research Foundation (2004).*Listening for direction II. National consultation on health services and policy issues for 2004-2007*. Ottawa, ON: Author.

Canadian Health Services Research Foundation.*Key research themes – Nursing leadership organization and policy*. Retrieved from the CHSRF website June 2, 2005: http://www.chsrf.ca/research_themes/nlop_e.php

Canadian Institute for Health Information [CIHI]. (2001). *Supply and distribution of Registered Nurses in Canada, 2000.*Ottawa, ON: Author.

Canadian Institute for Health Information [CIHI]. (2002a). *Supply and distribution of Registered Nurses in Canada, 2001*.Ottawa, ON: Author.

Canadian Institute for Health Information [CIHI]. (2002b). *Workforce trends of Registered Nurses in Canada, 2002*. Ottawa, ON: Author.

Canadian Institute for Health Information [CIHI]. (2004). *Workforce trends of Registered Nurses in Canada, 2004*. Ottawa, ON: Author.

Canadian Intergovernmental Conference Secretariat (2000). First Minister's Meeting Communiqué on Health. News Release. First Ministers' Meeting Ottawa, ON: September 11, 2000.

Canadian Nurse Association [CNA]. (2012). Expert Commission (June, 2012). *A Nursing Call to Action: The health of our nation, the future of our health system.* Retrieved from http://www.cna-aiic.ca.expertcommission/

Canadian Nurse Association [CNA]. (2012). Expert Commission (June, 2012). *A Nursing Call to Action: The health of our nation, the future of our health system.* Retrieved from http://www.cna-aiic.ca.expertcommission/

Canadian Nurses Association [CNA]. (2001). *Quality professional practice environments for Registered Nurses*. Ottawa, ON: Author.

Canadian Nurses Association [CNA]. (2002). *Planning for the future: Nursing human resource projections.* Ottawa, ON: Author

Canadian Nurses Association [CNA]. (2003a). *Succession planning for nursing leadership*. Ottawa, ON: Author.

Canadian Nurses Association [CNA]. (2003b). *Ethical distress in health care environments. Ethics in practice for Registered Nurses*. Retrieved February 23, 2005 from: http://www.cna-nurses.ca/cna/practice/ethics/inpractice/default_e.aspx

Canadian Nurses Association [CNA]. (2005). *Nursing leadership in a changing world. Nursing Now, Issues and Trends in Canadian Nursing*, *18*(1). Retrieved April 22, 2005 from: http://www.cna-nurses.ca/cna/

Canadian Nurses Association [CNA]. (2011). *2009 WORKFORCE PROFILE of Registered Nurses in Canada.* Retrieved from: http://www2.cna-aiic.ca/CNA/documents/pdf/publications/2009_RN_Snapshot_e.pdf

Canadian Nursing Advisory Committee [CNAC]. (2002). *Our health, our future: Creating quality workplaces for Canadian nurses.* Ottawa, ON: Advisory Committee on Health Human Resources.

Cardin, S. (1995). Outcomes of unit effectiveness in relation to the leadership role of nurse managers in critical care nursing. (Doctoral dissertation, University of California)

Carney, M. (2004). Middle manager involvement in strategy development in not-for profit organizations: the director of nursing perspective – how organizational structure impacts on the role. *Journal of Nursing Management*, *1*(12), 13-21.

Carper, B. (1978).Fundamental patterns of knowing in nursing.*Advanced Nursing Science,1*(1), 13-23.

Cartwright, N. (2007). *Hunting causes and using htem: Approaches in philosophy and economics.* New York: Cambridge University Press.

Cathcart, D., Jeska, S., Karnas, J., Miller, S. Pechacek, J., &Rheault, L. (2004). Span of control matters. *Journal of Nursing Administration*, *34*(9), 395–399.

Chandler, G. (1986). The relationship of nursing work environments to empowerment and powerlessness.(Doctoral Dissertation, University of Utah).

Cherniss, C., Goleman, D., Emmerling, R., Cowan, K., & Adler, M. (1998). *A technical report issued by the Consortium for Research on Emotional Intelligence in Organizations.* Retrieved April 21, 2004 from: http://www.eiconsortium.org/research/technical_report.htm

ChiokFoongLoke, J. (2001). Leadership behaviours: Effects on job satisfaction, productivity and organizational commitment. *Journal of Nursing Management*, *9*(4), 191-204.

Cho, S., Ketefian, S., Barkauskas, V., & Smith, D. (2003).The effects of nurse staffing on adverse events, morbidity, mortality and medical costs. *Nursing Research, 52*(2), 71–79.

Choi, J., Bakken, S., Larson, E., Du, Y., & Stone, P.W. (2004). Perceived nursing work environment of critical care nurses. *Nursing Research*, *53*, 370-8.

Clarke, M. &Oxman, A.D. (1999). *Cochrane Reviewers' Handbook*, 4th Ed.. Oxford, UK: The Cochrane Collaboration.

Clifford, J. (1998). *Restructuring: The Impact of hospital organization on nursing leadership.* San Francisco, CA: American Hospital Association.

Cochrane Collaboration. *Cochrane and systematic reviews: Levels of evidence for health care interventions.* Retrieved May 7, 2005 from: *http://www.cochrane.org/consumers/sysrev.htm#levels*

Coeling, H., & Simms, L. (1993). Facilitating innovation at the nursing unit level through cultural assessment, part 1: How to keep management ideas from falling on deaf ears. *Journal of Nursing Administration*, *23*(4), 46-53.

Coff, R., & Rousseau, D. (2000). *Sustainable competitive advantage and employability: Is it a "win-win" situation?* In Leana, C.R. and Rousseau, D.M. (Eds.). *Relational wealth: The advantages of stability in a changing economy*. Oxford: Oxford University Press.

Coile, R. (1999). Magnet hospitals: Ten Strategies to becoming a model nursing employer. *Russ Coile's Health Trends*,*11*(8), 1-4.

College of Nurses of Ontario [CNO]. (2002). *Professional standards*. Toronto, ON: Author

Collins, D. (2002). The effectiveness of managerial leadership development programs: A meta-analysis of studies from 1982-2001. (Doctoral dissertation. Louisiana State University and Agricultural and Mechanical College).

Collins, D., & Holton, E. (2004). The Effectiveness of managerial leadership development programs: A meta-analysis of studies from 1982 to 2001. *Human Resources Development Quarterly*, *15*(2), 217-248.

Conchie, B. (2004). The seven demands of leadership. What separates great leaders from all the rest? *Gallup Management Journal*, May 13, 2004. Retrieved December 8, 2004 from: http://gmj.gallup.com/content/default.asp?ci=11614

Conger, J., &Kanungo, J. (1988). The empowerment process: Integrating theory and practice. *Academy of Management Review*, *13*(3), 471-482.

Cook, J., & Wall, T. (1980). New work attitude measures of trust, organizational commitment and personal need non-fulfillment. *Journal of Occupational Psychology*, *53*, 39-52.

Cook, M. (2001). The renaissance of clinical leadership.*International nursing review, 48,* 38-46.

Cooke, R., & Lafferty, J. (1987). *Organizational Culture Inventory (OCI).* Plymouth, MI: Human Synergistics.

Cooper, M., & Wheeler, M. M. (2010). Building successful mentoring relationships. *Canadian Nurse, 106*(7), 34-35.

Cooperrider, D., &Srivastva, S. (1987). Appreciative inquiry in organizational life part 2.*Research in organizational Change and Development*, *1*, 129-169.

Corley, M. (1995). Moral distress of critical care nurses. *American Journal of Critical Care*, *4*(4), 280-285.

Corley, M., Elswick, R., Gorman, M., &Clor, T. (2001). Development and evaluation of a moral distress scale. Journal of Advanced Nursing*, 33(2) 250-256.*

Corrigan, P., Lickey, S., Campion, J., & Rashid, F. (2000).Mental health team leadership and consumers' satisfaction and quality of life. *Psychiatric Services*, *51*(6), 781-785.

Council of Ontario University Programs in Nursing [COUPN]. (2002). *Position statement on nursing clinical education*. Toronto, ON: Author.

Covey, S.R., (1990).*The 7 Habits of Highly Effective People,* New York: Simon & Schuster.

Cronkhite, L. (1991). Role of the hospital nursing administrator in a changing health care environment – A study of conflicts and values.(Doctoral dissertation, University of Milwaukee).

Crossley, J. (1993). Chief nursing officer governing body proximity, direct reporting relationship and professionalism as predictors of chief nursing officer role conflict and role ambiguity.*Dissertation Abstracts International*, *54* (4), 1, 887B.

Cummings, C., Lee. H., MacGregor, T., Davey, M., Wong, C., Paul, L., & et al. (2008). Factors contributing to nursing leadership" a systematic review. *Journal of Health Services Research & Policy, 13*(4), 240-248.

Cummings, G. G. (2004) Investing relational energy: The hallmark of resonant leadership. *Canadian Journal of Nursing Leadership. 17*(4), 76-87

Cummings, G. G. (2006). Hospital restructuring and nursing leadership: a journey from research question to research program. *Nursing Administration Quarterly, 30*(4)*,* 321-329.

Cummings, G. G., MacGregor, T., Davey, M., Lee, H., Wong, C. A., Lo, E., et al. (2010). Leadership styles and outcome patterns for the nursing workforce and work environment: a systematic review. *International Journal of Nursing Studies, 47*(4)*,* 363-385.

Cummings, G., & Estabrooks, C. (2003). The effects of hospital restructuring that included layoffs on individual nurses who remained employed: A systematic review of impact. *International Journal of Sociology* and Policy. 23(8/9), 8-53.

Cummings, G., & McLennan, M. (2005). Advanced practice nursing. Leadership to effect policy change. *Journal of Nursing* Administration, *35*(2), 61- 66.

Cummings, G., Hayduk, L., &Estabrooks, C. (2005). Mitigating the impact of hospital restructuring on nurses: the responsibility of emotionally intelligent leadership. *Nursing Research, 2*(54) 2-12.

Cummings,G.G, Olson, K., Hayduk, L., Bakker, D., Fitch, M., Green, E. (2008). The relationship between nursing leadership and nurses' job satisfaction in Canadian oncology work environments. *Journal of Nursing Management, 16*(5), 508-518.

Cunningham, G., & Kitson, A. (2000a). An evaluation of RCN clinical leadership development programme (part 1). *Nursing Standard*, *15*(12), 34-37.

Cunningham, G., & Kitson, A. (2000b). An evaluation of RCN clinical leadership development programme (part 2). *Nursing Standard*, *15*(13-15), 34-40.

Daly, B., Douglas, S., & Kelley, C. (2005).Benefits and challenges of developing a program of research.*Western Journal of Nursing Research*, *27*(3), 364-377.

Davenport, T., DeLong, D., & Beers, M. (1998). Successful knowledge management projects.*Sloan Management Review*, *39*(2), 43-57.

Davidson, P. M., Elliott, D., & Daly, J. (2006). Clinical leadership in contemporary clinical practice: implications for nursing in Australia. *Journal of Nursing Management, 14*(3)*,* 180-187.

December 31, 1998. Retrieved on February 22, 2005 from: http://www.nursingworld.org/ojin/topic8/topic8_1.htm

Definitions of Fairness. Retrieved June 2, 2005, from: http://www.google.ca/search?hl=en&lr=&oi=defmore&q=define:fairness www.cogsci.princeton.edu/cgi-bin/webwn

DeLong, D., & Fahey, L. (2000). Diagnosing cultural barriers to knowledge management. *Academy of Management Executive*, *14*(4), 113-127.

Dempster, J. (1991). *Dempster practice behaviours scale. Instrumentation for measurement of autonomy*. Los Angeles, CA: American Nurses Council of Nurse Researchers Meeting, 1991 Proceedings.

Devine, G., & Turnbull, L. (2002). *Nurses' definitions of respect and autonomy in the workplace: Summary of focus groups with Canadian nurses*. Retrieved May 4, 2005 from: www.hc-sc.gc.ca/english/for-you/nursing/cnac/report/appendixC.htm

Dickson, G. (2008). *Genesis of the leaders for life framework*. Victoria, BC: Leaders for Life (HCLABC).

Dirks, K., &Ferrin, D. (2002). Trust in leadership: Meta-analytic findings and implications for organizational research. *Journal of Applied Psychology, 87*, 611-628.

Disch, J., Walton, M., &Barnsteiner, J. (2001).The role of the clinical nurse specialist in creating a healthy work environment.*AACN Clinical Issues*, *12*(3), 345-355.

Disch, J., Dreher, M., Davidson, P., Sinioris, M., & Waino, J. (2011). The role of the chief nursing officer in ensuring patient safety and quality. *Journal of Nursing Administration, 41* (4), 179-185.

Donaldson, N., & Rutledge, D. (1998). Expediting the harvest and transfer of knowledge for practice in nursing: Catalyst for a journal. *The Online Journal of Clinical Innovations, 1*(2), 1-25.

Donner, G. & Wheeler, M. (2009). *Coaching in Nursing: An introduction*. International Council of Nurses and The Honor Society of Nursing, Sigma Theta Tau International.

Doran, D., Koh, M., Dick, A.,Heys, L.,VanWirchen,C., Yim,O. (2012). *Leading practices and programs for developing leadership among health care professionals at the point-of-care.Final Report for MOHLTC.*Retrieved from Nursing Health Services Research Unit: http://www.nhsru.com/wp-content/uploads/FINAL-for-Website_No-Appendix_Developing-Leadership-at-the-Point-of-care-Report_March2012.pdf

Dreachslin, J. (2002). Communication: Bridging the racial and ethnic divide in health care management. *Health Care Manager*, *20*(4), 10-18.

Drucker, P. (1990). *Managing the non-profit organization. Principles and practices*. New York: Harper Collins Publishers.

Dubuc, L. (1995). Job empowerment and commitment in military nursing: An extension study. (Master's thesis, University of Western Ontario).

Duffield, C., Roche, M., O'Brien-Pallas, L., Catling-Paull, C., & King, M. (2009).Staff satisfaction and retention and the role of the nursing unit manager.*Collegian: Journal of the Royal College of Nursing, Australia, 16*(1)*,* 11-17.

Dugan, J., Lauer, E., Bouquot, Z., Dutro, B., Smith, M., &Widmeyer, G. (1996). Stressful nurses: The effect on patient outcomes. *Journal of Nursing Care Quality, 10*(3), 46–58.

Dunham, J., & Fisher, E. (1990). Nurse executive profile of excellent nursing leadership.*Nursing Administration Quarterly*, *15*(1), 1-5.

Dunham-Taylor, J. (1995). Identifying the best in nurse executive leadership, Part 2, interview results. *Journal of Nursing Administration*, *25*(7), 24-31.

Dunleavy, J., Shamian, J., Thomson, D. (2003). Workplace pressures: Handcuffed by cutbacks. *Canadian Nurse, 99*(3), 23-26.

Duxbury, L., & Higgins, C. (2003). *Work-life conflict in Canada in the new millennium.A status report*. Retrieved February 15, 2006 from http://www.phac-aspc.gc.ca/publicat/work-travail/report2/index.html

Duxbury, M., Henly, G., & Armstrong, G. (1982).Measurement of the nurse organizational climate of neonatal intensive care units.*Nursing Research*, *32*(2), 83-88.

Ekvall, G., Arvonen, J., &Waldenstrom-Lindbald, I. (1983). *Creative organizational climate, construction and validation of a measuring instrument*. Stockholm: Fa-institute.

Emmerling, R., &Goleman, D. (2003). (October*). Emotional intelligence issues and common misunderstandings*. Retrieved June 8, 2005 from: http://eqi.org/gole3.htm

Englebart, S. (1993).The relationship of nurse manager behaviours and characteristics to subordinates' perceptions of the work unit climate. (Doctoral dissertation, Virginia Commonwealth University)

Erickson, J., Hamilton, G., Jones, D., &Ditomassi, M. (2003). The value of collaborative governance/staff empowerment.*Journal of Nursing Administration*, *33*(2), 96-104.

Erickson, M., Duffy, M., Gibbons, P., Fitzmaurice, J., Ditomassi, M., & Jones, D. (2004). Development and psychometric evaluation of the Professional Practice Environment (PPE) scale. *Journal of Nursing Scholarship*, *36*(3), 279-285.

Eriksen, L. (1988). Satisfaction with nursing care questionnaire. (Revised). Retrieved June 1, 2005 from: http://www.sph.uth.tmc.edu/ eriksen/ASP/instruments.asp?Instruments=Satisfaction+with+Nursing+Care+Questionnaire+%28revised%29

Estabrooks, C., Midodzi, W., Cummings, G., Ricker, K., &Giovannetti, P. (2005). The impact of hospital nursing characteristics on 30-day mortality. Nursing Research, *54*(2), 74-84.

Estabrooks, C., Tourangeau, A., Humphrey, C., Hesketh, K., Giovannetti, P., Thomson, D., et al. (2002). Measuring the hospital practice environment: A Canadian context. *Research in Nursing & Health*, *25*(4), 256-68.

Evans, J. (1992). *A preliminary study to develop an instrument to measure head-nurse self-efficacy*. Abstract from 5th national conference on Nursing Administration Research.

Farley, M. (1989). Assessing communication in organizations. *Journal of Nursing Administration*, *19*(12), 27-31.

Fenton, M. (1988). Moral distress in clinical practice: Implications for the nurse administrator. *Canadian Journal of Nursing Leadership*, *1*, 8-11.

Ferguson-Paré, M. (1998). Nursing leadership and autonomous professional practice of Registered Nurses. *Canadian Journal of Nursing Administration*, *11*(2), 7-30.

Ferguson-Paré, M., Mitchell, G., Perkin, K., & Stevenson, L. (2002).Academy of Canadian Executive Nurses (ACEN) background paper on leadership. *Canadian Journal of Nursing Leadership, 15*(3), 4-8.

Field, M., &Lohr, K. (1990).*Guidelines for clinical practice: Directions for a new program*. Washington, DC: Institute of Medicine, National Academy Press.

First Ministers' Meeting on the Future of Health Care (2004). Retrieved from Nov 2004 – June 2005: http://www.hc-sc.gc.ca/english/hca2003/fmm/index.html

Fletcher, C. (2001). Hospital RNs' job satisfaction and dissatisfactions.*Journal of Nursing Administration, 31*(6), 324-31.

Foley, R., &Wurmser, TA. (2004). Culture Diversity/A Mobile Workforce Command Creative Leadership, New Partnerships, and Innovative Approaches to Integration. *Nursing Administration Quarterly*, *28*(2), 122-128.

Fox, R., Fox, D., & Wells, P. (1999). Performance of first-line management functions on productivity of hospital unit personnel. *Journal of Nursing Administration*, *29*(9), 12-18.

Garvin, D. (1993). Building a learning organization. *Harvard Business Review*, (4), 78-91.

Gasper, J. (1992).Transformational Leadership: An integrative review of the literature. (Doctoral dissertation, Western Michigan University).

Gaudine, A., & Beaton, M. (2002). Employed to go against one's values: Nurse managers' accounts of ethical conflict with their organizations. *Canadian Journal of Nursing Research*, *34*(2), 17-34.

Gelinas, L., &Manthey, M, (1997). The impact of organizational redesign on nurse executive leadership.*Journal of Nursing Administration*, 27(10), 35-42.

George, V., Burke, L., Rodgers, B., Duthie, N., Hoffmann, M., Koceja, V., et al. (2002). Developing staff nurse shared leadership behaviour in professional nursing practice. *Nursing Administration Quarterly*, *26*(3), 44-59

Giber, D., Carter, L., & Goldsmith, M. (2000).*Best practices in leadership development handbook*. San Francisco, CA: Jossey-Bass.

Gifford W.A., Davies, B., Edwards, N., Griffin, P., Lybanon, V. (2007). Managerial leadership for nurses' use of research evidence: An integrative review of the literature. *Worldviews on Evidence-Based Nursing, 4*(3),126-145

Gifford, B., Zammuto, R., & Goodman, E. (2002). The relationship between hospital unit culture and nurses' quality of work life. *Journal of Healthcare Management*, *47*(1), 13-25.

Gifford, W.A., Davies, B., Graham, I.D., Lefebre, N., Tourangeau, A.E., Woodend, K. (2008). A mixed methods pilot study with a cluster randomized control trial to evaluate the impact of a leadership intervention on guideline implementation in home care nursing. *Implementation Science, 3*, 1-10

Gifford, W.A., Davies, B., Tourangeau, A.E., Lefebre, N. (2011). Developing team leadership to facilitate guideline utilization: Planning and evaluating a three month intervention strategy. *Journal of Nursing Management, 19*(1), 121-132

Gifford, W.A., Davies, B.L., Tourangeau, A.E., Woodend, K., Lefebre, N. (2013). Developing Leadership Capacity for Guideline Use: A Pilot Cluster Randomized Control Trial. *Worldviews on Evidence-Based Nursing, 10*(1), 51-65.

Gil, F., Rico, R., Alcover, C. M., Barrasa, A. (2005). Change-oriented leadership, satisfaction and performance in work groups: Effects of team climate and group potency. *Journal of Managerial Psychology*, *20*(3/4), 312-328.

Gillert, A., &Chuzischvili, G. (2004) Dealing with Diversity; A Matter of Beliefs. *Industrial and Commercial Training*, *36*(40), 166-170.

Gillespie, A. & Mann, L. (2004) Transformational leadership and shared values: The building blocks of trust. *Journal of Managerial Psychology*, *19*(6), 588-607.

Gittell, J. (2001). Supervisory span, relational coordination and flight departure performance: A reassessment of postbureaucracy theory. *Organization Science*, *12*, 468–483.

Glasgow, R.E., Klesges, L.M., Dzewaltowski, D.A., Bull, S.S., &Estabrooks, P. (2004). The future of health behavior change research: What is needed to improve translation of research into health promotion practice? *Annals of Behavioral* Medicine, *27*(1), 3-12.

Goddard, M., &Laschinger, H. (1997).Nurse managers' perceptions of power and opportunity.*Canadian Journal of Nursing Administration*, *10*(2), 40-66.

Gokenbach, V. (2004).The effects of an empowerment model intervention on registered nurse turnover and absenteeism. (Doctoral dissertation, University of Phoenix).

Goldhaber, G., & Rogers, D. (1979). *Auditing organizational communication systems: The ICA communication audit*. Dubuque, IA: Kendall/Hunt.

Goleman, D. (1998). *Working with emotional intelligence*. New York: Bantam Books.

Goleman, D., Boyatzis, R., & McKee, A. (2002). *The New Leaders: Transforming the Art of Leadership Into the Science of Results.* London, England: Little, Brown.

Goleman, D., Boyatzis, R., & McKee. (2002). *Primal leadership: Recognizing the power of emotional intelligence*. Boston, MA: Harvard Business School Press.

Goodman, P. (2001). *Missing organizational linkages: Tools for cross-level organizational research.* Thousand Oaks, CA: Sage Publications.

Government of Quebec. (1994). *An Act respecting health services and social services.R.S.Q., chapter S-4.2.*(Updated to 5 July 1994. Last amendment 17 June, 1994).

Govers, M. (1997). Workplace empowerment and job performance in ambulatory care.(Master's thesis, University of Western Ontario).

Greenberg, L. (1996). *Allowing and accepting emotional experience*. In: Kavanaugh, R., Zimmerberg, B., Fein, S. (Eds.*), Emotion: Interdisciplinary perspectives*. pp. 315-336. Mahwah, NJ: Erlbaum.

Griffin, P., El-Jardali, F., Tucker, D., Grinspun, D., Bajnok, I., & Shamian, J. (2008). *A comprehensive conceptual model for healthy work environments for nurses.* [Slide presentation]. Toronto: Registered Nurses' Association of Ontario.

Griffiths, P., Renz, A., Hughes, J., & Rafferty, A. M. (2009). Impact of organisation and management factors on infection control in hospitals: a scoping review. *Journal of Hospital Infection, 73*(1)*,* 1-14.

Grinspun, D. (2000). Taking care of the bottom line: Shifting paradigms in hospital management. In D.L. Gustafson (Ed.), *Care and consequences.* Halifax, NS: Fernwood Publishing.

Grinspun, D. (2010). The Social Construction of Nursing Caring. (Doctoral Dissertation, York University).

Grossman, J., & Mackenzie ,F.J. (2005). The randomized controlled trial: gold standard, or merely standard? *Perspectives in biology and medicine, 48*(4), 516-534.

Gullo, S.R., & Gerstle, D.S. (2004). Transformational leadership and hospital restructuring: a descriptive study. *Policy, Politics, & Nursing Practice*, *11*(5) 259-66.

Haines, J. (1993). *Leading in a time of change. The challenge for the nursing profession – A discussion paper*. Ottawa, ON: Canadian Nurses Association.

Hanna, L. (1999). Lead the way, leader. *Nursing Management*, *30*(11), 36-39.

Hansen, M., Nohria, N., & Tierney, T. (1999). What's your strategy for managing Knowledge? *Harvard Business Review*, *77*(2), 106-116.

Harrison, R. (1992). *Diagnosing organizational culture*. New York: Pfeiffer.

Harvard Business Review. (2001). *Managing Diversity*. Harvard Business School Press.

Hatcher, S. (1993).The relationship between power perceptions of nurse managers and burnout: A test of Kanter's theory of structural power. (Unpublished Masters thesis, University of Western Ontario).

Hatcher, S., & Laschinger, H. (1996). Staff nurses' perceptions of job empowerment and level of burnout: A test of Kanter's theory of structural power in organizations. *Canadian Journal of Nursing Administration*, *9*(2), 74-94.

Havens, D., & Vasey, J. (2003). Measuring staff nurse decisional involvement: decisional involvement scale. *Journal of Nursing Administration*, *33*(6), 331-336.

Health Canada 2003 First Ministers' Accord on Health Care Renewal. Retrieved May 5, 2005 from: www.healthservices.gov.bc.ca/bchealthcare/publications/health_accord.pdf

Health Canada. *Office of Nursing Policy*. Retrieved October 6, 2005 from: http://www.hc-sc.gc.ca/ahc-asc/branch-dirgen/hpb-dgps/onp-bpsi/index_e.html

Hechanova-Alampay, R., & Beehr., T. (2001). Empowerment, span of control, and safety performance in work teams after workforce reduction. *Journal of Occupational Health Psychology*, *6*(4), 275–282.

Heeley, F. (1998). Leading with integrity: How to balance conflicting values. *Health Progress*, *79*(5), 60-62.

Heifetz, R., & Laurie, D. (2001). The work of leadership.*Harvard Business Review*, (2), 106-117.

Heller, F. (2003). Participation and power: A critical assessment. *Applied Psychology: An International Review*, *52*, 144-163.

Hemman E. (2000). Leadership profiles of senior nurse executives *Canadian Journal of Nursing Leadership*, *13*(1), 21-30.

Henderson, A. (2003). Nurses and workplace violence: Nurses' experience of verbal and physical abuse at work. *Canadian Journal of Nursing Leadership*, 16(4), 82-98.

Herbert, R., & Edgar, L. (2004). Emotional intelligence: A primal dimension of nursing leadership? *Canadian Journal of Nursing Leadership*, *17*(4), 56-63.

Herold, D. M., Fedor, D. B., Caldwell, S., & Liu, Y. (2008). The effects of transformational and change leadership on employees' commitment to a change: a multilevel study. *Journal of Applied Psychology, 93*(2)*,* 346-357.

Hersey, P., & Blanchard, K. (1988). *Management of organizational behaviour: Utilizing human resources*. (5th ed.). Englewood Cliffs, NJ: Prentice-Hall.

Hinshaw, A. (1986). *Socialization and resocialization of nurses for professional nursing practice*. In: Hein, E.C., Nicholson. M.E. (Eds.), *Contemporary leadership behaviour: Selected readings*, 2nd ed. Boston: MA: Little, Brown.

Hinshaw, A., & Atwood, J. (1980). Anticipated turnover study: A pilot stage Instrument. (Abstract). *Communicating Nursing Research*, *12,* 56-56.

Hinshaw, A., & Atwood, J. (1983-1985). *Anticipated turnover among nursing staff study*. Final report pp.292-305). DHHS Division of Nursing Grant No. 1 ROl NU00908, U. S. Department of Health and Human Services, Division of Nursing, Rockville, MD.

Hood, J., & Smith, H. (1994). Quality of work life in home care: The contribution of leaders' personal concern for staff. *Journal of Nursing Administration*, 24(1), 40-47.

Houghton Mifflin Company. (1995). Identity.*Roget's II: The New Thesaurus*. 3rd ed. Retrieved June 6, 2005 from: Answers.com: http://www.answers.com/main/ntquery?tname=identity&print=true

Houghton Mifflin Company. (2004). Identity.*The American heritage dictionary of the English language*. 4th ed. Retrieved June 6, 2005 from: Answers.com: http://www.answers.com/main/ntquery?tname=identity&print=true

Howard, A. (1997). *The empowering leader: Unrealized opportunities*. In: *The Balance of Leadership and Followership Working Papers*, Baltimore, MD: Academy of Leadership Press.

Huber, D., Maas, M., McCloskey, J., Scherb, C., Goode, C., & Watson, C. (2000). Evaluating nursing administration instruments. *Journal of Nursing Administration*, *30*(5), 251-272.

Huffman, J. (1995). *Staff nurses' perceptions of work empowerment and control over nursing practice in community hospital settings*. (Master's thesis, University of Western Ontario).

Hui, C. (1994). Effects of leader empowerment behaviours and follower's personal control, voice and self-efficacy on inrole and extra-role performance.An extension of Conger and Kanungo's empowerment process model. (Doctoral dissertation, Indiana University)

Hurst, J. (1996). Building hospital TQM teams: Effective polarity analysis and maximization. *The Health Care Supervisor*, *15*(1), 68-75.

Huy, Q. (2002). Emotional balancing of organizational continuity and radical change: The contribution of middle managers. *Administrative Science Quarterly*, *47,* 31-69.

Ingersoll, G., Fisher, Ross, B., Soja, M., & Kidd, N. (2001). Employee response to major organizational redesign. *Applied Nursing Research, 14*(1), 18-28.

Institute of Medicine of the National Academies [IOM], Board on Health Care Services. (2004). *Keeping patients safe: Transforming the work environment of nurses.* Washington, DC: National Academy Press.

Institute of Medicine of the National Academies [IOM]. (2010). *The Future of Nursing: Leading Change, Advancing Health.*Washington, DC: National Academy Press.

Irvine, D., & Evans, M. (1992). Job satisfaction and turnover among nurses: A review and meta-analysis. *Quality of Nursing Worklife Research Unit Monograph Series*. Toronto, Canada.

Jameton, A. (1984). *Nursing practice: The ethical issues*. Englewoood Cliffs, NJ: Prentice Hall, Inc.

Jeans, M., &Rowat, K. (2005).*Competencies required of nurse managers: Identifying the skills, personal attributes and knowledge required of nurse managers, and the enablers and barriers for nurse managers to acquire and sustain these competencies. The pulse of renewal: A focus on nursing human resources. May, 2005. Special report*. Toronto, ON: Canadian Journal of Nursing Leadership.

Jeffs, L., MacMillan, K., McKey, C., & Ferris, E. (2009). Nursing leaders' accountability to narrow the safety chasm: insights and implications from the collective evidence base on healthcare safety. *Canadian Journal of Nursing Leadership, 22*(1), 86-98.

Johnson, B. (1996). *Polarity management: Identifying and managing unsolvable problems.* Amherst, MA: HRD.

Johnson, D., & Johnson, R. (1995). *Social interdependence, cooperative learning in education*. In: B.B. Bunker and J.Z. Rubin (Eds.), *Conflict, cooperation and justice.* San Francisco, CA: Jossey-Bass.

Joint Commission on Accreditation of Healthcare Organizations[*JCAHO*].*JCAHO Standards and Reference Crosswalk Contents*. Retrieved June 2, 2005 from: http://www.wramc.army.mil/JCAHO/Division.cfm?d_Id=13

Jones, K. (2005). Leading an empowered organization (LEO): does it work?. [Review] *British Journal of Community Nursing*,*10*, 92-6.

Jones, L., Soeken, K., &Guberski, T. (1986). Development of an instrument to measure self-reported leadership behaviours of nurse practitioners. *Journal of Professional Nursing*, *3*, 180-185.

Joni, S. (2004). The geography of trust.*Harvard Business Review*, *82*, 83-88

Judkins, S.K. (2004). Stress among nurse managers: can anything help? *Nurse Researcher*, *12*, 58-70.

Kanter, R (1979). Power failure in management circuits. *Harvard Business Review*, *57*(4), 65-75.

Kanter, R. (1993). *Men and women of the corporation* .2nd ed. New York: Basic Books.

Kanter, R. (1999). The enduring skills of change leaders.*Leader to Leader*, *13*(3). Retrieved April 29, 2004 from: http:www.pfdf.org/leaderbooks/121summer99/kanter.html

Kanungo, R. (1982). Measurement of job and work involvement.*Journal of Applied Psychology*, *67*, 341-349.

Katz, R. (1982). The effects of group longevity on project communication and performance. *Administrative Science Quarterly*, *27*, 81-104.

Katzman, E., (1989). Nurses' and physicians' perceptions of nursing authority.*Journal of Professional Nursing*, *5*(4), 208-214.

Kemerer, R. (2003). *Leadership: What works in the real health care world*. Healthcare Papers, *4*(1), 37-38.

Kilty, H. (2003). *Nursing leadership development in Canada. A descriptive status report and analysis of leadership programs, approaches and strategies: Domains and competencies; knowledge and skills; gaps and opportunities.* Ottawa, ON: Canadian Nurses Association.

King, T. (2000). Paradigms of Canadian nurse managers: Lenses for viewing leadership and management. *Canadian Journal of Nursing Leadership*, *12*(1), 15-20.

Kitson, A., Harvey, G., & McCormack, B. (1998). Enabling the implementation of evidence-based practice: A conceptual framework. *Quality in Health Care*, *7*(3), 149-158.

Knox, S., & Irving, J. (1997b). Nurse manager perceptions of health care executive behaviours during organizational change. *Journal of Nursing Administration*, *27*(11), 33-39.

Knox, S., & Irving, J., (1997a). An interactive quality of work life model applied to organizational transition. *Journal of Nursing Administration*, *27*(1), 39-47.

Kofman, R. (1994). Check-in, check-out: A tool for real conversations. *The Systems Thinker*, *5*(4), 8-9.

Kotter, J. P. (1996). *Leading change*. Boston: Harvard Business School Press.

Kouzes, J., & Posner, B. (1988). *The Leadership Practices Inventory*. San Diego, CA: Pfeiffer.

Kouzes, J., & Posner, B. (1995). *The leadership challenge. How to keep getting extraordinary things done in organizations.*San Francisco, CA: Jossey-Bass.

Kovner, A., Elton, J., & Billings, J. (2000). Transforming health management: An evidence-based approach. *Frontiers of Health Services Management*, *16*(4), 3-24.

Kovner, C., &Gergen, P. (1998). Nurse staffing levels and adverse events following surgery in US hospitals. *Image: Journal of Nursing Scholarship, 30*(4), 315-321.

Kramer, M., & Schmalenberg, C. (2003). Magnet hospital staff nurses describe clinical autonomy. *Nursing Outlook*, *51*, 13-19.

Kramer, M, Schmalenberg, C., & Maguire, P. (2004). Essentials of a magnetic work environment: part 3. *Nursing*, *8*(34) 44-7.

Kramer, M., & Schmalenberg, C. (1988). Magnet hospitals – Part I: Institutions of excellence. *Journal of Nursing Administration, 18(1), 13-24.*

Kramer, M., & Schmalenberg, C. (1988). Magnet hospitals – Part II: Institutions of excellence. *Journal of Nursing Administration*,*18(2), 1-11.*

Kramer, M., & Schmalenberg, C. (2002).*Staff nurses identify essentials of magnetism*. In: McClure, M., Hinshaw. A. (Eds.), *Magnet hospitals revisited: Attraction and retention of professional nurses*. Washington, DC: American Nurses Publishing.

Krecji, J. (1999). Changing roles in nursing: Perceptions of nurse administrators. *Journal of Nursing Administration*, *29*(3), 21-29.

Kroposki, M., Murdaugh, C., Tavakoli, A., & Parsons, M. (1999).Role clarity, organizational commitment and job satisfaction during hospital reengineering.*Nursing Connections*, *12*(1), 27-34.

Krugman, M. & Smith, V. (2003). Charge nurse leadership development and evaluation. *Journal of nurse in staff development, 33*(5), 284 -292.

Krugman, M. (1989). *An investigation of the relationship between nurse executive socialization and occupational image*. Doctoral dissertation. University of Denver.

Lageson C. (2004). Quality focus of the first line nurse manager and relationship to unit outcomes.*Journal of Nursing Care Quality*, *4*(19) 336-42

Lageson, C. (2001). First line nurse manager and quality: Relationship between selected role functions and unit outcomes. (Doctoral dissertation, University of Wisconsin-Milwaukee)

Lake, E. (2002). Development of the Practice Environment Scale of the Nursing Work Index.*Research in Nursing and Health*, *25*(3), 176-188.

Lambert, V., & Nugent, K.E. (1999). Leadership Style for facilitating the Integration of Culturally Appropriate Health Care.*Seminars for Nurse Managers*, *7*(4), 172-178.

Laschinger, H. (1996). A theoretical approach to studying work empowerment in nursing: A review of studies testing Kanter's theory of structural power in organizations. *Nursing Administration Quarterly*, *20*(2), 25-41.

Laschinger, H. (2004). Hospital nurses' perceptions of respect and organizational justice. *Journal of Nursing Administration*, *34*(7/8), 354-364.

Laschinger, H. (2004). *Scoring of nursing work empowerment scales.* Retrieved June 2, 2005 from: http://publish.uwo.ca/~hkl/scoring.html

Laschinger, H., & Havens, D. (1996). Staff nurse work empowerment and perceived control over nursing practice. Conditions for work effectiveness. *Journal of Nursing Administration*, *26*(9), 27-35.

Laschinger, H., & Havens, D. (1997). The effect of workplace empowerment on staff nurses' occupational mental health and work effectiveness. *Journal of Nursing Administration*, *27*(6), 42-50.

Laschinger, H., & Shamian, J. (1994). Staff nurses' and nurse managers' perceptions of job related empowerment and managerial self efficacy. *Journal of Nursing Administration*, *24*(10), 38-47.

Laschinger, H., Almost, J., & Tuer-Hodes, D. (2003). Workplace empowerment and magnet hospital characteristics. *Journal of Nursing Administration*, *33*(7/8), 410-422.

Laschinger, H., Almost, J., Purdy, N., & Kim, J. (2004). Predictors of nurse managers' health in Canadian restructured health care settings. *Canadian Journal of Nursing Leadership*, *17*(4), 88-105.

Laschinger, H. et al. (2013). Part 1: The influence of personal and situational predictors on nurses' aspirations to management roles: Preliminary findings of a national survey of Canadian nurses. *Journal of Nursing Management, 21*, 217-230.

Laschinger, H., Finegan, J., & Shamian, J. (2001a). Promoting nurses' health: Effect of empowerment on job strain and work satisfaction. *Nursing Economic$*, *19*(2), 42-52.

Laschinger, H., Finegan, J., & Shamian, J. (2001b). The impact of workplace empowerment, organizational trust on staff nurses' work satisfaction and organizational commitment.*Health Care Management Review*, *26*(3), 7-23.

Laschinger, H., Finegan, J., Shamian, J., & Casier, S. (2000). Organizational trust and empowerment in restructured health care settings: Effects on staff nurse commitment. *Journal of Nursing Administration*, *30*(9), 413-425.

Laschinger, H., Finegan, J., Shamian, J., & Wilk, P. (2000). Impact of structural and psychological empowerment on job strain in nursing work settings: Expanding Kanter's model. *Journal of Nursing Administration*, *31*(5), 260-272.

Laschinger, H., Sabiston, J., & Kutszcher, L. (1997). Empowerment and staff nurse decision involvement in nursing work environments: Testing Kanter's theory of structural power in organizations. *Research in Nursing & Health*, *20*, 341-352.

Laschinger, H. & Wong, C. (2007). *A profile of the structure and impact of nursing management in Canadian hospitals.* Final report for CHSRF Open Grants Competition Project #RC1-0964-06. Unpublished report.

Laschinger, H., Wong, C., McMahon, C., & Kaufmann, C. (1999). Leader behaviour impact on staff nurse empowerment, job tension and work effectiveness. *Journal of Nursing Administration*, *29*(5), 28-39.

Laschinger, H.K., Wong, C.A., Grau, A.L., Read, E.A., PineauStam, L.M. (2012). The influence of leadership practices and empowerment on Canadian nurse manager outcomes. *Journal of Nursing Management, 20*(7), 877-888.

Laschinger, H.K.S., Shamian, J., & Thomson, D. (2001). Impact of magnet hospital characteristics on nurses' perceptions of trust, burnout, quality of care and work satisfaction. *Nursing Economic$, 19*, 209-219.

Laschinger, H.K.S., Wong, C. (2007). *A profile of the structure and impact of nursing management in Canadian hospitals.* Ottawa: Canadian Health Services Research Foundation.

Leach, L.S. (2005). Nurse executive transformational leadership and organizational commitment. *Journal of Nursing Administration*, *35*, 228-37.

Leana, C., & VanBuren, H. (1999). Organizational social capital and employment practices.*Academy of Management Review*, *24*, 538-555.

Leatt, P. & Porter, J. (2003).Where are the healthcare leaders" the need for investment in leadership development. *Healthcare Papers, 4*(1), 14-31.

Lee, H., Spiers, J. A., Yurtseven, O., Cummings, G. G., Sharlow, J., Bhatti, A., et al. (2010). Impact of leadership development on emotional health in healthcare managers.*Journal of Nursing Management,18*(8), 1027-1039.

Leger Marketing. (2003). *How Canadians perceive various professions*. Retrieved June 8, 2005 from: www.rnantnu.ca/news/trusted_pros.pdf

Lemire Rodger, G. (2005). *Leadership challenges and directions*. In: Hibberd, J.M., Smith, D.L. (Eds.), *Nursing leadership and management in Canada,* 3rd Ed. Toronto, ON: Elsevier Canada.

Levasseur, R. (2004). The impact of a transforming leadership style on follower performance and satisfaction: A meta-analysis. (Doctoral dissertation, Walden University).

Lewicki, R., & Bunker, B. (1996). *Developing and maintaining trust in work relationships*. In Kramer, R.N., Tyler T.R. (Eds.), *Trust in organizations: Frontiers in theory and research*, pp. 114-139. Thousand Oaks, CA: Sage.

Lindholm, M., Dejin-Karlsson, P., Östergren, P.O., &Udén, G. (2003). Nurse managers' professional networks, psychosocial resources and self-rated health. *Journal of Advanced Nursing*, *42*(5), 506-515.

Litwin, G., & Stringer, R. (1968). *Motivation and organizational climate*, 2nd Ed. Boston, MA: Division of Research, Harvard University.

Long, J. (2004).*Factors that influence nurse attrition: An analysis of the relationship between supervisor leadership style and subordinate job satisfaction*. (Doctoral dissertation, Capella University).

Lowe, G. (2004a*). Thriving on healthy: Reaping the benefits in our workplaces.* Keynote presentation at the RNAO 4th Annual International Conference – Healthy Workplaces in Action 2004: Thriving in Challenge. 17 November 2004, Markham, ON

Lowe, G. (2004b). *Healthy workplace strategies: Creating change and achieving results*. Prepared for the Health Strategies Bureau, Health Canada. Graham Lowe Group Inc.

Lundstrom, T., Pugliese, G., Bartley, J., Cos, J., &Guither, C. (2002).Organizational and environmental factors that affect worker health and safety and patient outcomes.*American Journal of Infection Control, 30*(2), 93-106.

Maas, M., &Jacox, A. (1977).*Guidelines for nurse autonomy/patient welfare*. New York: Appleton-Century Crofts.

MacLeod, H. (2011). We have a perfect storm – Let's use it. *Healthcare Papers, 11* (3), 61-66.

MacLeod, L. (2010). Nursing Leadership: Ten Compelling Reasons for Having a Nurse Leader on the Hospital Board. *Nurse Leader, 8*(5), 44-47.

MacPhee, M., Bouthillette, F. (2008). Developing leadership in nurse managers: the British Columbia Nursing Leadership Institute. *Nursing Leadership, 21*(3), 64-75.

Macy, B., Peterson, M., & Norton, L. (1989). A test of participation theory in a work redesign field setting: Degree of participation and comparison site contrasts. *Human Relations*, *42*, 1095-1165.

Madison, J. (1994). The value of mentoring in nursing leadership: A descriptive study. *Nursing Forum, 29*(4), 16-23.

Maehr, J., & Braskamp, L. (1986). *The motivation factor: A theory of personal investment*. Lexington, MA: Lexington Books.

Manojlovich, M. &Talsma, A. (2007). Identifying nursing processes to reduce failure to rescue. *Journal of Nursing Administration, 27*(11), 504 -509.

Manojlovich, M. (2005). A leadership strategy to improve practice.*Journal of Nursing Administration*, *35*(5), 271-278.

Marville-Williams, C. (2007). Understanding the ideal inpatient unit environment where professional teams and employees provide patient-centred care. (Master's Thesis, Royal Roads University).

Maslach, C., & Jackson, S. (1986). *Maslach Burnout Inventory manual*. 3rd Ed.Palo Alto, CA: Consulting Psychologists Press.

Maslove, L. & Fooks, C. (2004). *Our health, our future: Creating quality workplaces for Canadian nurses – A progress report on implementing the final report of the Canadian Nursing Advisory Committee*. Ottawa, ON: Canadian Policy Research Networks Inc.

Matthews, S., Laschinger, H. K., &Johnstone, L. (2006). Staff nurse empowerment in line and staff organizational structures for chief nurse executives. *Journal of Nursing Administration, 36*(11), 526-533.

May, D., Hodges, T., Chan, A., &Avolio, B. (2003). Developing the moral component of authentic leadership. *Organizational Dynamics*, *32*(3), 247-260.

Mayer, J., &S alovey, P. (1997). *What is emotional intelligence?* In: Salovey, P., Sluyter, D.J. (Eds.), *Emotional development and emotional intelligence: Educational implications*. pp. 3-31. New York: Basic Books.

Mayer, J., Caruso, D., &Salovey, P. (1998). *The Multifactor Emotional Intelligence Scale*. Unpublished report available from the authors.

Mayer, R., & Gavin, M. (1999). *Trust for management and performance: Who minds the shop while the employees watch the boss*? Presented in an interactive paper session at Academy of Management annual meeting, Chicago.

Mayer, R., Davis, J., &Schoorman, F., (1995). An integrative model of organizational trust.*Academy of Management Review*, *20*(3), 709-734.

McBurney, M. (1997). The Relationship between first-line nurse managers' perceptions of job-related empowerment and occupational stress in a large acute care teaching hospital.(Master's thesis, University of Western Ontario).

McClure, M., Poulin, M., Sovie, M., &Wandelt, M. (2002).*Magnet hospitals: Attraction and retention of professional nurses (The Original Study)*. In M. McClure M., Hinshaw, A. (Eds.), *Magnet hospitals revisited.* Washington, DC: American Academy of Nurses.

McCutcheon, A. (2004). *The relationship between span of control, leadership and performance*.(Unpublished doctoral dissertation, University of Toronto).

McDaniel, C., & Wolf, G. (1992). Transformational leadership in nursing service.A test of theory.*Journal of Nursing Administration*, *22*(2), 60-65.

McDermott, K., Laschinger, H., &Shamian, J. (1996). Work empowerment and organizational commitment. *Nursing Management*, *27*(5), 44-49.

McDowell, A. (2004). What strategies will support leaders during rapid change? (Master's thesis, Royal Roads University).

McGillis Hall, L. (Ed.). (2004). *Quality work environments for nurse and patient safety*. Sudbury, MA: Jones and Barlett Publishers.

McGillis Hall, L., McGilton, K., Krejci, J., Pringle, D., Johnston, E., Fairley, L., & et al. (2005). Enhancing the quality of supportive supervisory behaviour in long-term care facilities. *Journal of Nursing Administration, 35(4), 181-187.*

McGilton, K. (2003). Development and psychometric evaluation of supportive leadership scales.*Canadian Journal of Nursing Research*, *35*(4), 72-86.

McGilton, K., McGillis Hall, L., Pringle, D., O'Brien-Pallas, L., &Krejci, J. (2004).*Monograph.* Toronto, ON: University of Toronto Faculty of Nursing and Toronto Rehabilitation Institute.

McKay, C. (1995). Staff nurses' job related power and perceptions of managerial transformational leadership. (Master's thesis, University of Western Ontario).

McKey, C. (2002). Leadership practices, organizational commitment, conditions of work effectiveness of chief nursing officers in Ontario's restructured hospitals. (Doctoral dissertation, Capella University)

McNally, K. & Lukens, R. (2006). Leadership development: An external-internal coaching partnership. *Journal of Nursing Administration, 36* (3), 155-161.

McNeese-Smith, D. (1995). Job satisfaction, productivity and organizational commitment: The result of leadership. *Journal of Nursing Administration*, *25*(9), 17-26.

McNeese-Smith, D. (1997). The influence of manager behaviour on nurses' job satisfaction, productivity, and commitment.*Journal of Nursing Administration*, *27*(9), 47-55.

McPhee, M & Bouthillette, N. (2008).Developing leadership in nurse managers: The British Columbia Nursing Leadership Institute, *Canadian Journal of Nursing Leadership, 21* (3), 64-75.

Medley, F., & Larochelle, D. (1995). Transformational leadership and job satisfaction.*Nursing Management*, *26*(9), 64JJ-LL, 64NN.

Meyer, R., O'Brien-Pallas, L., Doran, D., Streiner, D., Ferguson-Pare, M. & Duffield, C. (2011). Front-line managers as boundary spanners: Effects of span and time on nurse supervision satisfaction. *Journal of Nursing Management, 19*, 611-622.

Michigan Hospitals. *Glossary of Terms*. Retrieved October 4, 2004 from: http://www.michiganhospitalprofiles.org/glossary_of_terms.htm

Mishra, A., &Spreitzer, G. (1998). Explaining how survivors respond to downsizing: The roles of trust, empowerment, justice and work redesign. *Academy of Management Review*, *23*(3), 567-588.

Mohr, W., & Mahon, M. (1996). Dirty hands: The underside of marketplace health care. *Advances in Nursing Science*, *19*(1), 28-37.

Mok, E., & Au-Yeung, B. (2002). Relationship between organizational climate and empowerment of nurses in Hong Kong.*Journal of Nursing Management*, *10*(3), 129-137.

Morgan, J. C., &Konrad, T. R. (2008). A mixed-method evaluation of a workforce development intervention for nursing assistants in nursing homes: The case of WIN a STEP UP. *Gerontologist, 48*(SPEC. ISS. 1), 71-79.

Morrison, R., Jones, L., & Fuller, B. (1997). The relation between leadership style and empowerment on job satisfaction of nurses.*Journal of Nursing Administration*, *27*(5), 27-34.

Moynihan, R. (2004). *Evaluating health services*: *A reporter covers the science of research synthesis.* Millbank Memorial Fund. Retrieved November 22, 2004 from: http://www.milbank.org/reports/2004Moynihan/Moynihan.pdf

Mueller, C., & McCloskey, J. (1990). Nurses' job satisfaction: A proposed measure. *Nursing Research*, *39*(2), 113-117.

Mullen, B., Symons, C., Hu, L., & Salas, E. (1989). Group size, leadership behaviour and subordinate satisfaction.*Journal of General Psychology*, *116*, 155-169.

National Health and Medical Research Council. (1998). *A guide to the development, implementation, and evaluation of clinical practice guidelines*. National Health and Research Council [On-line]. Available: http://www.health.gov.au/nhmrc.publications/pdf/cp30.pdf.

Needleman, J., &Buerhaus, P. (2003). Nurse staffing and patient safety: Current knowledge and implications for action.(editorial). *International Journal for Quality in Health Care, 15*(4), 275-77.

Needleman, J., Buerhaus, P., Mattke, S., Stewart, M., &Zelevinsky, K. (2002).Nurse-staffing levels and the quality of care in hospitals.*New England Journal of Medicine, 346*(22), 1715–1722.

Nespoli, G. (1991). Staff nurse perceptions of a positive relationship with an appointed first-lime manager who is perceived as a leader. (Doctoral dissertation & Adelphi University.

Nicklin, W. (2001). "Thank you" isn't enough. (2001). *Healthcare Management Forum*, *13*(3), 6-9.

Norrish, B., &Rundall, T. (2001). Hospital restructuring and the work of Registered Nurses.*Millbank Quarterly*, *79*(1), 55-79.

Nursing Task Force. (1999). *Good nursing, good health: An investment for the 21st century*. Toronto, ON: Ontario Ministry of Health and Long-Term Care.

O'Brien, L. (1997). The relationship between Registered Nurses' perceptions of job-related empowerment and occupational mental health.A Test of Kanter's theory of organizational behaviour. (Master's thesis, University of Western Ontario).

O'Connor, M., Theol, B., & Chapman, Y. (2008). The palliative care clinical nurse consultant: An essential link. *Collegian, 15,* 151–157.

O'May, F., & Buchan, J. (1999). Shared governance: A literature review. *International Journal of Nursing Studies*, *36*, 281-300.

Oberle, K., &Tenove, S. (2000). Ethical issues in public health nursing. *Nursing Ethics*, *7*(5), 425-438.

O'Neil, E., Morjikian, R. L., Cherner, D., Hirschkorn, C., & West, T. (2008). Developing nursing leaders: an overview of trends and programs. *Journal of Nursing Administration, 38*(4)*,* 178-183.

Ontario Public Health Association. (1996). *Making a Difference! A workshop on the basics of policy change*. Toronto, Canada: Government of Ontario.

Ott, K.M., Haddock, K.S., Fox, S.E., Shinn, J.K., Walters, S.E., Hardin, J.W., et al. (2009). The Clinical Nurse Leader: impact on practice outcomes in the Veterans Health Administration. *Nursing Economic$, 27*(6), 363-367.

Ovretveit J. (2005). Leading improvement. *Journal of Health Organization and Management,19*(6), 413-430

Parsons, M., &Stonestreet, J. (2002).Factors that contribute to nurse manager retention.*Nursing Economic$*, 23(3), 120-126.

Paterson, K., Henderson, A., &Trivella, A. (2010). Educating for leadership: a programme designed to build a responsive health care culture. *Journal of Nursing Management, 18*(1)*,* 78-83.

Patrick, A., & White, P. (2005). Scope of nursing leadership.*In L. McGillis Hall (Ed.), Quality work environments for nurse and patient safety.* Sudbury, MA: Jones and Bartlett Publishers.

Patrick, A., Laschinger, H., Wong, C., & Finegan, J. (2011). Developing and testing a new measure of staff nurse clinical leadership: the clinical leadership survey. *Journal of Nursing Management, 19* (4), 449-460.

Peachy, G. (2002).The effect of leader empowering behaviours on staff nurses' workplace empowerment, psychological empowerment, organizational commitment and absenteeism. (Doctoral dissertation, McMaster University)

Pearson, A., Laschinger, H., Porritt, K., Jordan, Z., Tucker, D., & Long, L. (2004). *A comprehensive systematic review of evidence on developing and sustaining nursing leadership that fosters a healthy work environment in health care.Health Care Reports*. Adelaide, Australia: The Joanna Briggs Institute.

Peck, M. (1988). *Head nurse fit with staff, administration, and situation: Impact on unit performance and staff satisfaction.* (Doctoral dissertation, University of Utah).

Pederson, A. (1993). Qualities of the excellent head nurse. *Nursing Administration Quarterly, 18*(1), 40-50.

Perra, B. (2000).Leadership: The key to quality outcomes. *Nursing Administration Quarterly*, *24(2), 56-61*

Person, S., Allison, J., Kiefe, C., Weaver, M., Williams, O., Centor, R., &Weissman, N. (2004).Nurse staffing and mortality for medicare patients with acute myocardial Infarction.*Medical Care, 42*(1), 4–12.

Peters, T., & Waterman, Jr. R. (1982*).In search of excellence*. New York: Harper & Row.

Pielstick, C. (1998). The transforming leader: A meta-ethnographic analysis. *Community College Review, 26*(3), 15-35.

Pincus, J. (1986). Communication: Key contributor to effectiveness – The research. *Journal of Nursing Administration*, *16*(9), 19-25.

Ploeg, J., de Witt. L., Hutchison, B., Hayward, L., Grayson, K. (2008). Evaluation of a research mentorship program in community care. Evaluation and Program Planning, *31*(1), 22-33.

Porter, L., Steers, R., Mowday, R., &Boulian, P. (1974). Organizational commitment, job satisfaction and turnover among psychiatric technicians. *Journal of Applied Psychology*, *59*(5), 603-609.

Porter-O'Grady, T. (1992).Transformational leadership in an age of chaos. *Nursing Administration Quarterly*, *17(1), 17-24*.

Porter-O'Grady (2011). Future of nursing special: leadership at all levels. *Nursing Management, 42*(45), 32 – 37.

Posner, B., Kouzes, J., & Schmidt, W. (1985). Shared values make a difference: An empirical test of corporate culture. *Human Resources Management, 24*(3), 293-309.

Price, J., & Mueller, C. (1986). *Handbook of organizational measurement*. Marshfield, MA: Pitman.

Public Health Chief Nursing Officer Working Group (August 2011). *Public Health Chief Nursing Officer Working Group Report,* Ontario Ministry of Health and Long Term Care, Author.

Public Hospitals Act (1990). Regulation 965 (amended). Retrieved May 9, 2005 from: http://192.75.156.68/DBLaws/Regs/English/900965_e.htm

Ray, M., Turkel, M., & Marino, F. (2002).The transformation process for nursing in workforce redevelopment.*Nursing Administration Quarterly, 26*(2), 1-14.

Recker, D., Bess, C., &Wellens, H. (1996). A decision-making process in shared governance. *Nursing Management*, *27*(5), 48A-48D.

Redman, R.W. (2006). Leadership succession planning: An evidence-based approach for managing the future. *JONA, 36*(6), 292-297.

Redmond, G. (1995). "We don't make widgets here" voices of chief nurse executives. *Journal of Nursing Administration*, *25*(2), 63-69.

Registered Nurses Association of British Columbia. (2001). *Nursing leadership and quality care.* Vancouver, BC: Author

Registered Nurses Association of Nova Scotia. (2003). *Educational support for competent nursing practice*. Retrieved September 24, 2004 from: http://www.crnns.ca/default.asp?id=190&pagesize=1&sfield=content.id&search=1102&mn=414.70.80.223.320

Registered Nurses Association of Ontario [RNAO]. (2006). *Collaborative Practice Among Nursing Teams*. Toronto, Canada: Registered Nurses Association of Ontario.

Registered Nurses Association of Ontario [RNAO]. (2007). *Embracing Cultural Diversity in Health Care: Developing Cultural Competence*. Toronto, Canada: Registered Nurses Association of Ontario

Registered Nurses Association of Ontario and the Registered Practical Nurses Association of Ontario. (2000). *Ensuring the care will be there – Report on nursing recruitment and retention in Ontario*. Toronto, ON: Author.

Reid, K.B. & Dennison, P. (2011). The Clinical Nurse Leader: Point-of-care Safety Clinician. *The Online Journal Issue of in Nursing, 16*(3), 4.

Renz, D., & Eddy, W. (1996). Organizations, ethics, and health care: Building an ethics infrastructure for a new era. *Bioethics Forum*, *2*, 29-39.

Reyna, S. (1992). Leadership styles of nurse managers and how they affect the motivation level of nursing staff. (Doctoral Dissertation, University of Texas).

Roberts, K., & O'Reilly, C. (1974). Measuring organizational communication. *Journal of Applied Psychology*, *59*(3), 321-326.

Robertson, K. (1991). *Registered Nurses' perceptions of leadership systems of nurse managers and quality of work life conditions and feelings*. (Doctoral dissertation. University of Alabama at Birmingham.

Robinson, C. (2001). Magnet nursing services recognition: Transforming the critical care environment. *AACN Clinical Issues*, *12*(3), 1-18.

Rokeach, M. (1973). *The Nature of human values*. New York: Free Press.

Romanow, R., (2002). *Building on values: The future of health care in Canada*. Ottawa, ON: Government of Canada.

Rosengren, K., Bondas, T., Nordholm, L., & Nordstrom, G. (2010). Nurses' views of shared leadership in ICU: a case study. *Intensive & Critical Care Nursing, 26*(4)*,* 226-233.

Rothmann, S., & Coetzee, S. (2003).*Dispositional characteristics, quality of work life and effectiveness of members of self managing teams.* Poster presented at the 11th European Congress of Work and Organizational Psychology, Lisbon,Portugal, 14-17 May 2003.

Rousseau, D., &Tijorwala, S. (1999). What's a good reason to change? Motivated reasoning and social accounts in promoting organizational change. *Journal of Applied Psychology, 84*(4), 514-528.

Russell, J. E. A., & Adams, D. M. (1997).The changing nature of mentoring in organizations: An introduction to the special issue on mentoring in organizations. *Journal of Vocational Behavior, 51*, 1–14.

Rutledge, D., & Donaldson, N. (1995) Building organizational capacity in research ultilization.*Journal of Nursing Administration.*25(10), 12-6.

Rycroft-Malone, J., Kitson, A., Harvey, G., McCormack, B., Seers, K., Titchen, A., & et al., (2002). Ingredients for change: Revisiting a conceptual framework. *Quality and Safety in Health C*are, 11, 174-180.

Sabo, K., Duff, M. & Purdy, B. (2008). Building leadership capacity through peer career coaching: A case study. *Nursing leadership, 21*(1), 27-35.

Salovey, P., & Mayer, J. (1990). Emotional intelligence. *Imagination, Cognition and Personality, 9,* 185-211.

Sasichay-Akkadechanunt, T., Scalzi, C., &Jawad, A. (2003).The relationship between nurse staffing and patient outcomes. *Journal of Nursing Administration, 23*(9), 478–85.

Schein, E. H. (2004). *Organizational culture and leadership.* San Francisco: John Wiley and Sons.

Schutzenhofer, K. (1988). *Measuring professional autonomy in nurses*. In: Strickland, O.L., Waltz,, C.F. (Eds.), *Measurement of nursing outcomes. Measuring nursing performance: Practice, education and research*. New York: Springer.

Schwirian, P. (1978). Evaluating the performance of nurses: A multidimensional approach. *Nursing Research*, *27*(6), 347-351.

Scott, J., Sochalski, J., & Aiken, L. (1999). Review of magnet hospital research: Findings and implications for professional nursing practice. *Journal of Nursing Administration, 29*(1), 9-19.

Scottish Intercollegiate Guidelines Network [SIGN]. *Levels of evidence and grades of recommendation in:* A guideline developers' handbook. *Retrieved May 7, 2005 from: http://www.sign.ac.uk/guidelines/fulltext/50/section6.html#2*

Sellgren, S. F., Ekvall, G., & Tomson, G. (2008). Leadership behaviour of nurse managers in relation to job satisfaction and work climate. *Journal of Nursing Management, 16*(5)*,* 578-587.

Sellgren, S.F., Kajermo, K.N., Ekvall, G., & Tomson, G. (2009). Nursing staff turnover at a Swedish university hospital: an exploratory study. *Journal of Clinical Nursing, 18*(22), 3181-3189.

Senge, P. M. (1990) *The Fifth Discipline.The art and practice of the learning organization*. London: Random House

Severinsson, E. (1996). Nurse supervisors' views of their supervisory styles in clinical supervision: A hermeneutical approach. *Journal of Nursing Management*, *4*(4), 191-199.

Severinsson, E., & Hallbeerg, I. (1996). Clinical supervisors' views of their leadership role in the clinical supervision process within nursing care. *Journal of Advanced Nursing*, *24*(1), 151-161.

Shea, G. (2001*). Leading change*. In S. Rovin, (Ed.), *Medicine and business: Bridging the gap* (pp.33-52). Gaithersburg, MD: Aspen Publications.

Shindul-Rothschild, J. (1994). Restructuring, redesign, rationing and nurses' morale: A qualitative study of the impact of competitive financing. *Journal of Emergency Nursing, 20*(6), 497-504.

Shipton, H., Armstrong, C., West, M., & Dawson, J. (2008).The impact of leadership and quality climate on hospital performance.*International Journal for Quality in Health Care, 20*(6)*,* 439-445.

Shirey, M. (2004). Social support in the workplace: Nurse leader implications. *Nursing Economic$*, *22*(6), 313-319.

Sietsema, M., &Spradley, B. (1987).Ethics and administrative decision-making.*Journal of Nursing Administration*, *17*(4), 28-32.

Silva, M. (1998). Organizational and administrative ethics in health care: An ethics gap? *Online Journal of Issues in Nursing*,

Simms, L., Erbin-Roesemann, M., Darga, A., &Coeling, H. (1990). Breaking the burnout barrier: Resurrecting work excitement in nursing. *Nursing Economic$, 8*(3), 177-187.

Simpson, B., Skelton-Green, J., Scott, J., & O'Brien-Pallas, L. (2002). Building capacity in nursing: Creating a leadership institute. *Canadian Journal of Nursing Leadership*, *15*(3), 22-27.

Six, F. (2004).*Trust and trouble: Building interpersonal trust within organizations.* Retrieved November 4, 2004 from: http://hdl.handle.net/1765/1271

Skarlicki, D., & Dirks, K. (2002). Leader as a builder of trust. *HR.com June 28, 2002.* Retrieved May 28, 2004 from http://www.olin.wustl.edu/faculty/dirks/HRcom.pdf

Skelton Green, J. (1996). The perceived impact of committee participation on the job satisfaction of staff nurses. *Canadian Journal of Nursing Administration*, *9*(2), 7-35.

Skinner, C., & Spurgeon, P. (2005) Valuing empathy and emotional intelligence in health leadership: a study of empathy, leadership behaviour and outcome effectiveness. *Health Services Management Research, 18*(1)*,* 1-12.

Sleutel, M. (2000). Climate, culture, context, or work environment? Organizational factors that influence nursing practice. *Journal of Nursing Administration*, *30*(2), 53-58.

Snow, J. (2001). Looking beyond nursing for clues to effective leadership. *Journal of Nursing Administration*, *31*(9), 440-443

Snyderman, G. (1988). Leadership styles of head nurses and the job satisfaction of Registered Nurses and aides. (Doctoral dissertation, Temple University).

Song, B., Daly, B., Trudy, E., Douglas, S., & Dyer, M. (1997). Nurses job satisfaction, absenteeism and turnover after implementing a special care unit model. *Research in Nursing and Health*, *20*, 443-452.

Sovie, M., &Jawad, A. (2001).Hospital restructuring and its impact on outcomes.*Journal of Nursing Administration, 31*(12), 588–600.

Splane, R., &Splane, V. (1994).*Chief nursing officer positions in national ministries of health. Focal points for nursing leadership*. San Francisco, CA: University of California School of Nursing.

Spreitzer, G. (1995). Psychological empowerment in the workplace: Dimensions, measurement and validation. *Academy of Management Journal*, 38, 1442-65.

Squires A. (2004). A dimensional analysis of role enactment of acute care nurses. *Journal of Nursing Scholarship*, *3(36) 272-278.*

Srivastava, R. (2005) *Presentation: Culturally Competent Leadership Practices: The good, the bad, and the Uncertain*. Canadian Nurses Association, Nursing Leadership Conference, The Changing Face of Nursing Leadership: Diversity, Partnerships, Innovations. Ottawa, Ontario.

Stamps, P., &Piedmonte, E. (1986).*Nurses and work satisfaction: An index for measurement.* Ann Arbor, MI: Health Administration Press Perspectives.

Stanhope, M., & Lancaster, J. (2000).*Community and public health nursing*. St. Louis: Mosby.

Stogdill, R. (1963). *Manual for the leader behavior description questionnaire – Form XII*. Columbus: Ohio State University, Bureau of Business Research.

Stone, R., Reinhard, S., Bowers, B., Zimmerman, D., Phillips, C., Hawes, et al. (2002).*Evaluation of the Wellspring model for improving nursing home quality*.The Commonwealth Fund.

Storch, J., Rodney, P., Pauly, B., Brown, H., &Starzomski, R. (2002). Listening to nurses' moral voices: Building a quality health care environment. *Canadian Journal of Nursing Leadership*, *15*(4), 7-16.

Stordeur, S., Vandenbergeh, C. &D'hoore, W. (2000). Leadership styles across hierarchical levels in nursing departments. *Nursing Research, 49*(1), 37-43.

Storr L. (2004). Leading with integrity: a qualitative research study. *Journal of Health Organization & Management, 18*, 415-34.

Strader, M., & Decker, P. (1995).*Role transition to patient care management.*Norwalk, CT: Appleton and Lange.

Strasen, L. (1992). *The image of professional nursing: Strategies for action*. Philadelphia, PA: Lippincott.

Strebel, P. (1996). Why do employees resist change? *Harvard Business Review, 74*, 86-92.

Sullivan, J., Bretschneider, J., & McCausland, M. (2003). Designing a leadership development program for nurse managers: An evidence-driven approach. *Journal of Nursing Administration*, *33*(10), 55-549.

Suominen, T., Savikko, N., Puukka, P., Doran, D.I., & Leino-Kilpi, H. (2005). Work empowerment as experienced by head nurses. *Journal of Nursing Management*,*13,* 147-53.

Tagnesi, K., Dumont, C., Rawlinson, C., & Byrd, H., III (2009). The CNO: challenges and opportunities on the journey to excellence. *Nursing Administration Quarterly, 33*(2)*,* 159-167.

Taunton, R., Boyle, D., Woods, C., Hansen, H., &Bott, M. (1997). Manager leadership and retention of hospital staff nurses. *Western Journal of Nursing Research*,*19*(2), 205-226.

Taylor, A., Sylvestre, J., &Botschner, J. (1998). Social support is something you do, not something you provide: Implications for linking formal and informal support. *Journal of Leisurability*, 25(4). Retrieved March 3, 2005 from: www.lin.ca/resource/html/Vol25/v25n4a2.htm

The Ottawa Hospital Management Work-Group. (2003). *The Ottawa Hospital model of nursing clinical practice: Clinical management span of control decision-making indicators.* Unpublished work. The Ottawa Hospital, Ottawa, ON.

Thompson, J., &Bunderson, J. (2003). Violations of principle: Ideological currency in the psychological contract. *Academy of Management Review, 28*(4), 571-587.

Thomson, D. Dunleavy, J., & Bruce, S. (2002). *Nurse Job Satisfaction – Factors Relating to Nurse Satisfaction in the Workplace*. Report commissioned for the Canadian Nursing Advisory Committee, Ottawa, ON.

Titchen, A. (2000). Professional craft knowledge in patient-centred nursing and the facilitation of its development. (Doctoral dissertation, University of Oxford)

Tomblin Murphy, G., O'Brien-Pallas, L., Alksnis, C., Birch, S., Kephart, G., Pennock, M., et al.. (2003). *Health human resources planning: An examination of relationships among nursing service utilization, an estimate of population health and overall health status outcomes in the province of Ontario*. Executive summary. Retrieved on June 1, 2005 from: www.chsrf.ca/final_research/ogc/pdf/tomblin_e.pdf

Tomey, A. M. (2009). Nursing leadership and management effects work environments. *Journal of Nursing Management, 17*(1)*,* 15-25.

Tourangeau, A., Giovannetti, P., Tu, J., & Wood, M. (2002). Nursing-related determinants of 30-day mortality for hospitalized patients. *Canadian Journal of Nursing Research*, 33(4), 71-88.

Tourangeau, A., Lemonde, M., Luba, M., Dakers, D., & Alksnis, C. (2003).Evaluation of a leadership development intervention.*Canadian Journal of Nursing Leadership*, *16*(3), 91-104.

Traynor, M., & Wade, B. (1993). The development of a measure of job satisfaction for use in monitoring the morale of community nurses in four trusts. *Journal of Advanced Nursing*, *18,* 127-136.

Tucker Scott, K . (2004). *Nurses of influence: A paradigm of leadership*. (Doctoral dissertation, University of Toronto).

Tucker, A., & Edmondson, A. (2003). Why hospitals don't learn from failures: Organizational and psychological dynamics that inhibit system change. *California Management Review*, *45*(2), 1-18.

Udod, S., & Care, W. (2004). Setting the climate for evidence-based nursing practice: What is the leader's role? *Canadian Journal of Nursing Leadership*, *17*(4), 64-75.

United States Agency for Health care Research and Quality [USAHRQ]. (2003). *The effect of health care working conditions on patient safety.* Summary, evidence report /technology assessment. Number 74. Rockville, MD

University of Texas Repository of Nursing Administration Instruments. (n.d). Retrieved from http://www.sph.uth.tmc.edu/eriksen/

Upenieks, V. (2000).The relationship of nursing practice models and job satisfaction outcomes.*Journal of Nursing Administration*, *30*(6), 330-335.

Upenieks, V. (2002a). What constitutes successful nurse leadership? A qualitative approach utilizing Kanter's theory of organizational behaviour. *Journal of Nursing Administration*, *32*(12), 622-632.

Upenieks, V. (2002b). The interrelationship between and meaning of power and opportunity, nursing leadership, organizational characteristics of magnet Institutions and clinical nurse job satisfaction. (Doctoral dissertation, University of Washington).

Upenieks, V. (2002c). Assessing differences in job satisfaction of nurses in magnet and nonmagnetic hospitals. *Journal of Nursing Administration*, *32*(11), 564-576.

Upenieks, V. (2003a). What constitutes effective leadership? *Journal of Nursing Administration*, *33*(9), 456-467.

Upenieks, V. (2003b).The interrelationship of organizational characteristics of magnet hospitals, nursing leadership and nursing job satisfaction. *Health Care Manager*, *22*(2), 83-98.

Upenieks, V. (2003c).Nurse leaders' perceptions of what compromises successful leadership in today's acute inpatient environment.*Nursing Administration Quarterly*, *27*(2), 140-152.

Upshur R. (1997). Certainty, probability and abduction: why we should look to C.S. Pierce rather than Godel for a theory of clinical reasoning? *Journal of Evaluation in Clinical Practice, 3,* 201-206.

Urwick, L. (1956). The manager's span of control. *Harvard Business Review*, *3*, 39-47.

Villarruel, A.M., &Peragallo N. (2004). Leadership development of Hispanic nurses. *Nursing Administration Quarterly*, *3*(28), 173-80.

Vitello-Cicciu, J. (2003). Innovative leadership through emotional intelligence.*Nursing Management*, *34*(10), 28-32.

Volk, M., & Lucas, M. (1991).Relationship of management style and anticipated turnover. *Dimensions of Critical Care Nursing*, *10*(1), 35-40.

Waite, P., & Richardson, G. (2004). Determining the efficacy of resiliency training in the work site. *Journal of Allied Health*, *33*(3), 178-183.

Wallach, E. (1983). Individuals and organizations: The cultural match. *Training and Development Journal*, *37*, 29-36.

Walsh, C., & Clements C. (1995).Attributes of mentors as perceived by orthopaedic nurses.*Orthopaedic Nursing*, *14*(3), 49-56.

Walshe, K., &Rundall, T. (2001). Evidence-based management: From theory to practice in health care. *The Millbank Quarterly*, *79*(3), 429-458.

Walston, S., & Kimberly, J. (1997). Reengineering hospitals: Experience and analysis from the field. *Hospital and Health Services Administration, 42*(2), 143-63.

Ward, K. (2002). A vision for tomorrow: Transformational nursing leaders. *Nursing Outlook, 50*(3), 121-126.

Weberg, D. (2010). Transformational leadership and staff retention: An evidence review with implications for healthcare systems. *Nursing Administration Quarterly, 34*(3), 246-258.

Webster, G., &Baylis, F. (2000). *Moral residue*. In: Rubin, S.R., Zoloth, L. (Eds.), *Margin of error: The ethics of mistakes in the practice of medicine*. Hagerstown, MD: University Publishing Group.

Weiss, D., Dawis, R., England, G., &Lofquist, L. (1997). *Manual for the Minnesota Satisfaction Questionnaire*. Industrial Relations Center, University of Minnesota, 1967.

Wesorick, B. Shyiparski, L., Troseth, M., Wyngarden, K. (1998). *Council Field Book: Strategies and Tools for co-creating a healthy workplace.* Grand Rapids: Practice Field Pub.

Wesorick, B.T., &Shiparski, L. (1997). *Can the Human being thrive in the work place? Dialogue as a strategy of hope.* Grand Rapids: Practice Field Pub.

Wheatley, M. (2002). *Turning to one another: Simple conversations to restore hope to the future*. San Francisco, CA: Berrett-Koehler Publishers.

White, B. (2000). Moral leadership of nurse executives.(Doctoral dissertation, University of Northern Colorado).

Whyte, H. (1995). Staff Nurse Empowerment and Job Satisfaction. (Master's thesis, University of Western Ontario).

Wieck, K., Prydun, M., & Walsh, T. (2002). What the emerging workforce wants in its leaders. *Journal of Nursing Scholarship, 34*(3), 283-288.

Wilson, B., &Laschinger, H. (1994). Staff nurse perception of job empowerment and organizational commitment: A test of Kanter's theory of structural power in organizations. *Journal of Nursing Administration*, *24*(4S), 39-47.

Wolf, M. (1996). Changes in leadership styles. *Journal of Continuing Education in Nursing*, *27*, 245-252.

Wong, C. et al. (2012). Part 2: Nurses' career aspirations to management roles: Qualitative findings from a national study of Canadian nurses. *Journal of Nursing Management, 21*, 231-241.

Wong, C. A. & Cummings, G. G. (2007). The relationship between nursing leadership and patient outcomes: a systematic review. *Journal of Nursing Management, 15*(5), 508-521.

Wood-Allen, D. (1998). How nurses become leaders: Perceptions and beliefs about leadership development. *Journal of Nursing Administration*, *28*(9), 15-20.

Woodham-Smith, C. (1951). *Florence Nightingale, 1820-1910.* New York: McGraw-Hill Book Co.

Yang, K. (2003). Relationships between nurse staffing and patient outcomes. *Journal of Nursing Research, 11*(3), 149–58.

Zammuto, R., & Krakower, J. (1991). *Quantitative and qualitative studies of organizational culture, Volume 5*. Greenwich, CT: JAI Press.

Appendix A: Implementation strategies

Guideline implementation at the point-of-care is multifaceted and challenging at all levels. The uptake of knowledge in any practice setting requires more than the awareness and distribution of guidelines. Application of the guideline in any practice setting requires adaptation for the local context. Adaptation must be systematic and participatory to ensure recommendations are customized to fit the local context (Straus, Tetroe, & Graham 2009). The Registered Nurses' Association of Ontario recommends the use of the *Toolkit: Implementation of Best Practice Guidelines (2nd ed.)*(RNAO, 2012b),which provides an evidenced-informed process for a systematic, well-planned implementation.

The *Toolkit* is based on emerging evidence that the likelihood of achieving successful uptake of best practice in health care increases when:

- Leaders at all levels are committed to support facilitation of guideline implementation
- Guidelines are selected for implementation through a systematic, participatory process
- Stakeholders relevant to the focus of the guideline are identified, and engaged in the implementation process
- An environmental readiness assessment for implementation is conducted for its impact on guideline uptake
- The guideline is tailored to the local context
- Barriers and facilitators to use of the guideline are assessed and addressed
- Interventions are selected that promote guideline use
- Guideline use is systematically monitored and sustained
- Evaluation of the impacts of guideline use is embedded into the process
- There are adequate resources to complete the activities related to all aspects of guideline implementation

The *Toolkit* uses the knowledge-to-action model thatdepicts the process of choosing a guideline in the centre triangle, and follows a detailed step-by-step direction for implementing guideline recommendations at the local level. These steps are illustrated in Figure 3: "Knowledge to Action" framework (RNAO, 2012b; Straus et al., 2009).

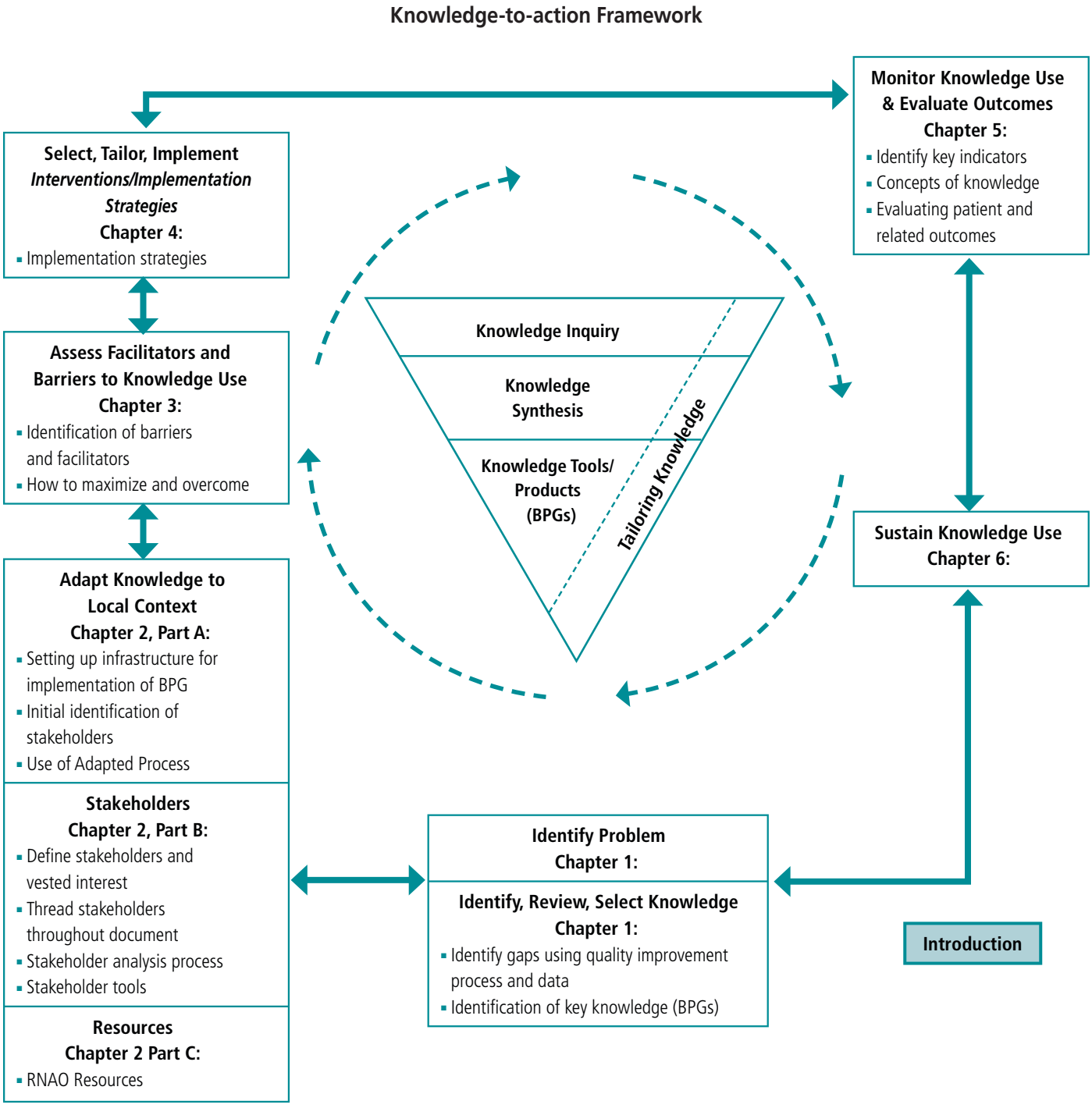

Figure 3. Revised Knowledge-to-Action Framework

Note. Adapted from "Knowledge Translation in Health Care: moving from Evidence to Practice," S. Straus, J. Tetroe, and I. Graham, 2009. Copyright 2009 by the Blackwell Publishing Ltd.

A full version of the *Toolkit: Implementation of Best Practice Guidelines (2nd ed.)* is available in PDF format at the RNAO website, http://rnao.ca/bpg.

In addition, RNAO is committed to widespread deployment and implementation of the guidelines and utilizes a coordinated approach to dissemination incorporating a variety of strategies. Guideline implementation is facilitated through RNAO specific initiatives that include the Nursing Best Practice Champion Network*, which serves to develop the capacity of individual nurses and foster awareness, engagement and adoption of BPGs; and the Best Practice Spotlight Organization* (BPSO*) Designation that supports BPG implementation at the organizational and system levels. BPSOs focus on developing evidence-based cultures with the specific mandate to implement, evaluate and sustain multiple RNAO clinical practice BPGs. In addition to these strategies, capacity-building learning institutes related to specific BPGs and their implementations are held annually." (RNAO, 2012b, p. 19-20).

Further information about each of these implementation strategies can be found at:

- RNAO Best Practice Champions Network : http://rnao.ca/bpg/get-involved/champions
- RNAO Best Practice Spotlight Organizations: http://rnao.ca/bpg/bpso
- RNAO capacity-building learning institutes and other professional development opportunities: http://rnao.ca/events

Appendix B: Measures Of Concepts Related To 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 (2005) chose to include only those instruments for the measurement of leadership behaviour that had been used in nursing research. This decision was based on the work of Leatt and Porter who contend health care has unique qualities that produce environments different from other industries. They further reported 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. (2000) 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 et al. (2000), Patrick and White (2005),and the University of Texas Repository of Nursing Administration Instruments (n.d.) 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 (1992)
Leader behaviour	Leadership Behaviour Description Questionnaire	Stogdill (1963)
Leadership style	LEAD	Hersey & Blanchard (1988)
Leader behaviour and actions	Leadership Practices Inventory – Self, Observer	Kouzes& Posner (1988)
Leader behaviour/style	Multifactor Leadership Questionnaire	Bass & Avolio (1990)
Leader behaviour/style	Multifactor Leadership Questionnaire – 5X	Bass (1995)
Self-perceived behaviour	Nurse Practitioner Leadership Questionnaire	Jones, Soeken & Guberski (1986)
Supportive behaviour in long-term-care	Supportive Leadership Styles – Charge Nurse Support Scale and Unit Manager Support Scale	McGilton (2003)
Staff nurse leadership performance	Six Dimension (6-D) Scale of Nursing Performance	Schwirian (1978)
Communication		
Nurses' perceptions of communication	Communication Assessment Questionnaire	Farley (1989)
Nurses' satisfaction with communication	Communication Satisfaction Questionnaire	Pincus (1986)
Perceived and ideal status of communication	ICA Communication Audit	Goldhaber& Rogers (1979)
Communication factors	Organization Communication Scale	Roberts & O'Reilly (1974)
Distributive justice/fairness – extent to which individuals perceive rewards	Distributive Justice Index	Price & Mueller (1986)
Trust		
Trust of peers and managers	Interpersonal Trust at Work Scale	Cook & Wall (1980)
Empowerment		
Nurses' perceptions of workplace empowerment	Conditions for Work Effectiveness Questionnaire I	Chandler (1986)
Nurses' perceptions of workplace empowerment	Conditions for Work Effectiveness Questionnaire II	Laschinger (2004); Laschinger (2001b)
Nurses' perceptions of power in the work environment	Job Activities Scale	Laschinger (1996; 2004)
Nurses' perceptions of leader's empowering behaviour	Leader Empowering Behaviour Scale	Hui (1994)

CONCEPT	INSTRUMENT	AUTHOR
Nurses' perceptions of informal power in the work environment	Organizational Relationships Scale	Laschinger (1996; 2004)
Nurses' perceptions of power	Job Activities Scale	Laschinger (2004)
Nursing Autonomy		
Meaningful work, competence, autonomy and impact	Psychological Empowerment Scale	Spreitzer (1995)
Attitudes and behaviour of students	Autonomy: the Care Perspective Instrument	Boughn (1995)
Nurses' perceptions of current and ideal autonomy/authority	Authority in Nursing Roles Inventory	Katzman (1989)
Nurses' perceptions of autonomy	Clinical Autonomy Ranked Category Scale	Kramer & Schmalenberg (2003)
Professional autonomy	Dempster Practice Behaviour Scale	Dempster (1991)
Professional autonomy	Nursing Activity Scale	Schutzenhofer (1988)
Nurses' perceptions of autonomy/authority	Nursing Authority and Autonomy Scale	Blanchfield& Biordi (1996)
Decision involvement	Decisional Involvement Scale	Havens & Vasey (2003)
Meaning of professional autonomy	Maas and Jacox Semantic Differential	Maas & Jacox (1977)
Meaning of professional autonomy	Maas and Jacox Concept Interview	Maas & Jacox (1977)
Autonomy in care/unit activities	Staff Nurse Autonomy Questionnaire	Blegen et al. (1993)
Control over practice	Nursing Work Index -R	Aiken & Patrician (2000)
Optimizing Competing Values & Priorities		
Moral distress	Moral Distress Scale	Corley et al. (2001)
Decision-making/risk taking	Patient/client Care Administration Ethics Survey	Sietsema& Spradley (1987)
Organizational Supports		
Organizational Culture and Climate		
Type of climate (e.g., risk taking, challenge)	Creative Climate Questionnaire	Ekvall et al. (1983)
Organizational and personal values	Harrison's Organizational Ideology Questionnaire	Harrison (1992)
Organizational climate (e.g., reward, risk, support)	Litwin and Stringer Organizational Climate Questionnaire	Litwin& Stringer (1968)
Organizational climate (e.g., support, innovation	Modified Litwin and Stringer Organizational Climate Questionnaire	Mok& Au-Yeung (2002)
Organizational climate	Nurse Organizational Climate Description Questionnaire	Duxbury et al. (1982)
Organizational culture/job satisfaction	Nursing Assessment Survey	Maehr& Braskamp (1986)
Organizational culture/style	Competing Values Framework Survey	Zammuto& Krakower (1991)
Unit professional culture	Nursing Unit Cultural Assessment Tool 3	Coeling& Simms (1993)
Bureaucracy, Innovation & Support	Organizational Climate Inventory	Wallach (1983)

CONCEPT	INSTRUMENT	AUTHOR
Organizational culture/thinking styles	Organizational Culture Inventory	Cooke & Lafferty (1987)
Nurses' perceptions of job characteristics/ work environment	Work Characteristics/Excitement Instrument	Simms, Erbin-Roesemann, Darga& Coeling (1990)
Professional Practice Environment		
	Nursing Work Index (R)	Aiken & Patrician (2000)
	Practice Environment Scale of NWI	Lake (2002)
	Professional Practice Environment Scale	Erickson et al. (2004)
	Canadian Practice Environment Index	Estabrooks et al. (2002)
	Perceived Nursing Work Environment	Choi et al. (2004)
Span of Control		
	The Ottawa Hospital Model of Nursing Clinical Practice Clinical Management Span of Control decision-making Indicators	The Ottawa Hospital (2003)
Personal Resources		
Emotional Intelligence		
360 feedback instrument	Emotional Competence Inventory	Goleman (1998)
Self-report assessment of personal qualities	Bar-On Emotional Quotient Inventory	Bar-On (1987)
Test of EI ability	Multifactor Emotional Intelligence Scale	Mayer, Caruso& Salovey (1998)
OUTCOMES		
Burnout		
	Maslach Burnout Inventory	Maslach& Jackson (1986)
Job Satisfaction		
	The Daphne Heald Research Unit Measure of Job Satisfaction	Traynor& Wade (1993)
	Index of Work Satisfaction	Stamps & Piedmonte (1982)
	McCloskey/Mueller Satisfaction Scare	Mueller & McCloskey (1990)
	Minnesota Satisfaction Questionnaire	Weiss, Dawis, England & Lofquist (1997)
	Nurse Job Satisfaction Scale	Hinshaw& Atwood(1983-1985)
	Work Satisfaction Scale	Hinshaw& Atwood(1983-1985)

CONCEPT	INSTRUMENT	AUTHOR
Motivation/Job Involvement		
	Motivation Tool - Kanungo	Kanungo (1982)
Organizational Commitment		
	Organizational Commitment Questionnaire	Porter et al. (1974)
Turnover		
	Anticipated Turnover Scale	Hinshaw& Atwood (1980)
Patient Satisfaction		
	Satisfaction with Nursing Care Questionnaire	Eriksen (1988)


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Staff Appreciation Board
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Appendix C: RNAO Framework and LEADS Framework Comparison

RNAO Framework	LEADS Framework
Organizational Supports ■ Valuing of Professional Nursing ■ Human/Financial Resources ■ Information/Decision Support	
Personal Resources ■ Professional Identity ■ Individual Attributes ■ Leadership Expertise ■ Social Supports	**Lead Self** ■ Are Self Aware ■ Manage Themselves ■ Develops Themselves ■ Demonstrates Character
Transformational Leadership Practices	
Build relationships and trust	**Engage Others** ■ Foster development of others ■ Communicates Effectively ■ Build Teams* **Develop Coalitions** ■ Purposefully builds partnerships and networks to create results*
Creates empowering work environment **Create a culture that supports knowledge development and integration**	**Engage Others** ■ Contribute to the Creation of Healthy Organizations **Develop Coalitions** ■ Mobilize Knowledge **System Transformation** ■ Encourage and Support Innovation
Leading and sustaining change	**Achieve Results** ■ Set Direction **System Transformation** ■ Champion and Orchestrate Change
Transformational Leadership Practices	

RNAO Framework	LEADS Framework
Balancing competing values and priorities	**Achieve Results** ■ Strategically Align Decisions with Vision, Values and Evidence ■ Take Action to Implement Decisions **Develop Coalitions** ■ Navigate Socio-Political Environments **System Transformation** ■ Demonstrates systems/Critical thinking* ■ Orient themselves strategically to the future
Healthy Outcomes **Nurse, Patient/Client, Organization, System**	**Achieve Results** ■ Assess and Evaluate **Develop Coalitions** ■ Demonstrate aCommitment toCustomers andService

Appendix D: Process For Systematic Review Of The Literature On Developing And Sustaining Nursing Leadership, 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, and 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. 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, were included in the review. The majority of papers was 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, professional development, positive behaviour and qualities, and the need for a supportive environment.[52]


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Appendix E: Glossary

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 (Cooperrider & Srivastva, 1987).

Benchmark: A standard, by which something can be measured, compared or judged. Benchmarking involves measuring another organization or person's product or service by specific standards and comparing it with one's own product or service (Michigan Hospitals, 2004).

Chief nursing executive: The senior nurse employed by the organization that reports directly to the administrator and is responsible for nursing services provided (Public Hospitals Act (1990).

Collaboration: Stanhope and Lancaster (2000) 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 believe she 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. Performance is usually measured against benchmarks or industry standards and this information is applied to improve 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 behaviour required to achieve leadership practices.

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.

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 (Mayer & Salovey, 1997) and is thought to contribute to workplace success (Emmerling & Goleman, 2003).

Empowerment: The ability to mobilize human and material resources to get things done (Kanter, 1979). It is a process through which stakeholders influence and share control over development initiatives, and the decisions and resources which affect them.

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.

Ethno-cultural identity: The connection and interplay between ethnicity, culture and identity. It refers to the unique characteristics that distinguish us as individuals and identify us as belonging to a group (RNAO, 2006).

Fairness: The ability to make judgments free from discrimination or dishonesty (Definitions of Fairness, 2005).

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 (Field & Lohr, 1990).

Individual characteristics: Innate traits of individuals that will influence their evaluation of themselves, their environment and their capabilities, and consequently their behaviour (Rothmann& Coetzee, 2003).

Integrity: The perception that the trustee adheres to a set of principles the trustor finds acceptable (Mayer et al., 1995) or does what they said they would do (Skarlicki& Dirks, 2002).

Knowledge: Nursing practice is informed by various ways of knowing (Carper, 1978). 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 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 (Carper, 1978).

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, they are a characteristic way of being or behaviour that distinguishes a successful nurse leader.

Magnet hospital: A label originally given to hospitals in the United States in the early 1980s that was 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 (Bliss-Holtz et al., 2004; Scott, et. al., 1999).

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 (Clarke & Oxman, 1999).

Nurses: Refers to registered nurses, licensed practical nurses (referred to as registered practical nurses in Ontario), and registered psychiatric nurses and nurses in advanced practice roles such as nurse practitioners and clinical nurse specialists.

Nursing Leadership: Leadership grounded or situated in nursing (Ferguson-Paré et al., 2002).

Organizational climate: Social, organizational, or situational influence on behaviour, reflected in overall performance or policies, practices and goals; how thing are done (Sleutel, 2000); the aspects perceived as important by individual organization members (McGillis Hall, 2004).

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 (CNO, 2002; Registered Nurses Association of Nova Scotia, 2003).

Point-of-care Leadership: occurs within a setting where accountability for care of a specific patient/client or group of clients is led by point-of-care health-care providers (also known as front-line or bedside health-care providers) through the incorporation and application of research-based information. Care for the patient/client is designed, implemented supervised, and evaluated via the patients'/clients' plan of care. This plan of care is coordinated and shared among the interprofessional health care team, including regulated, and un-regulated health professionals. (American Association of College of Nursing, 2007).

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 (Houghton Mifflin Company, 2004). The extent to which the individual ascribes to the values and beliefs of the profession (Houghton Mifflin Company, 1995).

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: a nurse learning experience aimed at enhancing nursing skills in: leadership, clinical, and best-practice-guideline implementation with the primary goal of improving patient care and outcomes in Ontario. With support from the Nurse Fellows 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 behaviour: Examples of specific actions of individuals that demonstrate core competencies.

Social supports: Social support refers to the transactions that occur in a person's social network that involve providing encouragement, sympathy, appreciation, or otherwise interacting with people in ways that support them emotionally (Haines, 1993).

Span of control: Number of persons who report directly to a single manager, supervisor, or leader and relate to the number of people not the number of full-time equivalent positions (Tourangeau et al., 2003).

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 (Baker et al., 1999). 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 (Ontario Public Health Association, 1996).

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 (CNA, 2003).

System recommendations: Statements of conditions required to enable the successful implementation of the best practice guideline throughout 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 (National Health and Medical Research Council, 1998). 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 (Clarke & Oxman, 1999).

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.

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 (Burns, 1978). Transformational Leadership occurs where the leader takes a visionary position and inspires people to follow.

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.

Appendix F: 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 took these steps in developing this 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 in 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 D** 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 G: Description of the toolkit

BPGs can only be successfully implemented if there are adequate planning, resources, organizational and administrative supports and appropriate facilitation.In this light, the Registered Nurses' Association of Ontario, through a panel of nurses, researchers and administrators, has developed the *Toolkit: Implementation of Best Practice Guidelines (2nd ed.)*(2012b). The *Toolkit* is based on available evidence, theoretical perspectives and consensus. The *Toolkit* is recommended for guiding the implementation of any clinical practice guideline in a health-care organization.

The *Toolkit* provides step-by-step directions to individuals and groups involved in planning, coordinating and facilitating the guideline implementation. These steps reflect a process that is dynamic and iterative rather than linear. Therefore, at each phase preparation for the next phases and reflection on the previous phase is essential. Specifically, the *Toolkit* addresses the following key steps, as illustrated in the "Knowledge to Action" framework (RNAO, 2012b; Straus et al., 2009) in implementing a guideline:

1. Identify problem:identify, review, select knowledge (Best Practice Guideline).
2. Adapt knowledge to local context:
   - Assess barriers and facilitators to knowledge use; and
   - Identify resources.
3. Select, tailor and implement interventions.
4. Monitor knowledge use.
5. Evaluate outcomes.
6. Sustain knowledge use.

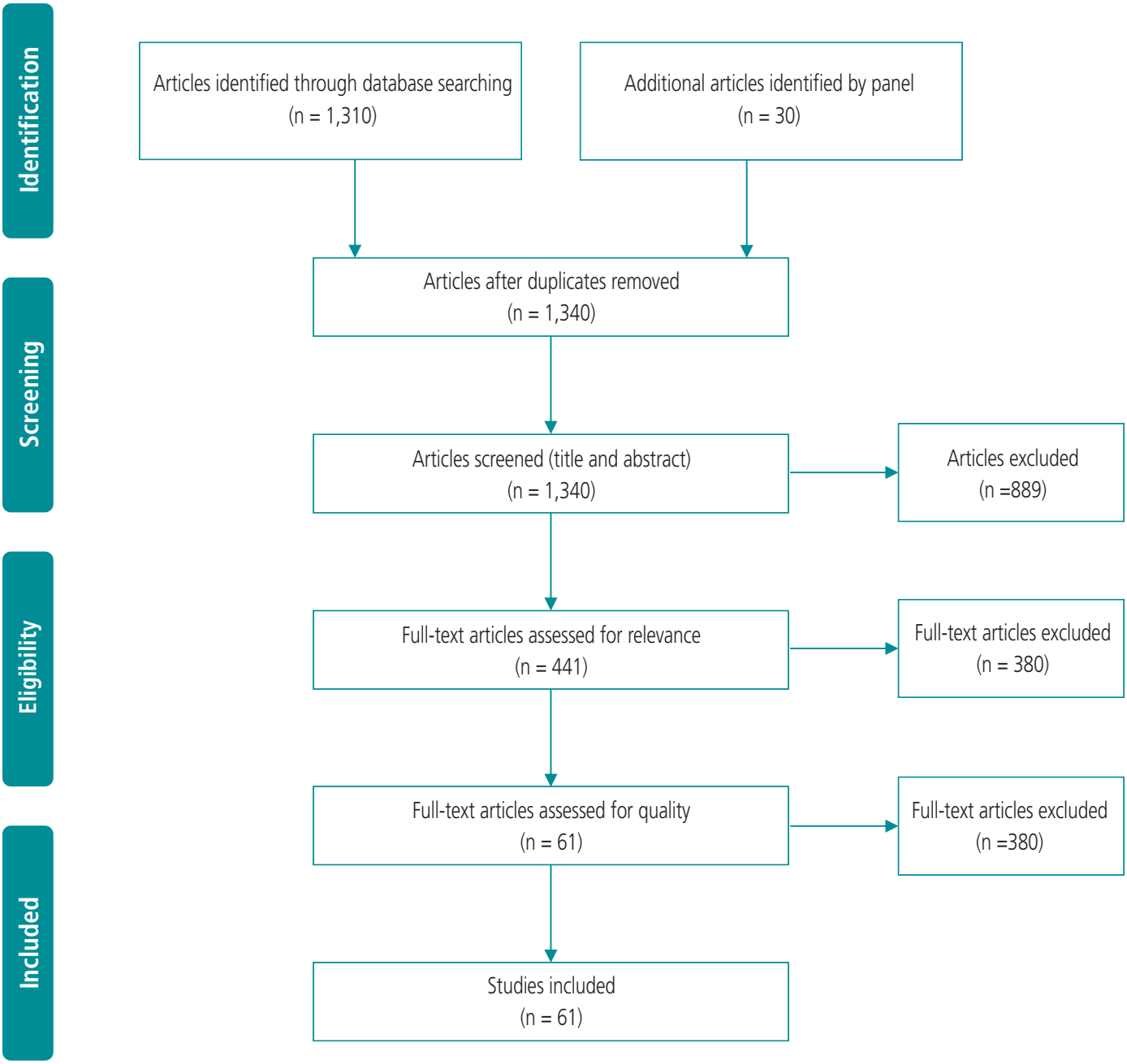
Implementing guidelines in practice that result in successful practice changes and positive clinical impact is a complex undertaking. The *Toolkit* is one key resource for managing this process. The *Toolkit* can be downloaded at http://rnao.ca/bpg.

Leadership is a shared responsibility. Nurses in all domains of practice and at all levels must maximize their leadership potential.

~ Canadian Nurses Association

Appendix H: Article Review Process Flow Diagram

Flow diagram adapted from D. Moher, A. Liberati, J. Tetzlaff, D.G. Altman, & The PRISMA Group (2009). Preferred Reporting Items for Systematic Reviews and Meta-Analyses: The PRISMA Statement. *BMJ 339,* b2535, doi: 10.1136/bmj.b2535



Healthy Work Environment Best Practice Guidelines

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